

BWC Board of Directors
Medical Services and Safety Committee Agenda

Thursday, August 26, 2010

William Green Building

Level 2, Room 3

8:00 A.M. – 10:00 A.M.

Call to Order

Jim Harris, Committee Chair

Roll Call

Jill Whitworth, scribe

Approve Minutes of July 28, 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

Transcutaneous electrical nerve stimulators (TENS) and
neuromuscular electrical stimulators, Rule 4123-6-43
Freddie Johnson, Director of Managed Care Services

B. For First Reading

Pharmacy and Therapeutics Committee Rule 4123-6-21.2
Johnnie Hanna, R. Ph, M.B.A. Pharmacy Program Director
Dr. Robert Balchick, Medical Director

Discussion Items

1. Medical Services Division Report

Robert Coury, Chief, Medical Services Division

2. Committee Calendar

Jim Harris, Committee Chair

Adjourn

Jim Harris, Committee Chair

Next Meeting: Thursday, September 23, 2010

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

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. . . .

Additional feedback from MCOs was received after the initial presentation to the Board. After consideration of that feedback, BWC is now proposing to amend paragraphs (B) and (C) 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 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. . . .

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

(1) Authorizations of TENS supplies or equipment received from the injured worker's MCO, and all other documentation relating to the injured worker's need for TENS supplies or equipment received by the provider prior to the delivery of the supplies or equipment, including any requests received from the injured worker, if applicable;

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 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 Authorizations of TENS supplies or equipment received from the injured worker's MCO, and all other documentation relating to the injured worker's monthly written need for TENS supplies or equipment received by the provider prior to the delivery of the supplies or equipment, including any requests received from the injured worker, 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



Bureau of Workers' Compensation

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

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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)	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. 2) To return equipment for reuse might not be good practice due to possible infestation of bed bugs.	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.	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.	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). 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...."

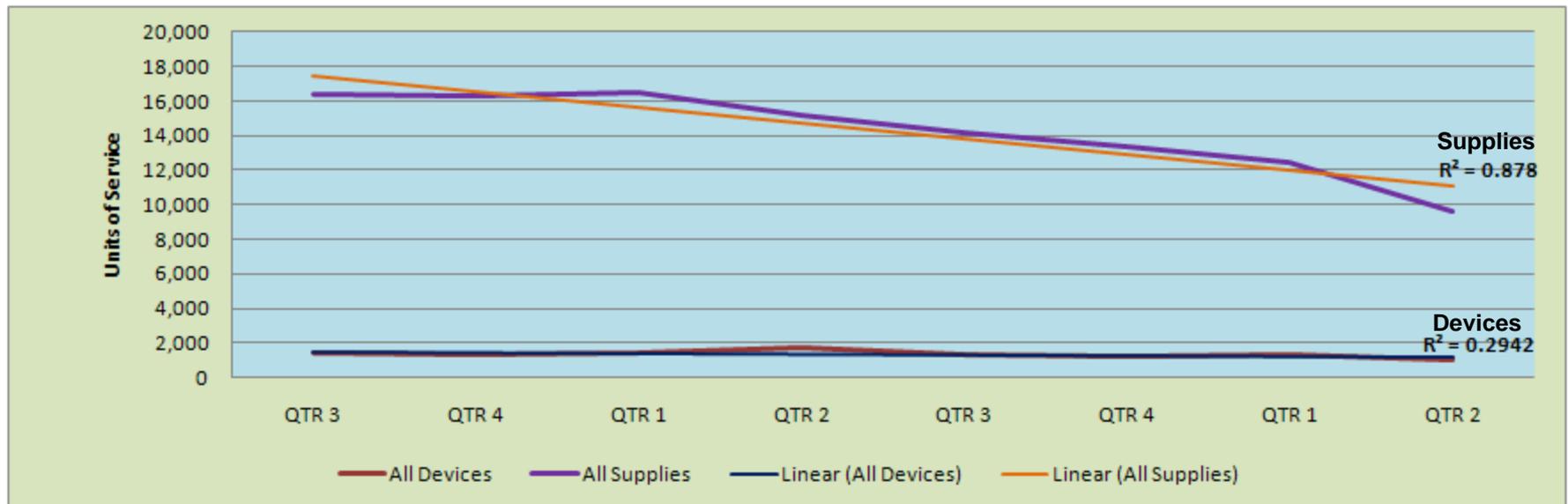
Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
13	General Comment	Deanna Kazamek, 1-800-OHIOCOMP (MCO)	<p>1) Monthly phone calls must be placed by the vendor to the IW to gather usage and supply quantity information; the vendor will send 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). 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) 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>
14	General Comment	Lori Finnerty, Careworks (MCO)	<p>1. Concern with the monthly timeframe language. 2. Language in paragraph C of the rule is inconsistent .</p>	<p>1. The rule does not need to have the monthly timeframe. Some injured worker's do not need monthly supplies . We think the overuse and abuse by vendors does need addressed, when it occurs, but the process needs to make administrative sense. 2. In section (C) it indicates that the TENS provider shall maintain the following records and (1) notes the injured worker's monthly written requests, if applicable. It appears the rule changes the entire process so perhaps this wording needs to be changed to "TENS provider must keep documentation of authorization for equipment and supplies and documented injured worker's need for supplies prior to delivery" or something of this nature.</p>	<p>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.</p>	<p>Modified the language to remove "monthly" from paragraph B. Modified language in paragraph C to make it more consistent with the rule changes.</p>

