

Medical Services and Safety Committee Agenda

Wednesday, July 28, 2010

William Green Building

Level 2, Room 3

8:30 A.M. – 10:30 A.M.

Call to Order

Jim Harris, Committee Chair

Roll Call

Mike Sourek, scribe

Approve Minutes of June 17, 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 Second 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

B. For First Reading

Transcutaneous electrical nerve stimulators (TENS) and neuromuscular electrical stimulators, Rule 4123-6-43

Freddie Johnson, Director of Managed Care Services

Discussion Items

1. Customer Services Division Report

Tina Kilmeyer, Chief of Customer Services

2. Committee Calendar

Jim Harris, Committee Chair

Adjourn

Jim Harris, Committee Chair

Next Meeting: Thursday, August 26, 2010

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

From: Brown Dave
Sent: Wednesday, July 28, 2010 7:56 AM
To: Heil Maryann
Subject: amputee video

Maryann,

If you follow this path, J:\Video ("J" drive, "Video" folder) you will find the Injured Worker Amputee/Chris Holt video (Holt072110.wmv).

Let me know if you have problems or need anything else.

Dave

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. An update proposed professional provider fee schedule was placed on www.ohiobwc.com on July 14, 2010.

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.

As a result of updating the RVUs for all CPT codes, an update proposed professional provider fee schedule was placed on www.ohiobwc.com on July 14, 2010.

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 by 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. 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 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	1.7500	1.000	1.7500	23.250	1.00	23.250
Practice Expense	1.8900	0.964	1.8220	14.230	0.964	13.717
Malpractice	0.2100	1.232	0.2587	3.360	1.232	4.139
Sum of Products			3.83			41.10
Times Conversion Factor			\$79.10			\$79.10
Reimbursement Rate (Fee Schedule)			\$303.01			\$3,251.58

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
Anesthesia	0.0%
Evaluation & Management	7.0%
Gen Med	1.3%
Pathology	-0.8%
Phys Med	3.5%
Radiology	-5.2%
Surgery	3.2%
Therapeutic Injection	8.8%
HCPCS & Local Codes	-0.1%
TOTALS	2.9%

As the chart indicated Radiology is projected to experience a 5.2% decrease in reimbursement. Given the potential impact on Radiology, 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 (ie Kraftmatic beds, Jacuzzis, application of hot and cold packs by rule) 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 2.9% or \$9,175,133.00. 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.

Addendum

Subsequent to the first reading, Medical Services identified errors and Medicare updates to the base CPT RVUs, which has resulted in changes to the estimated impact of Medical Services recommendations.

There were 2 BWC data issues which impacted the initial estimate. The first is that initial estimate was based on only 6 months of data instead of 12 months. Secondly, the initial estimate reflected a significant increase in payment for therapeutic injections services which resulted from the inadvertent application of the surgical conversion factor of \$79 instead of the actual conversion factor of \$51 being applied for some of the codes for this service.

Medicare modified the GPCI value for all of the CPT RVUs, as the practice component of the GPCI value was incorrectly reflected in the initial release of the CMS rule. Additionally, the newly released rule further modified and corrected RVUs for a number of other codes and selected categories of services.

Correcting the BWC data issues, and applying the updated Medicare CPT RVUs for 2010, resulted in the change in the projected estimated impact from the initial 1.6% to the current 2.9%. The estimated dollar impact changed from \$2.5 million to \$9.2 million.



Bureau of Workers' Compensation

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

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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/Sl 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	The projected increase in reimbursement, including office services, result from changes to the RVU values utilized in the fee schedule calculations. The underlying RVU values are based on empirical research designed to value the selected services. Based on BWC's analysis of the empirical research, and the weighting of what is needed to ensure injured workers' access to quality care, BWC does not at this time see a decrease as warranted.	Maintain current benefit plan and fee recommendations.
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 mentioned 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.	Modify the current recommendation to price and add HCPCS code K0739 and K0740.
3	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.

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
4	NC/NCR, RB Modifier	Judy Barrie, Director of Operations Support, CareWorks	<p>1. NC – the distinction is now being made for this category as NEVER covered. Why are there fees assigned to some of the NC codes if they are never covered? It will be misleading to providers that they could potentially be covered.</p> <p>2. NRC - Not Routinely Covered - how will these codes be paid? Will MCOs be given an override EOB, such as the 752, or will BWC still require a manual approval process through the MedPol mailbox as we do for the BR codes?</p> <p>3. The RB modifier is no longer on the fee schedule. Since it was on the earlier 2010 fee schedule that is currently in effect, is BWC considering that modifier only valid for one year (DOS 11/1/09 to 10/24/10)? In other words, if a provider uses this modifier on dates before 11/1/09 or after 10/25/10, is it considered an invalid modifier, subject to denial?</p> <p>4. To prevent the problems we had in 2010 for the new 2010 CPT and HCPCS codes, is there a way to include the 2011 codes in general terms for the rule making process or have an emergency rule as soon as the 2011 codes are published? Is there a reason to make the effective date 10/25 rather than waiting for the 2011 codes?</p>		<p>1-- There are some codes which are indicated as Never Covered in an non-facility (office setting) but are priced for a facility setting. This is appropriate as such would never be reimbursed for an inpatient consult in an office setting.</p> <p>2—The NRC codes will follow the same protocol as the NC codes currently require. Pricing was published where it was available so the MCO will not need to do cost comparisons. Additionally, the provider can see the published fee, should that service meet the Miller criteria.</p> <p>3—The HCPCS modifier RB was discontinued in 2010.. The window for use is 11/1/09 until 10/25/2010</p> <p>4— As we are charged with having a yearly fee schedule update, we must implement in October, 2010. There will be an emergency rule with a single read for the 2011 CPT codes and HCPCS changes. The HCPCS codes/pricing may be more of an issue because they are not always until December. They may require a BR designation or possible exclusion until we have a new fee schedule.</p>	Maintain current benefit plan and fee recommendations.
5	CPT Codes releases for 2010	Donna Bonar, Billing Manager Interventional Pain Specialists	Is BWC currently using any of the new CPT codes released for 2010 and if not, when they will be?	Asking for a guide for use of the 2010 CPT and HCPCS codes	As the 2010 CPT and HCPCS codes were not part of the current benefit package and would require a rule change for inclusion, BWC developed a crosswalk for the MCOs and providers to utilize until the new professional provider fee schedule is implemented	BWC will post the new crosswalk document on the website as well as notifying the professional organizations of the document
6	NRC Codes and BR	Becky Bolt, President/ CompManagement Health Systems	Suggestion: BWC should develop a database to house cost comparisons for the By Report and Never Covered codes- each MCO is negotiating with providers separately, which leads to inconsistent costs to employers and payment of fees to providers. Each MCO can send their cost comparisons to BWC to increase the availability of cost comparisons and to decrease the burden to the providers of providing and to the MCOs of obtaining, separate cost comparisons. The BWC database should include information on codes payable by RVU, and hospital costs payable by percentage.	By housing an MCO data base for cost comparisons, BWC can assist each MCO in the pricing process	BWC agrees that a data base for collective cost comparisons would increase the efficiency of processing unlisted and By Report HCPCS and CPT codes for professional services.	BWC will house a cost comparison data base which will be available to MCOs as they process unlisted and By Report codes. That database will not include pricing for hospital costs as those services are reimbursed as a DRG or cost-to-charge ratio

