

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

**Thursday, June 17, 2010, 2:00 PM**  
Level 2, Room 2 (Mezzanine)  
30 West Spring St.  
Columbus, OH 43215

Members Present: James Harris, Chair  
James Hummel  
Thomas Pitts  
William Lhota, *ex officio*

Members Absent: None

Scribe: Michael J. Sourek, Staff Counsel

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

**CALL TO ORDER**

Mr. Harris called the meeting to order at 2:06 PM, and the roll call was taken. All members were present.

**MINUTES OF MAY 27, 2010**

Mr. Harris asked for any changes to the minutes of May 27, 2010. With no changes, Mr. Hummel moved to approve the minutes of May 27, 2010, and Mr. Pitts seconded the motion. The motion passed with a 4-0 unanimous roll call vote.

**REVIEW AND APPROVAL OF AGENDA**

Mr. Harris asked for any changes to the agenda. With no changes, Mr. Pitts moved to approve the agenda, and the motion was seconded by Mr. Hummel. The motion passed with a 4-0 unanimous roll call vote.

**NEW BUSINESS/ACTION ITEMS**

**1. Motions for Board Consideration**

**A. For First Reading**

**1. Medical and Service Provider Fee Schedule, Rule 4123-6-08**

Mr. Freddie Johnson, Director of Managed Care Services, and Ms. Jean Stevens, ICD-9 Management Analyst Supervisor, Medical Policy, presented the first reading of the Medical and Service Provider Fee Schedule, (MSPFS), Rule 4123-6-08.

Mr. Johnson noted MSPFS touches almost every type of medical reimbursement outside of hospital services including durable medical equipment (DME) and medications. For the period of February, 2009 to February, 2010, MSPFS governed 39% of total payments made by the Bureau. There were two updates to MSPFS last year: in October, 2008, MSPFS was approved becoming effective in February, 2009; in May, 2009 a change was made with implementation in November, 2009. In 2009, MSPFS had Healthcare Common Procedure Coding System (HCPCS) codes, or Medicare Level 2 codes, added along with a modified conversion factor.

Mr. Johnson said recommendations for MSPFS included: adopting Medicare's relative value units (RVU) and HCPCS updates; new plan benefits and Bureau codes; and maintenance of the conversion factor. This proposed MSPFS would increase Bureau reimbursements by 1.6% or approximately \$2.6 million. If the rule is adopted by the Board of Directors, the expected implementation date was October 25, 2010. The proposed MSPFS was posted on the Bureau's website on May 28, 2010, and all feedback received by June 11, 2010 was included in the stakeholder grid. Feedback was solicited from managed care organizations (MCO), the MCO League, 56 medical associations, the Ohio Association for Justice, and self insured employers. The proposed MSPFS was also presented to the Bureau's Healthcare Quality Assurance Advisory Committee.

Mr. Johnson noted the BWC strategic method in developing the proposed MSPFS by: evaluating the current benefit plan; adding, deleting or modifying units; comparing to Ohio's Medicare and Medicaid fee schedules for 2009 and 2010; valuating the impact of Medicare changes, especially the conversion factor; and comparison to fee schedules for other states' workers compensation systems. MSPFS has approximately: 10,000 CPT codes, which include surgical procedures and anesthesia; 3,600 HCPCS codes (which cover DME, supplies, medications, and prosthetic devices); and 66 Bureau originated codes covering items not covered by Medicare, such as exercise equipment.

Ms. Stevens discussed one of the key components of the calculation under CPT coding was the RVU. Each RVU has 3 separate components: a work and practice portion, a malpractice portion, and a Geographical Practice Cost Index (GPCI). The GPCI code addresses the geographical price differences of providing service in different parts of the country; for example, New York has a higher cost for medical care than Ohio. After the RVU is determined for the service, it is then multiplied by the Bureau's conversion factor to give the cost of rendering service. An example of an arthroscopy with foreign body removal from the knee was presented. It was determined the Bureau's conversion factor was still competitive, but the lower GPCI code for Ohio was causing a decrease in reimbursements. Mr. Harris inquired if, in the example, reimbursement would decrease slightly from \$1129.94 to \$1084.56. Ms. Stevens replied in the affirmative. The GPCI code for Ohio is being reconsidered by Medicare, as are the GCPI codes of other states. Ms. Stevens noted the GPCI code needs to be examined to determine if the Bureau should adopt the current code. If the current GPCI code is adopted, then RVU goes down and reimbursements decrease. If the GPCI code is not adopted, RVU goes up in reimbursements. Mr. Harris inquired if the code was accepted now, would it be adjusted in the next MSPFS, and Mr. Johnson replied in the affirmative. Ms. Stevens said the Bureau examined the impact per category of service, and noted that radiology reimbursements are projected to decrease by 7.8%. However, further research indicated that radiology imaging was having a higher utilization rate or consumption/unit, and

Medicare, based on information provided by the American College of Radiology, was decreasing reimbursements/unit to reflect proper practice expense. Ms. Stevens indicated that the Bureau's goal to maintain access to quality care for injured workers would be maintained, and the Bureau's conversion factor will remain the same for radiology services. Mr. Harris asked if radiology reimbursements were decreasing due to economies of scale, and both Mr. Johnson and Ms. Stevens replied in the affirmative.

