

BWC Board of Directors

Medical Services and Safety Committee

Wednesday, December 16, 2009, 10:00 am

Level 2, Room 2 (Mezzanine)

30 West Spring St.

Columbus, OH 43215

Members Present: James Harris, Chair
James Hummel
Thomas Pitts

Members Absent: None

Other Directors Present: Charles Bryan, David Caldwell, Alison Falls, Kenneth Haffey, William Lhota, James Matesich, and Larry Price

CALL TO ORDER

Mr. Harris called the meeting to order at 10:04 AM and the roll call was taken. All members were present.

REVIEW AND APPROVAL OF MINUTES OF NOVEMBER 19, 2009

Mr. Harris opened the floor for any proposed changes to the minutes of the November 19, 2009 meeting. With no changes proposed, Mr. Harris moved to have the minutes of November 19, 2009 be approved, and Mr. Hummel seconded the motion. The motion passed with a 3-0 unanimous roll call vote.

REVIEW AND APPROVAL OF AGENDA

Mr. Harris opened the floor for any proposed changes to the agenda. With no changes proposed, Mr. Pitts moved to have the agenda approved, and the motion was seconded by Mr. Hummel. The motion passed with a 3-0 unanimous roll call vote.

Prior to presenting the first order of new business, Mr. Harris remarked that the Ohio Manufacturers' Association had published a bulletin concerning workers' compensation rate reform last week. Mr. Harris believed the document would be a useful reference for the Board of Directors and may be discussed at a later date.

NEW BUSINESS/ACTION ITEMS

1. Motions for Board Consideration

A. For Second Reading

1. Ambulatory Service Center Fee Schedule, Rule 4123-6-37.3

Mr. Freddie Johnson, Director of Managed Care Services, and Ms. Anne Casto, President of Casto Consulting, presented the second reading of the proposed 2010 Ambulatory Service Center Fee Schedule.

Mr. Johnson noted reference materials presented at the previous reading of the proposed 2010 Ambulatory Surgical Center Fee Schedule (ASCFS). Ambulatory Surgical Centers (ASCs) are standalone facilities providing surgical procedures that do not require an inpatient hospital stay. Examples of procedures include knee scopes and pain management injections. Mr. Johnson indicated ASCs represent a small fraction of total provider reimbursements, approximately \$7 million annually, which is less than one percent (1%) of all provider reimbursements.

Although ASCs are a small component of all provider reimbursements, Mr. Johnson reported ASCs were a critical component to the workers' compensation system. There are 200 ASCs statewide, and the majority is located around metropolitan areas. According to Mr. Johnson, ASCs provide increased availability of services to injured workers and treating physicians in a cost effective environment. Mr. Johnson indicated the proposed ASCFS would increase reimbursements to ASCs by an estimated sixteen percent (16%) or \$860,000 over what is estimated to be reimbursed in FY 2009. Mr. Johnson noted the effective date, upon recommendation by the Medical Services and Safety Committee and subsequent approval by the Board of Directors, is expected to be April 1, 2010. Mr. Johnson believed the proposed 2010 ACSFS met the Bureau's goal of ensuring high access to quality care for injured workers in a cost effective environment and ultimately enhancing the provider network for the Bureau.

Mr. Johnson stated the Ohio Association of Ambulatory Surgical Centers, (OAASC) was consulted in developing the proposed ASCFS and the proposal was posted to the Bureau's website. Mr. Johnson provided a stakeholder grid, and the Bureau's responses, to the Medical Services and Safety Committee.

Mr. Johnson reviewed the methodology in developing the proposed 2010 ACSFS. The 2009 ASCFS was reviewed along with policy changes. Mr. Johnson noted last year the Bureau began the transition to a Medicare prospective payment methodology, and the number of services was increased where ASCs could receive reimbursement. OAASC provided bill and cost data of ASCs because the information is not provided to Medicare. This bill and cost data allowed the Bureau to understand how to implement the ACSFS in a Medicare environment and assisted in setting payments at the right level to meet the Bureau's mission.

Ms. Casto noted this year marks the third year of transition with a blended payment format of 75% old system rate, 25% new system rate. Ms. Casto noted the Bureau's encounters in the ASC environment is broken down as: 45% orthopedic; 45% pain management; and 10% other. Under the blended rate structure, orthopedics demonstrated an increase, and pain management demonstrated a small decrease, in reimbursements.

Mr. Harris asked if the Bureau was paying 45% of the services to ASCs in pain management and 45% of the services to ASCs in orthopedics. Ms. Casto confirmed that statement was correct, and the remaining 10% was for eye procedures, laceration repairs, hernia repairs, and other miscellaneous services.

