

BWC Board of Directors
Medical Services and Safety Committee Agenda

Thursday, March 24, 2011

William Green Building

Level 2, Room 3

3:00 P.M. ** – 5:00 P.M.

Call to Order

Jim Hummel, Committee Vice-Chair

Roll Call

Mike Sourek, Scribe

Approve Minutes of February 23, 2011 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. Claimant Reimbursement Rule 4123-6-26
Johnnie Hanna, Pharmacy Program Director
 - B. For First Reading
 1. Vocational Rehab Fee Schedule
Freddie Johnson – Interim Chief of Medical Services and Compliance
Karen Fitzsimmons – Manager, Rehab Policy
 2. C-9 Rule 4123-6-16.2 - Medical Treatment Reimbursement Requests
Freddie Johnson – Interim Chief of Medical Services and Compliance
 3. Outpatient Medication Reimbursement Rule 4123-6-21
Johnnie Hanna, Pharmacy Program Director
 4. Self-insured Outpatient Medication Reimbursement Rule 4123-6-21.1
Johnnie Hanna, Pharmacy Program Director

Discussion Items***

1. Overview of Pain Management
Dr. Kort M. Gronbach, M.D.
First Capital Pain Management
Member of the BWC Pharmacy and Therapeutics Committee
Lecturer, Pain Medicine and Anesthesiology, Ohio University College of
Osteopathic Medicine

2. Customer Services Report
Tina Kielmeyer, Chief, Customer Services
Abe Al-Tarawneh, Superintendent, Division of Safety and Hygiene
3. Committee Calendar
Jim Hummel, Committee Vice-Chair

Adjourn

Jim Hummel, Committee Vice-Chair

Next Meeting: Thursday, April 28, 2011

* Agenda subject to change

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

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

Feedback to proposed rule 4123-6-26 Claimant Reimbursement

Stakeholder	Comment	BWC Response
Jim Kovacs Human Resources Manager City of Wadsworth	The proposed language is fine. I'd like to thank you for seeking our input into the proposed change. (received 2-16-11)	E-mail acknowledgement and thanks for comments. (sent 3-2-11)
Karen Winn LPN F & P America Mfg. 2101 Corporate Dr. Troy, Ohio 45373	I agree with the proposed changes to the Ohio Administrative Code rule 4123-6-26. Will the payor be required to submit proof with a receipt directly to the TPA (for those of us self-insured)? (received 2-16-11)	Via e-mail: "Thanks for your comment and question. Yes, for the self-insured group, the payor would be required to submit proof with a receipt, just as the BWC would require." (sent 3-3-11)
James R. Rough Executive Director Counselor, Social Worker & Marriage and Family Therapist Board Columbus	Draft Rule 4123-6-26 appears to me to be clear and accurate as sent for review. (received 2-25-11)	E-mail acknowledgement and thanks for comments. (sent 3-2-11)
Bob Kendis Kendis & Assoc., LPA Cleveland	As you already know, benefits for injured workers were to be paid without any cost to the injured worker. In most cases, the injured worker does not know this, so when he incurs a co-pay he believes it is his/her responsibility, very much like regular health insurance. This change is a welcome one and in the spirit of the drafters of the law almost 100 years ago. Thank you for your efforts. (received 2-25-11)	E-mail acknowledgement and thanks for comments. (sent 3-2-11)

<p>Paul T. Scheatzle DO Bailey Rehabilitation Services Massillon, OH</p>	<p>Regarding OAC4123-6-26, I support the procedure as outlined and have no recommendations regarding revisions. (received 2-25-11)</p>	<p>E-mail acknowledgement and thanks for comments. (sent 3-2-11)</p>
<p>Phil Fulton Fulton Law Columbus</p>	<p>I have reviewed the rule and speaking for OAJ and OACC (essentially the claimant's bar), we support the "modified" rule. We truly appreciate the BWC's effort to reimburse injured workers for their financial loss when they must make co-payments to get necessary treatment. Please let me know if you have any further questions or need any further information from me. (received 3-2-11)</p>	<p>E-mail acknowledgement and thanks for comments. (sent 3-2-11)</p>
<p>Dan Davis, MD Medical Director Ohio Employee Health Partnership</p>	<p>Maybe it's me, but the last sentence doesn't seem to make sense. If the provider has been paid, then the payor should be reimbursed. In such case, the provider doesn't owe the payor anything back. I don't see how the provider would have been paid twice. (received 3-3-11)</p>	<p>Via e-mail: We acknowledged and thanked Dr. Davis for his comments and explained that in the case of the payor as well as BWC having paid the provider, the payor should seek reimbursement of his co-pay from the provider. Dr. Davis replied that he understood and agreed with our intent. (sent 3-4-11)</p>
<p>Joanne Vargo Southwest General Middleburgh Heights,</p>	<p>I think that I get it up to the very last sentence. In the instance where a claimant's health insurer pays a bill to the provider, if I interpreted this correctly, we (the self-insured employer, BWC or MCO) reimburse the health insurer up to the UCR amount and also the claimant his/her co-pay if one was made. Is there another step in the process because the last</p>	<p>Via e-mail: We thanked Ms. Vargo for her comments, and told her that the rule was revised to address that confusion that she had expressed. We included a copy of the new proposed rule. (sent 3-15-11)</p>

	<p>sentence talks about the provider reimbursing the payor. There are really two payors, the original being the health insurer and the subsequent payor (in my example) being the self-insured employer, BWC or MCO. Who asks the provider for reimbursement? Maybe I'm just not following this, but if the provider reimburses anybody, doesn't that leave the provider without payment? Maybe it's the wording, but it has me confused. (received 3-8-11)</p>	
<p>Judy Barrie Director of Operations Support CareWorks</p>	<p>Thank you for the opportunity to allow comments to the proposed changes to OAC4123-6-26.</p> <p>While my comments may be related more to policy or operations, I would like to get the issues in front of you to assist with implementation.</p> <ul style="list-style-type: none"> • Current systems and EDI structure do not allow for two parties (ie, injured worker for the copayment and health insurer for the balance) to be paid for the <u>same</u> bill. Procedures and/or systems will need to be developed to accommodate this Rule. • If the health insurer is reimbursed up to the amount that would have been paid to the health care <u>provider</u> (ie, fee schedule) and the claimant will be reimbursed additionally for the copayment (above and beyond the fee schedule payment to the insurer?), this could create overpayments. Claimants not 	<p>Via e-mail: We thanked Ms. Barrie for her comments and explained that we have the ability to override the system when needed, which would address several of her concerns. We also said the rule had been revised since several comments reflected confusion about the last sentence. We sent a copy of the new proposed rule. (sent 3-16-11)</p>

	<p>only have copayments, but they also have deductibles as out of pocket health insurance expense and the amounts can be substantial.</p> <p>It is not uncommon for a provider to have been paid by a health insurer, claimant and also by BWC - and the injured worker requests the copay reimbursement from the MCO. Does the last line of the Rule apply to this situation where the claimant would seek reimbursement of the copay from the provider? Perhaps the sentence could be clarified. (received 3-8-11)</p>	
<p>Cindy Garver Associate Relations Administrator AAP St. Marys Corp. St. Marys, OH</p>	<p>The wording of this is much better. (received 3-8-11)</p>	<p>E-mail thanks. (sent 3-15-11)</p>

4123-6-26 Claimant reimbursement.

