

BWC Board of Directors
Medical Services and Safety Committee Agenda

Thursday, September 23, 2010

William Green Building

Level 2, Room 3

12:30 P.M. - 2:30 P.M.*

Call to Order

Jim Harris, Committee Chair

Roll Call

Mike Sourek, scribe

Approve Minutes of August 26, 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

Pharmacy and Therapeutics Committee Rule 4123-6-21.2

Johnnie Hanna, R. Ph, M.B.A. Pharmacy Program Director

Dr. Robert Balchick, Medical Director

B. For First Reading

1. Health Care Provider Quality Assurance Advisory Committee Rule
4123-6-22

Dr. Robert Balchick, Medical Director

Mamta Mujumdar, Pharmacy Program staff

2. 2011 Inpatient Hospital Fee Schedule Rule 4123-6-37.1

Freddie Johnson, Director Managed Care Services

Anne Casto, President Casto Consulting

Discussion Items**

1. Customer Services Division Report

a. Tina Kielmeyer, Chief, Customer Services Division

- Drug Free Safety Program update
- Lump Sum Settlement Process update
- Claim complexity project

b. Abe Al-Tarawneh, Superintendent of Division of Safety & Hygiene

Julie Darby-Martin, Management Analyst, Division of Safety & Hygiene
• Ohio Safety Congress Update

2. Committee Calendar
Jim Harris, Committee Chair

Adjourn
Jim Harris, Committee Chair

Next Meeting: Thursday, October 21, 2010

* Or after previous meeting adjourns

** 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 4123-6-21.2

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 but not limited to: 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 not more than thirteen nor less than five voting members who shall be licensed physicians and licensed pharmacists representing the diverse group of providers that provide care to the injured workers of Ohio as administered through the bureau. The committee may create any subcommittees that the committee determines are necessary to assist the committee in performing its duties. Any subcommittee recommendations **shall** be submitted to the P&T committee.

(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 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 may make such recommendations as it deems necessary to address any issue impacting the bureau related to pharmacy or medication therapeutics. The committee shall be responsible to respond to requests for action on any such issue 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.
- (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 subcommittees and P&T committee.

- (I) Each member of the P&T committee and its respective subcommittees may be paid such fees as approved by the administrator or the administrator's designee. 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

Feedback to Proposal for O.A.C. 4123-6-21.2

Stakeholder	Comments	Follow-up	BWC response	Resolution
Becky Bolt, Vice President, CompManagement Health Systems (MCO)	-Reappointment criteria is vague; -Physician representation should be varied; -Cost should be spelled out; -Why doesn't PBM perform this function; -Decisions should go to MCO for acceptance	Dr. Balchick discussed concerns with Ms. Bolt by phone on 9-15-10.	-Rule states 1-year-terms with reappointment by administrator. -Diverse Representation language is in the rule and it is BWC's intent as well. -Reimbursement will remain at current rate (\$400 per meeting) -This committee's role is advisory to the bureau on pharmacy specific issues	Rule clarified that physician representation will be diverse. This committee's responsibility in part, is to oversee the PBM.
Grace Mary Fein, RN BWC, Field North Region Canton Service Office	-Described idea as "refreshing" -Concerned for the cost	John Hanna responded by e-mail.	-New committee will have authority to address drug utilization through a formulary. -Reimbursement will remain at current rate.	No change necessary
Jon F. Wills, Executive Director, Ohio Osteopathic Association	- Supports the concept of the P & T committee as well as the draft language	BWC responded with e-mail thanking sender for comments.	N/A	No change necessary
Jennifer Artino, Risk Manager, Heinen's, Inc. (employer)	-Separate committee is a good thing as long as it doesn't increase self insured assessments to fund itself. -Has concerns that subcommittee roles not clearly defined	Dr. Balchick spoke with Ms. Artino on the phone on 9/8/10.	It was explained that all our committees have the ability to create sub committees, but any work would have to be approved by the entire committee of medical professionals.	Subcommittee reporting clarified in the rule.
Kathie A. Burns, Insurance Specialist, Montgomery County Risk Management	-Welcomes the P & T committee because it can help protect both the injured worker and employers from abuse and misuse of the	BWC responded with e-mail thanking sender for comments.	Provider review is part of the committee's responsibilities	No change necessary

Feedback to Proposal for O.A.C. 4123-6-21.2

	<p>pharmacy program</p> <p>-Committee should be able to recommend a review of a medical provider who consistently appears to prescribe narcotic and/or psychotropic medications in quantities or methods that exceed acceptable guidelines for an allowed condition.</p>			
<p>Bryson Cole, EHS&S Manager, Columbus Brewery</p>	<p>Questions about committee:</p> <p>-Primary purpose?</p> <p>-Created in response to a particular issue or system gap?</p> <p>-Specific targets for it?</p> <p>-What will be the immediate and tangible benefit to providers, injured employees, and employers?</p> <p>-Will it create a financial burden for employers?</p>	<p>Dr. Balchick followed up by phone on 8/26/10.</p>	<p>Mr. Cole's questions were addressed. Mr. Cole expressed no additional concerns.</p>	<p>No change necessary</p>
<p>Lewis Seeder, MD, HCQAAC Member</p>	<p>Concerned that the HCQAAC had reviewed pharmacy therapeutics in the past and felt that committee should still do so.</p>	<p>Discussed at the HCQAAC meeting on 9/16/10</p>	<p>There is a diverse group of doctors and pharmacists on the P&T committee, 2 who also serve on the HCQAAC, review by both committees not necessary</p>	<p>No change</p>

Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-22

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 would create a committee composed of a diverse group of medical providers that would advise the administrator, chief of medical services, and chief medical officer on medical quality issues, and would be consistent with O.R.C. 4123-6-21.2.

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 September 13, 2010. Stakeholders were given until October 6, 2010 to submit comments. The proposed rule changes were also discussed at BWC's HCQAAC meeting on September 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.

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
Health Care Quality Assurance Advisory Committee Rule
OAC 4123-6-22

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,

. . . was created to advise the administrator, the chief of medical services, and the chief medical officers with regard to medical quality issues...

BWC proposes to revise rule OAC 4123-6-22, which would acknowledge the internal organizational changes made within BWC and create consistency with other rules.

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

BWC submits that the current proposed rule, OAC 4123-6-22, be adopted. The purpose of the revised rule is to align the focus of this medical advisory committee with recent organizational changes within BWC. The main organizational change that has taken place is the creation of a chief medical officer who is responsible for improving working relationships with health care professionals that do business with BWC and overseeing the committees of those medical professionals that provide advice and guidance on medical issues. In addition, there was a need to ensure that all rule revisions would be consistent in style and format to enhance readability. Otherwise, no other changes are requested of the original rule.

Stakeholder Involvement

BWC's proposed HCQAAC Committee rule was e-mailed to the following lists of stakeholders on September 15, 2010 with comments due back by October 6, 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 discussed at BWC's HCQAAC meeting on September 16, 2010.

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

OAC 4123-6-22 Stakeholders' Health Care Quality Assurance Advisory Committee

The bureau of workers' compensation stakeholders' health care quality assurance advisory committee (HCQAAC) was created to advise the administrator, the chief of medical services, and the chief medical officer with regard to medical quality issues. A list of medical providers, each holding a professional license in good standing, who have agreed to serve on the HCQAAC, and who would add credibility and diversity to the mission and goals of the HCQAAC shall be developed and maintained by the chief medical officer. Providers may be nominated for inclusion on the list by provider associations and organizations including but not limited to: deans of Ohio's allopathic and osteopathic medical schools, deans of Ohio's colleges of pharmacy, the Ohio state medical association, the Ohio state osteopathic association, the Ohio state chiropractic association, specialty board associations of Ohio, the Ohio podiatric medical association, the Ohio psychological association, the Ohio dental association, the Ohio pharmacists association, the Ohio hospital association, the Ohio state medical board, the Ohio state chiropractic board, the Ohio state psychology board, the Ohio state pharmacy board, and the Ohio state dental board.