Ms. Casto noted the basic formula used to determine the proposed 2010 ACSFS was to take the Medicare rates and apply a two tiered adjustment factor in order to obtain the Bureau’s reimbursement rate. Orthopedic and other services would have a 100% adjustment factor, and pain management services would have an adjustment factor of 110%, summarized in the following chart:

Type of Service	Medicare rate	BWC Adjustment Factor	Estimated Net Effect
Orthopedic	+20%	100%	+20%
Pain Management	-2%	110%	+8%
Other	+10%	100%	+10%
Total:	+14%		+16%

Ms. Falls inquired, and Ms. Casto confirmed that for the 2009 ACSFS the Bureau’s adjustment factor was 100% across the board for all ASC services.

Mr. Hummel inquired and Mr. Johnson confirmed there were only two stakeholder comments. The OAASC and the Bureau had frank discussions about where the Bureau was at in the Medicare transition period. OAASC appreciated the recognition of the impact on pain management services while admitting their membership would have preferred a larger increase. Mr. Johnson indicated the other stakeholder who responded, Aetna, had no changes to the proposed 2010 ACSFS.

Mr. Johnson concluded by reiterating the estimated impact of the proposed 2010 ACSFS would increase overall reimbursement to ASCs by 16% with an estimated dollar impact of \$860,000. \$740,000 of the increase would be for pain management services with the remaining \$120,000 in orthopedics and other services.. Mr. Johnson maintained the proposed 2010 ACSFS would maintain a competitive fee schedule which ensures injured workers’ access to quality care.

Mr. Pitts inquired if the slide titled “ Estimated Impact of Recommendations” should have the word “ orthotics” replaced with “ orthopedics.” Mr. Johnson agreed.

Mr. Hummel moved that the Medical Services and Safety Committee recommend that the Bureau of Workers’ Compensation Board of Directors approve the Administrator’s recommendation to amend rule 4123-6-37.3 of the Administrative Code, “ Payment of Ambulatory Surgical Center Services,” with the motion consenting to the Administrator amending rule 4123-6-37.3 as presented at this meeting. The motion was seconded by Mr. Pitts, and the motion passed by a 3-0 unanimous roll call vote.

2. 2009 Vocational Rehabilitation Services Fee Schedule, Rule 4123-18-9, Revised

Mr. Robert Coury, Chief of Medical Services and Compliance, and Mr. Tom Sico, Assistant General Counsel, presented the second reading of the revised 2009 Vocational Rehabilitation Services Fee Schedule (VRSFS), Rule 4123-18-9.

Mr. Sico noted a fee schedule rule was previously approved by the Board of Directors and filed with JCARR; however, after concerns were raised at JCARR, the rule was withdrawn. The rule was modified under paragraph (B) to take away concerns raised at JCARR, and the language in paragraph (B) now reflects the wording in Ohio Rev. Code Sec. 4121.44(C).

Mr. Coury stated the main objection to the previous rule did not relate to the fee schedule itself; rather paragraph (B) was the issue, which reflected a longstanding obligation of managed care organizations to provide cost containment by negotiating provider fee agreements. The objection raised by the Ohio Association of Rehabilitation Facilities (OARF), was that paragraph (B) was overbroad, and JCARR representatives were sympathetic to their concerns. Given that the rule was unlikely to pass JCARR review in the previous form, the rule was withdrawn.

Mr. Coury said the Legal and Medical Departments of the Bureau worked on the revision. Mr. Coury noted neither department could find anything in the revision that would harm the cost containment initiative with these provider agreements. There was also no known impact of the revision that would impact certified providers from treating injured workers. The International Association of Rehabilitation Facilities (IARF) supported the rule to pass as previously filed. OARF indicated the revision was a step in the right direction, but the organization would not provide any further commitment. While Mr. Coury did not expect any further opposition from interested parties, he could not guarantee there would be no further objections raised again in the JCARR process when the rule is re-filed.

Mr. Matesich inquired if any other group other than OARF or IARF had commented on the proposed revisions, such as managed care organizations. Mr. Coury responded the managed care organizations did not agree with the objection raised by OARF. Mr. Coury reported managed care organizations believe the ability to engage in cost containment provider agreements is beneficial to employers and the State Insurance Fund.

Mr. Pitts commented that, at the last meeting on this rule some months ago, the fee schedule was not itself an issue. While the rates increased slightly, Mr. Pitts had heard concerns that the rates were below the national average. Mr. Pitts believed VRSFS should encourage quality people to come to Ohio to do the valuable services needed. Mr. Pitts hoped next year, when VRSFS is up for review, that further increases will be proposed.

