

BWC Board of Directors
Medical Services and Safety Committee

Friday, November 19, 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: Charles Bryan, David Caldwell, Kenneth Haffey, Larry Price,
Robert Smith

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

Consultant Present: Anne Casto, President, Casto Consulting

Staff Present: Marsha Ryan, Administrator
Donald Berno, Liaison to Board of Directors
Freddie Johnson, Director Managed Care Services
Carol Morrison, Manager, Division of Safety and Hygiene
Tina Kielmeyer, Chief of Customer Services

Scribe: Michael J. Sourek, Staff Counsel

CALL TO ORDER

Mr. Harris called the meeting to order at 8:00 AM, and the roll call was taken. All members were present.

MINUTES OF OCTOBER 21, 2010 MEETING

Mr. Harris asked for any changes to the minutes of October 21, 2010. With no changes, Ms. Falls moved to have the minutes of October 21, 2010 be approved, and Mr. Hummel seconded the motion. The motion passed with a 6-0 unanimous roll call vote.

REVIEW AND APPROVAL OF AGENDA

Mr. Harris indicated he would provide some introductory remarks before new business. With no further changes, Mr. Pitts moved to have the agenda approved, as amended, and the motion was seconded by Mr. Hummel. The motion passed with a 6-0 unanimous roll call vote.

NEW BUSINESS/ACTION ITEMS

1. Mr. Harris' Introductory Remarks

Mr. Harris noted October, 2010 marked the first anniversary of the Medical Services and Safety Committee (MSSC). Mr. Harris said the first meeting was a reading of the MSSC charter; in November, 2009, the first rule was presented: Ambulatory Surgical Center Fee Schedule (ASCFS). Mr. Johnson and Ms. Casto have been present at almost every MSSC meeting. MSSC is a unique committee of the Board of Directors (BoD) because MSSC is not statutorily required but created by the BoD. The creation of the MSSC is a clear indication of the BoD's commitment to safe workplaces and effective treatment of workplace injuries.

MSSC's accomplishments reflect that commitment. First, the Drug Free Work Place Program was revamped, with increased utilization by employers. Second, there have been 2 public forums conducted with managed care organizations ("MCOs"). Third, a study of MCO-vocational rehabilitation referral patterns was conducted along with a meeting of vocational rehabilitation providers. Fourth, MSSC reviewed the pharmacy program and completed the first of several studies on opiate usage in the Bureau system. Finally, rules have been approved to improve committee structure that staff uses to make recommendations to MSSC.

MSSC has not been perfect. MSSC modified the transcutaneous nerve stimulator rule with unintended consequences. The fact MSSC was willing to examine the data, and make additional changes to the rule, speaks highly of MSSC members. While Mr. Harris felt strongly about implementing the term "safeguard" in the safety rules, MSSC believed the safety rules provided sufficient guidance to employers.

Finally, alternating monthly reports between Medical Services and Customer Services provided education to both MSSC and the BoD on very important activities taking place in the Bureau.

2. Motions for Board Consideration

A. For Second Reading

1. Committee Charter Annual Review

Mr. Berno and Ms. Shannon presented the second reading of MSSC's charter annual review. A copy of the proposed charter is incorporated by reference into the minutes and provided to MSSC prior to the meeting. Mr. Berno noted the annual charter review began 2 months ago, and the Governance Committee had reviewed the MSSC charter yesterday and made some changes to make all committee charters read the same.

Mr. Berno reported there were 6 changes made to the MSSC charter. First, the first sentence of the charter now reads "The [MSSC], a standing committee of the Board of Directors, shall:" Second, the previous first sentence was deleted and made a footnote to the new first sentence. Third, bullet points on the page 1 were changed to present tense. Fourth, the role of MSSC's Chair was updated beginning on the bottom of page 1; in the absence of the Chair, MSSC's Vice Chair assumed the Chair's responsibilities. Fifth, the Board Chair is an *ex officio* member of MSSC; however, the Board Chair would not vote on a motion if the vote would create a tie. Finally, "that" on page 3 was changed to "which."

