

BWC Board of Directors

Audit Committee

Thursday, November 20, 2008, 4:00 p.m.

William Green Building

30 West Spring Street, 2nd Floor (Mezzanine)

Columbus, Ohio 43215

Members Present: Mr. Kenneth Haffey, Chair
Mr. Bob Smith
Mr. Bill Lhota
Mr. Jim Harris
Mr. Jim Matesich

Members Absent: None

Other Directors Present: Mr. Thomas Pitts
Ms. Alison Falls
Mr. Jim Hummel

CALL TO ORDER

Mr. Haffey called the meeting to order at 4:11 PM and the roll call was taken. All members were present except Mr. Matesich, who arrived at 4:21 PM.

MINUTES OF OCTOBER 28, 2008

The minutes were approved without further changes by a 4-0 roll call vote on a motion by Mr. Harris, seconded by Mr. Lhota. Mr. Matesich was not present to vote at the time this motion was presented.

NEW BUSINESS / ACTION ITEMS

1. External Audit Update

Mr. Haffey introduced this new business item by stating Ms. Tracy Valentino, Chief of Fiscal and Planning, had received word the audit findings had been released by the Auditor of State; therefore, it was not necessary to enter Executive Session.

Mr. Joseph J. Patrick, CPA of Schneider Downs was not available to present the audit findings to the Committee. Mr. Roy Lydic, CPA of Schneider Downs presented the audit findings with Mr. Patrick's apologies to the Committee.

Mr. Haffey introduced the audit findings by noting they included a financial statement audit with management disclosure, a management letter, and internal controls findings.

With regard to the financial statements, Mr. Lydic noted a unique disclosure statement. Specifically, due to the decline in financial market valuations, the statements were noted to be accurate as of June 30, 2008 and June 30, 2007, respectively. This disclosure was also noted in the footnotes and management analysis.

With regard to the “yellow book” report, Mr. Lydic noted general compliance with government auditing principles. However, one deficiency noted in the audit revealed some managed care organization reviews by independent auditors had substandard reports. Mr. Lydic noted that Bureau management was responding to this identified deficiency. Mr. Lhota inquired if “substandard” was the worst rating that could be received. Mr. Lydic replied it was the second worst rating. Mr. Haffey noted the MCO reviews were not outright audits, and there were no instances of noncompliance that were otherwise required.

Mr. Lydic then addressed the management letter, which involved execution of the audit findings by Bureau management. In lieu of reading the letter, Mr. Lydic noted the timeliness of internal reviews suggested room for improvement in BWC’s audit trail. There were more suggestions than findings in the management letter.

Mr. Haffey noted he had conversations with Mr. Patrick and Ms. Tracy Valentino, Chief of Fiscal and Planning, and others to insure the Bureau was in lockstep with the external auditing firm.

Mr. Lydic noted the Bureau’s responsibilities with general accounting standards were strongly adhered to, and there was no consultation to his knowledge with any other accounting firm. Mr. Lydic noted all journal entry errors had been corrected and posted to the books, and he believed the final documentation would be signed and sent to Bureau management in the next week or so.

Mr. Haffey concluded this presentation that this audit was a very long and involved process.

2. Executive Session -- Semi Annual Meeting with Inspector General

At 4:21 PM, Mr. Haffey moved for the Audit Committee to go into Executive Session pursuant to Ohio Rev. Code Sec. 121.22(G)(3) for the purpose of discussing personnel matters with the Inspector General. The motion was seconded by Mr. Matesich, and the motion passed by unanimous roll call vote.

At 4:43 PM, Mr. Lhota moved for the Audit Committee to leave Executive Session. The motion was seconded by Mr. Harris, and the motion passed by unanimous roll call vote.

3. FY 09 1st Quarter Executive Summary

Ms. Caren Murdock, Chief of Internal Audit, presented a quarterly overview of audit findings that were completed by October, 2008. The following audits findings were discussed: Lump Sum Settlement Audit; Permanent Partial/Scheduled Loss Audit; MCO #5 Audit; and the IT Physical and Environmental Security Audit.

Lump Sum Settlement Audit

Ms. Murdock presented the findings of the Lump Sum Settlement audit. There were four material, twelve significant and two minor comments resulting from this audit.

Ms. Murdock noted that settlement costs were on the rise, with \$172 million in settlements in fiscal year 2006, \$256 million in fiscal year 2007, and \$321 million in fiscal year 2008. Ms. Murdock provided an overview of what a lump sum settlement was, and how lump sum settlements were initiated and processed. The Bureau's responsibility was insuring the settlement was in the best interest of all parties, with final review of the settlement performed by the Industrial Commission. As a result of the audit findings, a settlement consultant has been retained. While the internal controls were adequately described in some instances, the controls were poorly implemented. In summary, the audit revealed the lump sum settlement process did not describe its purpose or goals, and cross divisional problems were identified. Furthermore, internal controls over the entire process were weak.

Seven key issues were discussed by Ms. Murdock. First, the process lacked mission goals and strategies that impacted the entire agency with regard to claim obligations. This issue was identified as a material weakness. Bureau management has agreed to describe the agency goals and the process of settlements. Additionally, Bureau management has agreed to determine what types of claims should be settled in consideration of investment risk.

Second, Ms. Murdock noted a material weakness in the policies and procedures of the settlement process. While many of the policies and procedures were documented, many were either outdated or undocumented. Bureau management has agreed to develop an end to end lump sum settlement process and complete a process map of the lump sum settlement process.

Third, Ms. Murdock noted a material weakness in the lump sum settlements as many settlements were not being reviewed and approved by the Industrial

Commission. Failing to have this approval subjected the Bureau to potential liability as claims -- previously thought to be settled—could be later challenged and held invalid. Recommendations were made to install a data warehouse query to supplement reporting and timelier quality assurance reviews. Management agreed to address this issue through compensation audits.

Fourth, Ms. Murdock noted a material weakness in quality assurance in the lump sum settlement process. There was no compilation by the Bureau's Legal Division, and there was no indication in any of the reviews to say the settlement was reasonable. In summary, quality assurance needed to be implemented into the process.

Fifth, Ms. Murdock noted a significant weakness in the lump sum settlement process performance results. There was no benchmarking of the results to industry practices. Ms. Murdock, in addition to the benchmarking, recommended trending analysis in the performance measurements and management reporting should include identified goals and objectives maintained by private carriers.

Sixth, Ms. Murdock noted a significant weakness in inconsistency with the "fast track" lump sum settlement process. "Fast track" settlements are those where verbal negotiations occur with settlement of claims of values of less than \$10,000. There were compliance errors in testing the process. Ms. Murdock recommended Bureau management develop and implement procedures for this process.

Finally, Ms. Murdock noted a significant weakness in failing to itemize medical costs in lump sum settlements. The United States Department of Health and Human Services has mandated this cost segregation under secondary payer laws. Failure by the Bureau to segregate these costs may expose the Bureau and the injured worker to subrogation by Medicare. Ms. Murdock has recommended that the Bureau develop a white paper to limit liability and risk exposure in this regard.

At the conclusion of her presentation, Mr. Haffey thanked Ms. Murdock for the detail and time involved in the audit. The audit had significant findings and took hundreds of hours to complete. As a result of the audit, Mr. Haffey noted Ms. Pat Drago has been retained as an outside consultant who has much expertise in this area.

Mr. Pitts inquired as to whether this audit applied to court settlements. Ms. Murdock replied that her audit findings addressed all settlements, including court settlements. Mr. Pitts also inquired as to the current settlement thresholds. Ms. Murdock agreed to provide this information to Mr. Pitts.

Permanent Partial/Scheduled Loss Audit

Ms. Murdock reported this was an overall good audit. The audit was to insure the Bureau had effective controls in place to effectively follow statutory and policy requirements. There were two significant and two minor comments resulting from this audit.

The primary significant weakness identified, according to Ms. Murdock, was located in the claim audit tool. The claim audit tool currently in use may be ineffective in identifying and addressing potential scheduled loss awards.

Mr. Pitts inquired if the audit focused only on scheduled loss permanent partial awards or if it included percentage of permanent partial awards. Ms. Murdock stated the audit only focused on scheduled loss permanent partial awards.

MCO #5 Audit

Ms. Murdock then presented the MCO #5 audit findings. There was one material, seven significant, and two minor comments resulting from this audit.

The primary policies and procedures reviewed in this audit were well designed but a material weakness was noted in the reconciliation of provider accounts. Ms. Murdock believed this material weakness needed to be addressed immediately as this finding had been made in prior audits. It was imperative that reconciliation of accounts with zero balancing occur, and this was not occurring.

Additionally, Ms. Murdock noted a significant weakness in the use of backup devices with confidential claims information. Ms. Murdock recommended that the MCO require encryption before releasing confidential data to an outside vendor.

Ms. Falls asked what internal controls are in place if nothing is done with Ms. Murdock's recommendations. Administrator Ryan indicated she speaks with department heads regarding the recommendations. If the recommendations are not being followed, she examines the failure to adhere to the recommendation from a risk standpoint.

IT Physical and Environmental Security Audit

Ms. Murdock then presented the audit findings of the IT Physical and Environmental Security Audit. There was one material, four significant and five minor comments resulting from this audit.

Ms. Murdock noted the internal controls reviewed during this audit were adequate. Fire, temperature and humidity risks to the data center were adequately protected, as was direct exposure from outside sources.

Ms. Murdock noted a material weakness existed where written policies or procedures were uncovered through the audit, but no evidence these policies

and procedures were actually being followed. Furthermore, there appeared to be an ad hoc implementation of policies and procedures with IT staff relying on more experienced staff to address issues as they arose. Ms. Murdock recommended the IT division implement policy and procedures and provide training on the policy and procedures.

Finally, Ms. Murdock noted a significant weakness in penetration, or “hacking.” Ms. Murdock recommended a policy on penetration testing be designed and implemented.