When the claimant or any other person ~~making payment or entity~~ on behalf of the claimant, including a volunteer, ~~pays~~ is the payor 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. When ~~payment~~ the bureau has been already made payment 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.~~

However, in cases where the payor is the claimant's health insurer and the claimant has paid an out-of-pocket copayment, 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 and the claimant may be reimbursed for the copayment.

Prior Effective Date: 2/12/97

Common Sense Business Regulation (BWC Rules)

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

Vocational Rehabilitation Provider Fee Schedule

Rule 4123-18-09

Rule Review

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

Citation: R.C. 4121.61, R.C. 4121.441(A)

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

What goal(s): The rule adopts a fee schedule for workers' compensation vocational rehabilitation services in accordance with R.C. 4121.61, R.C. 4121.441(A), and *Ohio Hosp. Assn. v. Ohio Bur. of Workers' Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499.

3. Existing federal regulation alone does not adequately regulate the subject matter.

4. The rule is effective, consistent and efficient.

5. The rule is not duplicative of rules already in existence.

6. The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.

7. The rule has been reviewed for unintended negative consequences.

8. Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: The proposed fee schedule recommended changes were on February 17, 2011, presented to and discussed with BWC's Labor-Management-Government Advisory Council (LMG), which is responsible for providing advice and recommendations to BWC on rehabilitation matters (see R.C. 4121.70 and OAC 4123-18-18). The proposed fee schedule recommendations were presented to the MCO Business Council on March 2, 2011. BWC also on March 8, 2011, provided the proposed fee schedule to the following stakeholder groups: the International Association of Rehabilitation Professionals (IARP), the Ohio Physical Therapy Association (OPTA) and the Ohio Association of Rehabilitation Facilities (OARF). On March 3, 2011 the fee schedule was placed on Ohiobwc.com with stakeholder and interested parties' feedback being accepted through March 16, 2011.

9. The rule was reviewed for clarity and for easy comprehension.

10. The rule promotes transparency and predictability of regulatory activity.

11. The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.

12. 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? _____

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
BWC Vocational Rehabilitation Provider Fee Schedule Rule
OAC 4123-18-09

Introduction

Chapter 4123-18 of the Ohio Administrative Code contains BWC rules providing for the vocational rehabilitation of injured workers in the Ohio workers' compensation system. The rules were first published as Industrial Commission (IC) rules in the early 1980's, and were converted to BWC rules in the early 1990's when H.B. 222 transferred authority over vocational rehabilitation services from the IC to BWC.

Background Law

Ohio Revised Code (O.R.C.) 4121.61 provides that the Administrator, with the advice and consent of the BWC Board of Directors, shall "adopt rules, take measures, and make expenditures as it deems necessary to aid claimants who have sustained compensable injuries or incurred compensable occupational diseases . . . to return to work or to assist in lessening or removing any resulting handicap."

O.R.C. 4121.441(A) provides that the 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 an employee for an injury or occupational disease"

Pursuant to the 10th District Court of Appeals decision in *Ohio Hosp. Assn. v. Ohio Bur. of Workers' Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499, BWC is required to adopt changes to its provider fee schedules, including the vocational rehabilitation provider fee schedule, via the O.R.C. Chapter 119 rulemaking process. BWC has undergone a systematic revision of its vocational rehabilitation provider fee schedule and now proposes to adopt the revised fee schedule as an Appendix to OAC 4123-18-09.

Proposed Changes

The major substantive changes proposed for the vocational rehabilitation fee schedule include:

Fee Increases

- BWC proposes an overall increase of 1.36% to all established vocational rehabilitation fees for service.

Elimination of Services

- BWC proposes the elimination of W0638 Body Mechanics Education as this service is rarely used and may be accomplished using CPT codes 97110 and 97112, or 97530 for therapy.

New Local Codes

- BWC proposes the creation of a new local code for Training – Books, Supplies and Testing.
- BWC proposes the creation of two new local codes for Career Counseling – In Person and Career Counseling – Research and Reporting.
- BWC proposes the creation of a new local code for Job Development.

- BWC proposes the creation of a new local code for Labor Market Survey report written by the Vocational Rehabilitation Case Manager

Changes in Definitions

- BWC proposes changing the definition of Job Placement and Development as a single service to Job Placement and Job Development as two separate services.
- BWC proposes changing the definition of Physical Conditioning Unsupervised to include a cap for services.
- BWC proposes to allow Career Counselors, Job Club facilitators, Job Development Providers, and Job Placement Providers to be reimbursed for Other Provider Travel and Other Provider Mileage.
- Other Provider Wait Time adds Job Placement and Job Development as provider types who may be reimbursed
- Job Seeking Skills Training adds a requirement for internet job search and online applications to be included as part of the skills set.
- Job Modifications includes language to allow review of modifications costing over \$5000 by BWC safety and hygiene personnel.
- BWC proposes modifying the definition of RAW Services -- Other Provider Travel, Wait Time and Mileage to eliminate provider types who are not authorized to provide RAW Services.

Stakeholder Involvement

The recommended changes were on February 17, 2011, presented to and discussed with BWC's Labor-Management-Government Advisory Council (LMG), which is responsible for providing advice and recommendations to BWC on rehabilitation matters (see R.C. 4121.70 and OAC 4123-18-18).

The proposed fee schedule recommendations were presented to the MCO Business Council on March 2, 2011.

BWC also on March 8, 2011, provided the proposed fee schedule to the following stakeholder groups: the International Association of Rehabilitation Professionals (IARP), the Ohio Physical Therapy Association (OPTA) and the Ohio Association of Rehabilitation Facilities (OARF).

On March 3, 2011 the fee schedule was placed on Ohiobwc.com with stakeholder and interested parties' feedback being accepted through March 16, 2011.