- (A) The HCQAAC shall consist of the bureau's chief medical officer and not more than 13 nor less than 5 voting members representing the diverse group of providers that provide medical care to the injured workers of Ohio as administrated through the bureau. The committee may create any subcommittees that the committee determines are necessary to assist the committee in performing its duties. Any subcommittee recommendations must be approved by the HCQAAC committee.
- (B) HCQAAC members must meet the following requirements:
 - (1) Providers must be familiar with issues relating to the treatment of injured workers in the Ohio workers' compensation system.
 - (2) Providers must possess significant clinical or administrative experience in health care delivery, including but not limited to, medical quality assurance, disease management, and utilization review.
 - (3) Providers must have experience with and an understanding of the concepts of evidence based medicine as well as contemporary best practices in their respective areas of practice.
- (C) The appointing authority for members of the HCQAAC shall be the administrator or the administrator's designee(s), who shall appoint members of the HCQAAC from the list of qualified providers developed and maintained by the chief medical officer. Terms of membership for individual members of the HCQAAC 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 chief medical officer of the bureau shall be the chairperson of the HCQAAC and shall provide notice of meeting to the members and be responsible for the meeting agenda. In addition, the chief medical officer may be self-designated as an ad hoc member of any subcommittees of the HCQAAC; however, the chief medical officer shall be a voting member of the HCQAAC and any subcommittees only in the case of tie votes. The bureau's medical director, the industrial commission's medical director, and one physician chosen by the MCOs may participate in discussions; however, they shall not be voting members.
- (E) The HCQAAC 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 and the chief medical officer.
- (F) The HCQAAC shall be responsible to respond to requests for action on any medical quality assurance issue submitted by the bureau's administrator, chief of medical services, or chief medical officer including, but not limited to:
 - (1) Review of medical treatment guidelines referred to the bureau.
 - (2) Review of any of the bureau's policies and procedures related to medical quality assurance issues.
 - (3) Review of any of the bureau's medical providers' professional performance and conduct, including bureau certification and malpractice issues. The HCQAAC shall perform peer review according to generally accepted standards of medical practice and may recommend sanctions as well as decertification of any provider determined to have consistently failed to meet those standards of care.
 - (4) Review of any of the bureau's managed care organizations' professional performance and conduct regarding the management of medical services for the bureau. This may include interfacing with any quality assurance committee of any of the individual managed care organizations.

The HCQAAC may make such recommendations as it deems necessary to address any medical quality assurance issue impacting the bureau.

- (G) The HCQAAC shall hold at least quarterly meetings. The HCQAAC 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 HCQAAC 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 HCQAAC and subcommittees shall be

submitted to the chief medical officer in a timely fashion upon completion and approval by the respective subcommittees and HCQAAC committee.

- (I) Each member of the HCQAAC and its respective subcommittees may be paid such fees as approved by the administrator or administrator's designee. The expenses incurred by the HCQAAC and its subcommittees and the fees of their members shall be paid in the same manner as other administrative costs of the bureau.

Effective: _____

R.C. 119.032 review dates: 03/03/2005 and 03/01/2009

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

Prior Effective Dates: 1/27/97, 1/15/99, 06/01/2005

TO BE RESCINDED

4123-6-22 STAKEHOLDERS HEALTH CARE QUALITY ASSURANCE ADVISORY COMMITTEE.

The bureau of workers' compensation stakeholders' health care quality assurance advisory committee is hereby created to advise the administrator and the chief, of injury management services of the bureau of workers' compensation with regard to medical issues.

(A) A list of physicians who have agreed to serve on the committee shall be developed by approval recommendations from the deans of Ohio's medical and osteopathic schools, presidents of the Ohio state medical association, the Ohio state osteopathic association, the Ohio state chiropractic association, Ohio board specialty associations, the Ohio podiatry association, the Ohio psychology association, the Ohio hospital association, the Ohio pharmacists association, the Ohio dental association, the Ohio state medical board, the Ohio state chiropractic board, the Ohio state psychology board, the Ohio state pharmacy board, the Ohio state dental board, and the industrial commission of Ohio. This list shall be maintained by the bureau's chief, of injury management and services and additional names may be added as needed or desired.

(B) The appointing authority for members of this advisory committee shall be the administrator or his designees, and shall appoint members of the committee from the lists of approved physicians.

(C) The bureau's chief, of injury management services shall be the chairman of the advisory committee, and may be self-designated an ad hoc member of any other subcommittees formed by the advisory committee. The chief of injury management services may delegate these duties to a chairperson elected by the voting members. The chief of injury management services shall be a voting member of the advisory and subcommittees only in case of tie votes.

(D) In addition to the bureau's chief of injury management services, the advisory committee shall consist of at least one M.D., one D.O., one D.C., one clinical psychologist and one pharmacist, each holding a license in good standing in the state of Ohio, and one person representing the Ohio hospital association. The bureau's medical director, the industrial commission's medical director, and one physician chosen by the MCOs may participate in discussions; however, they shall not be voting members.

(E) Terms of membership for individual members of the advisory committee shall be for twelve months, subject to review by the administrator. Vacated terms shall be filled in like manner as for the full term appointments.

(F) The advisory 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 and the bureau's chief of injury management services.

(G) The advisory committee may initiate assessment of any medical quality assurance issue impacting the bureau and shall be responsible to respond to requests for assessment of any medical quality assurance issue submitted by the bureau's chief of injury management including:

(1) Reviewing managed care data reporting;

(2) Recommending system-wide non-coverage policies or determinations that MCOs would be required to follow;

(3) Interfacing with MCO quality assurance committees;

(4) Reviewing performance measures;

(5) Addressing problems with MCO treatment guidelines;

(6) Providing ongoing peer review of the bureau's MCO and provider certification processes, including making recommendations to the bureau for imposing sanctions or granting or denying certification or recertification of a provider based upon a review of the provider's malpractice history;

(7) Advising the bureau regarding the decertification of providers and MCOs, including making recommendations to the bureau for imposing sanctions or decertification of a provider based upon a review of the provider's malpractice history; and

(8) Review of medical disputes referred to the bureau pursuant to rule 4123-6-16 of the Administrative Code.

(H) The advisory committee shall hold at least quarterly meetings. The advisory 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 bureau's chief of injury management services.

(I) The advisory committee shall submit an annual report of their activities and recommendations to the administrator. In addition to inclusion in the annual report, all recommendations from the advisory committee and subcommittees shall be submitted to the bureau's chief of injury management services in a timely fashion upon completion and approval by the respective committees.

(J) Each member of the advisory committee and its respective subcommittees may be paid such fees as may be approved by the administrator. The expenses incurred by the advisory committee and its subcommittees and the fees of their members shall be paid in the same manner as other administrative costs of the bureau.

(K) The administrator may request that the advisory committee appoint peer review subcommittees to review and provide recommendations to the administrator on disputes arising over quality assurance issues, determinations that a service provided to a claimant is not covered or is medically unnecessary, or billing adjustments arising from bureau audits or reviews of records involving individual health care providers. For these disputes the appointed panel shall consist of providers licensed pursuant to the same section of the Revised Code and system specialty as the individual health care provider for whom review has been requested. The panel may conduct an informal hearing, and shall advise the administrator, whose decision shall be final.

Effective: 6/1/05

Prior Effective Dates: 1/27/97, 1/15/99

Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-37.1

Rule Review

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

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

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

What goal(s): The rule adopts a discounted hospital inpatient reimbursement methodology based on Medicare’s “Medicare severity diagnosis related group” or “MS-DRG” methodology, 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 changes were presented by BWC staff to the Ohio Hospital Association on 8/12/10. The changes were also posted on BWC’s website on 8/26/10, with comments being taken up to 9/10/10.

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 Hospital Inpatient Services
Payment Rule**

Introduction

The Health Partnership Program (HPP) rules were first promulgated in 1996, prior to the implementation of the HPP in 1997. HPP rules establishing criteria for the payment of various specific medical services were subsequently adopted in February 1997.

Ohio Administrative Code 4123-6-37, initially adopted February 12, 1997 and amended March 1, 2004, provides general criteria for the payment of hospital services under the HPP. Ohio Administrative Code 4123-6-37.1 provides specific methodology for the payment of hospital inpatient services. It was initially adopted effective January 1, 2007, and has since been amended effective April 1, 2007, January 1, 2008, February 1, 2009, and February 1, 2010.

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)(8) 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, including but not limited to rules regarding “[d]iscounted pricing for all in-patient . . . medical services.”

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 methodology for the payment of hospital inpatient services via the O.R.C. Chapter 119 rulemaking process.

BWC's hospital inpatient reimbursement methodology is based on Medicare's “Medicare severity diagnosis related group” or “MS-DRG” methodology, which is updated annually. Therefore, BWC must also annually update OAC 4123-6-37.1, to keep in sync with Medicare.

Proposed Changes

Ohio Administrative Code 4123-6-37.1 currently incorporates by reference 42 Code of Federal Regulations (C.F.R.) Part 412 as published in the October 1, 2009 C.F.R., as well as Federal Register citations to the 2009 Medicare regulations under which the applicable MS-DRG reimbursement rate was determined during the last Medicare fiscal year. BWC is proposing to revise the Federal Register citations to the 2010 regulations, and the 42 CFR Part 412 citation to that published in the October 1, 2010 C.F.R.

BWC is proposing to adopt version 28.0 of the MS-DRGs and pricing factors as published in Medicare's Inpatient Prospective Payment System (IPPS) Final Rule.

BWC is proposing to maintain the current inlier payment adjustment factor (PAF) to hospitals at one hundred twenty percent (120%) of the applicable MS-DRG reimbursement rate.

BWC is further proposing to maintain the per diem rates to hospitals for direct graduate medical education at one hundred twenty percent (120%). Additionally, maintain the approach with using the effective date of the rule, February 1, 2011, as the date for calculating the annual per diem rates for direct graduate medical education.

BWC is further proposing to increase the current outlier PAF to one hundred eighty percent (180%) of the applicable MS-DRG reimbursement rate.

