

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

Wednesday, February 23, 2011

William Green Building

Level 2, Room 3

2:30 P.M. \*\* – 4:00 P.M.

**Call to Order**

Jim Hummel, Committee Vice-Chair

**Roll Call**

Mike Sourek, Scribe

**Approve Minutes of December 15, 2010 meeting**

Jim Hummel, Committee Vice-Chair

**Review and Approve Agenda**

Jim Hummel, Committee Vice-Chair

**New Business/ Action Items**

1. Motions for Board consideration:
  - A. For Second Reading
    1. OSHA/PERRP Cranes and Derricks rule  
Michael F. Rea, Industrial Safety Administrator
  - B. For First Reading
    1. Claimant Reimbursement Rule 4123-6-26  
Dr. Robert Balchick, Chief Medical Officer  
Johnnie Hanna, Pharmacy Program Director (Program overview)  
Christine Sampson, Pharmacy Program Manager

**Discussion Items\*\*\***

1. Rehabilitation Services Commission Review  
Freddie Johnson, Interim Chief, Medical Services  
Karen Fitzsimmons, Rehab Policy Unit Director
2. Medical Services Report  
Freddie Johnson, Interim Chief, Medical Services  
Teresa Arms, Director, MCO Business and Reporting
4. Committee Calendar  
Jim Hummel, Committee Vice-Chair

**Adjourn**

Jim Hummel, Committee Vice-Chair

**Next Meeting: Thursday, March 24, 2011**

\* Agenda subject to change

\*\* Or after previous meeting adjourns \*\*\* Not all discussion items may have materials

## Common Sense Business Regulation (BWC Rules)

(Note: The below criteria apply to existing and newly developed rules)

### **Rule 4167-3-04.2 Amending of standards**

#### **Rule Review**

1.  The rule is needed to implement an underlying statute.

Citation: R.C. 4167.7(A)(2)(b)

2.  The rule achieves an Ohio specific public policy goal.

What goal(s): The goal is to ensure that employers in the state of OHIO comply with the OAC requirements to provide a workplace safe from recognized workplace hazards and to protect employees' safety and health. This also aligns with the mission of the Ohio BWC to "protect workers and employers from a loss as a result of workplace accidents, and to enhance the general health and well-being of Ohioans and the Ohio economy"

3.  Existing federal regulation alone does not adequately regulate the subject matter. YES – Federal OSHA regulations when promulgated are not applicable to the Ohio public employer therefore it is necessary to adopt or amend under RC 4167 so they become rules or standards for the Ohio public sector.
4.  The rule is effective, consistent and efficient. YES
5.  The rule is not duplicative of rules already in existence. YES
6.  The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden. YES
7.  The rule has been reviewed for unintended negative consequences. YES
8.  Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: On October 9, 2008 OSHA published a Notice of Proposed Rulemaking (NPRM) (73 FR 59713) titled "Cranes and Derricks in Construction." The NPRM set January 22, 2009, as a deadline for submitting comments and for requesting an informal public hearing on the proposed rule. On March 17, 2009 OSHA convened a public hearing on the proposal, with Administrative Law Judge William S. Cowell presiding. At the close of the hearing Judge Colwell established a post-hearing comment schedule. Participants were given until May 10, 2009 to supplement their presentations and provide data and information in response to questions and requests made during the hearing, make clarifications to the testimony and record that they believe were appropriate, and submit new data and information that they considered relevant to the proceedings. Participants were also given until June 8, 2009 to comment on the testimony and evidence in the record, including testimony presented at the hearing submitted during the first part of the post-hearing comment period.

9.  The rule was reviewed for clarity and for easy comprehension. YES
10.  The rule promotes transparency and predictability of regulatory activity. YES
11.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently. YES
12.  The rule is not unnecessarily burdensome or costly to those affected by rule. NO
- If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_
13.  The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

**BWC Board of Directors**  
**Executive Summary**  
**Occupational Safety and Health Amended Rules for**  
**Cranes and Derricks**

## **Introduction**

Chapter 4167-3-04.2 of the Ohio Administrative Code requires the Public Employment Risk Reduction Program to amend rules promulgated by the Federal Occupational Safety and Health Administration (OSHA). Chapter 4167 was initially enacted in 1992 with the ratification of House Bill 308. The scope of H.B. 308 was to provide on the job safety and health protection to Ohio public employees through the adoption and application of federal safety and health rules and regulations for General Industry, Construction, and Agriculture.

## **Background Law**

Under House Bill 308, Chapter 4167.07 the administrator is to adopt rules for employment risk reduction standards.

(A) The administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall adopt rules that establish employment risk reduction standards. Except as provided in division (B) of this section, in adopting these rules, the administrator shall do both of the following: (1) By no later than July 1, 1994, adopt as a rule and an Ohio employment risk reduction standard every federal occupational safety and health standard then adopted by the United States secretary of labor pursuant to the "Occupational Safety and Health Act of 1970," 84 Stat. 1590, 29 U.S.C.A. 651, as amended; (2) By no later than one hundred twenty days after the United States secretary of labor adopts, modifies, or revokes any federal occupational safety and health standard, by rule do one of the following: (a) Adopt the federal occupational safety and health standard as a rule and an Ohio employment risk reduction standard; (b) Amend the existing rule and Ohio employment risk reduction standard to conform to the modification of the federal occupational safety and health standard; (c) Rescind the existing rule and Ohio employment risk reduction standard that corresponds to the federal occupational safety and health standard the United States secretary of labor revoked.

