

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

**Thursday, October 21, 2010**  
Level 2, Room 3 (Mezzanine)  
30 West Spring St.  
Columbus, OH 43215

Members Present: James Harris, Chair  
James Hummel, Vice Chair  
Alison Falls  
William Lhota, *ex officio*  
James Matesich  
Thomas Pitts

Members Absent: None

Other Directors Present: David Caldwell, Kenneth Haffey, Larry Price, Robert Smith

Counsel Present: James Barnes, BWC General Counsel and Chief Ethics Officer  
Ann Shannon, Legal Counsel

Staff Present: Marsha Ryan, Administrator  
Donald Berno, Liaison to Board of Directors  
Robert Coury, Chief of Medical Service and Compliance  
John Hanna, Pharmacy Program Director  
Freddie Johnson, Director Managed Care Services  
Raymond Mazzotta, Chief Operating Officer  
Mamta Mujumdar, Director of Medical Research

Consultant Present: Anne Casto, President, Casto Consulting

Scribe: Michael J. Sourek, Staff Counsel

**CALL TO ORDER**

Mr. Harris called the meeting to order at 12:31 PM, and the roll call was taken. All members were present.

**MINUTES OF SEPTEMBER 23, 2010 MEETING**

Mr. Harris asked for any changes to the minutes of September 23, 2010. He had requested minor changes before the meeting. With no further changes, Mr. Hummel moved to have the minutes of September 23, 2010 be approved, and Mr. Pitts seconded the motion. The motion passed with a 6-0 unanimous roll call vote.

**REVIEW AND APPROVAL OF AGENDA**

Mr. Harris asked for any changes to the agenda. With no changes, Mr. Matesich moved to have the agenda approved, and the motion was seconded by Mr. Hummel. The motion passed with a 6-0 unanimous roll call vote.

## **NEW BUSINESS/ACTION ITEMS**

### **1. Motions for Board Consideration**

#### **A. For Second Reading**

##### **1. Health Care Provider Quality Assurance Advisory Committee (HCQAAC) Rule 4123-6-22**

Mr. Coury and Ms. Mujumdar presented the second reading of the HCQAAC Rule 4123-6-22. A copy of the proposed, and rescinded, rules, CSBR form and executive summary are incorporated by reference into the minutes and were provided to the Medical Services and Safety Committee (MSSC) prior to the meeting.

Ms. Mujumdar said HCQAAC was statutorily required. Its primary functions are reviewing treatment guidelines, policies and procedures, and managed care organization (MCO) performance. The rule's content was significantly rearranged; thus the old rule is being rescinded and replaced with the proposed rule. The proposed rule's significant changes concerned governance structure; the previous rule had HCQAAC under the chief of medical services; since HCQAAC is a professional advisory committee, the committee is under the chief medical officer, who is responsible for the annual report, meeting reports, and agenda. The proposed rule mirrors the Pharmacy and Therapeutics Committee (PTC) rule for length of terms and voting. Members of HCQAAC will be paid \$600 per meeting because the Bureau values members' time and advice.

Ms. Mujumdar indicated the proposed rule was emailed to stakeholders to receive their feedback and comments were accepted September 15-October 6, 2010. There were 5 responses, with 2 from the same stakeholder. First, the Ohio Podiatric Medical Association requested the Ohio College of Podiatric Medicine be included in the list of medical schools that could be represented in HCQAAC. The Bureau has adopted their request to provide diversity to the panel. The Bureau also proactively added deans of the Ohio colleges of dentistry. The Ohio Council for Home Care and Hospice (OCHCH) also asked to be included in the list as the organization members: specifically provide home care and hospice services; would bring diversity to the panel; and could provide quality assurance data. The Bureau declined the request because the organization was too specialized, and HCQAAC members had already been selected for the coming year. The Bureau did encourage participation and attendance at HCQAAC meetings, and noted any potential agenda items should be submitted to the chief medical officer in advance. Two psychologists expressed concerns that diversity of HCQAAC members would be decreased and reviews of MCO practices would also decrease. The Bureau responded that the changes: would not affect diversity or composition of HCQAAC; the Administrator makes the final selection of the members; and reviews of MCO practices would remain the same. Finally, Compmangement Health Solutions had 2 inquiries. The first dealt with whether a review of an MCO could be preceded by an onsite visit or initial review prior to presenting to HCQAAC. The Bureau indicated a MCO review is a last resort, and issue resolution would be sought before a formal review. The MCO inquired if it could receive meeting summaries provided by the chief medical officer to the Administrator. The Bureau responded the information in the summaries would not contain any new information.