TENS Data Table & Charts

Medical Services Division
Freddie Johnson, Director, Managed Care Services
August 26, 2010

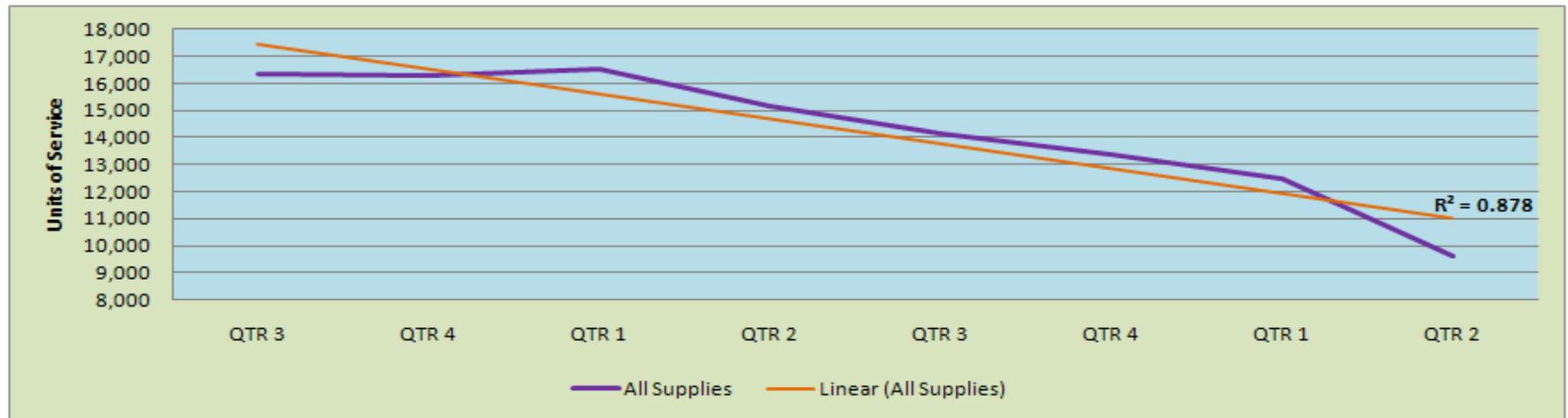
Utilization Trend: TENs/NMEs Devices & Supplies by Quarter - 2008 to 2010 Graphing Services by Units of Service

Year of Service	Quarter	All Devices	All Supplies	Devices Total \$\$	Supplies Total \$\$	Devices Avg \$\$	Supplies Avg \$\$
08	QTR 3	1,438	16,370	\$ 124,587.33	\$ 530,849.32	\$ 86.64	\$ 32.43
	QTR 4	1,338	16,300	\$ 118,780.24	\$ 523,797.31	\$ 88.77	\$ 32.13
09	QTR 1	1,424	16,510	\$ 162,231.18	\$ 598,296.14	\$ 113.93	\$ 36.24
	QTR 2	1,748	15,133	\$ 231,894.92	\$ 684,092.75	\$ 132.66	\$ 45.21
	QTR 3	1,341	14,135	\$ 219,070.44	\$ 642,529.32	\$ 163.36	\$ 45.46
	QTR 4	1,253	13,390	\$ 189,296.00	\$ 636,671.89	\$ 151.07	\$ 47.55
10	QTR 1	1,353	12,471	\$ 198,025.39	\$ 590,458.13	\$ 146.36	\$ 47.35
	QTR 2	1,018	9,619	\$ 170,804.10	\$ 460,068.13	\$ 167.78	\$ 47.83