## **Proposed Change**

OSHA is issuing this final rule to revise the Cranes and Derricks, Subpart N, section of its construction industry standards. These changes will address advances in the design of cranes and derricks, related hazards, and the qualifications of employees needed to operate them safely. The final rule is effective November 8, 2010

## **Stakeholder Involvement**

On October 9, 2008 OSHA published a Notice of Proposed Rulemaking (NPRM) (73 FR 59713) titled "Cranes and Derricks in Construction." The NPRM set January 22, 2009, as a deadline for submitting comments and for requesting an informal public hearing on the proposed rule. On March 17, 2009 OSHA convened a public hearing on the proposal, with Administrative Law Judge William S. Cowell presiding. At the close of the hearing Judge Colwell established a post hearing comment schedule. Participants were given until May 10, 2009 to supplement their presentations and provide data and information in response to questions and requests made during the hearing, make clarifications to the testimony and record that they believe were appropriate, and submit new data and information that they considered relevant to the proceedings. Participants were also given until June 8, 2009 to comment on the testimony and evidence in the record, including testimony presented at the hearing submitted during the first part of the post hearing comment period.

## **Cranes and Derricks**

The purpose of the Occupational Safety and Health Act of 1970, is to achieve to the extent possible safe and healthful working conditions for all employees. To achieve this goal, Congress authorized the Secretary of Labor to promulgate and enforce occupational safety and health standards. A safety or health standard is a standard that requires employers to maintain conditions or adopt practices that are reasonably necessary or appropriate to provide safe or healthful working conditions. A standard is reasonably necessary or appropriate within the meaning of the OSH Act if a significant risk of material harm exists in the workplace and the proposed standard would substantially reduce or eliminate that workplace risk. OSHA already determined that requirements for cranes and derricks reasonably necessary or appropriate within the meaning of Section 652(8).

### **SUMMARY: Explanation of Revisions to the Cranes and Derricks Standard**

OSHA is revising the Cranes and Derricks Standard and related sections of the Construction Standard to update and specify industry work practices necessary to protect employees during the use of cranes and derricks in construction. This final standard also addresses advances in the designs of cranes and derricks, related hazards, and the qualifications of employees needed to operate them safely. Under this final rule, employers must determine whether the ground is sufficient to support the anticipated weight of hoisting equipment and associated loads. The employer is then required to assess hazards within the work zone that would affect the safe operation of hoisting equipment, such as those of power lines and objects or personnel that would be within the work zone or swing radius of the hoisting equipment. Finally, the employer is required to ensure that the equipment is in safe operating condition via required inspections and that employees in the work zone are trained to recognize hazards associated with the use of the equipment and any related duties that they are assigned to perform.

Considerable technological advances have been made since the 1971 OSHA standard for cranes was issued. For example, hydraulic cranes were rare at that time, but are now prevalent. In addition, the construction industry has updated the consensus standards on which the original OSHA standard was based. For example, the industry consensus standard for derricks was most recently updated in 2003, and that was for crawler, locomotive, and truck cranes in 2007. In recent years, a number of industry stakeholders asked OSHA to update subpart N's cranes and derrick requirements. They were concerned that accidents involving cranes and derricks continued to be a significant cause of fatal and other serious injuries on construction sites and believed that an updated standard was needed to address the causes of these accidents and to reduce the number of accidents. They emphasized that the considerable changes in both work processes and technology since 1971 made much of former crane information obsolete.

In response to these requests, in 1998 OSHA's Advisory Committee for Construction Safety and Health established a workgroup to develop recommended changes to the subpart N requirements for cranes and derricks. The workgroup developed recommendations on some issues and submitted them to the full committee in a draft workgroup report.

### **Hazards Associated With Cranes and Derricks in Construction Work**

OSHA estimates that 89 crane-related fatalities occur per year in construction work. The causes of crane related fatalities were recently analyzed and published in the Journal of Construction Engineering and Management, "Crane-Related Fatalities in the Construction Industry," Of the 335 OSHA case files reviewed 125 were identified (involving 127 fatalities) as being crane or derrick related.

**The following 29 CFR 1926 sections provide an overview of significant changes to the standard.**

Sec. 1402, contains the provisions addressing operator training, qualification, and certification. Also contains provisions that will prevent tip-over accidents by ensuring that the operator is sufficiently knowledgeable and skilled to recognize situations when the crane may be overloaded. Under this section, employers must ensure that the surface on which a crane is operating is sufficiently level and firm to support the crane in accordance with the manufacturer's specifications.

Sec. 1403, addresses boom stops to prevent booms from being raised too far and toppling over backwards.

Sec. 1404, addresses the assembly and disassembly of a crane which now must be supervised by an individual who is well qualified and can take steps when necessary to protect workers against being struck by a counterweight.

Sec. 1407-1411, addresses power-line safety and contains requirements to prevent equipment from contacting energized power lines, ensures that a minimum safe distance from the power line is maintained, which prevents equipment from becoming energized. Also when working closer than the normal minimum clearance distance, the crane must be grounded, which reduces the chance of an electrical pathway through the workers.

Sec. 1412-1414, addresses structural deficiencies issues related to cable failure and includes wire rope inspection, selection, and installation to ensure that appropriate wire rope is installed, inspected, and removed from service when continued use is unsafe.

Sec. 1417, addresses crane tip-over hazards caused by factors such as overloading, improper use of outriggers and insufficient ground conditions. This section prohibits the equipment from being operated in excess of its rated capacity, and includes procedures for ensuring that the weight of the load is reliably determined and within the equipment's rated capacity. It also requires the competent person in charge of the operation to adjust the equipment and/or operations to address the effect of wind and other adverse weather conditions on the equipment's stability and rated capacity.

