

Medical Services and Safety Committee Agenda

Wednesday, December 15, 2010

William Green Building

Level 2, Room 3

9:00 A.M. - 10:30 A.M.

Call to Order

Jim Harris, Committee Chair

Roll Call

Jill Whitworth, Scribe

Approve Minutes of November 19, 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. 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

B. Emergency Rule (waiver of second reading)

1. Medical Services Provider Fee Schedule

Freddie Johnson, Director Managed Care Services

Jean Stevens, Medical Policy Senior Analyst

C. Recommend Board approval of FY 2010 Division of Safety and Hygiene

Annual Report

Abe Al-Tarawneh, Superintendent, Division of Safety and

Hygiene

D. For First Reading

1. OSHA/PERRP Cranes and Derricks rule

Michael F. Rea, Industrial Safety Administrator

Discussion Items**

1. Medical Services Report
Bob Coury, Chief, Medical Services
2. Committee Calendar
Jim Harris, Committee Chair

Adjourn

Jim Harris, Committee Chair

Next Meeting: Thursday, January 20, 2010

** Not all agenda items may have materials

*** Agenda subject to change

Common Sense Business Regulation (BWC Rules)

(Note: The below criteria apply to existing and newly developed rules)
Rule 4123-6-37.3

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 2010

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 226, Pages 72279 - 72330 (Addendum AA) and 72518 - 72540 (Addendum BB), November 24, 2010, multiplied by a 2011 bureau adjustment of 1.016.

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 1.016 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.



Stakeholder feedback and recommendations for changes to the BWC Ambulatory Surgical Center Fee Schedule Rule - O.A.C. 4123-6-37.3

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
1	General Comment	Claims Management, Inc.	In response to your request from SI employers/carriers, I am requesting the opportunity to provide you with some information. In regards to the OH claims for our company we have seen an increase in the average paid per bill from the change in 2009 to the APC payment methodology. However, the ability to utilize the Medicare APC payment methodology is much more efficient as well as the guidelines set are similar to other states fee schedules. Comparative to other states that are set with the same payment guidelines, Ohio has also set ground rules for what is covered and non-covered which is helpful in calculating payments.	N/A	BWC acknowledges an increase payment of bills which was expected with the adoption of the 2009 ASC fee schedule. Accordingly, the 2010 ASC fees schedule excluded the Medicare payment adjustment factor for pain management procedures. Pain Management services are reimbursed at 110% of the Medicare rate as opposed to the previous 100% of the Medicare fee schedule for ASC services. Now that Medicare rates are fully implemented, increases in our medical costs will be even more predictable as a result of using Medicare's ASC methodology.	Maintain current recommendation
2	General Comment	CompManagement	Are the NRC codes for ASC bills to be processed in the same manner as the NRC codes for physician fee schedule?	N/A	BWC will continue to utilized the same protocol as the professional provider fee schedule for services performed oin the ASC setting which are Not Routinely covered (NRC) As stated in the ASC fee schedule preamble: <i>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 procing is listed on the fee schedule.</i>	Maintain current recommendation
3	General Comment	Taylor Rd Surgical Center	As you might already know, ambulatory surgery centers (ASCs) are free standing same day surgery centers known in Ohio and across the nation for the superior level of quality, low infection rates, patient safety and cost efficiency. Procedures in centers such as ours are performed in a timelier manner than our hospital outpatient counterparts, thus allowing for quicker return to work times for the injured employees and a lower cost to the workers' compensation system as a whole. While this model of service delivery seems to be directly in line with the philosophy of Ohio's workers' compensations, I am shocked that your reimbursement methodology does not support with this philosophy. Your plans for a continuation of ASC reimbursements at existing Medicare rates, while at the same time reimbursing hospital outpatient departments 198% of their Medicare rates for the exact same procedures, flies in the face of both fiscal responsibility and quality of care for injured workers.	N/A	BWC agrees with the comment in part as pain management services are reimbursed at 110% of Medicare rates and the remainder of the fee schedule is reimbursed at 100% of Medicare reimbursement. BWC also agrees with stakeholder comments regarding the benefits of the Ambulatory Surgical Centers, which is why we have worked to ensure a competitive fee schedule which supports the existence of the ASC as part of the provider environment. The analysis which BWC performed in making the recommendations indicates the payment adjustment factor will provide an appropriate level of reimbursement for Ohio's ASCs. For those services reimbursed at 100% of the Medicare rate, there is a projected 12% increase, with a 7% overall projected increase for the ASC fee schedule	

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
4	General Comment	Ohio Association of Ambulatory Surgery	For three years, The Ohio Association of Ambulatory Surgery Centers (OAASC) and its members have agreed to partner with the BWC to transition to the new prospective payment system giving the BWC a “good faith” starting point for determining appropriate payment levels and for addressing issues that might be unique to the workers’ compensation system. However, we can no longer stand to the side and tacitly back actions, which we sincerely believe are harmful to the care of injured Ohio workers and are even fiscally irresponsible. As I am certain that you are aware, Medicare payments are some of the lowest received by ASCs – second only to Medicaid. While I know that last year you indicated that you had not seen an impact on access to care through ambulatory surgery centers (ASC) for injured workers, I can assure you that based on our analysis, this will no longer be true	N/A	As the final year of the transitional ASC fee schedule has been implemented, BWC will continue to partner with the The Ohio Association of Ambulatory Surgery Centers (OAASC) and its members to address issues and concerns regarding reimbursement and utilization in the ASC setting. BWC agrees with stakeholder comments regarding the benefits of the Ambulatory Surgical Centers, which is why we have worked to ensure a competitive fee schedule which supports the existence of the ASC as part of the provider environment. The analysis which BWC performed in making the recommendations indicates the payment adjustment factor will provide an appropriate level of reimbursement for Ohio's ASCs. For those services reimbursed at 100% of the Medicare rate, there is a projected 12% increase, with a 7% overall projected increase for the ASC fee schedule	Maintain current recommendation
5	General Comment	Kenwood Surgery Center	As you might already know, ambulatory surgery centers (ASCs) are free standing same day surgery centers known in Ohio and across the nation for the superior level of quality, low infection rates, patient safety and cost efficiency. Procedures in centers such as ours are performed in a timelier manner than our hospital outpatient counterparts, thus allowing for quicker return to work times for the injured employees and a lower cost to the workers’ compensation system as a whole. While this model of service delivery seems to be directly in line with the philosophy of Ohio’s workers’ compensations, I am shocked that your reimbursement methodology does not support with this philosophy. Your plans for a continuation of ASC reimbursements at existing Medicare rates, while at the same time reimbursing hospital outpatient departments 198% of their Medicare rates for the exact same procedures, flies in the face of both fiscal responsibility and quality of care for injured workers.	N/A	BWC agrees with the comment in part as pain management services are reimbursed at 110% of Medicare rates and the remainder of the fee schedule is reimbursed at 100% of Medicare reimbursement. BWC also agrees with stakeholder comments regarding the benefits of the Ambulatory Surgical Centers, which is why we have worked to ensure a competitive fee schedule which supports the existence of the ASC as part of the provider environment. The analysis which BWC performed in making the recommendations indicates the payment adjustment factor will provide an appropriate level of reimbursement for Ohio's ASCs. For those services reimbursed at 100% of the Medicare rate, there is a projected 12% increase, with a 7% overall projected increase for the ASC fee schedule	Maintain current recommendation

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
6	General Comment	Upper Arlington Surgery Center	As you might already know, ambulatory surgery centers (ASCs) are free standing same day surgery centers known in Ohio and across the nation for the superior level of quality, low infection rates, patient safety and cost efficiency. Procedures in centers such as ours are performed in a timelier manner than our hospital outpatient counterparts, thus allowing for quicker return to work times for the injured employees and a lower cost to the workers' compensation system as a whole. While this model of service delivery seems to be directly in line with the philosophy of Ohio's workers' compensations, I am shocked that your reimbursement methodology does not support with this philosophy. Your plans for a continuation of ASC reimbursements at existing Medicare rates, while at the same time reimbursing hospital outpatient departments 198% of their Medicare rates for the exact same procedures, flies in the face of both fiscal responsibility and quality of care for injured workers.	N/A	BWC agrees with the comment in part as pain management services are reimbursed at 110% of Medicare rates and the remainder of the fee schedule is reimbursed at 100% of Medicare reimbursement. BWC also agrees with stakeholder comments regarding the benefits of the Ambulatory Surgical Centers, which is why we have worked to ensure a competitive fee schedule which supports the existence of the ASC as part of the provider environment. The analysis which BWC performed in making the recommendations indicates the payment adjustment factor will provide an appropriate level of reimbursement for Ohio's ASCs. For those services reimbursed at 100% of the Medicare rate, there is a projected 12% increase, with a 7% overall projected increase for the ASC fee schedule	Maintain current recommendation
7	General Comment	Eastwind Surgical	As you might already know, ambulatory surgery centers (ASCs) are free standing same day surgery centers known in Ohio and across the nation for the superior level of quality, low infection rates, patient safety and cost efficiency. Procedures in centers such as ours are performed in a timelier manner than our hospital outpatient counterparts, thus allowing for quicker return to work times for the injured employees and a lower cost to the workers' compensation system as a whole. While this model of service delivery seems to be directly in line with the philosophy of Ohio's workers' compensations, I am shocked that your reimbursement methodology does not support with this philosophy. Your plans for a continuation of ASC reimbursements at existing Medicare rates, while at the same time reimbursing hospital outpatient departments 198% of their Medicare rates for the exact same procedures, flies in the face of both fiscal responsibility and quality of care for injured workers.	N/A	BWC agrees with the comment in part as pain management services are reimbursed at 110% of Medicare rates and the remainder of the fee schedule is reimbursed at 100% of Medicare reimbursement. BWC also agrees with stakeholder comments regarding the benefits of the Ambulatory Surgical Centers, which is why we have worked to ensure a competitive fee schedule which supports the existence of the ASC as part of the provider environment. The analysis which BWC performed in making the recommendations indicates the payment adjustment factor will provide an appropriate level of reimbursement for Ohio's ASCs. For those services reimbursed at 100% of the Medicare rate, there is a projected 12% increase, with a 7% overall projected increase for the ASC fee schedule	Maintain current recommendation

