

Medical Services and Safety Committee Agenda

Thursday, June 17, 2010

William Green Building

Level 2, Room 2

2:00 P.M. – 3:30 P.M.

Call to Order

Jim Harris, Committee Chair

Roll Call

Mike Sourek, scribe

Approve Minutes of May 27, 2010 meeting

Jim Harris, Committee Chair

Review and Approve Agenda

Jim Harris, Committee Chair

New Business/ Action Items

1. Motions for Board consideration:

A. For First Reading

Medical and Service Provider Fee Schedule, Rule 4123-6-08

Freddie Johnson, Director of Managed Care Services

Jean Stevens, ICD-9 Management Analyst Supervisor,

Medical Policy

Discussion Items

1. Medical Services Division Report

2. Committee Calendar

Jim Harris, Committee Chair

Adjourn

Jim Harris, Committee Chair

Next Meeting: Wednesday, July 28, 2010

* Not all agenda items may have materials ** Agenda subject to change

BWC Board of Directors

Medical Services and Safety Committee

Thursday, May 27, 2010

Level 2, Room 2 (Mezzanine)

30 West Spring St.

Columbus, OH 43215

Members Present: James Harris, Chair
James Hummel
Thomas Pitts
William Lhota, *ex officio*

Other Directors Present: Charles Bryan, David Caldwell, Alison Falls, Kenneth Haffey,
James Matesich, Larry Price, and Robert Smith

Members Absent: None

Counsel present: James Barnes, General Counsel

Scribe: Michael J. Sourek, Staff Counsel

CALL TO ORDER

Mr. Harris called the meeting to order at 2:35 PM, and the roll call was taken. All members were present.

MINUTES OF APRIL 29, 2010

Mr. Harris asked for any changes to the minutes of April 29, 2010. With no changes, Mr. Hummel moved to have the minutes of April 29, 2010 be approved, and Mr. Pitts seconded the motion. The motion passed with a 3-0 unanimous roll call vote.

REVIEW AND APPROVAL OF AGENDA

Mr. Harris asked for any changes to the agenda. With no changes, Mr. Pitts moved to have the agenda approved, and the motion was seconded by Mr. Hummel. The motion passed with a 3-0 unanimous roll call vote.

NEW BUSINESS/ACTION ITEMS

1. Motions for Board Consideration

A. For Second Reading

- 1. Group Experience and Group Retrospective Safety Program Requirements
– Rule 4123-17-68**

Mr. Abe Al-Tarawneh, Superintendent of the Division of Safety and Hygiene, (DSH), Ms. Michelle Francisco, Safety Council Program Manager, and Ms. Robin Watson, Industrial Safety Consultant Specialist, presented the second reading of the Group Experience and Group Retrospective Rating Safety Program Requirements, Rule 4123-17-68. Mr. Al-Tarawneh noted a interested parties grid was provided, and the Bureau has continued engagement with interested parties.

Mr. Al-Tarawneh noted the proposal requires sponsors to monitor the group membership's participation in training, and the sponsor must pick training topics related to group members' safety issues. The proposal modernizes the previous rule and provides ease in understanding. The proposal requires both sponsors and affiliates be held to the same standards. Also, the proposal will require sponsors to issue a safety accountability letter to their members, report the number of members participating in the 8-hour and 2-hour training; and changing the reference in the rule language from a "9 key safety elements" to the 10-Step Business plan for safety, and requiring sponsors to have training address common injury types among their members. In response to input from interested parties, Mr. Al-Tarawneh reported that the changes to the rule language were made since last month's reading and were related to employers not completing the two-hour training requirement as well as language that was perceived as requiring implementation of the Ten Step Business Plan for Safety by employers participating in the program. Mr. Al-Tarawneh also noted that BWC's Division of Safety and Hygiene intends to form a working group with interested parties to review and evaluate the rule in next year.

Mr. Hummel asked what changed with the 2-hour training requirement. Mr. Al-Tarawneh replied the Bureau proposed having employers not complying with this requirement become ineligible for the program in future years. Input from interested parties suggested employers may be removed from the program due to paperwork issues rather than not completing the training. Mr. Hummel asked if employers still had to do the 2-hour training requirement, and Mr. Al-Tarawneh replied in the affirmative.

Mr. Hummel moved that the Medical Services and Safety Committee recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to amend rule 4123-17-68 of the Administrative Code, "Group Experience and Group Retrospective Safety Program Requirements," with the motion consenting to the Administrator amending rule 4123-17-68 as presented at the meeting. The motion was seconded by Mr. Pitts, and the motion passed with a 3-0 unanimous roll call vote.

2. Fifteen Thousand Dollar Medical-Only Program – Rule 4123-17-59

Mr. Ronald Suttles, Supervisor, Employer Programs and Ms. Kathy Arnett, Management Analyst Supervisor, presented the second reading of the Fifteen Thousand Dollar Medical-Only Program, Rule 4123-17-59. Ms. Arnett noted the rule changes were necessary because of statutory changes. The rule now requires a medical provider accept the Bureau's fee schedule and cannot bill an injured worker the difference if an employer participates in this program. Based on a suggestion at last month's meeting, an

additional change requires an employer participating in the program must remit payment to the medical provider within 30 days of invoice receipt.

Mr. Hummel asked if balance billing had occurred in the past. Ms. Arnett replied in the affirmative, and in those instances, the Bureau educated the medical provider. Mr. Harris inquired if education meant the medical provider had to refund payments made by injured workers, and Ms. Arnett replied in the affirmative. Mr. Pitts questioned how many employers were in this program. Ms. Arnett indicated the figure has been consistently around 3,000 employers.

Mr. Pitts moved that the Medical Services and Safety Committee recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to amend rule 4123-17-59 of the Administrative Code, "Fifteen Thousand Dollar Medical-Only Program," with the motion consenting to the Administrator amending rule 4123-17-59 as presented at the meeting. The motion was seconded by Mr. Hummel, and the motion passed with a 3-0 unanimous roll call vote.

DISCUSSION ITEMS

1. Pharmacy Program Overview

Dr. Robert Balchick, Medical Director, Mr. Johnnie Hanna, Pharmacy Program Director, and Ms. Christine Sampson, Pharmacy Program Operations Manager, presented a continuation of the Pharmacy Program Overview. Mr. Hanna reiterated that during the first three quarters of 2009, the Bureau's drug rebate program covered all of the administrative cost for the pharmacy program. In 2010, drug rebates are expected to be \$6 million. The Bureau is developing a process to allocate these refunds to the benefit of employers.

Mr. Hanna noted the top 5 medication classes represented 80% of total reimbursements by the Bureau, but only 49% of the total number of prescriptions dispensed. Analgesics were first in each category, and a significant decrease in topical local anesthetics was based on limiting Lidoderm to only the approved usage by the Food and Drug Administration. Lidoderm reimbursements went from \$10 million to \$400,000 per annum.