After presentation of these audit findings, Ms. Murdock inquired to the Committee, if the detail provided was sufficient for the Committee. Mr. Haffey asked if all of these audits were completed in October, 2008, and Ms. Murdock replied they were. Mr. Haffey noted the findings provided to the Committee had a great amount of detail, and he was satisfied with the detail given.

Ms. Murdock then noted she was obligated to notify the Board of Directors if she made a recommendation, and Bureau management refused to implement her recommendation. This obligation notifies the Board of Directors that Bureau management has assumed a risk she has identified for corrective action. At the present time, Ms. Murdock notified the Committee there were two partial implementations of recommendations by Bureau management. One of the partial recommendations concerned the noncomplying employer audit, and the other concerned audit findings of a managed care organization.

Partial Implementation Notification of Noncomplying Employer Audit Recommendation

Ms. Murdock reported to the Committee that Bureau management had accepted a risk in partial implementation of a recommendation concerning when an employer goes into lapsed status. The audit recommendation was if an employer had not paid their full amount of premium when due, the employer would go into lapsed status immediately. This recommendation was consistent with industry standards. Bureau management partially implemented this recommendation by allowing employers to pay at least 65% of premiums by the due date without going into lapsed status.

Mr. Harris inquired if industry standards were other state fund programs or private insurance companies. Ms. Murdock replied the standard was based upon other state funds.

Mr. Lhota asked what Ms. Murdock was asking the Committee to do. Ms. Murdock replied if an audit recommendation was not fully implemented by management, the issue is presented to the Administrator. If the Administrator accepts the risk undertaken by management, her position required her to present

the risk undertaken by the Administrator to the Board to determine if the Board also accepts the risk.

Mr. Lhota asked Administrator Ryan for a rationale for undertaking the risk in this instance. Ms. Ryan noted implementing the no coverage on a certain date may end up disenfranchising too many employers. Ms. Ryan also noted the Attorney General's office does obtain certification for lapsed premiums. Ms. Ryan was of the opinion, at this time, the Bureau and Ohio employers would not be well served by trying to reach a much higher standard. Ms. Ryan also noted she was meeting tomorrow to discuss new methods of ensuring compliance, and there is a balance between being a public enterprise enforcing collections and finding those employers who are truly abusing the system.

Mr. Lhota then inquired as to the definition of lapsed coverage. Ms. Valentino noted employers can achieve lapsed status in a number of ways. First, failing to report premiums by the due date will place an employer in lapsed status, and the next due date is February 28th. Second, if an employer accumulates a \$1,000 debt that is certified to the Attorney General's Office, the employer is in lapsed status by virtue of statute. Third, an employer will also be lapsed under the current 65% rule discussed by Ms. Murdock. Ms. Valentino noted the 65% threshold currently in place is being examined by the Bureau from a financial impact perspective of increasing the threshold to 85%. Valentino added the effect of being in lapsed status means an employer will be liable for any claim allowed during the lapsed status on a dollar for dollar basis.

Mr. Harris inquired if the threshold for lapsed coverage was discretionary. Ms. Valentino noted the lapsing process is done systematically, and reiterated the Bureau was examining the financial impact of raising the threshold higher.

Mr. Harris inquired if this threshold was impacting any particular group of employers, such as small employers, differently. Ms. Valentino said smaller employers pay fewer premiums, and Ms. Ryan indicated the 65% policy was directed at both public and private employers. Ms. Valentino also noted lapsed status is in effect for an employer until their balance due is paid in full, and these employers cannot participate in various premium discount programs the Bureau offers.

Mr. Haffey said it sounded like the Bureau was headed in the right direction, and Mr. Harris said he had no present objections to the Bureau's current policy on this matter.

Partial Implementation Notification of MCO Audit Recommendation

Ms. Murdock reported to the Committee the second assumption of risk by the Bureau involved a managed care organization with a Columbus office which used a vendor located in Cleveland. The issue involved the fact that both the

Columbus office and the Cleveland vendor were not date stamping documents. The Cleveland vendor was using the date on the imaged documents as the received date, which could have some impact on incentive payments. The Bureau and the MCO have agreed the Columbus office will date stamp invoices as they are received, but the vendor will continue with their normal process. No concerns were raised by the Committee with this compromise.

Overview of Annual Audit Plan

Ms. Murdock then presented an overview of the annual audit plan to the Committee. She indicated all audits scheduled for completion in the coming year were on schedule with no proposed changes at this time. Ms. Murdock meets with the Administrator and management periodically to discuss the upcoming audits, and no concerns or questions were identified that would effect the current audit plan.

At the beginning of the last quarter, there were 83 outstanding comments. In the past quarter, 31 new comments were added, and 12 were validated, which left 102 outstanding comments at the conclusion of this past quarter. Of the 102 outstanding comments: 2 were rather old and not presently rated; 22 were material; and 78 were significant. However, there was a 19% decrease in outstanding comments on a year over year comparison. Ms. Murdock specifically noted management had partially implemented the employer non-compliance comment. Furthermore, according to the management quarterly responses, the bankrupt self insured comment is to be implemented in March, 2009 and the medical adjustment and billing audit comments were projected for implementation in December, 2008.

Many of the comments were expected to be validated in the coming year, but the scheduled implementation of 9 of the comments extended out to the first quarter, 2010. Those 9 comments involved IT benchmarking, which required long-term transition.

Ms. Murdock inquired if this portion of the presentation was sufficient in detail for the Committee's needs. Mr. Haffey noted there was a very nice story in the presentation, and overall the presentation was good.

Mr. Pitts inquired how the bankrupt self insured comments would be implemented by March, 2009 when it was noted that legislative change was required. Subordinate to that question, he inquired whether this position or policy is something that the Board should be advocating. Ms. Ryan stated she has had some discussions regarding this issue. She is waiting for the Deloitte study before seeing if the Bureau would actively pursue a legislative change.

Mr. Pitts then inquired regarding the Lump Sum Settlement audit. At present, the pre-PTD settlements appeared to be on hold. Mr. Pitts wanted to know if all

other settlements were being processed. Ms. Ryan replied the settlement process required a top to bottom review and the Bureau has retained Ms. Pat Drago, a consultant with experience in the settlement process. Several recommendations have been shared by the Bureau and Ms. Drago. Ms. Ryan said settlements are taking place, but enough work needs to be done regarding documentation and controls that some lump sum settlements require a second look.

Mr. Pitts finally asked about the status of permanent total disability vocational assessments with respect to the settlement process. Ms. Tina Kielmeyer, Chief of Customer Services, responded to Mr. Pitts. Ms. Kielmeyer replied that Ms. Drago is looking at elements and components of these evaluations. Mr. Pitts asked if there is only one person presently doing the evaluations at BWC, and whether or not this was causing a significant delay in the processing of pre-PTD settlement applications. Ms. Kielmeyer confirmed there was only one person at present doing these evaluations; however, the Bureau is evaluating whether or not a network of vocational evaluators could provide independent vocational evaluations. With regard to pre-PTD settlements, there was a backlog; however, the backlog did not impact the processing of the PTD application itself.

Mr. Pitts then inquired to Ms. Ryan whether the comments resulting from the lump sum settlement audit inferred a rather broad based reform was needed. Ms. Ryan responded the statement could be interpreted in that way from a perspective of needed document controls and internal attention of how settlements are affecting reserves and the activities of the Bureau. Mr. Pitts asked where the Bureau was going in this process. Ms. Ryan replied the settlement process needed to insure timeliness, with all parties being heard, as well as fulfilling requirements and potentially initiating methodologies used by other carriers and state funds to achieve settlements.

Mr. Pitts finally inquired regarding the Bureau's policies on settling pre-PTD claims. Some states had up to three times the number of PTD recipients, but peer states proactively settled PTD claims, which in turn reduced the number of PTD recipients on the books. Ms. Ryan replied this was an issue that was being discussed at the present time.

Mr. Harris made a statement that he wanted it clear he opposed offsets of Social Security from PTD. This topic was an issue of previous discussions with the Board, and he was opposed to it then, and he was opposed to it now. Mr. Pitts cited agreement with Mr. Harris' statement.

Ms. Murdock concluded her presentation to the Committee by noting there was a tentative start date for the Investment Auditor on December 12th. The new Investment Auditor has over twenty years experience in the field. Furthermore, Ms. Murdock reported there are six vacant auditor positions, but only three would be filled. Interviews were being conducted for one position, and one candidate

has been extended an offer. The two remaining positions will be posted in December, which requires a proficiency test be passed before conducting interviews.

4. Audit Committee Charter Review

Mr. Lhota reported the Governance Committee of the Board of Directors had reviewed the Audit Committee's Charter. Three recommendations were made by the Governance Committee for consideration by the Audit Committee. First, wording in the membership provisions was clarified so that non-members of the Board of Directors could serve on the Audit Committee. Second, the Governance Committee recommended a redundant clause regarding open meetings be removed. Third, the Governance Committee would be overtaking general rule review provisions, and thus, the Audit Committee's charter needed to reflect its rule review authority will be limited only to audit based rules.

After brief discussion, Mr. Lhota moved that the Audit Committee refer the Audit Committee Charter, as amended through incorporating the Governance Committee's recommendations in their entirety, to the Board of Directors for review and approval. The motion was seconded by Mr. Smith, and the motion passed by a unanimous roll call vote.

5. Rule Review – First Reading – Interstate Jurisdiction 4123-17-14, 4123-17-17, and 4123-17-23

Mr. Michael Glass, Director of Underwriting and Premium Audit, and Ms. Kilmeyer presented the first reading of proposed rules 4123-17-14, 4123-17-17, and 4123-17-23 to the Committee.