Mr. Pitts said this issue touched upon another topic: the vocational rehabilitation referral issue. Mr. Pitts wanted as many people in the system as the system can support and not limited to a select few who happen to be contracted with managed care organizations. Mr. Coury replied that, when Administrator Ryan

came to the Bureau, she first wanted to understand fee schedules as a whole. Previously fee schedules were either outdated, such as VRSFS, or given short shrift for updates. That commitment had been met, in Mr. Coury's opinion, and he believes the commitment is clear to the Board of Directors in light of the number of fee schedule adjustments that they have made. Mr. Coury noted, in VRSFS, we attempted to raise the mileage reimbursement rate a year ago, and when passed, VRSFS will represent a six percent (6%) increase, estimated to be \$2 million, to these providers. Mr. Coury reported Mr. Johnson will be back in July 2010 on this fee schedule as the goal of the Bureau was to evaluate fee schedules annually.

Mr. Harris inquired if VRSFS is coming back in July, 2010 for review, he would like to look at baselines as to what has been accomplished under the revisions.

Mr. Sico raised a technical point. He noted this rule is being re-filed, but there will be no public hearing on the rule revision. There will be a JCARR hearing in mid to late February, 2010. Mr. Sico also noted VRSFS currently has an effective date of January 1, 2010, but the date will be adjusted in paragraph (A) of the rule based on the JCARR calendar.

Mr. Harris asked, although one cannot predict how JCARR will respond, is the rule revision what JCARR was seeking? Mr. Coury responded that OARF has indicated the rule appears to be on the right track, but they wanted to meet with State Representative Skindell. Given the rule revision mirrors the Ohio Revised Code provisions, and JCARR was concerned about the over breadth of the previous filing, Mr. Coury was confident JCARR will approve the revised rule.

Mr. Pitts moved that the Medical Services and Safety Committee recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to revise and re-file Rule 4123-18-09 of the Administrative Code, the VRSFS rule, noting the Administrator revised paragraph (B) of the rule as originally presented to and approved by the Board of Directors at a prior meeting. The motion was seconded by Mr. Hummel, and the motion passed by a 3-0 unanimous roll call vote.

B. For First Reading

1. Outpatient Hospital Fee Schedule, Rule 4123-6-37.2

Mr. Johnson and Ms. Casto presented the first reading of the proposed 2010 Outpatient Hospital Fee Schedule (OHFS).

Mr. Johnson began by noting outpatient hospitalization (OH) reflects approximately seven percent (7%) of the total invoices and seventeen percent (17%) of medical expenses annually. OH includes emergency room visits that are typically the first treatment rendered after an injury occurs. Mr. Johnson indicated the proposed 2010 OHFS is the first update since September, 2007. The proposed 2010 OHFS incorporated changes from Medicare, which goes from a retrospective methodology to a prospective methodology. This proposal was similar to the proposed 2010 ACSFS discussed previously. Unlike other fee schedules presented

to the Board of Directors, the proposed 2010 OHFS called for a twenty-two percent (22%) decrease in reimbursements over a two year period. The proposed 2010 OHFS would reduce reimbursements for OH by \$30 million from 2008 reimbursements. Subject to approval, Mr. Johnson expected to file the proposed 2010 OHFS with JCARR in February, 2010 with an estimated effective date of April 19, 2010. Mr. Johnson believed the proposed 2010 OHFS met the Bureau's guiding principles of ensuring access to quality care to injured workers in a cost effective manner. Mr. Johnson said the Bureau met with the Ohio Hospital Association (OHA), in July, 2009 and on December 10, 2009. Additionally, the Bureau met with managed care organizations in August, 2009 and with self insured employers and OARF in September, 2009. A stakeholder grid with Bureau responses was provided, and the grid was updated as of December 12, 2009.

Mr. Johnson reported OH encounters by the Bureau had a decreasing trend from 2006 through 2008. This trend was not unique to OH, and the same type of experience was seen with ASCs. The Bureau was presently reimbursing for OH at 146% of cost and 212% of the Medicare reimbursement rate. On a per encounter basis, the Bureau paid \$622 in 2006; \$644 in 2007; and \$628 in 2008.

Mr. Johnson said the Bureau currently uses a retrospective reimbursement methodology, which provides a charge to service providers once services are billed. Mr. Johnson indicated this currently is the cost plus the Ohio Medicaid cost-to-charge ratio (CCR), plus sixteen percentage points in most instances with a cap of sixty percent (60%) of allowed billed charges. Each hospital has their own Medicaid CCR and the Bureau adds 0.16 to the ratio to determine the Bureau rate. As an example, Mr. Johnson said a CT head scan with an allowable charge of \$1,741.00 at a hospital with a CCR of 0.30 would be paid \$800.86 (\$1741.00 times 0.46). Mr. Johnson reported there are risks inherent in this current structure.