Mr. Hanna compared 2009 prescription data for the Bureau with national averages. The Bureau figures were validated with the pharmaceutical benefits manager (PBM). National averages were used as there are no workers' compensation specific figures available. The Bureau's generic fill rate was 74% versus 61% nationally. The Bureau's average cost of prescription was \$86.97 versus \$183.36 nationally, and the Bureau's average rebate per prescription was \$3.06 v. \$3.31 nationally. The Bureau's pursuit of generic substitutes has been very cost effective, and for 2009, prescription costs increased 5.4% versus 7% to 9% nationally. Lower cost drugs with large volumes tend to lead to misuse; one Bureau goal is to focus on safety and efficacy, and this goal was a driving force of the Pharmacy and Therapeutics Committee (PTC). Mr. Harris inquired if an injured worker could only receive a generic drug. Mr. Hanna replied that if the injured worker requests a brand drug over a generic equivalent, and the drug is on the Bureau's maximum allowable cost (MAC) list, the injured worker has to pay the difference between

the brand name and generic drug. Mr. Pitts asked if a physician recommended a brand name drug, whether the request would be reviewed by an MCO. Mr. Hanna said the request would be reviewed by the PBM, not an MCO. The prescription is known as a “dispense as written” prescription; if there is only one generic equivalent available for the drug, the Bureau would fully reimburse the prescription as these drugs are not on the Bureau’s MAC list. Mr. Hanna emphasized some drugs are available only in brand name form; if there is a need for one of these drugs available in brand name form only, the injured worker will get the brand name drug. Mr. Harris asked if there was no generic equivalent, the Bureau would reimburse the price in full, and Dr. Balchick responded in the affirmative.

Mr. Hanna said the Bureau’s Pharmacy Program had strategic goals for 2009-2012 broken down into 2 categories: improving utilization and monitoring utilization. There were 3 subcategories of improving utilization goals: developing a formulary by rule; amending or promulgating other rules as necessary; and working to improve therapeutic decisions and outcomes. Developing a formulary would provide prescribers with a comprehensive list of covered drugs, allow for proactive review of new drugs for admission, and focus all formulary decisions first on clinical safety and efficacy. Amending and promulgating rules would address first fill prescriptions and assignment, establish an autonomous PTC, establish a pharmacy lock-in program, establish a charge structure driven by strategic pricing, and manage injectable drugs presently managed by MCOs. Assignment involves claims at their onset; if a pharmacy does not accept assignment of the prescription until the claim is approved, an injured worker has to pay out of pocket for the prescription and then obtain reimbursement. PTC, a group of 6 physicians and 6 pharmacists that examines whether a drug works and whether the drug is safe, would be instrumental in developing the Bureau’s formulary and be driven from a clinical perspective. PTC is a subcommittee of the Healthcare Assembly and Advisory Committee. The Ohio Administrative Code requires changes to make the committee autonomous. The pharmacy lock-in program would improve safety and decrease misuse of medications by having injured workers choose their pharmacy provider. There was a recent instance where an injured worker went to 18 different pharmacies to fill prescriptions in a 3 month period. Strategic pricing is an issue because the “Average Wholesale Price” program will expire by September, 2011. Before implementing strategic pricing, the Bureau would present the recommendations to the Board of Directors. Likewise, injectable drug strategies were in their infancy, and stakeholder input would be obtained before seeking rule changes. Working to improve therapeutic decisions and outcomes involved maximizing application of the PBM’s monitoring and intervention capacity, implementing medication therapy management for chronic pain patients, partnering with other state agencies, and establishing comparative metrics through the OSU project.

With regard to monitoring utilization goals, Mr. Hanna noted 3 strategic goals: centralizing management of the Drug Utilization and Prior Authorization Review process, which would avoid discrepancies on how medications are reviewed statewide and maximize opportunities to create prospective and retrospective interventions in medication use; creating and monitoring key utilization metrics with PBM and Bureau databases; and engaging the PTC to provide therapeutic guidelines and oversight, which would be necessary in deciding medical utilization and what drugs should be reimbursed. Mr. Hanna noted all injured worker prescriptions go through edits with the PBM, including prescription volume, interaction with other drugs, multiple prescribers, and

multiple pharmacies. The PBM had significant capacity for data editing and determining why a medication is being used and if it is being used safely and effectively. Currently the Bureau was working with the Ohio Pharmacy Association for chronic pain situations.

Mr. Harris inquired on the timeframe of addressing the formulary. Mr. Hanna noted this goal required distributing the formulary as widely as possible and placing it on the internet. The process was iterative, and by end of summer more detailed information would be available. Mr. Matesich inquired how often pharmacies accepted assignment. Mr. Hanna replied there were no solid numbers because there was no way the Bureau could break down paper drug reimbursement claims; e.g., in some cases, the Bureau denied reimbursement that was later overturned by the Industrial Commission. The Bureau had no way of calculating what percentage of paper reimbursements relate to lack of assignment. Mr. Matesich suggested posting a list of pharmacies that will accept assignment by region. Mr. Harris asked for feedback from Mr. Pitts from his experiences on paper drug reimbursements. Mr. Pitts concurred that Mr. Hanna accurately described the issue, and the process was laborious. His experience was that assignment was not a small number problem. Mr. Hanna and Dr. Balchick confirmed that 9% of all prescriptions filled by our providers are thru the accepting assignment process but the number of times an injured worker attempts to get a prescription filled and the pharmacy will not accept assignment is very difficult to determine. Many of the large pharmacy chains do not accept assignment, and Dr. Balchick added that currently the Bureau will pay a \$2.50 fee for accepting assignment in addition to the \$3.50 dispensing fee per prescription. If the cost of the script was \$12.00, the return on investment for the pharmacy in light of the risk of assignment was worthwhile; however, if the drug cost \$90, the risk-reward is not there for a pharmacy. The Bureau needs to review cost benefit ratios with pricing to determine the appropriate level of assignment fee to generate pharmacy incentives. Mr. Caldwell asked if assignment occurs after a claim allowance. Mr. Hanna replied the issue was at the claim's onset; once the claim is allowed, all pharmacies participate. Mr. Pitts asked what drugs were injectable drugs. Mr. Hanna replied medications included comprehensive pain medications, such as Morphine or Clonidine that go into pain pumps, or local anesthetics. He noted that injectable medications are being given disparate treatment by the 19 MCOs.

Mr. Harris asked if the Bureau was working with stakeholders in the chronic pain study. Mr. Hanna stated the program was in its pilot stages, and OPA had access to independent and chain pharmacists. The study was open to stakeholder input. Mr. Pitts asked if the program was focusing on chronic pain situations, and Mr. Hanna noted pharmacists would collaborate with prescribing physicians on a more intensive basis as to whether the medication therapy was appropriate for chronic pain. Pharmacies would look at Ohio Automated Rx Reporting System (OARRS), laboratory values, opiate pain contracts, and what collaborative therapies could help. Dr. Balchick said the Bureau's role was administrative, not clinical. The Bureau is reimbursing the pharmacist for his/her role in managing the case, not setting medical parameters; the function is to facilitate the pharmacist's role. Mr. Pitts inquired if the goal was to create guidelines or suggestions for chronic pain cases. Dr. Balchick replied in the negative; the medication therapy management codes being developed are to encourage a pharmacist's role in a facilitative manner. The program does not tell the pharmacist how to manage the case. Mr. Harris hoped the Bureau would seek input from all stakeholders before implementing this plan. Mr. Pitts noted his experience of seeing drug reviews where some classes of medications

are deemed no longer warranted; his concern was a general one as while he could understand the need for cost control, he was seeing abstract reviews to justify no ongoing medical need for certain medications. Mr. Hanna noted his experience from acute care practice had 98% of pharmacist recommendations accepted. Medication therapy management will follow the same program and information, and the decisions will be made based on the case's complete information. The Bureau was partnering with Ohio Department of Jobs and Family Services (ODJFS) to collaborate on better medication outcomes. Dr. Thomas Gretter, Chairman of the ODJFS Drug Utilization Review Committee, will be a member of the BWC Pharmacy and Therapeutics Committee which meets next month. The agencies are looking for synergies in their programs. Finally, the OSU School of Public Health is looking at narcotics usage in the Bureau system, and the report should be finished later this year.