Sec. 1423, addresses protection against falling from equipment and requires that new equipment provide safe access to the operator work station, using devices such as steps, handholds, and grabrails.

Sec. 1424, this section requires that workers who are near equipment with a rotating superstructure be trained in the hazards involved, that employers mark or barricade the area covered by the rotating superstructure, and that the operator be notified whenever a worker must enter that area, and instructed not to rotate the superstructure until the area is clear.

## **Conclusion**

OSHA finds that the 89 fatal injuries suffered each year and employees will now be protected from the types of equipment covered by this final standard. Of that number, OSHA estimates that 21 fatalities would be avoided by compliance with the final standard. In addition, OSHA estimates that the final standard would prevent 175 non-fatal injuries each year. Based on its review of all the available evidence, OSHA finds that construction workers have a significant risk of death and injury resulting from equipment operations, and that the risk would be substantially reduced by compliance with this final standard.

DATES: This final rule is effective on November 8, 2010.

**2011 Common Sense Initiative Checklist (BWC Rules)**

(Note: The below criteria apply to existing and newly developed rules)

**OAC 4123-6-26**

**Rule Review**

1.  The rule is needed to implement an underlying statute.

Citation: O.R.C. 4123.66; O.R.C. 4121.441

2.  The rule achieves an Ohio specific public policy goal.

What goal(s): In cases where an injured worker's health insurer has paid for medical services or supplies prior to the allowance of the injured worker's claim or condition being treated, and the injured worker has made a copayment, the proposed rule revisions will specifically allow both reimbursement for the out-of-pocket copayment made by the injured worker and, if the health insurer requests it, reimbursement of the health insurer up to the amount BWC would have paid the provider for the medical services or supplies.

3.  The rule is effective, consistent and efficient.
4.  The rule is not duplicative of rules already in existence.
5.  The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.
6.  The rule has been reviewed for unintended negative consequences.
7.  Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: BWC's proposed changes to the rule were emailed to the BWC Medical Division's list of stakeholders for review on February 16, 2011. Stakeholders will be given until March 9, 2011, to submit comments.

8.  The rule was reviewed for clarity and for easy comprehension.
9.  The rule promotes transparency and predictability of regulatory activity.
10.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.
11.  The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_

**BWC Board of Directors**  
**Executive Summary**  
**Claimant Reimbursement Rule**  
**OAC 4123-6-26**

**Introduction**

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers.

BWC's Claimant Reimbursement rule, OAC 4123-6-26, states:

When the claimant or any other person making payment on behalf of the claimant, including a volunteer, pays for medical services or supplies directly to a health care provider. . . and the claim or condition is subsequently allowed, the payor shall be reimbursed upon submission of evidence of the receipt and payment for that services or supply. . .

BWC proposes to revise rule OAC 4123-6-26 so that, in cases where the injured worker's health insurer has paid for medical services or supplies prior to the allowance of the injured worker's claim or condition being treated, and the injured worker has made a copayment, the rule will specifically allow both reimbursement for the out-of-pocket copayment made by the injured worker and, if the health insurer requests it, reimbursement of the health insurer up to the amount BWC would have paid the provider for the medical services or supplies..

**Background Law**

R.C. 4123.66(A) provides that the BWC Administrator "shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper," and that the Administrator "may adopt rules, with the advice and consent of the [BWC] board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefor."

R.C. 4123.66(B) provides that "...The administrator shall reimburse the employer or welfare plan for the compensation and benefits [it] paid [to or on behalf of an injured employee] if, at the time the employer or welfare plan provides the benefits or compensation to or on behalf of employee, the injury or occupational disease had not been determined to be compensable under this chapter and if the employee was not receiving compensation or benefits under this chapter. The administrator shall reimburse the employer or welfare plan in the amount that the administrator would have paid to or on behalf of the employee under this chapter if the injury or occupational disease originally would have been determined compensable under this chapter..."

R.C. 4121.441(A) provides that the BWC Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP "to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies" to injured workers.

**Proposed Changes**

BWC requests that the proposed amendments to OAC 4123-6-26 be adopted. The purpose of the revised rule is to ensure that injured workers may be reimbursed for out-of-pocket copayments they have made for medical services or supplies prior to the allowance of the claim

or condition being treated, and that if the injured worker's health insurer so requests, it may also be reimbursed for payments it has made to or on behalf of the injured worker for medical services or supplies prior to the allowance of the claim or condition being treated, up to the amount BWC would have paid to the health care provider for the service or supply. This may occasionally result in BWC making total reimbursement in an amount above the BWC fee schedule, but these situations should be rare.

## **Stakeholder Involvement**

BWC's proposed Claimant Reimbursement rule was e-mailed to the following lists of stakeholders on February 16, 2011, with comments due back by March 9, 2011, 2011:

- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
  - Council of Smaller Enterprises (COSE)
  - Ohio Manufacturer's Association (OMA)
  - National Federation of Independent Business (NFIB)
  - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third Party Administrator (TPA) distribution list

Stakeholder responses received by BWC will be summarized on the Stakeholder Feedback Summary Spreadsheet for the second reading of this rule.