Mr. Price inquired about the OCHCH response. He asked if OCHCH could offer questions in advance of a HCQAAC meeting, and Ms. Mujumdar replied in the affirmative; the organization could provide topics to be discussed. Mr. Coury noted sections (D) and (F)

of the proposed rule address Mr. Price's concerns. Section (D) indicates the chief medical officer is responsible for setting HCQAAC's meeting agenda, but Section (F) allows HCQAAC to address issues as it deems necessary or important for the Bureau. Agendas are the responsibility of the chief medical officer, but HCQAAC can drive agenda topics. In the past, he had screened the requests and more often than not, the topic was added to the agenda. Mr. Price wanted to ensure clarity in the Bureau's response to OCHCH, particularly what happened when a request is submitted and how the Bureau responds. Mr. Coury noted any question concerning a medical policy would be sent to the Medical Policy Unit (MPU), to Dr. Balchick directly, or both. The question would be reviewed to determine if the issue is ripe to be addressed by MPU, another unit, HCQAAC or several areas. The responsibility lies with the chief medical officer, and if the organization is unhappy with the chief medical officer's response, the issue can be presented to HCQAAC. He emphasized OCHCH knows the proper procedure.

Mr. Hummel moved that the MSSC recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to rescind existing rule 4123-6-22 and adopt new rule 4123-6-22 of the Administrative Code, Stakeholders' HQAAC, to advise the Administrator and Chief Medical Officer on issues involving health care for injured workers, with the motion consenting to the Administrator rescinding and adopting rule 4123-6-22 as presented at the meeting. The motion was seconded by Mr. Matesich, and the motion passed with a 6-0 unanimous roll call vote.

## **2. 2011 Inpatient Hospital Fee Schedule (IHFS) Rule 4123-6-37.1**

Mr. Johnson and Ms. Casto presented the second reading of the 2011 IHFS Rule 4123-6-37.1. A copy of the proposed rule, CSBR form, executive summary, and a PowerPoint presentation are incorporated by reference into the minutes and were provided to MSSC prior to the meeting.

Mr. Johnson noted inpatient hospitalization (IH) addresses needs of the most significantly injured workers and is often the first treatment following injury. Maintaining an appropriate IHFS is integral to assuring injured workers receive access to quality care starting their road to success to achieving best possible recovery. IH represented less than 1% of all invoices received by the Bureau, but reimbursement was 11.1% of all medical reimbursements, or \$81 million.

Mr. Johnson noted 3 changes in the proposed IHFS. The Bureau recommends: adoption of the most current version of the Medicare MS-DRGs and pricing factors as published in the Medicare Inpatient Prospective Payment System; an increase to the Bureau payment adjustment factor (PAF) for outlier claims from 175% to 180% of the Medicare rate; and adoption of a Bureau adjustment factor (BAF), of 3.5% as an offset to Medicare adjustments made prior to the publication of its final rule. The projected impact of the proposed IHFS would increase reimbursements for IH by 5.7%, or \$4.9 million, for 2011 as compared to estimated 2010 reimbursement levels. The anticipated effective date is February 1, 2011. The Bureau discussed the proposed IHFS with the Ohio Hospital Association, who is supporting. The proposed IHFS was posted on the Bureau's website on September 10, 2010, and notice of the posting was provided to: all provider associations; the self insured association; employer organizations (Ohio Chambers of

Commerce and Ohio Manufacturers Association); MCOs; the MCO League; and the Ohio Association for Justice. Two stakeholder comments were received.