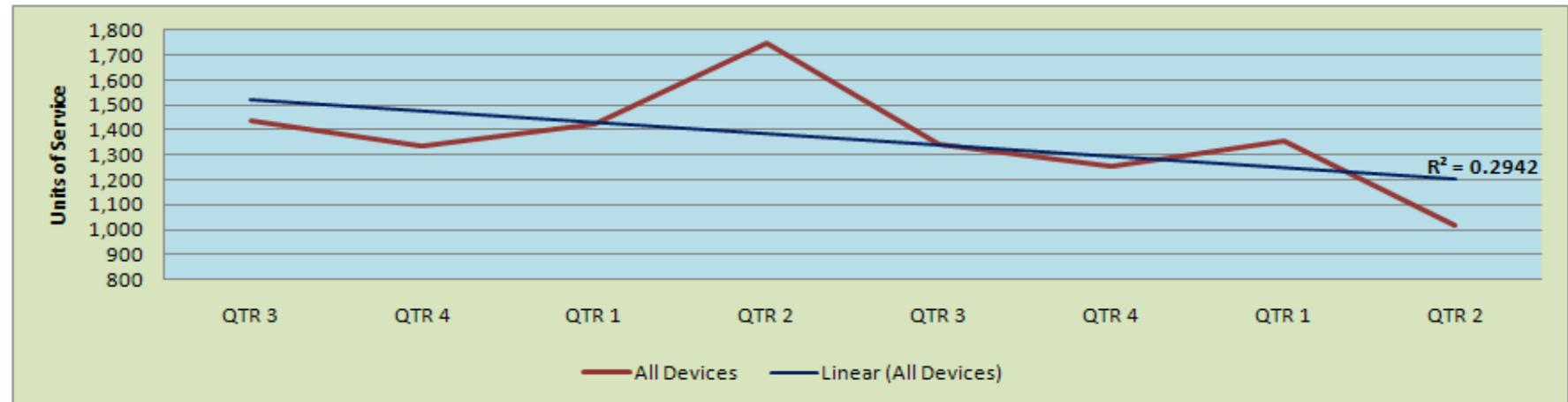


Utilization Trend: TENs/NMEs Devices & Supplies by Quarter - 2008 to 2010 Graphing Services by Units of Service