BWC 2011 Proposed Vocational Rehabilitation Services Provider Fee Schedule Summary

Medical Service Enhancements

Prompt, effective medical and vocational care makes a big difference for those injured on the job. It is often the key to a quicker recovery and timely return-to-work and quality of life for injured workers. Thus, maintaining a network of dependable vocational rehabilitation service providers ensures injured workers get the prompt care they need. It also ensures access to quality, cost-effective service. Access for injured workers, and employers, means the availability of quality, cost-effective treatment provided on the basis of medical and/or vocational necessity. It facilitates faster recovery and a prompt, safe return to work.

The Medical Services Division has focused on improving its core medical services functions. Our goals are as follows: enhance our medical and vocational provider network, establish a better benefits plan, institute an updated and competitive provider fee schedule, improve our managed care processes, and establish excellent medical bill payment services.

Vocational Provider Fee Schedule

Introduction and Methodology

As stated, implementing a sound and effective provider fee schedule is a critical component of the Medical Services Division's goals. The Ohio Bureau of Workers Compensation reimburses over 3600 vocational providers who are either independent providers or affiliated with a vocational rehabilitation service entity. An appropriate fee schedule is integral to maintaining an effective and comprehensive network of providers. An equitable and competitive fee for the right vocational service is essential to maintain a quality provider network across the wide range of necessary provider disciplines. Thus, the guiding principle is to ensure access to high-quality vocational services by establishing an appropriate Benefit plan and Terms of service with a competitive fee schedule which, in turn, enhances BWC's vocational provider network.

BWC Medical Services undertook a comprehensive review of the benefit plan and corresponding vocational fee schedule. The process for the comprehensive review included:

- A.** Reviewing specific service coverage statuses relative to indicators of vocational needs, and revising accordingly.
- B.** Assessing the existing number of service units for all services in relation to expected patterns of service delivery, and revising accordingly.
- C.** Evaluating current established fees for services, and adjusting accordingly.
- D.** Review proposed service fees and unit recommendations against other payers.

In applying the above process, the Rehabilitation Policy staff reviewed 77 local codes.

The method BWC uses to determine which services will be within the coverage plan and the fee schedule for those services is detailed below.

Determination of Coverage and Units of Services

BWC performed an assessment to determine what rehabilitation services are needed to include and/or exclude from the vocational benefit plan. Consideration is given to whether particular services are in line with BWC's objectives which are providing services that most effectively facilitate an injured worker's return to work, or remain at work. Based on this review a decision is made to add, keep or remove any particular rehabilitation service.

BWC gathered information from several sources to complete this assessment. Sources included feedback from stakeholders and/or providers, data on trends in vocational rehabilitation services taken from seminars, literature reviews etc., and data research of services provided in other state's workers' compensation systems.

At the same time, BWC determined for each benefit plan service, what the appropriate number of units or range of units for that service should be. Importance was placed on ensuring the injured worker gets the right treatment at the right time and in sufficient quantity to maximize positive outcomes without creating program inefficiencies.

Setting Fees

The fees for vocational rehabilitation services were also reviewed, and evaluated against the guiding principle as set forth above. As a result of that evaluation determinations were made whether fees should be increased, remain the same or decreased. Fees for any new services were also set during this step. The reimbursement level for any service took into account the Ohio environment, the existing fees and the determination of what change in fees would facilitate the achievement of the guiding principle.

After establishing the fees, BWC gathered service and reimbursement data from other payers and evaluated the established Ohio fees against the gathered information. The process for gathering comparison data involved performing research of various payers of rehabilitation services and of providers or vendors of equipment and tools. Because of the nature of local service definitions and the differences that can exist in services from one state to another, care was taken in comparing the gather data against Ohio's recommended plan and reimbursement levels. Thus, the evaluation of this data was used to add an additional confidence level check of BWC's recommended benefit plan design including reimbursement levels.

Once a decision is made about the need to adjust the base rates for specific services and fees to ensure delivery of quality services, BWC reviews the overall fee schedule to determine if there is a change to the cost of living that needs to be addressed within the fee schedule recommendations. A method for determining a relevant change in the costs of providing vocational rehabilitation services in Ohio is employed. A review of typical expenses of an

agency providing services similar to those provided within the BWC system found that approximately 78 percent of costs are directly related to the employment of personnel and their benefits. The other 22 percent of costs are related to operating expenses – facilities, utilities, goods and services. This split of 78/22 seems consistent based on the past experience of BWC’s reviewers and was used as the weighting basis for determination of the change in costs for voc rehab providers.

For the change in costs of employment, the U.S. Bureau of Labor Statics, Employment Cost Index, Private Industry Workers, Education and Health Services is consulted. This index reflects the costs of employment for workers in this industry grouping. (This occupational grouping was selected because vocational rehabilitation services are predominantly education, health and social services related.) This factor is weighted at 78%. For the purposes of the current recommendation, the Employment Cost Index for September 2010 is used and reflects approximately 1.5 percent increase from September 2009.

For the change in costs to operating and other expenses the U.S. Bureau of Labor Statistics, Consumer Price Index – Urban (CPI-U) Table 1. Consumer Price Index for All Urban Consumers: U.S. city average, by expenditure category and commodity and service group, Commodity and Service Groups, Services, is consulted. The aggregate of Services includes changes in costs in rents, utilities and other services. This factor is weighted at 22% of the overall change in costs. For the purposes of the current recommendation, CPI-U Table 1 from September 2010 is used and reflects approximately 0.8 percent increase from September 2009.

Operating costs change	Sept. 2009	Sept. 2010	change	Percent of change	Weight³	Weighted percent change
Services ¹	260.14	262.32	2.18	0.84	0.22	0.18
Employment cost change						
Education & health services ²	112.60	114.30	1.70	1.51	0.78	1.18
						1.36

¹ - U.S. Bureau of Labor Statistics, Table 1: Consumer Price Index - Urban (CPI-U): U.S. city average, by expenditure category and commodity and service group, commodity and service group, services from CPI-U September 2009 and September 2010

² - U.S. Bureau of Labor Statistics, Employment cost Index for total compensation, for private industry workers, by occupational group and industry, occupational group, Education and health services September 2009 and September 2010

³ Weighting based on research showing in vocational rehabilitation provider company 78% of costs related to personnel and benefits while 22% related to operational costs and supplies.

2011 Proposed Fee Schedule Updates

Fee Increases

- BWC proposes an overall increase of 1.36% to all established vocational rehabilitation fees for service.

Elimination of Services

- BWC proposes the elimination of W0638 Body Mechanics Education as this service is rarely used and may be accomplished using CPT codes 97110 and 97112, or 97530 for therapy.

