New/Revised/Updated Policies - Table of Contents

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I. POLICY PURPOSE:

The purpose of this policy is to ensure that the Bureau of Workers’ Compensation (BWC) provides direction for the billing of nursing home, residential care and assisted living facility services to Ohio’s injured workers.

II. APPLICABILITY

This policy applies to all parties involved in requesting, approving and reimbursing nursing home, residential care and assisted living facility services within the Ohio workers’ compensation system.

III. DEFINITIONS

There are no definitions in this policy.

IV. POLICY

A. Nursing Home Services
   1. Sub-acute facility and skilled nursing facility units within a hospital are enrolled separately as a Nursing Home.
   2. Nursing home services included in the all-inclusive per diem rate:
      a. Room and board;
      b. Laundry services;
      c. Activity programs;
      d. Maintenance therapy;
      e. Psychosocial services;
      f. Non-prescription medications;
      g. Personal hygiene supplies and services; and
      h. Equipment not used solely for the use of the injured worker.
   3. Billing and Reimbursement Requirements
      a. The nursing home may bill separately for physical, occupational and speech therapy using CPT® codes.
b. All bills, regardless of ownership, must be submitted to the MCO on the CMS-1500 using the appropriate all-inclusive per diem skilled nursing facility or intermediate level code.
c. In extenuating circumstances, when the injured worker’s condition requires services and supplies over and above those reimbursed using the skilled nursing or intermediate level per diem codes, the nursing home may negotiate an all-inclusive per diem rate with the MCO.
d. Often, skilled nursing facility bills, especially when the skilled nursing facility is located in a hospital, are submitted as transfers from an inpatient stay to the skilled nursing facility. If the initial inpatient bill has already been paid, the skilled nursing facility’s bill shall deny as a duplicate. The skilled nursing facility shall resubmit the charges on a CMS-1500 using the assigned provider number for the nursing home. If a hospital does not have a separate BWC provider number for its skilled nursing facility, it should contact BWC’s provider enrollment department at 1-800-644-6292.
e. Prescription medications shall be billed to BWC’s Pharmacy Benefits Manager by the pharmacy providing the medications.
f. Please refer to the Professional Provider Fee Schedule in effect on the date of service, for coding and reimbursement rates.
g. Current fee schedules are published on BWC’s website at https://www.bwc.ohio.gov/provider/services/agreement.asp.

B. Residential Care and Assisted Living Facilities
   1. The facility must detail services provided and billed for in the all-inclusive per diem rate in the medical documentation.
   2. Please refer to the Professional Provider Fee Schedule in effect on the date of service, for coding and reimbursement rates.
   3. Current fee schedules are published on BWC website at https://www.bwc.ohio.gov/provider/services/agreement.asp.
I. POLICY PURPOSE: GENERAL OVERVIEW

The purpose of this policy is to ensure that the Bureau of Workers’ Compensation (BWC) provides direction for the appropriate identification, provision of, and billing of health and behavior assessment/intervention (HBAI) services available to eligible injured workers (IW) who may benefit from an assessment that focuses on identifying behavioral barriers impeding the injured workers’ recovery which may be addressed through intervention services.

HBAI services are billed under code numbers 96150-96155, from the American Medical Association Common Procedural Terminology (CPT) manual. According to the CPT manual, these services focus “not on mental health but on biopsychosocial factors important to physical health problems and treatments.” A physical diagnosis (not psychological diagnosis) is required as the diagnosis treated and billed for under the HBAI service codes. Those conditions treated by HBAI do not qualify as mental health conditions. HBAI is limited to coaching and counseling for behavioral barriers that are negatively impacting an IW’s healing from a physical injury. These services are clearly distinguished in the CPT manual from psychological counseling (code numbers 90833-90838) and medical or chiropractic visits for physical conditions (code numbers 99211-99215). Use of HBAI services to diagnose or treat a psychological condition will not be reimbursed.

Although behavioral barriers may be present in mental health conditions, and mental health conditions may negatively impact physical recovery, they are two distinct and separate phenomena, and it is essential in HBAI to distinguish them. Emotional reactions are intrinsic to any injury, and in fact can be present in health or disease. These commonly include perceptions and expectations for recovery or disability, fear of re-injury, catastrophic thinking, and perceived injustice. The majority of injured workers recover fully without dedicated attention to these emotions. However, in some circumstances, they lead to behaviors which can negatively impact healing of the
physical injury, and so require additional coaching and counseling to achieve the goals of recovery.

Mental health conditions are distinctly diagnosed conditions, as individually defined in the International Classification of Diseases (ICD) manual, and often require medical management. Treatment of mental health conditions are not included in HBAI services, and are treated under separate psychological counseling and medical treatment codes as indicated above.

II. APPLICABILITY

This policy is in direct support of OAC 4123-6-33 and applies to all actions relevant to the request, approval and reimbursement of Health and Behavior Assessment and Intervention Services within the Ohio Workers’ Compensation System.

III. DEFINITIONS

Health and Behavior Assessment: This is a procedure used to identify the behavioral, emotional, cognitive, and social factors important to the prevention, treatment, and/or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.

Health and Behavior Intervention: These services are focused on improving the patient’s health and well-being by utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems. These services do not represent preventive medicine counseling and risk factor reduction interventions. Services are limited to counseling and coaching.

Behavioral Barriers: Any identified factor that prevents the injured worker from adhering to treatment protocols or causes the injured worker to act in a manner which undermines the medical management and/or healing of an injured worker’s allowed physical injuries, or that prevents the injured worker from effectively participating in the healing of the injured worker’s allowed physical injury. Examples of these barriers may be negative perceptions and expectations for recovery or disability which cause the injured worker to withhold important feedback needed by the physician in determining necessary medical treatment, or fear of re-injury which leads to the injured worker not adhering to a prescribed therapeutic treatment regime.

Initial Course of Treatment: A generally accepted standard clinical approach to addressing a physical injury. The clinical approach may vary depending on the nature of the physical injury, and will generally result from the informed medical opinion gained from an examination and/or other appropriate clinical evaluations (i.e. MRI, X-ray etc.).

Coaching: A service provided to the injured worker to facilitate moving the injured worker beyond his/her current state by assisting him/her after understanding the
impact of identified behaviors to establish action goals designed to improve healing and function of the injured worker’s allowed work injury.

Counseling: A service provided to the injured worker to facilitate moving the injured worker beyond his/her current state by providing actionable guidance to the injured worker to facilitate an understanding of the impact of behaviors on their inability to move forward in the healing of the injured worker’s allowed work injury.

IV. POLICY

A. IW Eligibility Criteria

An injured worker shall be eligible for consideration of health and behavior assessment/intervention services if:

1) The injured worker’s physician of record(POR) determines:
   a) The injured worker is not progressing with their injury after the initial course of treatment, and/or
   b) The injured workers’ healing appears to be delayed due to behavioral barriers.

2) The injured worker has the capacity to understand and respond meaningfully during the face-to-face encounter.
   a) When requesting each HBAI service the POR must indicate that the injured worker meets this requirement.
   b) An injured worker would not have the capacity to understand and respond meaningfully during the face to face encounter because of factors including but not limited to:
      i) Dementia;
      ii) Delirium;
      iii) Severe and profound cognitive impairment;
      iv) Persistent vegetative state or no discernible consciousness;
      v) Impaired mental status.

B. Prior Authorization Request and Documentation for Health and Behavior Assessment or Re-assessment Services

1) Requests for health and behavior assessment or re-assessment services shall only be submitted by the POR on a Request for Medical Services Reimbursement or Recommendation of Additional Conditions for Industrial Injury or Occupational Disease (C-9) form or equivalent, except when the health and behavior assessment or reassessment will be provided and billed pursuant to Paragraph G(1) of this policy.

2) Requests for health and behavior assessment shall include:
   a) Documentation of the physical injury and treatment:
      i) Onset and history of the initial diagnosis of the physical injury or occupational disease resulting in the allowed condition(s) in the claim;
ii) Summary overview of the IW’s treatment and diagnostic studies to date, and applicable results;
b) A statement documenting the IW’s ability to understand and respond meaningfully during the assessment;
c) The POR’s clear rationale for the assessment, as demonstrated by:
   i) Documentation of the behavior barriers that the POR believes exists; along with,
   ii) A statement explaining how the injured worker’s healing or recovery progress from the allowed condition(s) is impeded by the identified behavioral barriers;
d) A statement that the IW has not received a health behavior assessment in the prior twelve months.

3) Re-assessment may be considered reasonable and necessary when there has been a sufficient change in the injured workers’ status warranting re-evaluation. The POR must provide clear rationale for why a re-assessment is required as demonstrated by information provided by the POR including:
a) The date of the most recently performed health behavior assessment;
b) The results of the prior health behavior assessment, including documentation of the behavioral barriers identified;
c) Relevant reference to health behavior interventions received by the injured worker;
d) New and changed circumstances in the IW’s physical status requiring re-assessment.

C. Prior Authorization Request and Documentation for Health and Behavior Intervention Services
1) Requests for health and behavior intervention services shall only be submitted by the POR on a Request for Medical Services Reimbursement or Recommendation of Additional Conditions for Industrial Injury or Occupational Disease (C-9) form or equivalent, except when the health and behavior intervention service will be provided and billed pursuant to Paragraph G(1) of this policy.

2) When a request for health and behavior intervention services is received the medical necessity and appropriateness of the request will be evaluated against the following information:
a) The most recent assessment report providing the basis for the request of intervention services;
b) Recommendation(s) for specific goals, frequency and duration of proposed intervention services;
c) Medical documentation which provides a clear rationale for the health behavior intervention, including an assessment of how the injured worker may benefit from the intervention.
d) Documentation of the IW’s ability to understand and respond in a meaningful way to intervention services.

3) Limitation on providers of intervention services:
a) Intervention services may not be provided by the same provider who performed the health and behavior assessment of the injured worker;
b) Intervention services can be provided by a provider who is a member of the same group practice of a provider who has performed the health and behavior assessment of the injured worker.

4) Prior to the POR’s intervention services request being authorized, a completed health and behavior assessment report must be submitted and accessible to the MCO for a determination of medical necessity and appropriateness.