Mr. Glass noted prior to implementation of recent legislative changes, Ohio employers were at a competitive disadvantage. Specifically Ohio employers were required to report all payroll for all of their employees, regardless of whether work was to be done in other states. Furthermore, those employers subject to the Longshore Harbor Workers' Compensation Act (LHWCA) also had to report their longshoremen payroll to the Bureau even though the exclusive remedy was under that federal act.

Ms. Kilmeyer noted there was frequently confusion with injured workers as to which state they were to file for benefits. Ultimately this situation often led to a denial or a delay in benefits while jurisdictional issues were being sorted out. Ms. Kilmeyer also noted there was an issue of dual recovery of benefits from multiple jurisdictions, leading to various states trying to recover benefits and allegations of fraud. These proposed rules hopefully help clarify the jurisdictional requirements that have now been implemented through legislation.

Ms. Kielmeyer reported 95 employers currently subject to the LHWCA will benefit under the current legislation and rule proposal. With regard to interstate employers, the figure was more difficult to ascertain, but the figure could be as high as 40,000. Clearly the rule proposals will also benefit injured workers as the rules help clarify who will assert jurisdiction for their claims.

Mr. Glass noted reciprocity was the most advantageous portion of the new legislation. Ohio can agree with other states to enter into reciprocal agreements to waive the other states coverage requirements if the other state will waive our coverage requirements as well. The concept, while it makes perfect sense, unfortunately is difficult to enforce. Most other states cannot waive under their respective laws; however, currently West Virginia is fully favorable at the present time. They have a thirty day waiver currently in place, and thus they will have reciprocity with Ohio.

Mr. Glass then presented an overview of the changes encompassed by these new rules through a slide show presentation. Mr. Glass noted that proposed rule 4123-17-14 changed a requirement of all payroll had to be reported to Ohio, no matter where the work was performed. Additionally, in addition to having to disclose coverage and insurer on a separate form, a copy of the policy would also be required.

Mr. Pitts noted one correction was needed in proposed rule 4123-17-17(C) regarding changing a “the” to “an out of state.” Ms. Kielmeyer appreciated the suggestion which will be changed. She encouraged any other suggested changes be submitted to her attention before the next reading.

6. Rule Review – First Reading – Ambulatory Surgery Center (ASC) Fee Schedule

Mr. Freddie L. Johnson, Director of Managed Care Services, and Ms. Anne Casto, a private reimbursement and coding consultant retained by the Bureau, addressed the Committee regarding this proposed rule. This was the first reading of the rule, with the second reading expected at the December, 2008 meeting, and if approved, the fee schedule will be put into effect on April 1, 2009. Mr. Johnson was of the belief the proposed rule will provide injured workers better access to a higher quality of medical care.

Mr. Johnson provided a financial overview of the impact of the fee schedule of ASCs and the objectives of the underlying recommendations in the rule changes. Mr. Johnson noted appropriate revision of the Bureau’s ASC billing processes was needed due to inefficiencies and ineffectiveness of the rule as it was currently worded.

Ms. Casto discussed the ASC reimbursement changes and impacts under the current proposal. Ms. Casto noted the Medicare Modernization Act, first passed

in 1982, has undergone several changes over the years, most recently in 2003. One of the driving forces of the changes in 2003 was the increasing disparity between payments to ASCs and hospital outpatient settings. Medicare has evaluated this disparity again as recently as January of this year, and currently ASCs are reimbursed under that system at outpatient hospital rates with adjustment factors considering the lower cost setting. The proposed fee schedule will impact 700 procedures under the scope of service added by Medicare, and the Bureau will add approximately 400 procedures, depending on Bureau needs. The rule will also enhance billing and practice efficiencies with ASCs, and this proposal also is more in line with HIPAA and the Medicare Claims Procedure Manual. One of the biggest complaints from the ASCs has been they dislike the inefficiencies in dealing with the Bureau because of custom data required by the agency. Ms. Casto stated, while some procedures will increase and some decrease in reimbursement, the fee schedule as proposed will provide ultimately increased ease of access and lower costs to the Bureau.

Ms. Casto noted there were about 200 ASCs in the State of Ohio, and the Bureau has approximately a 90% penetration rate at present. The ASCs were providing outpatient services in a very cost efficient environment. Mr. Haffey inquired as to how the Bureau will see a cost benefit. Ms. Casto replied third party payers who pay less than Medicare rates is a bad situation, and this places access of the services at risk. By failing to provide competitive rates, outpatient hospital settings would replace ASCs, and the migration of injured workers from ASCs to the outpatient hospital setting would ultimately lead to higher costs.

Mr. Matesich inquired how an injured worker is to gain education about ASC facilities. Ms. Casto responded primary care physicians help by guiding the injured workers to appropriate facilities to obtain treatment. The condition of the injured worker, required services and other factors determine whether or not an ASC facility would be appropriate, or if the procedure should be done on an outpatient basis at a hospital.

Mr. Pitts noted familiarity with one ASC, Crystal Clinic of Akron, and that particular ASC has been a tremendous benefit to injured workers in the surrounding area. Ms. Casto noted that facility was the number two ASC provider of services in the BWC system. Mr. Pitts asked who the number one provider was, and Ms. Casto stated it was the Northeast Surgical Center.

ADJOURNMENT

Mr. Harris moved to adjourn the meeting at 6:10 PM, seconded by Mr. Smith. The meeting adjourned with a unanimous roll call vote.

Prepared by Michael J. Sourek, Staff Counsel November 25, 2008

**BWC Board of Directors
December 17, 2008
Bureau 50/50 Program
Rule 4123-17-14.2**

Executive Summary

In accordance with division (A)(3) of section 4123.29 of the Revised Code and paragraph (A)(2) of rule 4123-17-14 of the Administrative Code, the administrator is authorized to develop and make available to employers who are paying premiums to the state insurance fund alternative premium plans, which may include permitting employers to pay premiums in two installments.

An employer electing to pay the premium in two installments is required to report payroll and make the initial premium payment for this program through the bureau's website, ohiobwc.com. An employer participating in this payment option is considered a complying employer during the installment period if the employer reports total payroll and pays one-half of the premium by the regular due date. The 50/50 program is not available to employers after the due date.

Approximately 17,000 employers participated in the 50/50 program during the most recent reporting period. This is a 60% increase in participation compared to the same time period in 2005. BWC expects to see more employers participating in this program in the next reporting cycle as a result of economic difficulties currently being reported. In an effort to provide some relief to employers during this period, BWC is proposing to extend the second installment due date from May 1, 2009 to June 1, 2009.

Common Sense Business Regulation (BWC Rules)

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

Rules 4123-17-14.2

Rule Review

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

Citation: R.C. 4123.29, 4123.34

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

What goal(s): Rule 4123-17-14.2 establishes the rules for the BWC split payment program option. The rule amendment adds an additional month to a deadline for payment.

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

4. The rule is effective, consistent and efficient.

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

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

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

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

Explain: _____

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

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

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

4123-17-14.2 Bureau 50/50 program.

(A) Pursuant to division (A)(3) of section 4123.29 of the Revised Code and paragraph (A)(2) of rule 4123-17-14 of the Administrative Code, the administrator is authorized to develop and make available to employers who are paying premiums to the state insurance fund alternative premium plans, which may include, as the administrator may determine for any payroll period, that employers shall be permitted to pay the premium in two installments.

(B) Where the administrator determines for any payroll period that employers shall be permitted to pay the premium in two installments, the only method of reporting payroll and making the initial premium installment payment for this program shall be through the bureau's website, ohio**wc**.com, using the payroll reports 50/50 payment plan service offering. All payroll for the reporting period and payment information for the initial installment shall be entered in the service offering in the same online session.

(C) An employer electing to participate in this premium payment option shall report its payroll and pay one-half of the premium due by the regular due date in accordance with paragraph (A) of rule 4123-17-14 of the Administrative Code. The balance of the premium shall be paid through the bureau's website, ohio**wc**.com, using the accounts receivable balance service offering. The balance shall be paid by the first day of ~~May~~ June for the July 1 to December 31 reporting period, or by the first day of November for the January 1 to June 30 reporting period.

(D) An employer participating in this payment option shall be considered a complying employer during the installment payments if the employer reports payroll and pays one-half of the premium by the method prescribed in paragraph (B) of this rule by the regular due date, and the balance shall not be subject to penalties or interest under rule 4123-19-07 of the Administrative Code. If, by the regular due date, an employer

does not report payroll and pay one-half of the premium by the method prescribed in paragraph (B) of this rule or does not otherwise report payroll and pay the full premium due, the employer's coverage will be lapsed and the employer shall be subject to penalties and interest. If an employer participating in this payment option does not pay the balance of the employer's premium by the prescribed method and by the date such balance is due, the employer's coverage will be lapsed effective the date such balance is due.

(E) Any employer that fails to utilize the bureau's website for this premium payment program as required in paragraphs (B) and (C) of this rule shall not be permitted to participate in the installment premium option provided in this rule.

Promulgated Under: 111.15
Statutory Authority: 4121.12, 4121.121, 4121.30
Rule Amplifies: 4123.29, 4123.34
Prior Effective date: 7/1/06

Common Sense Business Regulation (BWC Rules)

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

Interstate Jurisdiction Rules

Rule Review

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

Citation: R.C. 4123.29, 4123.34

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

What goal(s): The rule amendments implement the legislative changes relating to interstate jurisdiction in Am. Sub. S.B. 334 of the 127th General Assembly, and the changes relating to jurisdiction for claims under the Longshore and Harbor Workers' Compensation Act as provided in Am. Sub. H.B. 562 of the 127th General Assembly.

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

4. The rule is effective, consistent and efficient.

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

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

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

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

Explain: *Ohio Trucking Association, NFIB, *Chamber of Commerce, *Ohio Association for Justice, OMA, Ohio Retail Merchants, AFL-CIO, Ohio Association of General Contractors, Connie Nolder – private lobbyist for trial lawyers and Tom Pappas and Associates – private lobbyist.

