

**BWC Board of Directors**  
**Medical Services and Safety Committee**

**Thursday, April 29, 2010**  
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: Alison Falls, Kenneth Haffey, William Lhota, James Matesich, Larry Price, and Robert Smith

**CALL TO ORDER**

Mr. Harris called the meeting to order at 2:05 PM, and the roll call was taken. All members were present.

**MINUTES OF MARCH 25, 2010**

Mr. Harris asked for any changes to the minutes of March 25, 2010. With no changes, Mr. Pitts moved to have the minutes of March 25, 2010 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 asked for any changes to the agenda. With no changes, Mr. Hummel moved to have the agenda approved, and the motion was seconded by Mr. Pitts. The motion passed with a 3-0 unanimous roll call vote.

**NEW BUSINESS/ACTION ITEMS**

**1. Motions for Board Consideration**

**A. For First Reading**

**1. Outpatient Hospital Fee Schedule, Rule 4123-6-37.2 (effective date change only)**

Mr. Freddie Johnson, Director of Managed Care Services, and Ms. Anne Casto, Consultant, Medical Services, presented a request to change the effective date of the Outpatient Hospital Fee Schedule, (OHFS), Rule 4123-6-37.2.

Mr. Johnson noted the rule was originally adopted in January, 2010. The rule adopted Medicare's outpatient hospital (OH) payment schedule, and a three year transition period to a prospective payment methodology rather than a retrospective payment methodology. The original effective date was May 1, 2010.

The Bureau understood the impact of these substantive changes and the effective date. Staff engaged in a thorough due diligence process to ensure no negative impacts to injured workers or providers. He reminded the Directors that if an identified significant negative impact to stakeholders was discovered, the Bureau would recommend a different effective date. The Bureau was recommending an effective start date for OHFS on January 1, 2011. and this date change should be reflected in the rule The new effective date was discussed, with positive reaction, with the Ohio Hospital Association, Catholic Healthcare Partners, and the Managed Care Organization (MCO) League.

Mr. Johnson also said the three year transition to a prospective payment process would now begin on January 1, 2011. Ms. Casto reported each year Medicare updates its reimbursement schedule, along with CPT and secondary "HCPCS" codes. If the Bureau fails to acknowledge the new codes as they are implemented by Medicare, the hospitals must manually enter the old codes. For this reason, the Bureau must update completely with Medicare's OPPS annually. The Bureau will return in October, 2010 to update the new Medicare codes for the 2011 OHFS.

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 rescind current rule 4123-6-37.2 and adopt new rule 4123-6-37.2 of the Administrative Code, "Payment of Outpatient Hospital Services," and the motion consented to the Administrator rescinding and adopting new rule 4123-6-37.2 as presented at the meeting. Mr. Pitts seconded the motion, and the motion passed with a 3-0 unanimous roll call vote.

## **2. Group Experience and Group Retrospective Rating Safety Program Requirements – Rule 4123-17-68**

Mr. Abe Al-Tarawneh, Superintendent of the Division of Safety and Hygiene, Ms. Michelle Francisco, Safety Council Program Manager, and Ms. Robin Watson, Industrial Safety Consultant Specialist, presented the first reading of the Group Experience and Group Retrospective Rating Safety Program Requirements, Rule 4123-17-68. The rule proposal was circulated to interested parties in the past month; no comments have been received.

Mr. Al-Tarawneh said the proposal strengthens the safety requirements of group and retrospective rated employers by establishing minimum safety requirements. The safety requirements will give a minimum level of membership participation, encourage training consistent with claims activity, and modernize the rule. The rule holds sponsors and affiliates to the same standards, sponsors documenting employers who attend eight hour training; submitting a list to the Bureau of employers attending the minimum two hour training; changing the ten step business plan to a safety model; developing training around common injuries; and employers must meet a two hour training requirement to maintain group eligibility.