## **4123-6-26 Claimant reimbursement.**

When the claimant or any other person making payment on behalf of the claimant, including a volunteer, pays for medical services or supplies directly to a health care provider ~~not participating in the HPP or QHP~~ and the claim or condition is subsequently allowed, the payor shall be reimbursed upon submission of evidence of the receipt and payment for that service or supply. The payor will receive no more than the amount that would have been paid to the health care provider as provided by the rules of this chapter of the Administrative Code. However, in cases where the payor is the claimant's health insurer, if the claimant seeks reimbursement for an out-of-pocket copayment and the claimant's health insurer has already been reimbursed or later seeks reimbursement, the claimant may be reimbursed for the copayment and the claimant's health insurer may be reimbursed up to the amount that would have been paid to the health care provider as provided by the rules of this chapter of the Administrative Code. When payment has been made to the health care provider, the payor shall be informed to seek reimbursement from the provider. The bureau shall inform a claimant or payor whether a health care provider participates in the HPP or QHP.

Prior Effective Date: 2/12/97



**Bureau of Workers'  
Compensation**

30 W. Spring St.  
Columbus, OH 43215-2256

Governor **John R. Kasich**  
Administrator/CEO **Stephen Buehrer**

ohiobwc.com  
1-800-OHIOBWC

February 16, 2011

**RE: Feedback on proposed Ohio Administrative Code rule 4123-6-26**

Dear Interested Parties:

We are seeking feedback from you on BWC's proposed revisions to Ohio Administrative Code (OAC) rule 4123-6-26. We are making modifications to the existing Claimant Reimbursement Rule to ensure that claimants and their health insurers are reimbursed for payments made for subsequently allowed conditions and claims.

After reviewing all comments and feedback, we will provide the BWC Board of Directors with a final recommendation. The board will then review the proposed rule revision and determine whether to accept it. If approved by the board, we will submit the rule to the Joint Committee on Agency Rule Review for final review and incorporation into the OAC.

**How to submit your feedback**

- We have created an e-mail box for you to provide your feedback. Please submit your comments to: [Rxfeedback@bwc.state.oh.us](mailto:Rxfeedback@bwc.state.oh.us).
- Remember to include contact information, including your name, phone number, e-mail address, and practice and/or specialty if applicable.
- We will accept comments through **March 9, 2010**. We appreciate your timely review and response.

We will give your insights and suggestions serious consideration. We plan to submit the rule proposal to the BWC Board of Directors Medical Services & Safety Committee for a first reading on February 23, 2010. We will then present it to the committee for a second reading on March 24, 2011.

Thank you for your input as we continue to improve the quality of our health-care services to Ohio's injured workers. We look forward to hearing from you.

Sincerely,

Robert Balchick, M.D., MBA

BWC Chief Medical Officer

# **The Ohio Rehabilitation Services Commission**

## **History of the Relationship**

The Ohio Rehabilitation Services Commission (RSC) is the state agency charged with partnering with Ohio citizens with disabilities to achieve employment, independence and Social Security disability determinations. The Bureau of Vocational Rehabilitation (BVR) and Bureau of Services for the Visually Impaired (BSVI) help people with disabilities get or keep a job. For those unable to work, the Bureau of Disability Determination (BDD) determines eligibility for Social Security disability benefits or Supplemental Security Income.

Similarly, The Bureau of Workers' Compensation (BWC) in its continuum of service to injured workers provides vocational rehabilitation services to help facilitate safe return to work. Vocational rehabilitation is a service designed to help individuals with disabilities return to employment. Vocational rehabilitation at BWC provides assistance to individuals who are injured while working based on the Ohio Revised Code 4121.61 to 4121.69. The injured workers goal is based on the sequential return to work vocational rehabilitation hierarchy (ORC 4123-18-02).

RSC provides many of the same rehabilitation services that BWC offers but their counselors have more expertise in managing cases that require more complex and longer term services such as individuals with mental health or developmental disabilities, persons with paraplegia or quadriplegia and individuals with traumatic head injuries. A large portion of BWC injured workers have less severe conditions requiring less complex and shorter term treatment which calls for a somewhat different skill set from the BWC case managers. However, there are a number of work place injuries which result in challenges for the workers experiencing the same which RSC is uniquely positioned to address. The unique but overlapping talents between the agencies allows for a continuum of rehabilitation services which BWC injured workers can leverage.

## **RSC/BWC Cooperative Agreement**

A Cooperative Agreement between BWC and RSC enables both agencies to fulfill their unique missions. This arrangement allows BWC and RSC to expand service delivery to a wider range of injured workers and facilitate safe return to work. It allows RSC the opportunity to meet its responsibilities in such a way that permits its monetary resource base to increase. This increase in funding base in turn permits expansion of services to a greater population via interagency partnership.

This Cooperative Agreement began in 1945 with a cash transfer agreement which allows BWC to provide services to injured workers through RSC by leveraging Ohio dollars for Federal dollars at a 21.3% to 78.7% match. The cash transfer agreement was formalized in 1985 as the Cooperative Agreement with a detailed accounting of the use of the fund, referral processes and coordination between the two agencies. The table below provides a recent review of the BWC funding and RSC federal match relative to the funding of the Cooperative Agreement.