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

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

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

12. The rule is not unnecessarily burdensome or costly to those affected by rule.
If so, how does the need for the rule outweigh burden and cost? _____

13. The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

Executive Summary

Interstate Jurisdiction Rules

Background Law

Am. Sub. S.B. 334

On June 11, 2008, Governor Strickland signed into law Am. Sub. S.B. 334, effective September 11, 2008. The Act prohibits an employee from filing a claim for workers' compensation benefits in Ohio if the employee has received a decision on the merits of a claim filed in another state for the same injury or occupational disease. The Act allows an Ohio employer to obtain workers' compensation insurance for claims arising in other states through BWC, if the Administrator elects to provide such insurance, or through a private insurance company. The Act permits an employer to segregate payroll between Ohio and the other states to avoid duplicate premium payments, and makes other changes to the Workers' Compensation Law regarding interstate workers' compensation claims.

Am. Sub. H.B. 562

On June 24, 2008, Governor Strickland signed into law Am. Sub. H.B. 562, effective September 23, 2008. The Act is 907 pages, and contains a wide variety of provisions relating to state government. The Legislature amended into the bill provisions relating to the federal Longshore and Harbor Workers' Compensation Act (LHWCA). H.B. 562 prohibits individuals covered under the LHWCA from applying for and receiving benefits under Ohio's Workers' Compensation Law, and requires BWC to adopt rules on the premium calculations applicable to employers who employ employees covered under both the LHWCA and Ohio's Workers' Compensation Law. Like S.B. 334 for interstate jurisdiction, this Act permits employers to segregate payroll to avoid dual payment of premium.

The federal LHWCA provides compensation for injuries to workers engaged in maritime employment that are incurred upon the navigable waters of the United States. The Secretary of the U.S. Department of Labor administers the LHWCA. An employee may receive compensation in respect to the employee's disability or death only if the disability or death results from an injury occurring upon the navigable waters of the United States. An Ohio employer may obtain LHWCA coverage either through a private insurance company or through BWC's Marine Industry Fund.

Under the Act, if an employee who is covered under the LHWCA is injured and if that claim is subject to the jurisdiction of the LHWCA, the employee is not entitled to apply for and must not receive compensation or benefits under Ohio's Workers' Compensation Law. The Act states that the rights of the employee under the LHWCA are the exclusive remedy against the employer for that injury after the effective date of the Act.

The Act requires BWC to adopt a rule providing that an employer who employs an employee covered under the LHWCA and Ohio's Workers' Compensation Law must be

assessed a premium in accordance with the expenditure of payroll attributable to only labor performed by such employee when the employee performs labor for which the employee is not eligible to receive compensation and benefits under the LHWCA.

Rule Changes

BWC has proposed amendments to three rate rules to implement the provisions of S.B. 334 and H.B. 562. Two of the rules (4123-17-23 and 4123-17-17) are exempt from public hearing and J.C.A.R.R.; one rule (4123-17-14) will require J.C.A.R.R. review.

4123-17-23 Duties outside the state

In Paragraph (A), BWC has amended the provision that an employer must report its entire payroll to BWC to provide that “if the employer elects to obtain other-states’ coverage under Section 4123.292 of the Revised Code, the employer shall include in the payroll report only the remuneration for work the employees perform in Ohio and other work not covered by the other-states’ policy.”

Paragraph (C) contains the requirement from S.B. 334 that BWC will not permit an out of state employer working in Ohio a temporary exemption from Ohio coverage “if the laws of the state of coverage do not provide this same exemption to Ohio employers and their employees working temporarily in that state.” In such cases, “the employer must obtain Ohio coverage and report to the bureau the remuneration of its employees for work performed in Ohio.”

New Paragraph (D) reinforces current law, that “employees hired to work specifically in Ohio must be reported for workers’ compensation insurance under the Ohio fund, regardless of where the contracts of hire were entered.”

4123-17-14 Rule controlling the completing of payroll reports

Paragraph (A) is amended to provide that on the semi-annual payroll report, the employer shall include only payroll for Ohio work if the employer elected to obtain other-states’ coverage under Section 4123.292 of the Revised Code. Also if the employer has employees covered under the federal LHWCA, the employer shall include on the payroll report only the remuneration for work the employees performed in Ohio for which the employees are eligible to receive Ohio workers’ compensation benefits.

New Paragraph (E) states that the employer shall notify and provide BWC a policy of its out of state coverage. On the BWC payroll report, the employer shall not include remuneration for work performed outside of Ohio and covered by the other-state’s policy, but shall submit that information to BWC on a separate form provided by BWC.

New Paragraph (F) states that if the employer employs an employee covered under the federal LHWCA and the Ohio workers’ compensation act, the employer shall, in writing, notify BWC of LHWCA insurer. On the payroll report the employer submits to BWC,

the employer shall include remuneration for work performed covered under the federal LHWCA, regardless of whether the employer has obtained such coverage from BWC or private insurance. This report is for informational purposes only, and BWC will not assign a premium rate to such payroll.

4123-17-17 Auditing and adjustment of payroll reports

Paragraph (A) of this rule requires employers to maintain records of Ohio payroll for five years. The amendment extends the requirement to records of all payroll reported to the other-states' insurer for work performed outside of Ohio.

Proposed Rules to SB 334

4123-17-23 Duties outside the state

(A) The entire remuneration of employees, whose contracts of hire have been consummated within the borders of Ohio, whose employment involves activities both within and without the borders of Ohio, and where the supervising office of the employer is located in Ohio, shall be included in the payroll report. However, if the employer elects to obtain other-states' coverage under Section 4123.292 of the Revised Code, the employer shall include in the payroll report only the remuneration for work the employees perform in Ohio and other work not covered by the other-states' policy.

(B) The remuneration of employees of other than Ohio employers, who have entered into a contract of employment outside of Ohio to perform transitory services in interstate commerce only, both within and outside of the boundaries of Ohio, shall not be included in the payroll report.

(C) The bureau of workers' compensation respects the ~~extra-territorial~~ extraterritorial right of the workers' compensation insurance coverage of an out-of-state employer for ~~his~~ its regular employees, ~~whose contracts of hire have been consummated in some~~ who are residents of a state other than Ohio, ~~while performing work in the state of Ohio for a temporary period not to exceed ninety (90) days.~~ However, if the laws of the state of coverage do not provide this same exemption to Ohio employers and their employees working temporarily in that state, the out of e employer must obtain Ohio coverage and report to the bureau the remuneration of its employees for work performed in Ohio. Employees whose contracts of hire are consummated at a job site in Ohio or employees who have been hired to work specifically in Ohio must be protected for workers' compensation insurance under the Ohio fund.

(D) Employees hired to work specifically in Ohio must be reported for workers' compensation insurance under the Ohio fund, regardless of where the contracts of hire were entered.

~~(D)~~ (E) Where there is possibility of conflict with respect to the application of the workers' compensation law because the contract of employment is entered into and all or some portion of the work is or is to be performed in different states, the employer and his employees may mutually agree to be bound by the workers' compensation laws of the State of Ohio by executing Form C-110, or mutually agree to be bound by the workers' compensation law of some other state by executing Form C-112, such forms to be obtained from and filed with the bureau of workers' compensation within ten days after execution.

4123-17-14 Rule controlling the completing of payroll reports

(A) In July and January of each year, the bureau will furnish private state fund employers with proper forms showing premium rates on which to report the actual wage expenditure and/or payroll in the conduct of the employer's operations for the preceding six months' period or portion thereof. However, if the employer elected to obtain other-states' coverage under Section 4123.292 of the Revised Code, the employer shall include on the payroll report only the remuneration for work the employees performed in Ohio and other work not covered by the other-states' policy. If the employer employs employees who are covered under the federal "Longshore and Harbor Workers' Compensation Act," 98 Stat. 1639, 33 U.S.C. 901 et seq., the employer shall include on the payroll report only the remuneration for work the employees performed in Ohio for which the employees are eligible to receive compensation and benefits under Chapter 4121. and 4123. of the Revised Code. The employer shall complete such report with the premium calculated, and the report and remittance of the premium shall be submitted to the bureau no later than August 31 or the last day of February for that report's preceding six-month period. For an employer that elected to obtain other-states' coverage, the remuneration for work performed in states other than Ohio and covered by the other-states' policy shall be reported to the bureau on a separate form in accordance with paragraph (E) of this rule. For an employer that employs employees who are covered under the federal "Longshore and Harbor Workers' Compensation Act," the remuneration for work performed for services for which the employees are eligible to receive compensation and benefits under the federal "Longshore and Harbor Workers' Compensation Act" shall be reported to the bureau on the payroll report in accordance with paragraph (F) of this rule.

(1) Except where the administrator has announced prior to the due date of the premium payment that an employer may pay the premium in installments, the amount of the premium due is to be paid in accordance with paragraph (A) of this rule or at the expiration of the coverage for early coverage terminations.

(2) The administrator may determine for any payroll period that employers shall be permitted to pay the premium in two installments and the method of those premium installment payments. An employer electing to participate in this option shall pay one-half of the premium due by the regular due date in accordance with paragraph (A) of this rule and the balance of the premium by the invoiced date following the original due date. An employer participating in this payment option shall be considered a complying employer during the installment payments if the employer pays one-half of the premium by the regular due date, and the balance shall not be subject to penalties or interest under rule 4123-19-07 of the Administrative Code.

(B) For all counties and public employer taxing districts, by January first of each year, the bureau will furnish the county auditor of each county and the chief fiscal officer of each public employer taxing district in each county with proper forms showing premium rates on which to report the actual wage expenditure or payroll expended in the conduct of the employer's operations for the preceding twelve calendar months. Such report shall be completed and the premium calculated on the report, and each such employer shall return the report and remit the amount of premium due to the bureau as follows:

(1) On or before May fifteenth of each year, no less than forty-five per cent of the premium due.