With no comments by Committee members, Mr. Hummel moved that MSSC approve its amended charter and refer the charter to the Board of Directors for review and approval. The motion was seconded by Mr. Pitts, and the motion passed with a 6-0 unanimous roll call vote.

B. For First Reading

1. Ambulatory Surgical Center Fee Schedule – Rule 4123-6-37.3

Mr. Johnson and Ms. Casto presented the first reading of the 2011 Ambulatory Surgical Center Fee Schedule (ASCFS) Rule 4123-6-37.3. A copy of the proposed rule, Common Sense Business Regulation form, executive summary, and a presentation are incorporated by reference into the minutes and provided to MSSC prior to the meeting. Mr. Johnson made an introductory comment commending MSSC, noting he appreciated MSSC's, and the BoD's, input on the issues and rules staff asks them to consider.

Ambulatory Surgical Centers (ASCs) provide services similar to outpatient hospitalization (OH), such as knee scopes and pain management injections. ASC services do not include inpatient hospitalization. ASCs are a small percentage of total Bureau reimbursements; in 2009, ASCs represented less than 1% of services, for a total of \$6.5 million. ASCs were a critical component of the Bureau provider environment with 200 ASCs in Ohio, mostly near metropolitan areas. ASCs are lower cost settings than OH, providing a cost effective environment. The proposed ASCFS recommends that the Bureau: adopt the Medicare reimbursement ASC fee schedule; introduce a Bureau adjustment factor ("BAF") of 1.3% to offset Medicare federal budget neutrality actions; and maintain the current payment adjustment factors ("PAFs") of 110% for pain management procedures and 100% for all other allowed procedures. The proposed ASCFS will increase payments to ASCs by an estimated 10% or \$677,000 over the 2011 calendar year. The proposed ASCFS will continue to provide injured workers access to high quality medical care. The anticipated effective date is April 1, 2011.

The Bureau met with the Ohio ASC Association and the Ohio Hospital Association (OHA.) There was an understanding and agreement by these associations to the proposed ASCFS. The Ohio ASC association indicated that they were pleased that during the 2009 presentation of the ASC fee schedule the MSSC had a discussion regarding the utilization and impact of ASC facilities. The Bureau is still gathering data, but there appears to be a slight increase in utilization of ASC facilities. The Bureau is looking at strategies to ensure providers and injured workers have relevant information to make informed decisions regarding utilization of ASC services and facilities. Providers and injured workers have the choice of where to receive services, and the Bureau is continually encouraging an informed decision when a service could be safely performed in a more efficient environment such as an ASC.

The proposed ASCFS was posted on the Bureau's website on November 12th, with a 2 week comment period ending November 26th. All provider associations, the Self Insured Association, the Ohio Manufacturer's Association, the Ohio Chambers of Commerce, MCOs, the MCO League, and the Ohio Association for Justice, and other stakeholders were provided notice of the posting. Posting of recommended rule changes normally occurs 2 weeks prior to the first reading of the rule. However, Medicare did not publish its rules until November 4, 2010, and the recommendations and proposed fee schedule

should not be fully revised and posted prior to November 12, 2010. All stakeholder feedback will be summarized at the second reading.

The Bureau took the current prospective payment methodology used in the ASCFS and examined Medicare empirical data, reviewed all Medicare updates, reviewed ASC services and expenses, and examined PAFs. Medicare is in the final year of a 4 year transition period of moving ASC rates to the fully implemented hospital outpatient prospective payment rates. The final implemented ASC rates resulted in an increase in ASC orthopedic base rates of 12%, and a decrease in ASC pain management rates of 2%. Mr. Johnson noted during the presentation that orthopedic services are most utilized by Ohio's injured workers population.