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
8	General Comment	Marysville Surgical Center	As you might already know, ambulatory surgery centers (ASCs) are free standing same day surgery centers known in Ohio and across the nation for the superior level of quality, low infection rates, patient safety and cost efficiency. Procedures in centers such as ours are performed in a timelier manner than our hospital outpatient counterparts, thus allowing for quicker return to work times for the injured employees and a lower cost to the workers' compensation system as a whole. While this model of service delivery seems to be directly in line with the philosophy of Ohio's workers' compensations, I am shocked that your reimbursement methodology does not support with this philosophy. Your plans for a continuation of ASC reimbursements at existing Medicare rates, while at the same time reimbursing hospital outpatient departments 198% of their Medicare rates for the exact same procedures, flies in the face of both fiscal responsibility and quality of care for injured workers.	N/A	BWC agrees with the comment in part as pain management services are reimbursed at 110% of Medicare rates and the remainder of the fee schedule is reimbursed at 100% of Medicare reimbursement. BWC also agrees with stakeholder comments regarding the benefits of the Ambulatory Surgical Centers, which is why we have worked to ensure a competitive fee schedule which supports the existence of the ASC as part of the provider environment. The analysis which BWC performed in making the recommendations indicates the payment adjustment factor will provide an appropriate level of reimbursement for Ohio's ASCs. For those services reimbursed at 100% of the Medicare rate, there is a projected 12% increase, with a 7% overall projected increase for the ASC fee schedule	Maintain current recommendation
9	General Comment	Ohio Surgery Center	As you might already know, ambulatory surgery centers (ASCs) are free standing same day surgery centers known in Ohio and across the nation for the superior level of quality, low infection rates, patient safety and cost efficiency. Procedures in centers such as ours are performed in a timelier manner than our hospital outpatient counterparts, thus allowing for quicker return to work times for the injured employees and a lower cost to the workers' compensation system as a whole. While this model of service delivery seems to be directly in line with the philosophy of Ohio's workers' compensations, I am shocked that your reimbursement methodology does not support with this philosophy. Your plans for a continuation of ASC reimbursements at existing Medicare rates, while at the same time reimbursing hospital outpatient departments 198% of their Medicare rates for the exact same procedures, flies in the face of both fiscal responsibility and quality of care for injured workers.	N/A	BWC agrees with the comment in part as pain management services are reimbursed at 110% of Medicare rates and the remainder of the fee schedule is reimbursed at 100% of Medicare reimbursement. BWC also agrees with stakeholder comments regarding the benefits of the Ambulatory Surgical Centers, which is why we have worked to ensure a competitive fee schedule which supports the existence of the ASC as part of the provider environment. The analysis which BWC performed in making the recommendations indicates the payment adjustment factor will provide an appropriate level of reimbursement for Ohio's ASCs. For those services reimbursed at 100% of the Medicare rate, there is a projected 12% increase, with a 7% overall projected increase for the ASC fee schedule	Maintain current recommendation

Ohio BWC

2011 Ambulatory Surgical Center Fee Schedule Proposal

Medical Services Division

Freddie Johnson, Director, Managed Care Services

Anne Casto, Casto Consulting

December 15, 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%)

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

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

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

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

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

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.
3. Apply 253% payment adjustment factor to OPPS rates for Children's Hospitals.

4. Apply 197% payment adjustment factor to OPPS 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, 2014~~ 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 implemented by the materials specified in paragraph (A)(6) of this rule ~~of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~, 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 implemented by the materials specified in paragraph (A)(6) of this rule ~~of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~ 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 implemented by the materials specified in paragraph (A)(6) of this rule ~~of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~.

(d) For purposes of this rule, the following hospitals shall be recognized as "children's hospitals": nationwide children's hospital (Columbus), Cincinnati children's hospital medical center, shriners hospital for children (Cincinnati), university hospitals rainbow

babies and children's hospital (Cleveland), Toledo children's hospital, children's hospital medical center of Akron, and children's medical center of Dayton.

In the event the centers for medicare and medicaid services makes subsequent adjustments to the medicare reimbursement rates under the medicare outpatient prospective payment system as implemented by the materials specified in paragraph (A)(6) of this rule, the "applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system" as specified in this paragraph shall be determined by the bureau without regard to such subsequent adjustments.

(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 implemented by the materials specified in paragraph (A)(6) of this rule~~of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered .~~

(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 implemented by the materials specified in paragraph (A)(6) of this rule~~of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~, 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 implemented by the materials specified in paragraph (A)(6) of this rule~~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.

(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 implemented by the materials specified in paragraph (A)(6) of this rule ~~of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered~~. 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. 71800 - 72580 (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 <i>Miller</i> 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. |
| Never Covered (NC) | The procedure or service is never covered. |

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 OPFS, 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.



Stakeholder feedback and recommendations for changes to the BWC Hospital Outpatient Services Fee Schedule - O.A.C. 4123-6-37.2

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
1	General Comment	Heinen's Inc.(commenting as self insured employer)	Concerned about method of distribution and timing of notification to self insured employers of hospital cost to charge ratios.	In the past, they have not received this information in a timely manner and they want to ensure proper reimbursement to the hospitals. When they do not receive this information timely, it takes considerable time to hunt the information down.	This comment does not directly relate to the language or recommended changes to the rule, but rather a needed component for SI employers to execute on their protocols for reimbursing providers. While the cost to charge information is readily available from Medicaid, BWC has as a service provided cost to charge data given this data use in BWC's reimbursement methodology. There is no change required in the rule is necessary; however, BWC will continue to provide the cost to charge data, and is exploring options for increasing the speed in which the data is made available.	BWC plans to post the updated Ohio Medicaid cost to charge ratios on ohioBWC.com. The expected date the updated outpatient cost to charge ratios will be posted is on or before 04/01/2011.
2	General Comment	OHA	OHA expressed a general comment of support for the recommendations as submitted noting that the recommendations continue to reflect the BWC philosophy previously shared with and understood by the OHA BWC committee. Besides the budget neutrality factors which BWC is addressing, OHA indicated they saw no other major issues.			No action needed.
	General Comment	OHA	Presented a question regarding the number of Children's Hospitals listed in the proposed rule.	The Children's Hospitals indentified in the proposed rule did not reflect all of the Ohio hospitals falling into this categories. Therefore, some there was concern that Children's Hospitals not listed in the rule as such, would not have the 253% payment adjustment factor applied in their formula calculating reimbursement for services rendered.	BWC after reevaluating Ohio hospital data, agreed with the assessment of OHA. There were other Children's Hospital facilities which were not appropriately identified in the rule. If these facilities were not identified in the rule, the 253% payment adjustment factor would not be applied, but rather the 197% payment adjustment factor would be applied. It was determined that BWC needed to identify Children's Hospitals by name to ensure the appropriate application of the 253% fee to the correct hospital type.	Rule was modified to add: Shriners Hospital for Children, University Hospitals Rainbow Babies and Children's Hospital, Toledo Children's Hospital.