(2) On or before September first of each year, no less than the total premium due.

(C) The terms "payroll" and "wage expenditures" as used in the rules of this chapter of the Administrative Code shall include the entire remuneration allowed by an employer to employees in the employer's service for the applicable period. "Remuneration" shall have the same meaning as defined in division (H) of section 4141.01 of the Revised Code as provided by the statutes of the Ohio bureau of employment services, in order that the payroll reporting requirements of the bureau of workers' compensation shall be coordinated with the remuneration reporting requirements of the Ohio bureau of employment services, except as otherwise modified by the rules of this chapter. The definition of remuneration shall apply to all amenable employers who are required or elect to obtain Ohio workers' compensation coverage and who pay premiums based upon payroll under Chapter 4123. of the Revised Code, and shall apply to all persons of such employers considered to be employees under the statutes or rules of the bureau of workers' compensation, regardless of whether the employer is required to report payroll or remuneration to the Ohio bureau of employment services under Chapter 4141. of the Revised Code or whether the employer reports payroll or remuneration to the Ohio bureau of employment services for such persons considered to be employees by the bureau of workers' compensation.

(D) In determining the reportable payroll or remuneration after July 1, 1995, for employees who customarily receive tips or gratuities, the employer shall report all actual wages paid and shall include all tips to the extent they are used to supplement the federal minimum wage requirements reportable as remuneration as defined in paragraph (C) of this rule.

(E) If an employer elects under Section 4123.292 of the Revised Code to obtain other-states' coverage from an other-states' insurer, the employer shall, in writing, notify the bureau of the election and the identity of the insurer providing the coverage. The employer shall also provide the bureau with a copy of the other-states' policy. On the payroll report the employer submits to the bureau in accordance with paragraph (A) of this rule, the employer shall not include remuneration for work performed outside of Ohio and covered by the other-state's policy. On a separate form to be submitted to the bureau with the payroll report described in paragraph (A), the employer shall report the amount of remuneration paid to its employees for work performed outside of Ohio and covered by the other-states' policy. The bureau shall make forms available to employers for fulfilling the notification and reporting requirements of this paragraph.

(F) If an employer employs an employee covered under the federal "Longshore and Harbor Workers' Compensation Act" and Chapter 4121. and Chapter 4123. of the Revised Code, the employer shall, in writing, notify the bureau of the identity of the insurer providing the federal "Longshore and Harbor Workers' Compensation Act" coverage. On the payroll report the employer submits to the bureau in accordance with paragraph (A) of this rule, the employer shall include remuneration for work performed covered under the federal "Longshore and Harbor Workers' Compensation Act," regardless of whether the employer has obtained such coverage from the bureau or from private insurance. This report is for informational purposes only, and the bureau will not assign a premium rate to such payroll.

4123-17-17 Auditing and adjustment of payroll reports

(A) Every employer amenable to the workers' compensation law shall keep, preserve and maintain complete records showing in detail all expenditures for payroll reportable to Ohio and the division of such expenditures in the various divisions and classifications of the employer's business. If an employer elects under Section 4123.292 of the Revised Code to obtain other-states' coverage, the employer shall also keep records of all payroll reported to the other-states' insurer for work performed outside of Ohio. ~~Such~~ Both types of payroll records shall be preserved for at least five years after the respective time of the transaction upon which such records are based.

(B) All books, records, papers, and documents reflecting upon the amount and the classifications of the payroll expenditures of an employer shall be kept available for inspection at any time by the bureau of workers' compensation or any of its assistants, agents, representatives or employees. If any private fund, county, or public employer taxing district employer fails to keep, preserve and maintain such records and other information reflecting upon payroll expenditures, or fails to make such records and information available for inspection, or fails to furnish the bureau or any of its assistants, agents, representatives or employees, full and complete information in reference to expenditures for payroll when such information is requested, the bureau may determine upon such information as is available to it the amount of premium due from the employer and its findings shall constitute prima facie evidence of the amount of premium due from the employer.

(C) The bureau shall have the right at all times by its members, deputies, referees, traveling auditors, inspectors or assistants to inspect, examine or audit any or all books, records, papers, documents and payroll of private fund, county, or public employer taxing district employers for the purpose of verifying the correctness of reports made by employers of wage expenditures as required by law and rule 4123-17-14 of the Administrative Code. The bureau shall also have the right to make adjustments as to classifications, allocation of wage expenditures to classifications, amount of wage expenditures, premium rates or amount of premium. No adjustments, however, shall be made in an employer's account which result in reducing any amount of premium below the amount of contributions made by the employer to the fund for the periods involved, except in reference to adjustments for the semi-annual or adjustment periods ending within twenty-four months immediately prior to the beginning of the current payroll reporting period. Except as provided in rule 4123-17-28 of the Administrative Code, no adjustments shall be made in an employer's account which result in increasing any amount of premium above the amount of contributions made by the employer to the fund for the periods involved, except in reference to adjustments for the semi-annual or adjustment periods ending within twenty-four months immediately prior to the beginning of the current payroll reporting period. The twenty-four month period shall be determined by the date when such errors affecting the reports and the premium are brought to the attention of the bureau by an employer through written application for adjustment or from the date that the bureau provides written notice to the employer of the bureau's intent to inspect, examine, or audit the employer's records.

(D) Experience will not be recalculated unless there is an adjustment of an employer's account due to a reclassification of operations. In such event the experience will be recalculated for the same period as the adjustment of the employer's account.

(E) Where the bureau has assigned two or more classifications for an employer's operations, the employer shall keep an appropriate record showing a correct and verifiable segregation of all payroll into such classifications. If it is found that the employer has failed to keep such record, the part of the payroll which cannot be reasonably determined by the bureau as belonging to any other classification shall be placed by the bureau under the assigned classification having the highest rate, and the employer will be assessed premium accordingly. To such payroll as is expended after the employer has been notified of these requirements and which is not segregated as herein provided, the highest rate of the employer's assigned classifications shall be applied.

h: rules subjects/rates

SB 334 proposed rules w HB 56 rev1.doc

October 2, 2008

BWC 2009 Proposed Ambulatory Surgical Center Fees

Medical Service Enhancements

For those injured on the job, prompt, effective medical care is often the key to a quicker recovery and timely return-to-work and quality of life. The maintenance of a network of quality providers, which include medical facilities such as ambulatory surgical centers, is an important element to ensure the best possible recoveries from workplace injury. Such also ensures access to quality, cost-effective service. Access for injured workers, and employers, means the availability of quality, cost-effective treatment provided on the basis of medical necessity.

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

Ambulatory Surgical Center Fee Schedule

As stated, implementing a sound and effective provider fee schedule is a critical component of the Medical Services Division's goals. Ambulatory Surgical Centers (ASCs) billing represents a small number of bills BWC processes annually. However, this provider segment is a critical component of BWC's provider network. ASCs provide services in connection with surgical procedures that do not require inpatient hospitalization. Services provided by ASCs are the same as those provided in a hospital outpatient setting, but with lower cost and generally increased ease of access. In financial terms, these bills represent less than one percent (.97%) of BWC's overall medical expenses. The total ASC expenditures in calendar year 2007 totaled \$7,490,719.

BWC Current Rates

Since June 1996, the BWC's ASC fee schedule has been based on Medicare's Ambulatory Surgical Center List (aka ASC Groups). Medicare's ASC Groups had been Medicare's prospective payment system from 1982 through 2007. The ASC Groups' payment scheme placed approved reimbursements into one of nine groups based on average cost. The reimbursement rate for each group was then based on the average overhead cost for the group. Cost data used for rate setting was last collected by Medicare in 1986. Federal legislation froze the Medicare ambulatory surgical center rates from 2002-2007.

BWC's ASC fees were last updated in 2005. The BWC 2005 rates were set at 121% of the then Medicare rate which, as stated above, was frozen in 2002. Since 2005, BWC performed only code maintenance for the fee schedule, which involved updating services eligible for the ambulatory surgical center based on added or deleted CPT¹ codes.

¹ *Current Procedural Terminology*, American Medical Association, 2008

BWC Proposed Changes

As stated in the previous section, the BWC's ASC fee schedule is based on what had been Medicare's Ambulatory Surgical Center List (aka ASC Groups). The Medicare Modernization Act of 2003 mandated that Medicare implement a new prospective payment system for the ambulatory surgical center setting by January 2008. Therefore, January 1, 2008 Medicare implemented the new Ambulatory Payment Classifications (APC) for the ambulatory surgical center setting.

One key change in Medicare's new APC was the replacement of the nine group classification reimbursement scheme. Payment rates for ASC services are now based on the hospital outpatient department rates. The new approach assigns reimbursement rates to covered services, but reduces those rates by a certain percent to reflect the lower relative costs of ASCs. The percent at which the APC rates are reduced is based on the Government Accountability Office study². Medicare's underlying objective was to decrease the disparity of payments present between the ASC and hospital outpatient department setting. As Medicare aligned the ASC and hospital outpatient department rates, the reimbursement rates for certain service lines experienced large shifts. The table below shows the financial impact based on the 2008 rates provided in the Medicare 2008 final rule.

Impact by Specialty		
Specialty	2008 Rates	Fully Implemented Rates
Dermatology	7%	28%
Gastrointestinal	-5%	-19%
General Surgery	20%	79%
OB/GYN	21%	85%
Ophthalmology	0%	3%
<i>Orthopedics</i>	23%	92%
Otolaryngology	18%	72%
<i>Pain Management</i>	0%	-15%
Pulmonary	-1%	5%
Urology	10%	40%
Vascular	23%	89%

FASA Update, *A New Year and New Medicare Payment System for ASCs*, page 34, 2007.

