DRAFT - NOT FOR FILING

4123-6-33 Payment for health and behavior assessment and intervention services.

This rule governs the bureau's reimbursement for health and behavior assessment and intervention (HBAI) services offered to injured workers who may benefit from an assessment that focuses on identifying behavioral barriers impeding the injured worker's recovery which may be addressed through intervention services.

(A) An injured worker shall be eligible for consideration of health and behavior assessment and intervention services if the injured worker has the capacity to understand and respond meaningfully during the health and behavior assessment process and:

(1) The injured worker's physician of record determines:

(a) The injured worker is not progressing with their injury after the initial course of treatment; and

(b) The injured worker's healing appears to be delayed due to behavioral barriers~~.~~; or

(2) ~~The injured worker has the capacity to understand and respond meaningfully during the face-to-face encounter.~~ The injured worker is being evaluated by the physician of record, treating physician or operating surgeon for lumbar fusion surgery pursuant to rule 4123-6-32 of the Administrative Code.

References in this rule to "physician of record" shall also include the "treating physician or operating surgeon" with regard to HBAI services requested or performed in connection with lumbar fusion surgery pursuant to rule 4123-6-32 of the Administrative Code.

(B) Providers must indicate the appropriate "International Classification of Diseases, clinical modification" codes for the injured worker's allowed physical condition(s) being treated, and must utilize 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 services being requested:

(1) Provider types who are eligible to bill evaluation and management codes must utilize evaluation and management codes when billing for HBAI services;

(2) Provider types who are not eligible to bill evaluation and management codes must utilize the applicable HBAI service codes when billing for HBAI services;

(3) HBAI services must be directed toward, and billed with, the injured worker's allowed physical condition(s);

(4) The bureau of workers' compensation shall not reimburse any HBAI services rendered to diagnose or treat psychological conditions, as the focus of these services is not on mental health but on factors impacting the prevention, treatment, or management of physical health problems and treatments.

(C) Health and behavior assessment services.

(1) The physician of record requesting a health and behavior assessment must submit a medical treatment reimbursement request for the assessment (on form C-9 or equivalent) to the injured worker's MCO.

(2) The physician of record must document the following to support the request for the assessment:

(a) History of the industrial injury or occupational disease resulting in the allowed conditions in the

claim;

(b) Recognized behavioral barriers impeding the injured worker's recovery from the allowed conditions in the claim;

(c) Documentation of the initial course of treatment, including all treatment and diagnostic studies as of the date of the request, including all results;

(d) The assessment is not duplicative of other provider assessments.

(3) The health and behavior assessment may be performed by any provider whose professional scope of practice as defined under state law includes health and behavior assessment services.

(4) The provider conducting the health and behavior assessment must provide a written summary report to the physician of record indicating the findings of the assessment and appropriate recommendations for intervention services, if any. The report shall include at a minimum the following:

(a) History of the industrial injury or occupational disease resulting in the allowed conditions in the claim;

(b) Overview of treatment and diagnostic studies to date and results;

(c) Use of one or more currently accepted and validated screening tools;

(d) Assessment conclusions/findings including, at a minimum:

(i) Identification and/or validation of existence of behavioral barriers;

(ii) A statement as to whether the injured worker's healing or recovery progress from the allowed conditions is impeded by the identified behavioral barriers;

(iii) Recommendation of possible intervention services and goals to address the identified behavioral barriers; and

(iv) The expected duration of the recommended intervention services;

(e) Length of time of assessment.

(5) Except as otherwise provided in rule 4123-6-32 of the Administrative Code, only one health and behavior assessment per year may be approved for an injured worker.

(6) Health and behavior re-assessment services.

(a) One re-assessment per year may be approved for an injured worker who has undergone health and behavior intervention services.

(b) A ~~POR~~ physician of record requesting a re-assessment must:

(i) Submit a medical treatment reimbursement request for the reassessment (on form C-9 or equivalent) to the injured worker's MCO; and

(ii) Provide clear rationale for why a re-assessment is required, including new and changed circumstances in the injured worker's physical status.

(7) The provider conducting the health and behavior assessment or re-assessment of an injured worker may not provide health and behavior intervention services for the same injured worker.

(D) Health and behavior intervention services.