Mr. Hummel believed the proposal was a great step to accountability. He asked if the 50% membership attendance was a goal or a requirement. Mr. Al-Tarawneh replied it was a goal. Mr. Hummel asked if the two hour training was in place already, and Mr. Al-Tarawneh replied in the affirmative. Mr. Hummel asked how the two hour training was

being monitored. Ms. Francisco reported this two hour training was in its first year, and the training requirement has not been compiled. Group rating sponsors and third party administrators were tracking, but there were no results. Mr. Hummel stated, and Ms. Francisco confirmed, the full picture was not reported yet but it is being tracked. Mr. Harris inquired if the Bureau knew the sponsoring organizations were tracking, and she replied in the affirmative.

### **3. Fifteen Thousand Dollar Medical-Only Program – Rule 4123-17-59**

Mr. Tom Prunte, Director of Employer Management Services, and Ms. Kathy Arnett, Management Analyst Supervisor, presented the first reading of the Fifteen Thousand Dollar Medical-Only Program, Rule 4123-17-59. Mr. Prunte noted the changes were needed as a result of statutory changes. Specifically, the rule indicates a participating employer would pay a provider's fee pursuant to the Bureau's provider fee schedule or negotiate the fee with the provider. Ms. Arnett noted the proposal requires that the provider accept payment in full subject to these provisions and cannot charge employees for the unpaid balance. The rule has been provided to stakeholders for feedback, but no feedback had been received.

Mr. Lhota inquired about the wording in paragraph (A) of the rule indicating an employer agrees to pay within 30 days. Ms. Arnett replied that provision had been in place since 1995, and the wording was not new. Mr. Pitts inquired if the rule applied to any bills received by the Bureau and the employer was participating in the program. Ms. Arnett responded the Bureau would send the bills for payment to the employer. The employer had to retain recordkeeping, office notes and bill payment records. Mr. Pitts asked if anyone other than the employer was aware of the payments made by the employer. Ms. Arnett replied the employer's managed care organization would be provided these records. Mr. Lhota suggested the wording be changed to say the 30 days began upon bill receipt. Ms. Arnett will make that change for the second reading.

## **B. For Second Reading**

### **1. Scheduled Loss Payment Rules 4123-3-15 and 4123-3-37**

Ms. Tina Kielmeyer, Chief of Customer Services, and Ms. Kim Robinson, Director of Policy, presented the second reading of the Scheduled Loss Payment Rules, Rules 4123-3-15 and 4123-3-37. Ms. Kielmeyer noted the rules' first reading occurred two months ago and additional analysis has been completed.

Ms. Kielmeyer noted scheduled loss payments are provided to injured workers for loss of a body part, vision or hearing due to a workplace accident. The scheduled loss award is in addition to any medical or indemnity payments. Scheduled loss payments are calculated by multiplying the statewide average weekly wage times the number of weeks as determined by statute. For example, loss of thumb is 60 weeks, loss of an arm is 225 weeks, and loss of vision in one eye is 125 weeks. In calendar year 2009 there were 954 claims with a paid scheduled loss award. This statistic did not mean there were 954 scheduled loss awards granted in 2009; some awards are paid over several years. The Bureau pays between 450-500 new scheduled loss awards each year, with 474 in 2009. \$22 million was paid for all scheduled loss awards last year.

Ms. Kilmeyer responded to a comment in the first reading regarding dollar impact of the proposal. She reported the impact would be estimated at less than \$4 million in 2009.

Ms. Kilmeyer noted the awards were: 60% for amputations, 37% for loss of use, and 3% for loss of vision, hearing, or paralysis. Mr. Harris inquired if the awards were declining over time. Ms. Kilmeyer replied scheduled loss awards were consistently 470-480 per year over the past 3 years reviewed.