BWC is further proposing adopting of a BWC adjustment factor (3.15%) to address Medicare reductions incorporated in Medicare's IPPS Final Rule.

BWC is further proposing that Medicare IPPS exempt hospitals who submitted a 2009 cost report to the Ohio Department of Job and Family Services (ODJFS) shall be reimbursed at their reported cost-to-charge ratio plus twelve percentage points (12%), not to exceed seventy percent (70%) of billed charges; Medicare IPPS exempt hospitals who did not submit a 2009 cost report to ODJFS shall be reimbursed at sixty-one percent (61%) of billed charges.

The proposed rule would also clarify that a QHP or self-insuring employer may reimburse hospital inpatient services at:

- the applicable rate under the or "MS-DRG" methodology; or
- cost-to-charge ratio plus twelve percentage points (12%), not to exceed seventy percent (70%) of billed charges for hospitals who submitted a 2009 cost report to ODJFS, and sixty-one percent (61%) of billed charges for hospitals who did not submit a 2009 cost report to ODJFS; or
- the rate negotiated between the hospital and the QHP or self-insuring employer in accordance with rule 4123-6-46 of the Administrative Code.

Finally, BWC proposes to make the new hospital inpatient reimbursement rule applicable to hospital inpatient services with a discharge date of February 1, 2011 or later.

Stakeholder Involvement

The proposed inpatient payment methodology was provided for review to the Ohio Hospital Association. OHA verbally expressed support of BWC's proposed changes to the 2011 inpatient hospital reimbursement fee schedule and rule.

The proposed rule and changes were also posted on the BWC website, with a comment period open from 8/27/10 to 9/10/10.

4123-6-37.1 Payment of hospital inpatient services.

(A) HPP.

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-10 of the Administrative Code, reimbursement for hospital inpatient services with a discharge date of February 1, ~~2010~~ 2011, or after shall be as follows:

(1) Reimbursement for hospital inpatient services, other than outliers as defined in paragraph (A)(3) of this rule or services provided by hospitals subject to reimbursement under paragraph (A)(4) of this rule, shall be ~~equal to one hundred twenty per cent of~~ calculated using the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system, multiplied by a 2011 bureau adjustment of 1.0315 and further multiplied by a payment adjustment factor of 1.20, according to the following formula:-

(MS-DRG reimbursement rate x 1.0315) x 1.20 = bureau reimbursement for hospital inpatient service.

(2) In addition to the payment specified by paragraph (A)(1) of this rule, hospitals operating approved graduate medical education programs and receiving additional reimbursement from medicare for costs associated with these programs shall receive an additional per diem amount for direct graduate medical education costs associated with hospital inpatient services reimbursed by the bureau. Hospital specific per diem rates for direct graduate medical education shall be calculated annually by the bureau effective February first of each year, using the most current cost report data available from the centers for medicare and medicaid services, according to the following formula:

$1.20 \times [(\text{total approved amount for resident cost} + \text{total approved amount for allied health cost}) / \text{total inpatient days}] = \text{direct graduate medical education per diem.}$

Direct graduate medical education per diems shall not be applied to outliers as defined in paragraph (A)(3) of this rule or services provided by hospitals subject to reimbursement under paragraph (A)(4) of this rule.

(3) Reimbursement for outliers as determined by medicare's inpatient prospective payment system outlier methodology shall be ~~equal to one hundred seventy five per cent of~~ calculated using the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system, multiplied by a 2011 bureau adjustment of 1.0315 and further multiplied by a payment adjustment factor of 1.80, according to the following formula:-

(MS-DRG reimbursement rate x 1.0315) x 1.80 = bureau reimbursement for hospital inpatient service outlier

(4) Reimbursement for inpatient services provided by hospitals, ~~and~~ distinct-part units of hospitals designated by the medicare program as exempt from the medicare inpatient prospective payment system, and hospitals enrolled or certified by the bureau as psychiatric hospitals shall be determined as follows:

(a) For Ohio hospitals who submitted a hospital cost report (JFS 02930) to the Ohio department of job and family services for the ~~2008~~ 2009 state fiscal year, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported facility inpatient cost-to-charge ratio (from schedule B, line 101 of the hospital

cost report) plus twelve percentage points, not to exceed seventy per cent of the hospital's allowed billed charges.

(b) For Ohio hospitals who did not submit a hospital cost report (JFS 02930) to the Ohio department of job and family services for the ~~2008~~ 2009 state fiscal year and for out-of-state hospitals, reimbursement shall be equal to ~~sixty-two~~ sixty-one per cent of the hospital's allowed billed charges.

(5) For purposes of this rule, the "applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate" or "value" shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 et seq. as amended, excluding 42 U.S.C. 1395ww(d)(4)(D) and 42 U.S.C. 1395ww(m), as implemented by the following materials, which are incorporated by reference:

(a) 42 C.F.R. Part 412 as published in the October 1, ~~2009~~ 2010 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' ~~"42 C.F.R. Parts 412, 413, 415, et al. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; and Changes to the Long-Term Care Prospective Payment System and Rate Years 2010 and 2009 Rates; "74 Fed. Reg. 43754 (2009) "42 C.F.R. Parts 412, 413, 415, et al. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for Providers of Inpatient Psychiatric Services; Final Rule," 75 Fed. Reg. 50041-50681 (2010).~~

(B) QHP or self insuring employer (non-QHP):

A QHP or self-insuring employer may reimburse hospital inpatient services at:

(1) The applicable rate under the methodology set forth in paragraph (A) of this rule;

or

(2)

(a) For Ohio hospitals who submitted a hospital cost report (JFS 02930) to the Ohio department of job and family services for the ~~2008~~ 2009 state fiscal year, the hospital's allowable billed charges multiplied by the hospital's reported facility inpatient cost-to-charge ratio (from schedule B, line 101 of the hospital cost report) plus twelve percentage points, not to exceed seventy per cent of the hospital's allowed billed charges;

(b) For Ohio hospitals who did not submit a hospital cost report (JFS 02930) to the Ohio department of job and family services for the ~~2008~~ 2009 state fiscal year and for out-of-state hospitals, ~~sixty-two~~ sixty-one per cent of the hospital's allowed billed charges; or

(3) The rate negotiated between the hospital and the QHP or self-insuring employer in accordance with rule 4123-6-46 of the Administrative Code.

Effective: ~~2/1/10~~ 2/1/11

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: 1/1/07, 4/1/07, 1/1/08, 2/1/09, 2/1/10

BWC 2011 Proposed Inpatient Hospital Fees

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. Maintaining a network of hospitals to provide appropriate care is an important element to ensure the best possible recoveries from workplace injuries. It also ensures access to quality, cost-effective service. Access for injured workers, and employers, means the availability of quality, cost-effective treatment provided on the basis of medical necessity. It facilitates faster recovery and a prompt, safe return to work.

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.

Inpatient Hospital Fee Schedule Methodology

Introduction

As stated, implementing a sound and effective provider fee schedule is a critical component of the Medical Services Division's goals. Inpatient bills represent a small number of the bills BWC processes annually, however, they are a critical segment as they represent the treatment given to our most seriously injured workers. Inpatient hospitalization may be the first treatment following an injury; it may also be part of later treatment intended to return the injured worker to employment.

In financial terms, these bills represent 11.1 percent of BWC's overall medical expenses, even though they are 0.12 percent of bills received by BWC. An appropriate inpatient fee schedule is integral to assuring that injured workers are receiving quality care so that they may achieve the best possible recovery from their injuries. For the period reviewed (Dates of service February 2009 - January 2010), BWC paid the following medical expenses: Inpatient Hospital - \$ 81 million, Outpatient Hospital - \$ 145 million, Pharmacy - \$ 130 million, and Professional and other - \$ 373 million.

Methodology

BWC, in January 2007, implemented Medicare's Inpatient Prospective Payment System (IPPS). The IPPS utilizes the diagnosis-related groups (DRGs) classification system. BWC adopted the then DRG classification system, along with customized outlier and medical education payment adjustment factors. In 2008, BWC revised its program to implement Medicare's new MS-DRG methodology. In 2009, BWC adopted Medicare's 2009 MS-DRG outlier formula and updated the payment adjustment factors. The BWC

inpatient fee schedule was last updated by the Board in 2009, and effective February 2010.

BWC update the inpatient hospital rule annually to reference the new federal rule reflecting the most current Medicare model. In addition, BWC's evaluation methodology includes an analysis: 1) of the Medicare rule changes relative to BWC's goal of ensuring access to quality care, and 2) of the current payment adjustment factors to determine if a change to the same is warranted.

The Medicare MS-DRG pricing standard methodology calculates a based fixed price for groupings of procedures and diagnoses. Medicare adjusts pricing for each hospital using hospital-specific factors that include the hospital's average costs, its typical patient population, and prevailing wages in the hospital's geographic area within the state. In addition, the calculation provides additional reimbursement for complicated cases to ensure that hospital expenses are covered more equitably. Medicare also supports medical education programs by making additional payments to teaching hospitals.