Additionally, with the implementation of APCs there is an increase in the scope of services eligible for performance in the ambulatory surgical center setting. Over 700 procedures were added to the ASC list of approved procedures in 2008.

The significant change in the new process will create a significant payment impact for Medicare. Thus, in order to dampen the large reimbursement swings a four year transition period was put in place. Over the four year period, there will be a gradual change from the old rate to the new rate with a shifting percentage blend of the old and new rates in years 2008, 2009 and 2010. The full schedule is provided in the table below.

² *Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System* (November 2006).

Type of Service	2008	2009	2010	2011
Surgical service on the 2007 ASC List	75% ASC List rate 25% APC rate	50% ASC List rate 50% APC rate	25% ASC List rate 75% APC rate	100% APC rate
Surgical service not on the 2007 ASC List	100% APC rate	100% APC rate	100% APC rate	100% APC rate
Office based procedure not on the 2007 ASC List	75% MPFS rate 25% APC rate	50% MPFS rate 50% APC rate	25% MPFS rate 75% APC rate	100% APC rate

Beginning January 2011, Medicare will have fully implemented APCs for the ambulatory surgical center setting.

BWCs current fee schedule continues to reflect Medicare's old ASC Group methodology. Of course, as Medicare moved to the new APC methodology in 2008, BWC is no longer in alignment with Medicare payment rates or scope of services. Historically, BWC reimbursement for ambulatory surgical centers has equaled 20% of billed charges. A reimbursement target of 20% of billed charges allowed BWC to reimburse above the Medicare rate and remain competitive in the healthcare payer market. When Medicare moved to the new methodology in 2008 the reimbursement rates for several specialties increased and thus, BWC's reimbursement rate then fell below Medicare's rate for many services.

Therefore, Medical Services is recommending that BWC move to Medicare's new Ambulatory Payment Classification methodology for 2009. Additionally, Medical Services is recommending that Medicare's 2009 transitional rate be adopted.

Medical Services is further recommending that BWC adopt the expanded scope of services provided under Medicare's new Ambulatory Surgical Center Prospective Payment System.

The service lines most utilized by BWC are orthopedics and pain management. Based on the impact by specialty figures provided by Medicare, the rates for orthopedic services will greatly increase while the rates for pain management will moderately decrease.

In addition to revising the ASC fee schedule, BWC is proposing several enhancements that will streamline the billing process for ASC facilities. By making modifications to allowed CPT codes, HCPCS Level II codes³, and appropriate modifiers, BWC's processes will be in alignment with standing billing protocols. Thus, ASC facilities will no longer be required to manually produce a BWC customized bill.

Projected Impacts and Outcomes

The goal of this update is to align BWC ASC fee schedule with Medicare's revised prospective payment system. This includes an update in payment rates as well as scope

³ *Healthcare Common Procedural Coding System*, Centers for Medicare and Medicaid Services, 2008

of services. This recommendation will result in an estimated increase payment of \$1.7 million dollars or 23% from the 2007 ASC reimbursements. Although this is a significant percent increase in reimbursement for this setting, it is necessary so that BWC can remain competitive in the payer market and continue to maintain access to care for our injured workers.

The recommendation would also result in expanding the scope of services that are currently reimbursed by BWC. This expansion of services will provide the physician greater flexibility in selecting the most appropriate surgical setting for the injured worker for an increased number of services. Additionally, it expands injured worker facility choices for surgical procedures. Lastly, since the ASC is a lower cost setting, BWC could potentially save money on outpatient surgical services.

As Medicare continues through the transition period for the revised ASC payment system, BWC will continue to propose modifications to the payment adjustment factor each year to ensure that our internal reimbursement targets are met.

Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-37.3

Rule Review

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

Citation: O.R.C. 4121.441(A)(8); O.R.C. 4123.66

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

What goal(s): The rule adopts a discounted pricing fee schedule for workers' compensation ambulatory surgical services in accordance with O.R.C. 4121.441(A)(8) and *Ohio Hosp. Assn. v. Ohio Bur. of Workers' Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499.

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

4. The rule is effective, consistent and efficient.

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

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

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

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

Explain: Conducted meeting in BWC home office with representatives of Ohio Association of Ambulatory Surgery Center (OAASC), including a facility member where feedback and support of the recommendations were very positive and supportive. Members of the BWC staff have been also scheduled to participate in a teleconference with additional facility members of the OAASC as a follow-up to the initial meeting.

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

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

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

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

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

13. The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

BWC Board of Directors
Executive Summary
BWC Ambulatory Surgical Center
Fee Schedule Rule

Introduction

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including rules relating to the adoption of provider fee schedules and payment for medical services and supplies to injured workers. BWC initially enacted the bulk of the Chapter 4123-6 HPP medical service rules (Ohio Administrative Code 4123-6-20 to 4123-6-46) in February 1997.

Background Law

R.C. 4121.441(A)(8) provides that the Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to injured workers, including but not limited to discounted pricing for medical services.

Prior to the 10th District Court of Appeals decision in *Ohio Hosp. Assn. v. Ohio Bur. of Workers' Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499, BWC adopted provider fee schedules in the manner provided for in O.R.C. 4121.32(D), which grants BWC authority to “establish, adopt, and implement policy guidelines and bases for decisions involving reimbursement issues including, but not limited to . . . reimbursement fees . . . set forth in a reimbursement manual and provider bulletins.”

However, pursuant to the Court of Appeals' decision in the *OHA* case, BWC is now required to adopt changes to its provider fee schedules via the O.R.C. Chapter 119 rulemaking process.

Rule Changes

4123-6-37.3 Payment of ambulatory surgical center services.

BWC is proposing to adopt a new rule, OAC 4123-6-37.3, to specifically address reimbursement for ambulatory surgical center services.

Under the proposed rule, unless an MCO has negotiated a different payment rate with an ambulatory surgical center, reimbursement for ambulatory surgical center services with a date of service of April 1, 2009 or after shall be equal to the lesser of the ambulatory surgical center's allowable billed charges or the BWC fee schedule for such services.

The BWC fee schedule for ambulatory surgical services shall be an appendix to the rule. As the appendix indicates, fees for covered ambulatory surgical services shall be set at 100% of the 2009 Medicare transitional Ambulatory Surgical Center Prospective Payment System rates.

4123-6-37.3 Payment of ambulatory surgical center services.

Unless an MCO has negotiated a different payment rate with an ambulatory surgical center pursuant to rule 4123-6-08 of the Administrative Code, reimbursement for ambulatory surgical center services with a date of service of April 1, 2009 or after shall be equal to the lesser of the ambulatory surgical center's allowable billed charges or the fee schedule amount indicated in the attached appendix A, developed with provider and employer input and effective April 1, 2009.

Appendix A

BUREAU OF WORKERS' COMPENSATION

AMBULATORY SURGICAL CENTER FEE SCHEDULE

EFFECTIVE APRIL 1, 2009

Effective: 4/1/2009

R.C. 119.032 review dates: _____

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates:

Appendix A

Ohio Bureau of Workers' Compensation (BWC) 2009 Ambulatory Surgical Center Fee Schedule

The five character codes included in the Ohio Bureau of Workers' Compensation (BWC) 2009 Ambulatory Surgical Center Fee Schedule are obtained from Current Procedural Terminology (CPT®), copyright 2008 by the American Medical Association (AMA). CPT® is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures by physicians.

The responsibility for the content of the BWC 2009 Ambulatory Surgical Center Fee Schedule is with the State of Ohio Bureau of Workers' Compensation and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the BWC 2009 Ambulatory Surgical Center Fee Schedule. No fee schedules, basic unit values, relative value guides, conversion factors or scales are included in any part of CPT. Any use of CPT outside of the BWC 2009 Ambulatory Surgical Center Fee Schedule should refer to the most current *Current Procedural Terminology* which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

For the purposes of this fee schedule, services and/or supplies must be medically necessary and appropriate for the treatment of the work related injury. The following definitions apply:

By Report The procedure, service, or supply is not typically covered and will not routinely be reimbursed. No fee is associated with the procedure, service or supply; therefore, a report is required to be obtained by the MCO for reimbursement consideration. Many of the –BR codes are unclassified/unspecified generic codes and are currently assigned a dollar amount of \$0.00. After review by the MCO, the report must be imaged into the BWC claim and a request must be submitted to BWC Medical Policy email box Medpol@bwc.state.oh.us for consideration for payment. Authorization and payment of codes identified as –BR require an individual analysis by the MCO prior to submission of the request for approval from BWC Medical Policy. The MCO analysis shall include researching the appropriateness of the code in relation to the service or procedure and cost comparisons in order to render high quality, cost-effective medical care. Research information from the MCO is required to be submitted to BWC Medical Policy with each request.

ASC Fee Reimbursement rate for the ASC facility for CPT® and HCPCS Level II codes. \$0.00 (without –BR indicator) indicates that reimbursement for the procedure, service or supply is bundled into the payment rate for the associated surgical procedure.

ASC Reimbursement Levels

The BWC 2009 Ambulatory Surgical Center Fee Schedule rates for covered services shall be set at 140% of the Medicare 2009 transitional Ambulatory Surgical Center Prospective Payment System rates published in Appendix AA and Appendix BB of the Department of Health and Human Services, Centers for Medicare and Medicaid Services' "Final Changes to the ASC Payment System and CY 2009 Payment Rates," 73 Fed. Reg. _____ (2008).