**Table 1. BWC-RSC Cooperative Agreement Funding**

<b>State Fiscal Year</b>	<b>BWC Allocated Funds</b>	<b>RSC Federal Match</b>	<b>Total Funds Available</b>
2006	\$587,774	\$2,171,728	\$2,759,502
2007	\$605,407	\$2,236,879	\$2,842,286
2008	\$605,407	\$2,236,879	\$2,842,286
2009	\$605,407	\$2,236,879	\$2,842,286
2010	\$605,407	\$2,236,879	\$2,842,286
2011	\$605,407	\$2,236,879	\$2,842,286

The current state fiscal year 2010-2011 Cooperative Agreement is a little more than three quarters complete. The Agreement commenced on July 1, 2009 for a two year fiscal period. As part of the continuing effort to enhance the success of the Agreement, RSC and BWC took a critical look at the Agreement's language relative to the objectives of both agencies, resulting in several modifications. Selected modifications in the current Agreement include:

- A provision for the return of unused Federal matching dollars, up to 64% of the total of the fund, to be returned to the BWC Agreement fund and the remaining 36% to roll to the RSC general fund.
- The enhancement of data elements required from RSC to allow BWC to perform a full evaluation of program efforts and return on BWC's investment.
- The designation of RSC counselors to serve as liaisons to the local BWC service offices for ease of collaboration.
- The improvement of the process for determining BWC injured workers and RSC consumers who were eligible to receive services paid for under the fund.
- The development of a "best practice" manual for front line counselors at both agencies which provides necessary detailed information of the commonalities and differences in laws and policies for returning their respective clients (injured workers or consumers) to work.

### **Obtaining Services through the Agreement**

Injured workers can obtain rehabilitation services paid for through the Cooperative Agreement by applying directly to a local RSC office or they can be referred to RSC by BWC or an MCO. If an injured worker has applied directly, the RSC counselor will ask the consumer if they have a BWC claim. If they do, the RSC counselor seeks verification of eligibility from BWC through an electronic file exchange system. The injured worker must meet BWC's eligibility criteria to receive services paid for through the Agreement fund.

Injured workers may work with a BWC counselor and an RSC counselor in a joint rehabilitation plan. In this situation the rehabilitation costs are shared between agencies, for example, RSC may pay the tuition for a long term training program while BWC may pay for books and supplies.

In some cases a joint rehab plan is not possible because the injured worker’s return to work goal is outside of requirements through BWC rule. For example, an injured worker may seek assistance from RSC because they desired, but did not qualify for a two year training program through BWC because they already possessed skills to return to appropriate work within the context of BWC’s RTW hierarchy. There is an advantage and disadvantage when an injured worker rejects BWC’s RTW hierarchy requirement and seeks long term training through RSC. The advantage is that the injured worker can get a training program paid for, but the disadvantage is that their weekly BWC compensation may terminate.

A clear understanding of both agencies’ systems is critical when counseling an injured worker through their decision making. Continued training and “meet and greet” sessions between RSC and BWC counselors helps to ensure this understanding.

**Current Challenges**

While the relationship has been positive over the course of its existence, there continues to be efforts to further improve outcomes and address challenges driven by regulatory requirements and interpretations. One of the more challenging impacts of regulatory requirements has been RSC’s change in the way the Agency manages consumers for services. RSC per governing regulation is required to implement an Order of Selection for services whenever the agency is unable to serve all the eligible consumers who apply for services. Due to decreased staffing and decreased available funds, RSC has in recent years been unable to serve everyone who has applied; therefore, they were forced to redefine and implement the Order of Selection rule which outlines which RSC applicants will be served first or at all. At this time, RSC rates eligible consumers as Most Significantly Disabled (MSD), Significantly Disabled (SD) or other eligible. The result of this rule is that only eligible consumers who are defined as MSD are at this time being served. The people who are found to be eligible but not MSD may opt to be placed on a waiting list for services. Unfortunately, it is found that while they are determined eligible, many of BWC’s injured workers are not found to be MSD and are not able to access RSC services or the Cooperative Agreement funds.

The number of BWC injured workers accepted into services by RSC during the second year of the current 2 year Agreement (since the new Order of Selection was enacted) has decreased by over 50%. Many injured workers seeking services through the Cooperative Agreement do not possess injuries or disabling conditions severe enough to qualify for the MSD designation. This has resulted in a significant portion of the BWC fund remaining unused.

**Table 2. BWC-RSC Cooperative Agreement Funding**

<b>State Fiscal Year</b>	<b>RSC Service Requests</b>	<b># of Requests Eligible</b>	<b>Actual Plans Initiated</b>
2009	947	407	197
2010	591	334	205
2011*	70	43	25

\*July 1, 2010 through Sept. 30, 2010

Despite the decreased usage of the fund, the RSC/BWC Cooperative Agreement is an effective investment of workers compensation funds. Matching federal funds have doubled the amount of monies spent on return to work services for injured workers through RSC. BWC and RSC have been aggressively working to analyze the characteristics of both BWC injured workers who have been accepted as MSD by RSC and those who have been wait-listed to develop ways to identify and refer qualified (MSD) injured workers for RSC services. While there are some limitations on how RSC may execute on the Agency's charge due to the implication of federal statutes, BWC and RSC are exploring other creative ways to fully utilize this partnership in light of those challenges.

# Medical Services Division Board Report

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## I. Managed Care Organization (MCO) 2011-2012 Contract – Key Elements

### Health Partnership Program (HPP) Generally – BWC and MCO Responsibilities

BWC determines compensability and pays indemnity benefits. It contracts with MCOs to manage the medical component of workers' compensation claims. MCOs educate employers and injured workers on HPP and process *First Report of an Injury, Occupational Disease or Death* (FROI) reports. They also help employers establish transitional/early return-to-work programs. In addition, MCOs process medical bills and make provider payments.