Pursuant to our annual evaluation methodology, BWC completed an analysis of the Medicare's 2011 Inpatient Prospective Payment System final rule. This analysis included completing a review of Medicare's modifications to the MS-DRG case rates. The analysis identified two provisions in Medicare's Inpatient Prospective Payment System final rule which medical services is proposing non-adoption by incorporating a proposed BWC adjustment to the 2011 BWC inpatient fee schedule.

The first Medicare modification which medical services is proposing to offset is the budget neutrality safeguard known as the Documentation and Coding Adjustment. The adjustment was proactively approved by Congress in anticipation of the adoption of a severity adjusted classification system (MS-DRGs) in 2008. Although strongly opposed by the provider community, by law¹ Medicare must make an adjustment in 2011 or 2012. Thus, Medicare proposed adjust hospital rates down by a 2.9 percent adjustment that will be applied to the hospital base rate for every acute care hospital.

Medical services after an analysis of the Documentation and Coding Adjustment determined that a BWC adjustment to our 2011 reimbursement formula would be appropriate to restore Medicare's 2.9 percent decrease. The Medicare adjustment is a budget neutrality adjustment executed to protect the Medicare Fund, and as such does not support BWC's goal of ensuring access to quality care. Additionally, all hospitals are subject to the adjustment irrespective of whether their documentation and coding patterns subsequent to the adoption of the severity-adjusted MS-DRG system had changed at all. Lastly, because BWC's protocols ensuring diligence in our coding team's reviews of MS-DRG assignment for hospital inpatient bills, medical services is confident that our case mix index for 2008 and 2009 is accurate and will not need future payment adjustment.

¹ The Transitional Medical Assistance, Abstinence Education and Qualifying Individuals Program Extension Act (TMA) of 2007 – requires Medicare to adjust the hospital standardized amounts during federal fiscal years 2010-2012 if actual payments for hospital inpatient admissions for federal fiscal years 2008 and 2009 are greater than expected.

The second Medicare modification medical services is proposing to offset is the Market Basket Adjustment. The Affordable Care Act (ACA) of 2010 requires that a market basket adjustment be applied to Medicare participating hospitals for federal fiscal years 2010 through 2019. The 2010 negative adjustment of 0.25 percent was retroactively enforced by Medicare, but not adopted by BWC, as BWC had already adopted by rule our 2010 fee schedule. However, the 2011 adjustment of -0.25 percent was adopted in the new IPPS final rule.

Medical services after analysis of the Market Basket Adjustment determined that a BWC adjustment to our 2011 reimbursement formula would be appropriate to restore Medicare's 0.25 percent decrease. The Medicare adjustment is purely a cost saving measure for the Medicare program, and as such does not support BWC's goal of ensuring access to quality care.

Medical Services in addressing the above two identified Medicare adjustments is proposing for 2011 to adopt a BWC adjustment factor which will be applied to the IPPS Medicare payment rate. The recommended BWC adjustment factor is 3.15 percent, which will fully offset the two Medicare negative adjustments.

Medical services also performed a payment simulation based on the latest Medicare inpatient final rule. The simulation showed that the payments inlier bills would be adequate to ensure access to quality care. However, the analysis also showed that payment for outlier bills would be inadequate if the adjustment factor remained at 175 percent for 2011. Specifically, the payment to cost ratio for outlier bills in 2011 would fall below 100 percent. Given the projected impact, medical services determined that an increase in the payment adjustment factor for outlier cases from the current 175 percent to 180 percent was appropriate. The proposed increase in the payment adjustment factor would result in an estimated 2011 payment to cost ratio of 102 percent, which is in alignment with the estimated 2011 payment to cost ratios for inliers and MS-DRG exempt cases (inpatient rehabilitation, psychiatric and long term care).

Per adoption of the above recommendations, the 2011 hospital inpatient fee schedule would be as follows:

Inliers

$((\text{Medicare rate} * 2011 \text{ BWC adjustment}) * \text{Payment adjustment factor}) + \text{Direct Graduation Medical Education Per Diem}$

$((\text{Medicare rate} * 1.0315) * 1.20) + \text{Direct Graduate Medical Education Per Diem}$

Outliers

$(\text{Medicare rate} * 2011 \text{ BWC adjustment}) * \text{Payment adjustment factor}$

$(\text{Medicare rate} * 1.0315) * 1.80$

Summary of 2011 Proposed Changes to the Current Inpatient Fee Schedule Rule

Medical Services is recommending that for 2011, BWC adopts version 28.0 of the MS-DRGs and pricing factors as published in Medicare's Inpatient Prospective Payment System (IPPS) Final Rule.

Medical Services is further proposing that for 2011 BWC increase the payment adjustment factor for outliers from 175 percent to 180 percent.

Medical Services is further proposing that BWC adopt a BWC adjustment factor of 3.5 percent as an offset of Medicare's Documentation and Coding and 2011 Market Basket adjustments. We are proposing to offset these provisions by creating a 2011 BWC adjustment as illustrated above.

Projected Impact of Recommendations

The projected impact of the recommended changes to the hospital inpatient rule for 2011 is an increase in reimbursement of 5.7% or \$4.9 million dollars over estimated 2010 reimbursements. Additionally, the changes to the rule will continue to ensure access to quality care for Ohio injured workers.



Bureau of Workers' Compensation

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

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

Stakeholder feedback and recommendations for changes to the BWC Hospital Inpatient Services Fee Schedule - O.A.C. 4123-6-37.1

Line #	Rule # / Subject Matter	Stakeholder/ Interested Party	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
1	General Comment	Ohio Hospital Association	General comment of support of the recommended rule changes with no objections.			Maintain current proposal
2	General Comment	CompManagement Health System (MCO)	BWC should work to further address facilities who are exempt from Medicare's IPPS, and therefore, 4123-6-37.1(A)(4) should be more specific. Couldn't the DRG reimbursement rate formula still be used a guideline to point out excessive cost and then set a pre-determined percentage or maximum reimbursement above the DRG formula to better handle these escalated charges rather than allowing 61% or 70 percent of the hospitals allowed billed charges?	Currently the new provision divides the reimbursement rate into two categories based on whether or not a hospital cost report was submitted for the previous year and then goes on to allow a percentage of reimbursement (either 70% or 61%)based on the hospitals allowed billed charges. With this method, facilities can continue to escalate their costs without concern or repercussion. When facilities determine that their final payment is a percentage off their charged amounts—this not only initiates a very vicious cycle of hyperinflation but ultimately encourages fraud.	BWC acknowledges the comments and merits of the submitted suggestion and the rationale underlying the same. The current method as reflected in the rule has been determine to be at this time the most efficient method to compute reimbursement for a very small population of hospital facilities. The current method also effectively address and facilitate the underlying BWC philosophy and goal of the inpatient fee schedule. While BWC's hospital analysis has identified a hospital facility which appears to be constantly outside the norm with its billing, BWC is currently assessing other more efficient methods to address that particular situation. However, BWC will further evaluate the submitted suggestion for future consideration.	Maintain current proposal

Ohio BWC Fee Schedule History and Calendar: 2007 – Current

Inpatient Hospital Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	Sept/Oct	Jan. 1, 2009	-0.9%	-\$471,950
2009	Sept/Oct	Feb. 1, 2010	+2.9%	+\$2.4 million
2010	Sept/Oct	Feb. 1, 2011	+5.7%	+\$4.9 million
2011				

Outpatient Hospital Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	N/A	N/A	N/A	N/A
2009	Dec/Jan/Apr	Jan. 1, 2011	-7.2%	-\$2.55 million
2010	Oct/Nov	Apr. 1, 2011	-7.2% from base rate*	-\$10.2 million
2011				

* BWC plans to maintain the same payment adjustment factor through Feb. 28, 2012; therefore, a total of a 7.2% decrease is expected for services rendered from January 1, 2011 through February 28, 2012.