Dr. Balchick noted the death rate in Ohio due to unintentional drug poisoning increased from 2.9 to 12.8 per 100,000 people between 1999 and 2008, or from 327 to 1,473 deaths per year. Several years ago, an increased trend in narcotics abuse was identified nationally, with Scioto County one of the most severe nationally. The Ohio Department of Alcohol and Drug Services and the Ohio Department of Health formed a Poison Action Group/New and Emerging Drug Trends committee, of which Dr. Balchick was a member. Currently unintentional drug overdose is the leading cause of injury death in Ohio, more than motor vehicle accidents. In terms of Bureau claims, the Bureau identified 137 deaths in 2008 because of narcotics abuse, representing 10% of the state's total, but the Bureau pays just 2% of all medical bills in the state.

Mr. Smith inquired what percentage of the unintentional drug overdoses were due to provider error. Dr. Balchick replied that was a very difficult question. If Mr. Smith was asking the number of deaths from a doctor prescribing 300 pills as opposed to 30, the number was exceptionally small. However, if the question involves whether the drug should have been prescribed, the question is very subjective and difficult. Mr. Smith believed the term "unintentional" was misleading; when a young adult steals pills from his grandmother's cabinet that would not seem to qualify. Mr. Smith inquired if Scioto County's problem was primarily due to one drug. Dr. Balchick said Scioto County had unique features where a number of national pain clinics operated. The clinics would operate on a cash-only basis and sometimes prescribe without a medical evaluation. Mr. Haffey indicated it seemed there was no difference between drug abuse and unintentional drug deaths. Dr. Balchick noted unintentional drug poisoning encompassed a broader term; while narcotics were most significant in unintentional drug poisoning deaths, other drugs were involved. Mr. Haffey inquired about what drugs are narcotics, and Dr. Balchick provided examples of Codeine, Percocet, Morphine, Oxycontin, and Vicodin. Mr. Caldwell asked if there were different classes for these medications. Mr. Hanna replied there are federal drug classes, and they are numbered I through V. Class I drugs have no medicinal value, such as LSD. Class II drugs include all analgesics and opiate derivatives, including the mother of all narcotics, Morphine, and Dilaudid, Percocet, Oxycontin, and Oxycodone. Mr. Caldwell asked if a class number made a drug illegal or legal, and Mr. Hanna replied in the negative; the Drug Enforcement Administration dictates the laws and guidelines for each class of medication. Vicodin was a Class III drug, but sleeping pills and barbiturates were Class IV drugs. Mr. Pitts asked how many drug poisoning cases in Dr. Balchick's experience involved alcohol, and Dr. Balchick said he did not have a figure, but alcohol was not the only problem. Persons

also abuse medication with Valium and sleeping medications, and this problem was why the Bureau was examining further. Dr. Balchick noted the number of U.S. deaths due to unintentional drug overdoses in 2006 exceeded that of a large jet crash every day for 2.5 months in a row.

Dr. Balchick noted the Pharmacy Program's vision was to be recognized as the national leader for its efficient and clinically effective delivery of innovative pharmacy services for Ohio's injured workers by 2012. The Governor has created the Ohio Prescription Drug Task Force comprised of legislators, law enforcement, and medical professionals. Dr. Balchick is a member of the task force. Phase I's report was released last week, and Phase II's report would come out in October. The task force focused on 5 areas: increasing public awareness; educating prescribers and pharmacists; legislative changes; data surveillance and research; and collaboration with law enforcement. As a first step, the OSU Department of Public Health is performing research into the problem and engaging in policy development; collaboration is occurring with anyone willing to assist in the study.

2. Customer Services Division Report

Mr. Al-Tarawneh and Mr. Michael Rea, Industrial Safety Administrator, presented the Customer Services Division Report. The focus of the presentation addressed the BWC's Safety services response to fatalities which are the worst type of injury that can occur at any work place, and that with such outcome, we are powerless. Mr. Al-Tarawneh added "while nothing can surpass the loss of life, the devastation associated with work related fatalities is overwhelming to the family, friends, coworkers and the employer. An unfortunate and sad crisis that is very unique, for the magnitude and effect of a fatal injury is never bounded. It is within such circumstances, where our mission at BWC proves resilience as our customer service is tested against these unbounded terms of magnitude and effect.

In most situations we learn about workplace fatalities through news reports before they are reported to us. When news reports surface, the service office area in which the company with the fatal injury operates is alerted and a response team is assembled to offer assistance to the employer. A claim specialist is assigned to the task of contacting the employer and MCO to offer assistance and to inform and assist the involved parties with the procedures and processes for filing a claim. Our Safety Violations Investigations Unit is also alerted to begin working with other Local, State, Federal agencies to investigate the circumstances that lead to the accident.

Unfortunately, this month, our system was tested with three instantaneous fatalities, one at a private employer workplace and two at two Ohio public employers workplaces. One occurred on May 6 and involved a 41 years old Highway Technician employee at the Ohio Department of Transportation District Five. The second occurred on May 7 and involved a 31 years old Inspector employee at the City of Middletown. The third occurred on May 12 and involved a 52 years old rolling mill operator at a private employer workplace.

Fatalities at public employers' workplaces carry added challenges since BWC has the jurisdiction to enforce the Public Employer Risk Reduction Program safety standards at public employers' workplaces. Accordingly, while we work with employers to handle the

claim in a timely and responsive manner, we have to carry on with our responsibility of investigating the circumstances that lead to the accident and resulted in the fatal injury and, when applicable, cite the employer where violations of PERRP's standards are identified in the workplace. While I do not want to provide any particulars about our investigations, these fatalities are under investigation by our PERRP safety consultants and Safety Violations Investigation Unit. Claims relative to these two fatalities were filed with BWC and are being processed in a timely fashion to prevent financial hardships to the families of the fatally injured workers.

Generally, our safety approach is very straight forward and includes evaluating the investigation and the circumstances that lead to the accident, offering assistance to the employer to abate the hazard, and if the hazard proves to be a newly recognized hazard to certain industries, to make sure we alert those employers to the newly recognized hazard.

Understanding the devastating effect of workplace fatalities, we have started a concerted effort at BWC to continually evaluate these claims in our system at the individual level and publish an annual analysis report with our findings. This work has been recently completed and a draft report has been prepared for that purpose, which provides analysis of work related and occupational disease fatalities in Ohio's workplaces for Calendar years 2007, 2008, and 2009.

Although the circumstances surrounding each of the fatalities evaluated in those three calendar years are sobering, the total number of fatalities in our workplaces has been going down over the past three calendar years, 181 in 2007, 156 in 2008, 129 in 2009, and 41 in the first five months of this year."

Mr. Smith inquired how the current fiscal year statistics would compare since 10 months of the fiscal year already passed. Mr. Al-Tarawneh did not have those figures as the analysis is performed by calendar year. Mr. Harris concurred with Mr. Al-Tarawneh regarding how sobering workplace fatalities are.