BWC monitors MCO managed care performance. For example, it measures the effectiveness of the MCOs' return-to-work efforts using the Degree of Disability Management (DoDM) measure. BWC also measures MCO FROI timing, FROI data accuracy, bill timing and bill data accuracy. In addition, it publishes most of these measures in an annual *MCO Report Card*, which is available on [ohiobwc.com](http://ohiobwc.com). BWC encourages employers to view this report before selecting an MCO.

There are now **17** certified MCOs statewide. The MCOs have just been recertified pursuant to Ohio Revised Code 4121.44 (B)(2) for the two-year period of 2011 to 2012. The 2011-12 BWC/MCO Agreements went into effect Jan. 1, 2011

### Key MCO 2011-2012 Contract Provisions and Enhancements

The changes in the 2011-12 MCO contract reflect BWC's and the MCOs' goal of advancing the development of key performance indicators that improve outcomes for prompt, safe injured worker return to work and medical management.

#### 1. MCO Payment

In the aggregate, MCOs can be paid up to \$166.7 million for 2011 services, which maintains 2010 payment levels. The amount available for 2012 will be increased 2% to \$170 million. Individual MCO payment is pro-rated based upon relative activity levels.

#### 2. MCO Performance Measures

##### A. Replacement of Degree of Disability Management (DoDM) Measure

The MCO performance measure, DoDM, has been replaced with a new metric (Measurement of Disability or MoD). Replacement of DoDM measure was a Deloitte recommendation<sup>1</sup>. One of the key MCO responsibilities is to help employers establish transitional and early return-to-work programs. In addition, they ensure that appropriate medical treatment is rendered and they process payments to providers. As a result, MCO decisions directly impact injured worker return-to-work outcomes. Their medical management decisions affect the duration of time an injured worker is off work and, thus, impact the \$1 billion in annual indemnity costs and \$800 million in annual medical costs. MCOs concur that the right metric is essential to support the desired outcome of prompt, safe return to work and stay at work.

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<sup>1</sup> Deloitte 2.6 at page 1, 2, 21, 29, 30, 31, and 34

# Medical Services Division Board Report

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45% of MCO compensation is based on the DoDM measure. DoDM was implemented in 1999 and was state of the art at the time. While we have made some enhancements in the last 11 years, the DoDM model has become outdated. The MoD metric design will improve the measurement of the MCOs' activity by more accurately measuring the effectiveness of the medical case management being provided by the MCOs in terms of the timeliness of injured worker return-to-work and the effectiveness of the management of medical care after injured workers have returned to work. Further, MoD measures a much larger population of claims than DoDM, as MoD includes claims that are outside the employers' experience and three times the number of diagnosis codes. The MoD metric also utilizes updated benchmarks that were developed using Ohio specific data. In addition, the measure is based upon actual return-to-work dates instead of release to work return dates obtained from the provider. Finally, not all claims are "equal" - each claim within the scoring is weighted for significance by severity/importance based upon the average duration of disability or medical complexity for each diagnosis code (ICD-9) within the metric. These changes enhance MCO focus on medical case management and return-to-work services for the entire population of claims that they manage.

## **B. Other Contract Performance Measures**

The 2011-2012 MCO Agreement also contains Performance benchmarks that have been further tightened, and two new measures have been added. Some of them include the following:

1. Any MCO receiving a qualified opinion on their SAS 70 will receive a 15% set-off to their next month's administrative payment. In addition, the MCO will be placed at capacity until the MCO has implemented its action plan to resolve the deficiency.
2. Any MCO that materially fails to timely submit requested audit and/or compliance materials shall receive a 1% set-off per day until the materials have been submitted.
3. The benchmark for First Report of Injury (FROI) Turnaround (MCO Receipt to BWC Receipt) has been lowered to 2.50 calendar days from 3.00 calendar days, and
4. The benchmark for submission of Provider of Record (POR) and Case Manager/Case Contact (CMCC) information has been raised to 92.50% populated from 90%.

## **II. Health Services Quality Improvement Unit Board Update**

The Mission of the Health Services Quality Improvement Unit (HSQI) is to provide a robust medical services quality oversight unit within the BWC Medical Services Division. Moreover, its mission is to improve MCO managed care processes and decision-making through education and corrective action by means of oversight, compliance audits, and performance measures which will in turn improve the quality of the medical services delivered to the injured worker.

### **Background**

Pursuant to Board rule, Effective November 1, 2009, BWC reformed its ADR process by eliminating the level two ADR review performed by BWC. ADR dispute issues include: MCO decisions regarding medical treatment and diagnostic testing, voc services, medical equipment and services, and others.

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This elimination frees up limited BWC resources for strategic program improvements – in this case, the creation of the HSQI. The unit will bolster the Medical Services Division’s oversight of injured worker medical and vocational service delivery furthering BWC’s goal of ensuring prompt, effective medical care to injured workers. Specifically, the Unit will perform quality assurance for the MCO treatment authorization process- approximately 200,000 provider treatment requests annually. The MCO evaluates all medical treatment reimbursement requests submitted by the eligible treating provider using the following three part *Miller* test: Are the requested services reasonably related to the injury (allowed conditions), are the requested services reasonably necessary for treatment of the injury (allowed conditions), and are the costs of the services medically reasonable.

