

BWC Board of Directors
Medical Services and Safety Committee Agenda

Friday, November 19, 2010

William Green Building

Level 2, Room 3

8:00 A.M. - 9:30 A.M.

Call to Order

Jim Harris, Committee Chair

Roll Call

Mike Sourek, scribe

Approve Minutes of October 21, 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

1. Committee Charter Annual Review

Donald C. Berno, Board Liaison

Ann Shannon, Legal Counsel

B. For First Reading

1. Ambulatory Surgical Center Fee Schedule Rule– Rule 4123-6-37.3

Freddie Johnson, Director Managed Care Services

Anne Casto, Casto Consulting

2. Outpatient Hospital Fee Schedule– Rule 4123-6-37.2

Freddie Johnson, Director Managed Care Services

Anne Casto, Casto Consulting

Discussion Items**

1. Customer Services Report

Tina Kielmeyer, Chief, Customer Services

2. Committee Calendar

Jim Harris, Committee Chair

Adjourn

Jim Harris, Committee Chair

Next Meeting: Wednesday, December 15, 2010

*Or after previous meeting adjourns

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

OBWC Board of Directors Medical Services and Safety Committee Charter

Purpose

~~The Ohio Bureau of Workers' Compensation Board of Directors has created the Medical Services and Safety Committee under authority granted by RC 4121.12(G)(2).~~ The Medical Services and Safety Committee, ~~is~~ a standing committee of the Board of Directors¹. ~~The Committee~~ shall:

- ~~A~~Assist the Board of Directors in the development of strategic policy for the provision of quality, cost-effective safety and accident prevention programs for the mutual benefit of injured workers and employers, and
- ~~a~~Assist the Board of Directors in the development of strategic policy for the provision of quality, cost-effective treatment and rehabilitation services necessitated as the result of workplace injuries for the mutual benefit of injured workers and employers
- ~~r~~Review opportunities and challenges the Board of Directors needs to discuss as they fulfill the statutory requirement to fix and maintain the lowest possible rates of premium consistent with the maintenance of a solvent state insurance fund.

Membership

The Committee shall be composed of a minimum of ~~three-five~~ (35) members. The Board, by majority vote, shall appoint at least three members of the Board to serve on the Medical Services and Safety Committee and may appoint additional members, who are not Board members, as the Board determines necessary. Bureau management personnel cannot serve as a Committee member.

The Chair and Vice Chair are designated by the Board, based on the recommendation of the Board Chair. If the Board Chair is not a member of the Committee, he/she shall be an ex-officio member. As an ex-officio member, he/she shall not vote if his/her vote will create a tie vote.

The Committee Chair will be responsible for scheduling all meetings of the Committee and providing the Committee with a written agenda for each meeting. In the absence of the Committee Chair, the committee Vice-Chair will

¹ RC 4121.12(G)(2) states the Board may create committees in addition to the audit, actuarial and investment committees that the Board determines are necessary to assist the Board in performing its duties.

assume the Chair's responsibilities. The Committee will have a staff liaison designated to assist it in carrying out its duties.

Members of the Medical Services and Safety Committee serve at the pleasure of the Board, and the Board, by majority vote, may remove any member.

Meetings

The Committee shall meet at least six (6) times annually. The Committee Chair will provide a report of the meeting at the next subsequent Board meeting. Additional meetings may be requested by the Committee Chair, 2 or more members of the Committee, or the Chair of the Board.

A quorum shall consist of a majority of Committee members. Committee meetings will be conducted according to Robert's Rules of Order. All Directors are encouraged to attend the Committee meetings.

The Committee will invite members of management, and/or others to attend meetings and provide pertinent information, as necessary.

Minutes for all meetings of the Committee will be prepared to document the actions of the Committee in the discharge of its responsibilities.

Duties and responsibilities

The Committee shall have the responsibility for ensuring the appropriateness and oversight of policy regarding BWC medical and managed care services and safety programs:

1. The Committee shall assist the Board in meeting the following statutory requirements, including but not limited to:
 - Consult with the Administrator and recommend to the Board the appointment of the Superintendent of Safety and Hygiene (RC 4121.37);
 - Review and make recommendations to the Board regarding administrative code rules related to BWC's Division of Safety and Hygiene, including specific safety rules (RC 4121.12 (F)(13)(b), and 4121.12(F)(13)(d));
 - Review and make recommendations to the Board regarding administrative code rules related to BWC's health partnership program (RC 4121.12 (F)(13)(c));
 - Review the Division of Safety and Hygiene annual report (RC 4121.37)

2. The Committee shall provide strategic oversight for BWC in the following areas:
- Composition of, modification of, and/or delivery of occupational safety and health programs;
 - Composition of or modification to medical, occupational safety and health research programs;
 - Initiation and development of collaborative partnerships between BWC and other agencies in and outside Ohio for the purpose of improving medical services, managed care services and workplace safety;
 - Composition of or improvement to BWC's medical provider network and practice guidelines;
 - ~~managed~~ Managed care and claims policies including an appropriate disability prevention delivery model;
 - ~~research~~ Research for injury prevention, treatment guidelines, the benefit plan, formularies, and corresponding fee schedules;
 - Improvements to the provider bill payment services, and
 - Development of metrics for all of the above showing comparative effectiveness.
 - Coordinate with the other Board Committees on items of common interest, including but not limited to an annual discussion of issues under their jurisdiction which would impact the Board's statutory requirement to fix and maintain the lowest possible rates of premium consistent with the maintenance of a solvent state insurance fund.
 - At least annually, review the Medical Services and Safety Committee charter and submit any proposed changes to the Governance Committee and to the Board for approval.
 - The Committee by majority vote may create a subcommittee consisting of one or more Directors on the Committee. In consultation with the Chair, other Board members may be appointed to the subcommittee as appropriate. The subcommittee shall have a specific purpose. Each subcommittee shall keep minutes of its meetings. The subcommittee shall report to the Committee. The Committee by majority vote may dissolve the subcommittee at any time; and
 - Perform such other duties required by law or otherwise as are necessary or appropriate to further the Committee's purposes, or as the Board may from time to time assign to the Committee.

Draft 102909
Reviewed and approved 112009, Jim Harris, Chair
[Reviewed and approved 111910](#)

Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-37.3

Rule Review

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

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

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

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

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

4. The rule is effective, consistent and efficient.

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

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

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

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

Explain: The BWC Medical Services Division presented the proposed ASC rule changes to the Ohio Association of Ambulatory Surgical Centers on November 2, 2010, and also posted the proposed rule changes to the BWC website on November 12, 2010, with a 2 week comment period ending November 26, 2010.

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

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

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

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

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

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

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

Introduction

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

BWC first adopted a Chapter 4123-6 rule regarding fees for ambulatory surgical center services effective April 1, 2009, and revised it effective April 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 ambulatory surgical center services via the O.R.C. Chapter 119 rulemaking process.

BWC’s ambulatory surgical center reimbursement methodology is based on Medicare’s Ambulatory Surgical Center Prospective Payment System, which is updated annually. Therefore, BWC must also annually update OAC 4123-6-37.3, to keep in sync with Medicare.

Rule Changes

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

BWC is proposing to amend OAC 4123-6-37.3 to update the reimbursement rates for ambulatory surgical center services.

Under the proposed rule, unless an MCO has negotiated a different payment rate with an ambulatory surgical center, reimbursement for ambulatory surgical center services with a date of service of April 1, 2011 or after shall be equal to the lesser of the ambulatory surgical center’s allowable billed charges or the BWC fee schedule for such services.

The BWC fee schedule for ambulatory surgical services are contained in an appendix to the rule. As the preamble to the appendix indicates, fees for covered ambulatory surgical services other than pain management shall be calculated using the 2011 Medicare Ambulatory Surgical Center Prospective Payment System rates, multiplied by a 2011 bureau adjustment of 1.013. Fees for covered ambulatory surgical pain management services shall be calculated using the 2011 Medicare Ambulatory Surgical Center Prospective Payment System rates, multiplied by a 2011 bureau adjustment of 1.013 and further multiplied by a payment adjustment factor of 1.10.

Stakeholder Involvement

The BWC Medical Services Division presented the proposed ASC rule changes to the Ohio Association of Ambulatory Surgical Centers on November 2, 2010, which verbally expressed its support for BWC's proposed changes.

The proposed ASC rule changes were also posted on the BWC website on November 12, 2010, with a 2 week comment period ending November 26, 2010. Stakeholder responses received to date by BWC are summarized on the Stakeholder Feedback Summary Spreadsheet.

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

Unless an MCO has negotiated a different payment rate with an ambulatory surgical center pursuant to rule 4123-6-08 of the Administrative Code, reimbursement for ambulatory surgical center services with a date of service of ~~April 1, 2010~~ April 1, 2011 or after shall be equal to the lesser of the ambulatory surgical center's allowable billed charges or the fee schedule amount indicated in the attached appendix A, developed with provider and employer input and effective ~~April 1, 2010~~ April 1, 2011.

Appendix A

BUREAU OF WORKERS' COMPENSATION

AMBULATORY SURGICAL CENTER FEE SCHEDULE

EFFECTIVE ~~APRIL 1, 2010~~ APRIL 1, 2011

Effective: 4/1/2011

R.C. 119.032 review dates: _____

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 4/1/09, 4/1/10

Ohio Bureau of Workers' Compensation 2011 Ambulatory Surgical Center (ASC) Fee Schedule

The five character codes included in the Ohio Bureau of Workers' Compensation (BWC) 2011 Ambulatory Surgical Center Fee Schedule are obtained from Current Procedural Terminology (CPT®), copyright 2010 by the American Medical Association (AMA) and from the Health Care Procedure Coding System (HCPCS) National Level II Medicare codes.

CPT® is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians.

HCPCS are released by the Center for Medicare and Medicaid Services (CMS) as a listing of five character codes and descriptive terminology used for reporting supplies, materials and services by health care providers.