New Local Codes

- BWC proposes the creation of a new local code for Training – Books, Supplies and Testing.
- BWC proposes the creation of two new local codes for Career Counseling – In Person and Career Counseling – Research and Reporting.
- BWC proposes the creation of a new local code for Job Development.
- BWC proposes the creation of a new local code for Labor Market Survey report written by the Vocational Rehabilitation Case Manager

Changes in Definitions

- BWC proposes changing the definition of Job Placement and Development to Job Placement.
- BWC proposed changing the definition of Physical Conditioning Unsupervised
- BWC proposes changes to Other Provider Travel and Other Provider Mileage to allow Career Counselors, Job Club facilitators, Job Development Providers, and Job Placement Providers to be reimbursed.
- Other Provider Wait adds job placement and job development
- Job Seeking Skills Training adds requirement for internet job search and online applications to be included as part of the skills set.
- Job Modifications has language added to allow review of modifications costing over \$5000 to be reviewed by BWC safety and hygiene personnel.
- BWC proposes modifying the definition of allowed providers under RAW Services -- Other Provider Travel, Wait and Mileage to eliminate those not authorized as part of RAW Services.

Projected Cost Impact

The financial impact to the state fund is as follows:

1. Estimated at \$452,122 or an increase of approximately 1.42 percent over the vocational rehabilitation costs projected to be incurred for calendar year 2010,
2. Improvement in provider reimbursement,
3. Appropriate provision of benefits necessary to address Ohio's injured worker's needs, i.e. returning to work or remaining at work,

4. Fully support the guiding principle: *ensure access to high-quality vocational services by establishing an appropriate Benefit plan and Terms of service with a competitive fee schedule which, in turn, enhances BWC's vocational provider network.*

2011 Vocational Rehabilitation Provider Fee Schedule Proposal

Freddie Johnson, Director, Medical Services

Karen Fitzsimmons, Manager, Rehab Policy

March 24, 2011

Introduction and Guiding Principles

- Proposed Time-line for Implementation
 - Board Presentation March / April
 - Proposed to JCARR – 5/13/11
 - Effective Date – 8/1/2011
- Guiding Principle:

Ensure access to high-quality medical care and vocational rehabilitation services by establishing an appropriate Benefit plan and Terms of service with competitive fee schedule which, in turn, enhances medical/vocational provider network

Fee Schedule Update Methodology

- Reviewed all 77 Vocational Rehabilitation Services code
- Coverage status was determined and changed when necessary
- The maximum number of units reimbursable for all codes was reviewed
- Benchmarking against other payers

Recommendations

- Provide a 1.36% CPI-U Adjustment

Cost of doing vocational rehabilitation business adjustment

Operating costs change	Sept. 2009	Sept. 2010	change	Percent of change	Weight ³	Weighted percent change
Services ¹	260.14	262.32	2.18	0.84	0.22	0.18
Employment cost change						
Education & health services ²	112.60	114.30	1.70	1.51	0.78	1.18
						1.36

¹ - U.S. Bureau of Labor Statistics, Table 1: Consumer Price Index - Urban (CPI-U): U.S. city average, by expenditure category and commodity and service group, commodity and service group, services from CPI-U September 2009 and September 2010

² - U.S. Bureau of Labor Statistics, Employment Cost Index for total compensation, for private industry workers, by occupational group and industry, occupational group, Education and health services September 2009 and September 2010

³ - Weighting based on research showing in vocational rehabilitation provider company 78% of costs related to personnel and benefits while 22% related to operational costs and supplies.

Recommendations

- Eliminate the code W0638 for Body Mechanics Education
 - Very limited usage of this code in recent years.
 - Service may be billed using existing CPT codes of 97110 or 97535 using the established fee schedule.
- Add 5 new codes
 - Training – Books Supplies and Testing
 - Career Counseling – In Person
 - Career Counseling – Research & Reporting
 - Job Development
 - Labor Market Survey report writing by the Voc Rehab Case Manager

Recommendations

- Modify Definitions to the following codes
 - Job Placement
 - Separate from Job Development
 - Physical Reconditioning Unsupervised
 - Adds to the rule definition the limits currently in policy – one three month program per referral up to \$225 for the entire program.
 - Other Provider Travel and Mileage
 - Allow use by providers of Career Counseling – In Person, re-instated the service of Job Club as type, and modified for change to Job Placement and Job Development
 - Other Provider Wait
 - Allow use by Job Placement and Job Development

Recommendations

- Job Seeking Skills Training
 - Clarified expectations of the training to include internet job search and on-line applications.
- Job Modifications
 - Language was added to allow review by BWC safety and hygiene personnel for modifications exceeding \$5000.00.
- RAW Service – Other Provider Travel, Wait and Mileage – 3 codes
 - Removed the services from the definitions that are not reimbursable as RAW services – job placement, job seeking skills, job club facilitator

Impacts and Outcomes

- Vocational Services Costs Impact
 - An estimated increase of \$452,122 which is a 1.42% increase from 2010 projected costs.
 - Addition of 2 Career Counseling codes accounts for \$43,757.08 or 10% of the increase. Addition of the other 3 new codes has no projected increase.
 - Increase based on the cost of doing business adjustment accounts for \$408,365 or 90% of the projected increase
- Appropriate Provision of Benefits Necessary to Address Ohio's Injured Workers' Needs
- Supports the Guiding Principle of Access to Quality Care

Thank You

Appendix

Recommendations:

Training – Books, Supplies and Testing

- No change in current costs as books and supplies are currently reimbursed using the codes for Training (W0694, W0692, W0691) or Tools and Equipment (W0665)
- Adding this code allows BWC to track the use of books, supplies and testing in vocational rehabilitation plans more accurately
- Improves the ability of the Vocational Rehabilitation Case Manager to accurately estimate costs on vocational rehabilitation plans by requiring inclusion of the costs for these items separate of tuition costs.
- Provides a code for required testing related to occupational certifications

Recommendations:

Career Counseling – In Person

- Currently reimbursed using CPT codes for Psychiatric/Psychological counseling and is not descriptive of the actual service.
 - Career Counseling has both vocational and adjustment to disability function for the small percentage of injured workers who require a **substantial change** in their vocation due to their injury.
 - Unlike psychological counseling which is based in medical treatment of a specific disorder, career counseling for BWC is a one tool in vocational services for people who have experienced a workplace injury.
- Creating a local code allows BWC the capacity to track this specific service to better analyze the effectiveness and outcomes.
- Allows for a distinction between reimbursement of direct service time to an injured worker and indirect service time.

Recommendations:

Career Counseling – Research and Reporting

- Creating a local code for indirect time allows BWC to reimburse direct and indirect service time at different levels.
- Allows BWC to require completion of both session notes and a final written report of recommendations and provides a method for reimbursement of same.
- Provides reimbursement to the Career Counselor for research necessary to the career counseling process; such as, labor market surveys, review of educational programs, etc.