Mr. Johnson noted the proposed 2010 OHFS would begin the transition to a prospective payment methodology, which had been recommended when the nationally recognized consulting firm Navigant reviewed the Bureau's billings in 2007. The methodology has already been applied to inpatient hospitalization and ASC settings, and OH providers are already familiar with Medicare's prospective payment methodology. The prospective payment methodology has two key benefits: rates and policies are established in advance; and rates remain constant during the effective period. Impacts from changing to a prospective payment methodology, according to Mr. Johnson, were: promoting predictability of payments; promoting equity and consistency of payments; encouraging facilities to improve efficiency of providing care; and rate increases are better controlled from year to year. Mr. Johnson said there was also a rate setting impact because it will be easier to project to employers exactly what costs are to be incurred in a claim.

Mr. Johnson provided an example of four hospitals with four different CCRs and four different charges for the same service of a blood count test. While the test is routine, there was a great disparity in what the Bureau pays a hospital for the service. The charges in the example ranged from \$51.30 to \$115.18, and payments by the Bureau ranged from \$18.50 to \$57.50. Under the proposed 2010 OHFS, the

new rate for the same treatment at all four hospitals would be \$21.05, and this rate is constant for all hospitals for the entire term of the OHFS.

Mr. Matesich asked for further clarification of the example as to why the rates are different between hospitals. Ms. Casto responded each hospital has its own CCR; one may be at 0.20 and one may be at 0.30. A 0.20 or 0.30 CCR means that for every \$1 billed, the hospital will be paid \$0.20 or \$0.30. The Bureau then adds 0.16 to each CCR and the payment is determined. Mr. Matesich asked if the current reimbursement rates are specific to each hospital, and Ms. Casto answered in the affirmative. Ms. Casto did note there was a geographic cost index factored in across the country by Medicare, but the rates used by the Bureau are based on Ohio Medicaid CCRs. Mr. Matesich asked, if the new proposal is adopted, whether the providers doing OH would continue to do so for injured workers. Mr. Matesich was concerned because, in one of the hospitals in the example, there was a rather substantial fifty percent (50%) decrease in payment. Mr. Johnson replied hospitals are constantly changing their policies and practices in response to reimbursement rates, and the new proposal actually encourages facilities providing OH to improve efficiencies in providing care. Mr. Johnson knew of no hospitals that would not serve injured workers by going to this new methodology. Mr. Matesich asked Mr. Johnson specifically if injured workers would not suffer because of the proposed rate schedule. Mr. Johnson replied that he had met with OHA, and there were fifteen hospitals represented in one meeting. Mr. Johnson indicated the hospitals would continue to provide service to injured workers, and there was no hospital saying this was a big problem. Mr. Johnson indicated the Bureau has a goal of maintaining access to quality care for injured workers. Under the proposed 2010 OHFS, hospitals will have the opportunity to make adjustments. Mr. Johnson concluded his remarks stating hospitals had been using the Medicare prospective payment methodology since 2000, and providers are accustomed to this billing reimbursement practice. Mr. Johnson noted the methodology was the same used for the 2010 ACSFS.

Mr. Hummel shared the same concerns as Mr. Matesich, and he inquired how the proposed change would be monitored. Mr. Johnson noted the Bureau was taking this issue seriously and making sure the Bureau understood the providers in their environment. Mr. Johnson said feedback was used to make sure the Bureau's resources were being used effectively. The Bureau met with OHA three or four times and more meetings would be planned. Mr. Johnson wanted a strategic partnership with the providers. If access through the proposal was being undermined, the Bureau would come back to the Board of Directors. Mr. Johnson assured the Medical Services and Safety Committee that measures would be put in place to monitor access.

Ms. Falls noted she would like specific statistics regarding inpatient hospitalization to ensure there was no diminution in access. Ms. Falls inquired if that was possible, the statistics would support Mr. Johnson's statements conceptually. Mr. Johnson replied he would take her request back to his team and see if the information could be provided next month. Mr. Hummel indicated as the numbers come in, he would like them provided to the Medical Services and Safety Committee, and Mr. Johnson agreed to do so.