Ohio BWC 2011 Hospital Outpatient Fee Methodology Proposal

Medical Services Division

Freddie Johnson, Director, Managed Care Services

Anne Casto, Casto Consulting

December 15, 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:

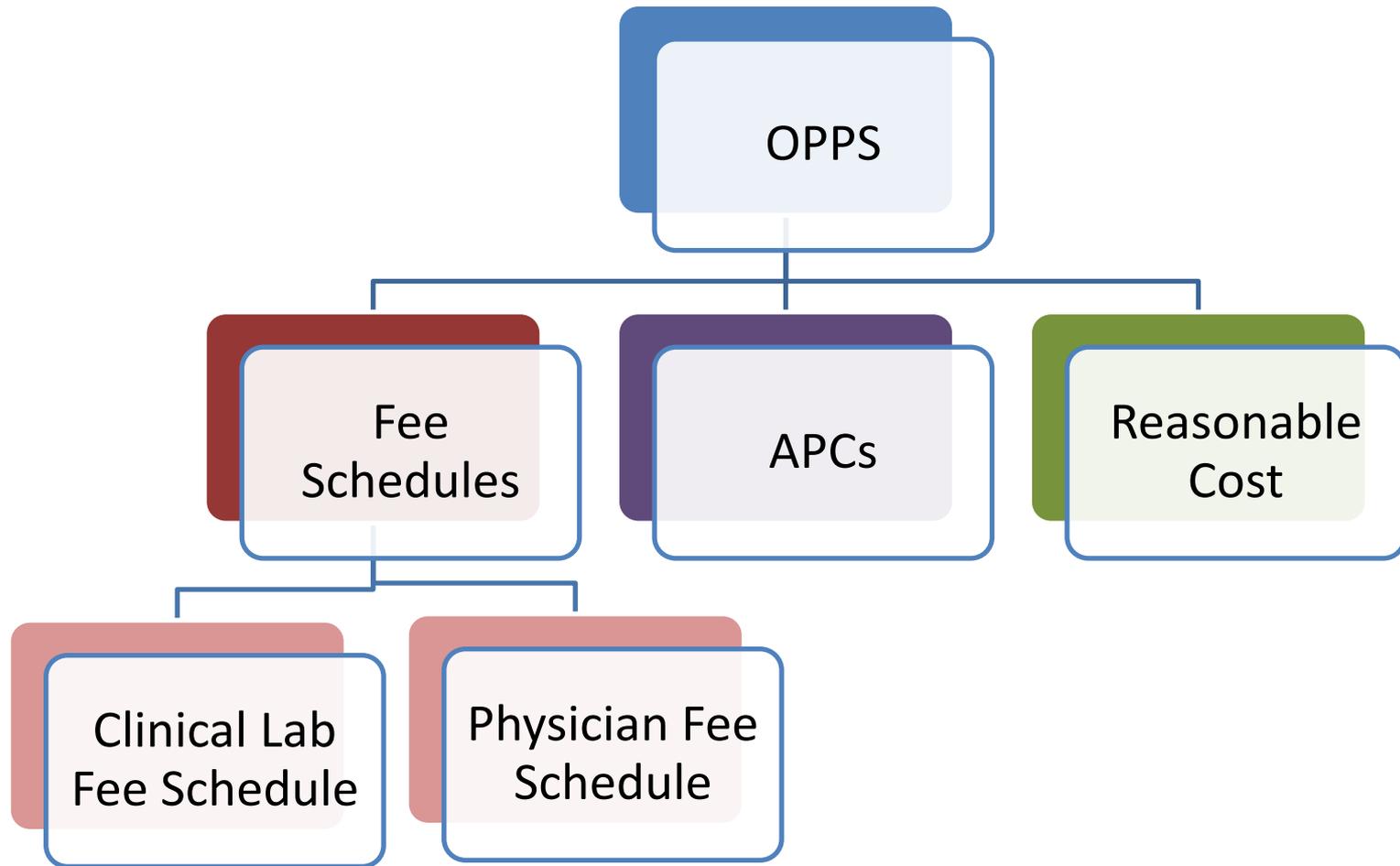
Ensure access to high-quality medical care and vocational rehabilitation services by establishing an appropriate Benefit plan and Terms of service with competitive fee schedule which, in turn, enhances medical/vocational provider network

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%

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

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

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 (-30.78%)
- Budget neutrality adjustments
- Separate BWC adjustment factors will be utilized to address the impact of the negative adjustments

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

Thank You

Appendix

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 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 - 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	$\$10 + (0.75 \times \$10) + (0.75 \times \$8)$.
Malpractice	\$1.00	\$1.00	\$1.00	\$3.00	\$3.00	No reduction
Total	\$18.00	\$18.00	\$20.00	\$56.00	\$51.50	$\$18 + \$7 + (0.75 \times \$10) + \$1 + \$11 + (0.75 \times \$8) + \$1$

\$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

Calculating OPSS Fees

2010: OPSS rate is calculated per the formula below:

Medicare OPSS rate * payment adjustment factor = BWC rate

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

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

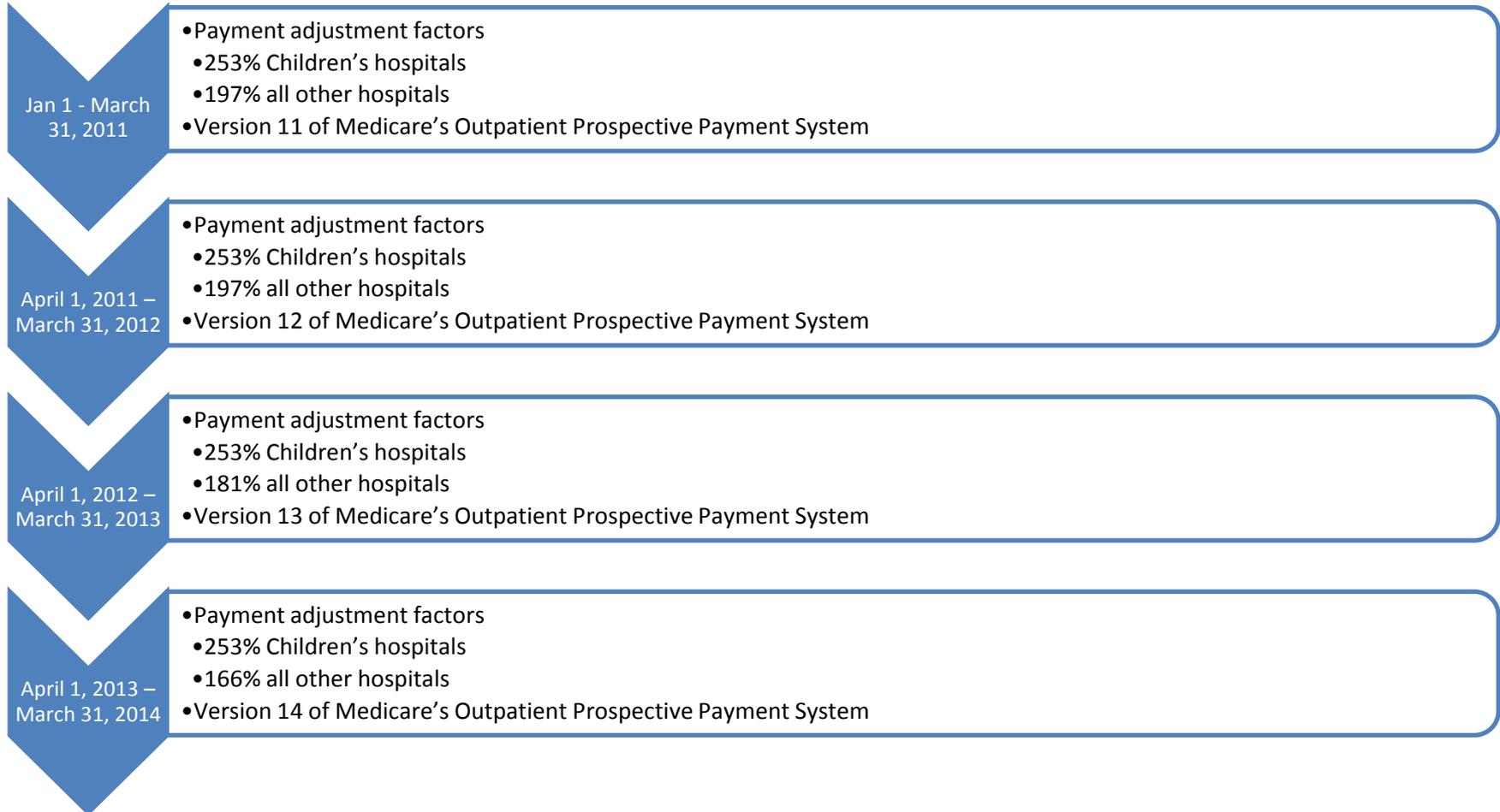
Please note that there are several specific payment formulas under the BWC modified OPSS. The above formula reflects the basic reimbursement formula.