OHIO BWC 2009 Ambulatory Surgical Centers (ASCs) Fee Schedule Proposal

Medical Services Division
Freddie L Johnson, Director Managed Care Services
Anne Casto, President-Casto Consulting LLC.
December 17, 2008

Introduction and Guiding Principles

- Legal Requirement for Fee Schedule Rule
- Proposed Time-line for implementation
- Guiding Principle:
Ensure access to high-quality medical care by establishing an appropriate Benefit plan and Terms of service with a competitive fee schedule, which in turn, enhances medical provider network

Summary of ASC Recommendation Impacts

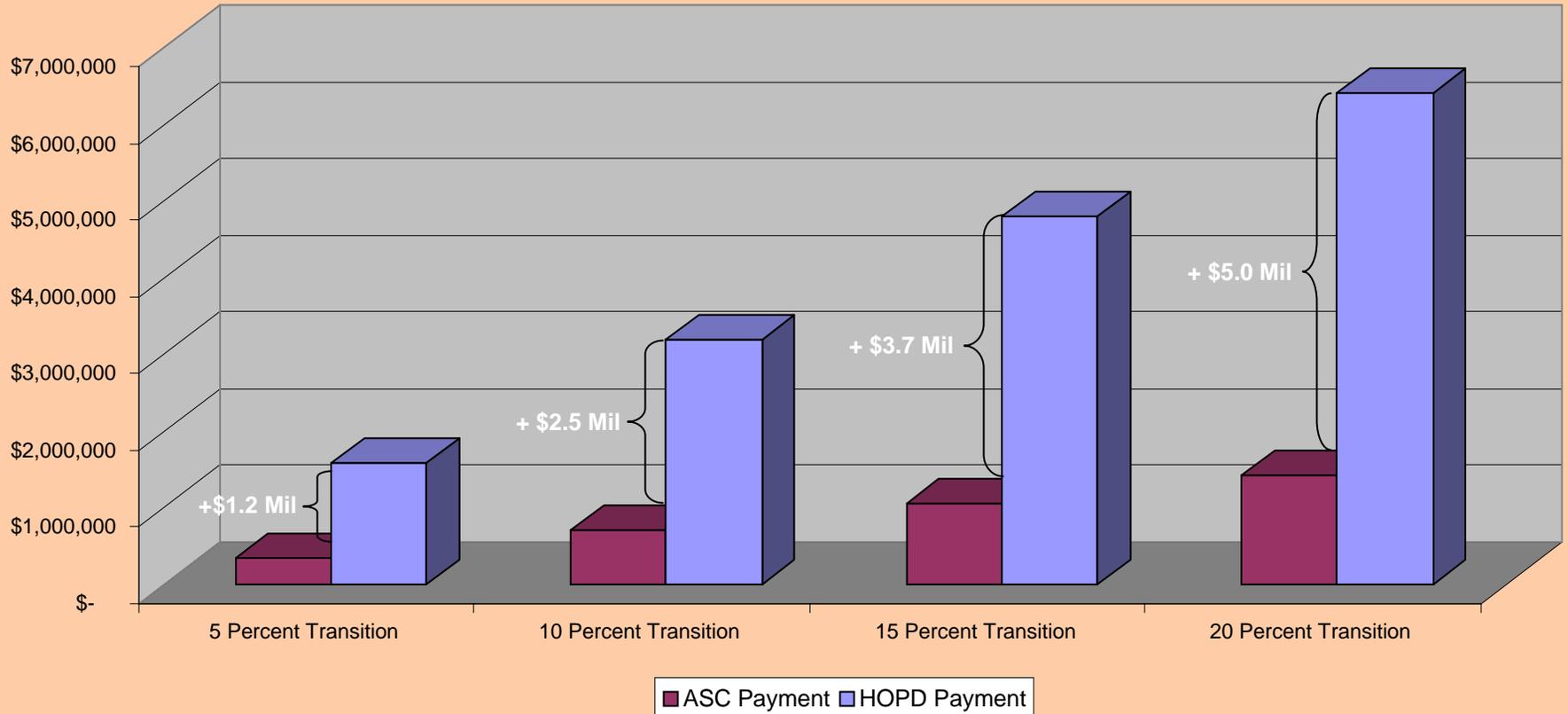
- Adopt Medicare's new ASC methodology and 2009 transitional rates
 - Projected reimbursement increase of \$1.7 million or 23% from 2007 reimbursements
- Expands the scope of services for which ASCs can receive reimbursements
 - Additional increase in ASC reimbursements
 - Positive decrease in overall outpatient services reimbursements
- Enhance service billing and practice efficiencies
 - Reduces ASCs expenses when providing services to BWC injured workers

Cost Benefit Slides

1. Slide one shows the reduction in reimbursement if services migrate from the HOPD to the ASC due to ASCs not being available
2. Slide two shows the potential additional reimbursement cost that BWC would experience if services migrated from the ASC to the HOPD.

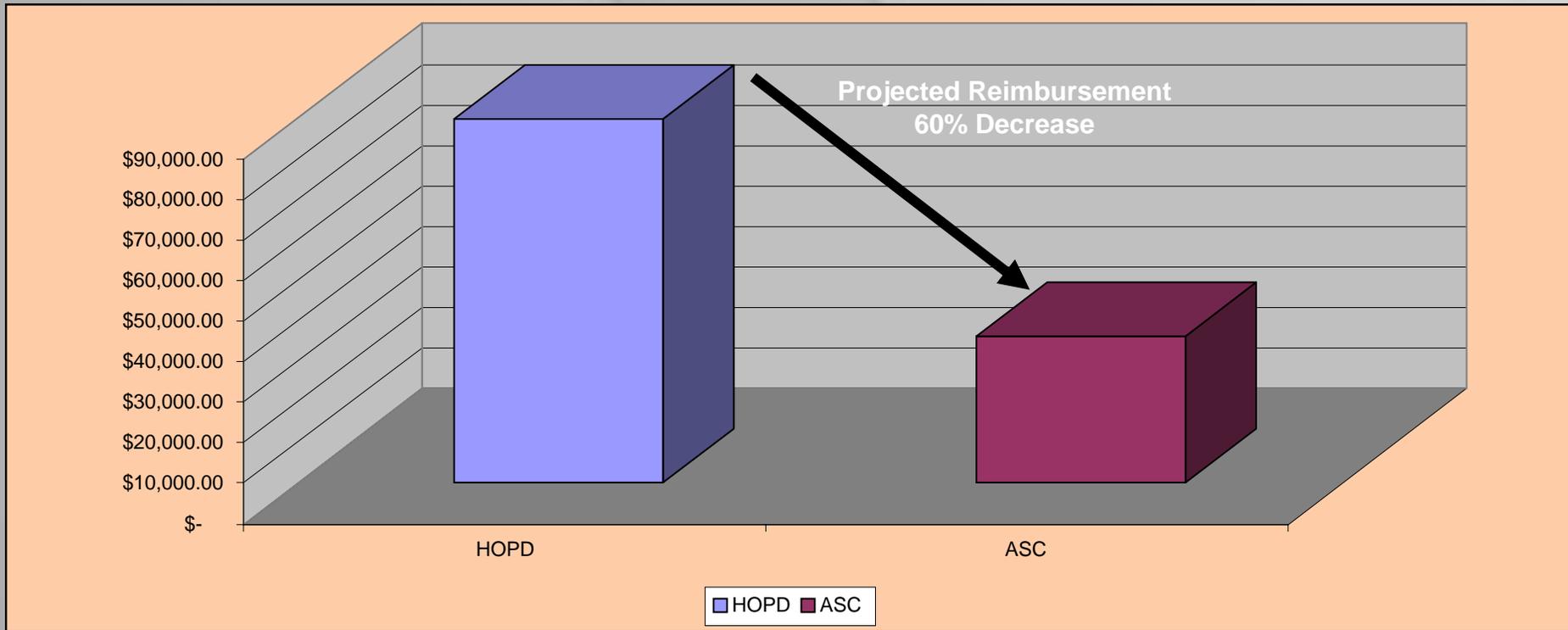
Comparative Projected Impact of ASC Services

Projected impacts of services migrating from the ambulatory surgery centers setting to the hospital outpatient setting



Comparative Projected Impact of ASC Services

Impact of service migration from hospital outpatient setting to ambulatory surgery center setting



Based on an estimate of 12% migration rate of services currently performed in the hospital outpatient setting, given the new service availability in the ambulatory surgery center setting.

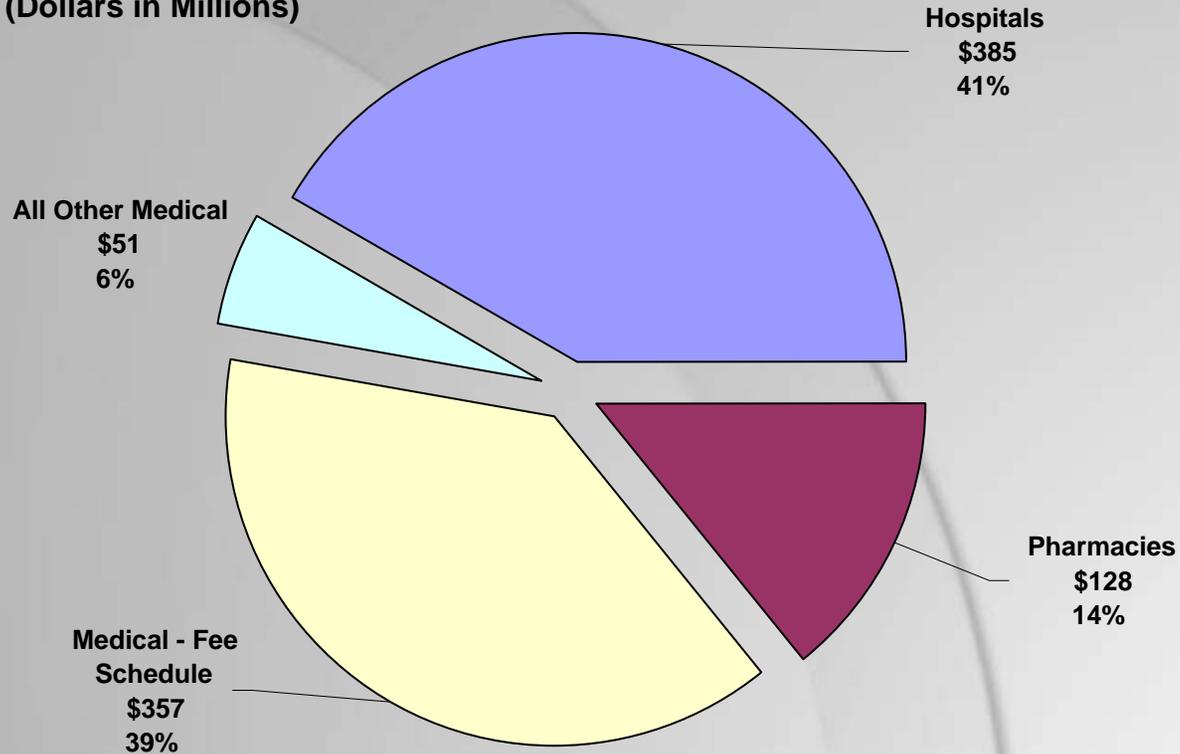
OHIO BWC 2009 Ambulatory Surgical Centers (ASCs) Fee Schedule Proposal