Vocational Rehabilitation Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	N/A	N/A	N/A	N/A
2009	Nov/Dec	Feb. 15, 2010	+5.86%	+\$1.9 million
2010	Nov/Dec	Feb. 2011		
2011				

Ohio BWC Fee Schedule History and Calendar Beginning with Adoption by Rule

Ambulatory Surgical Center Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2008	Nov/Dec	April 1, 2009	+23%	+\$1.73 million
2009	Oct./Nov.	April 1, 2010	+16%	+\$860,000
2010	Nov./Dec.	April 1, 2011		
2011				

Medical and Service Provider Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2008	Sept/Oct/Nov	Feb. 15, 2009	+6.0%	+\$23.8 million
2009	Sept/Oct	Nov. 1, 2009	+0.2%	+\$800,000
2010	June/July	Oct. 25, 2010	+2.9%	+\$9.2 million
2010	Dec (emergency)	January 1, 2011		
2011	Jan (final)			

* Emergency rule to add new codes

Ohio BWC

2011 Hospital Inpatient Fee Recommendations

OAC: 4123-6-37.1

Medical Services Division

Freddie Johnson, Director, Managed Care Services

Anne Casto, Casto Consulting

September 23, 2010

Introduction and Guiding Principles

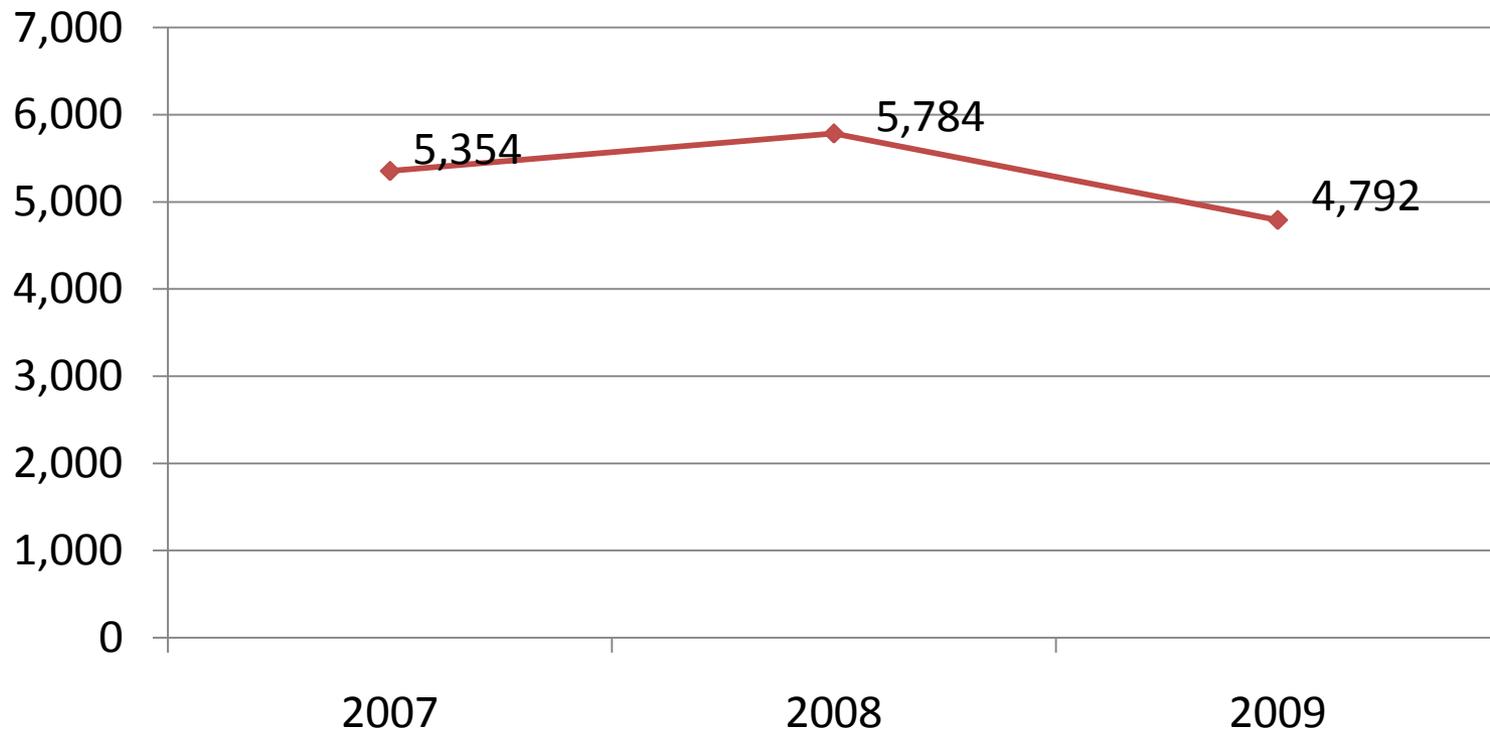
- Legal Requirements For Fee Schedule Rule
- Proposed Time-line for Implementation
 - Stakeholder Feedback - June 2010 – September 2010
 - Board Presentation – September/October
 - Proposed to JCARR – November 16, 2010
 - Effective Date – February 1, 2011
- Guiding Principle:

Ensure access to high-quality medical care and vocational rehabilitation services by establishing an appropriate Benefit plan and Terms of service with competitive fee schedule which, in turn, enhances medical/vocational provider network

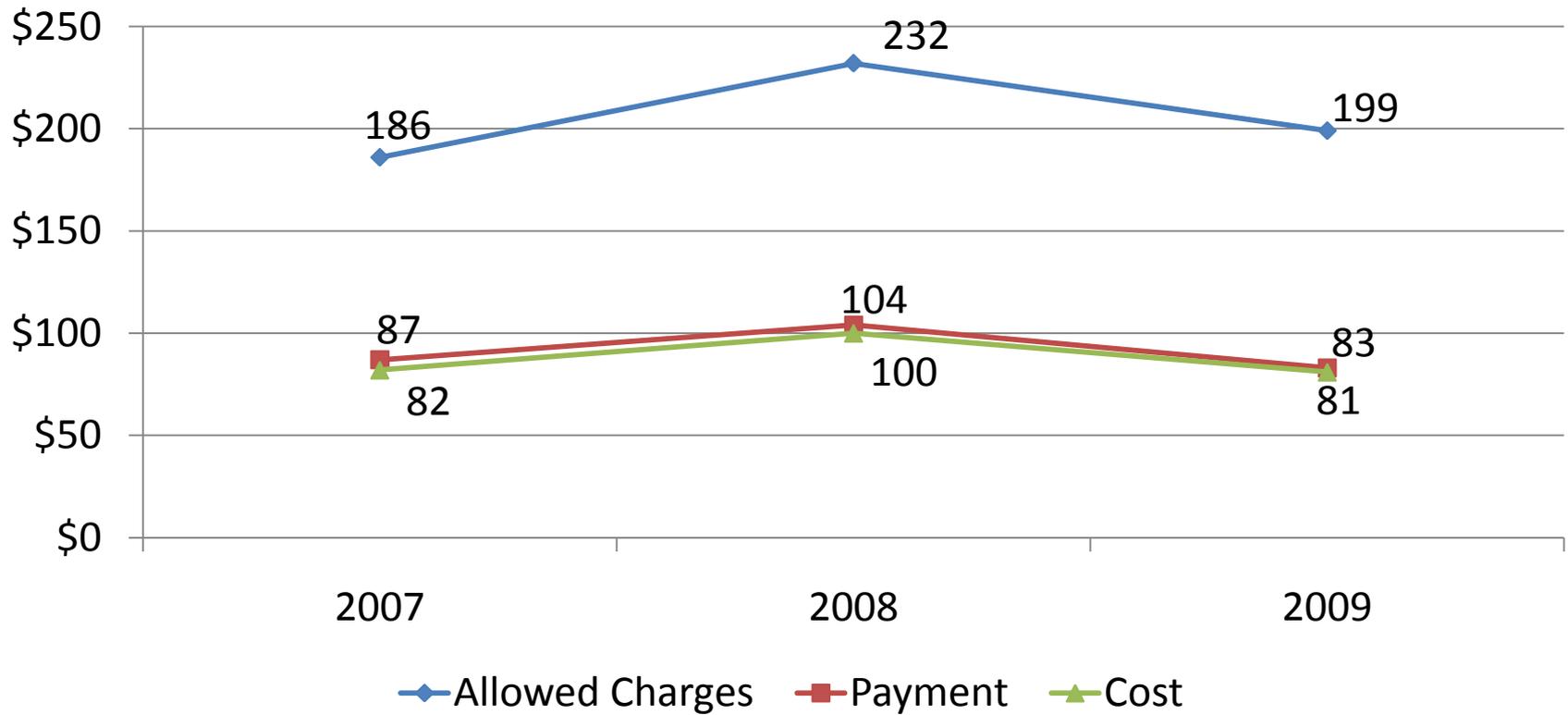
Fee Schedule Methodology

- Evaluation of current inpatient services and experiences, considering the need for annual payment updates and/or other policy changes
- Evaluation of the Medicare Inpatient Prospective Payment System Updates
- Setting payment adjustment factor (payment rate) at the right level
- Develop payment adjustments that accurately reflect market, service, and patient cost differences