Mr. Johnson noted while the Bureau relies on Medicare to set reimbursement rates, the Bureau reimburses medical providers above Medicare's rates. In addition to adopting Medicare's 2010 RVUs for all relevant CPT codes and the Bureau maintaining the conversion factor, there were other recommendations in the proposal. First, the Bureau should adopt additional HCPCS codes. Currently the Bureau pays for HCPCS codes with a 120% payment adjustment factor. This factor will remain unchanged as it is still competitive. The additional HCPCS codes were: S0630 (removal of sutures by another qualifying medical professional, other than the physician that placed the sutures); S0209 (wheelchair van mileage); S5199 (personal care items); and S8301 (infection control supplies). S0630 was recommended for addition to address a common billing issue because most injured workers do not have sutures removed by the same physician placing them. Mr. Hummel asked how unlisted services were addressed presently, and Mr. Johnson said the Bureau processes the billed services as an unlisted code which comes through the Medical Policy Mailbox, and the MCO does a cost comparison. Significant administrative burden would be removed by adding these codes. Mr. Hummel inquired if the amount billed is what is paid, and Ms. Stevens responded the MCO uses cost analysis to determine the amount of reimbursement. Ms. Stevens continued that S0209 was added because injured workers who are wheelchair bound do need van service to medical treatment. S5199 and S8301 were added because they were home healthcare services without a Medicare reimbursement. Mr. Johnson noted that other recommendations in the proposed MSPFS included adding a "never covered" category of service and modifying "non-covered" category of service to "not routinely covered" category of service. The need for these recommendations addresses the Ohio Supreme Court's *Miller* test that medical treatment must be reimbursed as long as the service was reasonably related to the allowed conditions in a claim, reasonably necessary, and with a medically reasonable cost. If all 3 criteria are met, the Bureau has to reimburse services, even if the services were deemed non-covered in the BWC benefit plan. However, a small number of services such as hot packs and cold packs and preventative medicine such as well baby checks will be listed as "never covered."

Mr. Johnson summarized by noting the estimated cost impact of the proposed MSPFS could be higher, dependent on the RVU factor. Additional codes will provide ease of access to medical care for injured workers. The addition of the new codes will reduce challenges which providers have faced in receiving reimbursement for certain services. Lastly, the recommended changes will bring additional clarity to benefits which are covered, or which can be covered pursuant to the application of the *Miller* test, versus services which have been determined to be never covered under the Ohio BWC workers' compensation benefit plan.

Mr. Johnson noted he would return in December 2010 to present a recommendation to adopt Medicare's updated HCPCS and CPT codes, which will be approved for use in January, 2011. In the past, such adoption had not been required; however, under the

current BWC rulemaking process, the Bureau finds it is virtually impossible to adopt the new codes in a timely fashion. The December presentation will be in two parts: first, the presentation will ask for one reading and approval of the Bureau's recommendations concerning Medicare's 2011 CPT and HCPCS codes; second, the presentation will contain an emergency rule for the Governor to implement the codes on the same effective date as Medicare. Emergency rules can be implemented for 90 days. At the same time the emergency rule is forwarded to the Governor, the Bureau would submit the rule through the JCARR process. While the Bureau does intend to use emergency rule procedure each year for adopting newly release CPT and HCPCS codes, our annual update process to the full MSPFS will continue to be implemented each October. Mr. Johnson noted that The Ohio Department of Job and Family Services uses this same procedure each year.

Mr. Harris asked if Medical Services would be appearing before the Medical Services and Safety Committee in December for a rule modification with one reading. Mr. Johnson replied in the affirmative. Mr. Harris asked if Medicare would have their codes updated in October or November, and Mr. Johnson indicated it would more likely be late November to early December. Mr. Johnson said providers would begin using the new codes in January, 2011. Mr. Hummel inquired if the "GPCI" codes were reduced across the board, and Ms. Stevens noted the reduction was made by Medicare. Mr. Johnson noted each state has at least one "GPCI" code, including Ohio, but some states have more than one to address regional differences within a state.

## **DISCUSSION ITEMS**

### **1. Medical Services Division Report**

Mr. Robert Coury, Chief of Medical Services and Compliance, presented the Medical Services Division Report. Mr. Coury's report dealt with four areas. The first area concerned the proactive allowance policy presented at the MCO Board Forum. The goal of the proactive allowance policy is to reduce additional condition determination timeframes. Objectives included improving coordination with MCO Nurse Case Managers and Bureau Medical Service Specialists and enabling MCO Nurse Case Managers to obtain immediate "buy-in" from employers to prevent objections, motion practice and delay. Claims Policy, Bureau and MCO staff collaborated on this policy through a BWC/MCO Prior Authorization QI Smart Objective workgroup. On April 7, 2010, the Bureau held a teleconference with Bureau staff and 13 MCOs. The goal was to provide improved workflows and tools to support the new process. Final drafts will be completed by June 25, 2010 for review and input. The Bureau's Training Director is assigning a Training Manager and team to work with Claims Policy to develop a training plan and materials for BWC and MCO staff. Training is expected to be implemented in September, 2010.