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

D. Provider Eligibility

1) Health and behavior assessment, reassessment or intervention may be performed by any provider whose professional scope of practice as defined under state law includes health and behavior services, and includes the following providers:
   a) Doctor of Osteopathic Medicine or Surgery (D.O.)
   b) Doctor of Medicine (M.D.)
   c) Doctor of Chiropractic (D.C.)
   d) Certified Nurse Practitioner (CNP)
   e) Clinical Nurse Specialist (CNS))
   f) Certified Rehabilitation Counselor (CRC)
   g) Occupational Therapist (OT)
   h) Physician Assistant (PA)
   i) Psychologist (Ph.D. or PsyD)
   j) Licensed Social Worker or Licensed Independent Social Worker
   k) Licensed Professional Counselor or Licensed Professional Clinical Counselor

2) BWC will recognize any provider type not listed in Section D 1) as eligible to provide health and behavior services upon submission of documentation satisfactory to BWC from their state’s licensing board that the service is within their defined scope of practice.

E. Provider Documentation after rendering an Assessment, Re-assessment, or Intervention

1) For any provider completing a health behavior assessment or re-assessment, a report of findings must be submitted to the POR and MCO, that shall include at a minimum the following information, as appropriate:
   a) History of the industrial injury or occupational disease resulting in the allowed condition(s) in the claim, including the date of the physical injury;
   b) Overview of the IW’s treatment and diagnostic studies to date, and the results;
   c) Identification and/or validation of existence of behavioral barriers or documentation to negate the existence of behavioral barriers;
d) A statement signifying whether the IW’s healing or recovery progress from the allowed condition(s) is or continues to be impeded by the identified behavioral barriers;

e) Recommendation(s) for specific goals and duration or recommended changes to goals and durations of proposed intervention services;

f) The results of one or more currently accepted health-focused questionnaire or risk screening tools. Those tools may include but are not limited to:

i) Keele STarT Back Screening Tool (SBST);

ii) Screener and Opioid Assessment for Patients with Pain (SOAPP);

iii) World Health Organization Disability Assessment Schedule 2.0 (WHODAS);

iv) Fear Avoidance Belief Questionnaire (FABQ);

v) Linton Tool;

vi) Functional Recovery Questionnaire (FRQ).

g) Length of time of assessment, including start and stop time.

2) To assist in the determination of appropriateness of reimbursement for intervention services performed, providers of intervention services must submit medical documentation which includes, at a minimum:

a) An overview of the intervention performed, including a reflection of the goals of the intervention services;

b) Documentation of the IW’s progress or lack of progress towards the goals of the intervention services for each visit;

c) Description of the IW’s engagement in his or her treatment; and

d) The time in and time out and duration of health and behavior intervention services.

F. Not Covered Intervention Services:

1) Preventive medicine counseling and risk factor reduction interventions are determined to not be reasonably related to, or medically necessary for, treatment of an industrial injury, and therefore are not reimbursable.

2) Because the focus and goals of Health and Behavior Intervention Services are directed to treating an injured worker’s physical injury, coaching and counseling services focused on personal, social, recreational, and general support are not reimbursable Health and Behavior Intervention Services. Examples are:

a) Family psychotherapy or mediation;

b) Personal, social, recreational, and general support services;

c) Maintain the patients or family’s existing health and overall well-being;

d) Individual social activities;

e) Teaching social interaction skills;

f) Socialization in a group setting;

g) General conversation;

h) Vocational or religious advice;

i) Tobacco or caffeine withdrawal support.
j) Teaching the patient simple self-care;
k) Exercise programs;
l) Weight loss management;
m) Maintenance of behavioral logs;
n) Updating or educating family about the injured worker’s condition;
o) Educating non-immediate family members, non-primary care-givers, non-guardians, the non-health care proxy, and other members of the treatment team, e.g., health aides, nurses, physical or occupational therapists, home health aides, personal care attendants and co-workers about the injured worker’s care plan;
p) Treatment planning with staff;
q) Education of diabetic patients and their family members;
r) Medical nutrition therapy;
s) Maintaining the injured worker’s or family’s existing health and overall well-being;
t) Provision of support services, not requiring the skills of a mental health provider;
u) Provision of personal, social, recreational, and general support services;
v) Stress management;
w) Craft skill training;
x) Cooking classes;
y) Comfort care services;
z) Social activities;
aa) Consciousness raising;
bb) General educational activities;
cc) Sensory stimulation;
dd) Games;
ee) Grooming skills or services;
ff) Monitoring activities of daily living;
gg) Teaching self-care;
hh) Memory enhancement training;
i) Case management;
jj) Activity principally for diversion.

G. Billing and Reimbursement

1) The following providers must use the appropriate Evaluation and Management (E&M) CPT® codes (99201-99205 and 99211-99215) for reimbursement for health and behavior assessment and intervention services:
a) Doctor of Medicine,
b) Doctor of Osteopathic Medicine or Surgery,
c) Doctor of Chiropractic,
d) Certified Nurse Practitioner,
e) Clinical Nurse Specialist,
f) Physician Assistants.

2) The following providers must use health and behavior CPT® codes (96150-96160) for reimbursement for health and behavior assessment and intervention services:
   a) Psychologist,
   b) Licensed Social Worker,
   c) Licensed Independent Social Worker,
   d) Licensed Professional Counselor,
   e) Licensed Professional Clinical Counselor,
   f) Clinical Rehabilitation Counselor,
   g) Occupational Therapist.

3) Reimbursement shall be made only when the health and behavior CPT® code is billed with a diagnosis for the physical injury allowed in the claim.

4) Reimbursement is subject to the following frequency limitations, except as otherwise provided pursuant to OAC 4123-6-32, Payment for Lumbar Fusion:
   a) One health behavior assessment per twelve month period;
   b) One reassessment per twelve month period may be approved for an injured worker, to evaluate progress after receiving health behavior intervention services;
   c) Six hours of health behavior intervention services every twelve months. Additional intervention services may be approved during the year, if the POR provides documentation that the additional services are medically necessary.
   d) The twelve-month period is a look-back for twelve months from the date of the prior authorization C-9 request for the health and behavior assessment, reassessment or intervention services.

H. Addendum: HBAI Clinical Examples

1) Consider the situation in which an injured worker (IW) returns to her physician of record (POR) for reevaluation of her knee injury at an interval at which the provider would have expected full recovery. At the time of the visit, the knee looks red, feels warm, and is swollen. Because of these physical signs, the POR would order medically necessary and appropriate diagnostic studies to direct further treatment for the knee. Consider an alternative scenario where the IW arrives back for follow up with the knee looking as though it is healing properly, however is stiff with decreased range of motion, and is causing the IW to walk with a lurch. There is poor eye contact, a request for more pain medicine, a history of some missed therapy visits, and reports from the family that the IW is not walking as much as was prescribed “because she is afraid she’ll hurt it again.” It is in this second scenario that the POR should be concerned that these signs point to behavioral barriers to the IW's physical recovery, specifically activity avoidance due to fear of re-injury. In this situation, referral for HBAI assessment is appropriate to address the behavioral barriers to physical healing, especially considering the alternatives of further unnecessary testing, possibly unnecessary procedures, more ineffective
physical therapy in which the patient is not engaged, or perpetuation and/or escalation of opioid pain medication.

2) An IW is under the care of an ophthalmologist for treatment of a corneal (eye) abrasion. An ointment is prescribed. The IW returns to the provider after one week with red, irritated eyes. After additional questioning, the provider discovers that the ointment is causing burning and itching, and the IW has been rubbing his eyes. The provider gives coaching and counseling for the IW to avoid the behavior of eye rubbing, as part of the normal course of the visit.

3) An injured worker was giving a presentation to her team and a group of prospective clients. As she pulled down the projection screen, it came loose from the wall striking her on the head, and knocking her to the floor. She was diagnosed with contusion to the head and left hip, and cervical strain. She was prescribed chiropractic care and physical therapy. She complained of continued neck pain and headache after an initial course of treatment. Tight muscles and decreased range of motion was observed by her POR, however she also confided that she was very embarrassed by the incident, and felt ashamed to go back and face her coworkers and clients, afraid they would think she was clumsy and inept. Her physical therapist noted that she did not appear fully engaged in her exercise program. Because of these behaviors, her POR requested HBAI, with intervention focused on cognitive and behavioral retraining.

4) An IW presents to the office complaining of moderate to severe low back pain after lifting a 50-pound drum off a skid at work. He describes the pain as a sharp, stabbing sensation bilaterally across his low back. He was seen at the ER where he was instructed to use ice and pain medication, and stay off for three days. He was instructed that if the pain persisted after three days that he was to consult his family physician or follow-up at the hospital’s Occupational Medicine department. At the follow up appointment, he had decreased range of motion and tests reproducing the pain along the lumbar spine. He was diagnosed with Acute Lumbar Sprain. The IW stated that he had trouble with his daily activities, especially walking short distances, getting up and down out of a seated position, and disturbed sleep. Simple household tasks such as light cleaning and doing the dishes were difficult to perform or complete since the injury. He stated he has never had anything like this before and feels helpless since getting hurt at work. He stated that he wants to get back to work, but not too soon in case he would re-injure his back and make things worse. Physical therapy and medication were prescribed, as well as a walking program. At follow up, evaluation for return to work was planned. However, this initial course of conservative medical care produced minimal improvement in pain control or function. Below are details of the initial care, and then some medical decision-making options:
### Scenario #1

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
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</thead>
<tbody>
<tr>
<td>3x/week for 4 weeks PT</td>
<td>$1200.00</td>
</tr>
<tr>
<td>L/S X-ray</td>
<td>$65.26</td>
</tr>
<tr>
<td>One month supply of Pain Meds</td>
<td>$800.00</td>
</tr>
<tr>
<td>Established Patient Exam (Re-eval)</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

**Est. Cost:** $1200.00

**L/S X-ray – Est. Cost:** $65.26

**One month supply of Pain Meds – Est. $800.00**

**Established Patient Exam (Re-eval): Est. $100.00**

**At 4 weeks, POR could:**
1. Extend PT additional time
2. POR could increase pain meds
3. Request additional diagnostic testing
4. Request consultation with a specialist

**Decision Time - Minimal Improvement @ 4wks**
IW reports high pain levels and says he cannot perform ADL’s.
Objective signs noted by POR indicate better than reported results by IW; however, POR determines to take a different approach with this case given the history, subjective, and objective findings.
IW has missed a few PT appointments because he feared re-injury and it hurt worse at times.