Mr. Johnson discussed 3 graphs depicting IH services, charges, payments and cost trends from 2007 through 2009. The analysis began with 2007 when the Bureau switched from a retrospective to prospective payment methodology. IH services, charges, and payments showed a slight increase from 2007 to 2008, with a sharper decrease from 2008 to 2009, and an overall decreasing trend. However, median charge and cost trends reflected a constant slightly increasing trend. The charts demonstrated the Bureau was able to stabilize median reimbursement rates in line with median charges. The Bureau did its analysis keeping in mind the historical trend lines and needing to ensure injured workers had access to quality care.

Mr. Johnson noted while the Bureau relies on Medicare's empirical data, the Bureau evaluates Medicare modifications. The Bureau accepts those modifications that ensure injured worker access to quality care. However, Medicare's 2011 changes had 2 safeguards addressing federally mandated budget neutrality. The first safeguard decreased IH base rates for 2011 by 2.9%, and the second further reduced IH rates by 0.25% pursuant to the Affordable Care Act. Thus, 2011 budget neutrality safeguards resulted in a 3.15% reduction for IH rates. Since these safeguards did not support or facilitate providing access to quality care, the Bureau recommended a BAF of 3.15% to offset these 2 Medicare adjustments. In recommending 180% outlier PAF, the Bureau's analysis indicated adopting Medicare's base rates at 175% would reimburse IH services at less than cost. The proposed outlier PAF is projecting IH services to be reimbursed at 102% of cost, consistent with inlier and exempt claims.

Of the projected \$4.9 million increase in reimbursements under the proposed IHFS, Mr. Johnson reported 92% of the proposed increase, or \$4.5 million, is from implementing the 3.15% BAF. The remaining 8%, or \$372,000, is from the proposed 180% outlier PAF. He referenced a graph of Bureau reimbursements as compared to the Consumer Price Index-Medical (CPI-Med) data from 2005 to 2009. While the CPI-Med has shown steady increases, the Bureau, beginning in 2007, and corresponding with implementation of prospective payment methodology, has started a decreasing trend. If the Bureau had not adopted that system, the Bureau's expenditures could be similar to the CPI-Med trend line. However, the Bureau was able to control the medical cost rate for IH while maintaining a vast provider network and effective access to care for injured workers.

Ms. Falls said there are discussions about reserving estimates, including medical inflation's impact on the estimates. She believed Mr. Johnson's presentation showed a striking picture as medical inflation is clearly raising costs, but the Bureau has been able to pay less. She believed there was a question as to whether the reserving estimates are encompassing this data. Mr. Johnson replied that while he could not definitively speak for Actuarial he believed that medical inflation, maybe not as depicted on the chart before the Committee, was a part of their reserving estimates. He further indicated that there currently is a joint project underway that includes Medical Services, Actuarial, and Safety which is focused on calculating the drivers of medical costs. Therefore, this type of information is definitely being looked at on a number of levels. He added the fee schedules have been meeting objectives of providing injured workers access to quality care while limiting costs and keeping medical inflation in line.

Mr. Pitts moved that the MSSC recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to amend rule 4123-6-37.1 of the Administrative Code, "Payment of Hospital Inpatient Services," with the motion consenting to the Administrator amending rule 4123-6-37.1 as presented at this meeting. The motion was seconded by Mr. Matesich, and the motion passed with a 6-0 unanimous roll call vote.

## **B. For First Reading**

### **1. Committee Charter Annual Review**

Mr. Berno and Ms. Shannon presented the first reading of the annual review of the MSSC Charter. Mr. Berno noted all committee charters were reviewed at last month's Governance Committee meeting. The charters, with recommended changes, have been referred back to their respective committees. After discussion, MSSC refers any additional recommended changes back to the Governance Committee. The Governance Committee reviews and approves the charters and then refers back to their respective committees next month with a vote anticipated. The amended charter is incorporated into the minutes by reference and was provided to MSSC prior to the meeting.