Supplies

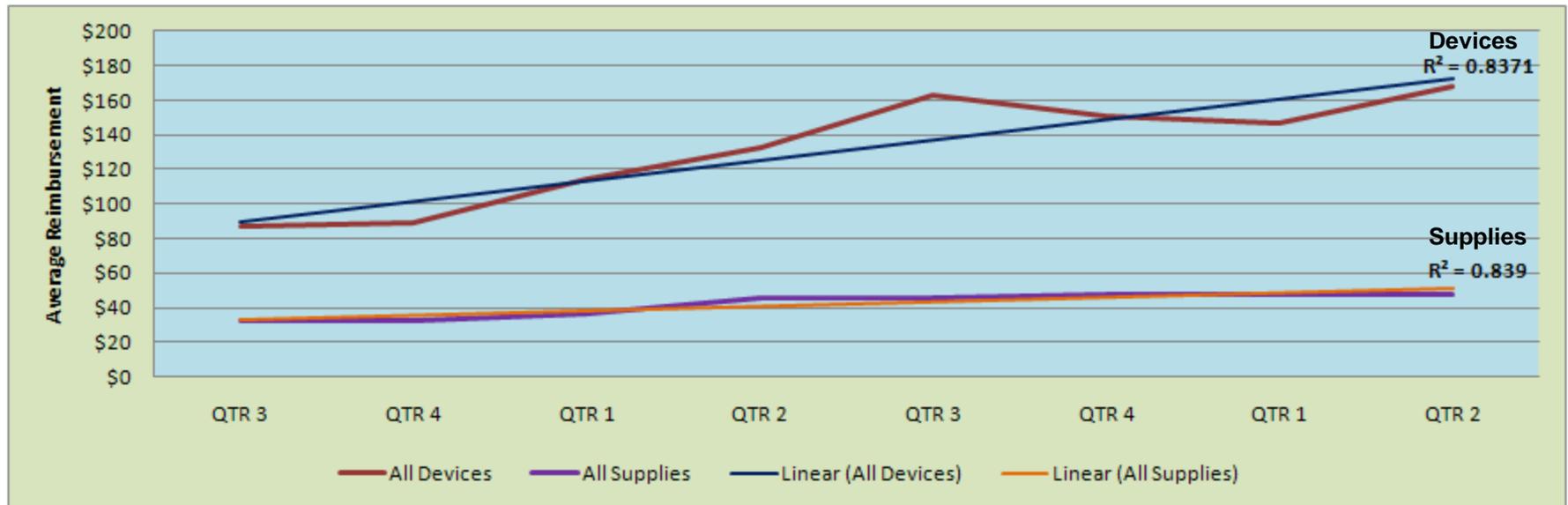


Devices



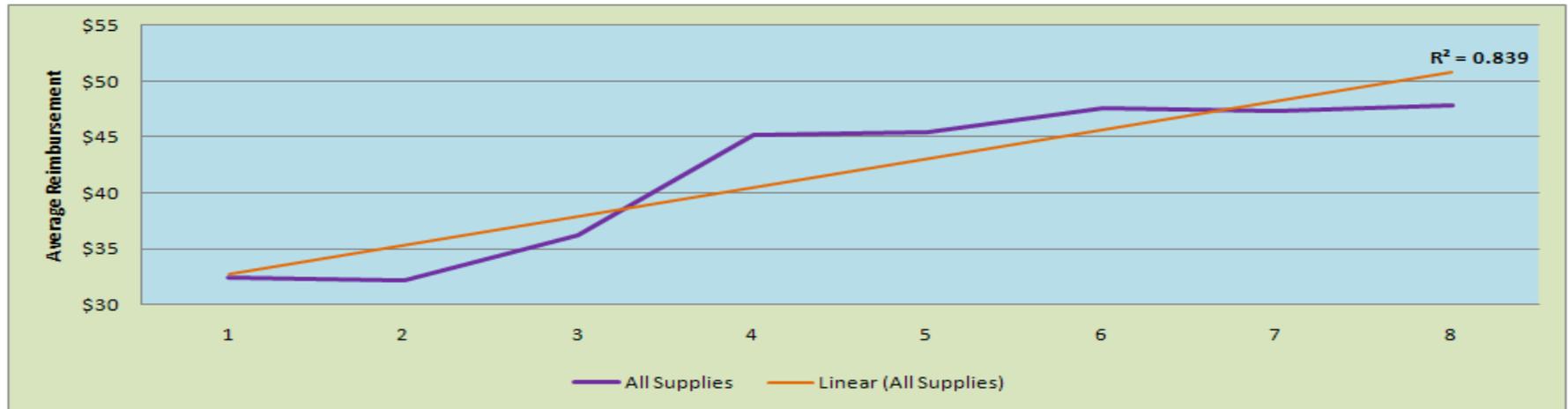
Utilization Trend: TENs/NMEs Devices & Supplies by Quarter - 2008 to 2010 Graphing Average Dollars Reimbursed

Year of Service	Quarter	All Devices	All Supplies	Devices Total \$\$	Supplies Total \$\$	Devices Avg \$\$	Supplies Avg \$\$
08	QTR 3	1,438	16,370	\$ 124,587.33	\$ 530,849.32	\$ 86.64	\$ 32.43
	QTR 4	1,338	16,300	\$ 118,780.24	\$ 523,797.31	\$ 88.77	\$ 32.13
09	QTR 1	1,424	16,510	\$ 162,231.18	\$ 598,296.14	\$ 113.93	\$ 36.24
	QTR 2	1,748	15,133	\$ 231,894.92	\$ 684,092.75	\$ 132.66	\$ 45.21
	QTR 3	1,341	14,135	\$ 219,070.44	\$ 642,529.32	\$ 163.36	\$ 45.46
10	QTR 4	1,253	13,390	\$ 189,296.00	\$ 636,671.89	\$ 151.07	\$ 47.55
	QTR 1	1,353	12,471	\$ 198,025.39	\$ 590,458.13	\$ 146.36	\$ 47.35
	QTR 2	1,018	9,619	\$ 170,804.10	\$ 460,068.13	\$ 167.78	\$ 47.83

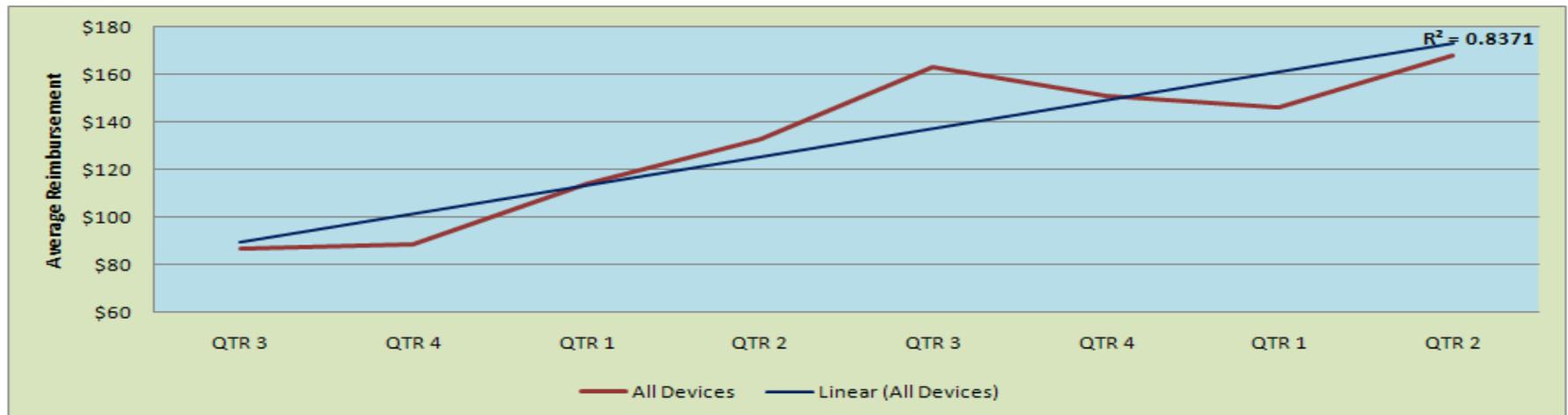


Utilization Trend: TENs/NMEs Devices & Supplies by Quarter - 2008 to 2010 Graphing Services by Units of Service