**Behavioral Barriers identified:**
- Feeling of helplessness as noted by IW
- Missed a few PT appts.
- Not stretching at home
- Fear of re-injury

**Can’t perform ADL’s – too much pain**

**HBAI OPTION:**
HBA requested – Est. Cost: $122.36
Identified Coping and/or Behavior Barriers – Intervention Services requested – Est. Cost: $449.44
HBA Reassessment at 6 weeks: $87.33

**CONTINUED MEDICAL CARE:**
Order MRI: Est. cost: $298.77
Additional PT 2-3x/wk for 4 weeks – Est. cost $1000.00
Additional supply of Pain Meds - Est. 800.00

POR develops strategy after barriers have been identified, confirmed, and addressed (i.e., helping him cope with his “fear of re-injury”) – IW returns to work light duty for two weeks with recommended PT 1xwk for 6 weeks (Est. cost- $600.00) as transition back to work – IW back to work FD at 4 weeks from transition of LD – IW continues to utilize home exercise and coping skills strategy – Pain medications are discontinued and IW is back to work.

**Estimate in Total Care Costs**
$3424.39
(savings in TT not included)

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### Scenario #2

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<th>Description</th>
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<tr>
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</tr>
<tr>
<td>Established Patient Exam (Re-eval): Est. $100.00</td>
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</table>

**Est. Cost:** $1200.00

**L/S X-ray – Est. Cost:** $65.26

**One month supply of Pain Meds – Est. $800.00**

**Established Patient Exam (Re-eval): Est. $100.00**

**At 4 weeks, POR could:**
1. Extend PT additional time
2. POR could increase pain meds
3. Request additional diagnostic testing
4. Request consultation with a specialist

**Decision Time-Minimal Improvement @ 4 wks.** IW reports high pain levels and he cannot perform ADL’s.
IW has missed a few PT appointments because he feared re-injury and it hurt worse at times.

**Objective signs noted by POR indicate better than reported results by IW, but determines to move forward with generally accepted medical approaches**

**Behavioral Barriers identified:**
- Feeling of helplessness as noted by IW
- Missed a few PT appts.
- Not stretching at home
- Fear of re-injury

**Can’t perform ADL’s – too much pain**

**HBAI OPTION:**
HBA requested – Est. Cost: $122.36
Identified Coping and/or Behavior Barriers – Intervention Services requested – Est. Cost: $449.44
HBA Reassessment at 6 weeks: $87.33

**CONTINUED MEDICAL CARE:**
Order MRI: Est. cost: $298.77
Additional PT 2-3x/wk for 4 weeks – Est. cost $1000.00
Additional supply of Pain Meds - Est. 800.00

IW reports no better POR recommends Pain Management Specialist Consult –Est. cost $200.00
Pain specialist recommends Injections – Est. cost $800.00 for (2) – Total: $1000.00

**IW still not back to work. Spine surgery consultation requested.**

**Estimate in Total Care Costs**
$5464.03

**Still not back to work**
I. POLICY PURPOSE: GENERAL OVERVIEW

The purpose of this policy is to ensure that the Bureau of Workers’ Compensation (BWC) provides direction for the billing of anesthesia services to Ohio’s injured workers.

II. APPLICABILITY

This policy applies to all actions relevant to the reimbursement of anesthesia services within the Ohio workers’ compensation system.

III. DEFINITIONS

There are no definitions in this policy.

IV. POLICY

A. BWC requires that providers bill anesthesia CPT® codes 00100 - 01999.

B. Refer to the Professional Provider Fee Schedule for coding and reimbursement in effect on the date of service. The anesthesia base unit list and fee schedule is located at http://www.bwc.ohio.gov/provider/services/agreement.asp.

C. If there are multiple procedures performed, the provider must bill only the anesthesia CPT® code of the primary procedure.

The provider may not bill CPT® codes for services other than general anesthesia with general anesthesia modifiers. BWC shall deny bills with explanation of benefits (EOB).

D. 380 EOB code: Payment is denied as the anesthesia modifier is not appropriate to be billed with this procedure code.
E. Although BWC accepts industry standard modifiers for anesthesia services, the provider may not use modifiers -P1 through -P6 for physical status.

F. Anesthesia services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services. Providers may not bill for these services separately.

G. Evaluation and management codes billed within the surgical follow-up period are not reimbursable.

H. Anesthesia time:
   1. Anesthesia time begins when the anesthesiologist or anesthetist is in personal attendance at the surgical procedure and ends when the anesthesiologist or anesthetist is no longer in personal attendance.
   2. BWC measures anesthesia time in minutes.
   3. Providers shall bill the minutes involved delivering anesthesia during the surgical procedure, and shall not include the base units.
## Ambulatory Surgical Center Billing and Reimbursement

<table>
<thead>
<tr>
<th>Policy Name:</th>
<th>Ambulatory Surgical Center Billing and Reimbursement</th>
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<tbody>
<tr>
<td>Policy #:</td>
<td>BRM-04</td>
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<tr>
<td>Code/Rule Reference:</td>
<td>OAC 4123-6-37.3</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>April 1, 2018</td>
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<tr>
<td>Origin:</td>
<td>Medical Policy</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>All medical policies, directives and memos regarding ambulatory surgical center services that predates the effective date of this policy.</td>
</tr>
<tr>
<td>History:</td>
<td>REVISED</td>
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<tr>
<td>Review date:</td>
<td>04/01/2023</td>
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**I. POLICY PURPOSE:**

The purpose of this policy is to ensure that the Bureau of Workers’ Compensation (BWC) provides direction for the billing of ambulatory surgical center (ASC) services to Ohio’s injured workers.

**II. APPLICABILITY**

This policy applies to all actions relevant to the reimbursement of ASC services within the Ohio Workers’ Compensation System.

**III. DEFINITIONS**

There are no definitions for this policy.

**IV. POLICY**

A. Covered Services/Reimbursement
   1. BWC reimburses ASCs using a fee schedule based on Medicare’s ambulatory surgical center prospective reimbursement system. The modifications adopted by BWC are specified in Ohio Administrative Code (OAC) 4123-6-37.3.
   2. Providers shall refer to the [ASC Fee Schedule](#) effective on the date of service for additional information.

B. Bundled Services:
   1. The following services are bundled into the reimbursement for surgical procedures and are not separately reimbursable:
      a. Nursing, technician and related services;
      b. Use of the facility where the procedure is performed;
      c. Drugs, biologicals (e.g., blood), surgical dressings, splints, casts, appliances and equipment directly related to the provision of the surgical procedures for which separate payment is not allowed;
d. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;

e. Administrative or record keeping items and services; and

f. Materials used for anesthesia.

2. Bundled services are identified by coverage status **BN** in the ASC fee schedule appendix tables.

C. Non-Covered Services. The following services are not reimbursable if billed by an ASC, but may be billed separately by a BWC enrolled provider that is licensed to provide the services:

1. Physician services;

2. Prosthetic and orthotic devices; and

3. Durable medical equipment for use in the injured worker’s home.

D. Modifiers

1. BWC accepts nationally recognized Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) modifiers for ambulatory surgical center services in effect on the billed date of service, except for bilateral procedures.

   a. BWC does not follow Medicare standard billing protocols for billing of bilateral procedures by an ASC.

   b. Reporting of bilateral procedures should be billed with modifier -50, and not with –RT or –LT.

2. Modifier reimbursement impacts are identified in the ASC fee schedule **OAC 4123-6-37.3** effective on the date of service.

3. Modifier Reporting Examples:

   a. Bilateral services with modifier -50: Bilateral lumbar transforaminal epidural injections are administered. The correct way to bill this bilateral procedure is CPT code® 64483-50. Do not bill 64483 and 64483-LT or 64483-RT and 64483-LT.

   b. Multi-level Spinal Procedures - Below are two (2) examples of the correct reporting for multi-level spinal procedures.

      i. Example - Lumbar transforaminal epidural injections are administered at L1, L2 and L3. The correct way to bill these procedures is CPT code® 64483, 64484-59 and 64484-59. Do not use modifiers L1, L2 or L3.

      ii. Example - Bilateral lumbar transforaminal epidural injections are administered at L1, L2 and L3. The correct way to bill these procedures is CPT code® 64483-50, 64484-50,-59 and 64484-50,-59. Do not use modifiers L1, L2, or L3.

   c. Multiple Tendons, Ligaments, Muscles or Joints - Below are two (2) examples of the correct reporting for a multiple tendons, ligaments, muscles or joints procedures that are described by CPT® as each tendon or each joint.

      i. Example - Excision of four (4) finger tendons; right thumb, right 2nd digit, right 3rd digit, right 4th digit. The correct way to bill these procedures are CPT code® 26180 -F5, 26180 -F6, 26180 -F7, and 26180 -F8. Do not use modifiers J1-J4.
ii. Example - Excision of four (4) finger tendons: right thumb flexor and extensor tendons, right 2\textsuperscript{nd} digit flexor and extensor tendons. The correct way to bill these procedures are CPT code\textsuperscript{©} 26180 -F5, 26180 -F5 -59, 26180 -F6, and 26180 -F6 -59. Do not use modifiers J1-J4.
I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for the utilization of drug testing (DT) for injured workers (IW), especially those who are receiving or being considered for chronic opioid therapy in the management of chronic non-cancer pain.

II. APPLICABILITY

This policy applies to MCOs and providers of drug tests.

III. DEFINITIONS

**Alternative drug testing (ADT):** a chemical analysis of bodily specimens, with the exception of urine, that are obtained to identify presence or absence of parent drugs or their metabolites. For the purpose of this policy, it is inclusive of both the immunoassay and a confirmation test such as gas chromatography, mass spectrometry or high-performance liquid chromatography.

**Chronic opioid therapy:** the consistent use of opioids for more than ninety (90) days.

**Chronic pain:** discomfort (i.e., pain) that extends beyond the expected period of healing.

**Point-of-care testing:** done at or near the site of patient care using commercial devices (e.g., in-office urine drug testing).