Mr. Berno discussed the changes in the MSSC Charter. With regard to page 1, Mr. Berno noted the section titled "Purpose" had 2 bullet points; however, in speaking with Mr. Harris prior to the meeting, Mr. Harris noted the first bullet point elicited 2 separate thoughts of accident prevention and medical treatment. The first bullet point has become 2 separate bullet points with no change in purpose. Mr. Harris remarked the original draft did not give enough credence to MSSC's purpose of improving and expanding safety services, and he appreciated the change. Membership on MSSC has been changed from 3 to 5 members. Finally, wording has been included that the Chair of MSSC was responsible for the written agenda, and in absence of the Committee Chair, the Vice Chair assumes responsibility of MSSC. With regard to page 3, and consistent with all other committee charters, a bullet point was clarified, with the change underlined in the amended MSSC Charter.

Mr. Lhota suggested: a portion of the first sentence of the Purpose section on page 1 of the amended MSSC Charter become a footnote; the second sentence be modified to read "The Medical Services and Safety Committee, a standing committee of the Board of Directors, shall:" MSSC was 1 of 2 committees created by the Board of Directors not required by statute. Ms. Falls and Mr. Harris agreed with Mr. Lhota's suggestions.

Mr. Matesich moved that MSSC refer the MSSC Charter to the Governance Committee to consider the recommended changes discussed at the meeting. The motion was seconded by Mr. Hummel, and the motion passed with a 6-0 unanimous roll call vote.

## **DISCUSSION ITEMS**

### **1. OSU/BWC Report re: Opioids Use**

Mr. Hanna and Ms. Mujumdar presented "Use of Opioids in the Ohio Bureau of Workers' Compensation (BWC) Population, Fiscal Years 2008 and 2009, Report: Phase I," a study developed in collaboration by the Bureau and The Ohio State University Center for Health Outcomes, Policy and Evaluation Studies (OSU/HOPES). The report is incorporated into the minutes by reference and was provided to MSSC prior to the meeting. Ms. Mujumdar noted the study was the first of several inquiries that will examine opioid prescription patterns and usage to improve treatment for injured workers.

Mr. Hanna discussed how opioids have increased in popularity in the past 20 years. The term “opioid” is a general term for any drug used for acute pain from injury, surgery or cancer. Until the last decade, opioids were not widely prescribed for noncancerous pain because of addiction potential. However, in the late 1990s chronic pain became recognized as a medical condition and pain management became a medical specialty. Patient advocates aggressively pursued use of opioids becoming acceptable therapy for non-cancer pain. The widespread opioid use not only addressed pain relief but led to misuse by pharmacists and patients.

Mr. Hanna noted “opioid” is derived from opiates, which is any drug developed from raw opium poppy. The first documented use of opium poppy for pain relief was by the Phoenicians. In 1805, morphine was developed from an active ingredient of the opium poppy; in 1806, codeine was developed. In 1898, heroin was extracted as an alternative drug that sparked research, and marked the first synthetic drug created from an opiate molecule. Between 1898 and 1920, these 3 drugs were the main opioids. Additional synthetic drugs were then developed that are still used today: meperidine/Demerol (1939); methadone (1946); fentanyl/Duragesic (1957); hydrocodone/Vicodin; oxymorphone/Dilaudid; and oxycodone, which is known as Percocet, Percodan and Oxycontin. These drugs have been all in existence for over 50 years. However there have been changes in dosage and form leading to widespread use and scrutiny today.