In response to Mr. Lhota Ms. Casto confirmed the example provided was based on real hospitals and real bill charges. Mr. Lhota asked if the disparity was solely due to the CCR for each hospital. Ms. Casto could not answer that question with 100% certainty. The CCR could be a factor, but additionally, some hospitals may mark up a bill charge in certain areas of their respective books of business. Ms. Casto noted there were a lot of billing schemes that are not regulated. Mr. Lhota said these responses reinforce concerns that something has to give, and hopefully that is not access to service by injured workers. Mr. Johnson responded that statement is why the Bureau started meeting with hospitals so early in the process.

Mr. Pitts noted one of the stakeholder comments was a concern about the complexity of the proposed 2010 OHFS; however, he did not see the complexity in the presentation. Mr. Johnson noted this presentation was mainly an overview, and there was complexity in the details, which the Bureau did not deny. Mr. Johnson stated there were multiple components in the methodology, and Medicare updated some data on a quarterly basis. Mr. Pitts asked if the proposal was not as simple as it looks, and Mr. Johnson agreed.

Mr. Johnson noted Medicare's Outpatient Prospective Payment System (OPPS), was one of the few publicly available prospective payment systems. Many private insurers use prospective payment models, but their data is proprietary. OPPS is empirically sound and is based on average resource consumption with provider services. In using the previous example, OPPS examined what were the average resources to have the blood test done. OPPS was reviewed, debated, and maintained each year based on changes in consumption. As changes in consumption are made, the relevant OPPS rate also changes. Comments are provided by clinics, hospitals and suppliers from across the country seeking improvements. The Medicare Payment Advisory Commission (MEDPAC) gives an annual advisory report to OPPS, along with the Ambulatory Payment Classification Advisory Panel. Mr. Johnson said OPPS was one of the most debated aspects of the Medicare system, and OPPS is maintained (reviewed/updated?) each year by law. OPPS was updated quarterly for inclusion of new coding. OPPS would provide improved editing of bill data and improved monitoring of bill data accuracy for the Bureau. Mr. Johnson said seven other state workers' compensation systems use Medicare's OPPS model: Washington, California, West Virginia, South Carolina, Tennessee, North Dakota, and Texas. Mr. Johnson also said Blue Cross/Blue Shield of Mississippi and Michigan use the Medicare OPPS model, along with Medicaid programs in Vermont and Michigan. Each system using the Medicare OPPS model has a payment adjustment factor.

Ms. Casto recalled the retrospective reimbursement formula would take the allowed charge multiplied by the CCR plus sixteen percentage points to determine the Bureau reimbursement rate. Mr. Matesich asked if there was a difference between RCC, as noted on the slide, versus CCR. Ms. Casto noted there was no difference in the terminology. Ms. Casto noted the proposed prospective reimbursement formula had some hidden details and other formulas involved, but essentially the Medicare rate plus an add-on amount multiplied by the Bureau's payment adjustment factor would provide the Bureau reimbursement rate. Add-

on amounts involved some complexity, such as a rural community hospital as a sole hospital in the community, costs more. Outlier providers with high cost encounters are adjusted prospectively to account for their services. Examples are children's hospitals or cancer centers. Mr. Harris inquired if community hospitals would be the only ones with a positive add-on factor, and not all hospitals. Ms. Casto replied in the affirmative. Mr. Harris asked how that was determined, and Ms. Casto replied research could be provided to show which community hospitals would be eligible for the add-on.

Ms. Casto noted there are three modifications in the Bureau's implementation of Medicare's OPPS. First, there would be a modification of coverage because there are some Medicare non-covered services, such as vocational rehabilitation, that the Bureau would want to cover. Likewise, there would be non-coverage for supplies not applicable to the injured worker environment, such as pediatric supplies. Second, Ms. Casto noted there would be a modification to the reimbursement formula that would modify add-on payment formula for cancer hospitals and children's hospitals at the line item level. Ms. Casto noted Medicare makes quarterly and annual adjustments, but the Bureau would apply these adjustments at the line item level to comply with the law. Finally, Ms. Casto noted the Bureau's implementation would deactivate edits not applicable to the workers' compensation system.

The next issue was setting the payment adjustment factor for the Bureau. Mr. Johnson said this required financial analysis of the percent of cost and percent of allowed billed charges by type of service. The recommendation is the payment adjustment factor be set at 166% of the Medicare OPPS rate, or 114% of cost. According to MEDPAC, private insurers over the past twenty years have paid between 115% and 132% of the Medicare payment to cost ratio. Presently, the Bureau reimburses at 146% of the Medicare payment to cost ratio for OH services. Mr. Hummel asked if this type of study had been done for previous fee schedules. Ms. Casto said not for the ASCFS or the provider fee schedule. Ms. Casto noted slide 17 demonstrated where the Bureau was presently, at 146% over Medicare's payment to cost ratio and well above the national average; slide 18 demonstrated the recommendation of a 166% payment adjustment factor would lead to an expected payment to cost ratio of 114%. Ms. Falls asked if the Bureau is currently paying 146% of cost and the recommendation is to take it to 114%. Mr. Johnson replied in the affirmative. Ms. Falls asked if the 166% payment adjustment factor is from a level of 212% presently. Mr. Johnson replied in the affirmative. Ms. Falls inquired if OHA approved this recommendation, and Mr. Johnson replied in the affirmative. Mr. Matesich inquired if the terms "OPPS," "CMS," and "Medicare" are essentially the same. Mr. Johnson replied in the affirmative.