The responsibility for the content of the BWC 2011 Ambulatory Surgical Center Fee Schedule is with the State of Ohio Bureau of Workers' Compensation and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the BWC 2011 Ambulatory Surgical Center Fee Schedule. No fee schedules, basic unit values, relative value guides, conversion factors or scales are included in any part of CPT®. Any use of CPT® outside of the BWC 2011 Ambulatory Surgical Center Fee Schedule should refer to the most current *Current Procedural Terminology* which contains the complete and most current listing of CPT® codes and descriptive terms. Applicable FARS/DFARS apply.

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

By Report (BR)

The procedure or service is not typically covered and will not routinely be reimbursed. Many of the –BR codes are unclassified/unspecified generic codes and are currently assigned a dollar amount of \$0.00. A report is required to be obtained by the MCO for reimbursement consideration. Authorization and payment of codes identified as –BR require an individual analysis by the MCO prior to submission. The MCO analysis shall include researching the appropriateness of the code in relation to the service or procedure and cost comparisons in order for the MCO to approve high quality, cost-effective medical care. Research information from the MCO is required to be submitted to the BWC Medical Policy with each request. After review by the MCO, the report must be imaged into the BWC claim and a request must be submitted, utilizing the sensitive data transmission policy, to the BWC Medical Policy email box Medpol@bwc.state.oh.us for an adjustment to be processed. MCOs should note that most CPT® codes have an assigned Relative Value Unit which must be utilized to determine reimbursement. Fees for CPT® codes that do not have an established RVU must be compared to a like service to assist in determining appropriate fees. HCPCS codes are priced through multiple cost comparisons.

Not Routinely Covered (NRC)

The procedure or service is not covered unless application of the *Miller* criteria requires an exception. See: OAC 4123-6-16.2(B)(1) through (B)(3). Where coverage is required, the pricing is listed on the fee schedule.

ASC Fee

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

ASC Reimbursement Levels 2011

The BWC 2011 Ambulatory Surgical Center Fee Schedule rates for covered services other than pain management (CPT® ranges 62310-62319, 64400-64425, 64445-64495, 64510, 64520, and 64620-64627) shall be calculated using the Medicare 2010 transitional Ambulatory Surgical Center Prospective Payment System rates published in Addendum AA and Addendum BB of the Department of Health and Human Services, Centers for Medicare and Medicaid Services' "42 CFR Parts 410, 411, 412, 413, 416, 419, and 489 Medicare Program: Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Payments to Hospitals for Graduate Medical Education Costs; Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations; Payment for Certified Registered Nurse Anesthetist Services Furnished in Rural Hospitals and Critical Access Hospitals; Final Rule," Federal Register, Volume 75, Number ___, Pages ___-___ (Addendum AA) and ___-___ (Addendum BB), November 24, 2010, multiplied by a 2011 bureau adjustment of 1.013.

The BWC 2010 Ambulatory Surgical Center Fee Schedule rates for covered pain management services (CPT® ranges 62310-62319, 64400-64425, 64445-64495, 64510, 64520, and 64620-64627) shall be calculated using the Medicare 2010 transitional Ambulatory Surgical Center Prospective Payment System rates published in Addendum AA and Addendum BB of the Department of Health and Human Services, Centers for Medicare and Medicaid Services rule specified above, multiplied by a 2011 bureau adjustment of 1.013 and further multiplied by a payment adjustment factor of 1.10.

BWC 2011 Proposed Ambulatory Surgical Center Fees

Medical Service Enhancements

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

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

Ambulatory Surgical Center Fee Schedule

As stated, implementing a sound and effective provider fee schedule is a critical component of the Medical Services Division's goals. Ambulatory Surgical Centers (ASCs) billing represents a small number of bills BWC processes annually. However, this provider segment is a critical component of BWC's provider network. ASCs provide services in connection with surgical procedures that do not require inpatient hospitalization. Services provided by ASCs are the same as those provided in a hospital outpatient setting, but with lower cost and generally increased ease of access. In financial terms, these bills represent less than one percent (.97%) of BWC's overall medical expenses. The total ASC expenditures in calendar year 2009 totaled \$5,523,739.

BWC Current Rates

Beginning with services on April 1, 2009, BWC adopted the Centers for Medicare and Medicaid Services (CMS) Ambulatory Surgical Center (ASC) rates published in the 2009 Ambulatory Surgical Center Prospective Payment System (ASC PPS). The adoption of the 2009 Medicare and Medicaid Services rates also marked was the first update to ASC rates since 2005. Thus, the April 2009 fee schedule update also reflected BWC's adoption of the new Medicare and Medicaid reimbursement methodology.

Prior to April 2009 and since June 1996, the BWC's ASC fee schedule had been based on Medicare's Ambulatory Surgical Center List (aka ASC Groups). Medicare's ASC Groups had been Medicare's prospective payment system from 1982 through 2007. The ASC Groups' payment scheme placed approved reimbursements into one of nine groups based on average cost. The reimbursement rate for each group was then based on the average overhead cost for the group. Cost data used for rate setting was last collected by Medicare in 1986. Federal legislation froze the Medicare ambulatory surgical center rates from 2002-2007.

BWCs old fee schedule reflected Medicare’s old ASC Group methodology. When Medicare moved to the new methodology in 2008 the reimbursement rates for several specialties increased and thus, BWC’s reimbursement rate under the old methodology fell below Medicare’s rate for many services; which precipitated BWC’s change from the old methodology. BWC, in adopting the new Medicare methodology, set its reimbursed level for covered services and supplies at 100% of the ASC PPS rate.

As part of the 2010 ASC PPS update process, BWC performed an analysis on the impacts of the identified changes on Ohio’s ASC facilities. BWC performed this analysis using a sample of cost data provided to BWC from the Ohio Association of ASCs (OAASC) for several orthopedic and pain management procedures. The analysis indicated that reimbursing orthopedics at 100% of the CMS 2010 ASC PPS rate would result in reimbursements covering 113% of the facility cost; which was up from 91% in 2009. The analysis further showed that reimbursing pain management procedures at 100% of the CMS 2010 ASC PPS rate would result in reimbursements covering 64% of cost; which was down from an estimated 70% in 2009. Therefore BWC adopted a payment adjustment factor of 110% of the Medicare ASC PPS rate for designated pain management services. All other services are reimbursed at 100% of the Medicare ASC PPS rate.

BWC evaluated the proposed 2011 changes to the Medicare ASC rule. There were for the most part only minor changes in benefit coverage and or service shifts. The primary changes were in the reimbursement rates for covered procedures, which reflected the final phase of CMS’s transition to ASC PPS rates. CMS is in the fourth and last year of their transition period, and beginning January 2011, will have fully implemented the ASC PPS system and updated rate. The transition schedule is provided in the table below.

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

The service lines most utilized by BWC in the ASC setting are orthopedics and pain management. A review of the rates changes published for 2011 showed that orthopedic rates have increased and pain management rates have slightly decreased. Based on the rate structure adopted in the ASC PPS we were fully aware that some rates would be changing throughout the transition period.

Part of the BWC’s fee schedule analysis as indicated included a review of changes in Medicare provisions executed in the ASC PPS. The Affordable Care Act of 2010 calls for the implementation of a productivity adjustment for all healthcare settings. The productivity adjustment is activated in various years for the different healthcare settings. This adjustment begins for the ASC setting in 2011. Therefore, CMS is adopting a -1.3%

productivity adjustment for the 2011 ASC PPS. The productivity adjustment will significantly decrease the annual increase for the ASC PPS. The ASC PPS utilizes the consumer price index for all urban consumers (CPI-U) to account for inflation. The estimated CPI-U for 2011 is 1.5%. Therefore, with the productivity adjustment executed, the annual increase for ASCs will be 0.2%.

The productivity adjustment is the method that Medicare is using to account for economy-wide productivity increases. The measure of productivity improvement that Medicare is using is the 10-year moving average of all-factory productivity, included in the Medical economic index (MEI). This cost saving measure, along with the market basket reductions, is estimated to reduce Medicare spending significantly over the next 10 years.

When considering the adoption of the productivity adjustment provision, BWC sought out information about the impact that such a significant payment adjustment would have on our provider network. In an April 22, 2010 report, "Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended," the CMS Office of the Actuary (OACT) discusses that even though the productivity adjustment is a strong incentive for facilities to improve efficiency, it is doubtful that many facilities will be able to improve their productivity to the level achieved by the economy at large. Further, the report suggests that projected long-term saving from the productivity adjustments may be unrealistic. OACT estimates that approximately 15% of Part A providers could become unprofitable within the 10-year projection period as a result of productivity adjustments, and may therefore opt to end their participation in Medicare.

Therefore, BWC is proposing to modify the ASC payment formula to include a 2011 BWC adjustment which will adjust Medicare rates by 1.3% to negate the productivity adjustment.

Therefore, Medical Services is recommending the following:

1. BWC adopt the rates published under the 2011 ASC PPS Ambulatory Payment Classification;
2. That 110% of ASC PPS 2011 transitional rate be adopted for designated pain management services; and
3. That 100% of the ASC PPS 2011 transitional rate be adopted for services other than designated pain management services.
4. That BWC adopt the 2011 BWC adjustment of 1.3% to counteract the Medicare productivity adjustment for 2011.

Projected Impacts and Outcomes

This recommendation will result in an estimated increase payment of \$677,000 dollars or 10% from the 2010 ASC reimbursements. The recommendation will also ensure that BWC maintain a competitive fee schedule with appropriate benefits and quality services being provided Ohio injured workers in a lower cost setting.