Recommendations

Job Development

- Creates separate codes for Job Development and Job Placement as they have distinct activities.
 - Job Development focuses on identifying unadvertised job opportunities or creating jobs (hidden job market).
 - Job Placement focuses on advertised existing jobs.
- Does not increase the level of services allowed as the current 80 hours is split to 40 hours for each service.
- Separating the codes allows BWC to better track service delivery and emphasize expectations for both to be part of the service.

Recommendations

Labor Market Survey Report Writing by VRCM

- Labor Market Surveys are written reports that identify the potential employment opportunities based on the specific job goal within a specific geographic area.
- The new code will allow BWC to systemically track delivery of the service
 - There is no specific code for this service.
 - Labor Market Surveys are currently required by policy and best practice.



Bureau of Workers' Compensation

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Columbus, OH 43215-2256

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

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Recommendations for changes to the vocational rehabilitation fee schedule from LMG Advisory Council, International Association of Rehabilitation Professionals (IARP), Ohio Association of Rehabilitation Facilities (OARF), and Ohio Physical Therapy Association (OPTA).

<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
Methodology	OARF -- If BWC implements the current fee schedule methodology, if either index decreases, will BWC reduce fees?		BWC considers a number of factors in setting and changing fees. BWC would not change the fees based solely upon the Consumer Price Index measure.	No modification to the fee schedule needed.
Methodology	IARP -- Did we consider using a Consumer Price Index for Rural areas?	The speaker believes the cost of doing business is higher in rural areas especially related to travel costs.	The methodology was developed with the help of BWC Actuarial. The CPI reflects the broadest, average data to reflect general changes of costs in the state as a whole.	No modification to the fee schedule needed.
Methodology	OPTA -- Appreciates the across the board fee increase for services; however, BWC needs to ensure that our rationale are tempered with other service benchmarks to account for disparity in the unique services.	OPTA and OARF are concerned that in the future on the Consumer Price Index will be considered and not the base rate.	BWC considers a number of factors in setting and changing fees. BWC would not change the fees based solely upon the Consumer Price Index measure.	No modification to the fee schedule needed.

<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
W0523/W0524 Career Counseling	IARP -- What professional qualifications are needed to provide career counseling? Did BWC consider CRCs?	Certified Rehabilitation Counselors (CRCs) are capable of providing this service too.	BWC evaluated the provider types and determined that licensed counselors would most effectively provide career counseling toward return to work. The rule reads: "Only professionals who are experienced with career counseling who have a working knowledge of the labor market, and who are licensed as one of the following provider types may provide Career Counseling services: Licensed Social Worker, Licensed Independent Social Worker, Licensed Professional Counselor, Licensed Professional Clinical Counselor, Psychologist, Doctor of Medicine or Doctor of Osteopathy. "	No modification to the fee schedule needed.
W0659 Job Development W0660 Job Placement	IARP and OARF -- BWC should consider a different split in the number of units allowed for each service than the 40 - 40 proposal.	IARP believes that more time may be required for Job Placement. OARF believes that more time is required to do Job Development.	BWC understands both stakeholder's comments and clearly there is disagreement between the entities. In analyzing the issue BWC felt it was more important to separate the code into each service and will evaluate the usage of each later and change as needed.	No modification to the fee schedule needed.
W0659 Job Development W0660 Job Placement	OARF -- BWC should clarify the language concerning who may provide the service.	At this time, each definition indicates that if services are provided by someone other than the Vocational Rehabilitation Case Manager (VRCM), the other provider must provide both services.	BWC agrees with the comment from OARF. BWC's intent was that these services be provided by the case manager alone, a single job placement and job development provider alone, or by the case manager and one other provider for job placement or job development. BWC does not intend that two providers for these services in addition to the case manager would be involved in a plan.	BWC clarified the rule language.

Issue	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
W0513 Ergonomic Implementation W0644 Ergonomic Study W0645 Job Analysis W0637 Transitional Work	OPTA and OARF -- Recommend that providers of these services have their own travel time code with reimbursement reflecting the professional fee schedule for these services.	The "case manager" and "other provider" travel time is paid at 1/2 of their respective professional rates, so the physical and occupational therapists think they should be paid at 1/2 of their professional rates.	BWC recognizes the difference in travel time rates as raised by the stakeholders, however, at this point BWC believes the rates are reflective of the relative importance of each service provider in the service continuum. The case manager plays a critical role in coordinating all services. BWC will assess the appropriate response of moving to one flat travel time rate for all providers.	No modification to the fee schedule needed.
W0702 W0703 Occupational Rehabilitation Comprehensive W0710 Work Conditioning	OPTA -- Does BWC have a policy to address the priority of these services or in what order these services are to be rendered?	The speaker indicates that from the therapist's perspective the services are the same, so it should be that the service which reimburses better and is more intense be used first W0702/W0703.	BWC has no specific policy indicating in what order these particular services are to be provided. BWC evaluates the benefit plan so that the services needed to get the injured worker back to work are provided at the right time. Where BWC has determined that a specific order of service provision is the best practice, policies have been developed.	No modification to the fee schedule needed.
W3039 Labor Market Report Writing by the Vocational Rehabilitation Case Manager	IARP -- Suggest BWC change to name of this proposed code to be more inclusive of the entire service.	The speaker notes that prior to actually writing a Labor Market Survey, the VRCM would conduct research and the current proposed title seems to limit use to the report writing.	BWC does intend that the code be used for both the research and report writing components of the Labor Market Survey.	Changed name of service from "Labor Market Report Writing by the Vocational Rehabilitation Case Manager" to "Labor Market Survey by the Vocational Rehabilitation Case Manager".
W0648 Physical Reconditioning, Unsupervised	OPTA -- Suggests that BWC change the name of this service to "Physical Fitness Facility Membership".	OPTA expressed concern that the current name might entail some liability to a professional if the injured worker were injured in their facility. IARP believes the name is fine and that the designation of "unsupervised" in the title removes any liability from the therapist.	BWC understands the comment and cannot validate that this would occur. The definition of this code is clear and historically there have been no problems with it.	No modification to the fee schedule needed.

<u>Issue</u>	<u>Stakeholder/Interested Party Recommendations/Questions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
W0638 Body Mechanics Education	OPTA -- Concerns were expressed that MCO's have denied CPT codes when "W" codes are in use on the same visit even though the policy indicates use of both is valid.	Providers have experienced this result in the past when using both CPT and W codes.	BWC has noticed the same MCO activity.	BWC has provided and will continue to provide education to MCOs regarding this issue. No modification to the fee schedule needed.

2011 Common Sense Initiative Checklist (BWC Rules)

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

OAC 4123-6-16.2

Rule Review

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

Citation: R.C. 4121.441(A)

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

What goal(s): The proposed changes reflect in part a collaboration of ideas between BWC and MCO staff to remove provider barriers to treatment in the workers' compensation system and provide quality improvement to the medical treatment reimbursement request process.