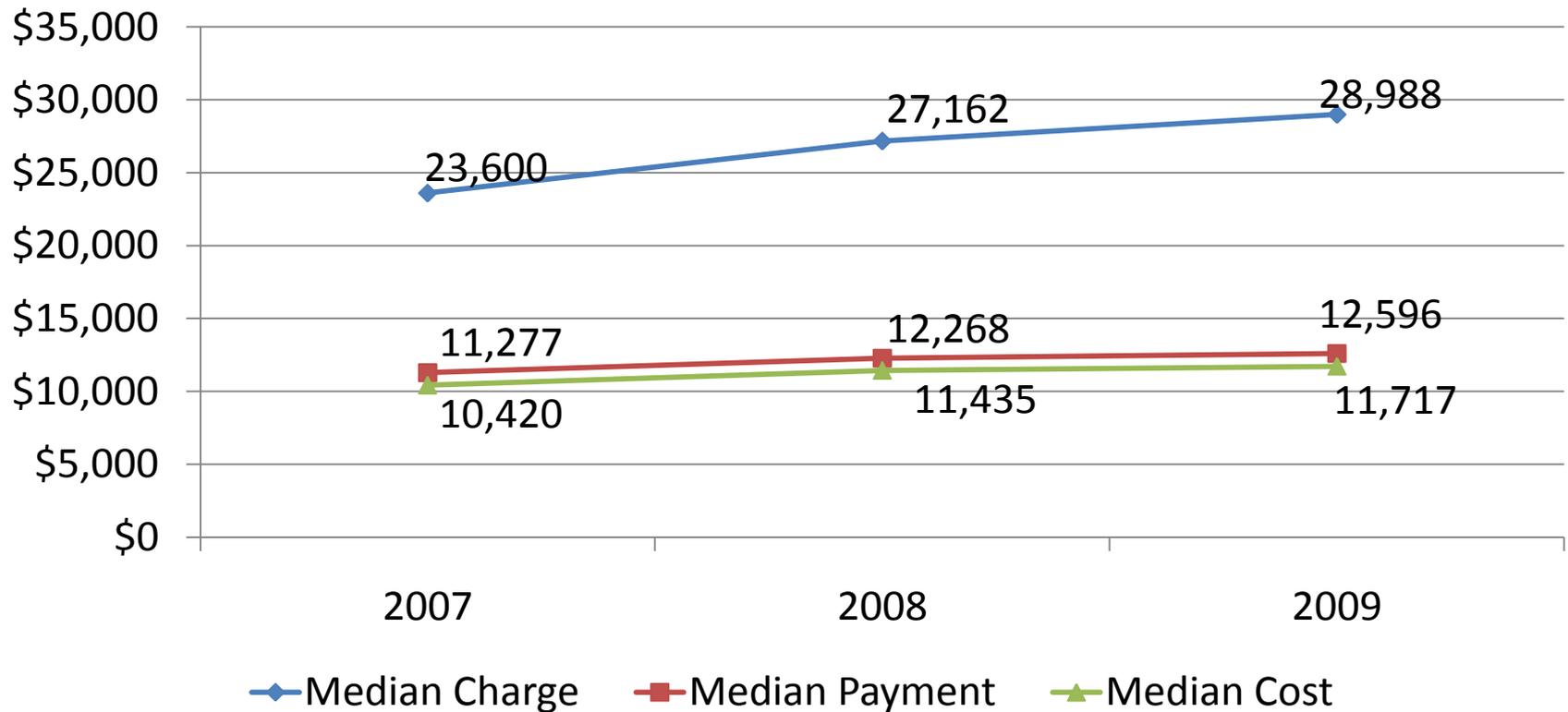
Hospital Inpatient Services Volume Trend: 2007 - 2009



Hospital Inpatient Trends (in millions): 2007 - 2008



Hospital Inpatient Trends: 2007 - 2009



Calculating Rates

- MS-DRG Formula 2010
 $(\text{Medicare Rate} * \text{PAF}) + \text{DGME}$
 - MS-DRG Formula 2011
 $((\text{Medicare Rate} * \text{BWC Adjustment}) * \text{PAF}) + \text{DGME}$

 - Outlier Formula 2010
 $\text{Medicare Rate [includes outlier add-on]} * \text{PAF}$
 - Outlier Formula 2011
 $(\text{Medicare Rate [includes outlier add-on]} * \text{BWC Adjustment}) * \text{PAF}$
- ✓ Note: the formula change is required because adding the market basket adjustment to the payment adjustment factor is not a true simulation of restoring the market basket.

BWC Adjustment = 2011 BWC adjustment of 3.15% or 1.0315

Medicare 2011 Inpatient Updates

- Documentation and Coding Adjustment
 - Imposed by TMA of 2007
 - *Transitional Medical Assistance, Abstinence Education and Qualifying Individuals Programs Extension Act of 2007*
 - Budget neutrality safeguard proactively executed to address the move to a severity-adjusted classification system for hospital inpatient services
 - Move from DRGs to MS-DRGs effective 2008
 - 2.9 percent decrease to hospital base rates for 2011

DRGs – Diagnosis Related Groups

MS-DRGs – Medicare Severity Diagnosis Related Groups

Medicare 2011 Inpatient Updates

- Documentation and Coding Adjustment
 - Foundation
 - Hospitals utilized documentation and coding enhancement programs to improve physician documentation and in turn the coding of diagnoses and procedures
 - Improved documentation and coding leads to a more accurate MS-DRG assignment and in some cases a higher case mix index
 - Adjustment is applied to ALL hospitals
 - Even if hospitals experienced an equal or lower case mix index during the transition to MS-DRGs
 - Adjustment is opposed by the hospital community

Medicare 2011 Inpatient Updates

- Affordable Care Act cost saving measure
 - Yearly market basket adjustment from 2010 to 2019
 - .25 percent reduction for 2011

Market Basket Reduction Schedule under ACA of 2010			
FFY	MB Reduction	FFY	MB Reduction
2010	.25%	2015	.20%
2011	.25%	2016	.20%
2012	.10%	2017	.75%
2013	.10%	2018	.75%
2014	.30%	2019	.75%

Outlier Payment Adjustment Factor

- During our annual review we examine performance metrics
 - Percent of payment to cost
 - Percent of billed charges
- Review of outlier bill metrics revealed that in 2009 BWC paid slightly below estimated costs
- Adjustment to payment adjustment factor for outliers recommended to address estimated impact on costs
 - Currently payment adjustment factor set at 175%
 - Recommending a new payment adjustment factor of 180%
 - Estimated impact on cost is reimbursing at 102% of cost.

States Using MS-DRG Methodology

Payment Adjustment Factors
MS – 200% MCR
CO – 160% MCR
MT – 148/108% MCR (included vs. excluded device payment)
TX – 143%
SC – 140% MCR
KS – 138/134% MCR (based on peer groups)
WV – 135% MCR
ND – 130% MCR
OH – 120/175% MCR (inlier vs. outlier)
CA – 120% MCR

Recommendation

- Adopt rates as published in 2011 IPPS final rule, version 28.0 of MS-DRGs
- Maintain the 120% PAF to IPPS rates for MS-DRG bills
 - DGME also to remain at 120%
- Adopt a 180% PAF to IPPS rates for all Outlier bills
- Apply a 2011 BWC adjustment factor of 3.15% to address Medicare reductions
 - Documentation and Coding Adjustment (2.9%)
 - Market basket reduction required by the Affordable Care Act of 2010 (.25%)
- Maintain current Exempt methodology
 - Medicaid Cost-to-charge ratio (CCR) plus 12 percentage point, not to exceed 70% allowed billed charges
 - Average CCR + 12 percentage points for 2009 is .61 which is used for providers without a Ohio Medicaid CCR

Recommendation Impact

- Estimated impact for 2011
 - Increase 4.9 million
 - 5.7% increase from 2010

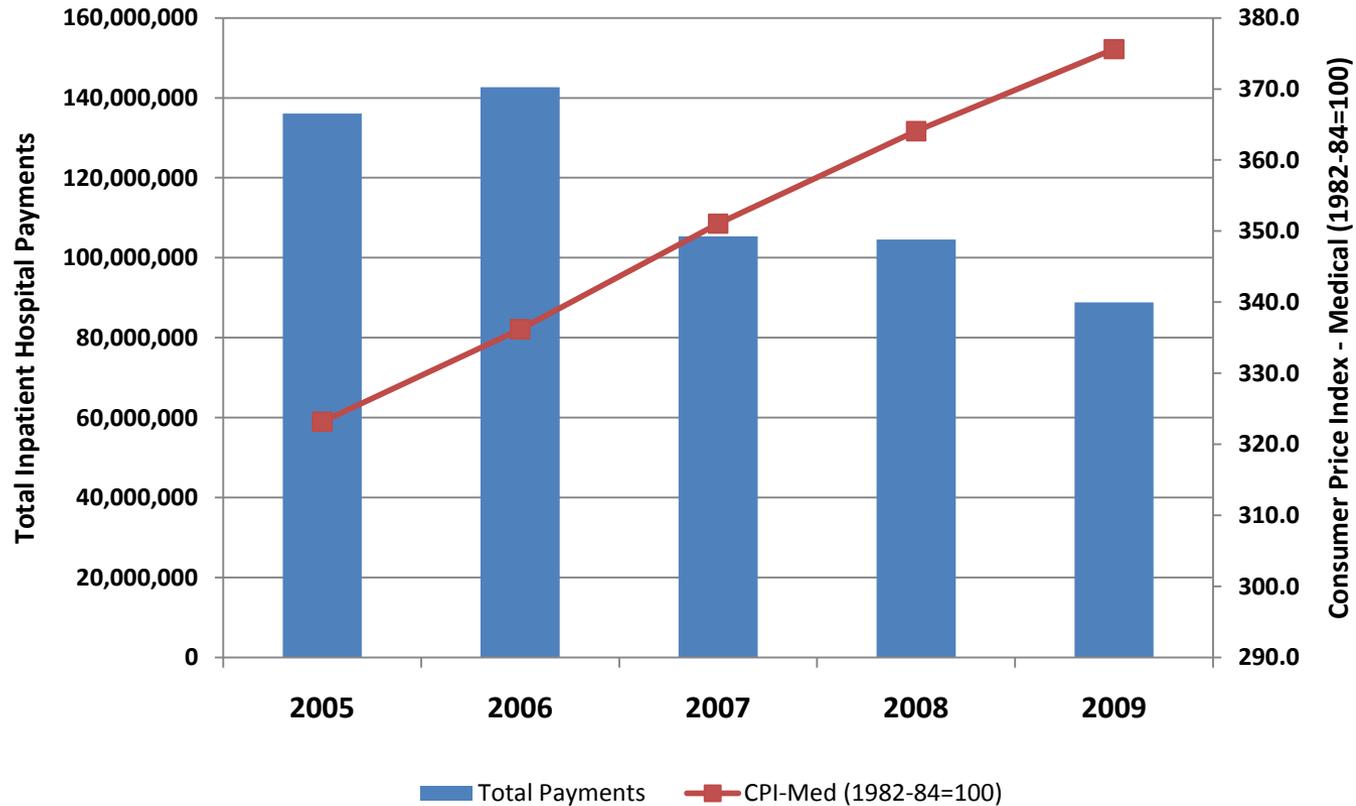
2011 Proposed Rule Impact Distribution	
Category	Estimated Impact
2011 BWC adjustment (3.15%)	\$2,597,758
Annual MS-DRG maintenance	\$1,939,490
Payment adjustment factor for outliers	\$371,734
All categories	\$4,908,980