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
7	Review of proposed fee schedule	Beth Foster, Ohio Council for Homecare and Hospice	Upon review of the codes that affect Home Health and Hospice Agencies we noted there were increases in the rehabilitative therapy fees and we are very appreciative of these increases	OCHCH has no recommendations		Maintain current benefit plan and fee recommendations.
8	Review of proposed fee schedule	Hugo R. Trux, IV, Executive Director Ohio State Chiropractic Association	The OSCA volunteer committees examined your proposed rates, and noticed that among the procedures most often used by doctors of chiropractic, there is NO increase in reimbursed fees. This was a troubling revelation because our providers' expenses continue to escalate (rent, utilities, supplies, labor, etc). With no subsequent increase in rates, our doctors are being financially squeezed. The Bureau of Labor Statistics indicates Ohio (Cleveland SMSA) CPI rose 2.1% from March '09 to March '10. Furthermore, the same report indicates that medical expenses rose 4% in the same period. http://www.bls.gov/ro5/cpicl.html Chiropractors do not prescribe drugs or utilize expensive treatment modalities, therefore they are not party to the high healthcare inflationary cycle.	They do however, need to stay even, and hereby request the BWC to increase the reimbursement rates by 2.1% for the several procedural codes	Evaluation and Management services increased 7.0%, physical medicine services increased 3.5%. Based on BWC's analysis of the empirical research, and the weighting of what is needed to ensure injured workers' access to quality care, BWC does not at this time find it a further adjustment recommendation warranted.	Maintain current benefit plan and fee recommendations.
9	Anesthesia Reimbursement	Brenda Lewis D.O Department of Anesthesia Cleveland Clinic Foundation G3 9500 Euclid Avenue Cleveland Ohio, 44195	On behalf of the Ohio Society of Anesthesiologists I have a comment on the 2010 proposed Ohio BWC fee schedule. The comment is the anesthesia conversion factor which has not changed in several years. As an organization of over 1100 anesthesiologist we would appreciate some consideration of this flat payment. On more than one occasion members of our organization have met with BWC and presented evidence to show that This payment rate is not keeping pace with average payments from private payers.	<ul style="list-style-type: none"> Surveys for private payers in Ohio 2006 showed an average private pay conversion factor of \$49.33. In 2007 the American Society of Anesthesiologists conducted a nationwide survey for private payer conversion factors which showed a median anesthesia conversion factor for anesthesia was \$55.00 Medicare is not the benchmark for anesthesia payment rates. Medicare payments woefully undervalue anesthesia services. In 2007 A GAO report supported this statement. In the report payments to physicians who are paid under the RBRVS methodology receive payments from Medicare that are only 17% lower than commercial payers. However, anesthesia payments by Medicare were 51-71% lower than commercial payers. 	BWC is reimbursing anesthesia services at 201% of the Medicare fee schedule. This specialty is the second highest reimbursement rate among the BWC professional providers. BWC's analysis of the empirical research, and the weighting of what is needed to ensure injured workers' access to quality care, BWC does not at this time find it a further adjustment recommendation warranted.	Maintain current benefit plan and fee recommendations.

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
10	Review of proposed fee schedule	MANCAN, INC.	As a self insured employer in the State of Ohio it appears that your new proposed fee schedule is on track to cripple Ohio self insured businesses as well as probably increase premiums for state fund employers through increased medical costs.	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	The projected increase in reimbursement, including office services, result from changes to the RVU values utilized in the fee schedule calculations. The underlying RVU values are based on empirical research designed to value the selected services. Based on BWC's analysis of the empirical research, and the weighting of what is needed to ensure injured workers' access to quality care, BWC is continually working to ensure reimbursement rates are appropriate, and with system edits in place that increase cost efficiency and effectiveness.	Maintain current benefit plan and fee recommendations.
11	Modifier for rental	Cory Wedding/Modern Medical	There are several HCPCS codes which were previously rented DME that do not have modifier RR appended to indicate rental pricing	MM would like to verify whether these DME items are available as rental services	These items are available as rental equipment	BWC will add the codes with a rental modifier and pricing

OHIO BWC 2009 PROFESSIONAL FEE SCHEDULE PROPOSAL

Medical Services Division

Freddie Johnson, Director, Managed Care Services

Jean Stevens, Medical Policy Analyst

July 28, 2010

Fee Schedule Service Categories

- Over 10,000 CPT® codes
 - Current Procedure Terminology
 - Services include surgery, anesthesia, etc.

- Over 3,600 HCPCS codes
 - Healthcare Common Procedure Coding System
 - Services include durable medical equipment, supplies, medications, vision services, prosthetics, etc.

- 66 Local Codes
 - Local version of HCPCS
 - Services include vocational rehabilitation, mileage, exercise equipment, etc.