## **MCO Performance measures**

Currently, the Medical Services Division measures and monitors how MCOs perform their responsibilities. As stated, we measure the effectiveness of their return-to-work efforts using the Degree of Disability Management (DoDM) model (now replaced with MoD). We also measure other MCO processes including FROI timing and accuracy, and bill timing and accuracy. However, while we currently have strong administrative metrics to measure MCO performance, the Quality Improvement unit will greatly enhance BWC’s *qualitative* review and measurement of MCO performance. This is also consistent with Deloitte’s recommendation to enhance treatment quality by implementing corresponding MCO metrics.<sup>2</sup>

## **HSQI Objectives**

- Improve treatment outcomes and return to work (RTW)
- Improve related policy and processes
- Improve the accuracy, timeliness, cost-effectiveness, and the alignment of the delivery of medical services to injured worker needs
- Provide education and training internally, to MCOs, and interested parties
- Improve customer (injured worker and employer) satisfaction

## **Implementation Progress**

The steps for full implementation of the HSQI Unit duties include the following:

1. Creation of the unit plan - completed
2. Staffing requirements - completed
3. Business process workflow – near completion
4. Creation of the definitions and tools to determine treatment authorization audit methodology - in progress
5. Approval of forms – in progress

The treatment authorization audit process is in the research and analysis phase and the team is presently identifying the measures and audit tools. As stated, the purpose of the HSQI compliance process is to reduce the number of treatment authorization errors and improve the

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<sup>2</sup> Deloitte 2.6 at page 3, 18, 29, 31

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quality of the medical services delivered to the injured worker. Specifically, the unit will audit the quality of the MCO treatment authorization decisions and determine whether the approval and/or denial of provider treatment requests were within the requirements of the law (*Miller*), standard treatment guidelines and pathways, and presumptive authorization guidelines established by BWC. The HSQI team has preliminarily established the compliance metrics, developed the auditing tool in excel, and has completed a 5% audit on MCO treatment request decisions from 7/1/10 to 7/31/10, which included 370 records. Presently, staff is in the process of verifying the data. With this trial, we will determine whether our metrics are correct and staff members are auditing claims consistently. Once completed, we will begin to fully implement the treatment authorization audit process consistent with the documented process.

### **III. WILMAPC Board Update**

On February 10, 2010, a performance-driven approach to managing state agency workers disability was implemented. The state agencies and the labor unions share a common goal which is ensuring that injured employees receive effective and efficient care resulting in a timely and safe return to work. The program was developed by a joint effort between DAS and Ohio's labor unions representing state agency employees. BWC is providing ongoing subject matter expertise and consulting for the project. The name of the program is WILMAPC, Workplace Injury Labor management Approved Provider Committee. This program is also consistent with Deloitte recommendations for improving provider performance.

In summary, the program provides an option to a state agency employee who has been injured at work. They may be eligible for one of two benefits: salary continuation or occupational injury leave. To be eligible, they must select a provider from the WILMAPC approved provider panel to manage their workers' compensation claim. A provider panel will help the employer develop a partnership with providers and in turn help state agency employees receive the best medical care. If an injured worker opts to select a provider outside the panel, they will have their claim managed under the workers' compensation system exclusively and receive the standard workers' compensation indemnity benefit for a lost time claim. A webpage has been provided on DAS's website which provides program details and links to a description of the provider performance metrics. Also, it is from this page that injured workers are able to use a web based tool to locate an approved provider to address their workers compensation medical needs.

The approved provider panel has approximately 11,000 providers. As the program has progressed, provider awareness and desire to participate has continued to grow. This is evidenced by the fact that a number of providers who were not initially invited to join the panel have requested inclusion and have been included on the panel. Since its inception, the panel has managed about 1,100 state agency workers compensation claims. Initial results of program data indicate that approximately 750 different providers were involved in the care of workers in those claims.

BWC has calculated the providers' performance scores across the four performance measures: Release to Work, Duration of Disability, Relapse, and Cost. There are separate scores for the periods ending June 30, 2010 and October 30, 2010. The scores were posted in December 2010, on a website for providers to access to assess their current level of performance within the WILMAPC program. As planned, the complete evaluation of provider performance, upon which

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a determination will be made as to their continued provider panel status, will occur in March 2011, one year after the commencement the WILMAPC program.

### IV. Benefits Plan Summary

For injured workers to have access to high-quality medical care, BWC must have an appropriate benefit plan and terms of service in place and offer competitive fee schedules to enhance the medical provider network. BWC has markedly improved its medical, vocational rehabilitation and pharmaceutical services offerings by revising its benefits plans and their corresponding fee schedules. The Medical Services Division has instituted annual reviews for updates as appropriate. Below is a summary of the fee schedule updates in place or planned for fiscal year 2011.

Fee schedule	Effective date	Update summary
<b>Medical providers and services:</b> Covers all medical providers and medical services not covered by any of the other schedules	Oct. 25, 2010	Update to Medicare's 2010 RVUs, adding new benefit service codes, and other refinements as needed to the Nov. 1, 2009, fee schedule
<b>Hospital outpatient:</b> Covers facilities for outpatient services	Jan. 1, 2011	Begin the three-year implementation of the OPPS/APC prospective reimbursement methodology
<b>Medical providers and services:</b> Emergency rule to incorporate new service codes	Jan. 1, 2011	Update to add new CPT and HCPCS codes that are effective nationally as of Jan. 1, 2011
<b>Hospital inpatient:</b> Covers facilities for inpatient services	Proposed: Feb. 1, 2011	Update the Medicare Severity — Diagnosis Related Grouping to the 2011 federal fiscal-year values and update the payment for Medicare exempt providers to the 2009 cost-to-charge ratios
<b>Hospital outpatient:</b> Covers facilities for outpatient services	Proposed: April 1, 2011	Update to implement the 2011 Medicare annual OPSS updates
<b>Ambulatory surgical centers (ASC):</b> Covers surgical procedures not requiring inpatient hospitalization	Proposed: April 1, 2011	Update ASC payment rates to the 2011 ASC PPS Medicare rates and the payment adjustment factors used in calculating Ohio rates
<b>Vocational rehabilitation services:</b> Covers all vocational rehabilitation services	Proposed: June 2011	Update rates and add new custom service codes as needed

### Billing and Payment Reforms

The Medical Services Division is also preparing to implement additional clinical edits to ensure compliance with benefits plan structure and reimbursement limits. The division estimates that clinical edits implemented in October 2008 helped BWC avoid nearly \$2.9 million in incorrect reimbursements. BWC has also continued contracting with a recovery vendor who retrospectively reviews inpatient bills identified by BWC and recovers any identified overpayments. This vendor also recovers overpayments identified by hospitals.