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%

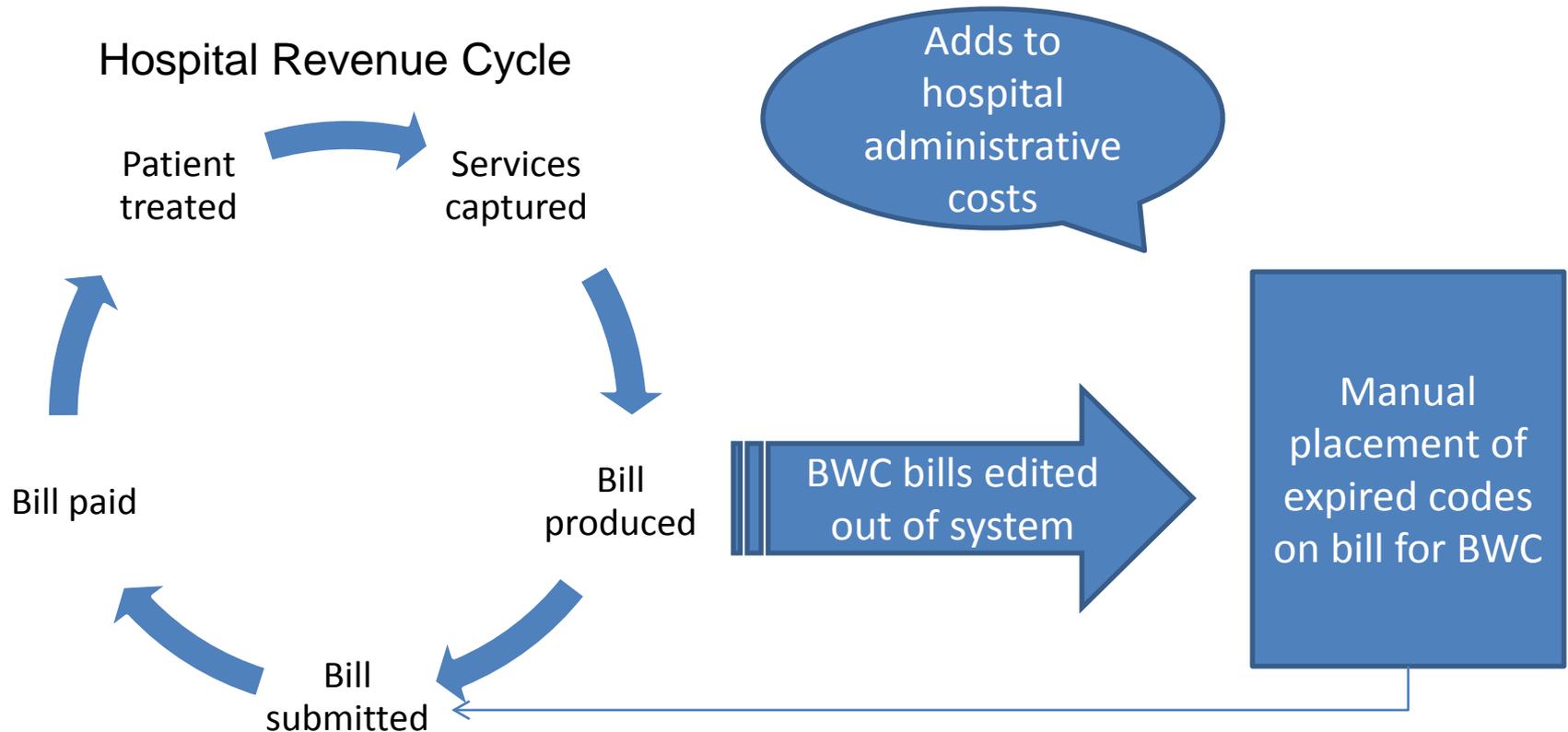
*Updated to reflect impact of the Multiple Procedure Payment Reduction provision for therapy services.

OPPS Version Update Schedule

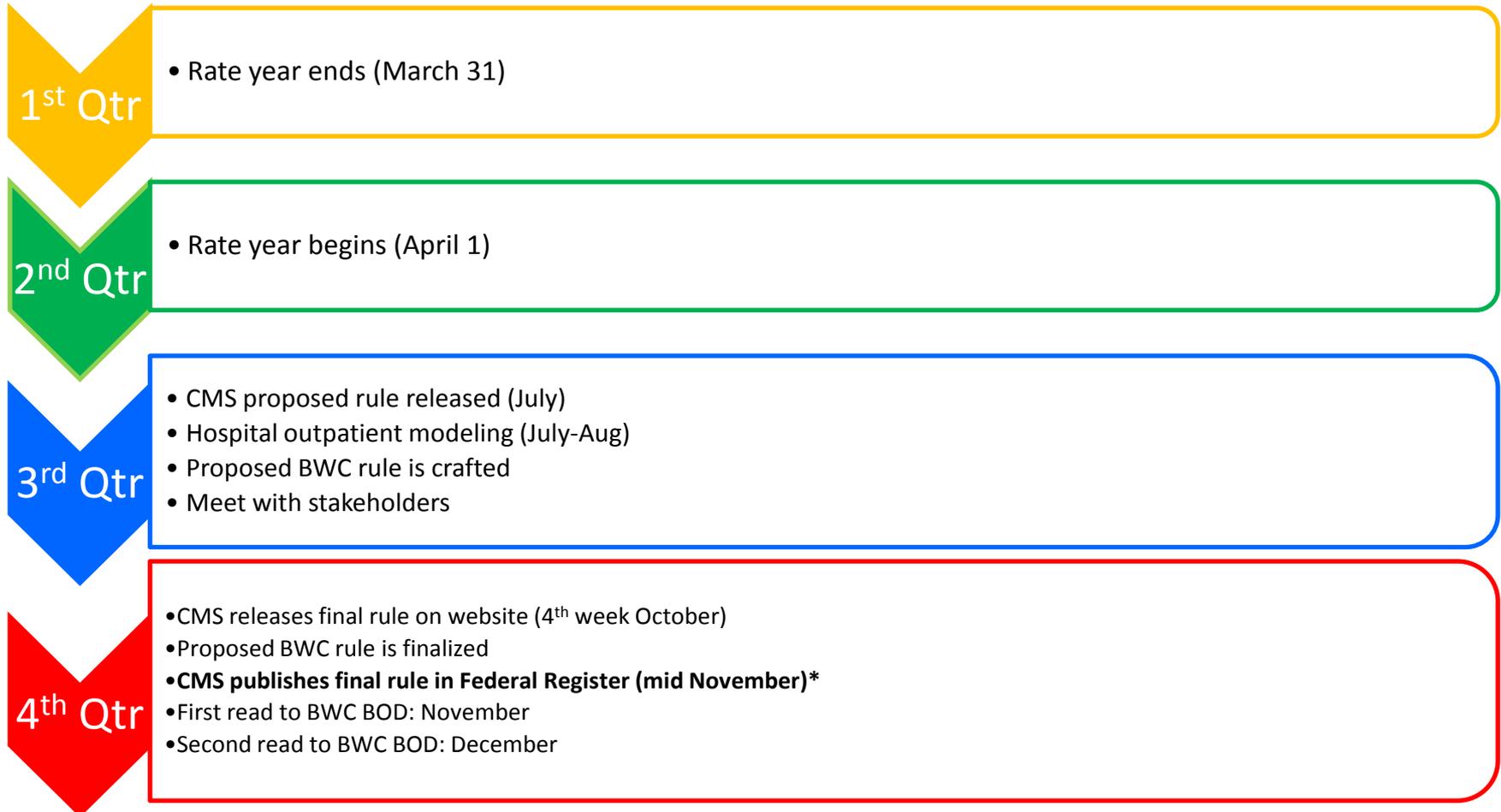


Why Adopt The Correct Version of OPPS?