Proposed CPT© Revisions

Conversion Factor (CF)

- Conversion Factor (CF)
 - BWC's assigned price for each category of service

CPT Code 29874 Arthroscopic knee surgery (scope) with removal of loose body

	RVU	x	GPCI	x	CF	= Provider Fee
2009-	13.56602	x	1.0530	x	79.10	= \$1129.94

Initial Read

2010 -	13.71119	x	1.0000	x	79.10	= \$1084.56
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RVU Revision

2010-	14.00196	x	1.0653	x	79.10	= \$1179.88
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Projected Impact of RVU Change

Specialty	Percent Change
Anesthesia	0.0%
Evaluation & Management	7.0%
Gen Med	1.3%
Pathology	-0.8%
Phys Med	3.5%
Radiology	-5.2%
Surgery	3.2%
Therapeutic Injection	8.8%
HCPCS & Local Codes	-0.1%
TOTALS	2.9%

Proposed CPT© Revisions

Conversion Factors

Current Fee Schedule

Service Grouping	CF	Pct of Medicare
Radiology	\$51.00	141%
Physical Medicine	\$51.00	141%
General Medicine	\$51.00	141%
Surgery (*)	\$79.10	221%
Pathology	Fee Schedule	125%
Anesthesia (**)	\$42.50	201%

2010 Update

Service Grouping	CF	Pct of Medicare
Radiology	\$51.00	141%
Physical Medicine	\$51.00	141%
General Medicine	\$51.00	141%
Surgery (*)	\$79.10	221%
Pathology	Fee Schedule	125%
Anesthesia (**)	\$42.50	201%

**** Injections paid at \$51.00 CF**

***** Anesthesia is currently paid at \$42.50 time the number of base units plus \$42.50 per 15 minutes/2009 Medicare's Anesthesia is base rate is \$21.11. 2010 Medicare's Anesthesia is base rate is \$21.11**

Recommendations

- o Adopt the 2010 Medicare RVU updates
- o Maintain the current conversion factors
- o Adopt the 2010 Medicare HCPCS II Codes
- o Adopt the following additional HCPCS II Codes
 - S0630 removal of sutures by another qualifying medical professional, other than the physician that placed the sutures
 - S0209 for wheelchair van mileage
 - S5199 for personal care items
 - S8301 for infection control supplies
- o Adopt a category of service titled “Never Covered (NC)”
- o Modify the title of the category of service currently titled “Non-Covered” to “Not Routinely Covered (NRC)”
- o Maintain the current Local Codes

Impacts and Outcomes

- o Medical Costs Impact
 - **An estimated 2.9% increase above the estimated current fee schedule impact**
 - Estimated dollar figure is \$9,175,133.00
- o Increase the ease of access to injured worker to receive appropriate services
- o Reduce challenges which providers have faced in rendering and receiving reimbursement for related services; thereby reducing operational expenses
- o Increase clarity around which benefits are covered, or never covered under the Ohio BWC workers' compensation benefit plan

Thank You

Appendix

Fee Schedule Update Methodology

- o Evaluated the current benefit plan to identify recommendations to add to, delete or further modify the current benefits including services and units of services
- o Evaluated the 2009 Ohio fee schedule against the Medicare and Medicaid Services 2010 fee reimbursements publications including CPT and HCPCs codes
- o Evaluated impacts of Medicare changes to determine if recommendations for modification of Ohio's conversion factors is warranted
- o Researched and evaluated the benefit plans and reimbursement levels of other States

Calculating CPT Fees

- The RVU for each CPT code includes three components:
 - Work - level of difficulty to provide the service
 - Practice Expense - overhead such as staff, rent, utilities
 - Malpractice – level of risk associated with the service
- Geographical Practice Cost Index (GPCI)
 - Modifier reflecting cost-of-living differences
 - Is different for each State, and in some cases Regions
- Conversion Factor (CF)
 - BWC's assigned price for each category of service

HCPCS and Local Codes Revisions

- o Adjust current HCPCS to reflect 2010 Medicare Schedule
 - Medicare's values will be increased by 20%
 - Add some non-Medicare S codes

- o Local Codes
 - Maintain local fees

Proposed CPT© Revisions

Relative Value Units (RVU)

- RVUs updated to Medicare’s 2010 Unadjusted RVUs
 - The RVU for each CPT code includes three components:
 - Work - level of difficulty to provide the service
 - Practice Expense - overhead such as staff, rent, utilities
 - Malpractice – level of risk associated with the service

 - Geographical Practice Cost Index (GPCI)

2009 GPCI	2010 GPCI
Work—1.00	Work—0.993
Practice Expense—0.927	Practice Expense—0.927
Malpractice—1.232	Malpractice—1.232

Conversion Factor Comparison

2010 CF comparison	Anesthesia	Surgery	Radiology	Physical Medicine/ Chiro	General Medicine
Alabama WC	\$47.22				
Arkansas WC	\$41.76	\$70.00	\$70.00		\$44.28
Colorado WC	\$50.87	\$66.35	\$17.43	\$5.73	\$7.56
Florida WC ('08)	\$29.49	\$34.07	\$34.07	\$34.07	\$34.07
Idaho Workers Comp	\$60.05	\$108.40	\$87.72	\$46.44	\$66.56
Kansas WC		\$80.81	\$58.49	\$50.92	\$48.40
Maryland WC	\$19.92	\$55.23		\$41.80	\$41.80
Michigan WC		\$50.70	\$50.70	\$50.70	\$50.70
Minnesota WC		\$81.63		\$70.77	\$81.63
Nevada WC	\$63.69	\$182.50	\$33.06		\$8.58
North Dakota WC	\$52.62	\$61.69	\$61.69	\$61.69	\$61.69
South Carolina WC	\$19.92	\$50.00		\$50.00	\$50.00
Tennessee WC	\$75.00	\$95.47	\$80.40	\$52.30	\$64.32
Texas Workers Comp	\$54.32	\$61.26	\$54.32	\$54.32	\$54.32
Utah Workers' Comp	\$41.00	\$58.00	\$53.00	\$46.00	\$46.00
Washington WC	\$47.85	\$61.53	\$61.53	\$61.53	\$61.53
Mean	\$51.26	\$74.51	\$58.63	\$51.71	\$54.25
Median	\$51.75	\$61.69	\$58.49	\$50.81	\$50.70
Ohio	\$42.50	\$79.10	\$51.00	\$51.00	\$51.00

Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-43

Rule Review

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

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

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

What goal(s): The rule adopts criteria and procedures for the authorization and payment of transcutaneous electrical nerve stimulators and neuromuscular electrical stimulators for the treatment of injured workers.