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 Medical Treatment Reimbursement Requests rule was e-mailed to the Medical Services Division's lists of stakeholders on March 7, 2011, with comments due back by March 21, 2011. Additionally, on March 8, 2001 BWC discussed the proposed rule with representatives from the International Association of Rehabilitation (IARP), Ohio Association of Rehabilitation Facilities (OARF), and the Ohio Physical Therapy Association (OPTA). Providers who attended Medical Services Provider forums in June and Nov 2010 were also provided an overview of the C9 initiative which included changes to the rule and related treatment request forms.

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
Medical Treatment Reimbursement Requests

Introduction

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including rules relating to the adoption of a provider fee schedule. BWC initially enacted the bulk of the Chapter 4123-6 HPP operational rules (Ohio Administrative Code 4123-6-01 to 4123-6-19) in February 1996.

Background Law

R.C. 4121.441(A)(5) and (A)(9) provide 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, including but not limited to rules providing for:

- Adequate methods of peer review, utilization review, quality assurance, and dispute resolution to prevent, and provide sanctions for, inappropriate, excessive or not medically necessary treatment; and
- Provisions for provider referrals, pre-admission and post-admission approvals, second surgical opinions, and other cost management techniques.

Pursuant to this statute, BWC adopted OAC 4123-6-16.2, requiring providers to request prior approval for all non emergency medical treatment from the MCO managing the medical part of an injured worker's claim on form C-9 or equivalent, in April 2007.

Proposed Changes

The major substantive changes proposed for the medical treatment reimbursement requests rule:

- Add a definition of "eligible treating provider" to the rule to clarify the provider types who may submit medical treatment reimbursement request (C-9);
- Provide that BWC may require providers to include the applicable Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS) codes in effect on the date of the request for the procedures or services being requested, and further provide that the MCO's review shall not be construed as approving or denying payment for the specific codes listed by the provider;
- Eliminate the reference to the timeframe for inactive claims being 13 months, since this has since been changed to 24 months, and replace it with a cross-reference to claim reactivation rule OAC 4123-3-15;
- Provide that medical treatment reimbursement requests submitted by a physical therapist or occupational therapist must be accompanied by a prescription as required in BWC's physical medicine rule OAC 4123-6-30, and that approval of such requests shall be valid for no longer than 30 days unless the approval specifies a longer period and such longer period is supported by the prescription;
- Provide that approval of all other medical treatment reimbursement requests shall be valid for no longer than six months unless the approval specifies a longer period;

- Add three more circumstances under which an MCO may dismiss a medical treatment reimbursement request without prejudice to those currently in the rule:
 - The underlying claim has been disallowed or dismissed in its entirety, or the only allowances in the underlying claim are for substantial aggravation of a pre-existing condition, and the conditions have been determined in a final administrative or judicial determination to be in a non-payable status;
 - The services or supplies being requested are never covered by the bureau pursuant to other bureau statutes or rules;
 - The MCO has requested supporting medical documentation from the submitting physician of record or eligible treating provider necessary to the MCO's evaluation and determination, and such documentation is not provided to the MCO.

Stakeholder Involvement

BWC's proposed Medical Treatment Reimbursement Requests rule was e-mailed to the following lists of stakeholders on March 7, 2011, with comments due back by March 21, 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

Additionally, on March 8, 2011 BWC discussed the proposed rule with representatives from the International Association of Rehabilitation (IARP), Ohio Association of Rehabilitation Facilities (OARF), and the Ohio Physical Therapy Association (OPTA).

Providers who attended Medical Services Provider forums in June and Nov 2010 were also provided an overview of the C9 initiative which included changes to the rule and related treatment request forms.

The proposed changes in part reflect a collaboration of ideas between BWC and MCO staff through the framework two Medical Services SMART Objectives workgroups: 1) Provider Barriers Removal & 2) C9 QI Improvement. Throughout the development revision to the rule and related business forms were shared and discussed with MCO Medical Directors (April 2009), the MCO Business Council and the MCO Quality of Care Committee (August – Dec 2010).

Currently received stakeholder and interested party responses are summarized on the Stakeholder Feedback Summary Spreadsheet.

4123-6-16.2 Medical treatment reimbursement requests.

(A) Medical treatment reimbursement requests must be submitted by the physician of record or eligible treating provider (on form C-9 or equivalent) to the MCO responsible for medical management of the claim prior to initiating any non-emergency treatment.

For purposes of this rule, “eligible treating provider” means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor.

(B) Medical treatment reimbursement requests shall be evaluated by the MCO using the following three-part test (all parts must be met to authorize treatment reimbursement):

- (1) The requested services are reasonably related to the industrial injury (allowed conditions);
- (2) The requested services are reasonably necessary for treatment of the industrial injury (allowed conditions);
- (3) The costs of the services are medically reasonable.

(C) For informational purposes, the bureau may require the provider to include on the medical treatment reimbursement request the applicable codes, from the edition of the centers for medicare and medicaid services’ healthcare common procedure coding system (HCPCS) in effect on the date of the request, for the procedures or services being requested.

However, review of the request shall be directed to the treatment being requested, and shall not be construed as approving or denying payment for the specific codes listed by the provider.

(D) Medical treatment reimbursement requests in inactive claims ~~which have not had activity or a request for further action within a period of time in excess of thirteen months~~ shall be processed in accordance with the provisions of rule 4123-3-15 of the Administrative Code.

(E) Medical treatment reimbursement requests submitted by a physical therapist or occupational therapist must be accompanied by a prescription as required in paragraph (B) of rule 4123-6-30 of the Administrative Code, and approval of such requests shall be valid for no longer than thirty days unless the approval specifies a longer period and such longer period is supported by the prescription. Approval of all other medical treatment reimbursement requests shall be valid for no longer than six months unless the approval specifies a longer period.

~~(D)~~(F) The MCO may dismiss without prejudice medical treatment reimbursement requests under the following circumstances:

(1) The request has been submitted by ~~providers~~ a provider who ~~are~~ is not enrolled with the bureau and who ~~refuse~~ refuses to become enrolled, or who ~~are~~ is enrolled but non-certified and ~~are~~ is ineligible for payment as a non-certified provider under rules ~~4123-6-06.3~~ 4123-6-06.2 or ~~4123-6-12~~ 4123-6-10 of the Administrative Code or division (J) of section 4121.44 of the Revised Code.