Ms. Kilmeyer noted the rules had been reviewed by many stakeholders. Support had been received from the Ohio Association for Justice, and many other comments were received from other stakeholders. Ms. Kilmeyer noted that 4123-3-15(C) (3) contained the proposed changes. Currently, policy provides that the Bureau calculate payments and pay for a number of weeks into the future. The proposal will change this procedure to allow the award to be paid in one payment after a final administrative or judicial order. This proposal allows injured workers to have full access to benefits sooner. The Bureau also saw a benefit by not having to build complex payment plans over time. The proposal had been changed based on stakeholder comments to reflect the award would not be paid in full until after a final administrative order. The wording was also clarified to apply to state fund and self insured claims. Finally, Mr. Pitts' suggestion was incorporated to clarify the process for orders issued but not paid prior to an injured worker's death. Several comments supported the change, but some comments challenged the Bureau's authority to make this change; Ms. Kilmeyer replied legally it was the Administrator's discretion how to make these payments.

Mr. Pitts and Mr. Harris commended the staff on the process they followed and the revisions; some small changes really clarified the Bureau's intent. 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 amend rule 4123-3-15 of the Administrative Code, "Claim Procedures Subsequent to Allowance," and rule 4123-3-37, "Lump Sum Advancements," to establish scheduled loss payment rules, with the motion consenting to the Administrator amending rules 4123-3-15 and 4123-3-37 as presented at the meeting. The motion was seconded by Mr. Hummel, and the motion passed with a 3-0 unanimous roll call vote.

## **DISCUSSION ITEMS**

### **1. MCO Voc Rehab Referral Report**

Mr. Robert Coury, Chief of Medical Services, and Mr. Johnson presented the MCO Voc Rehab Referral Report, a follow-up from the December 15, 2009 meeting. The report has been reviewed with Board members, stakeholders, and interested parties. The purpose was to: examine impacts of vocational rehabilitation providers (VPR's), quantify and qualify cost/service outcomes, and identify challenges present in the system. The report did not look at the fee schedule but did look at the role of Disability Management Coordinators (DMC's) caseloads and system updates. Vocational rehabilitation will be denoted as "VR."

Mr. Coury reported MCOs were acting consistently, and there was no evidence that MCOs were working outside of Bureau policies. Mr. Coury noted the MCOs were managing their conflicts of interests regarding affiliation with VRPs. Notwithstanding the consistency by MCOs, the Bureau was seeing systemic failure in return to work results; absent optimizing workflows, internal controls and policies, the failure would continue. While VRP referrals were in even disbursement, that figure alone does not reflect the case's material outcome.

Mr. Coury noted distinctions between "affiliated MCOs" and "unaffiliated MCOs," with an affiliated MCO meaning an MCO is affiliated directly with a VRP. Mr. Coury reported that this relationship overrides whom a case is referred for VR. In cases of unaffiliated MCOs, 93% of the time the MCO refers the case to an unaffiliated VRP, and only 7% of the time the MCO refers the case to a competitor's VRP. Questions are certainly raised as to how the market has developed while the market is not impeding access to care. The Bureau has to better align service with performance, and the issue was axiomatic in that the Bureau could not manage what it did not measure. The measurement would be through provider metrics contained in provider report cards and case outcomes. The Bureau was also considering using DMCs for eligibility and feasibility determinations and vocational referral case processes.

Consistent with the Deloitte study and October, 2007 audit findings, the Bureau is preparing a letter that will be sent to injured workers notifying them of the VR referral process and the affiliation, if any, of the VRP. In performing this study, there was a 100% review of all VR cases closed over the past two years which was an extensive undertaking.