Ms. Casto reported Medicare, pursuant to the Affordable Care Act (ACA) uses the urban Consumer Price Index (CPI-U) to account for inflation; in 2011 the CPI-U for ASC is 1.5%. During the previous discussions of the 2011 Inpatient Hospitalization Fee Schedule recommendations, market basket adjustments were covered. The second piece to Medicare adjustments are productivity adjustment factors (PrAFs). Depending on the health care setting, the effective dates of PrAF differ; for ASCs, the effective date is January, 2011. PrAFs involve budget neutrality issues, and the 2011 PrAF is -1.3%. Thus, Medicare offset the CPI-U of 1.5% by the productivity adjustment factor of -1.3%, which resulted in an updated total reimbursement adjustment for ASCs of 0.2%. The Bureau will use a BAF to offset impacts of the negative PrAF. Ms. Casto noted that Medicare's Office of the Actuary estimates in 10 years 15% of healthcare providers could become unprofitable because of PrAFs and opt out of Medicare.

The Bureau does not believe cost savings adjustments support a fee schedule to facilitate access to quality care. The Bureau supports a BAF of 1.3% to account for this PrAF. The BAF, in conjunction with maintaining the current Ohio PAFs, makes ASC services rates stable this coming year. Ms. Casto again noted that the fully implemented rates and not the BAF adjustment was resulting in an overall 12% increase in orthopedic services rates and a 0% change in pain management services rates. She further indicated that next year, rate changes such as those experienced in orthopedic services should not occur, as only the CPI-U and the PAF will be modified which should reflect an estimated 2-4% overall increase.

Mr. Smith asked if the Bureau was adjusting for the PrAFs so there would be an adequate amount of ASCs; i.e., did this action fix or prevent a problem. Ms. Casto replied there was not a current problem as no ASCs have discontinued services to injured workers, but the issue could occur. Since the Bureau is reimbursing ASCs at or a little above Medicare rates, the Bureau was not a top payer. The payment is reasonable, but if the Bureau followed Medicare's guidance, ASCFS would be inadequate. Ms. Casto further underlined the seriousness of the representation by Medicare's actuary that a high percentage of providers could withdraw from service due to PrAFs. Ms. Casto believed Congress will have to modify the current ACA, particularly the PrAFs which are ineffective. Mr. Johnson emphasized the Bureau uses Medicare reimbursement rates as a starting point; if Medicare's adjustments are in accordance with the Bureau's goals, the adjustments will be followed by the Bureau. When the ASC PrAF was examined, this factor did not support the Bureau's goal of access to care.

Mr. Hummel asked if the Bureau's view, by Medicare reducing reimbursements by 1.3% and the Bureau upwardly adjusting by 1.3%: could be considered a neutral Medicare position. Ms. Casto replied 1.3% is a PrAF adjustment to CPI-U which reflects resource consumption for 2011. The PrAF is a cost averaging measure to save Medicare dollars and extend the Medicare Fund's life. Mr. Johnson emphasized the Bureau was being neutral with respect to the reduction Medicare was implementing. Mr. Pitts concurred with the Medicare actuary's concerns; not implementing this Medicare change was important, so the Bureau does not witness the same flight from service. Ms. Casto added if a provider would opt out of Medicare, the same provider would most likely opt out of other programs first because Medicare covers a high percentage of patients.

2. Outpatient Hospital Fee Summary – Rule 4123-6.37.2

Mr. Johnson and Ms. Casto presented the first reading of the 2011 Outpatient Hospital Fee Summary (OHFS) Rule 4123-6-37.2. A copy of the proposed rule, CSBR form, executive summary, and a presentation are incorporated by reference into the minutes and were provided to MSSC prior to the meeting.

Mr. Johnson noted OHs represented 7% of all Bureau bills reimbursed and 17% of total medical reimbursements. OH services represent emergency room treatment, surgical procedures, and rehabilitation services. In April, 2010, the Bureau adopted a prospective payment methodology for OH to be implemented on January 1, 2011. The methodology reflected a full implementation impact of decreased overall hospital outpatient services reimbursement of 22%, or \$30 million. The BoD approved a 3 year 1 quarter transition period, with each period representing about 7.2% of the total projected decrease.