Recommendation Impact

BWC Hospital Inpatient Payments 2005 - 2009

FDOS Year	Number of Unique Claims	BWC Payment Amount	Average Payment	CPI-Med (1982-84=100)
2005	5488	\$ 136,047,284	\$ 24,790	323.2
2006	5261	\$ 142,647,893	\$ 27,114	336.2
2007	5096	\$ 105,359,424	\$ 20,675	351.1
2008	4698	\$ 104,581,426	\$ 22,261	364.1
2009	4145	\$ 88,823,969	\$ 21,429	375.6

BWC Hospital Inpatient Payments 2005 - 2009



Thank You

Appendix

- 2010 Fee Schedule Changes
- 2009 Hospital Inpatient Experience
- 2008 Hospital Inpatient Experience
- Hospital Inpatient Payment Trends
- Review of Payment Methodologies used by other Workers Compensation Jurisdictions; Other Methodologies

Current Fee Schedule

- FFY 2010 IPPS system as published in CMS final rule (version 27.0 MS-DRGs)
 - Exclude Hospital Acquired Conditions provision
 - Remains unchanged from 2009
- Payment adjustment factors (unchanged from 2009)
 - 120% inliers
 - 120% direct graduate medical education (DGME)
 - 175% outliers
- Exempt methodology (unchanged from 2009)
 - Medicaid Cost-to-charge ratio (CCR) plus 12 percentage point, not to exceed 70% allowed billed charges
 - Average CCR for 2008 is .62 which is used for providers without a Ohio Medicaid CCR
 - Unchanged from 2009 fee schedule

2009 Hospital Inpatient Experience

Bill Type	Volume	Percent of Total Volume	Allowed Billed Charges	Percent of Total Allowed Billed Charges	Payment	Percent of Total Payment
MS-DRG	3982	83%	\$144,947,498	73%	\$56,434,745	68%
Outlier	141	3%	\$25,528,385	13%	\$8,976,528	11%
Exempt	669	14%	\$28,847,503	14%	\$17,703,544	21%
Total	4792		\$199,323,386		\$83,114,817	

2009 Hospital Inpatient Experience

Bill Type	Vol.	Allowed Billed Charges	Cost	Payment	Percent of Charge	Percent of Cost
MS-DRG	3,982	\$144,947,498	\$56,042,977	\$56,434,745	39%	101%
Outlier	141	\$25,528,385	\$9,139,265	\$8,976,528	35%	98%
Exempt	669	\$28,847,503	\$15,941,404	\$17,703,544	61%	111%
Total	4,792	\$199,323,386	\$81,123,646	\$83,114,817	42%	102%

2008 Hospital Inpatient Experience

Bill Type	Volume	Percent of Total Volume	Allowed Billed Charges	Percent of Total Allowed Billed Charges	Payment	Percent of Total Payment
MS-DRG	4,531	78%	\$147,809,133	64%	\$62,690,444	60%
Outlier	544	10%	\$52,691,661	23%	\$21,976,077	21%
Exempt	709	12%	\$31,069,184	13%	\$19,475,843	19%
Total	5,784		\$231,569,978		\$104,142,364	

2008 Hospital Inpatient Experience

Bill Type	Vol.	Allowed Billed Charges	Cost	Payment	Percent of Charge	Percent of Cost
MS-DRG	4,531	\$147,809,133	\$58,317,723	\$62,690,444	42%	107%
Outlier	544	\$52,691,661	\$22,546,542	\$21,976,077	42%	97%
Exempt	709	\$31,069,184	\$19,009,887	\$19,475,843	63%	102%
Total	5,784	\$231,569,978	\$99,874,152	\$104,142,364	45%	104%

2007 Hospital Inpatient Experience

Bill Type	Vol.	Percent of Total Volume	Allowed Billed Charges	Percent of Total Allowed Billed Charges	Payment	Percent of Total Payment
MS-DRG	4,130	77%	\$114,782,724	62%	\$49,856,672	58%
Outlier	677	13%	\$49,280,225	26%	\$22,743,249	26%
Exempt	547	10%	\$22,418,075	12%	\$14,136,796	16%
Total	5,354		\$186,481,024		\$86,736,717	

2007 Hospital Inpatient Experience

Bill Type	Vol.	Allowed Billed Charges	Cost	Payment	Percent of Charge	Percent of Cost
MS-DRG	4,130	\$114,782,724	\$48,639,143	\$49,856,672	43.3%	102.4%
Outlier	677	\$49,280,225	\$22,119,313	\$22,743,249	46.2%	103.1%
Exempt	547	\$22,418,075	\$11,526,132	\$14,136,796	63.0%	122.6%
Total	5,354	\$186,481,024	\$82,284,588	\$86,736,717		

Average and Median Charge, Cost and Payment Trends

	2007	2008		2009	
Average Allowed Charge	\$34,830	\$40,036	15%	\$41,442	4%
Average Cost	\$16,201	\$17,267	7%	\$16,951	-2%
Average Payment	\$16,200	\$18,005	11%	\$17,354	-4%
BWC CMI	1.8007	1.9848	10%	1.9215	-3%
	2007	2008		2009	
Median Allowed Charge	\$23,600	\$27,162	15%	\$28,988	7%
Median Cost	\$10,420	\$11,435	10%	\$11,717	2%
Median Payment	\$11,277	\$12,268	9%	\$12,596	3%

States Using a Modified MS-DRG Methodology

PA: Frozen relative weights / updated base rates

Groupers frozen at 1994 DRG version 12 + hospital specific base rates

NC : MS-DRGS with stop loss on both ends

If MS-DRG Rate between 75% BC and 100% BC pay MS-DRG rate

If MS-DRG Rate less than 75% BC then pay 75% BC

If MS-DRG Rate greater than 100% BC then pay 100% BC

OK: MS-DRG with reduced base rate, separate payment for implants and stop loss

79% MS-DRG Rate

Implants at 4.5% invoice cost

Stop loss at 70% BC if allowed charges exceed \$70,000

States Using Percent of Billed Charges Methodology

Percent of Billed Charges
NE – 96/92.5% (based on bed size)
ME – 95/100% (based on billed to paid date)
ID – 90/85% (based for facility size)
DE – 85%
MN – 85%
VT – 83%

States Using Per Other Methodologies

Per Diem

States
AL
AR
FL
NV
NY
TN
WA

Contracted/UCR*

States
CT
MI
MN
OR
RI
UT
VA
WY

*Usual, Customary & Reasonable

I. Drug Free Safety Program

- Currently there are 4,700 employers enrolled in BWC's Drug Free Safety program (DFSP) for the period beginning 7/1/10.
- Applications for the 1/1/11 period are beginning to come in. We anticipate another 1,500 to 2,000 additional employers may join beginning 1/1/11.
- History of Participation:
 - 17% had some previous participation in the former DF program
 - 70% are former DF participants who exhausted eligibility
 - 13% are new DF participants
- Level of Participation:
 - 40% are in the Advanced Level
 - 57% of advanced participants are also in group rating
 - 35% are in the Basic Level
 - 47% of basic participants are also in group rating
 - 25% are at level 0 (comparable program participants)
- Participation by Size of Payroll
 - 27% reported < \$250,000 annual payroll
 - 37% reported \$250K to \$1M annual payroll
 - 31% reported \$1M to \$5M annual payroll
 - 5% reported > \$5M annual payroll
- Participation by Industry classification
 - 51% are in the construction industry class
 - 13% are in the manufacturing industry class
 - 13% are in the service industry class
 - 8% are in the commercial industry class
 - Remaining 15% are dispersed among other industry classes

 - Participation within select industry classes
 - 8% of all employers in the extraction class are in the DFSP
 - 7% of all employers in the construction class are in the DFSP
 - 7% of all employers in the utility class are in the DFSP
 - 5% of all employers in the manufacturing class are in the DFSP
 - 4% of all employers in the high risk class are in the DFSP
 - 3% of all employers in the transportation class are in the DFSP
- Additional program evaluation will take place as we begin analyzing safety survey, audit analysis and drug testing results.
- Effective 10/1/10 the new federal government drug testing guidelines take effect. These changes will effectively lower the cut off levels for cocaine and amphetamines and add testing for ecstasy. These new, lower limits will automatically be applied to testing that is done as part of BWC's DFSP.