(1) After review of the assessment, the physician of record shall:

(a) Determine the medically necessary and appropriate health and behavior intervention services to be provided; and

(b) Submit a medical treatment reimbursement request for the services (on form C-9 or equivalent) to the injured worker's MCO.

(2) The health and behavior intervention services may be performed by any provider whose professional scope of practice as defined under state law includes health and behavior intervention services.

(3) Health and behavior intervention services are limited to coaching and counseling services that address the behavioral barriers identified or validated in the assessment.

(4) Documentation for each intervention encounter must include the following:

(a) Goals;

(b) Progress, or lack thereof, toward goals and objectives;

(c) Description of injured worker engagement; and

(d) Time in and time out.

(5) Health and behavior intervention services shall be limited to up to six hours per year. Additional intervention services may be approved during the year, if the physician of record provides documentation the additional services are medically necessary.

DRAFT - NOT FOR FILING

4123-6-32 Payment for lumbar fusion surgery.

Effective January 1, 2018, reimbursement for lumbar fusion surgery for treatment of allowed conditions in a claim resulting from an allowed industrial injury or occupational disease shall be limited to claims in which current best medical practices as implemented by this rule are followed.

This rule governs the bureau's reimbursement of lumbar fusion surgery to treat a work related injury or occupational disease. It is not meant to preclude, or substitute for, the surgeon's responsibility to exercise sound clinical judgment in light of current best medical practices when treating injured workers.

A provider's failure to comply with the requirements of this rule may constitute endangerment to the health and safety of injured workers, and claims involving lumbar fusion surgery not in compliance with this rule may be subject to peer review by the bureau of workers' compensation stakeholders' health care quality assurance advisory committee (HCQAAC) pursuant to rule 4123-6-22 of the Administrative Code or other peer review committee established by the bureau.

Medical treatment reimbursement requests (on form C-9 or equivalent) for lumbar fusion surgery are not subject to dismissal by the MCO pursuant to paragraph (F)(7) of rule 4123-6-16.2 of the Administrative Code.

(A) Prerequisites to consideration of lumbar fusion surgery.

~~Authorization~~ Except as otherwise provided in paragraph (A)(4) of this rule, authorization for lumbar fusion shall be considered only in cases in which the following criteria are met:

(1) Conservative care.

(a) ~~Except as otherwise provided in paragraph (A)(1)(c) of this rule, the~~ The injured worker must have had at least sixty days of conservative care for low back pain, with an emphasis on:

(i) Physical reconditioning;

(ii) Avoidance of opioids, when possible; and

(iii) Avoidance of provider catastrophizing the explanation of lumbar MRI findings.

(b) The injured worker's comprehensive conservative care plan may include, but is not limited to, one or more of the following:

(i) Relative rest/ice/heat;

(ii) Anti-inflammatories;

(iii) Pain management / physical medicine rehabilitation program;

(iv) Chiropractic / osteopathic treatment;

(v) Physical medicine treatment as set forth in rule 4123-6-30 of the Administrative Code;

(vi) Interventional spine procedures / injections.

~~(c)~~ (c) ~~The requirement of a trial of at least sixty days of conservative care prior to consideration of~~

~~lumbar fusion surgery may be waived with prior approval from the MCO in cases of:~~

~~(i)~~ (i) ~~Progressive functional neurological deficit;~~

~~(ii)~~ (ii) ~~Spinal fracture;~~

~~(iii)~~ (iii) ~~Tumor;~~

~~(iv)~~ (iv) ~~Infection;~~

~~(v)~~ (v) ~~Emergency / trauma care; and/or~~

~~(vi)~~ (vi) ~~Other catastrophic spinal pathology causally related to the injured worker's allowed conditions.~~

(2) The operating surgeon requesting authorization for lumbar fusion surgery must have personally evaluated the injured worker on at least two occasions prior to requesting authorization for lumbar fusion surgery.

(3) The injured worker must have undergone a comprehensive evaluation, coordinated by both the injured worker's physician of record or treating physician and the operating surgeon, in which all of the following have been documented:

(a) Utilization and correlation of all of the following tools:

(i) Visual analog scale (VAS);

(ii) Pain diagram;

(iii) Oswestry low back disability questionnaire.

(b) A comprehensive orthopedic / neurological examination, including documentation of all of the following categories:

(i) Gait;

(ii) Spine (deformities, range of motion, palpation);

(iii) Hips and sacroiliac joints;

(iv) Motor;

(v) Sensation;

(vi) Reflexes;

(vii) Upper motor neuron signs.