Ohio BWC

2011 Ambulatory Surgical Center Fee Schedule Proposal

Medical Services Division

Freddie Johnson, Director, Managed Care Services

Anne Casto, Casto Consulting

November 19, 2010

Introduction and Guiding Principles

- Legal Requirements For Fee Schedule Rule
- Proposed Time-line for Implementation
 - Stakeholder Feedback - November
 - Board Presentation - November/December
 - Proposed to JCARR - January
 - Effective Date – April 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

Medicare Ambulatory Surgical Center Prospective Payment System (ASC PPS) Update

- This is the final year of the transition period for the revised ASC PPS
- ASCs rates are based on the full Outpatient Prospective Payment System rate
 - Result is an increase in orthopedic rates (12%)
 - Result is a small decrease in pain management rates (-2%)

CMS ASC PPS Transition Schedule

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

Medicare ASC PPS Update – Affordable Care Act

- ASCs use the Consumer Price Index (CPI-U) to account for inflation
 - Similar to market basket
 - 2011 the CPI-U for ASCs is 1.5%
- Productivity Adjustment begins in the ASC setting
 - Budget neutrality
 - Productivity adjustment is -1.3%
- Separate BWC adjustment factor will be utilized to address the impact of the negative adjustment

Calculating ASC Fees

2010: ASC rate is a listed dollar amount and is calculated per the formula below:

$$\text{ASC PPS Rate} * \text{Adjustment Factor} = \text{BWC Rate}$$

2011: Modify the formula to account for the budget neutrality adjustment

$$\text{ASC PPS rate} * \text{BWC adjustment} * \text{payment adjustment factor} = \text{BWC rate}$$

Analysis of the 2011 ASC PPS

Service Area	Reimbursement Rate Impact			
	MCR Percent Change 2010-2011	MCR Percent Change 2010-2011 + 1.3%	BWC 2011 Proposed Payment Adjustment Factors	BWC Percent Change 2010-2011
All Services*	5%	7%		7%
Orthopedics	11%	12%	100% MCR	12%
Pain Management	-2%	0%	110% MCR	0%
Other Services	6%	8%	100% MCR	8%

*from BWC 2009 experience

Recommendation

- Adopt the calendar year 2011 ASC PPS rates as published in the CMS final rule
 - Rates are published in Addendum AA and BB
- Apply a BWC adjustment of 1.3%
- Maintain current payment adjustment factors
 - 110% designated pain management procedures
 - 100% all other allowed procedures

Estimated Impact of Recommendations

- Estimated overall reimbursement increase estimated at 10%
 - 6.5 million to 7.1 million in total payments
 - Estimated dollar impact is \$677,000
- Maintains access to quality care of service to injured workers in a low cost setting

Thank You

Appendix

2009 ASC Experience

Charge Type	Allowed Charges	Reimbursement	Percent of Reimbursement to Allowed Billed Charges
Separately Payable	\$31,640,657	\$5,523,739	17%
Bundled	\$1,909,439	\$0.00	0%
Total	\$33,550,096	\$5,523,739	16%

Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-37.2

Rule Review

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

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

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

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

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

4. The rule is effective, consistent and efficient.

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

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

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

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

Explain: The BWC Medical Services Division presented the proposed hospital outpatient services rule changes to the Ohio Hospital Association on November 12, 2010, and also posted the proposed rule changes to the BWC website on November 16, 2010, with a 2 week comment period ending November 30, 2010.

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

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

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

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

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

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

BWC Board of Directors
Executive Summary
BWC Hospital Outpatient 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 4123-6-37.2 provides specific methodology for the payment of hospital outpatient services. It was initially adopted effective September 1, 2007. Amendments to the rule adapting the Medicare Outpatient Prospective Payment System to BWC were approved earlier this year and are scheduled to take effect January 1, 2011.

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 . . . out-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 outpatient services via the O.R.C. Chapter 119 rulemaking process.

BWC's hospital outpatient services reimbursement methodology is based on Medicare's Outpatient Prospective Payment System (OPPS), which is updated annually. Therefore, BWC must also annually update OAC 4123-6-37.2 to keep in sync with Medicare.

Proposed Changes

As more fully set forth in the accompanying document “BWC 2011 Proposed Hospital Outpatient Fee Summary,” for hospital outpatient services with a date of service on or after April 1, 2011, BWC is recommending the following changes to OAC 4123-6-37.2:

1. Adoption of the 2011 hospital outpatient rates as published in the Medicare OPPS final rule.
2. Adoption of 2011 BWC payment adjustment factors to negate payment reductions executed under the Affordable Care Act of 2010.

BWC Hospital Outpatient Services
Payment Rule
November 2011

3. Apply 253% payment adjustment factor to OPSS rates for Children's Hospitals.
4. Apply 197% payment adjustment factor to OPSS rate for all other facilities.

Stakeholder Involvement

The BWC Medical Services Division presented the proposed hospital outpatient services rule changes to the Ohio Hospital Association on November 12, 2010.

The proposed hospital outpatient services rule changes were also posted on the BWC website on November 16, 2010, with a 2 week comment period ending November 26, 2010. Stakeholder responses received to date by BWC are summarized on the Stakeholder Feedback Summary Spreadsheet.

4123-6-37.2 Payment of hospital outpatient 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 outpatient services with a date of service of ~~January 1, 2011~~ April 1, 2011 or after shall be as follows:

(1) Except as otherwise provided in this rule, reimbursement for hospital outpatient services shall be equal to the applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system as of ~~the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~ January 1, 2011, multiplied by a bureau-specific payment adjustment factor, which shall be 2.53 for children's hospitals and 1.97 for all hospitals other than children's hospitals, with the following additional adjustments for specific services:

For services reimbursed under a medicare ambulatory payment classification, excluding drugs, biological, devices reimbursed via pass-through, and reasonable cost items, the applicable medicare rate specified above shall be further multiplied by a 2011 bureau adjustment factor of 1.0025;

For services reimbursed under the medicare clinical lab fee schedule, the applicable medicare rate specified above shall be further multiplied by a 2011 bureau adjustment factor of 1.0175;

For services reimbursed under the medicare physician fee schedule, the applicable medicare rate specified above shall be further multiplied by a 2011 bureau adjustment factor of 1.3078.

(a) The medicare integrated outpatient code editor and medicare medically unlikely edits in effect as of ~~the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~ January 1, 2011 shall be utilized to process bills for hospital outpatient services under this rule; however, the outpatient code edits identified in table 1 of appendix A of this rule shall not be applied.

(b) The annual medicare outpatient prospective payment system outlier reconciliation process shall not be applied to payments for hospital outpatient services under this rule.

(c) For purposes of this rule, hospitals shall be identified as ~~"children's hospitals,"~~ "critical access hospitals," "rural sole community hospitals," "essential access community hospitals" and "exempt cancer hospitals" based on the hospitals' designation in the medicare outpatient provider specific file in effect as of ~~the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~ January 1, 2011.

(d) For purposes of this rule, the following hospitals shall be recognized as "children's hospitals": nationwide children's hospital (Columbus, Ohio), Cincinnati children's hospital medical center, children's hospital medical center of Akron, and children's medical center of Dayton.

(2) Services reimbursed via fee schedule. These services shall not be wage index adjusted.

(a) Services reimbursed via fee schedule to which the bureau-specific payment adjustment factor shall be applied.

(i) Except as otherwise provided in paragraphs (A)(2)(b)(ii) and (A)(2)(b)(iii) of this rule, hospital outpatient services reimbursed via fee schedule under the medicare outpatient prospective payment system shall be reimbursed under the applicable medicare fee schedule in effect as of ~~the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~ January 1, 2011.

(b) Services reimbursed via fee schedule to which the bureau-specific payment adjustment factor shall not be applied.

(i) Hospital outpatient vocational rehabilitation services for which the bureau has established a fee, which shall be reimbursed in accordance with table 2 of appendix A of this rule.

(ii) Hospital outpatient services reimbursed via fee schedule under the medicare outpatient prospective payment system that the bureau has determined shall be reimbursed at a rate other than the applicable medicare fee schedule in effect as of ~~the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~ January 1, 2011, which shall be reimbursed in accordance with table 3 of appendix A of this rule

(iii) Hospital outpatient services not reimbursed under the medicare outpatient prospective payment system that the bureau has determined are necessary for treatment of injured workers, which shall be reimbursed in accordance with tables 4 and 5 of appendix A of this rule.

(3) Services reimbursed at reasonable cost. To calculate reasonable cost, the line item charge shall be multiplied by the hospital's outpatient cost to charge ratio from the medicare outpatient provider specific file in effect as of ~~the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~ January 1, 2011. These services shall not be wage index adjusted.

(a) Services reimbursed at reasonable cost to which the bureau-specific payment adjustment factor shall be applied.

(i) Critical access hospitals shall be reimbursed at one hundred and one per cent of reasonable cost for all payable line items.

(b) Services reimbursed at reasonable cost to which the bureau-specific payment adjustment factor shall not be applied.

(i) Services designated as "inpatient only" under the medicare outpatient prospective payment system.

(ii) Hospital outpatient services reimbursed at reasonable cost as identified in tables 3 and 4 of appendix A of this rule.

(4) Add-on payments calculated using the applicable medicare outpatient prospective payment system methodology and formula in effect as of ~~the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~ January 1, 2011. These add-on payments shall be calculated prior to application of the bureau-specific payment adjustment factor.

(a) Outlier add-on payment. An outlier add-on payment shall be provided on a line item basis for partial hospitalization services and for ambulatory payment classification (APC) reimbursed services for all hospitals other than critical access hospitals.

(b) Rural hospital add-on payment. A rural hospital add-on payment shall be provided on a line item basis for rural sole community hospitals, including essential access community hospitals; however, drugs, biological, devices reimbursed via pass-through and reasonable cost items shall be excluded. The rural add-on payment shall be calculated prior to the outlier add-on payment calculation.

(c) Hold harmless add-on payment. A hold harmless add-on payment shall be provided on a line item basis to exempt cancer centers and children's hospitals. The hold harmless add-on payment shall be calculated after the outlier add-on payment calculation.

(5) Providers without a medicare provider number.

(a) Providers without a medicare provider number shall be reimbursed for hospital outpatient services at forty-seven per cent of billed charges for all payable line items.