Mr. Johnson highlighted statistics to support Mr. Coury's statements. The original report was provided to the Labor Management Government Advisory Council (LMG), the Managed Care Organization (MCO) League, vocational services providers, the Ohio Alliance for Justice (OAJ) and other stakeholders. The stakeholder grid contains the underlying data. The report focused on three areas: referral, costs, and outcomes. The time period for all closed cases reviewed was July, 2007 through June, 2009, consisting of 6,754 claims with \$47.5 million in VR services. There were 25 MCOs, 12 of which are affiliated MCOs and 9 of the affiliated MCOs have their own VRP company. The report studied claim activity and multiple referrals individually. This analysis provided a clear picture of what was occurring. Another refinement examined was analysis of the activity of case managers who were the key to facilitating services, who like MCOs, were either affiliated or non-affiliated. There was a 70%-30% ratio between VR referrals in affiliated v. unaffiliated MCOs, but a 47%-53% ratio in affiliated v. unaffiliated case managers, or 13% more of the cases went to unaffiliated case managers. However, out of the pool of 131 VRPs, 9 affiliated VRPs accounted for the 47% of all cases, and 122 VRPs accounted for the remaining 53%.

While unaffiliated MCOs referred to unaffiliated VRPs 93% of the time, affiliated MCOs referred to affiliate VRPs 70% of the time. While there was this disparity in referrals, the caseloads for each group were consistent near 22 referrals/case manager. In terms of cost, unaffiliated case managers were approximately 6% more expensive.

VR was then analyzed in terms of case management services, facility based services, and other services. These services revealed similar patterns by affiliation in synch with case management referral. Mr. Johnson noted affiliated MCOs case managers referred 71% of facility based services, as well as other services, to affiliated providers; unaffiliated MCO case managers referred the same services 96% and 100%, respectively, to unaffiliated providers. When looking at cost, affiliated providers were slightly higher in two out of three categories.

In terms of return to work outcomes, the MCOs, regardless of affiliation, had returns to work in 38% of cases. However, affiliated MCO case managers had a higher percentage of NE16 closures, or closed plans due to return to work but no plan implemented before a return to work. Obviously, minimizing NE16 closures (where the injured worker returns to work prior to a voc rehab plan being implemented) would avoid costs and improve efficiencies. A February, 2010 audit of NE16 closures revealed the majority were unnecessary referrals with little or no intervention. Return to work breakdowns by affiliation were marginal with different job-different employer and same job-same employer return to work most common.

Mr. Johnson noted the data was mixed as to cost outcome impacts. There are positives, but improvements can be made in the system through a more appropriate selection of VRPs. Mr. Johnson believed further case mix and complexity analysis was needed to better evaluate the system. The Bureau is looking at transferring case assignments to DMCs based upon a 2007 internal audit. Furthermore a provider report card in conjunction with the performance outcome and service referral would be helpful to develop the most effective, but efficient, system possible. Moving forward, MCOs will have to notify injured workers of their relationships with VRPs. This disclosure is intended to allow injured workers to make a more informed decision.

Mr. Hummel thought the report was excellent; he inquired when new notification to injured workers would be done. Mr. Johnson responded within 30 days; based on MCO contracts, the Bureau is moving as fast as possible under contract terms. Mr. Hummel inquired who had final say if there are different preferences in a VRP. Mr. Johnson replied the injured worker did. Mr. Pitts added, in many cases, an injured worker is contacted about a VR referral with a certain VRP in mind. Instead of a conscious choice for the injured worker, the referral source recommends a VRP without advising the injured worker of a choice. Mr. Coury stated he would want a referral made by an MCO; however, the issue is when the referral is made that needs improvement in terms of eligibility, feasibility and internal processes. Mr. Pitts asked if DMCs are taking VR plans. Mr. Johnson said there were six recommendations in the rehabilitation redesign project along with other steps. DMCs would take activities from VR case managers; the structure is in place and in the final phase of completion. Mr. Johnson added the Bureau continues to look at different referral patterns. In FY2011, the Bureau will be looking at those activities and be ready to move in that direction. Mr. Pitts commented a qualified agency, or MCO, can approve a VRP, but there appeared to be different factors in play. The Bureau may have a policy with an injured worker to not merely accede to an MCO telling what was best. Mr. Pitts indicated the dialogue has to include a discussion of options with the injured worker. Mr. Coury commented that there could be a false dichotomy present. Assuming that a transparent approach would not be inappropriate, there is recurring self interest with affiliated and non-affiliated MCOs; when the MCOs have gone