Ms. Falls asked for a point of clarification relative to enforcement and accident investigations in private employer's workplaces Mr. Al-Tarawneh indicated the Bureau had enforcement powers over public employers and not private employers. Mr. Al-Tarawneh noted that Violations of Specific Safety Requirement, or "VSSR," rules do exist and were updated last year. Ms. Falls inquired what enforcement meant, such as taking an employer to Court or fines. Mr. Al-Tarawneh said SVIU will investigate when VSSRs are alleged. Mr. Caldwell indicated VSSRs were an additional award to an injured worker. Mr. Thomas Wersell, Director of Special Investigations, noted SVIU had a working relationship with the Occupational Safety and Health Administration (OSHA) and that OSHA has enforcement authority in private employer's workplaces, and Mr. Al-Tarawneh comments regarding VSSRs applied when a VSSR is filed. Mr. Harris indicated a VSSR award to an injured worker ranges from 15% to 50% of compensation paid, which is in addition to payments made to an injured worker or his family. The VSSR payment comes from the employer and not the Bureau. Ms. Falls stated the term "enforcement" was used more broadly than her understanding. Mr. Wersell said the Bureau was in uncharted waters with OSHA; the Bureau always had a working relationship with the federal agency, but now there is a sharing of information. The Bureau was receiving front end information from OSHA that could be used later. Mr. Pitts commented if an employer is subject to multiple violations in a certain time period, fines can be assessed

by OSHA. Mr. Harris complimented SVIU for working with OSHA, as he was of the understanding that there was no collaboration between the BWC and OSHA in the past. Mr. Wersell commented the relationship is working well.

3. Follow-Up on MCO Public Forums

Mr. Harris said many issues brought up in the MCO Public Forums were being collaboratively addressed. A report outlining timelines and implementation targets has been distributed to the Directors. He encouraged any questions be directed to Mr. Donald Berno, Liaison for the Board of Directors, or to Mr. Robert Coury, Chief of Medical Services and Compliance.

4. Committee Calendar

Mr. Harris noted the June calendar would have a first reading of the Medical and Service Provider Fee Schedule and Medical Services Report, which Mr. Berno confirmed.

ADJOURNMENT

Mr. Pitts moved to adjourn the meeting at 3:46 PM, seconded by Mr. Hummel. The meeting adjourned with a 3-0 unanimous roll call vote.

Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-08

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 an updated discounted pricing fee schedule for workers' compensation medical 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: The proposed fee schedule was placed on www.ohiobwc.com on May 28, 2010. Stakeholders were notified via email and were given until June 11, 2010 to submit comments.

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 Professional Provider 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 a provider fee schedule. BWC initially enacted the bulk of the Chapter 4123-6 HPP operational rules (Ohio Administrative Code 4123-6-01 to 4123-6-19), including OAC 4123-6-08, the professional provider fee schedule rule, in February 1996.

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.

Pursuant to this statute, BWC adopted OAC 4123-6-08. Since its promulgation in February 1996, OAC 4123-6-08 has provided that “. . . the bureau shall develop, maintain, and publish a provider fee schedule for the various types of billing codes. The fee schedules shall be developed with provider and employer input.”

Pursuant 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 is required to adopt changes to its fee schedules via the O.R.C. Chapter 119 rulemaking process. BWC has undergone a systematic revision of its professional provider fee schedule, and now proposes to adopt the newly revised professional provider fee schedule as an Appendix to OAC 4123-6-08.

Proposed Changes

The major substantive changes proposed for the professional provider fee schedule Appendix to OAC 4123-6-08 are as follows:

1. BWC adopt Medicare's 2010 RVUs for all relevant CPT codes.
2. BWC maintain the current conversion factors
3. BWC add the following additional HCPCS codes:
 - a. HCPCS code S0630 removal of sutures by another qualifying medical professional, other than the physician that placed the sutures.
 - b. HCPCS code S0209 for wheelchair van mileage. This code is being added to provide a specific reimbursement for wheelchair van mileage.
 - c. HCPCS code S5199 Personal care items and HCPCS code S8301 infection control supplies.
4. BWC add a category of service titled “Never Covered (NC).
5. BWC modify the title of the category of service currently titled “Non-Covered” to “Not Routinely Covered (NRC)”.

Stakeholder Involvement

The proposed professional provider fee schedule was placed on www.ohiobwc.com on May 28, 2010. The following stakeholders were notified via email and were given until June 11, 2010 to submit comments to BWC via a dedicated email box, providerfeedback@bwc.state.oh.us:

- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- Ohio Association for Justice
- Employer Organizations
 - National Federation of Independent Business (NFIB)
 - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list

Feedback received by BWC is summarized on the Stakeholder Feedback Summary Spreadsheet.

4123-6-08 Bureau fee schedule.

(A) Pursuant to division (A)(8) of section 4121.441 of the Revised Code, the administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall develop, maintain, and publish a provider fee schedule for the various types of billing codes. The administrator hereby adopts the fee schedule indicated in the attached appendix A, developed with provider and employer input effective ~~November 1, 2009~~ October 25, 2010.

(B) Whether the MCO has elected to retain a provider panel or not, an MCO may contract with providers. Every provider contract shall describe the method of payment to the providers. The MCO shall provide an MCO fee schedule to each provider that contracts with the MCO. The MCO fee schedule may be at different rates than the bureau fee schedule. The MCO shall make the MCO fee schedule available to the bureau as part of its application for certification. The bureau shall maintain the MCO fee schedule as proprietary information.

Appendix A

BUREAU OF WORKERS' COMPENSATION

PROFESSIONAL PROVIDER FEE SCHEDULE

EFFECTIVE ~~NOVEMBER 1, 2009~~ OCTOBER 25, 2010

Effective: 10/25/2010

R.C. 119.032 review dates: 3/1/2009

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: 2/16/96, 1/1/01, 2/19/09

BWC 2010 Proposed Professional Provider and Medical Services Fee Schedule Update

Medical Service Enhancements

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

Professional Provider Fee Schedule

Introduction and Methodology

As stated, implementing a sound and effective provider fee schedule is a critical component of the Medical Services Division's goals. The Ohio Bureau of Workers Compensation reimburses over 70,000 providers for medical services rendered to Ohio's injured workers. An appropriate fee schedule is integral to maintaining an effective and comprehensive network of physicians, specialists, and support services and supplies. An equitable and competitive fee for the right medical service is essential to maintain a quality provider network across the wide range of necessary provider disciplines. The fee schedule for provider and professional services was updated twice in 2009, with the initial updates being implemented in February 2009, and the second updates being implemented in November 2009.

The Medical Services Division, pursuant to the yearly fee schedule maintenance schedule has completed a review of the current fee schedule with the goal of implementing updated Medicare base data used in BWC's calculations, and identifying corrections to benefit coverage or pricing. The proposed updates to the current 2009 BWC fee schedule resulted from the following steps:

- A.** The evaluation of the 2009 Ohio Fee Schedule against the 2010 coding publication for the Federal Center for Medicare and Medicaid Services' 2010 providers and services fee reimbursements;
- B.** A review of the current 2009 Professional Provider and Medical Services fee schedule as adopted to identify benefit coverage and/or policy changes.

Calculating Provider Fees Per the CPT codes

BWC currently utilizes the Resource-Based Relative Value Scale (RBRVS) developed in 1992, by the Federal Center for Medicare and Medicaid Services (CMS) for professional reimbursements associated with the CPT© codes. Each year Medicare updates its CPT fees under the RBRVS approach. The fee schedule includes services such as office visits, hospital care, procedures, etc. Medicare fees are composed of two component parts: the relative value unit (RVU) and a conversion factor (CF).