The proposed 2011 OHFS recommendations are: adoption of the 2011 Medicare reimbursement rates; adoption of 3 BAF to address ACA budget neutrality adjustments; and retention of the current PAF set to go into effect on January 1, 2011. The proposed recommendations for the April 2011 date would result in an additional 0.8% reduction to the initial projected 7.2% total reduction for the period of March 1, 2011 and March 1, 2012. The effective date of the proposed OHFS is April 1, 2011. Mr. Johnson said OHA was contacted on November 12, 2010 and expressed support of these recommendations, noting that the recommendations as presented continued to reflect the BWC philosophy previously shared with and understood by their committee. Beyond budget neutrality issues, OHA had no major issues. The proposed OHFS was posted on the Bureau's website beginning on November 16, 2010, and would continue until November 30, 2010. Mr. Johnson noted that while it is the Bureau's intention to post the recommended schedules earlier for stakeholder review and feedback, given the late release of Medicare's rule updates, the development of the schedule could not have been completed and posted earlier. A complete stakeholder grid will be presented at next month's meeting.

Ms. Casto reviewed the Outpatient Prospective Payment System, which is comprised of Medicare fee schedules, Ambulatory Physician Classifications (APCs) that cover most outpatient emergency room services, and reasonable cost considerations. The fee schedule portion is focused upon in dialogue with MSSC. MSSC is familiar with the Provider Fee Schedule portion in an outpatient setting. The Bureau uses calculated rates in that fee schedule and not modifiers. Medicare's Physician Fee Schedule for 2011 has adopted a multiple payment procedure reduction provision for therapy services, which is being adopted in the hospital outpatient setting. The reduction methodology applies to

physical, occupational, and speech therapy. The reduction methodology realizes duplicate practice expense for therapy services that should be accounted when multiple services are performed in one session. The theory is fewer resources are consumed when all therapies are done at once, and fees should be better aligned to reflect this point. The estimated impact on therapy services is a projected 7% decrease in reimbursement.

Ms. Casto provided an example of this multiple payment procedure reduction provision using an example of a physical therapy session wherein a patient receives neuromuscular reeducation and therapeutic exercises on the same day. The illustration showed how duplicate payments were made in terms of practice expenses and supply reduction for the services rendered. Mr. Matesich inquired if a rule could be written so if Congress restored Medicare payments, the Bureau would not automatically increase our payments, thus, doubling the reimbursement rates. Ms. Casto replied the rule states rates as published on November 29, 2010 in the Federal Register which means that we would not be applying any additional update irrespective of Medicare changes.

Ms. Casto next covered 3 adjustments Medicare was making to the OPSS schedule pursuant to the requirements of the ACA. Under the APC schedule, Medicare applied a market basket reduction of .25%. Additionally, Medicare applied a 1.75% reduction to the OPSS Clinical Lab Fee schedule. Lastly, Medicare applied a 30.78% reduction to the OPSS Physician Fee schedule. Ms. Casto indicated that these particular adjustments are budget neutrality adjustments which Medicare by law must make as required by the ACA, and do not reflect or support BWC's goal of ensuring Ohio's injured workers' access to quality care. Mr. Johnson reiterated the Bureau understood Medicare's budget neutrality adjustments, and Medicare rates are adjusted accordingly to meet the Bureau's goals.

Recommendations in the proposed OHFS are as follows: adopt 2011 Medicare rates; apply a BAF of 0.25% for services under APCs; apply a BAF of 1.75% for laboratory services; apply a BAF of 30.78% for services covered under the Medicare Physician Fee Schedule; and PAFs would remain at 253% for Children's Hospitals and 197% for all other facilities. The estimated overall reimbursement decrease would be 8.0%, or \$11.4 million; the recommendations would further facilitate the Bureau's implementation of the newly adopted OH prospective payment methodology.