Mr. Hanna discussed what effectively is considered a high dose. Morphine is the gold standard for pain treatment, and all analgesics are measured as a dose of morphine, known as a Morphine Equivalent Dose, or MED. A chart in the report documents codeine at 0.155 MED, with Dilaudid at 4.0 MED. Hydrocodone, which is 37% of all narcotics prescribed in the Bureau’s population, has the same effective strength as Morphine at 1.0 MED. Oxycontin and Percocet are 50% stronger than morphine, at 1.5 MED. The MED measurement provides a useful tool when examining concurrent use of opioids.

Ms. Mujumdar summarized the study’s findings. She noted, with prevalent opioid prescription usages, Ohio needs to be more knowledgeable of prescription practices. The study provided a good foundation for understanding: how providers use narcotics to treat workplace injuries; the nature of injuries; and injured workers who are likely to receive pain medications. The study was done concurrently with state efforts to manage narcotic overutilization and with recommendations of the Ohio Prescription Drug Abuse Task Force (OPDATF), which was designed to reduce risks of excessive opioid use including dependence, addiction and death.

Ms. Mujumdar said the Bureau requested OSU/Center for HOPES to study opioid use in the claimant population. The study was initiated in December, 2009 with 3 aims: the overall opioid use of injured workers during the past 2 fiscal years (July 1, 2007 through June 30, 2009); the proportion of opioid use that could be considered “high dose” use; and the impacts of opioid use over the past 2 fiscal years. The study was possible because of the vast amount of information in the Bureau’s data warehouse.

In terms of methods, Ms. Mujumdar reported injured workers who were treated with opioids and those who were not treated with opioids were compared. OSU/HOPES used outpatient pharmacy records filed and paid by the Bureau in the 2 years, which included: number of pills, strength of drug, and number of days for all opioid prescriptions; drug

type; age and sex of the injured worker; type of injury and date of injury; number of lost work days; and medical and indemnity costs. All claims in the 2 year window that had paid for at least one prescription were analyzed. Opioid data was then aggregated to assess each claimant's level of opioid use. Less than 5% of all injured workers filed more than one Bureau claim in this 2 year timeframe. Self insured data was not used because the data was not available. The daily MED in milligrams was the standard measure used to evaluate opioid use in the population.

Ms. Mujumdar noted the key findings of the study. First, 13.6% of all active claims in the study had an opioid prescription, representing 78,550 claims out of 579,700 total claims. Second, the averaged daily MED dose was 61.7 mg in 2008 and 64.0 mg in 2009. To put this dosage level in context, she noted 8 Percocets in one day represents 60 mg. Third, approximately 7% of injured workers had a daily MED level of 120 mg or higher that could be considered as warranting caution in the absence of improved functioning or pain relief based on recent studies from the Center on Disease Control and the State of Washington. Fourth, there were over 1 million opioid prescriptions filled and paid by the Bureau in each fiscal year. Fifth, injured workers who had opioid prescriptions filled at 4 or more pharmacies had much higher daily MED rates (132 mg in 2009) compared to injured workers who had prescriptions filled at 3 or fewer pharmacies (69 mg in 2009). Sixth, opioid use was substantially higher in southeastern Ohio than other regions with 295 per 10,000 injured workers having an opioid prescription. Finally, high dose opioids relative to the Bureau population were defined as the top 20% of the MED distribution of opioid users, which included injured workers with a daily MED level of 72 mg and above, or equivalent to 10 Percocet per day.

Ms. Mujumdar said the study had 3 takeaways. First, daily MED is the standard measurement for opioid use, regardless if the opioid is derived directly from opium or a synthetic. Second, 78,550 claims, or 13.6% of the total number of claims in the study, received opioid prescriptions. Third, 5,498 injured workers, representing approximately 7% of injured workers studied, had a daily MED of 120 mg or above, which is a cautionary level if there are no improvements in function and pain relief; this dosage level was equivalent to 13-14 Percocets per day. The study provides a workable foundation and constituted Phase I of studying opioid use among Ohio's injured workers. The study: will be used in future evidenced based studies towards specific areas of opioid utilization; provides the Bureau with a starting point to examine outcomes from various medication regimens; and the study's data could be a basis for establishment of best practice recommendations for prescribers. The study could be predictive of regimens or prescribing patterns to be discouraged due to documented suboptimal outcomes for injured workers.