**Urine drug testing (UDT):** a chemical analysis of the urine to identify presence or absence of parent drugs or their metabolites. For the purpose of this policy, it is inclusive of both the immunoassay and a confirmation test such as gas chromatography, mass spectrometry or high-performance liquid chromatography.
IV. POLICY

A. It is the policy of BWC to:
   1. Ensure appropriate use of opioids in the treatment of chronic pain management by allowing DTs;
   2. Require provider submission of the IW’s level of risk to the MCO prior to determining the appropriate number of DTs to authorize for the IW;
   3. Allow up to four DTs yearly as determined by the injured worker’s (IW) individual risk assessment, which shall be submitted no less than once a year; and
   4. Allow up to two additional DTs yearly when a provider documents the demonstration of aberrant behavior by an IW.

B. Drug testing methods:
   1. It is the policy of BWC that UDTs are the preferred method of drug testing.
   2. It is the policy of BWC to allow Alternative Drug Testing (ADT) (e.g., blood, saliva and hair follicle):
      a. **Only** when a urine specimen is unobtainable due to medically documented reasons; and
      b. **Only** when testing facilities/labs use FDA approved test kits/devices to obtain ADTs.

C. It is the policy of BWC to reimburse for:
   1. DT performed in a laboratory that is CLIA (Clinical Laboratory Improvement Amendments) certified;
   2. DTs performed following the process outlined in the procedure section of this document;
   3. DT billed under codes reflected in this link (DT codes).
   4. Quantitative testing for an individual drug that the IW is prescribed which is not included in the standard drug panel listed in C.5;
   5. A standard drug panel immunoassay test that includes the following drugs:
      a. Amphetamines;
      b. Opiates;
      c. Cocaine;
      d. Benzodiazepines;
      e. Barbiturates;
      f. Oxycodone;
      g. Methadone;
      h. Fentanyl;
      i. Marijuana; and
      j. Hydrocodone.
   6. DT that includes the standard drug panel listed above in Section IV.C.5. a-j, when the IW is taking a prescription drug that is not paid for by BWC.
   7. Additional tests for drugs not included in the standard drug panel listed above in Section IV.C.5. a-j when:
      a. The IW is prescribed the drug; and/or
      b. The physician deems the testing medically necessary.
   8. Point-of-care DTs when medical documentation identifies an immediate need.
   9. Drug confirmation by gas chromatography, mass spectrometry or high-performance liquid chromatography solely for the drug in question when the immunoassay results are positive or when:
a. An unexpected drug or its metabolites are identified;
b. The prescribed drug or its metabolites are not identified in the DT.

10. DTs immediately prior to the initiation of opioid therapy for chronic non-cancer pain or for the extension of opioid therapy beyond the acute phase (e.g., a patient has been on opioids for the treatment of an acute injury for six weeks or more and the practitioner is considering opioids for chronic pain).

11. DTs while a patient is on opioid therapy for chronic non-cancer pain to:
a. Verify compliance with the treatment regimen; and/or
b. Identify undisclosed drug use and/or abuse.

V. PROCEDURE FOR UDT AND ADT COLLECTION

A. UDT

1. Providers of urine drug tests shall ensure a collection protocol that protects the security and integrity of the urine collection by:
   a. Testing the IW as soon as possible after the physician order is given;
   b. Verifying the IW's identification via a photo identification or other confirming ID;
   c. Collecting only one specimen at a time;
   d. Having the IW remove any garments which might conceal substances or items to adulterate the urine specimen;
   e. Instructing the IW to wash and dry his/her hands prior to urination;
   f. Securing all water sources;
   g. Ensuring the water in the toilet tank and bowl are blue;
   h. Inspecting the testing site to ensure no unauthorized substances are present;
   i. Removing all soaps, disinfectants, cleaning agents or other possible adulterants from the testing area;
   j. Providing individual privacy for the IW during specimen collection;
   k. Measuring the specimen temperature within four (4) minutes of its collection to ensure the temperature is between 90-100 Fahrenheit;
   l. Visually inspecting the urine for color and contaminants;
   m. Sealing and labeling the specimen with seals containing the date and specimen number in the presence of the IW;
   n. Having the IW initial the seals, certifying that it is his/her specimen.

2. A chain of custody form (appendix A) or equivalent form containing a minimum of the following elements shall be used in the collection and processing of the urine specimen:
   a. IW’s name, address, date of birth, signature, date of signature and claim number;
   b. Collection site’s name, address, phone and fax number;
   c. Reason for the test;
   d. Drugs to test for;
   e. Specimen temperature within four (4) minutes of collection;
   f. Additional comments;
   g. Collection time, date and printed name and signature of collector;
   h. Date and name of courier to whom the specimen was released;
   i. Printed name and signature of lab employee receiving the specimen and the date of specimen receipt;
   j. Documentation that the specimen bottle seals were intact upon the labs receipt of the specimen;
k. Results and result date.
B. ADT shall be collected pursuant to the FDA approved drug kit.
C. Specimens failing to meet the above listed criteria shall be rejected for testing.
## Chain of Custody Form

### Appendix A

### Injured worker (donor) demographics

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact number:</th>
<th>Claim number:</th>
<th>Address, City, State and Zip Code:</th>
<th>Date of birth:</th>
</tr>
</thead>
</table>

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

Injured worker’s signature: ____________________________ Date (mm/dd/yy): ______________________

### Collection site demographics

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address, City, State and Zip Code:</th>
<th>Phone number:</th>
<th>Fax number:</th>
</tr>
</thead>
</table>

### To be completed by the collector

- **Reason for testing:**
  - Random
  - Reasonable Suspicion/cause
  - Follow-up
  - Other (specify) ______________________

- **Drug test to be performed:**
  - Amphetamines
  - Opiates
  - Cocaine
  - Benzodiazepines
  - Barbiturates
  - Oxycodone
  - Methadone
  - Fentanyl
  - Marijuana metabolite
  - Hydrocodone
  - Other (specify) ______________________

- **Temperature within 90 and 100 F within 4 minutes of collection:**
  - Yes
  - No

- **Specimen collection:**
  - Split
  - Single
  - None provided (explain) ______________________

- **Additional observations:**

- **Time of collection:** ______________________
  **Date of collection (mm/dd/yy):** ______________________

  I certify that the specimen given to me by the donor was collected, labeled, sealed and released to the courier service noted in accordance with applicable Federal requirements.

  Collector’s name (please print): ______________________
  Signature of collector: ______________________

  **Time of specimen release:** ______________________
  **Date of specimen release (mm/dd/yy):** ______________________

  Name of courier the specimen bottles were released to: ______________________________________

### To be completed by the lab upon receipt of the specimen

- **Accessioner’s name (please print):** ______________________
  **Signature of accessioner:** ______________________

  **Specimen receipt date:** ______________________
  **Specimen bottle seal intact?**
  - Yes
  - No

  **Name of person specimen bottles released to:**

  - Negative
  - Positive
  - Dilute
  - Test cancelled
  - Refusal to test
  - Adultered
  - Substituted

  **Remarks:** ______________________________________

  **Positive for:**
  - Amphetamines
  - Opiates
  - Cocaine
  - Benzodiazepines
  - Barbiturates
  - Oxycodone
  - Methadone
  - Fentanyl
  - Marijuana metabolite
  - Hydrocodone

  **Other (list):** ______________________________________

  **Remarks:** ______________________________________

  **Lab technician’s name (please print):** ______________________
  **Signature of Lab technician:** ______________________
  **Date (mm/dd/yy):** ______________________
I. POLICY PURPOSE: GENERAL OVERVIEW

The purpose of this policy is to ensure that the Bureau of Workers’ Compensation (BWC) provides direction for the billing of chronic pain management programs for Ohio’s injured workers.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of chronic pain management programs within the Ohio workers’ compensation system.

III. DEFINITIONS

There are no definitions for this policy.

IV. POLICY

A. Chronic Pain Management Program Requirements

Chronic pain management programs must include a multidisciplinary, comprehensive treatment approach that addresses the physiological, psychological, social and vocational aspects of chronic pain.

1. Chronic pain management program objectives shall include but are not limited to:
   a. Maximize physical function (strength, stamina and flexibility) within the constraints of the injured worker’s physical limitations;
   b. Reduce or eliminate overuse of health services and invasive medical procedures relative to the primary pain complaints;
   c. Reduce or eliminate the use of pain medications;
   d. Reduce the subjective pain intensity by relieving pain and/or modifying the injured worker’s reaction to the pain;
   e. Develop skills for self-management of chronic pain and related problems;
   f. Improve emotional function and reduce harmful emotional states associated with chronic pain;
   g. Improve interpersonal relationships;
h. Identify vocational goals, if applicable;
i. Return to work-readiness, if applicable.

2. Program services may include but are not limited to:
a. Physician services;
b. Psychological services (individual and/or group);
c. Physical therapy;
d. Occupational therapy;
e. Group educational services;
f. Acupuncture;
g. Biofeedback;
h. Chiropractic treatment;
i. Diagnostic testing;
j. Laboratory testing, including drug testing;
k. Nutritional counseling;
l. Recreational therapy; and
m. Structured progressive withdrawal from pain medications.

B. Chronic Pain Management Program Types
1. Services may be provided by hospital or free-standing chronic pain program provider types.

2. Inpatient Programs (hospital provider types only)
a. Inpatient programs are appropriate only when injured worker’s condition is such that a highly supervised and monitored program is essential for success. Inpatient programs are appropriate when one (1) or more of the following conditions are met:
i. The injured worker requires structured, progressive reduction of a prescribed medication before any possible benefit of the pain management program can be realized;
ii. The injured worker exhibits personality/behaviors such that effective participation would be unlikely in an unsupervised/unmonitored setting;
iii. The injured worker requires a structured environment for psychological support and/or medical monitoring;
iv. The injured worker’s pain behavior is reinforced in the home to the point that it is necessary for the injured worker to be removed from the home in order to succeed in a chronic pain management program.
v. The injured worker will not be granted frequent off site passes.
b. An inpatient program of three (3) to four (4) weeks is generally appropriate to modify pain behavior. On occasion, a program longer than four (4) weeks may be appropriate when substantiated by medical documentation.