outside of their focus affiliation, it has been due to case manager availability. Mr. Pitts did not disagree with Mr. Coury's statement; his concern was there were options for injured workers. Injured workers have to make a reasoned judgment; some injured workers may choose the path of least resistance and go with an MCO's recommendation, but others want to know the choices available. Mr. Johnson agreed, and the Bureau is looking for educational opportunities to improve the injured workers awareness of all options. The Bureau values how VR works and the suggestion is among options to determine how to make the right referral.

Mr. Harris noted the obvious preferences due to MCO affiliation. He was concerned about the motivation and wanted further exploration into why this issue exists. Mr. Coury replied the Bureau could only eliminate rationales of effective returns to work, hierarchy of returns to work, and average costs by provider under a price neutral setting. When looking at the numbers, affiliated MCOs have an 8% better return to work rate than non-affiliated MCOs with aggregate cost 5-6% better. The data shows the affiliation is not due to cost, not due to return to work and leaves the unexplained variable. Mr. Coury noted some affiliated MCOs were doing better in cost containment and NE16 closures; whether that is logical or rational, all the Bureau is left with is the affiliation relationship. Currently the Bureau does not regulate or dictate guidelines; absent specific requirements, all that can be singled out is the self-interest.

Mr. Pitts, stated from his experience, the parties have the right to self represent and can choose. Unrepresented injured workers, or those who do not pay attention, believe they must engage in VR even though the program is voluntary. Mr. Pitts believed the Bureau should pursue educational possibilities so that injured workers can better manage their own care. Mr. Coury noted affiliated MCOs had a successful return to work in their VR cases 38% of the time, with a range of 25-50%. These statistics do not in any way demonstrate the affiliated MCOs do a better job than unaffiliated MCOs. Mr. Harris asked for the numbers on unaffiliated MCOs, and Mr. Coury said the range was 15-44% for unaffiliated MCOs. Smaller populations caused disparity in the range of numbers for both affiliated and unaffiliated MCOs.

Mr. Matesich asked if the Bureau needed a better grasp on the study. Mr. Coury replied in the affirmative; if the Bureau did not analyze this data from MCO specifics, the Bureau would have continued to muddle. He believed the Bureau was on the cutting edge of developing provider metrics.

Mr. Pitts noted his concern with nine affiliated MCO VRPs providing 47% of all VR services. Mr. Pitts noted there was an issue in a state where nine providers had the majority of medical care of injured workers 1 ½ years after injury. Mr. Pitts said there may be a reason for that trend, and perhaps it is valid; however, whenever a small group dominates an otherwise open market, something does not seem right. He was pleased the Bureau was examining the issue.

## **2. Pharmacy Program Overview**

Dr. Robert Balchick, Medical Director, Mr. Johnnie Hanna, Pharmacy Program Director, and Ms. Christine Sampson, Pharmacy Program Operations Manager, presented the Pharmacy Program Overview.

Dr. Balchick said changes in the past year for this department included: Mr. Hanna joining the Bureau; the Bureau is receiving drug rebates; operational improvements; and a new Pharmaceutical Benefits Manager, or "PBM," SXC Healthcare Solutions. Dr. Balchick stated the Pharmacy Department oversees prescription reimbursements (\$128 million or 16% of the Bureau's medical costs). The Pharmacy Department's goal is to ensure injured workers obtain the prescriptions needed to relieve discomfort and improve healing.

Dr. Balchick reported challenges facing pharmacy providers and medical practitioners, especially with pain medicines because of addiction and safety issues. The Pharmacy Department collaborates with the PBM to improve pharmacy services.