Supplies

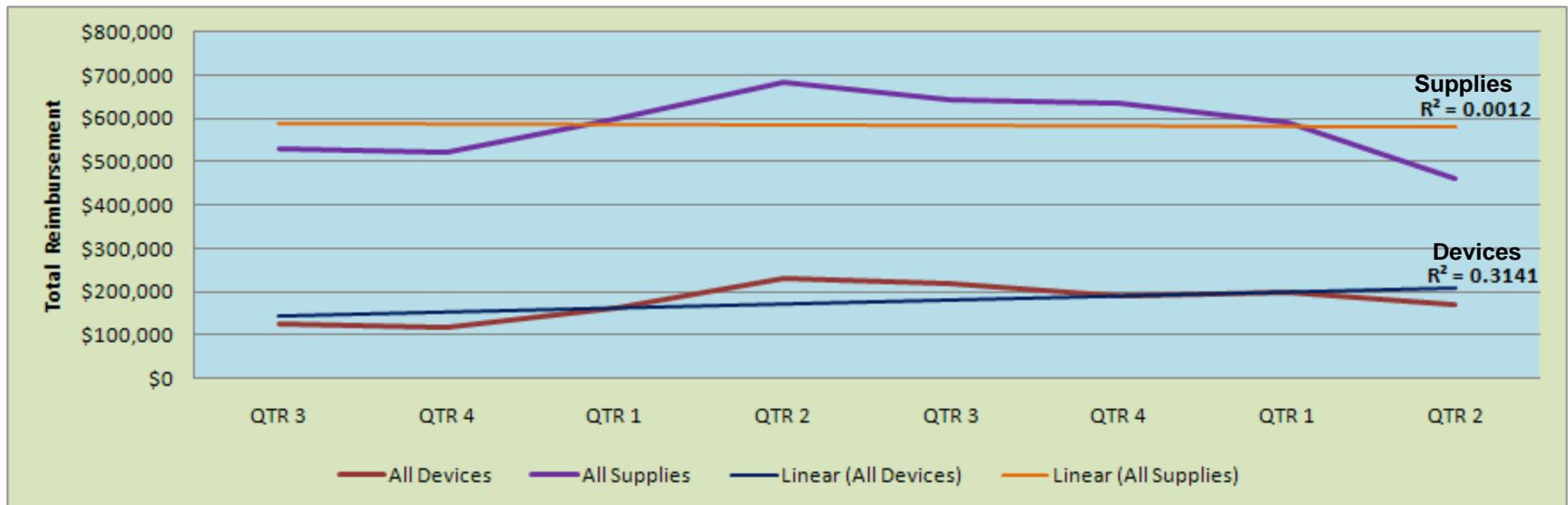


Devices



Utilization Trend: TENs/NMEs Devices & Supplies by Quarter - 2008 to 2010 Graphing Total Dollars Reimbursed

Year of Service	Quarter	All Devices	All Supplies	Devices Total \$	Supplies Total \$	Devices Avg \$	Supplies Avg \$
08	QTR 3	1,438	16,370	\$ 124,587.33	\$ 530,849.32	\$ 86.64	\$ 32.43
	QTR 4	1,338	16,300	\$ 118,780.24	\$ 523,797.31	\$ 88.77	\$ 32.13
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Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-21.2

Rule Review

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

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

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

What goal(s): The rule would create a stand-alone pharmacy and therapeutics (P&T) committee, rather than the current P&T subcommittee of the Health Care Quality Assurance Committee (HCQAAC), that is able to make recommendations regarding pharmacy issues directly to the BWC Administrator.

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 August 11, 2010. Stakeholders were given until September 1, 2010 to submit comments. A draft of the proposed rule was also discussed at BWC's P&T committee meeting on June 9, 2010, and the final proposed rule was sent to the P&T committee members on July 16, 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
Pharmacy And Therapeutics Committee Rule
OAC 4123-6-21.2

Introduction

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers.

BWC's Health Care Quality Assurance Committee (HCQAAC), an advisory committee to BWC on medical issues created by rule OAC 4123-6-22, allows subcommittees to be created for specific purposes. More specifically, paragraph (Q) of BWC's outpatient medication rule, OAC 4123-6-21, provides that BWC

. . . may consult with a pharmacy and therapeutics committee, which shall be a subcommittee of the stakeholders' health care quality assurance advisory committee established by rule 4123-6-22 of the Administrative Code, on the development and ongoing annual review of a drug formulary and other issues regarding medications.

BWC proposes to adopt new rule OAC 4123-6-21.2, which would create a stand-alone pharmacy and therapeutics (P&T) committee, rather than a subcommittee of the HCQAAC, that is able to make recommendations regarding pharmacy issues directly to the Administrator.