Mr. Johnson noted there were two impacts/concerns caused by the recommendation of setting the payment adjustment factor for the Bureau at 166%. The first concern was the impact on the 4 major children's hospitals. Using the proposed 166% payment adjustment factor, these facilities would lead to a Bureau payment to the facility at 53% of cost, which was not acceptable. The recommendation was to have the payment adjustment factor for these facilities at 253%, which would keep reimbursements at their current level. Mr. Harris

inquired why the Children's Hospital Medical Center in Akron had so many more visits in 2008 than the other children's hospitals. Mr. Pitts reported that hospital was a leading burn unit for the upper quarter of Ohio.

The second concern Mr. Johnson reported was the \$30 million decrease in reimbursement to these providers. Mr. Johnson noted the proposal was spread out over two years, with the 2010 having a Bureau payment adjustment factor of 189%, and in 2011 phasing in the recommended 166% figure. This action would decrease reimbursements each year by an estimated 11%, or \$15 million. In conclusion, Mr. Johnson recommended the Bureau adopt a modified OPSS reimbursement model for a hospital outpatient setting, adopt rates as published in the 2010 OPSS final rule, apply a 253% payment adjustment factor to OPSS for children's hospitals, and apply 189% payment adjustment factor to OPSS rates for all other facilities with the understanding that the same rate in the next year would be 166%. Mr. Johnson predicted the proposal would have an estimated 22% reduction in reimbursements, with an estimated 11% or \$15 million decrease in 2010 and 2011, respectively. Mr. Johnson noted the proposal would: increase predictability of medical payments; improve data for rate setting, and maintain a competitive fee schedule ensuring access to quality care for Ohio's injured workers.

Mr. Matesich asked for the proposal's purpose: to develop a new rating system, or to save \$30 million. Mr. Johnson replied, as he said to OHA, this proposal was not cost containment based. Mr. Johnson stated, by using the same methodology as other fee schedules, in most instances led to increased Bureau payments. First, Mr. Johnson indicated the methodology allowed more predictability of results. Second, Mr. Johnson noted the proposal allowed the Bureau to pay appropriate fees while providing access to quality care. Finally, Mr. Johnson concluded the fee schedule gave hospitals time to adjust accordingly. Mr. Matesich agreed with the first two portions of the response, but disagreed with the third. Mr. Matesich noted the fee schedule would be going into place in 2010 with serious reductions. Mr. Johnson understood Mr. Matesich's concerns, and reiterated the Bureau was working with OHA.

Mr. Price noted the Bureau looked last year at fees, and fee levels are always a concern. Clearly, the data showed the Bureau needed to make some adjustments here, but how fast the Bureau should get there is the issue. Mr. Price noted with abrupt change comes a requirement of due diligence. While the Bureau is not trying to change the marketplace overnight, the Bureau is trying to change.

Mr. Hummel inquired if private payers are presently paying less for the same services than the Bureau. Ms. Casto replied in the affirmative, based on the national averages. Mr. Hummel noted that if Blue Cross/Blue Shield and Medicare are paying less than the Bureau, clearly there is a basis to the recommendations.

Mr. Price asked about the example given and verified that the proposal would have all providers receive the same payment. Mr. Johnson replied in the affirmative. Mr. Hummel inquired if the \$21.05 figure was based upon the recommended proposal. Mr. Johnson and Ms. Casto replied in the affirmative, with Ms. Casto

adding the figure was based on the OPPS rate times the 2010 recommended payment adjustment factor of 189%.

Mr. Bryan commented there is no negotiation involved in this process. In the private sector, such as Blue Cross/Blue Shield, the provider and insurer negotiate a fee structure; if there is no agreement reached, the provider chooses not to enter the network. Mr. Johnson reiterated the Bureau was working with hospitals and treating them like all other providers, as partners. Once the right rate is set, the hospitals are free to negotiate with self insured employers and managed care organizations if they choose. Mr. Bryan inquired if a hospital could opt out of the system. Mr. Johnson replied a hospital could refuse to serve injured workers like any other provider. Mr. Harris believed that statement was an important point. Mr. Harris noted the Medical Services and Safety Committee was skeptical, and he was personally concerned, about the hospitals being able to opt out of servicing injured workers. Mr. Harris noted if hospitals were to opt out, the effect would be brutal, particularly at the emergency room level. Mr. Harris suggested Mr. Johnson propose some different numbers and recommendations if cost containment was not the issue. Mr. Harris asked that the proposal be reviewed again in light of the concerns raised by the Medical Services and Safety Committee.