~~(2)(E) The MCO may dismiss without prejudice medical treatment reimbursement requests that are~~ request is not accompanied by supporting medical documentation that the submitting physician of record or eligible treating provider has seen and examined the injured worker within thirty days prior to the request, or that the injured worker requested a visit with the provider, and such evidence is not provided to the MCO upon request (via form C-9A or equivalent).

~~(3)(F) The MCO may dismiss without prejudice a medical treatment reimbursement request that~~ duplicates a previous medical treatment reimbursement request that has been denied in a final administrative or judicial determination where the new request is not accompanied by supporting medical documentation of a new and ~~change in~~ changed circumstances impacting treatment, and such evidence is not provided to the MCO upon request (via form C-9A or equivalent).

~~(4)(G) The MCO may dismiss without prejudice a medical treatment reimbursement request when the~~ underlying claim has been settled, and the dates of service requested are on or after the effective date of the settlement. If the medical treatment reimbursement request includes both dates of service on or after the effective date of the settlement and dates of services prior to the effective date of the settlement, the MCO may dismiss without prejudice only that portion of the request relating to dates of service on or after the effective date of the settlement.

(5) The underlying claim has been disallowed or dismissed in its entirety, or the only allowances in the underlying claim are for substantial aggravation of a pre-existing condition, and the conditions have been determined in a final administrative or judicial determination to be in a non-payable status.

(6) The services or supplies being requested are never covered by the bureau pursuant to other bureau statutes or rules.

(7) The MCO has requested supporting medical documentation from the submitting physician of record or eligible treating provider (via form C-9A or equivalent) necessary to the MCO's evaluation and determination, and such documentation is not provided to the MCO.

(H) If the MCO determines that any approved medical treatment reimbursement request is not medically indicated or necessary, is not producing the desired outcomes, or the injured worker is not responding, the MCO may notify the parties of its decision to discontinue payment of approved treatment that has not already been rendered.

This decision shall be subject to alternative ~~medical~~ dispute resolution pursuant to rule 4123-6-16 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.12, 4121.44, 4121.444, 4123.66

Prior Effective Dates: 4/1/07; _____



Bureau of Workers' Compensation

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Columbus, OH 43215-2256

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

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Stakeholder Feedback Recommendations for Changes to the 4123-6-16.2 Medical treatment reimbursement requests.

<u>Line #</u>	<u>Rule #/Subject Matter</u>	<u>Stakeholder</u>	<u>Draft Rule Suggestions</u>	<u>Stakeholder Rationale</u>	<u>BWC Response</u>	<u>Resolution</u>
	4123-6-16.2	FootCare Associates, Inc. David A. Kutlick, D.P.M. kutlick@sbcglobal.net 15700 St. Rt. 170 Suite B East Liverpool, OH 43920 (330) 385-2227	A) Medical treatment reimbursement requests must be submitted by the physician of record or eligible treating provider (on form C-9 or equivalent) to the MCO responsible for medical management of the claim prior to initiating any non-emergency treatment.	Requiring more paperwork for a provider's office is not conducive to effective time management . By forcing providers to request the opportunity to treat a patient prior to rendering services, you may just lose providers .	There is no change to the amount of paperwork – just better information on the C9 form to facilitate communication and negotiation upfront between providers and MCOs.	recommend : no change

	4123-6-16.2	<p><i>James R. Rough</i> <i>Executive Director</i> <i>Counselor, Social Worker & Marriage and Family Therapist Board</i> <i>50 West Broad Street, Suite 1075</i> <i>Columbus, Ohio 43215-5919</i> <i>614-752-5161</i></p>	<p>For purposes of this rule, “eligible treating provider” means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor.</p>		<p>For purposes of this rule, “eligible treating provider” means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</p>	Correction adopted
	4123-6-16.2	<p>RKaplansky@aol.com Ronald Kaplansky, DPM</p>		<p>I concur with the changes/language of the proposed Ohio Administrative Code 4123-6-16.6, Medical treatment reimbursement request for medical services and supplies.</p>		
	4123-6-16.2	<p>Richard Robilotto Workers' Compensation Manager KeyBank 216-689-0833</p>	<p>For purposes of this rule, “eligible treating provider” means a physician as defined in rule 4123-6-01 of</p>	<p>Strike "advanced practice nurse, physician assistant" from the second full paragraph. Only the</p>	<p>These provider types are currently allowed to submit C9s in policy – we are updating the rule to match current policy & practice.</p>	No change

		richard_d_robilotto@keybank.com	the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor	physician of record and those non-physician practitioner types listed that the physician of record referred the injured worker to and received approval from the MCO should have entitlement to reimbursement. Paragraph (C), strike the "may" and replace with "will" in the first sentence so that it reads, "For informational purposes, the bureau will require the provider to include on the medical treatment reimbursement request the applicable codes, from the edition of the centers for Medicare and Medicaid services' healthcare common procedure coding system (HCPCS) in effect on the date of the request, for the procedures or services being requested	The word may provides BWC with discretion to require CPT codes	
4123-6-16.2 Medical treatment reimbursement requests	From: Brent Russell [mailto:brent.russell@ameritech.net] Brent C. Russell P.A.-C.		A) Medical treatment reimbursement requests must be submitted by the physician of record or eligible treating provider (on form C-9 or equivalent) to the MCO responsible for	It sounds as if a C-9 would be required for every office visit, including rechecks. This would be an excessive burden to both provider and MCO staff, with	Office visits do not require prior authorization.	No Change

			medical management of the claim prior to initiating any non-emergency treatment	potential delay of approving the appropriate care.		
		Leslie Lansky [mailto:llansky@rrohio.com] Leslie LanskyceGrandview Family Practice, Inc. 488-7929 x 24 488-3201 fax		Thank you for the proposed changes. Dr. May read through them and does not have any comments at this time.		
4123-6-16.2 Medical treatment reimbursement requests		From: Dan Davis MD [mailto:dand@oehpmco.com] OEHP MCO Medical Director	(C) For informational purposes, the bureau may require the provider to include on the medical treatment reimbursement request the applicable codes, from the edition of the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) in effect on the date of the request, for the procedures or services being requested. However, the MCO's review shall be directed to the treatment being requested,	1) in section (C) it says that the Bureau may request specific CPT's and the MCO is not guaranteeing payment for specific CPT's. It seems to me you want to say that the MCO may request the CPT's, or at least "the Bureau and/or the MCO." 2) Also, related to the same section, I believe the MCO's do want to approve payment for specific CPT's whenever possible. We get requests, for instance, for "physical therapy" or "chiropractic care" and it	<ol style="list-style-type: none"> 1.) Bureau sets policy and so it is the Bureau may require ... 2.) The language is consistent with the Industrial Commission's practice of approving and denying services and not codes – the payment is for the services provided. 3.) 10 days is already in the MCO policy guide and will be included in the BRM when we update to alert providers that MCOs may dismiss C-9s if information is not provided within 10 days of the C9A. 	No Change