3. Outpatient Programs (hospital provider types or free-standing chronic pain programs)
a. Outpatient programs are appropriate when the injured worker’s condition does not warrant the highly supervised environment of an inpatient program.
b. Half day programs are required to include a minimum of three and one half (3 1/2) hours of treatment, excluding break and meal times.
c. Full day programs are required to include a minimum of seven (7) hours of treatment, excluding break and meal times.
d. Treatment times (i.e. start and end time or service duration) for each service shall be documented in the injured worker’s medical record to ensure compliance with the full or half day treatment requirements.
C. Injured Worker Eligibility Requirements

1. In order to be eligible for participation in a chronic pain management program, the injured worker must meet the following requirements:
   a. The injured worker is symptomatic of excessive pain behaviors disproportionate to the compensable injury or condition;
   b. The injured worker has not responded to traditional medical treatment;
   c. The cause of the injured worker’s pain is unknown or attributable to a physical cause (i.e. not purely psychogenic in origin);
   d. The injured worker’s pain has affected his/her level of function for activities of daily living;
   e. The injured worker’s current use/abuse of alcohol or drugs is not expected to interfere with full participation in the program;
   f. The injured worker is not currently experiencing any acute medical problems, is not anticipating any medical or surgical intervention and is considered to be medically stable to participate in a multidisciplinary, physically challenging program;
   g. The injured worker has previously completed no more than one (1) multidisciplinary pain management program;
   h. The injured worker is demonstrating significant emotional distress (e.g. depression, anxiety or impaired interpersonal, familial, occupational or social functioning)
      i. As a result of pain associated with the allowed injury; and
      ii. The injured worker is psychiatrically stable, such that they can actively and safely participate in the program.
   i. The injured worker has expressed interest and desire to participate in a chronic pain management program with a goal of returning to work, if appropriate;
   j. The injured worker has the cognitive ability to understand and carry out instructions.

2. The injured worker is not required to have a psychological allowance in his/her claim to be eligible for participation a chronic pain management program

D. Injured Worker Eligibility Evaluation

1. When a physician of record (POR) or treating physician determines an injured worker may benefit from a chronic pain management program, the physician shall request prior authorization for a comprehensive, multidisciplinary chronic pain management program eligibility evaluation (i.e. pre-admission evaluation).

2. The evaluation shall be performed on an outpatient basis at the hospital or free-standing chronic pain management program facility.

3. The injured worker program eligibility evaluation shall include:
   a. Medical history and physical/neuromuscular examination which includes review of medications;
   b. Review of past, pertinent medical records;
   c. Psychological and social evaluation;
   d. Physical therapy evaluation;
   e. Occupational therapy evaluation;
   f. Cardiac stress test, if necessary; and
   g. Specialist consultation(s), if necessary
4. Documentation from the injured worker eligibility evaluation shall be submitted to the MCO and shall include:
   a. Indication if the injured worker meets each of the eligibility criteria listed in section IV.C.1. of this policy;
   b. Identification of barriers, if any, preventing the injured worker from participating in the program;
   c. Preliminary recommended treatment plan, if injured worker meets eligibility requirements and no other barriers exist.

E. Chronic Pain Management Program Authorization
1. Following the injured worker eligibility evaluation, the POR or treating physician shall request prior authorization for the chronic pain management program. The request shall include:
   a. Program type (inpatient or outpatient);
   b. Frequency and duration of treatment (e.g. full day or half day request for outpatient services).

F. Billing and Reimbursement
1. Injured worker eligibility evaluation
   a. Services provided under section IV.D. of this policy shall be reported using BWC local level code for chronic pain program preadmission evaluation, per day, as listed in the hospital outpatient reimbursement rule (OAC 4123-6-37.2) and in the professional provider and medical services reimbursement rule (OAC 4123-6-08).
   b. Hospitals shall submit bills for the injured worker eligibility evaluation on the CMS-1450 (UB-04 Uniform Bill form).
   c. Free-standing chronic pain programs shall submit bills for the injured worker eligibility evaluation on the CMS-1500 (Health Insurance Claim Form).
   d. Reimbursement for the injured worker eligibility evaluation is an all-inclusive rate for all professional provider and facility services.
2. Hospital-based inpatient chronic pain management services
   a. Services provided by hospital-based inpatient programs shall be reported using ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting for hospital inpatient services.
   b. Bills shall be submitted on the CMS-1450 (UB-04 Uniform Bill form).
   c. Services shall be reimbursed according to the hospital inpatient reimbursement rule (OAC 4123-6-37.1).
3. Hospital-based outpatient chronic pain management services
   a. Full and half day outpatient per diem services provided by hospital-based outpatient programs shall be reported with chronic pain program per diem codes listed in the hospital outpatient reimbursement rule (OAC 4123-6-37.2).
   b. The unbundling of services by reporting CPT and HCPCS codes in place of per diem codes is prohibited.
   c. Bills shall be submitted on the CMS-1450 (UB-04 Uniform Bill form).
   d. Reimbursement for chronic pain program services under the full or half day outpatient per diem rate is an all-inclusive rate for all professional provider and facility services.
4. Free-standing outpatient chronic pain management services
a. Full and half day outpatient per diem services provided by free-standing outpatient programs shall be reported with per diem codes listed in the professional provider and medical services reimbursement rule (OAC 4123-6-08).
b. The unbundling of services by reporting CPT and HCPCS codes in place of per diem codes is prohibited.
c. Bills shall be submitted on the CMS-1500 (Health Insurance Claim Form).
d. Reimbursement for chronic pain program services under the full or half day outpatient per diem rate is an all-inclusive rate for all professional provider and facility services.

5. Professional provider chronic pain management services
   a. Professional providers may not separately bill for services provided as part of chronic pain management program.
   b. Reimbursement for services provided as part of a chronic pain management program are included in the hospital inpatient reimbursement rate or in the outpatient per diem rate (hospital outpatient or free-standing program).

6. Injured worker travel is reimbursed according to BWC’s Travel Reimbursement policy and procedure (CP-20-01 and CP-20-01.PR1).
I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for the billing of opioid use disorder treatment directly supporting coverage as specified in Ohio Administrative Code 4123-6-21.7.

This policy defines when service limitations are applicable. It also provides multiple levels of reimbursable coverage on a continuum of care when the American Society of Addiction Medicine (ASAM) Criteria confirm the level of service required by the injured worker.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of opioid use disorder treatment within the Ohio Workers’ Compensation System.

III. DEFINITIONS

**Acute Inpatient detoxification:** A level of care in which nursing services and medications are routinely administered under a physician’s supervision to facilitate the patient’s withdrawal from drugs. The following are features of this level of care:

- Most appropriate for more acute/severe cases with on-going issues;
- Patients require 24-hour care and medical monitoring;
- The patient is weaned off the opioid under direct medical supervision;
- Treatment in this setting typically lasts 3-10 days (but most often between 3 and 5 days);
- Main focus of care is medical monitoring for managing withdrawal; and
- American Society of Addiction Medicine (ASAM) Level 3.7 or 4.

**American Society of Addiction Medicine (ASAM) Criteria:** Treatment criteria for addictive, substance-related and co-occurring conditions. The criteria help providers make objective decisions to match a patient to the most appropriate level of care.
Intensive outpatient treatment (bundled): A level of care in which the patient receives part time, intensive treatment. The following are features of this level of care:

- Most appropriate for patients that do not require medically-supervised detoxification, or immediately following successful completion of detoxification;
- Allows patients to continue recovery therapies they learned and practiced while in a residential inpatient treatment center;
- Includes individual therapy, but is largely focused on group therapy;
- Patients must be in treatment for a minimum of 3 days a week for 3-4 hours per day;
- Treatment in this setting may extend from a few months to a year;
- Patients are encouraged to be a part of a 12-step program; and
- ASAM Level 2.1.

Opioid use disorder: A medical condition characterized by a problematic pattern of opioid use that causes clinically significant impairment or distress. A diagnosis is based on specific criteria such as unsuccessful efforts to cut down or control use, as well as use resulting in social problems and a failure to fulfill obligations at work, school, or home.

Outpatient individualized treatment (unbundled): A level of care in which the patient receives personalized services, including individual or group psychological/behavioral counseling, physician medication management, and laboratory testing and medications. The following are features of this level of care:

- Most appropriate for patients who have maintained sobriety for a period of time;
- The intensity of treatment is dependent upon the needs and motivation of the individual patient;
- Treatment in this setting is typically no more than 1-2 times per week for 1 hour (duration and frequency of the appointments can be adjusted as needed);
- Treatment is typically a non-programmatic unbundling of services delivered by different providers which might be coordinated through a case manager;
- Services are billed individually by each professional provider; and
- ASAM Level 1.

Partial hospitalization (bundled): A level of care in which the patient receives treatment for opioid use disorder as well as monitoring of psychiatric symptoms in an outpatient setting. The following are features of this level of care:

- Most appropriate for a patient who has completed inpatient detoxification and/or inpatient residential treatment;
- Less structured than an inpatient program but more structured than an intensive outpatient program;
- Strong focus on dual diagnosis and offers supervision and monitoring of psychiatric symptoms;
- Patients attend treatment sessions 5 to 7 days a week for more than 4 hours, up to 8 hours a day; and
- ASAM Level 2.5.

Prescriber: The physician (or treatment facility) that is responsible for directing and managing an injured worker’s (IW) opioid treatment program.

Subacute inpatient detoxification: A level of inpatient care in which a patient’s withdrawal from drugs is facilitated by utilizing primarily social interaction between
patients and staff in a supportive environment designed to facilitate safety for patients during recovery from the effects of withdrawal. Withdrawal medications are ordered by the physician and self-administered by the injured worker (IW), not staff. The following are features of this level of care:

- Patients are generally more stable than those in an acute inpatient detoxification program, but still require 24-hour medical monitoring for clinical management of withdrawal symptoms due to their higher risk for potential serious side effects;
- Programs may include medications, counseling and therapy sessions;
- Treatment in this setting typically lasts 3-10 days (but most often between 3 and 5 days);
- Physician evaluation and management services may be separately billable; and
- ASAM Level 3.5.

IV. POLICY

A. **IW Eligibility:** An injured worker is eligible for treatment for opioid use disorder when:

1. The IW has been prescribed opioids for treatment of an allowed condition for more than 12 weeks after the:
   a. Date of injury or occupational disease; or
   b. Surgery related to the allowed condition in the claim.
2. The IW agrees to discontinue opioid use and has requested treatment; and
3. The intent to discontinue opioid treatment is documented in the medical record.
4. The IW is not required to have a claim allowance for opioid use disorder (or an equivalent diagnosis such as opioid dependence) if treatment is being authorized pursuant to OAC 4123-6-21.7, but the opioid use must be related to the industrial injury.