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



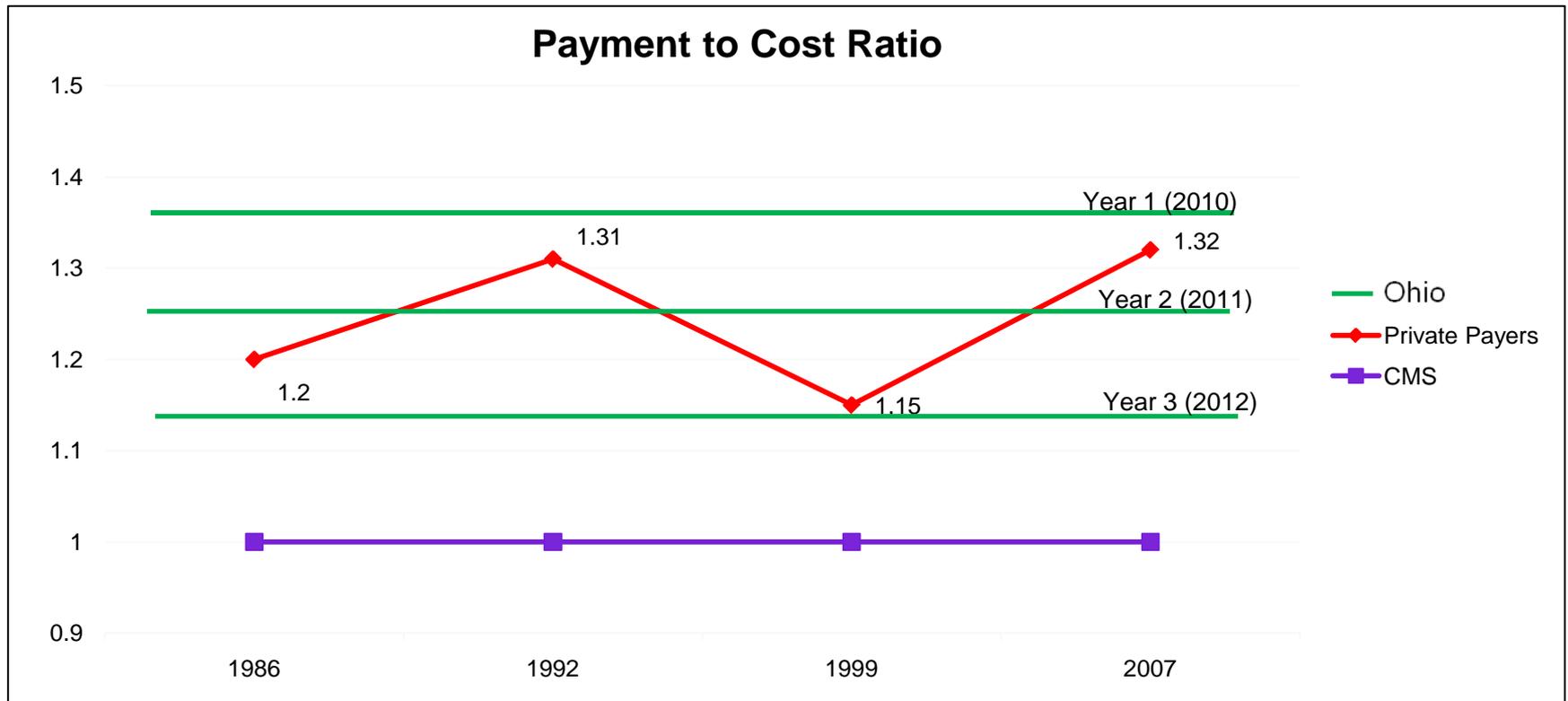
Hospital Outpatient Fee Schedule Cycle



* Key publication required for BWC rulemaking

BWC Proposed Rate Impact

Payment to Cost Ratio Adjusted Recommendation



Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-08

Rule Review

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

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

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

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

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

4. The rule is effective, consistent and efficient.

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

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

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

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

Explain: Stakeholders were informed of BWC's intention to implement OAC 4123-6-08 with the new CPT and HCPCS code changes as an emergency rule effective January 1, 2011 and thereafter as a permanent rule effective April 1, 2011 at various meetings including BWC's Medical Provider Stakeholder Meeting on November 30, 2010, and BWC received no objections.

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

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

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

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

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

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

BWC Board of Directors
Executive Summary
BWC Professional Provider Fee Schedule Rule

Introduction

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including rules relating to the adoption of a provider fee schedule. BWC initially enacted the bulk of the Chapter 4123-6 HPP operational rules (Ohio Administrative Code 4123-6-01 to 4123-6-19), including OAC 4123-6-08, the professional provider fee schedule rule, in February 1996.

Background Law

R.C. 4121.441(A)(8) provides that the Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to injured workers, including but not limited to discounted pricing for medical services.

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

Pursuant to the 10th District Court of Appeals decision in *Ohio Hosp. Assn. v. Ohio Bur. of Workers' Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499, BWC is required to adopt changes to its fee schedules via the O.R.C. Chapter 119 rulemaking process. BWC has undergone a systematic revision of its professional provider fee schedule, and now proposes to adopt the newly revised professional provider fee schedule as an Appendix to OAC 4123-6-08.

Proposed Changes

BWC's professional provider fee schedule is composed of the following standardized billing codes: 10,000 Current Procedural Terminology (CPT®) codes, 3600 Healthcare Common Procedural Coding System (HCPCS) codes and 170 local codes. The 170 local codes are developed and maintained by BWC; CPT codes by the American Medical Association (AMA) [and adopted by the Centers for Medicare and Medicaid Services (CMS)]; and HCPCS codes by CMS.

BWC annually adopts its new professional provider fee schedule in October; the most recent taking effect October 25, 2010. This period of adoption is necessary to provide BWC staff sufficient time to evaluate the empirical data, get stakeholder feedback, and make recommendations for the overall update of BWC's reimbursement methodology.

The AMA and CMS also update their CPT® and HCPCS codes annually, eliminating some codes and adding new ones. These new coding schemes are not released until the month of December, and are effective on January 1st of the following year. BWC's professional provider fee schedule must be updated to reflect these changes. For 2011, the total number of new CPT and HCPCS codes is 190, with the number of current 2009 codes to be deleted totaling 144. There are no projected measurable changes in provider reimbursements.

In order to implement the changes to the CPT® and HCPCS codes on January 1, 2011, BWC is seeking BWC Board approval to request the Governor's office to issue an Executive Order implementing OAC 4123-6-08 with the new CPT and HCPCS code changes as an emergency

rule effective January 1, 2011. Pursuant to O.R.C. 119.03(F), an emergency rule is only effective for 90 days. Therefore, BWC is also seeking BWC Board approval to concurrently proceed with the normal Chapter 119 rulemaking process to implement OAC 4123-6-08 with the new CPT and HCPCS code changes as a permanent rule effective April 1, 2011.

The Ohio Department of Job and Family Services (ODJFS) follows a similar procedure every year to implement the January 1 changes to the CPT® and HCPCS codes for its Medicaid fee schedule [see Governor Ted Strickland's Executive Orders 2009-24S, 2008-23S, and 2007-42S].

Stakeholder Involvement

Stakeholders were informed of BWC's intention to implement OAC 4123-6-08 with the new CPT and HCPCS code changes as an emergency rule effective January 1, 2011 and thereafter as a permanent rule effective April 1, 2011 at various meetings including BWC's Medical Provider Stakeholder Meeting on November 30, 2010, and BWC received no objections.

During 2010 BWC observed that the incongruence of codes resulting when BWC's professional provider fee schedule is out of sync with the AMA and CMS' CPT® and HCPCS codes creates additional expense to correct denials of otherwise valid services, inconveniencing the providers treating our injured workers. BWC implemented work-a-round procedures for 2010 to minimize the number of bills being denied. However, these work-a-round procedures are labor intensive processes, and constitute administrative challenges that can be a barrier to provider participation, potentially adversely impacting BWC's opportunity to maintain and/or increase Ohio's injured workers' access to quality care.

4123-6-08 Bureau fee schedule.

(A) Pursuant to division (A)(8) of section 4121.441 of the Revised Code, the administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall develop, maintain, and publish a provider fee schedule for the various types of billing codes. The administrator hereby adopts the fee schedule indicated in the attached appendix A, developed with provider and employer input effective ~~October 25, 2010~~ January 1, 2011.

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

Appendix A

BUREAU OF WORKERS' COMPENSATION

PROFESSIONAL PROVIDER FEE SCHEDULE

EFFECTIVE ~~OCTOBER 25, 2010~~ JANUARY 1, 2011

Effective: 1/1/2011

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96, 1/1/01, 2/19/09

BWC 2010 Proposed Emergency Rule Changes for BWC's Professional Provider and Medical Services Fee Reimbursement Schedule

Preface

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

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

Professional Provider Fee Schedule

Introduction and Methodology

As stated, implementing a sound and effective provider fee schedule is a critical component of the Medical Services Division's goals. The Ohio Bureau of Workers Compensation reimburses approximately 70,000 providers for medical services rendered to Ohio's injured workers. An equitable and competitive fee for the right medical service, as well as the effectiveness and efficiency of the reimbursement process is essential to maintain a quality provider network across the wide range of necessary provider disciplines.

Critical to having an effective and efficient reimbursement process is the procedural codes which providers use to bill for their services and on which BWC evaluates and computes reimbursements for services provided by those providers. The medical services fee schedule is composed of the following codes which providers use for billing: 10,000 Current Procedural Terminology (CPT®¹) codes, 3600 Healthcare Common Procedural Coding System (HCPCS²) codes and 170 local codes. The 170 local codes are developed and maintained by BWC.

¹ Current Procedure Terminology - The manual published by the American Medical Association (AMA) which assigns numeric codes to describe procedures for professional services.