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: BWC's proposed changes to the rule were e-mailed to the BWC Medical Division's list of stakeholders for review on June 24, 2010. Stakeholders were given until July 7, 2010 to submit comments. The proposed rule changes were also discussed at BWC's MCO Business Council meeting on July 22, 2010.

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
HPP TENS/NMES Payment Rule
OAC 4123-6-43

Introduction

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including the rule governing authorization and payment of transcutaneous electrical nerve stimulator (TENS) and neuromuscular electrical stimulator (NMES) units. BWC enacted the HPP TENS/NMES payment rule, OAC 4123-6-43, in February 1997. The rule underwent five-year rule review in 2004 and 2009.

OAC 4123-6-43 was recently amended as part of the 2009 five-year rule review of the HPP rules. The amended rule became effective February 1, 2010.

Subsequent to the rule amendment becoming effective, BWC received feedback from stakeholders that the portion of the rule amendment requiring injured workers to submit signed written requests for TENS supplies on a monthly basis was placing an unintended burden on injured workers disproportionate to the goal being sought. BWC is proposing to amend the rule to require the MCO to determine the injured workers' need for supplies.

Background Law

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

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

Proposed Changes

As recently amended effective February 1, 2010, paragraph (B) of rule OAC 4123-6-43 provides in part:

(B) Claimants who have TENS units must complete and submit to the TENS provider a monthly written request for specific supplies needed in the following month. The written request must be initiated and signed by the claimant, and must be received by the TENS provider prior to the delivery of supplies and/or equipment. . .

BWC originally proposed to amend paragraph (B) of the rule to provide:

(B) The claimant's MCO shall have contact with the claimant monthly and determine the specific supplies needed by the claimant in the following month. The TENS provider must receive authorization from the claimant's MCO prior to the delivery of supplies and/or equipment. . . .

After receiving additional feedback from the MCO Business Council and other stakeholders, BWC is now proposing to amend paragraph (B) of the rule to read:

(B) The claimant's MCO shall regularly determine the specific TENS supplies needed by the claimant throughout the period of time authorized for TENS use. The TENS provider must receive monthly authorization from the claimant's MCO prior to the delivery of supplies and/or equipment. The TENS provider shall then deliver the supplies and bill the claimant's MCO after authorization is received. . . .

Under the proposed rule change, self insuring employers may, but are not required to, follow the same procedure; however, self insuring employers are prohibited from requiring injured workers to submit a written request for TENS supplies.

Several other minor, related clarifications to paragraphs (B) and (C) of the rule are also proposed.

Stakeholder Involvement

BWC's proposed changes to the TENS/NMES rule were e-mailed to the following lists of stakeholders on June 24, 2010 with comments due back on July 7, 2010:

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

The proposed rule changes were also discussed at BWC's MCO Business Council meeting on July 22, 2010.

Stakeholder responses received by BWC are summarized on the Stakeholder Feedback Summary Spreadsheet.

4123-6-43 Payment for transcutaneous electrical nerve stimulators and neuromuscular electrical stimulators.

(A) Payment will be approved for a transcutaneous electric nerve stimulator (TENS) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in this rule.

(1) Prior authorization is required for TENS units and supplies. A claimant shall be provided only one TENS unit at a time. For each TENS unit request approved, the unit shall be rented for a thirty day trial period before purchase of the TENS unit. This trial period is to evaluate the medical necessity and effectiveness of the TENS treatment. TENS treatment will be discontinued at the end of the thirty day trial period month where the treatment has not proven to be medically necessary or effective. Reimbursement of rental costs will be considered only for the trial period that the TENS unit was actually used before treatment was discontinued. For each TENS unit provided, payment shall be limited to necessary disposable or rechargeable batteries, but not both.

(2) The bureau shall apply all rental payments previously made to the purchase price of the TENS unit. A TENS unit purchased and furnished to the claimant is not the personal property of the claimant, but remains the property of the bureau or self-insuring employer. The bureau or self-insuring employer reserves the right to reclaim and recover the TENS unit from the claimant at the completion of the course of TENS treatment. Once a TENS unit is purchased, the bureau or self-insuring employer will reimburse for repair or replacement of the unit upon submission of a request from the physician of record or treating provider that includes medical documentation substantiating the continued medical necessity and effectiveness of the unit.

~~(B) Claimants who have TENS units must complete and submit to the TENS provider a monthly written request for~~ The claimant's MCO shall regularly determine the specific TENS supplies needed in the following month by the claimant throughout the period of time authorized for TENS use. The written request must be initiated and signed by the claimant, and must be received by the TENS provider must receive monthly authorization from the claimant's MCO prior to the delivery of supplies and/or equipment. The TENS provider shall then deliver the supplies and bill the bureau, claimant's MCO, QHP, or self-insuring employer after the claimant's written request authorization is received. A self-insuring employer may, but is not required to, follow the same procedure as an MCO under this rule; provided, however, that in no event shall a self-insuring employer require a claimant to submit a written request for TENS supplies and/or equipment. The provider claimant's MCO shall retain the original written request documentation of the contact with the claimant substantiating the claimant's need for supplies in accordance with the time frames set forth in rule 4123-6-45.1 4123-6-14.1 of the Administrative Code. The TENS provider's bill must indicate the actual date of service, reflecting the date that services or supplies were provided. The bureau, MCO, QHP, or self-insuring employer may adjust bills upon audit if the audit discloses the provider's failure to comply with this rule.

(C) The TENS provider shall maintain the following records and make them available for audit upon request:

- (1) The injured worker's monthly written requests, if applicable;
- (2) Records of the provider's wholesale purchase of TENS supplies or equipment; and,
- (3) Records of delivery of supplies to injured workers and of the delivery or return of TENS units.

Upon request, the provider shall supply copies of the record information to the requester at no cost. Failure to provide the requested records may result in denial or adjustment of bills related to these records.

(D) Payment will be approved for a neuromuscular electrical stimulator (NMES) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in the bureau's provider billing and reimbursement manual.