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

Previously, the BWC pharmacy department utilized the authority granted under OAC 4123-6-22 and OAC 4123-6-21(Q) to create a pharmacy and therapeutics (P&T) subcommittee of the HCQAAC to serve its needs. This P&T committee had been dormant since 2007.

In 2008, the pharmacy department was reorganized, and the need for an advisory committee on pharmacy issues was quickly felt. The P&T committee was reorganized, and since fall 2009 it has been meeting quarterly, advising the pharmacy department regarding formulary development, development of a list of non-covered medications, development of prior authorization criteria, medication treatment guidelines, bureau policies and procedures related to drug utilization, review of providers' professional performance, and review of the pharmacy benefit manager's performance. The P&T committee is composed of 6 pharmacists and 6 physicians who are actively practicing in their fields.

Under the current structure as a subcommittee of the HCQAAC, the P&T committee makes recommendations on pharmacy issues to the HCQAAC for its review and approval. The HCQAAC committee is composed of physicians, chiropractors, psychologists and one pharmacist, and will have potential membership of dentists and podiatrists. Some of these members are restricted from prescribing medications. The HCQAAC committee also meets quarterly, which creates a time lag in the approval process for necessary changes in the pharmacy program.

BWC submits that the current proposed rule, OAC 4123-6-21.2, be adopted. It provides for a stand-alone P&T committee that is able to make recommendations regarding pharmacy issues directly to the Administrator (BWC will submit to the Board for consideration next month changes to BWC's outpatient medication rule, OAC 4123-6-21, including removal of the language making the P&T committee a subcommittee of the HCQAAC.).

BWC believes this will improve the operational efficiency of, and enhance the credibility of, the process of professional advice and consensus decision making for the BWC pharmacy department.

Stakeholder Involvement

BWC's proposed P&T Committee rule was e-mailed to the following lists of stakeholders on August 11, 2010 with comments due back by September 1, 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

A draft of the proposed rule was also discussed at BWC's P&T committee meeting on June 9, 2010, and the final proposed rule was sent to the P&T committee members on July 16, 2010.

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

OAC 4123-6-21.2 Pharmacy and Therapeutics Committee

The bureau of workers' compensation pharmacy and therapeutics (P&T) committee is hereby created to advise the administrator and the chief medical officer with regard to issues involving medication therapy for injured workers. A list of physician and pharmacist providers, each holding a professional license in good standing, who have agreed to serve on the P&T committee and who would add credibility and diversity to the mission and goals of the committee shall be developed and maintained by the chief medical officer. Providers may also be nominated for inclusion on the list by provider associations and organizations including: deans of Ohio's allopathic and osteopathic medical schools, deans of Ohio's colleges of pharmacy, presidents of Ohio's various allopathic and osteopathic medical associations, the Ohio pharmacists association, the Ohio state medical board, and the Ohio state pharmacy board.

- (A) The P&T committee shall consist of the bureau pharmacy program director, and six physician and six pharmacist providers. The committee may create any subcommittees that the committee determines are necessary to assist the committee in performing its duties.
- (B) P&T committee members must meet the following requirements:
 - (1) Each provider must be familiar with issues relating to the prescribing or dispensing of medications in the Ohio workers' compensation system.
 - (2) Physicians must be a doctor of medicine (MD) or doctor of osteopathic medicine (DO).
 - (3) Providers must possess significant clinical or administrative experience in health care delivery, including but not limited to pain management, pharmacy practice, medical quality assurance, disease management and utilization review.
 - (4) Providers must have experience with and an understanding of the concepts of evidence based medicine as well as contemporary best practices in appropriate prescribing, dispensing, and monitoring of outpatient medications.
 - (5) Providers must not be, or within the previous twenty-four months have been, an employee of any pharmaceutical manufacturer, pharmacy benefits manager, or any non-governmental firm or entity administering state purchased health care program benefits or pharmaceutical rebates.
- (C) The appointing authority for members of the P&T committee shall be the administrator or the administrator's designee(s), who shall appoint members of the committee from the list of qualified providers developed and maintained by the chief medical officer. Terms of membership for individual members of the P&T committee shall be for one year. Individuals may be reappointed to subsequent terms as determined by the administrator. Vacated terms shall be filled in a like manner as for the full term appointments and shall be for the remaining term of the vacated member.