The foundation of RBRVS is a strong, empirical research methodology. BWC has utilized the RBRVS, at least, since 1997. The original foundation for RVUs resulted from a late 1980s Harvard University study.¹ CMS, as indicated above, maintains the schedule and Congress is required to update the RVUs no less than every five years, as well as develop RVUs for new services. As part of this updating process, CMS relies on the advice and recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC).

An individual RVU is calculated for each procedure by looking at the associated relative work and costs of services. RVUs allow comparison of apples to oranges (i.e., surgery to primary care visits) and can relatively and appropriately set the allowable payment for any service in any specialty.² Each specific CPT code for a medical service is assigned a RVU based on the degree of service intensity the procedure requires. Further, the RVUs reflect costs for overhead and malpractice expenses. Finally, there is a regional cost adjustment. The regional cost adjustment is called the Geographical Practice Cost Index (GPCI). There is a separate GPCI for work expended, overhead, and malpractice.

The fee, or the amount of payment, for service, is a function of the multiplication of the service's designated RVU by the "conversion factor (CF). The CF is the dollar amount selected for that category of service. CMS cannot change its overall budget, which requires CMS to use a budget neutrality factor to maintain reimbursement expenditures in line with the budget. If the RVU adjustments results in a change to CMS's budget picture, CMS will appropriately modify the CF to redress the budget neutrality issue. While the BWC adopts Medicare's RVUs for relevant CPT Codes, we use our own CF to set the final fee for service.

¹ Laura A. Dummit, The Basics: Relative Value Units (RVUs), National Health Policy Forum, The George Washington University, (February 12, 2009)

² Johnson and Newton, Resource-Based Relative Value Units: A Primer for Academic Family Physicians, Department of Family Medicine, University of North Carolina (2002)

The following table provides BWCs current CF.

Current Conversion Factors

Service Grouping	Current	% over Medicare
Radiology	\$ 51.00	141%
Physical Medicine	\$ 51.00	141%
General Medicine	\$ 51.00	141%
Surgery (*)	\$ 79.10	221%
Pathology (**)	See Below	
Anesthesia (***)	\$ 42.50	201%

* Injections proposed to be paid at \$50.00 CF
 **Pathology is currently paid at 125% of Medicare Fee Schedule
 *** Anesthesia is currently paid at \$42.50 time the number of base units plus \$42.50 per 15 minutes
 Medicare has a single CF of \$36.000 Medicare's Anesthesia base rate is \$21.114

Ohio Bureau of Workers' Compensation

The following table demonstrates the payment calculation for two varied services – a simple laceration repair and total knee replacement:

Calculating Fee Schedule for a CPT code

Fee Schedule	12001 - simple laceration repair			27447 - total knee replacement		
	RVU	GPCI	Product	RVU	GPCI	Product
Work	1.7499	0.993	1.7377	23.249	0.993	23.087
Practice Expense	1.9000	0.927	1.7613	13.1704	0.927	13.209
Malpractice	0.2000	1.232	0.2464	3.2897	1.232	4.053
Sum of Products			3.74			40.35
Times Conversion Factor			\$79.10			\$79.10
Reimbursement Rate (Fee Schedule)			\$296.26			\$3,191.71

Ohio Bureau of Workers' Compensation

Calculating Provider Fees Utilizing HCPCS Codes

The 3600 HCPCS codes mentioned earlier includes services such as durable medical equipment, supplies, medications, vision services, prosthetics and others. Medicare annually evaluates all of

the services and supplies listed under those codes and establish a fee for each of those services. The BWC has, at least since 1997, utilized the Medicare set fees with a twenty percent (20%) addition.

An example of a HCPCS calculation is as follows: calculation for a: Range of Motion Device (rental)

$$\begin{array}{rclclcl} \text{Medicare Fee} & + & 20\% & = & \text{Provider Fee} \\ \$22.00 & + & \$4.40 & = & \$26.00 \end{array}$$

Calculating Provider Fees Utilizing 66 Local Codes

The 66 Local codes include services such as supplies, mileage reimbursement, and others. Local codes have been devised to assign a coding scheme for services not included in the Medicare HCPCS manual. The BWC performs market pricing to establish the recommended fee schedule for professional services and products placed under these codes.

2010 Proposed Fee Schedule Recommendations and Analysis

Medical Services recommends that BWC adopt Medicare’s 2010 RVUs for all relevant CPT codes. In 2010, the CMS adopted several major changes to the practice-expense portion of the relative value unit system that determines pay for individual services, along with more minor changes to the work and liability insurance RVUs. The CMS based some of its RVU changes on new information from the Physician Practice Information Survey, a joint effort led by the American Medical Association and including 72 specialty societies — among them the American College of Radiology and American College of Cardiology, as well as other professional health care organizations. The results were modest increases in average pay for physicians traditionally considered to be in primary care, but larger reductions in average pay for some other specialists, especially Radiology.

Medical Services further recommends that the current conversion factors, as exhibited in table above, remain at their current level. When evaluating the objective of access to quality care against the projected impact of the changes in RVU as illustrated in the table below, it is Medical Services belief that access to quality care can be maintained.

Projected Impact of RVU

Specialty	Percent Change
Evaluation & Management	5.3%
Gen Med	-0.3%
Pathology	-1.9%
Phys Med	1.6%
Radiology	*-7.8%
Surgery	1.3%
Therapeutic Injection	12.3%
Undefined	0.0%
HCPCS & Local Codes	-0.2%
TOTALS	1.6%

Given the potential impact on Radiology reimbursement, a projected 7% decrease, BWC did perform further analysis to determine if an Ohio adjustment to offset the RVU impact was warranted. Our research indicated that CMS made a decision to increase the imaging equipment utilization rate assumption within the practice-expense RVUs. What this means is that Medicare assumes the amount of time advanced diagnostic imaging equipment is in use during physician office hours will increase from 50% to 90% over the next four years. Given the projected increase in usage volume, a decrease in the relative value of radiology service is and will continue to be necessitated over the next few years to appropriately reflect the proper expense level for each service. Per that analysis, and Medical Services not having identified an access to quality care for this service for Ohio injured workers, the conclusion was that it is appropriate to maintain the current conversion factor level for radiological services.

Medical Services further recommends the adoption of Medicare's 2010 HCPCS fees with a twenty percent (20%) addition. The 2010 HCPCS were marginally adjusted from the 2009 Medicare fees.

Medical Services further recommend adding additional HCPCS codes to facilitate additional ease in providers rendering and billing for certain selected services. We proposed to add HCPCS code S0630 removal of sutures by another qualifying medical professional, other than the physician that placed the sutures. This code is being added to enable physicians to bill for follow-up care for minor surgeries performed in the emergency department. CPT code 12001 (simple repair of a superficial wound) is one of the most frequently billed services to Ohio BWC (#24). Generally, this initial repair is performed in an emergency department. Injured workers usually return to a different setting (clinic/office) to have the sutures removed, which proves to be more convenient for an IW as well as being a more cost effective site of service. The BWC recognizes the benefit of access to care when post-op suture removal is rendered by a provider other than the ED physician. Therefore we believe this to be a positive inclusion within the benefit package.