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: 2/12/97, 3/1/04, 2/1/10



Stakeholder feedback and recommendations for changes to the O.A.C. 4123-6-43, Payment for transcutaneous nerve stimulators and neuromuscular electrical stimulators

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
1	General Comment	Duane Szymanski, CorVel Corporation (MCO)	Add additional requirement under section (C) for the TENS provider to maintain a copy of the MCO's written authorization as described in section (B) of the rule.	No additional rationale provided.	BWC does not see a need to require providers to maintain copies of the authorization. Authorizations should be documented and/or imaged in the MCO's and BWC's systems.	Maintain current recommendations
2	General Comment	Kim Jaconette, Health Management Solutions (MCO)	1) Recommend allowing MCOs to authorize up to 6 months of supplies at one time contingent on provider receiving the written request from IW prior to shipping and that the MCO contact the IW upon receipt of the additional request for supplies in order to determine whether continued supplies are appropriate rather than doing this monthly. 2) Recommend adding additional requirement under section (C) for the TENS provider to maintain records of progress reports (effectiveness, usage, etc.). 3) Upon receipt of the written request for supplies, recommend that the vendor contact the IW in order to do a progress report.	1) Requiring MCOs to contact all IW's that receive TENS supplies monthly seems rather unrealistic. This MCO has 247 IW's who received TENS supplies from 6/1/09 to 5/31/10. 2) It would seem that the DME provider would be in contact with the IW upon receipt of a request for additional supplies and would inquire about the effectiveness, usage, etc. 3) There would be no interpretation of solicitation from the provider; they are simply responding to a request for additional supplies and can answer any questions regarding the unit itself if needed.	1) Neither the current nor proposed rule limits an MCO's ability to authorize supplies for a specific period of time. MCOs retain the authority to determine the length of the authorization period. The proposed rule addresses only the verification of the IW's need for additional supplies. Additionally, MCOs have the responsibility for ensuring that goods and services for which they are authorizing are needed and being provided to the injured workers. The verification that supplies are needed and are provided to the injured workers is even more necessary where a blanket authorization is given for a specific time period (i.e. 6 months). 2) BWC does not see a need to require providers to maintain copies of the authorization. Authorizations should be documented and/or imaged in the MCO's and BWC's systems. 3) This action is within the purview of the MCO responsibilities.	Maintain current recommendations
3	General Comment	Mark Benson, Miller Pipeline (employer)	Likes the idea of applying all rental costs to the purchase price.	There is a lot of abuse in this area. Too often these units are loaned out and the IW doesn't even use them after a few times.	This comment relates to a part of the current rule that will not be changing.	No action required.
4	General Comment	Judi Carollo, Associate Health and Wellness, OhioHealth (commenting as an employer)	Stakeholder is questioning why electronic stimulators are allowed under Ohio BWC regulations. Recommend that Ohio BWC require documentation of the efficacy of a procedure before allowing it to be compensable.	Statistics show the success rate is only 5 to 8 percent for this procedure. The state of Washington does not allow payment for this procedure under their workers' comp system.	This proposed rule does not address the BWC benefit package with regard to electronic stimulators. However, this comment will be considered as BWC assesses its benefit package and policies in the future.	No action required.
5	General Comment	Arnold Delossantos, Baker Concrete Construction, Inc. (employer)	Recommend that the following be added to the rule: The Bureau or self insured reserves the right to select the most cost effective TNS unit, with agreement from a physician, which will provide and promote relief of chronic pain and/or can substitute a comparable working and inspected TNS unit from the provider's supply of warehoused recovery units. A physician's prescription is required every 6 months to support the necessity and continued benefit of the TNS.	Baker Concrete Construction, Inc. truly values the continued efforts made to improve the quality of health care services in support of the Ohio Workers' Compensation system.	BWC previously established minimum technical criteria for TENS units, NMES units and electrodes to ensure that effective devices are utilized. In addition, the current rule requires that reimbursement for total rental costs cannot exceed reimbursement for purchase of the unit. BWC believes this combination of minimum technical criteria and reimbursement limitations helps to ensure cost effectiveness. The current rule further allows BWC or the self insuring employer to reclaim and recover the TENS unit after the course of treatment. The rule does not prohibit re-use of the units. BWC will consider as part of future evaluation on the efficacy of TENS units the addition of a requirement of a 6 month medical necessity review.	Maintain current recommendations

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
6	General Comment	Karen Agnich, Advocare (MCO)	Recommend that when the MCO receives a new C9 (request for authorization) for supplies for 6 months, that the MCO contact the IW at that time to see how much they use the TENS and how effective it is. There should be 3 attempts at contact then the MCO should be able to deny the C9 if the IW does not respond to documented attempts at contact. The MCO should also tell the IW if the TENS unit usage is stopped, the IW should notify the MCO.	This is absurd. We authorize supplies for 6 months at a time. Who is going to be responsible for calling the IW each month to see if they need supplies? We will need someone to do this as we have a lot of TENS units out there. I just do not see this working well or efficiently.	This appears to be a strict interpretation of the phrase that "...the claimant's MCO shall contact claimant monthly...". Specifically, the "shall contact" appears to be strictly construed. MCOs may continue to determine the authorization time period for supplies as the rule does not address this issue. To potentially further alleviate this issue, we have revised the language to read "The claimant's MCO shall regularly determine...." The suggested changes should provide the MCO the flexibility to work with the claimant to determine supply needs and subsequently authorize the same. This preserves the intent of the changes to the rule, alleviating a signature requirement on a request by the injured worker, while increasing the option for MCOs implementing an efficient process for executing on the rule.	Modify select component of the recommendation language from "shall contact" to "shall have contact with" to "The claimant's MCO shall regularly determine...."
7	General Comment	Dan Davis, MD, Ohio Employee Health Partnership (MCO)	The requirement for the IW to notify the provider of the need for additional supplies is the best option. The provider can send the documentation to the MCO.	There is no way you can expect MCOs to contact that many IW's monthly to determine the exact number of needed supplies. Tracking down the IW by phone is sometimes difficult and sometimes impossible and with the number of TENS units out there, the time spent on this would be exorbitant.	This appears to be a strict interpretation of the phrase that "...the claimant's MCO shall contact claimant monthly...". Specifically, the "shall contact" appears to be strictly construed. MCOs may continue to determine the authorization time period for supplies as the rule does not address this issue. To potentially further alleviate this issue, we have revised the language to read "The claimant's MCO shall regularly determine...." The suggested changes should provide the MCO the flexibility to work with the claimant to determine supply needs and subsequently authorize the same. This preserves the intent of the changes to the rule, alleviating a signature requirement on a request by the injured worker, while increasing the option for MCOs implementing an efficient process for executing on the rule.	Modify select component of the recommendation language from "shall contact" to "shall have contact with" to "The claimant's MCO shall regularly determine...."
8	General Comment	Maury Nauman, LeSaint Logistics (employer)	Should be approved.	No additional rationale provided.	No response required.	
9	General Comment	Marilyn Estep, CorVel Corporation (MCO)	<p>1) IW should take responsibility to get supplies monthly; provider should determine medical necessity to continue treatment or not; MCO is responsible to determine if requested treatment meets Miller criteria. MCO making call every month would promote dependence-- goal of case management is to promote independence. Rule change seems to be setting up busy work for the MCOs.</p> <p>2) To return equipment for reuse might not be good practice due to possible infestation of bed bugs.</p>	<p>1) MCO making call every month would promote dependence-- goal of case management is to promote independence. Rule change seems to be setting up busy work for the MCOs. 2) Bed bug infestation is severe at present and they are difficult to get rid of. They like to live in dark electronic equipment.</p>	<p>1) MCOs have the responsibility for ensuring that goods and services for which they are authorizing are needed and being provided to the injured workers. The verification that supplies are needed and are provided to the injured workers is even more necessary where a blanket authorization is given for a specific time period (i.e. 6 months). To potentially further alleviate this issue, we have revised the language to read "The claimant's MCO shall regularly determine...." The suggested changes should provide the MCO the flexibility to work with the claimant to determine supply needs and subsequently authorize the same. This preserves the intent of the changes to the rule, alleviating a signature requirement on a request by the injured worker, while increasing the option for MCOs implementing an efficient process for executing on the rule. 2) This important comment has been noted. While the rule currently allows BWC or the self insuring provider to reclaim and recover units from the IW, it is not a requirement. BWC does not want to eliminate the option of reclaiming devices at this time.</p>	Modify select component of the recommendation language from "shall contact" to "shall have contact with" to "The claimant's MCO shall regularly determine...."