² Health Care Procedural Coding System as provided by Federal Center for Medicare and Medicaid Services (CMS)

Provider fees for each of the grouping of codes utilize a different calculation. Provider fees for the CPT® code grouping utilize a Relative Value Unit, a Geographical Practice Cost Index and a BWC Conversion Factor (or dollar amount). Provider fees for the HCPCS code grouping utilizes Medicare's published fee schedule which BWC increases by twenty percent (20%). Provider fees for the 170 Local codes groupings utilizes BWC's separately developed fee schedule.

Emergency Rule Recommendation Considerations

Each year, codes are added, primarily to indicate a new service. Codes may also be discontinued or the narrative description may be revised. While BWC is able to develop and adopt local codes as needed within the timeframe necessary to ensure consistent implementation across providers, adoption and implementation of CPT and HCPCS codes are more challenging due to Chapter 119 rulemaking requirements.

Prior to 2007, BWC under the approach of adopting fee schedule changes by policy would as a part of that process adopt new codes released by the AMA and CMS. Thus, BWC and the various providers were in step with billing and reimbursement protocols reflecting new and/or expired billing codes.

In 2007 chapter 119 and BWC specific rulemaking protocols were put in place for fee schedule rule changes. These protocols includes 2 reading to the BWC Board and the standard JCARR process which could result in an estimated period in excess of 120 days for a proposed rule to become effective. The new coding schemes are not released until the month of December, and are effective on January 1st of next year. Under the current rulemaking process and fee schedule development methodology, it is virtually impossible to be in a position to adopt the new codes once they are release. However, providers do adopt those codes once they are release and submit bills in accordance with the new codes.

Providers adoption and application of the new codes on January 1st of each year, has and will continue to result in unnecessary challenges to reimbursing providers. BWC annually adopts and implements the new professional providers and medical services fee schedule in October. This period of adoption is necessary to provide the staff the time to evaluate Medicare changes to its empirical data on which BWC relies for its fee schedule, get stakeholder feedback, and make recommendations for the overall update of the reimbursement methodology. The billing codes reflected in the October implemented schedule are those in existence in the year in which the schedule is adopted and implemented. Those codes are approved for a period of 12 months beginning in October of the year implemented.

In 2010, providers billing for services reflected the new 2010 codes implemented on January 1, 2010. This billing approach resulted in providers bills being denied as the only codes which could properly used for billing were the 2009 codes as adopted by BWC. This impact of the incongruence of codes used creates additional expense to correct denials of otherwise valid services. BWC in 2010 implemented work-a-round

procedures to minimize the number of bills being denied. The work-a-round procedures are avoidable labor intensive process.

Providers who also wish to avoid unnecessary denial must maintain a separate set of BWC billing code and the nationally updated set of billing codes. The need to undertake such action increases providers' administrative challenges of serving Ohio's injured workers population. These administrative challenges results in increased costs to the system. Moreover, such increase administrative challenges can be a barrier to provider participation, thus, reducing the BWC's opportunity to maintain and/or increase Ohio's injured workers' access to quality care.

Emergency Rule Recommendations

Medical Services is recommending adoption of the new 2011 CPT codes changes as published by the 2011 AMA and adopted by CMS.

Medical Services is further recommending adoption of the new 2011 HCPCs code changes as published by the 2011 CMS.

Medical Services is further seeking BWC Board approval to submit to the Governor's office, an emergency rule allowing BWC's immediate adoption of the new CPT and HCPCs code changes.

Finally, Medical Services is requesting Board approval in one reading in order to facilitate a smooth transition from the emergency rule to the formally adopted rule changes pursuant to Chapter 119 rulemaking process. The emergency rule is good for 90 days. Therefore, in order to get through the complete Chapter 119 rulemaking process, including presentation to the Board, public hearing and the JCARR process, we will need to have one reading of the final recommendation of the new code updates.

Projected Impacts

The changes being recommended reflect a very narrow update to new 2011 CPT and HCPCs codes. The total number of new CPT and HCPCs codes is 190, with the number of current 2009 codes to be deleted totaling 144. There are no projected measurable changes in provider reimbursements. The codes changes would not impact execution of BWC's standard methodology and project plan for the normal annual evaluation and recommendation for the Professional Providers and Medical Services fee schedule; which will still occur in October, 2011.

Common Sense Business Regulation (BWC Rules)

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

Rule 4167-3-04.2 Amending of standards

Rule Review

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

Citation: R.C. 4167.7(A)(2)(b)

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

What goal(s): The goal is to ensure that employers in the state of OHIO comply with the OAC requirements to provide a workplace safe from recognized workplace hazards and to protect employees' safety and health. This also aligns with the mission of the Ohio BWC to "protect workers and employers from a loss as a result of workplace accidents, and to enhance the general health and well-being of Ohioans and the Ohio economy"

3. Existing federal regulation alone does not adequately regulate the subject matter. YES – Federal OSHA regulations when promulgated are not applicable to the Ohio public employer therefore it is necessary to adopt or amend under RC 4167 so they become rules or standards for the Ohio public sector.
4. The rule is effective, consistent and efficient. YES
5. The rule is not duplicative of rules already in existence. YES
6. The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden. YES
7. The rule has been reviewed for unintended negative consequences. YES
8. Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: On October 9, 2008 OSHA published a Notice of Proposed Rulemaking (NPRM) (73 FR 59713) titled "Cranes and Derricks in Construction." The NPRM set January 22, 2009, as a deadline for submitting comments and for requesting an informal public hearing on the proposed rule. On March 17, 2009 OSHA convened a public hearing on the proposal, with Administrative Law Judge William S. Cowell presiding. At the close of the hearing Judge Colwell established a post-hearing comment schedule. Participants were given until May 10, 2009 to supplement their presentations and provide data and information in response to questions and requests made during the hearing, make clarifications to the testimony and record that they believe were appropriate, and submit new data and information that they considered relevant to the proceedings. Participants were also given until June 8, 2009 to comment on the testimony and evidence in the record, including testimony presented at the hearing submitted during the first part of the post-hearing comment period.

9. The rule was reviewed for clarity and for easy comprehension. YES
10. The rule promotes transparency and predictability of regulatory activity. YES
11. The rule is based on the best scientific and technical information, and is designed so it can be applied consistently. YES
12. The rule is not unnecessarily burdensome or costly to those affected by rule. NO
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
Occupational Safety and Health Amended Rules for
Cranes and Derricks

Introduction

Chapter 4167-3-04.2 of the Ohio Administrative Code requires the Public Employment Risk Reduction Program to amend rules promulgated by the Federal Occupational Safety and Health Administration (OSHA). Chapter 4167 was initially enacted in 1992 with the ratification of House Bill 308. The scope of H.B. 308 was to provide on the job safety and health protection to Ohio public employees through the adoption and application of federal safety and health rules and regulations for General Industry, Construction, and Agriculture.

Background Law

Under House Bill 308, Chapter 4167.07 the administrator is to adopt rules for employment risk reduction standards.

(A) The administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall adopt rules that establish employment risk reduction standards. Except as provided in division (B) of this section, in adopting these rules, the administrator shall do both of the following: (1) By no later than July 1, 1994, adopt as a rule and an Ohio employment risk reduction standard every federal occupational safety and health standard then adopted by the United States secretary of labor pursuant to the "Occupational Safety and Health Act of 1970," 84 Stat. 1590, 29 U.S.C.A. 651, as amended; (2) By no later than one hundred twenty days after the United States secretary of labor adopts, modifies, or revokes any federal occupational safety and health standard, by rule do one of the following: (a) Adopt the federal occupational safety and health standard as a rule and an Ohio employment risk reduction standard; (b) Amend the existing rule and Ohio employment risk reduction standard to conform to the modification of the federal occupational safety and health standard; (c) Rescind the existing rule and Ohio employment risk reduction standard that corresponds to the federal occupational safety and health standard the United States secretary of labor revoked.

Proposed Change

OSHA is issuing this final rule to revise the Cranes and Derricks, Subpart N, section of its construction industry standards. These changes will address advances in the design of cranes and derricks, related hazards, and the qualifications of employees needed to operate them safely. The final rule is effective November 8, 2010

Stakeholder Involvement

On October 9, 2008 OSHA published a Notice of Proposed Rulemaking (NPRM) (73 FR 59713) titled "Cranes and Derricks in Construction." The NPRM set January 22, 2009, as a deadline for submitting comments and for requesting an informal public hearing on the proposed rule. On March 17, 2009 OSHA convened a public hearing on the proposal, with Administrative Law Judge William S. Cowell presiding. At the close of the hearing Judge Colwell established a post hearing comment schedule. Participants were given until May 10, 2009 to supplement their presentations and provide data and information in response to questions and requests made during the hearing, make clarifications to the testimony and record that they believe were appropriate, and submit new data and information that they considered relevant to the proceedings. Participants were also given until June 8, 2009 to comment on the testimony and evidence in the record, including testimony presented at the hearing submitted during the first part of the post hearing comment period.