Medical Services further recommend the addition of HCPCS code S0209 for wheelchair van mileage. This code is being added to provide a specific reimbursement for wheelchair van mileage. The BWC has many injured workers that are wheelchair bound who require routine transportation between home and other sites, such as a physician office or a hospital outpatient clinic. By adding this code, we can ensure that companies that transport injured workers will be appropriately reimbursed. Additionally, this code allows BWC to better evaluate and manage injured workers' transportation needs.

Medical Services further recommend the addition of HCPCS code S5199 Personal care items and HCPCS code S8301 infection control supplies. These codes are being added to have a specific reimbursement for items such as wipes and anti-bacterial soap.

Lastly, Medical Services recommends addition of a category of service titled "Never Covered (NC), and a modification of the title for "Non-Covered" to "Not Routinely Covered (NRC)". These two changes are being made to reduce the confusion that occurred as a result of the application of the *Miller* Test. Procedures and services listed as "Non-Covered" were defined as not covered unless application of the *Miller* criteria (see OAC 4123-6-16.2(B)(1) – (B)(3)) required an exception. Based on feedback and analysis, it was determined that a title of "Not

Routinely Covered” better reflected the reality of the impact of the *Miller* Test on those procedures and services. Additionally, there are certain procedures and services (i.e. application of hot and cold packs) which will never be covered under the benefit plan. Therefore, to further reduce confusion and the misapplication of the *Miller* test to those procedures and services, the new category of “Never Covered” is being created.

Projected Impacts and Outcomes

The financial impact to the state fund is estimated to increase by approximately 2% or \$2,568,606.00. The addition of the new codes will increase the ease of access to injured worker to receive appropriate services. Further, the addition of the new codes will reduce challenges which providers have faced in rendering and receiving reimbursement for related services. Lastly, the recommended changes will bring additional clarity to benefits which are covered, or which can be covered pursuant to the application of the *Miller* Test, versus services which have been determined never covered under the Ohio BWC workers’ compensation benefit plan.



Bureau of Workers' Compensation

Governor **Ted Strickland**
Administrator **Marsha P. Ryan**

30 W. Spring St.
Columbus, OH 43215-2256
ohiobwc.com
1-800-OHIOBWC

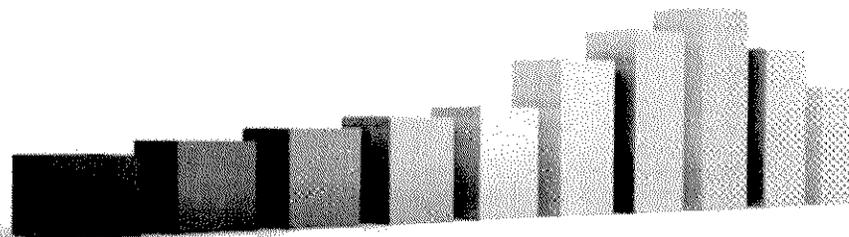
Stakeholder feedback and recommendations for changes to the BWC Professional Provider and Medical Services Fee Schedule - O.A.C. 4123-6-08

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
1	Increase in reimbursement, particularly office visits	Nancy Seymour/SI administrator	Would like to see fees for office service decrease	The 2009 increase in the Conversion Factor coupled with the increase in Relative Value Unit for Evaluation and Management services has made an impact on their medical expenses	BWC understands and expected that a potential increase in this area of reimbursement would occur, as the 2009 reimbursement rate was increased with the goal of ensuring ensuring access to quality care for Ohio's injured workers. The increase reflected the reimbursement level necessary to facilitate that goal. Analysis of the environment did not result in a different finding.	Maintain recommendation for Conversion Factor.
2	Pricing of additional HCPCS codes	Cory Wedding/Modern Medical	Would like to have two new HCPCS codes added to the fee schedule along with the new additions in the July, 2010 HCPCS update	HCPCS code E1340 was deleted from the 2010 HCPCS codes. New codes have replaced them. Additionally, several codes will be added in July, 2010 which he would recommend be included	The codes that the are a part of the stakeholder inquiry were not evaluated as they were not a part of the Medicare data download against which BWC evaluated procedures and services. BWC has evaluated the codes presented by the stakeholder. HCPCS code K0739 and K0740 did replace a previously deleted code and both will be priced and added into the rule. There are six additional newly created HCPCS codes which would be new to BWC's benefit plan, and will need to be vetted to determine inclusion as part of the 2011 update or benefit plan.	HCPCS code K0739 and K0740 will be priced and added into the rule.
4	Additional codes for mileage reimbursement for PT/OT services on the medical services fee schedule	Rick Wickstrom/President Workability Network	Would like to have travel reimbursement added for PT/OT mileage	PT and OTs should be paid for all travel time and mileage both at home and work-site locations	BWC does not reimburse travel time and mileage to individual PT/OT providers under this particular fee schedule. PT/OT providers in order to render services under this fee schedule must be a staff member of a BWC certified home health agency. PT/OT providers can receive travel time and mileage reimbursement via the home health agency for which they are rendering services . On an individual provider basis, travel time and mileage for work site therapy is a benefit included as part of the Vocational Rehabilitation fee schedule (RAW program).	Maintain current benefit plan and fee recommendations.

12 - Month Medical Services & Safety Calendar

Date	June 2010	Notes
6/17/10	1. Medical & Service Provider Fee Schedule (1st read)	
	2. Medical Services Report	
Date	July 2010	
7/28/10	1. Medical & Service Provider Fee Schedule (2nd read)	
	2. Customer Services Report	
Date	August 2010	
8/26/10	1. Medical Services Report	
Date	September 2010	
9/23/10	1. Inpatient Hospital Fee Schedule (1st read)	
	2. Vocational Rehab fee schedule (1 st read)	
	3. Customer Services Report	
Date	October 2010	
10/21/10	1. Outpatient Hospital Fee Schedule (1st read)	
	2. Inpatient Hospital Fee Schedule (2nd read)	
	3. Vocational Rehab fee schedule (2nd read)	
	4. Committee Charter review (1 st read)	
	5. Medical Services Report	
Date	November 2010	
11/18/10	1. Outpatient Hospital Fee Schedule (2nd read)	
	2. Ambulatory Surgical Center Fee Schedule Rule (1 st read)	
	3. Committee Charter Review (2 nd read)	
	4. Customer Services Report	
Date	December 2010	
12/15/10	1. Update Medical and Service Provider Fee Schedule to conform with new Medicare rates (possible waive 2 nd read)	
	2. Ambulatory Surgical Center Fee Schedule Rule (2nd read)	
	3. Medical Services Report	
2011		
Date	January 2011	
TBD	1. Customer Services Report	
Date	February 2011	
TBD	1. Medical Services Report	
Date	March 2011	
	1. Customer Services Report	
Date	April 2011	
TBD	1. Medical Services Report	
Date	May 2011	
TBD		

2010 MCO Report Card



BWC has created the *MCO Report Card* to help you evaluate the performance of managed care organizations (MCOs). The report card measures components contributing to the quality of medical management, safe return-to-work strategies and timeliness of service.

This report card serves as an objective source of information to help you select an MCO. You may receive marketing materials from other sources. Keep in mind, these sources create the materials with the intent to influence your MCO selection.

The report card components are:

- Number of employers;
- Number of claims;
- First report of injury (FROI) timing;
- FROI turnaround time;
- Optimal return to work.

Described below are each of the components and how we measured the MCO information.