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
10	General Comment	Lori Finnerty, Careworks (MCO)	Changes are not appropriate. Careworks recommends that the IWs be instructed to contact the MCO (phone, mail, fax) when additional monthly supplies are needed. MCO would contact vendor. Written letter communicating the process would be sent to any IW upon purchase/rental of new TENS/NMES unit.	1) Change puts the MCO in the middle for contacting the IW. Many IWs are hard to reach via telephone as some are working, so this MCO middleman role would not adequately address coordination. We see many problems arising with this process. Recommended process would allow for a better workflow and allow the IW to request supplies based on need, similar to the process used for pharmacy benefits. 2) It appears most other payors control this issue through their coverage policy (e.g. acute 30 days and chronic only upon meeting certain criteria). The State of Washington no longer covers TENS, IFC, PNT devices for use outside of medically supervised facility settings. This is more consistent with ODG for our population of patients.	MCOs have the responsibility for ensuring that goods and services for which they are authorizing are needed and being provided to the injured workers. The verification that supplies are needed and are provided to the injured workers is even more necessary where a blanket authorization is given for a specific time period (i.e. 6 months). To potentially further alleviate this issue, we have revised the language to read "...the claimant's MCO shall have contact with claimant monthly..." The suggested changes should provide the MCO the flexibility to work with the claimant to determine how the contact should occur. This preserves the intent of the changes to the rule, alleviating a signature requirement on a request by the injured worker, while increasing the option for MCOs implementing an efficient process for executing on the rule.	Modify select component of the recommendation language from "shall contact" to "shall have contact with" to "The claimant's MCO shall regularly determine..."
11	General Comment	Linda Hritz, CompManagement Health Systems (MCO)	1) if the MCO can't reach the IW, there will be a delay in supplies. Can we contact the IW by mail and have the request sent back by mail? How do we confirm receipt? 2) How will the MCO know which vendor will be supplying initial supplies and how is MCO notifying vendor of approval? 3) This rule change increase MCO costs due to the number of TENS units being used. It would be more reasonable to authorize necessary supplies for a 3 or 6 month period. 4) This rule change will increase ADR appeals. 5) Makes more sense when DME companies are contacting IWs to document their use and efficacy to find out what supplies are needed.	1) No additional rationale provided; 2) No additional rationale provided; 3) For MCO to follow up monthly would be an enormous amount of work; 4) When MCO can't reach IW, they will deny the authorization request leading to increased ADR appeals; 5) No additional rationale provided	MCOs have the responsibility for ensuring that goods and services for which they are authorizing are needed and being provided to the injured workers. The verification that supplies are needed and are provided to the injured workers is even more necessary where a blanket authorization is given for a specific time period (i.e. 6 months). To potentially further alleviate this issue, we have revised the language to read "...the claimant's MCO shall have contact with claimant monthly..." The suggested changes should provide the MCO the flexibility to work with the claimant to determine how the contact should occur. This preserves the intent of the changes to the rule, alleviating a signature requirement on a request by the injured worker, while increasing the option for MCOs implementing an efficient process for executing on the rule.	Modify select component of the recommendation language from "shall contact" to "shall have contact with" to "The claimant's MCO shall regularly determine..."
12	General Comment	Lisa Lachendro, Medical Administrators (MCO)	1) MCO does not think it is the role of the MCO to determine if a medical device or procedure is being used and is effective; 2) Supply verification shouldn't have to be documented monthly. Instead, the note should be documented at the expiration of the C9 authorization so if the physician orders supplies for 6 months, then he/she should document the need for continued supplies every 6 months, not monthly.	1) we believe this is the role of the physician; 2) this is burdensome especially considering supplies are ordered 3-6 months at a time which means monthly verification would be of no benefit.	MCOs have the responsibility for ensuring that goods and services for which they are authorizing are needed and being provided to the injured workers. The verification that supplies are needed and are provided to the injured workers is even more necessary where a blanket authorization is given for a specific time period (i.e. 6 months). o potentially further alleviate this issue, we have revised the language to read "The claimant's MCO shall regularly determine..." The suggested changes should provide the MCO the flexibility to work with the claimant to determine supply needs and subsequently authorize the same. This preserves the intent of the changes to the rule, alleviating a signature requirement on a request by the injured worker, while increasing the option for MCOs implementing an efficient process for executing on the rule.	Modify select component of the recommendation language from "shall contact" to "shall have contact with" to "The claimant's MCO shall regularly determine..."