(6) For purposes of this rule, the "applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system " and the "medicare outpatient prospective payment system " 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, as implemented by the following materials, which are incorporated by reference:

(a) 42 C.F.R. Part 419 as published in the ~~October 1, 2009~~ October 1, 2010 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' ~~"42 CFR Parts 410, 416, and 419 Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Final Rule"~~ 74 Fed. Reg. 60315-61012 (2009) ~~"42 CFR Parts 410, 411, 412, 413, 416, 419, and 489 Medicare Program: Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Payments to Hospitals for Graduate Medical Education Costs; Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations; Payment for Certified Registered Nurse Anesthetist Services Furnished in Rural Hospitals and Critical Access Hospitals; Final Rule,"~~ 75 Fed. Reg. - (2010).

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

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

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

(2)(a) For Ohio hospitals that annually report a total outpatient cost-to-charge ratio to Ohio medicaid, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio as set forth below plus sixteen percentage points, not to exceed sixty percent of the hospital's allowed billed charges.

To assist QHPs and self-insuring employers in determining reimbursement under this paragraph, the bureau shall make available to QHPs and self-insuring employer the hospital's most recently reported cost-to-charge ratio not later than thirty days following the bureau's receipt of the hospital's most recently reported cost-to-charge ratio from Ohio medicaid.

(b) For Ohio hospitals that do not annually report a total outpatient cost-to-charge ratio to Ohio medicaid and out-of-state hospitals, reimbursement shall be equal to fifty-six percent 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: 04/01/2011

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: 9/1/07, 1/1/11

**Ohio Bureau of Workers' Compensation
2011 Hospital Outpatient Services
Appendix A**

The five character codes included in the Ohio Bureau of Workers' Compensation (BWC) 2011 Hospital Outpatient Services Fee Schedule (Table 3 of this Appendix A) are obtained from Current Procedural Terminology (CPT®), copyright 2010 by the American Medical Association (AMA) and from the Health Care Procedure Coding System (HCPCS) National Level II Medicare codes.

CPT® is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians.

HCPCS are released by the Center for Medicare and Medicaid Services (CMS) as a listing of five character codes and descriptive terminology used for reporting supplies, materials and services by health care providers.

The responsibility for the content of the BWC 2011 Hospital Outpatient Services Fee Schedule (Table 3 of this Appendix A) is with the State of Ohio Bureau of Workers' Compensation and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the BWC 2011 Hospital Outpatient Services Fee Schedule (Table 3 of this Appendix A). No fee schedules, basic unit values, relative value guides, conversion factors or scales are included in any part of CPT®. Any use of CPT® outside of the BWC 2011 Hospital Outpatient Services Fee Schedule (Table 3 of this Appendix A) should refer to the most current *Current Procedural Terminology* which contains the complete and most current listing of CPT® codes and descriptive terms. Applicable FARS/DFARS apply.

For the purposes of the BWC 2011 Hospital Outpatient Services Fee Schedule (Table 3 of this Appendix A), services and/or supplies must be medically necessary for the treatment of the work related injury. The following definitions apply:

By Report (BR)

The procedure or service is not typically covered and will not routinely be reimbursed. Many of the -BR codes are unclassified/unspecified generic codes and are currently assigned a dollar amount of \$0.00. A report is required to be obtained by the MCO for reimbursement consideration. Authorization and payment of codes identified as -BR require an individual analysis by the MCO prior to submission. The MCO analysis shall include researching the appropriateness of the code in relation to the service or procedure and cost comparisons in order for the MCO to approve high quality, cost-effective medical care. Research information from the MCO is required to be submitted to the BWC Medical Policy with each request. After review by the MCO, the report must be imaged into the BWC claim and a request must be submitted, utilizing the sensitive data transmission policy, to the BWC Medical Policy email box Medpol@bwc.state.oh.us for an adjustment to be processed. MCOs should note that most CPT® codes have an assigned Relative Value Unit which must be utilized to determine reimbursement. Fees for CPT® codes that do not have an established RVU must be compared to a like service to assist in determining appropriate fees. HCPCS codes are priced through multiple cost comparisons.

Reasonable Cost (RC)

To calculate reasonable cost, the line item charge shall be multiplied by the hospital's outpatient cost to charge ratio from the medicare outpatient provider specific file in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered. These services shall not be wage index adjusted.

Not Routinely Covered (NRC)

The procedure or service is not covered unless application of the *Miller* criteria requires an exception. See: OAC 4123-6-16.2(B)(1) through (B)(3). Where coverage is required, the pricing is listed on the fee schedule.

BWC 2011 Proposed Hospital Outpatient Fees

Medical Services 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.

Hospital Outpatient Fee Schedule

As stated, implementing a sound and effective provider fee schedule is a critical component of the Medical Services Division's goals. An appropriate outpatient 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. Hospital outpatient bills represent about seven percent of the bills BWC processes annually; and about seventeen percent of BWC's overall medical expenses. Hospital outpatient services include emergency department visits which may be the first treatment following an injury; as well as surgery or rehabilitation services intended to return the injured worker to employment. BWC hospital outpatient fee schedule rule was last updated in April 2010 for a fee schedule effective date of January 1, 2011.

BWC will implement a prospective payment methodology for hospital outpatient services beginning January 1, 2011. The prospective methodology is different from the current retrospective methodology in that, reimbursement rates and policies for providers are established in advance and remain constant during the effective period. A key benefit of the prospective methodology is that all facilities experience consistent and equitable reimbursement for services rendered during the effective period. The current retrospective methodology could result in payments for one facility which was double or even triple that of another facility for the same medical service.

Additionally, under the prospective payment methodology being adopted, Medicare's Outpatient Prospective Payment System (OPPS), a wage index adjustment is built into the reimbursement rate. This allows facilities located in a geographical area with a greater wage level to receive a slightly higher reimbursement rate to account for the wage level differences from the national average wage. Utilizing the wage index adjustment ensures that a provider in a geographical area with higher wage levels is not penalized for costs which are out of the facility's arm of control. Geographical areas are derived from the Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget in December 2003. Wage index values are updated yearly as required by the Social Security Act.

Under the prospective methodology, BWC will know prior to a service being rendered the reimbursement amount for that service. Such information will allow BWC to be more effective in estimating hospital outpatient expenditures from year to year. BWC will be able to determine rate increases or decreases at various levels, even down to the procedure code level, from one effective period to another. Further, with the aid of historic data from the BWC data warehouse, we will be able to examine the utilization rate of classifications of services such as emergency department visits, clinic visits, x-rays and MRIs.

Lastly, under the prospective payment system, providers are encouraged to practice cost containment. Rates are established in advance, which provides facilities the data they can use to determine the best mix of their resources to achieve established budget goals without foregoing the provision of quality services.

2011 Proposed Hospital Outpatient Fee Schedule Recommendation

Medical Services Division is recommended the following changes to the currently approved 2010 Hospital Outpatient Fee Schedule:

1. Adoption of the hospital outpatient rates as published in the Medicare OPPS final rule.
2. Adoption of three 2011 BWC payment adjustment factors to negate payment reductions executed under the Affordable Care Act of 2010
3. Maintain the current payment adjustment factors to go into effect on January 1, 2011:
 - a. 253% payment adjustment factor to OPPS rates for Children's Hospitals
 - b. 197% payment adjustment factor to OPPS rate for all other facilities

1. Adoption of the 2011 Medicare OPPS Rates

The adoption of the prospective payment methodology in May of 2010 for implementation on January 1, 2011 requires annual updates to the most current Medicare OPPS rates. Rates, wage index values, and other adjustments are reviewed and updated each year by Medicare with the most current bill data available. By adopting the yearly Medicare updates, BWC is ensuring the baseline payment rates are in alignment with national utilization benchmarks, and are an

appropriate foundation from which to start and make adjustments in the development of an Ohio fee schedule that ensures injured workers access to quality care. It should be noted that BWC does not necessarily adopt all of Medicare's updates, but rather performs an extensive evaluation of the various changes Medicare makes to its baseline data to determine if those changes reflect and/or support the philosophy and goals of BWC and the Ohio workers' compensation system. If it is determined that a change Medicare is not in line with the philosophy and/or goal of BWC and the Ohio workers' compensation system, the change is either not adopted or a BWC adjustment factor is added to the reimbursement methodology to redress the change.

In performing the analysis of Medicare's 2011 changes to OPSS, Medicare has implemented a change which will impact hospital outpatient therapy services. Medicare proposed and adopted a multiple procedure payment reduction component for therapy services. While the roots of the change lie in the Medicare Physician Fee Schedule (MPFS) rule, the impact is also experienced by the hospital outpatient facility sector. Physical, occupational and speech language pathology therapy services when performed in a hospital outpatient setting are reimbursed at the MPFS rates. Thus, application of the MPFS rates to those services when performed in the hospital outpatient setting results in the application of the multiple procedure payment reduction component.

Based on the July 2009 Government Accounting Office (GAO) report entitled, *"Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved when Services are Provided Together,"* Medicare studied bill data to determine if there is a duplication of payment when multiple therapy services are provided on the same date of service. Their research efforts since July 2009 show that an adjustment is warranted to account for duplicate inputs to the practice expense component of the RVU. Medicare reported that activities such as cleaning the treatment room and equipment, providing education, instruction, counseling and coordinating home care, greeting patient, and obtaining measurements such as range of motion and strength are duplicate labor activities that are currently included in the practice expense for each therapy service. When multiple therapy services are provided during the same session these activities are not duplicated by staff. Therefore, Medicare will reduce the practice expense component payment amount by 25 percent to account for the reduction in activities when multiple units or services of designated therapy services are performed on the same date of service.

Medical Services is in agreement with Medicare's research and the application of the multiple therapy services adjustment in the hospital outpatient setting. The estimated payment reduction as published in the MPFS final rule is a 7% reduction for applicable therapy services rendered in the hospital outpatient setting.

Medical Services is recommending adoption of the Medicare 2011 OPPS rates as published in its final rule.

2. Proposed Adoption of BWC 2011 Adjustment Factors

The Affordable Care Act of 2010 (ACA) brought about numerous modifications to the Medicare prospective payment systems for all healthcare settings. The ACA requires that a market basket adjustment be applied to Medicare participating hospitals for federal fiscal years 2010 through 2019. The 2011 adjustment of -0.25 percent was adopted in the OPPS final rule and is applied to Ambulatory Payment Classification (APC) based services. Since this is purely a cost saving measure for the Medicare program, the BWC is proposing to not adopt this adjustment. A 2011 BWC adjustment of 0.25 percent will be applied to applicable APC services.