2. PERRP adoption of Federal OSHA final rules for personal protective equipment and acetylene, Rule 4123-3-04.2

Mr. Michael Rea, Industrial Safety Administrator for the Division of Safety and Hygiene (DSH), appeared for the first reading of the Public Employment Risk Reduction Program (PERRP) adoption of Federal OSHA final rules for personal protective equipment and acetylene.

Mr. Rea noted House Bill 308 created PERRP. PERRP then adopted, as part of its rules, the federal occupational safety and health standards for general industry, construction and agriculture, for public employers. This action provided job safety and health protection to public employees in Ohio similar to what exists in the private sector. In June, 2005 the PERRP program became part of the Bureau. To eliminate any confusion, Mr. Rea noted the rules being presented are not related to the Ohio Administrative Code Specific Safety Requirements.

The first proposed rule reviewed by Mr. Rea concerned acetylene. Mr. Rea noted the revisions proposed in this presentation would adopt OSHA's acetylene standard, which is consistent with current industry practices, thereby eliminating confusion, clarifying employer obligations, and reducing compliance costs. OSHA also believed the proposed revisions would enhance employee protection. The updated acetylene standard would include: mandatory requirements for acetylene piping systems; special requirements for high-pressure piping systems; prohibitions against the storage of acetylene cylinders in confined spaces; and provision to employers of new and more extensive information than the current standards, thereby facilitating compliance. The rule had two substantive changes. First, the addition of storage rules and the second addressing flow rates of acetylene.

The second proposed rule reviewed by Mr. Rea concerned personal protective equipment. OSHA will require safety equipment manufacturers to comply with more current applicable personal protective equipment standards. Three examples provided by Mr. Rea concerned head, eye, and foot protection. For example, helmet designations now address impacts to the top and lateral sides of helmets. Also, eye protection must meet radiant energy transmission protection standards. Finally, Mr. Rea noted the 1967 ANSI standard for footwear must now meet any of the consensus standards developed in 1991, 1999 or 2005. Mr. Rea concluded that the proposed rule neither reduces employee protection nor alters an employer's obligations under the existing standard. Employers will be able to use the same equipment they have been using to meet their compliance obligation under existing standards.

Mr. Harris asked Mr. Rea if this rule was developed by OSHA, and Mr. Rea confirmed this statement. Mr. Lhota asked if the rule would require a wholesale replacement of hats and goggles, and Mr. Rea confirmed this rule would not have that impact.

C. Consider Recommending Board Approval of FY2009 Division of Safety and Hygiene Annual Report

Mr. Abe Al-Tarawneh, Superintendent of DSH, discussed the FY2009 Division of Safety and Hygiene Annual Report. Mr. Al-Tarawneh reported that highlights of the report were presented last month, and asked if there were any additional questions. Being none, Mr. Hummel moved that the Medical Services and Safety Committee of the Workers' Compensation Board of Directors accept the recommendation of the Administrator to approve the BWC Division of Safety and Hygiene Annual Report and refer to the Board of Directors for review, approval and release. The motion was seconded by Mr. Pitts, and the motion passed by a 3-0 unanimous roll call vote.

DISCUSSION ITEMS

1. Safeguard/Safeguarded/Safeguarding Discussion

Mr. Al-Tarawneh next discussed the terms "safeguard," "safeguarded," and "safeguarding." Mr. Harris introduced the presentation as a culmination of efforts originating this past summer.

Mr. Al-Tarawneh noted that during the review and update of Ohio Administrative Code Specific Safety Requirements (SSRs.), the Board of Directors asked DSH to explore, and if needed, provide and/or enhance the definitions of the terms "guard" and/or "safeguard" in the SSRs. Recognizing the importance of these definitions within the context of the SSRs, Mr. Al-Tarawneh reported there were many discussions with interested parties representing different stakeholders. Mr. Al-Tarawneh said those discussions were very enlightening to all parties involved, as they emphasized the value and importance of the high level of due diligence required and practiced in proposing any changes to the SSRs.