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
13	General Comment	Deanna Kazamek, 1-800-OHIOCOMP (MCO)	<p>1) Monthly phone calls must be placed by the vendor to the IW to gather usage and supply quantity information; the vendor will send a copy of the documentation to the MCO. No automatic shipping of supplies is allowed. 2) BWC needs to define maximum payable amounts for TENS unit CPT codes</p>	<p>1) If TENS and supplies are approved for a specified time, once a month contact is not needed from the MCO to determine usage. 2) Maximum payable amounts on TENS units has not been defined over the past couple of years. Rental and subsequent purchase may fall under 2 different fee schedules; modifiers have been added to the fee schedules which further complicate reimbursement rates.</p>	<p>1) MCOs have the responsibility for ensuring that goods and services for which they are authorizing are needed and being provided to the injured workers. The verification that supplies are needed and are provided to the injured workers is even more necessary where a blanket authorization is given for a specific time period (i.e. 6 months). o potentially further alleviate this issue, we have revised the language to read "The claimant's MCO shall regularly determine...." The suggested changes should provide the MCO the flexibility to work with the claimant to determine supply needs and subsequently authorize the same. This preserves the intent of the changes to the rule, alleviating a signature requirement on a request by the injured worker, while increasing the option for MCOs implementing an efficient process for executing on the rule. 2) BWC previously established minimum technical criteria for TENS units, NMES units and electrodes to ensure that effective devices are utilized. In addition, the current rule requires that reimbursement for total rental costs cannot exceed reimbursement for purchase of the unit. BWC believes this combination of minimum technical criteria and reimbursement limitations helps to ensure cost effectiveness. However, this comment will be considered in further evaluation of this service.</p>	<p>Modify select component of the recommendation language from "shall contact" to "shall have contact with" to "The claimant's MCO shall regularly determine...."</p>

Customer Services Division Report

The Customer Services Division consists of the following departments: Customer Services Administration, Customer Contact Center, Employer Management Services, Field Operations, and Safety & Hygiene.

Customer Contact Center:

Bill Teeven, Director

The multi-site Customer Contact Center (CCC) is the Agency's main point of contact with externals. The CCC is responsible for educating customers on agency services, rules, laws and policies; linking the customer with internal/external resources, and performing general claims and employer transactions. The CCC acts as a liaison between customer and internal/external groups (e.g. MCO, provider community, Service Desk, etc.) and provides support on issues/concerns.

Employer Management Services:

Tom Prunte, Executive Director

The employer management services section consists of underwriting & premium audit, business development & management, self insured, PEO & systems support, employer programs (DFWP, DFSP, One Claim, Group Rating, Retro Rating, PEO, PDP+), and employer compliance. These departments are responsible for initiating employer policies, assigning manual classifications to employers' operations and to claims, responding to employer inquiries, maintaining records of all employer policy information, administering the Bureau's special programs such as Drug-Free Workplace, the One Claim Program (OCP), the Premium Discount Program Plus (PDP+), Group Rating, and Retrospective Rating Program.

Field Operations:

Steve Dyer, Field Operations Manager

Field Operations is responsible for providing injury management and employer management services to Ohio's injured workers and employers. Field Operations consists of 13 field offices around the state, plus our Columbus and Central Claims offices. Each office consists of claims, risk and safety personnel who are assigned to customers for all claims, risk and safety activities.

Safety & Hygiene:

Abe Al-Tarawneh, Safety & Hygiene Superintendent

The Division of Safety and Hygiene (DSH) is tasked with helping Ohio workers and employers in the prevention of occupational accidents and injuries at the workplace. To carry out that task, the DSH sponsors a wide range of occupational safety and health activities and programs throughout the state of Ohio. DSH is currently going through a re-evaluation of its programs, and re-organization and re-engineering of its operations, procedures and processes.

I. Customer Services Training

This summer, we kicked off a customer service training initiative for all BWC employees called *You are the brand!* The campaign began in late April and runs through Labor Day. The key message for employees is one we all can agree on: Customer service is everyone's job — whether you have direct or indirect contact with injured workers and employers.

The *You are the brand!* initiative seeks to:

1. Increase awareness among BWC employees about the importance of customer service excellence;
2. Promote BWC training classes that can help enhance employee skills and service;
3. Recognize employees for outstanding customer service — internally and externally;
4. Increase awareness among employees about their part in building the BWC brand;
5. Build morale and foster a customer-centered culture;
6. Reinforce BWC's mission and goals: Safer workplaces; Accurate rates; Stable costs; Better services.

Campaign includes:

- A series of 12 training vignettes running weekly on our Intranet;
- A monthly brand-builder profile of an employee or team who exemplifies the best of BWC;
- Statewide customer service training;
- All hands meeting at the close of the campaign.

Although the *You are the brand!* campaign officially ends this summer, the enduring message for our employees is: "We are the brand!"

II. Drug Free Safety Program

BWC's new Drug-Free Safety Program (DFSP) was effective July 1, 2010.

Accomplishments to date include:

■ **Training:**

- Trained all BWC staff with employer contact responsibilities, beginning with a DFSP Kick-off presentation for BWC employer staff and including TPAs, drug-free vendors and other interested parties on April 8.
- Training of all levels of BWC with employer contact throughout April, May and June with program details as well as roles and responsibilities.

■ **Marketing:**

- Developed correspondence to advise July program year employers regarding sun-setting of DFWP/DF-EZ and selling the value of DFSP, including a DFSP application with each letter;
- Developed correspondence to group-experience rated employers and employers that previously participated in DFWP/DF-EZ to encourage participation in DFSP;
- Creation of a DFSP headline on BWC home Web page to link to DFSP information;
- Promotional flyer for Ohio Safety Congress, emailed to TPAs and group sponsors;
- On-going Web articles and news releases promoting DFSP and providing information on how to apply and link to the application;
- Answers to Frequently Asked Questions (FAQ) on DFSP Web page along with PowerPoint of what was shared at the DFSP Kick-off;
- DFSP marketing brochure.