In addition to the market basket adjustment, the ACA call for a productivity adjustment to be applied all healthcare settings for which it is not currently utilized. The productivity adjustment is activated in various years for the different healthcare settings. This adjustment begins for the Medicare Clinical Lab Fee Schedule (CLFS) in 2011. Therefore, CMS is adopting a -1.75% productivity adjustment for the 2011 CLFS. Since the OPPS utilizes the CLFS for numerous laboratory services the reduction to payment rates must be addressed in this rule. Since this is purely a cost saving measure for the Medicare program, the BWC is proposing to not adopt this adjustment. A 2011 BWC adjustment of 1.75 percent will be applied to applicable laboratory services.

The productivity adjustment has been attempted to be executed in the Medicare Physician Fee Schedule (MPFS) for numerous years. However, each year act(s) of Congress have negated the adjustment and returned the MPFS conversion factor to the amount established by yearly data analysis. Under the OPPS, therapy services (physical, occupational, and speech language pathology) are reimbursed under the MPFS rates. In the MPFS Final Rule, released on display November 2, 2010, the conversion factor is reported at \$25.5217 down 30.78 percent from the 2010 conversion factor of \$36.8729. Since this is purely a cost saving measure for the Medicare program, BWC is proposing to not adopt the conversion factor of \$25.5217, but instead to adjust MPFS payments utilized by the OPPS therapy services by 30.78% to restore the payment rates.

3. Maintain January 1, 2011 scheduled payment adjustment factors

As indicated above, in April 2010, the Board approved the new hospital outpatient prospective payment system. As part of that approval, the Board approved the recommended payment adjustment factor of 253% of the Medicare rate for Children's Hospitals and a payment adjustment factor of 197% for all other hospital facilities. Additionally, the Medical Services Division provided a thirty-nine month transition schedule for the adoption of the new prospective payment system, which included an intent to maintain the January 2011, payment adjustment factors for fifteen 15 months.

The analysis performed on the Medicare updates to its 2011 OPPS rates indicated that adoption of the new Medicare changes with the adjustments recommended above would provide an appropriate fee schedule with the application of the adopted January 2011 payment adjustment factors. Therefore, Medical Services recommends that the payment adjustment factors slated for January 1, 2011, be maintained for the Ohio hospital outpatient April 1, 2011 fee schedule updates.

Projected Impacts and Outcomes

The hospital reimbursement methodology adopted in April 2010 reflected a full implementation impact of decreased overall hospital outpatient services reimbursements by 22% or approximately \$30 million. The recommended three year and one quarter transition plan for full implementation was estimated to distribute the reduction equitably over the entire transition period. The projected impact for the second period of the transition period (April 1, 2011 through March 31, 2012) reflected a decrease of 7.2%.

The proposed recommendations for the April 2011 update would have a change in the projected forecasted reduction of payment expected during the BWC transition period. The multiple procedure payment reduction provision for therapy services reimbursed under the Medicare physician fee schedule will result in an estimated reduction of 7 percent for therapy services during the 2011 rate year. Thus, this change would result in an additional 0.8% reduction to the initial projected decrease of 7.2% resulting in a projected decrease of 8.0%.

The recommended changes will allow BWC to update to the most current Medicare underlying empirical research and base hospital reimbursements. Further, the recommended changes will continue to facilitate BWC's effective implementation of the newly adopted hospital outpatient prospective payment system. Finally, the recommended changes continue to support BWC's philosophy of maintaining an effective fee schedule which supports Ohio's injured workers' access to quality care.

Ohio BWC

2011 Hospital Outpatient Fee Methodology Proposal

Medical Services Division

Freddie Johnson, Director, Managed Care Services

Anne Casto, Casto Consulting

November 19, 2010

Introduction and Guiding Principles

- Legal Requirements For Fee Schedule Rule
- Proposed Time-line for Implementation
 - Stakeholder Feedback - August 2010 –
 - Board Presentation – November/December
 - Proposed to JCARR - pending
 - Effective Date – April 1, 2011
- Guiding Principle:

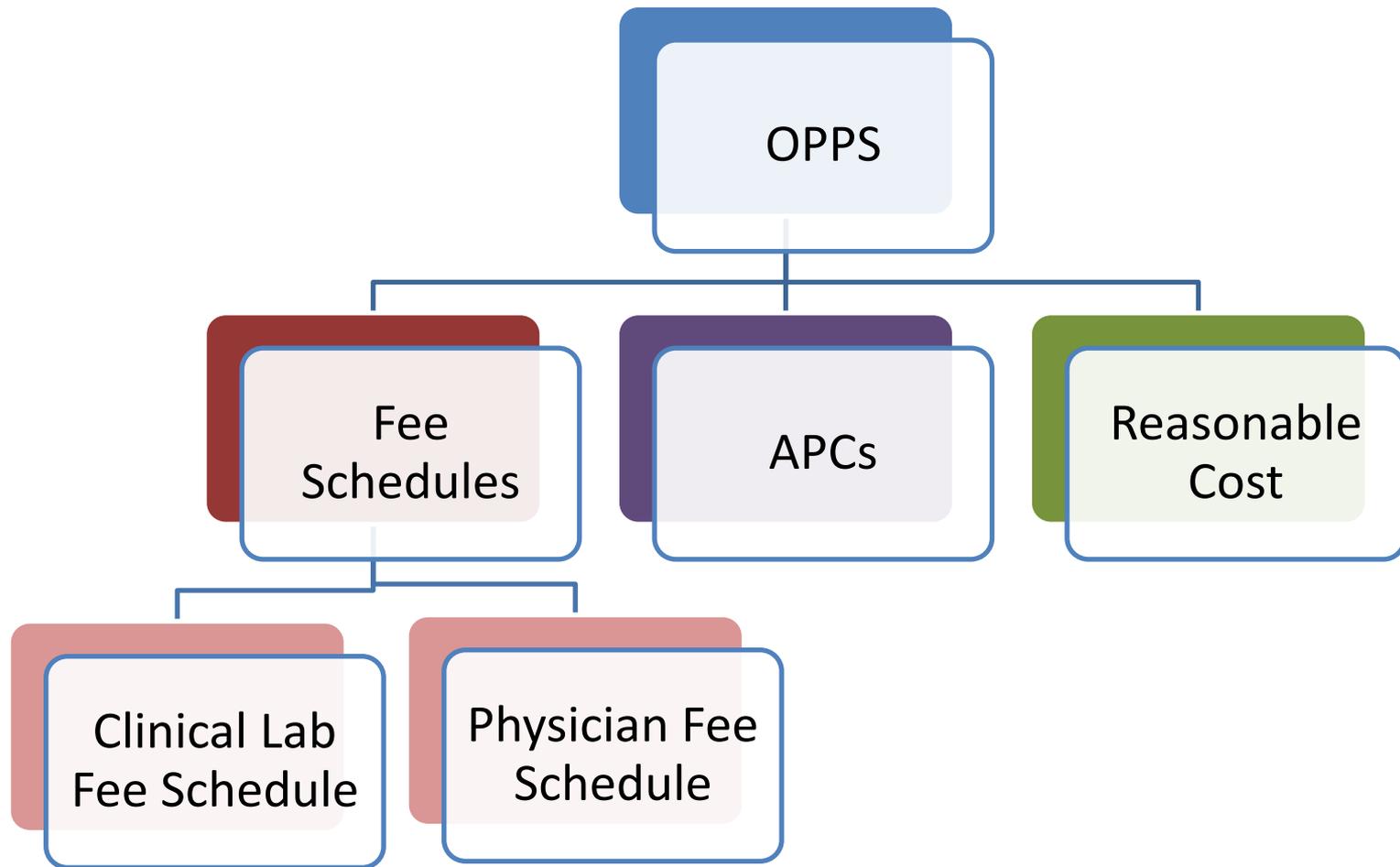
Ensure access to high-quality medical care and vocational rehabilitation services by establishing an appropriate Benefit plan and Terms of service with competitive fee schedule which, in turn, enhances medical/vocational provider network

OPPS Transition Schedule

Revised Proposal: Three Year Transition Plan for Hospital Outpatient Services		
Time Period	PAF	Percent of BWC Cost
May 2010-December 2010	212%	146%
January 2011-March 2011	197% 253%	135%
April 2011-March 2012	197% 253%	135%
April 2012-March 2013	181% 253%	124%
April 2013-March 2014	166% 253%	114%

Phase
In Plan

Outpatient Prospective Payment System



Medicare Update for 2011

- The Medicare Physician Fee Schedule has adopted a multiple procedure reduction methodology for therapy services
 - Utilized in Outpatient Prospective Payment System (OPPS)
 - Applies to reimbursement of physical therapy and occupational therapy services
 - Duplicate practice expense inputs for therapy services that should be accounted for when multiple services are furnished in one session
 - Average number of services/units per session is four
 - Estimated overall decrease for therapy services is 7%

Multiple Procedure Payment Reduction Example: Physical Therapy Visit

- 97112 – Therapeutic procedure;
 - neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing
 - 15 minutes – 1 unit of service

- 97110 – Therapeutic procedure;
 - therapeutic exercises to develop strength and endurance, range of motion and flexibility
 - 15 minutes – 1 unit of service

Example of Practice Expense Reduction

Staff Description	Labor Task Description	Code A 97112 labor task time	Code B 97110 labor task time	Total minute reduction
PT Aide	Clean room/equipment	1 min	1 min	1 min
PT Assistant	Education/instruction/counseling/coor dinating home care	2.5 min	2.5 min	2.5 min
PT Aide	Greet patient/provide gowning	1.5 min	1.5 min	1.5 min
PT Assistant	Obtain measurements, e.g. ROM/strength/edema	1.5 min	1.5 min	1.5 min
PT Assistant	Obtain vital signs	1 min	1 min	1 min
PT Assistant	Phone calls between visits with patient, family	1 min	1 min	1 min
PT Aide	Post treatment patient assistance	1 min	1 min	1 min
PT Assistant	Review/read documentation, plan of care, treatment goals	1.5 min	1.5 min	1.5 min
PT Aide	Verify/coordinate availability of resources/equipment	1.5 min	1.5 min	1.5 min