B. **Authorization for IW Assessment Prior to Treatment Plan Determination:**

BWC requires the IW to be assessed prior to requesting or initiating treatment. The assessment:

1. Shall be authorized separately from the opioid use disorder treatment.
2. Shall be administered
   a. at a licensed drug and alcohol clinic,
   b. a psychiatric hospital, or
   c. by an appropriately licensed provider whose scope of practice permits the provider to perform the assessment.
3. Shall be used to develop treatment recommendations including a determination of the most appropriate level of care using the application of the ASAM Criteria in effect on the date of the assessment as the basis for this determination.
4. Documentation shall include:
   a. Patient history, including substance use history;
   b. Family history;
   c. Physical and mental status exam;
      i. Physical manifestations of acute intoxication/withdrawal;
      ii. Signs of any chronic illnesses;
      iii. Symptoms and their relation to substance abuse;
   d. Determination of disease morbidity;
   e. Conclusion and diagnoses;
i. In general, all IWs accepted for treatment must meet the diagnostic criteria for substance-related disorder;
ii. Exceptions may be made for IWs whose symptoms are suggestive enough to warrant additional assessment;
f. Evaluation of support system and vulnerabilities that might impact treatment;
g. The use of an interdisciplinary team, if applicable;
h. ASAM Criteria level; and
i. Treatment recommendations.

C. Authorization of Opioid Use Disorder Treatment:
   1. Following an assessment, treatment may be requested by:
      a. The POR;
      b. Treating physician; or
      c. With a referral, the facility the treatment is being referred to.
   2. The injured worker’s treatment plan must correspond to the applicable ASAM level identified in the assessment.
   3. The treatment period:
      a. Shall begin on the IW’s first date of treatment;
      b. May include inpatient and/or outpatient treatment.
   4. Opioid Use Disorder treatment will be limited as follows:
      a. Eighteen months of treatment may be authorized and reimbursed pursuant to paragraph (F) of the rule OAC 4123-6-21.7 following the initiation of the treatment period;
      b. When placement for inpatient treatment is appropriate, the thirty days of inpatient treatment pursuant to paragraph (F) of the rule OAC 4123-6-21.7 does not need to be consecutively rendered.
      c. If opioid use disorder (or an equivalent diagnosis such as opioid dependence) is allowed in the claim, treatment is not subject to these time limits.

D. Noncompliance: Prescribers must proactively notify the MCO of evidence of non-compliance as documented within the medical file within 48 hours of determining an event of non-compliance.

E. Reimbursement of Opioid Use Disorder Treatment:

   1. BWC reimburses for the treatment of opioid use disorder based on the BWC fee schedule:
      a. In effect on the date of service, and
      b. Corresponding to the applicable ASAM Criteria level of placement. (i.e. ASAM level 1, 2.1, 2.5, 3.5, 3.7, or 4).
         i. BWC does not reimburse for ASAM levels not identified in the applicable fee schedule.
         ii. Inpatient detoxification services (ASAM Levels 3.5, 3.7 or 4) are reimbursed pursuant to OAC 4123-6-37.1 Payment of Hospital Inpatient Services;
         iii. The all-inclusive, bundled programs - Intensive outpatient program and partial hospitalization (ASAM levels 2.1 and 2.5) are reimbursed pursuant to OAC 4123-6-37.2 Payment of Hospital Outpatient Services;
iv. Outpatient individualized treatment (unbundled) (ASAM Level 1) is reimbursed pursuant to OAC 4123-6-08 Bureau Fee Schedule;
c. Outpatient medication is:
i. Paid pursuant to OAC 4123-6-21;
ii. Payable only to a BWC enrolled pharmacy; and
iii. Not payable to the treatment facility unless the treatment facility’s pharmacy is BWC enrolled.
iv. Not payable for office-based dispensing of outpatient medication for medication management of opioid use disorder, including but not limited to:
   a) Tablets, or
   b) wafer/strips, or
   c) other outpatient medication for medication management of opioid use disorder;
   d) except for a monthly naltrexone injection which may be covered in the outpatient office setting as part of an MCO authorized treatment plan.
d. Physician services are separately billable in any level of care and are subject to reimbursement under OAC 4123-6-08 Bureau Fee Schedule.

2. Where pursuant to the applicable fee schedule rule(s), the provider elects or is subject to an all-inclusive per diem service, BWC shall limit reimbursement to the per diem rate which is all-inclusive of the following services:
a. Individual counseling or therapy;
b. Group counseling or therapy;
c. Education and support;
d. Biofeedback;
e. Stress management (e.g., counseling, aromatherapy, meditation, massage therapy, yoga);
f. Relapse prevention;
g. Recovery meetings;
h. Lab tests;
i. Crisis intervention;
j. Case management;
k. Pain management counseling;
l. Acupuncture;
m. Nursing support;
n. Dietary support or nutritional counseling;
o. Fitness counseling;
p. Peer support;
q. Individual or group activities (e.g., swimming, equine therapy, etc.);
r. Occupational and recreational therapies (e.g., art and music therapy);
s. Life skills training;
t. Any activity or amenity designed to facilitate an individual’s success in the program;
u. Meals (if applicable for the level of care);
v. Semi-private room (if applicable for the level of care); and
w. Emergency access as defined by the ASAM Criteria level of care.

3. Pursuant to OAC 4123-6-21.7(F)(2)(c), prescriber documentation of three or more events of noncompliance by the IW, as described in Section IV. D. of this
policy, constitutes cause for termination of reimbursement of the opioid use disorder treatment.

a. Documentation must be submitted by the injured worker requesting continued treatment.
b. The prescriber and treatment facility will provide a recommendation regarding continuation of care.
c. This information will be taken into consideration in determining the continuation or termination of reimbursement.
I. POLICY PURPOSE: GENERAL OVERVIEW
Ohio Administrative Code (OAC) 4123-6-32 payment for lumbar fusion surgery - through this policy, BWC provides direction and clarification on the sixty day conservative care waiver, pre-surgical operating surgeon evaluations, pre-surgical health behavioral assessment, surgery request prerequisite documentation and after care requirements for lumbar fusion surgery services under the rule.

II. APPLICABILITY
This policy governs the application of OAC 4123-6-32 paragraphs (A)(1)(c), (A)(2), (A)(3), and (D) to requests for lumbar fusion surgery received on or after the OAC 4123-6-32 effective date.

III. DEFINITIONS
Health and Behavior Assessment: This is a procedure used to identify the behavioral, emotional, cognitive, and social factors important to the prevention, treatment, and/or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.

Behavioral Barrier: Any identified factor that prevents the injured worker from adhering to treatment protocols or causes the injured worker to act in a manner which undermines the medical management and/or healing of an injured worker’s allowed physical injuries, or that prevents the injured worker from effectively participating in the healing of the injured workers allowed physical injury. Examples of these barriers may be negative perceptions and expectations for recovery or disability which cause the injured worker to withhold important feedback needed by the physician in determining necessary medical treatment, or fear of re-injury which leads to the injured worker not adhering to a prescribed therapeutic treatment regimen.

IV. POLICY
A. Sixty (60) Day Conservative Care Waiver Documentation:
In situations where the operating surgeon is requesting the sixty (60) day conservative care requirement of OAC 4123-6-32(A)(1)(c) to be waived, the operating surgeon:
1. Must, at the time of the waiver request, submit medical documentation to justify the waiver; and
2. Must receive prior approval from the Managed Care Organization (MCO) for this waiver, prior to the consideration of the lumbar fusion surgery.
B. Pre-Surgical Operating Surgeon Evaluations:
   1. Pursuant to paragraph OAC 4123-6-32(A)(2), the operating surgeon must evaluate the injured worker on at least two occasions prior to requesting surgical authorization.
   2. Unless the 60-day conservative care requirement was waived, at least one of the required evaluations should occur after the sixty (60) days of conservative care.

C. Pre-Surgical Health Behavior Assessment (HBA) for Lumbar Fusion Services:
   1. An injured worker’s biopsychosocial factors that may affect treatment of the allowed lumbar condition must be considered prior to surgery per OAC 4123-6-32(A)(3)(f).
   2. The health behavior assessment is not to be authorized, performed or reimbursed as a psychological evaluation.
   3. Providers permitted to request HBA or HBAI services:
      a) Either the POR or the surgeon may request HBA or HBAI services which meet rule requirements of OAC 4123-6-32.
      b) In all other situations when HBA or HBAI services are needed, OAC 4123-6-33 and subsequent Policy #BRM-02 requires the POR to be the requestor of services.
   4. For a lumbar fusion surgery, a health behavior assessment should be performed by an independent provider other than the POR.
   5. The HBA report must reflect:
      a) Any behavioral barrier(s);
      b) Their potential impact(s) on the healing of the allowed physical lumbar condition if present; and
      c) Any recommended intervention services to address the identified barriers.
   6. Identified barriers must be addressed with relevant interventional services prior to requesting lumbar fusion surgery.

D. Surgery Request Prerequisite Documentation:
   1. When lumbar fusion surgery is requested, the operating surgeon shall provide documentation to support that all prerequisite rule requirements of OAC 4123-6-32(A) have been met.
   2. The POR and operating surgeon must effectively discuss lumbar fusion surgery outcomes with the injured worker prior to surgery. The rule Appendix shall:
      a) Be signed by the IW, the POR, and the operating surgeon as an educational requirement acknowledgement for the injured worker
      b) Be provided to the MCO by the operating surgeon.

E. Lumbar Fusion Surgery After Care Requirements:
   1. During the first six months post-operatively, maximum medical improvement for the allowed lumbar condition(s) must be documented by the operating surgeon, with concurrence from the POR.
2. Postoperative visits rendered by the POR and operating surgeon following lumbar fusion surgery shall not be subject to the sixty (60) day postoperative global surgical period identified in:
   a) *BWC’s Global Surgical Care for Professional Services policy*, and
   b) The preamble to the Professional Provider Medical Services Fee Schedule *Appendix to OAC 4123-6-08*. 
I. POLICY PURPOSE
The purpose of this policy is to ensure that BWC provides direction for the authorization, billing and reimbursement of synchronous telemedicine services.