■ Roll Out:

- Ongoing coordination with BWC's Information Technology staff in support of systems changes required to accommodate online reporting (safety review, accident reporting, safety action plan, program application and annual reporting) and new program "levels" as well as efforts to reduce manual processes including evaluating whether employers receive a DFSP discount in conjunction with concurrent participation in other BWC rating programs.
- Online service offerings include:
 - a DFSP Web page with information about the sun setting of DFWP and DF-EZ and the important difference that the focus on integrating drug free into safety will make DFSP more effective and worth participating in;
 - Accident-analysis training;
 - Safety review;
 - Accident reporting capability;
 - Safety action plan.
- Creation of a host of program documents and marketing materials:
 - Revised DFSP Application form and design of new Annual Reports for DFSP Basic/Advanced and for comparable (state construction, no discount) employers;
 - Development of a safety policy and individual program element policies;
 - DFSP Guide pdf on Web page, limited print run;
 - DFSP Self-Implementation Workbook pdf on Web page, limited print run;
 - Program Compatibility Chart.
- Revamped grant program with a new DFSP SafetyGRANT\$ booklet in process along with readiness to put the new grant rules on ohiobwc.com along with a DFSP grant chart that was emailed to drug-free vendors;
- State Construction Contractor Guide (in process);
- BWC has received approximately 4,500 applications for the new program through 06-30-2010 along with almost 100 applications for 01-01-11;
 - Underwriting applications to determine participation eligibility.

III. Medical Repository

BWC's Medical Repository, established in 1998, is an online storage of medical documents relating to injured worker claims. When providers fax medical documents to the respective managed care organization (MCO), an image of the document is simultaneously captured in the medical repository for indexing to the appropriate BWC claim.

Over 9.7 million pages are processed through the medical repository each year.

An external vendor has historically provided the indexing function for the medical repository. However, a recent in-depth analysis confirmed that internal BWC clerical resources were available to assume a portion of this function, thus reducing the administrative cost associated with the vendor.

In February 2010, after reaching a service level agreement with OCSEA labor representatives, BWC began a pilot in the Garfield Heights service office to determine if BWC could cost effectively assume a portion of medical repository indexing duties.

Pilot performance expectations were met and BWC realized administrative cost savings of nearly \$92,000.

In August, 2010, additional BWC resources will be allocated to medical repository processing and BWC will assume 55% of the medical repository volume resulting in expected administrative cost savings of \$500,000+/year.

IV. Medicare Reporting

The federal government passed legislation in December 2007 that requires insurers, including BWC, to report allowed claims to Centers for Medicare & Medicaid Services (CMS). The purpose of reporting workers' compensation claims to CMS is to enable CMS to perform cross matches of Medicare recipients against other payer data to ensure CMS is only paying for appropriate medical care.

Initial Reporting : BWC started querying the CMS database for eligible Medicare recipients in March. Over 900,000 injured worker social security numbers were sent and 106,000 returned as positive hits. Since then, we have queried CMS and found an additional 7,000 to be Medicare eligible. Beginning the first week of September 2010, BWC will report the claims of these 113,000 injured workers to CMS.

Ongoing Reporting: Quarterly thereafter, BWC will be responsible for reporting all newly filed claims of Medicare eligible injured workers for which BWC has ongoing responsibility for making medical payments. In addition, BWC will report any material updates to claims previously reported.

The federal legislation includes fines of \$1,000 per day per claim for insurers who fail to comply with reporting requirements.

Congress estimates that fines collected due to non-compliance with reporting requirements could amount to \$1.5 billion over five years.

V. August 2010 Payroll Reporting Period Preparations

In August, private employers will report payroll and pay premium for the 2nd half of policy year 2009. Several enhancements have been made to improve services for employers such as e-invoice, payment via interactive voice response (IVR), and enterprise assistance.

■ e-invoice (paperless payroll)

E-invoice is a no paper, no printing, no postage, cost savings paperless payroll method that was offered to employers in January of this year. For customer convenience, an email is sent to those 1,258 employers that enrolled in this service, with a quick link to online filing and payment. Deadline for payment is August 31st.

■ Payment via IVR

Employers with two or fewer manual classifications can now submit their payroll and pay premium by using BWC's IVR self-service options via their telephone. This method is available for approximately 80 percent of all active, private (PA) employers. Employers are required to provide only their policy number, payroll and a valid credit card/checking account number and all computations are done automatically.

Customer Services Division Report

■ **Enterprise assistance**

Service Office employees with employer and claims expertise log into the 1-800 OhioBWC call queue and assist customers. Over 150 field employees are trained and available to assist the CCC during peak call times.

Expected August call volumes

February 2009 16,931

March 2009 18,614

Average speed of answer:

37 seconds

12 - Month Medical Services & Safety Calendar

Date	July 2010	Notes
7/28/10	1. Medical & Service Provider Fee Schedule (2nd read)	
	2. TENS rule (1st read)	
	3. Customer Services Report	
Date	August 2010	
8/26/10	1. TENS rule (2nd read)	
	2. Pharmacy and Therapeutics Committee Rule 4123-6-21-1 (1 st read)	
	3. Medical Services Report	
Date	September 2010	
9/23/10	1. Pharmacy and Therapeutics Committee Rule 4123-6-21-1 (2nd read)	
	2. HCPQAAC Rule 4123-6-22 (1st read)	
	3. Inpatient Hospital Fee Schedule (1st read)	
	4. Vocational Rehab fee schedule (1st read)	
	5. Pharmacy Payment Rule 4123-6-21 (1st read)	
	6. Customer Services Report	
Date	October 2010	
10/21/10	1. HCPQAAC Rule 4123-6-22 (2nd read)	
	2. Inpatient Hospital Fee Schedule (2nd read)	
	3. Vocational Rehab fee schedule (2nd read)	
	4. Pharmacy Payment Rule 4123-6-21 (2nd read)	
	5. Committee Charter review (1st read)	
	6. Outpatient Hospital Fee Schedule (1st read)	
	7. Medical Services Report	
Date	November 2010	
11/18/10	1. Outpatient Hospital Fee Schedule (2nd read)	
	2. Ambulatory Surgical Center Fee Schedule Rule (1st read)	
	3. Committee Charter Review (2nd 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 2nd 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		
Date	June 2011	
TBD	1. Medical & Service Provider Fee Schedule (1st read)	
	2. Medical Services Report	