(c) Diagnostic testing.

(i) Lumbar X-rays (including flexion/extension views), lumbar MRI, or lumbar CT (with or without myelography) must be performed;

(ii) Electromyography (EMG) / nerve conduction study (NCS) may be performed if questions still remain during surgical planning.

(d) Discussion and consideration of opportunities for vocational rehabilitation.

(e) Review of current and previous medications taken.

(i) If opioid management is in process, review for best practices;

(ii) Consider impact of surgery on opioid load.

(f) Health behavioral assessment (pre-surgical).

Biopsychosocial factors that may affect treatment of the injured worker's allowed lumbar conditions are considered modifiable conditions that may change the need for surgery or improve surgical outcomes if appropriately addressed, and must be addressed if identified in the assessment. The health behavioral assessment and any identified interventions may be ordered by the injured worker's physician of record or treating physician, or the operating surgeon.

(g) Accounting and assessment of the following co-morbidities to stratify additional associated risks:

(i) Smoking;

(ii) Body mass index (BMI);

(iii) Diabetes;

(iv) Coronary artery disease;

(v) Peripheral vascular disease.

The co-morbidities indicated above are considered modifiable conditions that may improve surgical outcomes if appropriately addressed, and must be addressed if identified in the assessment.

(h) The injured worker~~,~~ and the physician of record, ~~or~~ the treating physician, ~~and~~ or the operating surgeon must have reviewed and signed the educational document, "What BWC Wants You to Know About Lumbar Fusion Surgery," attached as an appendix to this rule.

(4) The prerequisites to consideration of lumbar fusion surgery set forth in paragraphs (A)(1) to (A)(3) of this rule may be waived in cases of:

(a) Progressive functional neurological deficit;

(b) Spinal fracture;

(c) Tumor;

(d) Infection;

(e) Trauma care;

(f) Emergency as defined in rule 4123-6-01 of the Administrative Code; and/or

(g) Other catastrophic spinal pathology causally related to the injured worker's allowed conditions.

(B) Authorization for lumbar fusion surgery where the injured worker has no prior history of lumbar surgery.

(1) Authorization for lumbar fusion shall be considered in cases where the injured worker has no prior history of lumbar surgery only when the injured worker remains highly functionally impaired despite a trial of at least sixty days of conservative care as provided in paragraph (A)(1)(a) of this rule (unless waived ~~with prior approval by the MCO~~ pursuant to paragraph ~~(A)(1)(c)~~(A)(4) of this rule) and one or more of the following are present:

(a) Mechanical low back pain with instability of the lumbar segment and no history of lumbar surgery.

(b) Spondylolisthesis of twenty-five per cent or more with one or more of the following:

(i) Objective signs/symptoms of neurogenic claudication;

(ii) Objective signs/symptoms of unilateral or bilateral radiculopathy, which are corroborated by neurologic examination and by MRI or CT (with or without myelography);

(iii) Instability of the lumbar segment.

(c) Lumbar radiculopathy with stenosis and bilateral spondylolysis.

(d) Lumbar stenosis necessitating decompression in which facetectomy of greater than or equal to fifty per cent or more is required.

(e) Primary neurogenic claudication and/or radiculopathy associated with lumbar spinal stenosis in conjunction with spondylolisthesis or lateral translation of three mm or greater or bilateral pars defect.

(f) Degenerative disc disease (DDD) associated with significant instability of the lumbar segment.

(g) Spinal stenosis, disc herniation, or other neural compressive lesion requiring extensive, radical decompression with removal of greater than fifty per cent of total facet volume at the associated level.

The surgeon must document why the surgical lesion would require radical decompression through the pars interarticularis (critical stenosis, recurrent stenosis with extensive scarring, far lateral lesion).

(2) For purposes of this paragraph, instability of the lumbar segment is defined as at least four mm of anterior/posterior translation at L3-4 and L4-5, or five mm of translation at L5-S1, or eleven degrees greater end plate angular change at a single level, compared to an adjacent level.

(C) Request for lumbar fusion surgery where the injured worker has a history of prior lumbar surgery.