This policy defines reimbursement for synchronous, two-way, interactive videoconferencing as the modality by which telemedicine services are provided. The use of other modern technologies such as virtual reality, email, store and forward, e-consults without the injured worker (IW) present, remote monitoring devices are not included in this policy, however, may be otherwise covered and reimbursed through the BWC Professional Provider Fee Schedule.

II. APPLICABILITY
This policy applies to all actions relevant to the request, approval and reimbursement of synchronous telemedicine services within the Ohio Workers’ Compensation System.

III. DEFINITIONS
Asynchronous telecommunications (also known as store and forward telemedicine or non-interactive telecommunications): Medical information that is stored and forwarded to be reviewed at a later time by a health care provider at a distant site. Information may include, but is not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, lab results, audio clips and text.

Distant site: Location of the health care provider that is providing medical services. Authorized distant sites are health care provider offices or clinics, hospitals, critical access hospitals (CAHs), and skilled nursing facilities (SNFs).

Medical Peripherals: Any medical device that is attached to a computer externally such as pulse oximeters, weight scales, blood pressure cuff, stethoscope, etc.

Modifier 95: Modifier that denotes a synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.
Originating site: Location where the IW is physically located at the time when services are being performed by a provider via audio and visual telecommunications. Authorized originating sites may be one of the following locations: health care provider clinic or office, hospital, critical access hospital (CAHs), skilled nursing facilities (SNFs), and an employer’s secure, private location that allows an IW access to a remote provider.

Synchronous telecommunications: Live video conferencing: Medical information that is communicated in real-time with the use of interactive audio and video communications equipment. The real-time communication is between the IW and a distant health care provider who is providing the service.

Telehealth: A broad array of means or methods to enhance health care delivery and education through technology, including ehealth, mhealth applications, and distance education.

Telemedicine: A subset of telehealth, is defined as the delivery of health care services such as diagnosis, consultation, or treatment through the use of synchronous telecommunications, live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Telemedicine does not include the use of audio-only telephone, e-mail, store and forward, or facsimile.

Telepresenter: Medical professional with clinical background (e.g. medical assistant, LPN, RN, etc.) at the originating site that facilitates the visit, including the physical examination, at the direction of the distant site provider.

IV. POLICY

A. Licensure and Scope of Practice
   1. Telemedicine providers shall comply with relevant licensing or certification laws in the jurisdiction:
      a. Where the provider is physically located when providing telemedicine; and
      b. Where the IW is physically located when receiving care.
   2. Telemedicine providers must submit to the MCO proof of applicable licenses or certifications for all jurisdictions when requesting prior authorization or reimbursement for telemedicine services, including when an interstate licensure compact applies.
   3. Providers of telemedicine services shall not:
      a. Utilize telemedicine to expand the scope of practice of the health care provider; or
      b. Practice in a jurisdiction where the provider does not have the required license or certification.
   4. Telemedicine visits shall be held to the same standard of practice as those in traditional face-to-face settings (e.g. privacy, informed consent, medical documentation).

B. Location of Care for Telemedicine
   1. An IW may receive medical care delivered through telemedicine provided the IW is located at an appropriate originating site, and the provider is at a distant site.
2. An originating site may be the IW’s employer, but only when the employer provides a secure, private location that allows an IW access to a remote provider.

3. An originating site may not be the IW’s residence, other than residence at a SNF or other long term care facility.

C. Provider Responsibilities

1. The telemedicine provider at the distant site must employ the use of a telepresenter when applicable, at the originating site to:
   a. Facilitate the physical examination; and
   b. Problem solve equipment and connectivity problems; and
   c. Administer or apply the use of medical equipment when someone other than the IW must administer or apply.

2. Medical documentation shall clearly state:
   a. The service was delivered by synchronous telemedicine;
   b. When a telepresenter is used to assist with the physical examination at the originating site;
   c. The originating site location: physical location of the IW (i.e. The IW was present at Dr. Smith’s Office Practice at 123 Main Street, Columbus, Oh. for his/her telemedicine visit); and
   d. The distant site location: physical location of the provider (i.e. the provider’s servicing address).

3. Telemedicine providers shall be responsible for the telemedicine technology and security requirements for both the distant and originating site.

4. If the IW is presenting symptoms that are not appropriate for a telemedicine visit, the provider shall arrange within 24 hours:
   a. A face to face visit with the IW; or
   b. Refer and transfer care of the IW to a traditional brick and mortar provider if a face to face visit is not possible due to distance; or
   c. Immediately refer the IW to appropriate emergency services when applicable.

D. Telemedicine Technology and Security Requirements

1. Technology requirements will apply to both the distant and originating site.

2. The telemedicine network and technology shall:
   a. Be synchronous using interactive audio and visual telecommunications, permitting real-time communications between the distant site provider and the IW receiving health care services;
   b. Utilize technically sufficient equipment and transmission speed to support the service provided:
      i. Videoconferencing picture resolution, at a minimum, shall have a data rate of 30 frames per second (fps) with each frame containing 288 lines and 352 pixels per line.
      ii. Telemedicine systems shall have a minimum of 384 kilobytes per second (Kbps) of bandwidth, and the distant site shall have the capacity to zoom and follow the IW at the originating site.

3. The originating site must have technology to support the telemedicine visit that:
   a. Shall be stationary;
   b. Shall connect to medical peripherals to facilitate a physical examination, when applicable;
   c. Shall have a screen size equal to or greater than 12 inches diagonal;
   d. Shall not be a cell phone.
E. Billing and Reimbursement

1. Telemedicine services are reimbursable pursuant to the Professional Provider Fee Schedule OAC 4123-6-08 in effect on the date of service.
   a. Billing codes are limited to those with a -95 modifier in the fee schedule.
   b. Place of service 02 must be used by the distant site provider in addition to the -95 modifier.

2. When prior authorization for a service is required pursuant to BWC's prior authorization requirements defined in the Provider Billing and Reimbursement Manual, the telemedicine provider must obtain prior authorization including when the service will be provided by telemedicine.

3. An originating site facility fee is payable to the originating site provider, except:
   a. When the originating site is:
      i. The employer;
      ii. An inpatient hospital; or
      iii. A SNF when the IW resides at the facility.
   b. When the originating site:
      i. Also billed for an evaluation and management service or other service provided to the same IW on the same day; and
      ii. The distant site provider is part of the same group practice; and/or
      iii. The distant site is not more than 25 miles from the originating site.

4. The following forms of technology and communication are not considered telemedicine and shall not be reimbursed as telemedicine services:
   a. Telephone conversations;
   b. Text messages;
   c. Electronic mail messages;
   d. Facsimiles (faxes);
   e. Asynchronous or "store and forward" services;
   f. Conversations between practitioners when the IW is not present.

5. Telemedicine services are not billable or reimbursable for the following:
   a. Communication to the IW only to report results, provide education material, and/or address administrative matters;
   b. Services that occur the same day as a face-to-face visit, when performed by the same provider and for the same condition;
   c. Purchase, rental, installation or maintenance of telecommunications equipment or systems used in the delivery of telemedicine;
   d. Provision of telemedicine using an unauthorized originating site;
   e. Services provided in a jurisdiction where the health care provider does not have the required license or certification.
   f. Multiple simultaneous sessions for different IWs by a single provider, other than group therapy.
I. POLICY PURPOSE
The purpose of this policy is to ensure that BWC provides direction for the authorization and billing of outpatient medications.

II. APPLICABILITY
This policy applies to all actions relevant to the request, approval and reimbursement of outpatient medications within the Ohio Workers’ Compensation System.

III. DEFINITIONS
Compound prescription (sterile and non-sterile): A prescription that meets the following criteria: two (2) or more solid, semi-solid, or liquid ingredients, that are weighed or measured then prepared according to the prescriber's order and the pharmacist's art.

IV. POLICY
A. **Outpatient Medication Coverage:**
   1. BWC shall only reimburse for:
      a. Medications for the treatment of an allowed injury or illness;
      b. Medications prescribed by the treating provider or physician of record;
      c. Medications listed in the formulary appendix to OAC 4123-6-21.3 or as otherwise provided by OAC 4123-6-21.3; and
      d. [Food and Drug Administration](http://www.fda.gov) approved legend and over-the-counter drugs.
   2. The prescribing physician may verify the allowed conditions in a claim by visiting our website at [www.bwc.ohio.gov](http://www.bwc.ohio.gov) or by calling 1-800-644-6292.
B. Pharmacy Benefits Manager (PBM)
   1. BWC requires outpatient medication to be authorized and adjudicated through a PBM. The PBM:
      a. Processes outpatient medication bills for state-fund, Black Lung and Marine Industry Fund claims;
      b. Is a single source for accepting and adjudicating prescription drug bills;
      c. Is separate from the Managed Care Organization (MCO).
   2. The PBM’s responsibilities are:
      a. Performing on-line, point-of-service adjudication of outpatient medication bills with prescription information transmitted electronically between a pharmacy and PBM;
      b. Enrolling pharmacy providers in a BWC-specific network;
      c. Processing prescription bills based on the BWC closed formulary list of covered medications and restrictions;
      d. Utilizing drug relatedness editing for prescribed medications; and
      e. Performing desktop and on-site prescription audits of pharmacies.

C. Outpatient Medication Prior Authorization
   1. BWC requires prior authorization for certain drugs not typically used to treat work-related injuries or illnesses when a condition is not allowed in the claim that supports the Food and Drug Administration’s approved uses of that prescribed drug.
   2. The prescribing physician must complete the Request for Prior Authorization of Medication Form (MEDCO-31) to request prior authorization.
   3. BWC requires prior authorization for:
      a. Medical Only claims beyond sixty (60) days from the date of injury;
      b. All claims beyond two-hundred seventy (270) days of last paid prescription; and
      c. A pending surgery:
         i. To request pain medication or other post-surgically related medications subsequent to the MCO approval yet prior to the surgery date.
         ii. The surgery date must be included on the request for consideration.
         iii. A medication request of this type would be limited to a thirty (30) day fill.
   4. To access BWC’s formulary covered drugs, restrictions and prior authorization visit our website at https://www.bwc.ohio.gov/provider/services/ICD10FormularyLookup/Default.aspx.