- (D) The pharmacy program director of the bureau shall be the chairperson of the P&T committee and shall provide notice of meetings to the members and be responsible for the meeting agenda. In addition, the pharmacy program director may be self-designated as an ad hoc member of any subcommittees of the P&T committee; however, the pharmacy program director shall be a voting member of the P&T committee and any subcommittees only in the case of tie votes. The bureau chief medical officer and bureau staff pharmacist may participate in discussions; however, they shall not be voting members.
- (E) The P&T committee shall develop and establish bylaws for the organization and operations of the committee and subcommittees, subject to the requirements of this rule and approval by the administrator.
- (F) The P&T committee shall be responsible to respond to requests for action on any issue impacting the bureau related to pharmacy or medication therapeutics submitted by the bureau's administrator, chief of medical services, chief medical officer or pharmacy director, including but not limited to:
- (1) Development, approval and annual review of a formulary of approved medications.
 - (2) Development, approval and annual review of a list of non-covered, non-reimbursable medications.
 - (3) Development and approval of prior authorization criteria.
 - (4) Review and approval of proposed medication treatment guidelines.
 - (5) Review and approval of bureau policies and procedures related to drug utilization review or specific medication issues.
 - (6) Review of the bureau's pharmacy providers' professional performance. The P&T committee shall perform peer review according to generally accepted standards of pharmacy practice and may recommend sanctions as well as termination of any pharmacy provider determined to have consistently failed to meet those standards of care.
 - (7) Review of the performance of the bureau's pharmacy benefit manager and conduct regarding its management of prescription benefit services for the bureau.

The P&T committee may make such recommendations as it deems necessary to address any issue impacting the bureau related to pharmacy or medication therapeutics.

- (G) The P&T committee shall hold at least three meetings annually. The P&T committee and all subcommittees shall keep written records of the agenda and minutes of each meeting. The records of all committees shall remain in the custody of the chief medical officer.

- (H) The P&T committee shall submit an annual report of its activities and recommendations to the administrator. In addition to inclusion in the annual report, all recommendations from the P&T committee and subcommittees shall be submitted to the chief medical officer in a timely fashion upon completion and approval by the respective committees.
- (I) Each member of the P&T committee and its respective subcommittees may be paid such fees as may be approved by the administrator. The expenses incurred by the P&T committee and its subcommittees and the fees of their members shall be paid in the same manner as other administrative costs of the bureau.

Effective: __

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Medical Services Division Board Report

Hospital Outpatient Program

Implementation of the hospital outpatient prospective payment system is on target for January 1, 2011 consistent with the rule requirement. Hospital outpatient services include but are not limited to the following: emergency department services, ambulatory surgery performed in the hospital setting, physical therapy and occupational therapy, and hospital clinic visits.

A BWC-MCO workgroup, which includes representatives from each MCO, continues its efforts to ensure MCOs are prepared to effectively process bills and assist providers with this new program. The Medical Services Division has also partnered with the Ohio Hospital Association, the HealthCare Financial Management Association, and two professional patient account manager groups to offer educational sessions and materials to prepare hospitals for the January implementation. Internally, BWC is continuing its progress toward system implementation as we work with our vendor on programming and testing. Finally, BWC is coordinating end-to-end systems testing with several hospitals, MCOs, and data transmission vendors to ensure that all data required for bill processing will be successfully transmitted between the involved entities.

Proactive Allowance Policy Revision

The objective of the revision is to improve additional condition determination timeframes thereby facilitating timely and appropriate medical treatment. The process improvements include the following:

- Improving communication and coordination with MCO Nurse Case Managers and BWC Medical Service Specialist (MSS) early in the decision-making process for improved quality and elimination of redundant processes.
- Enabling the MCO Nurse Case Manager to obtain prompt buy-in from the employer to prevent needless delays and objections, as well as assist in reducing the proactive allowance timeframes.
- Creating a checklist to outline the process steps for BWC and MCO staff to document decision points and outcomes in a format that supports a sensitive data environment.
- Resolving internal and external conflicts to reduce the unnecessary motion practice.

The Proactive allowance policy, workflow and procedure update is complete. BWC claims policy and training department staff have completed the *Building Successful Relationship Workshop* training packet that will be used to train both BWC and MCO staff. The statewide training sessions that will include both BWC and MCO staff have been scheduled to begin the week of September 6th, 2010 and will conclude the first week of October, 2010. The effective date for program implementation is October 12, 2010.

Managed Care Organization (MCO) Performance Measures – Replacement of Degree of Disability Management (DoDM) Measure

BWC is working to replace the MCO performance measure, DoDM, with a new metric (Measurement of Disability or MoD) and is close to completion of the design.

One of the key MCO responsibilities is to help employers establish transitional and early return-to-work programs. In addition, they ensure that appropriate medical treatment is rendered and they process payments to providers. As a result, MCO decisions directly impact injured worker return-to-work outcomes. Their medical management decisions affect the duration of time an injured worker is off work

and, thus, impact the \$1.9 billion in annual indemnity costs and more than \$800 million in annual medical costs. The right metric is essential to support the desired outcome of prompt, safe return to work and stay at work.