Mr. Smith inquired whether the data was adequate if self insured data was excluded; there were not as many self insured employers in southeast Ohio as in other regions. Ms. Mujumdar replied the self-insured data was not excluded, the data was simply not available and would have been used. Mr. Smith asked if there was a critical mass from the study as to whether the system is being gamed. Ms. Mujumdar replied the study was very preliminary, and the study only gave a snapshot of information. Administrator Ryan remarked, for many self insured employers, the data would not be available as the workers compensation program is part of a comprehensive health plan, but the Bureau will be examining regions further. Additionally, there were many more state fund

employers in other regions than southeastern Ohio and did not believe the data was skewed as a result. Mr. Harris commented southeastern Ohio was sparsely populated compared to the rest of the state.

Mr. Pitts asked if the study's purpose was simply to report usage patterns, and Ms. Mujumdar replied in the affirmative. Mr. Pitts commented data showing gaming was speculation; the issue was simply usage, and no moral comments result. Ms. Mujumdar concurred. Mr. Smith inquired what prompted the study. Mr. Hanna replied the sheer percentage of prescriptions in the opioid class in the pharmacy benefits system demonstrated the need to examine utilization. Administrator Ryan said in 2007 and 2008 there was a preliminary, but not very comprehensive study, of pharmacy products, and Ohio relative to other states had higher usage of opioids. Dr. Balchick has been participating in OPDATF, and the findings of this study coincide with their recent recommendations. There was a timing perspective that also drove the study, and the Bureau had the data to have the study done Ms. Mujumdar added deaths due to opioid overdoses were more common than motor vehicle accidents.

Mr. Price appreciated the study. Mr. Harris noted a level of concern is present when people die from excessive opioid usage. Mr. Hanna remarked the data showed high dosage use and very high dosage use. Decreasing treatment can be just as problematic; if the treatment is reduced too low, the patient could experience an increase in pain, or withdrawal symptoms, and turn to unprescribed drugs. The Bureau's intention is to use the data as to how to best improve treatment. Mr. Hummel asked, from the 2009 MED dose levels significantly differing when injured workers used 4 or more pharmacies, if any suspicions were raised. Ms. Mujumdar replied in the affirmative by stating we have theories as to why this occurs and the subsequent phases of this study will test our theories.

Mr. Caldwell asked if there were any effective alternatives to opiates. Mr. Hanna replied in the affirmative, with examples of physical therapy, acupuncture or massage. As part of guidelines, every physician or clinic uses a continuum. Part of the problem is that pills are easiest to provide relief and require the least amount of patient engagement. Mr. Caldwell asked if any other medications can be used instead of opiates to treat pain. Mr. Hanna replied in the affirmative. For example, some anticonvulsants are used to treat neuropathic pain. The type of pain guides the medication used. For soft tissue injuries, opiates are still the gold standard, but dose level is important. An injured worker should not be treated with Oxycontin as the first medication for a soft tissue injury; medication should begin typically with an NSAID such as Celebrex or ibuprofen, or even lower with Tylenol. Treatment guides the next level of therapy. Mr. Caldwell admitted he was not knowledgeable on the subject, but as an injured worker, he was happy to take whatever the doctor prescribed. Mr. Smith inquired to a pharmacist's standard of care for dispensing medications. Mr. Hanna replied, under the drug laws of Ohio, a pharmacist has a corresponding liability with the prescribing physician to prescribe medication for a legitimate medical use. Mr. Smith noted persons who abuse these drugs know they have to shop around. Mr. Hanna agreed, the fact there is no one point where medications are gathered is the problem; no one is looking at the entire picture.