Number of employers

Note: To better reflect and maintain consistency in recording MCO work activity, the definition of this measurement has been changed from the one used in the report cards prior to 2009. The new measurement includes all employers in one of the three active statuses.

This measure includes the number of employers assigned to the MCO as of Dec. 31, 2009 that were in an Active, Reinstated, or Debtor in Possession status.

Number of claims

Note: To better reflect and maintain consistency in recording MCO work activity, the definition of this measurement has been changed from the one used in the report cards prior to 2009. The new measurement includes all claims, regardless of date of injury, that have received medical case management or utilization review in the last 13 months.

This measure includes the number of claims assigned to the MCO on Dec. 31, 2009, regardless of date of injury, that were in an active status, excluding claims with a date of death populated, claims in disallowed, dismissed or settled status, and out-of-statute claims.

FROI timing*

The sooner a claim is filed, the sooner an injured worker can receive medical treatment and benefits, and the quicker he or she can safely return to work. FROI timing is the average of the number of days between the date of injury and the date the claim is filed with us. We removed the 5 percent of claims with the longest lag times per MCO.

This measure is a reflection of how long it takes us to receive notification of a workplace injury. It includes the time from the date of injury to when the employer, injured worker or provider notifies the MCO, and the time from when the MCO is notified to the time the claim is filed with us.

FROI turnaround*

FROI turnaround measures an MCO's efficiency in submitting claims. MCOs must gather and validate the required information before submitting the claim to us. FROI turnaround is the average of the number of days between the date MCOs receive the FROI notice and the date they electronically file the claim with us.

Optimal return to work

Optimal return to work compares actual time lost against established benchmarks. We identify these benchmarks as loosely managed and well managed. Optimal return to work only counts injured workers who remain at work 90 days or more after returning to work from an injury. We base an MCO's return-to-work score on the MCO's progress from its loosely managed benchmark toward its well managed benchmark.

DoDM (degree of disability management) is the model we use to evaluate the optimal return to work measure of each MCO. Optimal return to work looks at the injured worker's injury(ies) and occupation. For example, we expect a construction worker who breaks a leg to be off work longer than an office worker because of how the injury relates to his or her job.

* FROI average scores are based on claims with dates of injury between March 1, 1997, and Dec. 31, 2009, sent to us between Jan. 1, 2009, and Dec. 31, 2009.

2010 MCO Report Card



Bureau of Workers' Compensation

Commissioner: Ted Strickland
 Director: Michael B. Ryan

	Number of employers	Number of claims	FROI timing	FROI turnaround	Optimal return to work	
MCO average score			6.40	0.99		
					Loosely managed → Well managed	
1-888-OHIOCOMP	13,673	17,965	5.22	0.96		
3-hab	8,628	7,901	7.10	1.76		
AdvoCare	9,414	8,451	7.51	1.29		
AultComp	3,420	4,075	4.79	0.67		
CareWorks	85,203	72,615	6.24	0.64		
Comp One	1,090	1,345	6.49	1.56		
CompManagement Health Systems	26,871	38,663	5.98	1.26		
Corvel Ohio MCO	5,115	10,296	6.71	1.36		
GENEX Care for Ohio	1,867	2,185	6.89	1.31		
Health Management Solutions	9,481	8,176	7.92	2.12		
Medical Administrators	4,365	6,420	5.72	1.50		
Ohio Employee Health Partnership	4,573	5,034	7.42	0.71		
Premier Managed Care Services	1,738	2,022	7.30	1.87		
Sheakley UNICOMP	21,106	25,565	6.42	0.89		
The Health Plan	3,791	3,522	5.67	1.26		
University Hospitals CompCare	4,590	4,835	6.61	1.14		
Vantage Occupational Health Plan	1,734	1,370	9.64	1.98		
WorkStar Health Services	*NA	*NA	*NA	*NA	*NA	

*WorkStar Health Services did not have employers assigned as of Dec. 31, 2009, because it wasn't BWC certified until April 12, 2010.

Your MCO, your choice



May 3-28, 2010

MCO Open Enrollment Guide

Dates to remember



7:30 a.m., May 3
Open enrollment begins

5:30 p.m., May 28
Open enrollment ends

June 28

MCOs selected during open enrollment begin medical management of claims. **Note:** Employers who do not select a new MCO during open enrollment will have claims managed by their current MCOs prior to and after June 28.

Open enrollment information

Your managed care organization (MCO) works with you to help file your claims promptly and make sure your injured workers receive the quality medical care they deserve to return to work as safely and quickly as possible.

Choosing an MCO that meets the needs of your business and your workers is an important decision. To explain your options and help you make the best choice for your employees, BWC has produced this MCO Selection Guide and an accompanying MCO Report Card, which is also available on ohiobwc.com.



If you have a good relationship with your MCO and you are satisfied with the service it provides, you don't need to do anything during the 2010 open enrollment period.



However, if you want to switch to a new MCO, you may do so between 7:30 a.m. May 3 and 5:30 p.m. May 28.

This guide will walk you through the selection process while the report card provides 2009 MCO performance information. You may select an MCO using the online selection form on ohiobwc.com or the printable version on page 5. If you need additional assistance, please call our MCO selection line at 800-859-6631. Representatives are available from 7:30 a.m. to 5:30 p.m. Monday through Friday.

If you wish to choose a new MCO, please continue reading. The following three easy steps will guide you through the open enrollment process. You have from May 3 to May 28, 2010, to make your selection and submit a change via one of the methods described under Step 3.

If you select a new MCO during open enrollment

You will receive a confirmation letter from BWC within seven to 10 business days after your selection. If you believe we updated your selection incorrectly or you decide on another MCO, you have until 5:30 p.m., May 28, 2010, to change your selection. You can speak with a BWC representative from 7:30 a.m. to 5:30 p.m., Monday through Friday, by calling 1-800-859-6631.

After open enrollment, we will send you a fact sheet that explains the claims transition process. We will also send a fact sheet, notification letter and new MCO identification card to any injured workers with active claims.

Your new MCO will start managing the medical part of your claims June 28, 2010.

Is it possible my selection would not be accepted?

Yes. Some MCOs may be at capacity, which means they cannot accept additional employers. MCOs may be at capacity because they:

- o Have voluntarily asked to be placed at capacity;
- o Are in non-compliance with BWC requirements;
- o Are pending a merger or decertification.

We may remove an MCO from capacity at any time during the open enrollment period. So, you can either make another selection or wait to see if the MCO is accepting new employers before May 28. If you have questions, contact the MCO.

Instructions

Step 1 Review the Alphabetical MCO list found on page 4.

Step 2 Use our MCO Report Card, which is also available on ohiobwc.com, to compare the performance of MCOs. In the report card, BWC has evaluated each MCO based on quality of medical management, safe return-to-work strategies and timeliness of service. You can access the report card from the open enrollment link found at the bottom of the ohiobwc.com home page.

We have listed the MCOs' contact information under the Alphabetical MCO list on page 4. We encourage you to call the MCOs you are considering choosing to find out more about their services and network providers.

Continued on page 3

Step 3

Submit your request to select a new MCO using **one** of these five options.