The second area discussed MCO Open Enrollment. Mr. Coury noted every 2 years employers are allowed to freely choose their MCO. The 2010 Open Enrollment period ran from May 3<sup>d</sup> through May 28<sup>th</sup>. Employers had Internet access to the MCO Selection Guide and an MCO Report Card. The MCO Selection Guide provided step-by-step selection and enrollment instructions. The MCO Report Card provided the following information for each MCO as of December, 2009: Number of Active Employers; Number of Active Claims under the MCO's management; FROI Timing Score (measuring the lag

between the date of injury and when a claim is filed); FROI Turnaround Score (measuring the lag between when the MCO receives the claim application and when the application is sent to the Bureau); and Optimal Return to Work/DoDM score for 4<sup>th</sup> Quarter, 2009. The last figure is used to determine 50% of the fees paid to MCOs. Employer Services, under Tina Kielmeyer, Chief of Customer Services, ensured documentation was provided to employers and answered all inquiries. The effective date of employer changes of MCO is June 28, 2010; injured workers will be provided a new Bureau ID card with the new MCO information. This open enrollment period had 27,000 employers change MCOs, or approximately 10% of all employers, representing about 32,000 active claims, also approximately 10%. This slightly higher turnover may have been the result of MCO mergers during the past year. Historically, there were the following estimated numbers of employers changing MCOs: 18,000 in 2008; 23,000 in 2006; 20,000 in 2004; and 14,000 in 2002.

Mr. Haffey inquired whether the MCOs were cooperative with one another during open enrollment. Mr. Coury responded the Bureau received about 6-7 marketing complaints. These complaints are forwarded to the MCO Marketing Compliance Committee, which reviews the complaint, determines if there is a violation, and makes a recommendation for penalty and/or corrective actions. Their findings are reported to Teresa Arms, Director of MCO Business and Reporting Unit and Mr. Coury. In about 90% of the cases, the MCO Marketing Compliance Committee's recommendations are adopted. Currently 1 or 2 complaints are being resolved.

The third area discussed was the Health Services Quality Improvement Unit (HSQIU) Plan. The goal is to provide robust medical services oversight with the Medical Services Director and improving MCO decision processes through training, compliance audits and performance measures. Effective November 1, 2009, the Bureau amended the Alternative Dispute Resolution (ADR) process by eliminating the level two ADR review performed by the Bureau. The ADR process involves MCO decisions on medical treatment, vocational services, medical equipment, and other areas. The cost savings from eliminating that second level of review has allowed the Bureau to improve care to injured workers through creation of HSQIU. HSQIU will ensure prompt, effective medical care to injured workers. MCOs are responsible for medical management and cost containment, and a half million treatment requests go through ADR annually. In addition to MCO performance measures discussed in the previous section, HSQIU will greatly enhance the Bureau's qualitative review of MCO performance, which was recommended in the Deloitte study. Goals and objectives of HSQIU include improving: treatment outcomes and return to work; related policy and processes; alignment of delivery of medical services; education and training internally and to interested parties; and customer satisfaction. Audit and sampling tools are being developed with projected implementation of this plan set for September, 2010.

The final area discussed was emergency rule requirements. The Bureau staff understands the importance the Directors place on the "2 read" practice outlined in the Governance Guidelines. As noted previously, the Bureau will be presenting a recommendation in December for the Board of Directors to adopt an update of Medicare's new 2011 Medicare CPT and HCPCs codes after only one reading. Since the Bureau is following the chapter 119 rule making process, the Bureau cannot adopt the newly released Medicare codes by policy. Under the "2 read" process, the lag between

the effective date of the rule and the effective date of the Medicare update will create billing conflicts between providers and the Bureau. Otherwise valid provider bills would be denied solely on coding errors, with an increase in provider and Bureau administrative costs to correct the issue. Mr. Harris appreciated the content of this presentation. He requested as soon as the Bureau has the Medicare information, the information should be forwarded to the Board of Directors. Mr. Coury agreed, and he would be back before the committee in 2 months and explain the December, 2010 recommendations.

## **2. Committee Calendar**

Mr. Harris noted that each month the Medical Services and Safety Committee would have either a Medical Services Report or a Customer Services Report. The reports will keep the committee aware of issues. Next month there would be a Customer Services Report followed by a Medical Services Report in August. The second reading of the MSPFS is scheduled for July. Mr. Harris asked Mr. Donald Berno, Liaison for the Board of Directors, for any other topics on next month's agenda. Mr. Berno replied a first reading on a rule regarding transcutaneous nerve stimulator (TENS) units would be presented.

## **ADJOURNMENT**

Mr. Hummel moved to adjourn the meeting at 2:56 PM, seconded by Mr. Pitts. The meeting adjourned with a 4-0 unanimous roll call vote.

After adjournment, Director Falls announced the Governance Committee meeting would begin at 3:05 pm.