Cranes and Derricks

The purpose of the Occupational Safety and Health Act of 1970, is to achieve to the extent possible safe and healthful working conditions for all employees. To achieve this goal, Congress authorized the Secretary of Labor to promulgate and enforce occupational safety and health standards. A safety or health standard is a standard that requires employers to maintain conditions or adopt practices that are reasonably necessary or appropriate to provide safe or healthful working conditions. A standard is reasonably necessary or appropriate within the meaning of the OSH Act if a significant risk of material harm exists in the workplace and the proposed standard would substantially reduce or eliminate that workplace risk. OSHA already determined that requirements for cranes and derricks reasonably necessary or appropriate within the meaning of Section 652(8).

SUMMARY: Explanation of Revisions to the Cranes and Derricks Standard

OSHA is revising the Cranes and Derricks Standard and related sections of the Construction Standard to update and specify industry work practices necessary to protect employees during the use of cranes and derricks in construction. This final standard also addresses advances in the designs of cranes and derricks, related hazards, and the qualifications of employees needed to operate them safely. Under this final rule, employers must determine whether the ground is sufficient to support the anticipated weight of hoisting equipment and associated loads. The employer is then required to assess hazards within the work zone that would affect the safe operation of hoisting equipment, such as those of power lines and objects or personnel that would be within the work zone or swing radius of the hoisting equipment. Finally, the employer is required to ensure that the equipment is in safe operating condition via required inspections and that employees in the work zone are trained to recognize hazards associated with the use of the equipment and any related duties that they are assigned to perform.

Considerable technological advances have been made since the 1971 OSHA standard for cranes was issued. For example, hydraulic cranes were rare at that time, but are now prevalent. In addition, the construction industry has updated the consensus standards on which the original OSHA standard was based. For example, the industry consensus standard for derricks was most recently updated in 2003, and that was for crawler, locomotive, and truck cranes in 2007. In recent years, a number of industry stakeholders asked OSHA to update subpart N's cranes and derrick requirements. They were concerned that accidents involving cranes and derricks continued to be a significant cause of fatal and other serious injuries on construction sites and believed that an updated standard was needed to address the causes of these accidents and to reduce the number of accidents. They emphasized that the considerable changes in both work processes and technology since 1971 made much of former crane information obsolete.

In response to these requests, in 1998 OSHA's Advisory Committee for Construction Safety and Health established a workgroup to develop recommended changes to the subpart N requirements for cranes and derricks. The workgroup developed recommendations on some issues and submitted them to the full committee in a draft workgroup report.

Hazards Associated With Cranes and Derricks in Construction Work

OSHA estimates that 89 crane-related fatalities occur per year in construction work. The causes of crane related fatalities were recently analyzed and published in the Journal of Construction Engineering and Management, "Crane-Related Fatalities in the Construction Industry," Of the 335 OSHA case files reviewed 125 were identified (involving 127 fatalities) as being crane or derrick related.

The following 29 CFR 1926 sections provide an overview of significant changes to the standard.

Sec. 1402, contains the provisions addressing operator training, qualification, and certification. Also contains provisions that will prevent tip-over accidents by ensuring that the operator is sufficiently knowledgeable and skilled to recognize situations when the crane may be overloaded. Under this section, employers must ensure that the surface on which a crane is operating is sufficiently level and firm to support the crane in accordance with the manufacturer's specifications.

Sec.1403, addresses boom stops to prevent booms from being raised too far and toppling over backwards.

Sec.1404, addresses the assembly and disassembly of a crane which now must be supervised by an individual who is well qualified and can take steps when necessary to protect workers against being struck by a counterweight.

Sec. 1407-1411, addresses power-line safety and contains requirements to prevent equipment from contacting energized power lines, ensures that a minimum safe distance from the power line is maintained, which prevents equipment from becoming energized. Also when working closer than the normal minimum clearance distance, the crane must be grounded, which reduces the chance of an electrical pathway through the workers.

Sec. 1412-1414, addresses structural deficiencies issues related to cable failure and includes wire rope inspection, selection, and installation to ensure that appropriate wire rope is installed, inspected, and removed from service when continued use is unsafe.

Sec.1417, addresses crane tip-over hazards caused by factors such as overloading, improper use of outriggers and insufficient ground conditions. This section prohibits the equipment from being operated in excess of its rated capacity, and includes procedures for ensuring that the weight of the load is reliably determined and within the equipment's rated capacity. It also requires the competent person in charge of the operation to adjust the equipment and/or operations to address the effect of wind and other adverse weather conditions on the equipment's stability and rated capacity.

Sec. 1423, addresses protection against falling from equipment and requires that new equipment provide safe access to the operator work station, using devices such as steps, handholds, and grabrails.

Sec. 11424, this section requires that workers who are near equipment with a rotating superstructure be trained in the hazards involved, that employers mark or barricade the area covered by the rotating superstructure, and that the operator be notified whenever a worker must enter that area, and instructed not to rotate the superstructure until the area is clear.

Conclusion

OSHA finds that the 89 fatal injuries suffered each year and employees will now be protected from the types of equipment covered by this final standard. Of that number, OSHA estimates that 21 fatalities would be avoided by compliance with the final standard. In addition, OSHA estimates that the final standard would prevent 175 non-fatal injuries each year. Based on its review of all the available evidence, OSHA finds that construction workers have a significant risk of death and injury resulting from equipment operations, and that the risk would be substantially reduced by compliance with this final standard.

DATES: This final rule is effective on November 8, 2010.

Medical Services Division Board Report

I. Managed Care Organization (MCO) 2011-2012 Contract – Key Elements

A. Health Partnership Program (HPP) Generally – BWC and MCO Responsibilities

BWC determines compensability and pays indemnity benefits. It contracts with MCOs to manage the medical component of workers' compensation claims. MCOs educate employers and injured workers on HPP and process *First Report of an Injury, Occupational Disease or Death* (FROI) reports. They also help employers establish transitional/early return-to-work programs. In addition, MCOs process medical bills and make provider payments.

BWC monitors MCO managed care performance. For example, it measures the effectiveness of the MCOs' return-to-work efforts using the Degree of Disability Management (DoDM) measure. BWC also measures MCO FROI timing, FROI data accuracy, bill timing and bill data accuracy. In addition, it publishes most of these measures in an annual *MCO Report Card*, which is available on ohiobwc.com. BWC encourages employers to view this report before selecting an MCO.

There are **18** certified MCOs statewide, which remains unchanged since last reported. Recertification of the MCOs pursuant to Ohio Revised Code 4121.44 (B) (2) is near completion for the two-year period of 2011 to 2012. Negotiations for the BWC/MCO Agreements to be effective Jan. 1, 2011 have concluded.

B. Key MCO 2011-2012 Contract Provisions and Enhancements

The changes in the 2011-12 MCO contract reflect BWC's and the MCO's goal of advancing the development of key performance indicators that improve outcomes for prompt, safe injured worker return to work and medical management.

MCO Payment

In the aggregate, MCOs are currently paid \$166.7 million for 2010 services. Individual MCO payment is pro-rated based upon relative activity levels. Aggregate payment for 2011 services is frozen at 2010 levels; payment for 2012 will be increased 2% to \$170 million.

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

The MCO performance measure, DoDM, has been replaced with a new metric (Measurement of Disability or MoD). One of the key MCO responsibilities is to help employers establish transitional and early return-to-work programs. In addition, they ensure that appropriate medical treatment is rendered and they process payments to providers. As a result, MCO decisions directly impact injured worker return-to-work outcomes. Their medical management decisions affect the duration of time an injured worker is off work and, thus, impact the \$1.9 billion in annual indemnity costs and more than \$800 million in annual medical costs. MCOs concur that the right metric is essential to support the desired outcome of prompt, safe return to work and stay at work.

45% of MCO compensation is based on the DoDM measure. DoDM was implemented in 1999 and was state of the art at the time. While we have made some enhancements in the last 11 years, the DoDM model has become outdated. The MoD metric design will improve the measurement

Medical Services Division Board Report

of the MCOs' activity by more accurately measuring the effectiveness of the medical case management being provided by the MCOs in terms of the timeliness of injured worker return-to-work and the effectiveness of the management of medical care after injured workers have returned to work. Further, MoD measures a much larger population of claims than DoDM, as MoD includes claims that are outside the employers' experience and three times the number of diagnosis codes. The MoD metric also utilizes updated benchmarks that were developed using Ohio specific data. In addition, the measure is based upon actual return-to-work dates instead of release to work return dates obtained from the provider. Finally, not all claims are "equal" - each claim within the scoring is weighted for significance by severity/importance based upon the average duration of disability or medical complexity for each diagnosis code (ICD9) within the metric. These changes enhance MCO focus on medical case management and return-to-work services for the entire population of claims that they manage.