(1) If a trial of at least sixty days of conservative care as provided in paragraph (A)(1)(a) of this rule has failed to relieve symptoms (or has been waived ~~with prior approval by the MCO~~ pursuant to paragraph ~~(A)(1)(c)~~(A)(4) of this rule) and the injured worker has had a prior laminectomy, discectomy, or other decompressive procedure at the same level, lumbar fusion should be considered for approval only if the injured worker has one or more of the following:

(a) Mechanical (non-radicular) low back pain with instability at the same or adjacent levels.

(b) Mechanical (non-radicular) low back pain with pseudospondylolisthesis, rotational deformity, or other condition leading to a progressive, measureable deformity.

(c) Objective signs/symptoms compatible with neurogenic claudication or lumbar radiculopathy that is supported by EMG/NCS, lumbar MRI, or CT and detailed by a clinical neurological examination in the presence of instability of three mm lateral translation with at least two prior decompression surgeries at the same level.

(d) Evidence from post laminectomy structural study of either:

(i) One hundred per cent loss of facet surface area unilaterally; or

(ii) Fifty per cent combined loss of facet surface area bilaterally.

(e) Documented pseudoarthrosis or nonunion, with or without failed hardware, in the absence of other neural compressive lesion.

(2) For purposes of this paragraph, instability of the lumbar segment is defined as at least four mm of anterior/posterior translation at L3-4 and L4-5, or five mm of translation at L5-S1, or eleven degrees greater end plate angular change at a single level, compared to an adjacent level.

(D) Lumber fusion surgical after care.

~~Both the~~ The physician of record or treating physician ~~and the operating surgeon~~ must follow the injured worker until the injured worker has reached maximum medical improvement (MMI) for the allowed lumbar conditions.

The operating surgeon must follow the injured worker until the injured worker has reached a plateau relative to the lumbar fusion and the surgeon has determined no further surgical related treatment is medically necessary.

(1) In the first six months post-operatively, the injured worker must be seen by both the physician of record or treating physician and the operating surgeon at least every two months to monitor the injured worker's progress, rehabilitation needs, behavioral patterns or changes, and return to work willingness and/or status.

During this period, the physician of record or treating physician and the operating surgeon shall determine the following:

(a) Fusion status;

(b) Pain and functional status;

(c) MMI status of injured worker;

(d) Residual level of functional capacity;

(e) Appropriateness for vocational rehabilitation.

(2) From six months to one year post-operatively, if the injured worker continues to experience significant

functional impairment despite the lumbar fusion, the following actions are recommended:

(a) Pain and functional status (repeat VAS / pain diagram / Oswestry)

(b) Repeat baseline orthopedic / neurological examination;

(c) Repeat health behavioral assessment;

(d) Revisit appropriate diagnostic imaging.

(e) Coordinate with MCO to develop a plan of care / return to functional status.

DRAFT - NOT FOR FILING

4123-6-16.2 Medical treatment reimbursement requests.

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

The following provider types are eligible to submit medical treatment reimbursement requests to the MCO:

(1) A physician as defined in rule 4123-6-01 of the Administrative Code;

(2) The following non-physician practitioner types:

(a) Advanced practice nurses;

(b) Physician assistants;

(c) Physical therapists;

(d) Occupational therapists;

(e) Optometrists;

(f) Audiologists;

(g) Licensed independent social workers;

(h) Licensed professional clinical counselors.

(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 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 medical treatment

reimbursement requests shall be valid for no longer than six months unless the approval specifies a longer period.

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

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

(2) The request is not accompanied by supporting medical documentation that the submitting provider has 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 (through form C-9A or equivalent).

(3) The request duplicates a previous request that has been denied in a final administrative or judicial determination where the new request is not accompanied by supporting medical documentation of new and changed circumstances impacting treatment, and such evidence is not provided to the MCO upon request (through form C-9A or equivalent).

(4) The underlying claim has been settled, and the dates of service requested are on or after the effective date of the settlement. If the 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~~ Unless otherwise provided in this chapter of the Administrative Code, the MCO has requested from the submitting provider (through form C-9A or equivalent) supporting medical documentation necessary to the MCO's evaluation and determination, and such documentation is not provided to the MCO.

(8) A fee bill for the service was not submitted to the bureau or commission within the applicable time frame as set forth in rule 4123-3-23 of the Administrative Code.

(G) 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 dispute resolution pursuant to rule 4123-6-16 of the Administrative Code.