II. Claims Complexity

- Overview of Claims Complexity Project:
 - The claims complexity team was formed to develop a methodology to predict claim complexity levels and assign claims to individuals with the appropriate skill sets for optimal management.
 - Team consists of BWC and MCO members. Both parties are integral in the management of claims. Processes will be developed to maximize strengths and eliminate duplication.
 - The team also represents a joint labor and management initiative. Both unions, OCSEA and SEIU, are participating and have appointed representatives to the team.
 - Performance measures will be developed on new processes for both BWC and MCO to ensure proficiency and accountability.
- How we plan to improve customer service:
 - Provide the right services to the right customer at the right time utilizing the most efficient service delivery method
 - Assigning claims in a timely manner to the most appropriate team
 - Facilitates good management and claim outcomes
 - Fosters ability to customize services
 - Allows staff managing claims to develop expertise and specialization
 - Training opportunities can be more specific to what an individual is doing
 - Defining roles for BWC and MCO will maximize respective strengths and eliminate unnecessary duplication
- CAT Event pilot and rollout
 - A CAT event is defined as a high priority incident that results in more than one injured worker requiring treatment where at least one of the injuries sustained has the potential for an overnight hospital stay or results in death.
 - 3 Regional CAT Event teams (Dayton, Youngstown, Columbus)
 - Training for CAT Event teams completed on 8/31
 - CAT Event pilot began operation on 9/1
- Next Steps:
 - Validation for predictive model is taking place in conjunction with OSU
 - Develop triage methodology incorporating predictive modeling to enable BWC to systematically assign claims to specialized teams when appropriate, (e.g., death, at risk, PTD, maintenance, etc....)

III. Lump Sum Settlement (LSS) Update

- LSS Enhancement team is comprised of BWC staff, IW reps, employer reps and TPAs. This team provides input into the LSS process and assists with communicating changes to their respective communities.
- Project consists of three phases:
 - **Phase 1 – Completed in 2009**
 - Largely internal focus
 - Internal controls
 - Consistency through policy clarification and training
 - CSS tools to improve decision making
 - Internal performance measures
 - Organizational restructuring (LSS teams, service office roundtables, executive committee sign off, and authority levels)
 - **Phase 2 – Presently Underway**
 - MSA
 - BWC is in the process of contracting with several vendors to assist with obtaining MSA certification on certain high dollar LSS claims where the injured worker is currently on Medicare or soon to be eligible for Medicare
 - Rate Age
 - Rated age is a common insurance practice to predict an individual's life expectancy, particularly when there are known co-morbidities
 - BWC will begin using rated ages in the settlement of claims where there is a contemplation of lifetime benefits such as PTD, survivor and, lifetime medical
 - BWC will contract with vendors/insurers who have experience in rated age assessments
 - Skills Enhancement
 - Later this month BWC will begin a comprehensive evaluation of its settlement staff
 - We will begin with LSS supervisors and follow-up, early next year, with the LSS staff
 - The supervisors will be evaluated on their knowledge and understanding of the LSS policy/procedures, compliance with performance standards and measures and quality of audits
 - The staff will be evaluated on timeliness, compliance with performance expectations, claim audit results and negotiation skills
 - **Phase 3 – TBD**
 - Analysis of impact of MSA
 - Studying indemnity only settlements
 - Pursuit of settlements
 - Structured settlements

Medical Services and Safety Committee

Summary of the Post Event Analysis for the 2010 Ohio Safety Congress & Expo

Between March 30 and April 1, 2010, BWC hosted the 80th annual Ohio Safety Congress & Expo at the Greater Columbus Convention Center. Approximately 5,900 participants representing 2,340 businesses gathered to receive education and training in primarily occupational safety and health, accident and injury prevention, claims and risk management and control, and workers' compensation. Furthermore, participants had a chance to view and interact with 209 vendors of industrial and construction equipment, safety gear and services as well as workers' compensation services from all over the United States.

Post event analysis of the 2010 Safety Congress, themed "saving lives, saving money," shows that the event was very successful. BWC managed to achieve a sixteen percent increase in attendance (5,900 participants) and an eight percent increase in the number of participating vendors (209) compared to 2009. Expo booth sale revenue (\$198,975) declined by about two percent compared to 2009; due to vendors taking advantage of an early booth sale discounted pricing scheme. Also, although we managed to increase the number of participating vendors, the total number of booths sold (247) declined by one percent. We also managed to increase our advertising revenue (\$6,260) by 39 percent over the 2009 amount.

Excluding personnel time cost, the total expenditures associated with the event was the lowest in ten years (\$195,819). The expo and advertising revenue was the second highest (\$205,235) in 10 years; only second to 2009 (\$208,605). Personnel time cost estimate for planning and executing the event was lowest in 10 years (\$131,114) and professional development benefits for BWC staff is estimated at approximately \$110,000 which reflects a 12-percent increase over 2009.

In terms of employer type, the 2010 event experienced increases in the number of employers' representation across the board including state and federal agencies, public taxing districts as well as self insured and private employers. Participants from private employers represented 48 percent of the total participation. Close to 50% of participants were involved in a workplace safety responsibility at their workplaces. About 51% of the participants worked for employers with 10 to 100 employees and 23 percent worked for employers with less than 9 employees, emphasizing that the Ohio Safety Congress continues to be a valuable resource for training and professional development for smaller employers in Ohio. In terms of industrial sector representation, the majority of participants came from manufacturing (21.7%), public (18.9%), and construction (8.2%) sectors. Also, close to 38% percent of the participants indicated that they are first time participants.

In terms of programming, a total of 152 IACET accredited one-hour lecture sessions and 15 roundtable sessions were offered. BWC staff worked with 183 external volunteers representing 36 industries in the development of 135 safety-related lecture sessions. The program was also expanded this year to include workers' compensation as well as medical and legal topics. This new programming was developed and

delivered by 23 BWC subject matter experts through 17 one-hour lecture sessions. The inclusion of workers' compensation programming in the 2010 event resulted in a positive effect on the event and increased participation. Close to 93 percent of the respondents to the post event survey indicated that they benefited from this offering. Continuing education credits covered 12 professions and five BWC rating programs.

A post event survey of 585 participants indicated that 83% of the participants' decision to attend the event is based on the program quality as it relates to the topics and speakers at the educational sessions. When asked about their overall satisfaction with Safety Congress, 35 percent of the respondents were very satisfied, 53% were satisfied, 9% were neutral, 2% unsatisfied, and 1% very unsatisfied. Sources of dissatisfaction were related to not extending the expo over the three days of congress and not being able to attend certain sessions because those sessions reached full capacity. Extending the expo over only two days of the three-day event was implemented over the past three years to satisfy requests by the majority of exhibitors.

A post event survey of the exhibitors with 112 respondents indicated that 38 percent were very satisfied, 50 percent were satisfied, 7 percent were neutral, and 5 percent were unsatisfied. Sources of dissatisfaction were related to not allowing exhibitors to breakdown their booths earlier in the second day of the expo.

The 2011 Ohio Safety Congress & Expo is scheduled March 29 to 31 at the Greater Columbus Convention Center with a goal to increase attendee and exhibitor participation by 5 percent each.

Educational programming will continue to focus on workplace safety, accident and injury prevention and workers' compensation topics. Sessions will provide continuing education credit. Sessions in high-demand will be repeated to offer more participants an opportunity to attend.

Development is underway for educational sessions including:

Up to 155 safety sessions, including programming relevant to market segmentation findings; up to 18 worker's compensation sessions, 3 general sessions, 3 to 5 full-day sessions and up to 2 live demonstrations.

In response to exhibitor feedback, the Safety Congress schedule will offer a two day exposition with an early closing time on day two, and modified session times to offer more consistent visitor traffic on the expo floor.

Registration for the 2011 Ohio Safety Congress will open in January.

12 - Month Medical Services & Safety Calendar

Date	September 2010	Notes
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. Outpatient Hospital Fee Schedule (1st read)	
	7. Medical Services Report	
	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	
	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. 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 2011	
7/28/11	1. Medical & Service Provider Fee Schedule (2nd read)	
	2. Customer Services Report	
8/28/11	August 2011	
	1. Inpatient Hospital Fee Schedule (1st read)	
	2. Medical Services Report	