# 12 - Month Medical Services & Safety Calendar

Date	February 2011	Notes
2/23/11	1. OSHA/PERRP crane rule (2nd read)	
	2. Claimant Reimbursement Rule 4123-6-26 (1st read)	
	3. Medical Services Report	
	4. Rehabilitation Services Commission Review	
	<b>March 2011</b>	
3/24/11	1. Vocational Rehab fee schedule (1st read)	
	2. Claimant Reimbursement Rule 4123-6-26 (2nd read)	
	3. Outpatient Reimbursement Rule (1st read)	
	4. SI Outpatient Reimbursement Rule (1st read)	
	5. C-9 rule changes (1st read)	
	6. Customer Services Report	
	<b>April 2011</b>	
4/28/11	1. Vocational Rehab fee schedule (2nd read)	
	2. Outpatient Reimbursement Rule (2nd read)	
	3. SI Outpatient Reimbursement Rule (2nd read)	
	4. C-9 rule changes (2nd read)	
	5. Formulary Rule (1st read)	
	6. Medical Services Report	
	<b>May 2011</b>	
5/26/11	1. Formulary Rule (2nd read)	
	2. Lock in Pharmacy Rule (1st read)	
	3. Customer Services Report	
	<b>June 2011</b>	
6/15/11	1. Medical & Service Provider Fee Schedule (1st read)	
	2. Lock in Pharmacy Rule (2nd read)	
	3. Medical Services Report	
	<b>July 2011</b>	
7/28/11	1. Medical & Service Provider Fee Schedule (2nd read)	
	2. Customer Services Report	
	<b>August 2011</b>	
8/25/11	1. Inpatient Hospital Fee Schedule (1st read)	
	2. Medical Services Report	
	<b>September 2011</b>	
9/29/11	1. Inpatient Hospital Fee Schedule (2nd read)	
	2. Customer Services Report	
	<b>October 2011</b>	
10/27/11	1. Committee Charter review (1st read)	
	2. Inpatient Hospital Fee Schedule (2nd read)	
	3. Medical Services Report	
	<b>November 2011</b>	
11/17/11	1. Ambulatory Surgical Center Fee Schedule Rule (1st read)	
	2. Outpatient Hospital Fee Schedule (1st read)	
	3. Committee Charter Review (2nd read)	
	4. Customer Services Report	
	<b>December 2011</b>	
12/14/11	1. Update Medical and Service Provider Fee Schedule to conform with new Medicare rates (possible waive 2nd read)	
	2. Ambulatory Surgical Center Fee Schedule Rule (2nd read)	
	3. Outpatient Hospital Fee Schedule (2nd read)	
	4. Medical Services Report	

# 12 - Month Medical Services & Safety Calendar

	January 2012	Notes
1/xx/12	1. Customer Services Report	

## Ohio BWC Fee Schedule History and Calendar: 2007 – Current

### Inpatient Hospital Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	Sept/Oct	Jan. 1, 2009	-0.9%	-\$471,950
2009	Sept/Oct	Feb. 1, 2010	+2.9%	+\$2.4 million
2010	Sept/Oct	Feb. 1, 2011	+5.7%	+\$4.9 million
2011				

### Outpatient Hospital Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	N/A	N/A	N/A	N/A
2009	Dec/Jan/Apr	Jan. 1, 2011	-7.2%	-\$2.55 million
2010	Oct/Nov	Apr. 1, 2011	-7.2% from base rate*	-\$10.2 million
2011				

\* BWC plans to maintain the same payment adjustment factor through Feb. 28, 2012; therefore, a total of a 7.2% decrease is expected for services rendered from January 1, 2011 through February 28, 2012.

### Ambulatory Surgical Center Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	Nov/Dec	April 1, 2009	+23%	+\$1.73 million
2009	Oct./Nov.	April 1, 2010	+16%	+\$860,000
2010	Nov./Dec.	April 1, 2011		
2011				

## Ohio BWC Fee Schedule History and Calendar

### Vocational Rehabilitation Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	N/A	N/A	N/A	N/A
2009	Nov/Dec	Feb. 15, 2010	+5.86%	+\$1.9 million
2010	N/A	N/A		
2011	Jan/Feb	June, 2011		

### Medical and Service Provider Fee Schedule

Year	Reviewed/ Approved	Effective Date	Est. % Change	Est. \$ Change
2007	N/A	N/A	N/A	N/A
2008	Sept/Oct/Nov	Feb. 15, 2009	+6.0%	+\$23.8 million
2009	Sept/Oct	Nov. 1, 2009	+0.2%	+\$800,000
2010	June/July	Oct. 25, 2010	+2.9%	+\$9.2 million
2010	Dec (emergency)*	January 1, 2011		
2011	Jan (final)			

\* Emergency rule to add new codes