* Taken from Table 19: Examples of Duplicate PE Inputs for Therapy Services That Should be Accounted for When Multiple Services Are Furnished in One Session; MPFS Final Rule; display copy, November 2, 2010; modified

Example of Supply Reduction

Supply Description	Code A 97112 quantity	Code B 97110 quantity	Code B 97110 quantity reduction
Pack, minimum multi-specialty visit	0.5	0.5	0
Thera-bands (6 in width)	1.5	1.5	1.5

* Taken from Table 19: Examples of Duplicate PE Inputs for Therapy Services That Should be Accounted for When Multiple Services Are Furnished in One Session; MPFS Final Rule; display copy, November 2, 2010; modified

Sample Proposed Payment Calculation

	Proc. 1	Proc. 2	Current total payment	Proposed 2011 total payment	Proposed Payment Calculation
Work	\$7.00	\$11.00	\$18.00	\$18.00	No reduction
Practice Expense	\$10.00	\$8.00	\$18.00	\$16.00	$\$10 + (0.75 \times \$8)$.
Malpractice	\$1.00	\$1.00	\$2.00	\$2.00	No reduction
Total	\$18.00	\$20.00	\$38.00	\$36.00	$\$18 + \$11 + (0.75 \times \$8) + \1

\$8.00 is reduced by 25% = \$6.00

* Taken from Table 20: Sample Proposed Payment Calculation for Multiple Therapy Services Furnished to a Single patient on the Same Day; MPFS Final Rule, Display copy; November 2, 2010; modified

Sample Proposed Payment Calculation - Multiple Units

	Proc. 1 Unit 1 (1 st 15 min)	Proc. 1 Unit 2 (2 nd 15 min)	Proc. 2	Current total payment	Proposed 2011 total payment	Proposed Payment Calculation
Work	\$7.00	\$7.00	\$11.00	\$25.00	\$25.00	No reduction
Practice Expense	\$10.00	\$10.00	\$8.00	\$28.00	\$23.50	\$10 + (0.75 x \$10) + (0.75 x \$8).
Malpractice	\$1.00	\$1.00	\$1.00	\$3.00	\$3.00	No reduction
Total	\$18.00	\$18.00	\$20.00	\$56.00	\$51.50	\$18 + \$7 + (0.75 x \$10) + \$1 + \$11 + (0.75 x \$8) + \$1

\$10.00 is reduced by 25% = \$7.50

\$8.00 is reduced by 25% = \$6.00

* Taken from Table 20: Sample Proposed Payment Calculation for Multiple Therapy Services Furnished to a Single patient on the Same Day; MPFS Final Rule, Display copy; November 2, 2010; modified

Medicare Updates

- BWC takes the calculated reimbursement values as the fee schedule foundation
- Calculated values reflect Affordable Care Act 2010 market basket adjustments
 - APC Services (-.25%)
 - Clinical Lab Services (-1.75%)
 - Physician Services (-30.75%)
- Budget neutrality adjustments
- Separate BWC adjustment factors will be utilized to address the impact of the negative adjustments

Calculating OPPS Fees

2010: OPPS rate is calculated per the formula below:

Medicare OPPS rate * payment adjustment factor = BWC rate

2011: Modify the formula to account for the budget neutrality adjustment

Medicare OPPS rate * **BWC adjustment** * payment adjustment factor = BWC rate

Please note that there are several specific payment formulas under the BWC modified OPPS. The above formula reflects the basic reimbursement formula.

Recommendation

- Adopt rates as published in 2011 OPPS final rule
- Apply the following separate 2011 BWC adjustment factor
 - 0.25% for services reimbursed under APCs
 - 1.75% for laboratory services reimbursed under the Medicare Clinical Lab Fee Schedule
 - 30.78% for services reimbursed under the Medicare Physician Fee Schedule
- Maintain the approved January 1, 2011 payment adjustment factors
 - 253% payment adjustment factor for Children's Hospitals
 - 197% payment adjustment factor for all other facilities

Estimated Impact of Recommendations

- Estimated overall reimbursement decrease estimated at 8.0%
 - Estimated dollar impact is (\$11,434,847)
- Further facilitate BWC's implementation of the adopt hospital outpatient methodology
- Further support the goal of maintaining an effective fee schedule which supports Ohio's injured workers' access to quality care

General Update on OPPS Implementation

- Systems Preparation
- Provider community education
- MCO Workgroup

Thank You

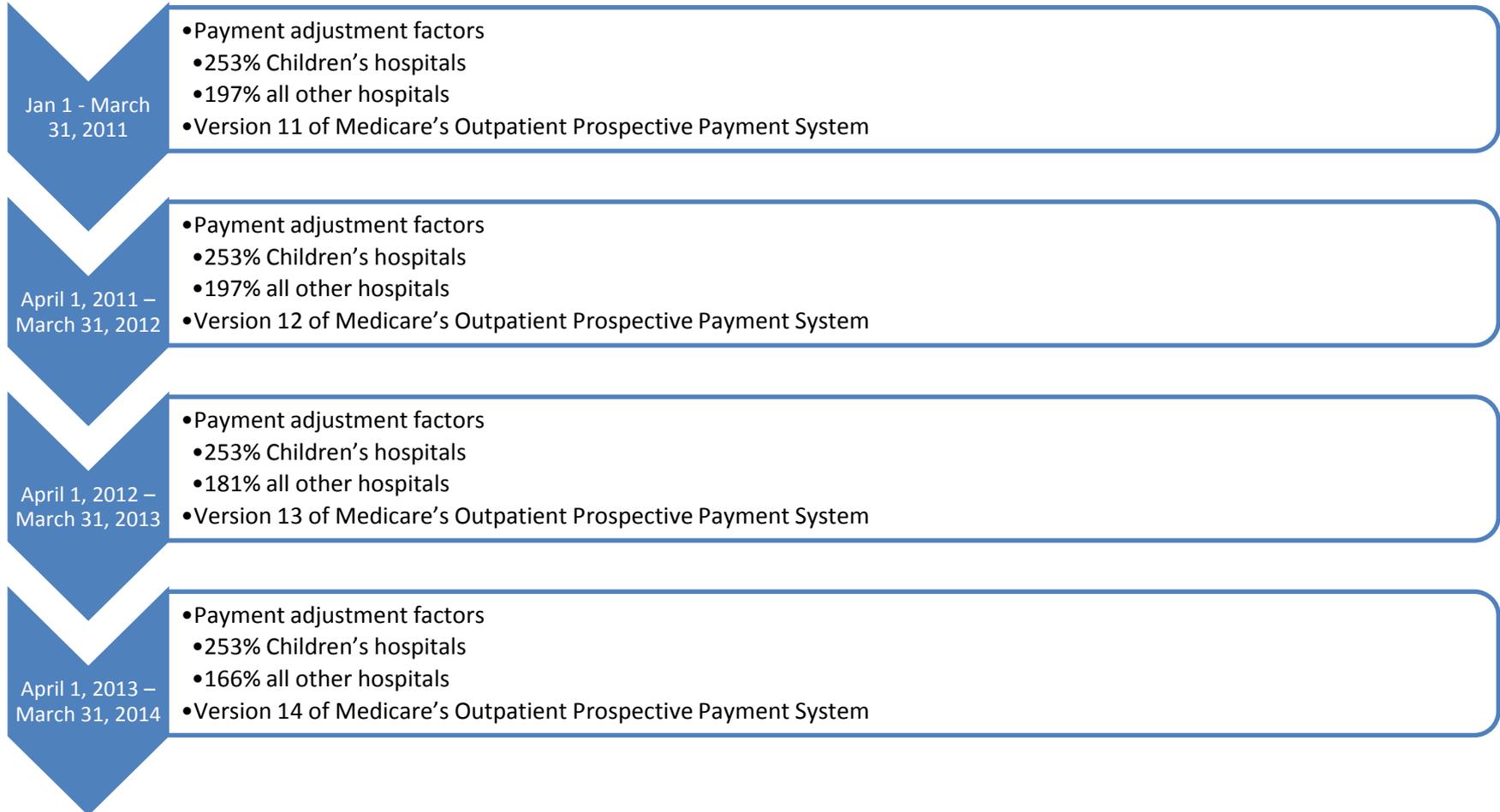
Appendix

OPPS Implementation Projected Impact

Revised Proposal: Three Year + One Quarter Transition Plan for Hospital Outpatient Services				
Time Period	PAF	Percent of BWC Cost	Estimated Impact each Year/from Base Year	Estimated % Impact each Year/from Base Year
Jan 2011 – March 2011	197% 253%	135%	\$2,558,711	-7.2%
April 2011 – March 2012	197% 253%	135%	\$11,434,847*	-8.0%*
April 2012 – March 2013	181% 253%	124%	\$10,621,261	-7.4%
April 2013 – March 2014	166% 253%	114%	\$9,957,431	-7.0%