At the onset of these discussions, Mr. Al-Tarawneh said his staff explored changes to the definition of the term “guard.” After thorough evaluation internally and through input from interested parties relative to the impact that any proposed changes would have on the technical and legal use of the term, DSH proposed keeping the current definition of the term “guard” in the SSRs.

DSH, also through these discussions with interested parties, established that the term “safeguard,” or its permutations “safeguards,” “safeguarding,” and “safeguarded,” are used sporadically in different parts of the SSRs. Mr. Al-Tarawneh reported a perception that there might be a need to provide a definition for the term “safeguard,” and DSH evaluated, both internally and with interested parties, proposing certain language for such definition. After careful review of various contexts in which the term “safeguard” and its permutations are mentioned in the SSRs, DSH concluded that a definition that will satisfy those contexts will be very broad, possibly resulting in unknown and/or undesired misinterpretations of some of the contexts in which the term is mentioned in the SSRs.

Mr. Al-Tarawneh then reviewed how DSH reached this conclusion. Mr. Al-Tarawneh noted that the word “safeguard” is not used anywhere in the SSRs. However, the words “safeguards,” “safeguarded” and “safeguarding” were used twenty times. The terms were used: four times in the construction SSRs; fourteen times in the workshops and factories SSRs; and two times in the window cleaning SSRs. Mr. Al-Tarawneh indicated, in the construction SSRs, the term “safeguard” either referred to a standard of care or part of a design in scaffold loading, such as planks and guardrails. Two times the term “safeguarding” was used to reflect due diligence relative to the use of personal protective equipment. Under the workshops and factories SSRs, “safeguards” often referred to concepts of guarding and safe operation of power presses. The term referred to the means and concepts to assure keeping workers’ body parts from the point of operation when the press is in operation. Under the workshops and factories SSRs pertaining to forklifts, Mr. Al-Tarawneh noted the terms reflect OSHA’s guidelines for their use in a factory or plant environment.

Mr. Al-Tarawneh concluded that the common theme that emerged from these different uses is that “safeguarding” is a concept related to insuring that an “acceptable level” of due diligence has been exercised to prevent an undesired outcome. In the case of the SSRs, Mr. Al-Tarawneh said this undesired outcome is an injury to an employee. Such “acceptable level” of due diligence can be very broad and subjective. In most cases, employers rely on regulations and standards to better understand what needs to be done. However, in some other cases, a reasonable judgment would need to be made based on context, expectations, and comparative analysis. Mr. Al-Tarawneh said in these cases a limiting, or a broad definition of “safeguard,” could result in undesired interpretation. Accordingly, DSH recommended a specific definition of the word not be adopted. Mr. Al-Tarawneh said the definition should be as it relates to the circumstances governing such interpretation.

Mr. Harris made a personal comment that, when this issue was raised last spring, he was concerned with tightening of accident and safety rules. From his experience, Mr. Harris said "safeguarding" was more stringent than "guarding." Mr. Harris also indicated he was sensitive to comments made by the Legal Division and the potential impacts of defining the terms discussed. Mr. Harris added it was never his intention to disrupt the process, but to improve safety to workers. Mr. Al-Tarawneh replied that, through this effort, DSH gained a better understanding of the various ways in which the terminology is used, and this effort will be very beneficial for DSH in the future.

2. Vocational Services referral pattern, report-out

Mr. Johnson discussed an evaluation of MCO vocational rehabilitation services referral patterns.

Mr. Johnson indicated the interested parties had been contacted for feedback on the report, which included: IARF; OARF; Ohio Physical Therapy Association; managed care organizations; and the Labor Management Government Advisory Committee. Mr. Johnson said the latter organization actually had a subcommittee working on this project. In the next few weeks, Mr. Johnson expected feedback would be returned from the interested parties to improve the report's presentation. Mr. Johnson noted he would reappear at the January, 2010 meeting of the Medical Services and Safety Committee for a full report on this issue.

Mr. Pitts commended the staff to date that had worked on this report and investigated the issue. Mr. Pitts strongly believed this work was the type the Medical Services and Safety Committee should be doing.

3. Committee Calendar

Mr. Donald Berno, Liaison for the Board of Directors, discussed the committee's calendar. Mr. Berno noted the topics for the January and February meetings were being filled. In reviewing the current calendar, Mr. Berno did note the safeguarding definition topic would be removed in light of Mr. Al-Tarawneh's presentation. Additionally, Mr. Berno noted the OHFS will be presented again in January.

ADJOURNMENT

Mr. Hummel moved to adjourn the meeting at 12:05 PM, seconded by Mr. Pitts. The meeting adjourned with a 3-0 unanimous roll call vote.

Prepared by Michael J. Sourek, Staff Counsel
December 30, 2009