II. Health Services Quality Improvement Unit Board Update

The Mission of the Health Services Quality Improvement Unit (HSQI) is to provide a robust medical services quality oversight unit within the BWC Medical Services Division. Moreover, its mission is to improve MCO managed care processes and decision-making through education and corrective action by means of oversight, compliance audits, and performance measures which will in turn improve the quality of the medical services delivered to the injured worker.

Background

Pursuant to Board rule, Effective November 1, 2009, BWC reformed its ADR process by eliminating the level two ADR review performed by BWC. ADR dispute issues include: MCO decisions regarding medical treatment and diagnostic testing, vocational services, medical equipment and services, and others.

This elimination frees up limited BWC resources for strategic program improvements – in this case, the creation of the HSQI. The unit will bolster the Medical Services Division's oversight of injured worker medical and vocational service delivery furthering BWC's goal of ensuring prompt, effective medical care to injured workers. Specifically, the Unit will perform quality assurance for the MCO treatment authorization process- approximately 200,000 provider treatment requests annually. The MCO evaluates all medical treatment reimbursement requests submitted by the eligible treating provider using the following three part *Miller* test: Are the requested services reasonably related to the injury (allowed conditions), are the requested services reasonably necessary for treatment of the injury (allowed conditions), and are the costs of the services medically reasonable.

MCO Performance measures – Currently, the Medical Services division measures and monitors how MCOs perform their responsibilities. As stated, we measure the effectiveness of their return-to-work efforts using the Degree of Disability Management (DoDM) model (Now replaced with MoD). We also measure other MCO processes including FROI timing and accuracy, and bill timing and accuracy. However, while we currently have strong administrative metrics to measure MCO performance, the Quality Improvement unit will greatly enhance BWC's *qualitative* review and measurement of MCO performance. This is also consistent with

Medical Services Division Board Report

Deloitte's recommendation to enhance treatment quality by implementing corresponding MCO metrics.¹

Goal and Objectives include:

- Improve treatment outcomes and RTW
- Improve related policy and processes
- Improve the accuracy, timeliness, cost-effectiveness, and the alignment of the delivery of medical services to injured worker needs
- Provide education and training internally, to MCOs, and interested parties
- Improve customer (injured worker and employer) satisfaction

Implementation Progress

The steps for full implementation of the HSQI Unit duties include the following:

1. Creation of the unit plan - completed
2. Staffing requirements - completed
3. Business process workflow – near completion
4. Creation of the definitions and tools to determine treatment authorization audit methodology - in progress
5. Approval of forms – in progress

The treatment authorization audit process is in the research and analysis phase and the team is presently identifying the measures and audit tools. As stated, the purpose of the HSQI compliance process is to reduce the number of treatment authorization errors and improve the quality of the medical services delivered to the injured worker. Specifically, the unit will audit the quality of the MCO treatment authorization decisions and determine whether the approval and/or denial of provider treatment requests were within the requirements of the law (*Miller*), standard treatment guidelines and pathways, and presumptive authorization guidelines established by BWC. The HSQI team has preliminarily established the compliance metrics, developed the auditing tool in excel, and has completed a 5% audit on MCO treatment request decisions from 7/1/10 to 7/31/10, which included 370 records. Presently, staff is in the process of verifying the data. With this trial, we will determine whether our metrics are correct and staff members are auditing claims consistently. Once completed, we will begin to fully implement the treatment authorization audit process consistent with the documented process.

III. WILMAPC Board Update

On February 10, 2010, a performance driven approach to managing state agency workers disability was implemented. The state agencies and the labor unions share a common goal which is ensuring that injured employees receive effective and efficient care resulting in a timely and safe return to work. The program was developed by a joint effort between DAS and Ohio's labor unions representing state agency employees. BWC is providing ongoing subject matter expertise and consulting for the project. The name of the program is WILMAPC, Workplace Injury Labor management Approved Provider Committee.

¹ Deloitte 2.6 at page 3, 18, 29, 31

Medical Services Division Board Report

In summary, the program provides an option to a state agency employee who has been injured at work. They may be eligible for one of two benefits: salary continuation or occupational injury leave. To be eligible, they must select a provider from the WILMAPC approved provider panel to manage their workers' compensation claim. A provider panel will help the employer develop a partnership with providers and in turn help state agency employees receive the best medical care. If an injured worker opts to select a provider outside the panel, they will have their claim managed under the workers' compensation system exclusively and receive the standard workers' compensation indemnity benefit for a lost time claim. A webpage has been provided on DAS's website which provides program details and links to a description of the provider performance metrics. Also, it is from this page that injured workers are able to use a web based tool to locate an approved provider to address their workers compensation medical needs.

The approved provider panel has approximately 11,000 providers. As the program has progressed, provider awareness and desire to participate has continued to grow. This is evidenced by the fact that a number of providers who were not initially invited to join the panel have requested inclusion and have been included on the panel. Since its inception, the panel has managed about 1,100 state agency workers compensation claims. Initial results of program data indicate that approximately 750 different providers were involved in the care of workers in those claims.

BWC is in the final stages of calculating the providers' performance scores across the four performance measures: Release to work, Duration of disability, Relapse, and Cost. Once completed, there will be separate scores for the periods ending June 30, 2010 and October 30, 2010. The scores will be posted on a website for providers to access to assess their current level of performance within the WILMAPC program. The scores will be posted by the end of this month. As planned, the complete evaluation of provider performance, upon which a determination will be made as to their continued provider panel status, will occur in March 2011, one year after the commencement the WILMAPC program.

IV. Benefits plan summary

For injured workers to have access to high-quality medical care, BWC must have an appropriate benefit plan and terms of service in place and offer competitive fee schedules to enhance the medical provider network. BWC has markedly improved its medical, vocational rehabilitation and pharmaceutical services offerings by revising its benefits plans and their corresponding fee schedules. The Medical Services Division has instituted annual reviews for updates as appropriate. Below is a summary of the fee schedule updates in place or planned for fiscal year 2011.

Fee schedule	Effective date	Update summary
Medical providers and services: Covers all medical providers and medical services not covered by any of the other schedules	Oct. 25, 2010	Update to Medicare's 2010 RVUs, adding new benefit service codes, and other refinements as needed to the Nov. 1, 2009, fee schedule

Medical Services Division Board Report

Hospital outpatient: Covers facilities for outpatient services	Jan. 1, 2011	Begin the three-year implementation of the OPPS/APC prospective reimbursement methodology
Medical providers and services: Emergency rule to incorporate new service codes	Proposed: Jan. 1, 2011	Update to add new CPT and HCPCS codes that are effective nationally as of Jan. 1, 2011
Hospital inpatient: Covers facilities for inpatient services	Proposed: Feb. 1, 2011	Update the Medicare Severity — Diagnosis Related Grouping to the 2011 federal fiscal-year values and update the payment for Medicare exempt providers to the 2009 cost-to-charge ratios
Hospital outpatient: Covers facilities for outpatient services	Proposed: April 1, 2011	Update to implement the 2011 Medicare annual OPPS updates
Ambulatory surgical centers (ASC): Covers surgical procedures not requiring inpatient hospitalization	Proposed: April 1, 2011	Update ASC payment rates to the 2011 ASC PPS Medicare rates and the payment adjustment factors used in calculating Ohio rates
Vocational rehabilitation services: Covers all vocational rehabilitation services	Proposed: June 2011	Update rates and add new custom service codes as needed

Billing and Payment Reforms - The Medical Services Division is also preparing to implement additional clinical edits to ensure compliance with benefits plan structure and reimbursement limits. The division estimates that clinical edits implemented in October 2008 helped BWC avoid nearly \$2.9 million in incorrect reimbursements. BWC has also continued contracting with a recovery vendor who retrospectively reviews inpatient bills identified by BWC and recovers any identified overpayments. This vendor also recovers overpayments identified by hospitals.

12 - Month Medical Services & Safety Calendar

Date	December 2010	Notes
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. Outpatient Hospital Fee Schedule (2nd read)	
	4. OSHA/PERRP crane rule (1st read)	
	5. Medical Services Report	
2011		
January 2011		
1/20/11	1. OSHA/PERRP crane rule (2nd read)	
	2. Vocational Rehab fee schedule (1st read)	
	3. Customer Services Report	
	4. Rehabilitation Services Commission Review	
February 2011		
2/23/11	1. Vocational Rehab fee schedule (2nd read)	
	2. Pain Management education session	
	3. 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	
August 2011		
8/25/11	1. Inpatient Hospital Fee Schedule (1st read)	
	2. Medical Services Report	
September 2011		
9/29/11	1. Inpatient Hospital Fee Schedule (2nd read)	
	2. Customer Services Report	
October 2011		
10/27/11	1. Committee Charter review (1st read)	
	2. Inpatient Hospital Fee Schedule (2nd read)	
	3. Medical Services Report	
November 2011		
11/17/10	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	

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	N/A	N/A		
2011	Jan/Feb	June, 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