Mr. Pitts commented the data did not show using or gaming the system, but injured workers victimized by the system through the wholesale prescribing of drugs. Injured

workers are becoming drug addicts through no fault of their own. Drug addiction was defined by the American Medical Association as a disease in 1952. There is no abuse trying to treat a horrible injury. Use of narcotics creates a serious challenge to the system and to injured workers prescribed these drugs. Mr. Mazzotta echoed Mr. Pitts' comments. He noted that the driving basis of the study was to determine whether the Bureau system was causing harm. Administrator Ryan noted Mr. Pitts had encouraged the Bureau to look at the State of Washington's work, which was fine, cutting edge work and timely. The Bureau hopes there will be higher quality medical care for injured workers through these studies.

Mr. Caldwell asked if Percodan and Percocet were the same. Mr. Hanna responded both drugs have the same active ingredient, oxycodone. Percodan also has aspirin, and Percocet also has Tylenol. The study benchmarked Percocet because of its overall familiarity. Administrator Ryan noted that high usage of these drugs can lead to high levels of aspirin or Tylenol, which in and of itself can be problematic. Mr. Hanna concurred; noting greater than 4 mg of Tylenol per day is dangerous. Mr. Matesich asked Ms. Mujumdar if the positive finding from the study is the generation of many questions needing answers. Ms. Mujumdar agreed. Mr. Matesich asked if the other treatment modalities mentioned, such as acupuncture and physical therapy, are accepted in the Bureau system. Mr. Berno replied in the affirmative. Mr. Hanna said there was no established cutoff for opiates. Injured workers receiving extremely high doses of opioids that still function within their activities of daily living is a clinical success. To parallel, a diabetic is expected to be treated with insulin, and equal concern exists about high insulin usage. Some patients using 1 g of morphine daily can continue to function.

Mr. Harris observed many Board members had little experience with these issues, and education must be a key point to these presentations. Ms. Falls inquired to the next phases of the study. Ms. Mujumdar said discussions with OSU/HOPES for Phase II of the study are underway. Ms. Falls asked what areas are planned to be explored, and Ms. Mujumdar replied treatment outcomes, medical recommendations, and return to work are a few areas being explored. Mr. Pitts agreed further education would be valuable. He recommended a presentation by Dr. Balchick or the Cleveland Clinic's director of pain management, a world renowned expert.

Mr. Price inquired how the Bureau plans to control what prescription a doctor gives a patient. Mr. Hanna replied that comment interferes with the doctor-patient relationship. The goal is to determine best practices and monitor data on prescription patterns. Administrator Ryan noted PTC will have the level of professional experience needed to develop best practices and developing a Bureau formulary. She noted the OPDATF report had been distributed to Board members. The Bureau has ignored this issue for 20 years, which cannot continue. Mr. Caldwell appreciated Mr. Price's comment, and what he obtained from this discussion is to be mindful if a physician prescribes someone 14 Percocets a day. He had taken Percodan and he could not see how someone could function at 14 pills a day. Mr. Pitts noted the Bureau does drug reviews of on long term usage patterns and issues orders indicating the drugs are no longer reimbursable under the claim; the reviews do not cover just opiates, but all medications paid on a claim. The basis of denial is the medications are no longer within acceptable guidelines. Injured workers can object and attempt to establish with medical proof that the drugs continue to be appropriate. In sum, there is a review process as to reimbursement, and the physician

can continue to prescribe the medications, but the Bureau may no longer pay for them. Ms. Falls and Mr. Harris were happy to hear Mr. Pitts' comments.

## **2. Committee Calendar**

Mr. Harris said "Outpatient Hospital Fee Schedule (2<sup>nd</sup> read)" was removed from the next month's agenda. He reminded the Board members present that the meeting was scheduled to begin at 8:00 a.m. on November 18, 2010.

## **ADJOURNMENT**

Mr. Matesich moved to adjourn the meeting at 2:00 PM, seconded by Mr. Hummel. The meeting adjourned with a 6-0 unanimous roll call vote.