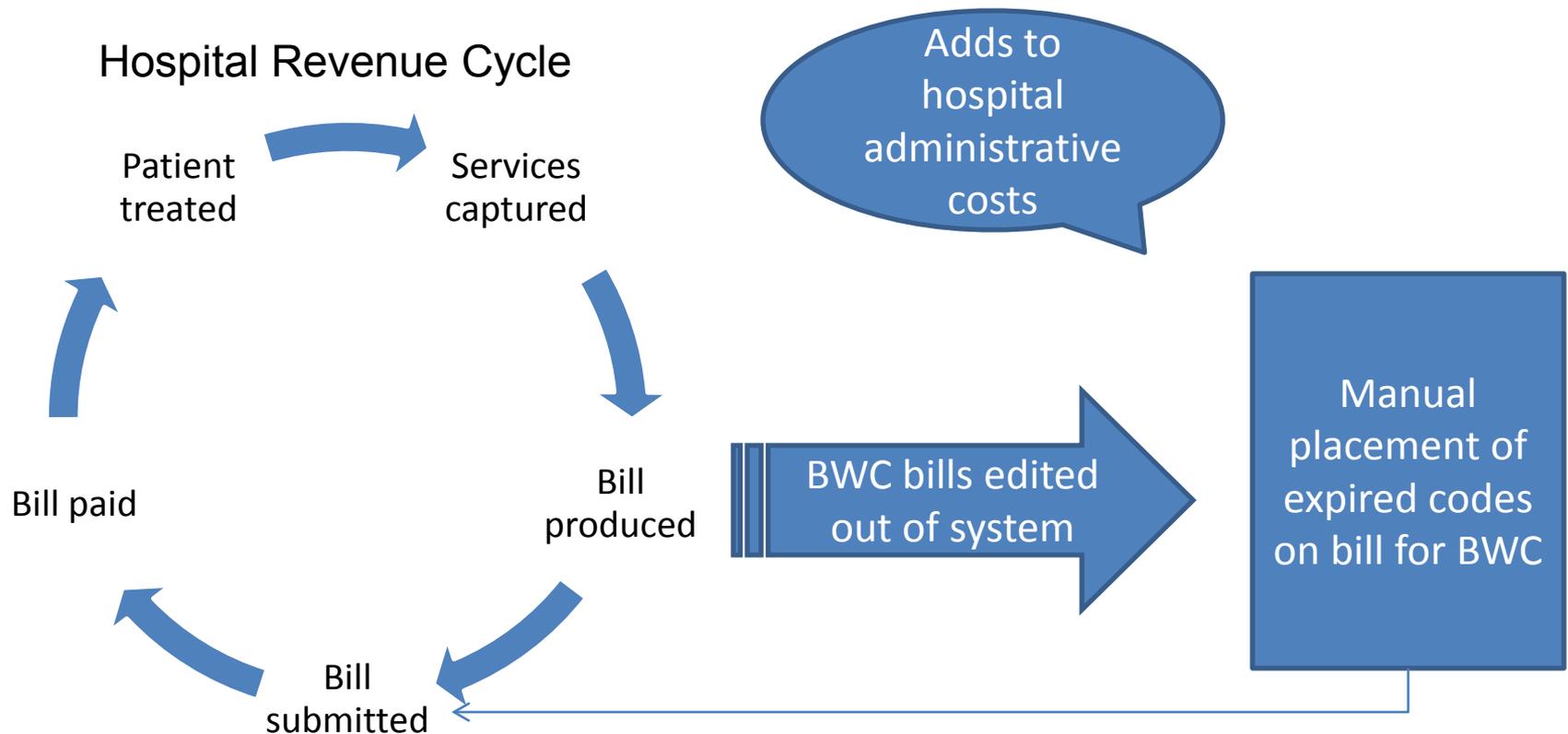
*Updated to reflect impact of the Multiple Procedure Payment Reduction provision for therapy services.

OPPS Version Update Schedule

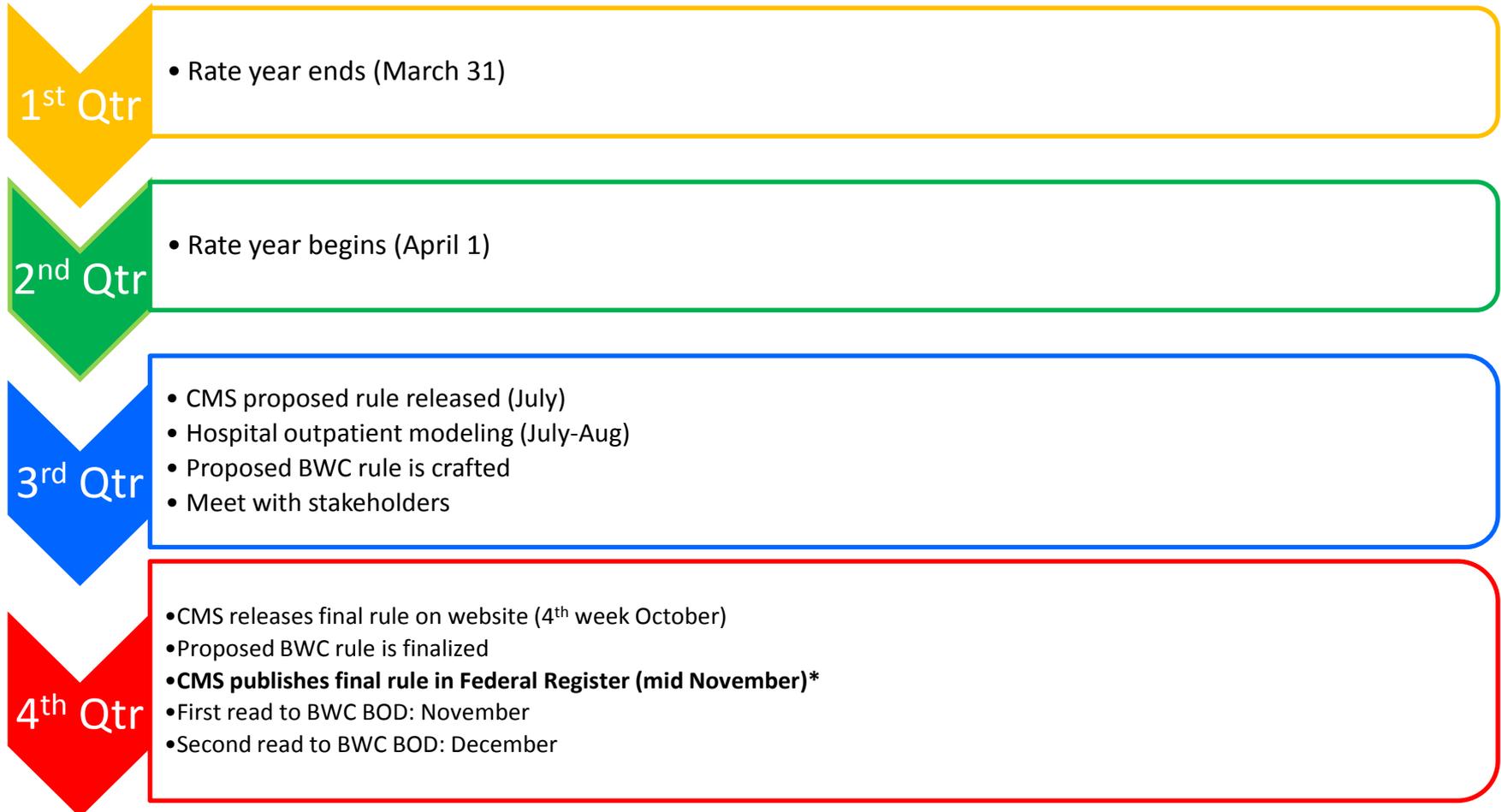


Why Adopt The Correct Version of OPPTS?

- Remain in alignment with national billing requirements
 - Stay up to date with designated code sets (CPT, HCPCS level II codes)



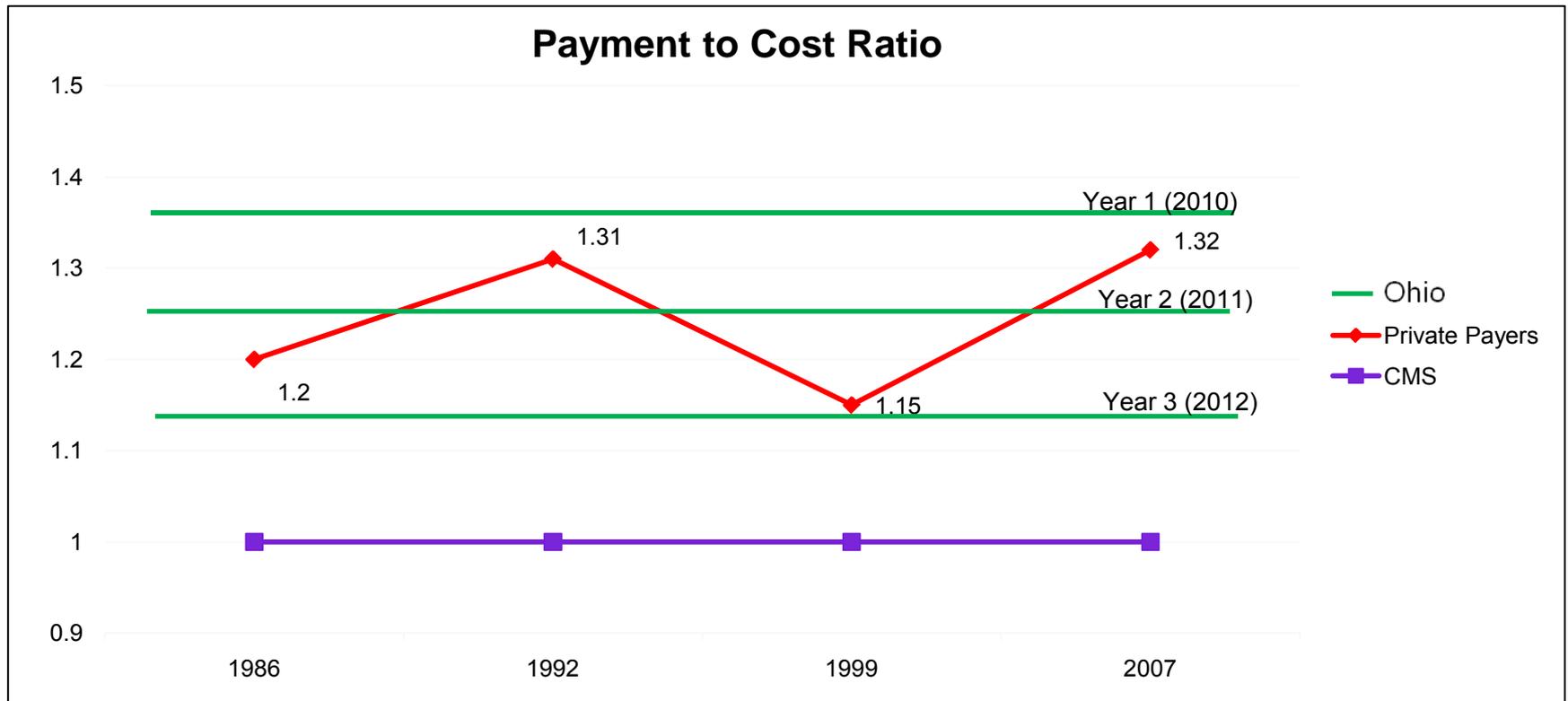
Hospital Outpatient Fee Schedule Cycle



* Key publication required for BWC rulemaking

BWC Proposed Rate Impact

Payment to Cost Ratio Adjusted Recommendation



Presentation to Medical/Safety Committee

I. **Medicare Reporting and Implementation of Causation Coding**

In September BWC started reporting claim data to Center for Medicare Services (CMS) for all injured workers who are Medicare recipients. Beginning in January 2011, BWC will begin quarterly reporting. In addition to the data set used in the initial reporting, BWC is also required to assign an International Classification of Diseases, Series 9, (ICD-9) series E (causation code) to all new claims and all claims already reported when their status changes.