Thank You

Appendix

Financial Overview

TOTAL MEDICAL PAYMENTS = \$799
April 2007 to March 2008
(Dollars in Millions)



[ASC Locations](#)

All Other Medical include payments such as:

- Payments to Ambulatory Surgical Centers
- Payments (thru MIIS) for W-codes -- most notably file reviews and IMEs

Objectives Underlying Recommendations

- Implement a fee schedule which facilitates BWC's principle of ensuring **access to quality care** for Ohio's injured workers
- Appropriate re-alignment update of BWC's ASC fee methodology to Medicare's current methodology
- Appropriate revision of selected BWC's ASC billing processes to better reflect best practice billing standards

ASC Reimbursement Changes & Impacts

- Medicare Modernization Act of 2003
 - Resulted in the new Ambulatory Payment Classification (APC)
 - This new approach would reduce the disparity of payments between ASCs and hospital outpatient settings
- New APC Methodology
 - Eliminated use of the 9 categories of payments
 - Rates now based on the hospital outpatient department rates
 - Those rates are then reduced by a certain percent reflecting lower relative costs of ASCs
 - Increased scope of services by +700 new procedures
- Implementation of New APC Methodology
 - Medicare is using a 4 year transition approach
 - Began the transition in 2008

[Impacts by Specialty](#)

[Transitional chart](#)

ASC Current Reimbursement Approach

- Ambulatory Surgical Centers
 - Provider services connected with surgical procedures which do not require inpatient hospitalization
 - Same as those provided in hospital outpatient setting
 - Represented about .97% of bills in 2007
 - Dollars paid \$7.5 million
- Since 1996 fee schedule has been based on Medicare's ASC Groups
 - Consisted of 9 separate groups based on average overhead cost for the group
 - BWC last updated reimbursement rates in 2005
- Two key advantages
 - Increased ease of access
 - Lower costs

Summary of ASC Recommendation Impacts

- ASC Scope of Service Criteria
 - Procedures that could pose a significant safety risk to patients when performed in the ASC setting are excluded from the scope of service based on the following:
 - Generally result in extensive blood loss
 - Require major or prolonged invasion of body cavities
 - Directly involve major blood vessels
 - Are emergent or life-threatening in nature
 - Commonly require systemic thrombolytic therapy

ASC Selected Locations

- Wildwood Surgical Center — Toledo
- Riverside Outpatient Surgery Center - Columbus
- Crystal Clinic Surgery Center - Akron
- Surgery Center Cleveland - Cleveland

Summary of ASC Recommendation Impacts

Transition Schedule

Type of Service	2008	2009	2010	2011
Surgical service on the 2007 ASC List	75% ASC List rate 25% APC rate	50% ASC List rate 50% APC rate	25% ASC List rate 75% APC rate	100% APC rate
Surgical service not on the 2007 ASC List	100% APC rate	100% APC rate	100% APC rate	100% APC rate
Office based procedure not on the 2007 ASC List	75% MPFS rate 25% APC rate	50% MPFS rate 50% APC rate	25% MPFS rate 75% APC rate	100% APC rate

Summary of ASC Recommendation Impacts

Impact by Specialty

Impact by Specialty		
Specialty	2008 Rates	Fully Implemented Rates
Dermatology	7%	28%
Gastrointestinal	-5%	-19%
General Surgery	20%	79%
OB/GYN	21%	85%
Ophthalmology	0%	3%
Orthopedics	23%	92%
Otolaryngology	18%	72%
Pain Management	0%	-15%
Pulmonary	-1%	5%
Urology	10%	40%
Vascular	23%	89%

Summary of ASC Recommendation Impacts

Procedures Added to ASC Scope of Services 2008 Sample	
20103	Exploration of penetrating wound, extremity
20665	Removal of fixation device (tongs or halo)
21360	Treat cheek bone fracture
22523	Kyphoplasty
25431	Repair of nonunion of carpal bone
27726	Repair of nonunion; fibula

ASC 2009 Fee Schedule Recommendation

- Adopt Medicare new ASC rate schedule and methodology
 - Reimbursement Rates
 - Reimburse at the 2009 Medicare transitional amount for **BWC covered** services
 - Impact
 - 23% increase from BWC 2007 reimbursements
 - 21.43% of billed charges
- Adopt the Medicare approved scope of services for the ASC setting
 - Includes office-based and surgical procedures, separately payable ancillary services and supplies
- Adopt changes to selected billing protocols
 - Remove the limit on the number of procedures that can be reported for a single admission
 - Update Modifiers application and usage
 - Update BWC-specific code applications to use standard codes

BWC's Disaster Recovery Plan (DRP)

BWC's Disaster Recovery Plan (DRP)

Presentation Topics

- Systems are covered (policy)
- DRP Readiness Costs (premium)
- DRP Readiness Planning (process)
- Recovery Incidents (fender benders)

BWC's Disaster Recovery Plan (DRP)

BWC's systems are secured in case of disaster

- Extent of Local IT Asset
 - Mission Critical Systems
 - Ancillary Systems
- Day-to-Day Recovery Preparations
 - Redundancy
 - Backups
 - Local
 - Offsite

BWC's Disaster Recovery Plan (DRP)

BWC's systems are secured in case of disaster

- IBM Contract for remote recovery site
 - New York State Data Center
 - Plain City Command Center
- OIT agreement for server-based recovery
- MailGard contract for remote printing
- Expected recovery for mission-critical systems within 48 hours

BWC's Disaster Recovery Plan (DRP)

BWC's systems are secured in case of disaster

- Offsite mission critical recovery testing 2/year
- Command center in Plain City vs. Wm. Green
 - Avoid disrupting Wm. Green activities
 - Realistic test
- Network staff travel to remote site (NY)
- Includes check printing with MailGard 2/year

BWC's Disaster Recovery Plan (DRP)

DRP Readiness Costs: (to declare a disaster)

- \$25,000 for remote data center
- \$10,000 for remote check printing center
- \$38,900 for travel/lodging of network staff
 - 15 people, 3 days

BWC's Disaster Recovery Plan (DRP)

DRP Readiness Costs: (for standby contracts)

- 3-year term contract - \$353,700/year with IBM
- Prior to '08 competitive bidding - \$547,000/year with SunGard
- MailGard contract = \$65,862/year
- Talking with OIT regarding consolidated DRP offsite strategy

BWC's Disaster Recovery Plan (DRP)

DRP Readiness Planning/Testing

- Most recent test - weekend of Dec 6/7
- Network up between NY and Ohio
- All mission critical systems restored
- Finance and HR systems restored
- Imaging, email, shared network drives restored
- Post mortem underway

BWC's Disaster Recovery Plan (DRP)

BWC Recovery Incidents (past 12 months)

- Scheduled Power Shutdown Project
 - Notorious fuse
- Transformer fire of 11/14
 - UPS/Generator provided power
 - Wm. Green Evacuation – Emergency Power Off

BWC's Disaster Recovery Plan (DRP)

Q & A

12-Month Audit Committee Calendar

Date	December	Notes
12/17/2008	1. Annual Disaster recovery/Business Continuity Plan	
	2. 4123-17-14.2 Bureau 50/50 program (First reading)	
	3. 4123-1714, 4123-17-17, and 4123-1723 Interstate Jurisdiction (Second Reading)	
	4. 4123-6-37.3 Ambulatory Surgery Center Fee Schedule (Second reading)	
Date	January	
1/22/2009	1. Quarterly Litigation Update (Executive Session)	
	2. External audit outstanding comments	
Date	February	
2/19/2009	1. Internal Audit QES Review	
Date	March	
3/19/2009	1. Inspector General Annual Report	
Date	April	
4/29/2009	1. Discussion of external audit	
	2. Quarterly Litigation Update	
Date	May	
5/28/2009	1. Internal Audit QES Review	
	2. FY10 Administrative Budget -(1st reading)	
Date	June	
6/18/2009	1. FY2010 Audit Plan	
	2. FY2010 Financial Projections - (1st reading)	
	3. FY2010 Admin Budget (2 nd reading)	
Date	July	
7/30/2009	1. External audit update	
	2. FY2010 Financial projections (2nd reading)	
	3. Quarterly Litigation Update	

12-Month Audit Committee Calendar

Date	August	Notes
8/27/2009	1. Internal Audit QES Review	
Date	September	
9/24/2009	1. External Audit Update	
	2. IG Semi-Annual Update	
Date	October	
10/29/2009	1. Operation Review Report	
	2. Charter Review	
	3. Quarterly Litigation Update	
	4. Semi-annual meeting with the IG	
Date	November	
11/19/2009	1. External Auditor Retention Letter	
	2. Annual Financials MD&A Review	
	3. Internal Audit QES Review	
	4. Comprehensive Report	
	5. Approve Committee Charter Changes	
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