Mr. Hanna stated the Pharmacy Program is within the Medical Services Division and manages outpatient prescription benefits. The prescriptions are for home use only; medications administered in a physician's office or inpatient drugs are processed through MCOs. The Pharmacy Program covers medications for state fund claims only by rule. Ms. Sampson stated in 2009 the Pharmacy Department managed processing of 1.47 million prescriptions submitted by 5,700 pharmacies; covered prescriptions for 8,600 national drug codes (3,800 different drugs) in 77,000 injury claims; and collected nearly \$4.5 million in rebates on 400 drugs.

Mr. Hanna noted there were six core business functions of this department. First, there was PBM oversight consisting of: reviewing electronically point of service bill payment; prior authorizations processing by clinical pharmacists, about 1,300 reviews monthly; financial controls of continuous bill payment monitoring; and monthly pharmacy provider auditing of 200 desk audits and 100 onsite audits. The on-site audits look at excessive dispensing of controlled substances, verifying a hard copy of the prescription and signature log, and the drug was dispensed and not returned to stock. Second, the Pharmacy Department performs PBM contract compliance, which requires payment of a paper bill in 7 days of receipt. There are 27 performance guarantees in the current contract. Third, the Pharmacy Department monitors rebate management contract compliance, which the Bureau gives 6% of all funds collected to the rebate manager. Fourth, the Pharmacy Department provides customer support for service offices, parties, and representatives. Staff handles 300 inquiries monthly. Fifth, the Pharmacy Department provides a clinical program involving: formulary management, which in 2010 will be the Bureau's first in-house formulary by rule intending to assist providers in drug selection; Pharmacy and Therapeutics Committee consisting of practicing physicians and pharmacists making recommendations; drug utilization and prior authorization review procedures, which involves proper use and relationship of a drug to a claim and unfortunate high misuse of controlled substances. Finally, the Pharmacy Department provides current and consistent program policy management with rule development.

Mr. Smith inquired if random sampling was statistically valid. Ms. Sampson replied due to staff restrictions, only 2% random sampling is done. Mr. Smith inquired if the Bureau was confident rebates were being completely forwarded. Ms. Sampson replied the PBM applies for the rebates for the Bureau, but a rebate administrator is a separate vendor. The rebate is audited for accuracy.

Mr. Hanna went through program statistics compiled over the last ten years. Pharmacy reimbursements were 13-18% of total medical expenditures, currently at 16%. The

average prescription cost has risen 84% over this time; 8.5% per year was expected. The average prescription cost decreased between 2004 and 2006 due to the introduction of a Maximum Allowable Cost program for generic drugs. The cost stayed flat between 2008 and 2009 because of the Bureau's initiatives concerning Lidoderm. In early PBM contracts, the PBM was allowed to keep prescription rebates. The current PBM contract cost almost \$1.9 million in 2009; however, the Bureau collected almost \$4.5 million in rebates with \$603,177 in rebate administrative costs. The rebate program pays the administrative costs for the PBM and rebate manager as well as covering all other program administrative and staff costs. In addition to covering all administrative costs, rebates produced an additional \$2 million in cost savings.

Mr. Hummel inquired if the Bureau was paying a PBM, and the PBM collecting rebates, in 2005-2007. Mr. Hanna replied in 2004 the PBM contract was changed; no one was collecting rebates.

Due to time constraints, the presentation will continue at the May meeting.

### **3. Committee Calendar**

In addition to continuing the Pharmacy Program Overview, Mr. Donald Berno, Liaison for the Board of Directors confirmed next month's calendar called for: first reading of the Medical and Service Provider Fee Schedule; follow-up report on MCO Public Forums; and Customer Services Report. The OPPS effective date item was eliminated through actions at this meeting, and the Fifteen Thousand Dollar Medical-Only Program, Rule 4123-17-59, will be a second reading.

### **ADJOURNMENT**

Mr. Hummel moved to adjourn the meeting at 3:56 PM, seconded by Mr. Pitts. The meeting adjourned with a 3-0 unanimous roll call vote.

Prepared by Michael J. Sourek, Staff Counsel  
May 4, 2010