Currently, BWC tracks Workers Compensation Insurance Organizations' causation codes (WCIO) only on Lost Time claims (non SI claims), but in preparation for the mandatory coding requirements for Medicare claims, BWC will switch to E codes on lost time and medical only claims, excluding SI.

An outside vendor has been secured to develop and present E code theory to BWC employees. Training for the support team in Columbus will take place on November 29th and on December 6th it will be provided statewide, via videoconference. After training is complete, V3 Coordinators and nurses will provide support to employees and filter questions back to project team.

Beginning in mid December all new claims will be assigned an E code at the time of determination. In addition BWC will begin assigning an E code to existing claims where the IW is also a Medicare recipient.

While causation coding is required by CMS and federal reporting laws, BWC will also be able to take advantage of causation data for accident prevention and research.

II. **Claims Severity Update**

Subgroup teams were created to develop strategies for each type of claim that falls within the Claim Complexity Level 4 category. The subgroup team updates are as follows:

Death Claims - A subgroup of the claims complexity workgroup presented recommendations to improve the management of death claims. The team recommended that all death claims statewide be centralized and handled by specially trained CSSs in the Columbus Service Office. This team will also handle claims allowed with certain occupational conditions such as asbestosis and mesothelioma. Centralizing the handling of death claims will improve the accuracy and timeliness of this highly specialized claim type.

PTD Claims - Another subgroup of the claims complexity workgroup presented recommendations to improve the management of PTD claims. The team presented recommended moving PTD and DWRF claims statewide to the Dayton and Youngstown Service Offices. PTD and DWRF claims associated with the Special Claims office such as SI Bankrupt, CoEmp and etc will continue to be handled in this unit. Specialized handling of PTD and DWRF claims will improve the accuracy and timeliness of this highly specialized claim type.

CAT Claims - The claim complexity team is currently developing claim strategies and best practices for handling catastrophic claims to assure optimal outcomes. The definition for a CAT claim has been clarified to be consistent between BWC policies and the MCO Policy Reference Guide. The life cycle of a claim is being utilized to identify specific strategies and the most appropriate person to initiate and employ these strategies. Timelines are being discussed and workflows will be developed. Recommendations from the group will impact the Customer Service Teams as well as MCOs.

Customer Services Division Report

Virtual Nurse Support Team - A BWC Nurse Workgroup presented recommendations to improve the reach and range of BWC's nursing resources. The recommendations include consistent workflows, development of a virtual nursing model and systematic distribution of work, to promote equitable workloads. Currently, the Toledo and Mansfield Service Offices are testing a virtual support model and will provide the results of the model to the Claim Complexity Project Leads by the end of the year.

OSU Complexity Analysis - initial results of the factors to predict claim complexity have been returned from OSU and are currently being validated internally. When validation is completed claim complexity categories will be finalized. Sub teams will be formed as needed to discuss strategies to employ for Claim Complexity Level 4 claims not mentioned above and Claim Complexity Level 3 and 2 claims.

III. Service Office Safety Services Business Plans Initiative

Through a concerted effort to streamline and bring more consistency to our safety services, DSH and BWC Service Offices developed individualized Safety Services Business plans for FY 2011.

The underlying goals of this initiative are three fold:

1. Increase the reach and improve the effect of BWC safety services. The objectives of this goal include reaching out to employers we have not serviced before, and increasing the number of distinct employers served through our various safety programs including: field consulting, safety intervention grants, and the number of employers and employees benefiting from our training and education programs, as well as participation in safety councils and safety congress.
2. Align the safety services with the agency strategic goals and initiatives in terms of the development and support of current and future projects as well as rating programs. The objectives of this goal include providing flexibility in the delivery of safety services to meet the ongoing and changing needs of our customers, and to capitalize on some safety requirements of the rating programs to deliver quality safety services to employers who need those services. A major project in this area is the Market Segmentation project, which provided valuable information to better understand the needs of our customers including the area of accident and injury prevention.
3. Develop a continuous quality improvement process through objective measurement and evaluation. The objectives of this goal include the development of objective measurement tools of safety activities and services in the service offices, to provide timely feedback and adjustments to meet the varying demands and needs of our customers, to perform reviews of work product to improve quality and value, to provide better and quality opportunities for staff professional development activities, to provide timely transfer of knowledge and expertise among the service offices in which successful activities in one or more offices can be readily transferred and used in other offices.

First Quarter results include:

- the number of distinct employers receiving field consulting services has increased by 8 percent.
- attendance at BWC safety education and training classes has increased by 21%; however, the number of distinct employers who benefited from this service has decreased by 21%.
- safety grants awarded has increased by 675%. The significant increase in grant awards for the first quarter of this year is due to the significant reduction in the number of safety intervention grant applications and awards, which we all noticed, in the first 5 months of FY 2010. However, that reduction was picked up in the last seven months of FY 2010 as the total number of safety intervention grant awards for FY 2010 increased by 17 percent compared to FY 2009.

Customer Services Division Report

We are currently planning to hold a full-day statewide safety staff meeting in Columbus on December 13 to provide the staff with an overview of their accomplishments during the first 5 months of the implementation of the plans, provide learning and adjustment feedback relative to where we had success and where we did not succeed, as well as solicit direct feedback from the staff relative to our future plans through focused group sessions

12 - Month Medical Services & Safety Calendar

Date	November 2010	Notes
11/18/10	1. Ambulatory Surgical Center Fee Schedule Rule (1st read)	
	2. Outpatient Hospital Fee Schedule (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. Vocational Rehab fee schedule (1st read)	
	3. Ambulatory Surgical Center Fee Schedule Rule (2nd read)	
	4. Outpatient Hospital Fee Schedule (2nd read)	
	5. Medical Services Report	
	2011	
Date	January 2011	
1/20/11	1. Vocational Rehab fee schedule (2nd read)	
	2. Customer Services Report	
	3. Rehabilitation Services Commission Review	
	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	
9/29/11	September 2011	
	1. Pharmacy and Therapeutics Committee Rule 4123-6-21-1 (2nd read)	
	2. Inpatient Hospital Fee Schedule (1st read)	
	3. Customer Services Report	
10/27/11	October 2011	
	1. Committee Charter review (1st read)	
	2. Inpatient Hospital Fee Schedule (2nd read)	
	3. Medical Services Report	

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.

Ambulatory Surgical Center Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
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				

Ohio BWC Fee Schedule History and Calendar

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	Dec/Jan	May 2011		
2011				

Medical and Service Provider Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
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

Wind Turbine Training Grant

The BWC's safety grant intervention program has recently approved a grant application from the Warren Electrical Joint Apprenticeship Training Facility for \$112,580 to purchase a wind turbine training tower. In addition to training Ohio workers on safe operation and maintenance of the towers, BWC intends to develop a partnership with the Warren Electrical Joint Apprenticeship Training Facility to provide BWC safety staff access to the turbine simulator for the purpose of building safety staff skills specific to this emerging industry in Ohio.

The IBEW, a parent organization of the Warren Electrical Joint Apprenticeship, was awarded an American Recovery and Reinvestment Act (ARRA) Green Jobs Training Grant for the purpose of providing training to transition Ohio workers into green jobs. However, the ARRA Grant award cannot be used for the purchase of training equipment and hardware. Therefore, the IBEW/Warren Electrical Joint Apprenticeship requested funding for the training tower which will be used to train 600 workers at the Warren, Ohio training facility.

This grant program partnership provides a unique opportunity for the BWC. Electrical workers will receive training on the safe operation and maintenance of wind turbines. Construction workers, fire fighters, engineers, emergency first responders, and safety professionals will also use the training tower. In addition to this training, BWC safety professionals will partner with the IBEW/Warren Electrical Joint Apprenticeship to develop industry best practices and safety protocols specific to the construction, operation, and maintenance of wind turbines. These best practices and safety protocols will be shared with Ohio employers through the safety services and programs offered by the Division of Safety & Hygiene.

Ohio will see rapid growth in the wind energy industry over the next 2-5 years. The Ohio Power Siting Board (OPSB)¹ recently approved five wind farms with a combined total of 472 wind turbines. Also, applications are pending for two wind farms with a combined total of 91 turbines. In addition to these onshore wind farms, GE announced they will construct the "world's first freshwater wind farm in Lake Erie near Cleveland."² Through a partnership with Lake Erie Energy Development Corporation (LEEDCo), GE intends to construct five wind turbines standing about 200 feet tall six miles north of Cleveland by 2012.

The anticipated time frame for completion of the training tower is twelve to fifteen weeks, from receipt of the funds. The training tower will be located at 4550 Research Parkway in Warren, Ohio.

¹ Ohio Power Siting Board (<http://www.opsb.ohio.gov>).

² "GE plans world's first freshwater wind farm on Lake Erie near Cleveland." Columbus Dispatch, May 24, 2010.