MCOs can earn \$166.7 million in CY 2010 for the services they provide. 45% or \$75 million of that total amount is based on the DoDM measure. DoDM was implemented in 1999 and was state of the art at the time. While we have made some enhancements in the last 11 years, the DoDM model has become outdated. The MoD metric design will improve the measurement of the MCOs' activity by more accurately measuring the effectiveness of the medical case management being provided by the MCOs in terms of the timeliness of injured worker return-to-work and the effectiveness of the management of medical care after injured workers have returned to work. Further, MoD measures a much larger population of claims than DoDM, as MoD includes claims that are outside the employers' experience. The MoD metric also utilizes updated benchmarks that were developed using Ohio specific data. Finally, the measure is based upon actual return-to-work dates instead of release dates. These enhancements target MCO focus on medical case management and return-to-work services for the entire population of claims the MCOs are managing.

BWC collaborated with the MCOs to develop the new outcome metric, starting the workgroup meetings in late 2008. Then, BWC engaged a consultant, an Ohio State professor, to review the metric design for statistical soundness and incorporated many of his recommendations. The original design of the metric was presented to the MCOs on Dec 4, 2009 and Jan 6, 2010. We reviewed the MCOs' comments and recommendations on the original metric design and made appropriate modifications accordingly. These changes were reviewed at the March 16, 2010 MCO Business Council meeting. As a result, further changes to the design were made. All components of the new model were provided to the MCOs on June 12, 2010. We met with the MCOs on June 29, 2010 and presented the metric revisions and answered any questions. We received their comments on July 16th. The MCOs also engaged a statistician to review the metric.

BWC is reconvening the workgroup on Tuesday, August 31st to discuss the outstanding design issues for further, anticipated metric enhancements that BWC is recommending for the metric. Target implementation is for 1st quarter 2011.

BWC has also presented the MoD metric to our advisory Board and interested parties including the Healthcare Provider Quality Assurance Advisory Committee (HCPQAAC), the MCO Medical Directors, and the Ohio Association for Justice

Rehab Redesign

The rehab redesign proposal encompasses six recommendations, all of which are in the implementation phase:

1. BWC has strengthened the required qualifications for the Disability Management Coordinators (DMCs). Currently, all DMCs have are required to obtain at least one of the required certifications.
2. DMCs and Injury Management Specialists at BWC have received extensive training in several key areas to bolster their effectiveness in executing oversight of the rehabilitation program.
3. System enhancements, specifically V3 diaries for use by the DMCs, are scheduled for implementation in October, 2010. This infrastructure enhancement will provide increased

consistency and quality of rehabilitation plans and DMC services. The diaries will also function as a quality oversight tool for staff performance.

4. Quality Assurance for DMC activities has been enhanced through the development of a vocational rehabilitation process quality assurance tool. The tool will enable the Injury Management Supervisors to ensure the quality, consistency, and timeliness of DMC decision making and monitor DMC adherence to BWC policies and procedures.
5. A Performance measurement is currently being established for DMC activities. Additionally, performance metrics are being developed for the community of vocational rehabilitation providers. Key steps in the metric development include identification of metric objectives and desired outcomes – these include quality assurance and case assignment determination. Further, a tool is being developed for case assignment to vocational rehab case managers based on performance and geographic location.
6. Internal controls have been strengthened to align with internal audit findings in the area of Rehabilitation Services Commission (RSC) cooperative agreement, oversight and evaluation. A process is being established for DMCs to review rehabilitation expenditures for reasonableness and appropriateness. These reviews will begin next month.
7. The reporting infrastructure for the vocational rehab program is undergoing renovation to improve BWC's ability to analyze, validate, and improve program effectiveness.

12 - Month Medical Services & Safety Calendar

Date	August 2010	Notes
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	
	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. Pharmacy Payment Rule 4123-6-21 (1st read)	
	5. Customer Services Report	
	October 2010	
10/21/10	1. HCPQAAC Rule 4123-6-22 (2nd read)	
	2. Inpatient Hospital Fee Schedule (2nd read)	
	4. Pharmacy Payment Rule 4123-6-21 (2nd read)	
	5. Committee Charter review (1st read)	
	6. Medical Services Report	
	November 2010	
11/18/10	1. Outpatient Hospital Fee Schedule (1st read)	
	2. Ambulatory Surgical Center Fee Schedule Rule (1st read)	
	3. Committee Charter Review (2nd read)	
	4. Customer Services Report	
	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. Vocational Rehab fee schedule (1st read)	
	4. Outpatient Hospital Fee Schedule (2nd read)	
	5. Medical Services Report	
	2011	
	January 2011	
1/20/11	1. Vocational Rehab fee schedule (2nd read)	
	2. Customer Services Report	
	February 2011	
2/23/11	1. Medical Services Report	
	March 2011	
3/24/11	1. Customer Services Report	
	April 2011	
4/28/11	1. Medical Services Report	
	May 2011	
5/26/11	1. Customer Services Report	
	June 2011	
6/15/11	1. Medical & Service Provider Fee Schedule (1st read)	
	2. Medical Services Report	
	July 2010	
7/28/11	1. Medical & Service Provider Fee Schedule (2nd read)	
	2. Customer Services Report	