Mr. Johnson provided MSSC with an overview of the status of the OPSS implementation. Mr. Johnson noted that in April when the Board approved the new methodology changes, Medical Services committed to making the implementation as smooth as possible. MCOs, OHA, and self insured employers have all been engaged in an effort to create the necessary infrastructure to make the transition smoothly. Training guides were developed for consistency of terminology, and understanding. On November 9, 2010, the Bureau conducted a training session for all MCO staff on the new methodology. The Bureau has worked hand in hand with the MCOs to implement necessary changes to our systems. Extensive testing has begun in May with MCOs and in July with hospitals; examples of hospitals participating in testing included Altman Hospital and Cleveland Clinic. BWC's provider relations department has worked with the OHA and various regional hospital associations providing 6 regional training sessions on the methodology change. OHA commented that the training sessions were exceptional and well received.

The Bureau has a video available on the website and is well prepared for the transition on January 1, 2011.

Mr. Johnson reminded the MSSC about the emergency rule request staff will present at the December meeting. MSSC will be asked to approve and adopt Medicare's Current Procedural Terminology (CPT) codes and Health Care Procedure Code System (HCPCS) codes. Both are important in reimbursing providers under BWC's Professional Providers and Medical Services fee reimbursement schedule. Each year when new CPT and HCPCS codes are released in January, providers start to use those codes on bills. If the Board does not approve an emergency rule, coding issues create problems for providers and increased expenses to the system because bills are denied not because the services are unwarranted, but rather because the codes being used have not been adopted by BWC. The Bureau in 2010 provided a crosswalk to MCOs so new 2010 codes could be matched with codes BWC adopted in 2009. This inefficient work around will be avoided with the adoption of the emergency rule and one reading of the recommendations to the Board. The Bureau will be requesting MSSC, after one reading, recommend adoption of Medicare's 2011 CPT and HCPCS codes and submission to the Governor's Office for an emergency rule to begin January 1, 2011. One reading of the recommendation is important as the emergency rule would allow implementation for 90 days. One reading would also allow all of the rulemaking steps to be completed prior to the expiration of the 90 day period, thus avoiding any lapse in coverage.

DISCUSSION ITEMS

1. Customer Services Report

Ms. Kilmeyer presented the Customer Services Report (CSR). A summary of the report is incorporated by reference into the minutes and was provided to MSSC prior to the meeting.

Medicare Reporting and Implementation of Causation Coding. This topic was a previous item in a MSSC CSR. Due to federal legislation, the Bureau and other insurers are required to report active claims to Medicare. This reporting will allow Medicare to ensure that they are only paying for medical treatments for which they are the primary payer. The Bureau successfully transmitted the initial batch of claims data to Medicare this fall. Beginning in January, 2011, the Bureau begins quarterly reporting to Medicare. With quarterly reporting Medicare requires will require that each claim record include a causation code. While the Bureau currently uses ICD-9 coding for injury reporting we had not adopted the, "E" codes which are used to report the cause of the accident. The Bureau hired a vendor to assist with training of BWC claims and medical staff. In addition to coding all new claims, the Bureau will be applying causation codes to all existing claims. Mr. Robert Coury, Chief of Medical Service and Compliance, and Ms. Kilmeyer have been very involved with this process. Ms. Kilmeyer mentioned that Mr. Haffey previously inquired if there was a silver lining to the Medicare reporting mandate, and Ms. Kilmeyer replied the project allowed the Bureau to validate Social Security number accuracy. Ms. Kilmeyer added that Mr. Abe Al-Tarawneh, Superintendent of the Division of Safety and Hygiene (DSH), was interested in the new causation codes for use in his research and analysis in accident prevention.