D. Generic & Brand Name Drugs
   1. An injured worker shall be subject to out-of-pocket cost liability when:
      a. An injured worker requests a brand name drug or
      b. A physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication, and
      c. Single source or multi-source medications exist that are pharmaceutically and therapeutically equivalent.
      d. In this circumstance, the injured worker shall be liable for the product cost difference between:
         i. The established maximum allowable cost price of the drug product, and
         ii. The AWP discounted rate of the dispensed brand name drug.
   2. BWC may approve reimbursement of the dispensed brand name drug at the AWP discounted rate if:
      a. The injured worker has a documented, systemic allergic reaction which is consistent with known symptoms or clinical findings of a medication allergy
b. The injured worker has been prescribed, and has tried, other drugs in the therapeutic class and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.

E. Injectable & Compounded Medication
1. Compounded medications have a National Drug Code (NDC) number for each ingredient that is included in the compounded product.
2. All compounded medications require prior authorization.
3. All outpatient sterile and non-sterile compounded medications shall be obtained from a licensed pharmacy provider.
4. The PBM point of sale system only reimburses:
   a. For sterile compounds that are intended for use in pain pumps as part of the accepted claim conditions; and
   b. An approved C-9 for pain pump implantation is required for reimbursement.

F. Billing
1. Existing Claims
   a. A pharmacy provider is required to submit bills for outpatient medications at the point-of-service in all claims, including situations prior to assigning a BWC claim number. To submit a bill at the point-of-service, the pharmacist must transmit at least two (2) of the following three (3) items, along with the other billing information, to the PBM:
      i. BWC claim number;
      ii. Social Security number; and/or
      iii. Date of injury.
   b. The PBM shall verify the information, process the bill and send the pharmacist an appropriate message based on the claim's status, allowed conditions and formulary coverage and restrictions.
   c. The PBM shall pay pharmacy provider bills according to OAC 4123-6-21.
   d. Medications administered at a skilled nursing facility must be obtained from a licensed pharmacy provider that electronically submits the bill(s) to the PBM for payment, and delivers the medication to the facility for administration.
2. First Fill Program:
   a. BWC has established a program to provide reimbursement for the first fill of prescription drugs for medical conditions identified in a pending workers' compensation claim.
   b. The program is limited to the first fill list (click here) of prescription drugs that occur prior to the date BWC issues an initial claim determination order.
   c. Prescription reimbursement is limited to the following:
      i. A period of ten (10) days or less at the most commonly prescribed dosing schedule, and no refills shall be approved;
      ii. One (1) drug per therapeutic drug class listed in the appendix to OAC 4123-6-21.3;
      iii. Extemporaneous compounded prescriptions are not eligible for reimbursement under the first fill program; and;
   d. Prescription drugs not listed in the appendix to OAC 4123-6-21.3 are not eligible for reimbursement.
   e. The prescribing physician or the prescribing physician's agent must write 'work-related injury' on and sign the prescription for the prescription to be eligible for the first fill program.
      i. The pharmacist and pharmacy intern is permitted to write the phrase and sign telephone prescriptions.
ii. BWC shall guarantee payment for reimbursement for prescription drugs to a pharmacy provider when the first fill program requirements are followed, regardless of final claim acceptance or denial.

f. First fill prescriptions are reimbursed in the same manner as other prescriptions.
   i. The pharmacy provider should follow the steps outlined in Section IV.F.1 of this policy for billing guidelines.
   ii. Custom messaging shall direct the pharmacy provider to resubmit the prescription after consulting the first fill medication list to ensure coverage.

3. Durable Medical Equipment:
   a. The PBM does not reimburse for durable medical equipment or medical supplies purchased at a pharmacy.
   b. Durable medical equipment and medical supplies are subject to the BWC Professional Provider Fee Schedule OAC 4123-6-08.
   c. Durable medical equipment and medical supplies must be billed to the MCO on the CMS-1500.

G. Reimbursement Rates
   1. Refer to OAC 4123-6-21 for reimbursement rates and/or calculations for state-fund employers for the following:
      a. Single Source/Brand Drug;
      b. Multi-Source/Generic Drug; and
      c. Compounded product-dispensing fees for non-sterile and sterile compounds; and
      d. The maximum reimbursement for any one (1) compounded prescription; and
      e. The product cost component of payment for prescription drugs.
   2. BWC does not distinguish between legend and over the counter medications when determining reimbursement. Over the counter drugs must be prescribed by a provider licensed to prescribe medications for the drug to be considered for reimbursement.

H. Supply & Quantity Limits - BWC established maximum day supply and maximum quantity limits for both standard and catastrophic/chronic claim types.
   1. A standard claim can only receive the greater of a thirty-four (34) day supply or one-hundred twenty (120) units per dispensing.
   2. Catastrophic claims may receive up to a ninety (90) day supply with no quantity limitations.

I. Payment for outpatient medication by a self-insuring employer
   1. The PBM program defined in this policy does not apply to self-insured employers.
   2. Questions related to self-insured claims, including billing and reimbursement should be referred to the injured worker’s employer.
   3. Payment for outpatient medication by a self-insuring employer will be made pursuant to OAC 4123-6-21.1.

J. Forms
   1. The prescribing physician uses the MEDCO-31 form to request prior authorization for medications not typically used for industrial injuries or occupational disease. Please fax completed forms to 1-866-213-6066.
   2. The physician uses the Formulary Medication Request Form (MEDCO-35) to ask the Pharmacy & Therapeutics Committee to consider additions or deletions of a particular drug to the formulary.
   3. The injured worker uses the Request for Injured Worker Outpatient Medication Reimbursement (C-17) to obtain reimbursement for prescribed outpatient medication only.
a. This form is not used for medical supplies, durable medical equipment (e.g., crutches, walkers) and other non-drug items regardless of the prescribing provider.

b. The pharmacy provider is expected to submit bills electronically, even before the injured worker has a claim number.

c. The use of the C-17 should be rare and limited to special circumstances.

d. The completed C-17 form shall be submitted to the PBM with the medication labels, pricing information or a pharmacy printout with pricing information and the pharmacist’s signature.

K. Contacts

1. The PBM is prepared to answer technical support inquiries from the pharmacy provider and inquiries from the injured worker regarding the status of a submitted C-17. To contact the PBM call 1-800-644-6292, and follow the prompts.

2. BWC Pharmacy Department: Providers, injured workers, employers and their representatives can inquire about the prior authorization program or other drug coverage related questions by calling 1-877-543-6446 and follow the prompts.

3. Questions and comments about pharmacy benefits should be emailed to the Pharmacy.Benefits@bwc.state.oh.us, by phone at 877-543-6556, or by mail to: Ohio Bureau of Workers’ Compensation, Pharmacy Department, 30 W. Spring St. L-21, Columbus, OH 43215-2256.
I. POLICY PURPOSE
The purpose of this policy is to provide direction for the billing and reimbursement of surgical care for professional services when a global surgical period applies, including when more than one provider participates in the surgical care (pre-, intra- and post-operative).

II. APPLICABILITY
This policy applies to all actions relevant to the billing and reimbursement of surgical care within the Ohio Workers’ Compensation System, as it relates to the global surgical period.

III. DEFINITIONS
Minor Procedure: Procedure codes with global surgery indicators of 010 in the Medicare National Physician Fee Schedule Relative Value File (PPRRVU) for the applicable calendar year.

Major Procedure: Procedure codes with global surgery indicator of 090 in the Medicare National Physician Fee Schedule Relative Value File (PPRRVU) for the applicable calendar year.

Preoperative Services: Services performed prior to surgery which may include, but are not limited to, medical examinations, diagnostic tests, medical management of underlying diseases, and counseling.

Intraoperative Services: Services performed that are normally a usual and necessary part of rendering the surgical procedure.

Postoperative Services: Services performed after surgery which include all additional medical or surgical supplies or services required of the surgeon during the post-operative
period because of complications that do not require additional trips to the operating room. Includes follow-up visits that are related to the recovery from surgery and post-surgical pain management.

**Global Surgery Package:** Includes all the necessary services normally furnished and as stipulated in the definitions for preoperative, intraoperative, or postoperative services.

**IV. POLICY**

A. BWC follows the national established guidelines by Centers for Medicare and Medicaid Services (CMS) for global surgical package in effect on the date of service, except as follows:

1. Otherwise provided in Section IV. E. of this policy
2. BWC recognizes a sixty (60) day post-operative global surgical period instead of the CMS industry standard of ninety (90) days for major procedures.
3. Modifier reimbursement percentages.

B. **Global Surgery Package Timeframe**

1. BWC adheres to the global surgery package period for minor procedures as follows:
   a. Preoperative – 0 days
   b. Intraoperative – 1 day
   c. Postoperative – 10 days
2. BWC adheres to a global surgery package period for major procedures as follows:
   a. Preoperative – 1 day
   b. Intraoperative – 1 day
   c. Postoperative – 60 days

C. **Reimbursement:** BWC will reimburse the components of the global surgical package pursuant to the BWC Professional Provider fee schedule (Appendix to Ohio Administrative Code (OAC) 4123-6-08) in effect on the date of service.

D. **Billing for Split Surgical Care**

1. BWC recognizes the national established guidelines by CMS for modifiers 54, 55, and 56 appended to a service to indicate when a physician furnishes only part of a global surgical package, and relinquishes the other portion(s) of the surgical package to another physician.
2. In any instance(s) where a physician furnishes part of a global surgical package, BWC requires all physicians involved in the injured worker’s care to keep a copy of the written transfer of care agreement in the medical record.
3. The transfer of care shall be documented as indicating transfer of care by the surgeon to another physician(s), in the form of a letter or annotation in the medical note.
4. Surgical procedures performed in the Emergency Department (ED), place of service 23:
   a. Modifier 54 must be appended to major surgical procedures performed in the Emergency Department (ED) place of service 23 for all professional services.
   b. BWC will automatically append modifier -54 in major surgical cases where the modifier isn’t appended.
5. The global surgical period does not apply:
   a. When the surgical procedure was performed in the ED place of service; and
   b. When the provider rendering the follow up services is not the surgeon.
   c. This exception applies to both major or minor surgical procedures performed in the ED.
E. Lumbar Fusion Exception to Global: BWC exempts Evaluation and Management services rendered during lumbar fusion post-operative surgical care from the 60-day postoperative global surgery package period for major procedures, pursuant to OAC 4123-6-32.