Option 1	Complete and submit a selection form electronically	Go to the ohiobwc.com home page and click on the 2010 open enrollment link on the bottom right-hand side of the page. From there, scroll down to Related links and click on the link to the online selection form. Follow the instructions to complete and submit the form electronically.
Option 2	Complete a hard-copy selection form and mail or fax it to BWC	Complete the form on page 5 of this guide and mail or fax it to BWC. The address and fax number are included on the form. We must receive your signed form by 5:30 p.m., May 28, 2010.
Option 3	Make your selection using our automated phone line	Call 1-800-859-6631 from 6 a.m. until midnight, Monday through Saturday. The automated phone line will walk you through the process. Before calling, we recommend you note your policy number, county code and new MCO number below. You must call the selection line before 5:30 p.m., May 28. Policy number: ○○○○○○○○ <i>Your BWC policy number is included on your certificate of coverage.</i> County code: ○○ <i>Please see page 4 for a list of two-digit county codes. If you already have an MCO, the automated line will ask you to confirm the county we have on file for you.</i> New MCO number: ○○○○○○ <i>You can find this five-digit number under the MCO's name in the Alphabetical MCO list on page 4.</i>
Option 4	Complete a selection form provided by the MCO	You may have received an enrollment form from an MCO. If you choose to complete this form, mail or fax it to the selected MCO. Note: The MCO must receive your signed form by the date indicated by the MCO.
Option 5	Submit an official "letter of change" to BWC	You may select a new MCO by submitting an official "letter of change" on your company letterhead. In your letter, please provide the same information we ask for on our selection form and mail it to: Ohio Bureau of Workers' Compensation Attn: Open Enrollment 30 W. Spring St., 22nd Floor Columbus, OH 43215-2256 You may also fax the letter to 614-728-0278. Note: We must receive your signed letter by 5:30 p.m., May 28, 2010.

Employer's right to select During open enrollment, an employer may select any MCO that meets its individual business needs. The MCO selection is solely the employer's decision.

County codes

Below is a list of all 88 Ohio counties and their corresponding two-digit code. Please locate your county of main business operations and make note of its code number. **You'll need this county code number to complete your selection form or when calling the automated selection line.**

Two-digit county codes

01 Adams	45 Licking
02 Allen	46 Logan
03 Ashland	47 Lorain
04 Ashtabula	48 Lucas
05 Athens	49 Madison
06 Auglaize	50 Mahoning
07 Belmont	51 Marion
08 Brown	52 Medina
09 Butler	53 Meigs
10 Carroll	54 Mercer
11 Champaign	55 Miami
12 Clark	56 Monroe
13 Clermont	57 Montgomery
14 Clinton	58 Morgan
15 Columbiana	59 Morrow
16 Coshocton	60 Muskingum
17 Crawford	61 Noble
18 Cuyahoga	62 Ottawa
19 Darke	63 Paulding
20 Defiance	64 Perry
21 Delaware	65 Pickaway
22 Erie	66 Pike
23 Fairfield	67 Portage
24 Fayette	68 Preble
25 Franklin	69 Putnam
26 Fulton	70 Richland
27 Gallia	71 Ross
28 Geauga	72 Sandusky
29 Greene	73 Scioto
30 Guernsey	74 Seneca
31 Hamilton	75 Shelby
32 Hancock	76 Stark
33 Hardin	77 Summit
34 Harrison	78 Trumbull
35 Henry	79 Tuscarawas
36 Highland	80 Union
37 Hocking	81 Van Wert
38 Holmes	82 Vinton
39 Huron	83 Warren
40 Jackson	84 Washington
41 Jefferson	85 Wayne
42 Knox	86 Williams
43 Lake	87 Wood
44 Lawrence	88 Wyandot

Alphabetical MCO list

We have assigned a five-digit number to identify each MCO. This number is located under the MCO's name below. **If you select a new MCO, you will include this number when completing your selection form. Note: All of the MCOs in this list have statewide certification.**

1-888-OHIOCOMP

10041
2900 Carnegie Ave.
Cleveland, OH 44115
Phone: 888-644-6266
Fax: 888-644-7339

3-hab

10013
9916 Carver Road, Suite 400
Cincinnati, OH 45242
Phone: 800-869-1871, 0 for operator or
513-221-3422, 0 for operator
Fax: 800-869-1872 or 513-221-2008

AdvoCare

10026
25001 Emory Road, Suite 300
Cleveland, OH 44128
Phone: 800-659-4025

AultComp

10016
100 Lincoln Way E., Suite 360
P.O. Box 4817
Massillon, OH 44648-4817
Phone: 888-738-5800 or 330-830-4919

CareWorks

10010
5555 Glendon Court
Dublin, OH 43016
Phone: 888-627-7586

Comp One

10073
725 Boardman-Carfield Road, Unit A-3
Boardman, OH 44512
Phone: 877-281-9821 or 330-259-0083

CompManagement Health Systems

10005
6377 Emerald Parkway
P.O. Box 1040
Dublin, OH 43017
Phone: 888-247-7799

CorVel Ohio MCO

10008
5080 Tuttle Crossing Blvd., Suite 320
Dublin, OH 43016
Phone: 800-987-5515 or 614-793-8400
Fax: 614-846-7097

GENEX Care for Ohio

10042
1329 E. Kemper Road,
Building 400 - Suite 4218
Cincinnati, OH 45246
Phone: 800-447-6250

Health Management Solutions

10006
1901 Indian Wood Circle
Maumee, OH 43537
Phone: 888-202-3515

Medical Administrators

10011
28301 Ranney Parkway
Westlake, OH 44145
Phone: 800-542-9479 or 440-899-2400

Ohio Employee Health Partnership

10017
445 Hutchinson Ave., Suite 205
Columbus, OH 43235
Phone: 888-844-0039 or 614-885-0039

Premier Managed Care Services

10015
P.O. Box 609
Lewis Center, OH 43035-0609
Phone: 800-510-4155

Sheakley UNICOMP

10002
One Sheakley Way
Cincinnati, OH 45246
Phone: 888-743-2559 or 513-326-8003

The Health Plan

10060
52180 National Road E.
P.O. Box 97
St. Clairsville, OH 43950-0097
Phone: 888-847-7810

University Hospitals CompCare

10052
P.O. Box 12778
Cleveland, OH 44122
Phone: 800-818-7273

Vantage Occupational Health Plan

10061
P.O. Box 1549
Dublin, OH 43017-1549
Phone: 877-847-5459

WorkStar Health Services

10074
7116 Sennet Place, Suite 201
West Chester, OH 45069
Phone: 800-256-8833

MCO Selection Form

Complete this form, then mail or fax it to BWC using the address or fax number found below.

Employer policy number: (Use the policy number found on your certificate of coverage.)

Company name: _____

Doing business as: _____

Contact name: _____

Number of employees: _____

Phone number with extension: _____ -- _____ -- _____ ext. _____

Fax number: _____ -- _____ -- _____

County of operation: (Use the two-digit number from the County codes on page 4 of the MCO Open Enrollment Guide.)

Mailing address: _____

City: _____ State: _____ ZIP code: _____

Name of MCO selected: _____

MCO number: (Use the five-digit number from the Alphabetical MCO list on page 4 of the MCO Open Enrollment Guide.)

Employer's signature: _____

Employer name (print): _____

Employer title: _____

Date: - -

Employer's right to select
An employer may select any MCO that meets its individual business needs. The MCO selection is solely the employer's choice.

Mail or fax form to: Ohio Bureau of Workers' Compensation
Attn: Open Enrollment
30 W. Spring St., 22nd floor
Columbus, OH 43215-2256
Fax: 614-728-0278