Claims Severity Update. Ms. Kilmeyer noted this topic was a previous discussion item, particularly the catastrophic event (CAT) team. Claims complexity analysis triages claims

by severity. Claim severity is sometimes recognizable from the onset of the filing. This is especially true in very minor injury claims and very severe claims; however, there are claims in the middle that may be at risk for a long term disability. The Bureau is developing methodology to assess complexity of those claims at the onset to ensure proper handling. The Ohio State University recently completed an analysis for risk triggers of long term disability, aimed to the middle level of claims complexity. The Bureau is validating this analysis and will incorporate these triggers into our claims triage process.

For PTD and death claims, the Bureau is developing better strategies for managing the consistency and accuracy of claims handling. Death claims will become a centralized process. The Bureau is developing a small group of professionals in Columbus to improve accuracy and timeliness issues identified in a recent audit. For PTD claims, there is also a high level of complexity. PTD claims will not be centralized but regionally managed out of the Youngstown and Dayton service offices. All PTD determinations will be processed in those offices. Correlated with the PTD claims, is the management of Disabled Workers' Relief Fund (DWRF) payments, which is managed by 3 Columbus claims service specialists; when PTD claims are regionalized, DWRF will also be regionalized. Mr. Pitts asked for confirmation that current PTD claims will be reassigned to these regional offices only after the award has been decided and Ms. Kilmeyer replied in the affirmative.

The Bureau has a limited amount of nurse resources located around the state in our service offices. The Bureau is strategizing work flows and developing a pooling concept to be better able to use our nursing resources remotely. A nurse pooling project presently is being piloted in the Mansfield and Toledo service offices with excellent results.

Service Office Safety Services Business Plans Initiative. Ms. Kilmeyer reported Mr. Al-Tarawneh and Mr. Steve Dyer, Field Operations Manager, continue developing individual safety business plans for each service office to improve the range of services. This business plan development aligns the services with the agency's safety goals. First quarter results for fiscal year 2011 include: the number of distinct employers receiving field consulting services increased by 8%; attendance at Bureau safety education and training classes increased by 21%, but the number of distinct employers who benefitted from these services decreased by 21%; and safety grants awarded this year has increased 675%.

Ms. Kilmeyer introduced Ms. Carol Morrison of the Division of Safety and Hygiene, and Mr. Eric Davis of the Warren Joint Apprenticeship and Training Committee (WJATC). They were pleased to announce WJATC had been recently approved for a Bureau safety grant to purchase a wind turbine training tower. The training tower provides statewide benefits to employers in the prevention of injuries as well as educating the Ohio workforce. Trainers will learn hands-on in the safe operation and develop best practices in safety protocols, construction, operation, and maintenance of wind turbines. There are presently 5 wind farms in Ohio with 725 wind turbines. The safety grant will assist electrical workers and others to transfer into Ohio "green" jobs. Additionally firefighters and other first responders will be trained in rescue operations. This training transfers to corn silos and sewer systems. WJATC, in its partnership with the International

Brotherhood of Electrical Workers (IBEW) will provide a one week, 45 hour, training session. Finally, Bureau safety staff will obtain first-hand knowledge of this new technology. Mr. Davis was honored to appear before MSSC. WJTAC was very excited in obtaining the safety grant and working with the Bureau to develop best safety practices for wind turbine technology.

Mr. Lhota, Mr. Caldwell, and Mr. Harris commended the IBEW and Bureau for undertaking this initiative. Mr. Caldwell added IBEW did tremendous work in apprenticeship programs, and green energy is an exciting new area, citing projects in Pennsylvania and Indiana. He believed the safety and training aspects of this grant are important, and Ohio should be ahead, and not behind, this technological wave. Mr. Harris concurred and commended DSH being responsive to the IBEW and WJATC.

2. Committee Calendar

Mr. Harris noted MSSC had a full calendar for next month's meeting.

ADJOURNMENT

Mr. Matesich moved to adjourn the meeting at 9:25 AM, seconded by Mr. Pitts. The meeting adjourned with a 6-0 unanimous roll call vote.