			<p>and shall not be construed as approving or denying payment for the specific codes listed by the provider.</p>	<p>would be much better to require specific codes and approve coverage only for those specific codes. I'm not sure why you want to say "shall not be construed as approving or denying payment for the specific codes" since I believe that's exactly what MCO's actually do.</p> <p>3) In (F) 7, I think adding a time frame (such as ten 10 days) would be a good idea.</p>		
		<p>stoneangel@earthlink.net Brianna Flint P.O. Box 585 Lancaster Oh 43130 740 438 2337</p>	<p>For purposes of this rule, "eligible treating provider" means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</p>	<p>On your proposed changes, I do not see Licensed massage therapist listed? We are not physical therapist as listed, or does BWC consider them one in the same under another regulation.</p> <p>Are you asking for a prescription in place of a C9 from the physician</p>	<p>No change from the current process for Licensed Massage Therapist - the prescription if signed by the physician is the same as a C9.</p>	<p>No Change</p>

	4123-6-16.2 Medical treatment reimbursement requests	<p>William S. Pease, MD Physical Medicine and Rehabilitation William.pease@osumc.edu 614-293-7604</p>			Looks fine to me. Thanks		
		<p>DBillock@aol.com Dottie J. Billock, Patient Services Coordinator O&P Rehab. Engineering Centre Warren, OH 44484 330-856-2553 330-856-4619 - fax</p>	<p>For purposes of this rule, "eligible treating provider" means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</p>	<p>I am asking for clarification to the definition of "eligible treating provider". According to the proposed rules, we do not see where an eligible treating provider can mean an Orthotist or Prosthetist. Currently, as an eligible Worker's Compensation provider, we are able to submit C-9's with the physician of record's approval/signature, for authorization of our services. Does this proposed rule change affect that? Please clarify.</p>	<p>No change from the current process - the POR is the eligible treating provider</p>	No Change	
	4123-6-16.2	<p>Theresa Roberts [mailto:trober1@att.net] Office Manager</p>	<p>For purposes of this rule, "eligible treating provider" means a physician as defined in rule 4123-6-01 of the Administrative Code and</p>	<p>It would be great if the physical therapist could submit the C-9 to the MCO for approval with records to back up the request.</p>	<p>Yes – orders from the POR is still required per rule 4123-6-30</p>	NO Change	

			<p>the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</p>	<p>Would the POR still need to provide the orders for additional physical therapy, if so; that would just create more work on our end. A physical therapist would have to send the request to the physician for approval and then turn around and resubmit everything to the MCO for approval.</p>			
		<p>Rick Wickstrom PT, DPT, CPE, CDMS President, WorkAbility Network WorkAbility Wellness Center 7665 Monarch Court, Suite 109 West Chester, OH 45069 Work 513-821-7420 Mobile 513-382-5818 Fax 513-672-2552 Rick@WorkAbility.US</p>	<p>E) Medical treatment reimbursement requests submitted by a physical therapist or occupational therapist must be accompanied by a prescription as required in paragraph (B) of rule 4123-6-30 of the Administrative Code, and approval of such requests shall be valid for no longer than thirty days unless the approval specifies a longer period and such longer period is supported by the prescription. Approval of all other medical treatment reimbursement requests shall be valid for no longer than six months unless the approval specifies a longer period</p>	<p>As an FYI, I have already gotten multiple emails from physical therapists who are particularly upset by the drafted wording in paragraph (E) language that singles out physical and occupational therapists as the only ones on the list of non-physician practitioners that are required to have a prescription and limit on treatment services. This language as worded is contrary to the intent of this rule to foster appropriate, cost-effective care.</p>	<p>The changes in the rule will delete the semantics barrier on C-9s to allow worksite therapy to take place and enhance transitional work .</p>		<p>No Change</p>

		<p>Daniel J Brustein, MD, FACOEM Medical Director, University CompCare Commerce Park IV</p> <p>23240 Chagrin Blvd – Suite 301</p> <p>Beachwood, OH 44122</p> <p>216 488 4761</p>	<p>(B) Medical treatment reimbursement requests shall be evaluated by the MCO using the following three-part test (all parts must be met to authorize treatment reimbursement): (1) The requested services are reasonably related to the industrial injury (allowed conditions); (2) The requested services are reasonably necessary for treatment of the industrial injury (allowed conditions); 3) The costs of the services are medically reasonable.</p>	<p>In the absence of specific language that says that requests for DIAGNOSTIC procedures must be related to the allowed INJURY (rather than the allowed CONDITIONS) we will continue to see recommendations of denial by reviewers, claiming that the request is for a services related to conditions not allowed under the claim. I am not aware of language that specifically addresses diagnostic (rather than treatment) procedures</p>	<p>Diagnostics are addressed by rule 4123-6-31 (F)</p>	<p>No Change</p>	
		<p>From: 10017 - Conger Karen</p>	<p>(C) For informational purposes, the bureau may require the provider to include on the medical treatment reimbursement request the applicable codes, from the edition of the centers for Medicare and Medicaid services'</p>	<p>They left out having CPT codes and Place of service on the C9, they got HCPCS but not the others?????</p>	<p>CPT codes are a level of HCPCS and this is consistent with 4123-6-25 (c) 1a.</p> <p>Place of service is on the form as data element and not the rule.</p>	<p>No Change</p>	

			healthcare common procedure coding system (HCPCS) in effect on the date of the request, for the procedures or services being requested.				
		From: Susan Clunk [mailto:ClunkS@SmithClinic.com] Susan Clunk, PT Director of OT/PT Marion Area Health Center 1040 Delaware Ave Marion, OH 43302 Phone: 740-383-8056 Fax: 740-383-7096 Clunks@smithclinic.com Marion Area Health Center		No concerns at this time			
		From: Rhonda R. Simms [mailto:rsimms@occhealth.com]	A) Medical treatment reimbursement requests must be submitted by the physician of record or eligible treating provider (on form C-9 or equivalent) to the MCO responsible for medical management of the claim prior to initiating any non-emergency treatment	Please advise if follow up visits are considered part of the non-emergency treatment that would require authorization prior to scheduling	Office visits do not require prior authorization.		
		Amanda Sines Director, Government Relations	For purposes of this rule, “eligible treating provider”	I represent the Ohio Counseling Association. In	For purposes of this rule, “eligible treating provider” means a physician as defined in rule 4123-	Correction adopted	

		<p>Towner Policy Group 33 North Third Street, Suite 320 Columbus, OH 43215 (614)-221-7157 (614)-221-0756 (fax)</p>	<p>means a physician as defined in rule 4123-6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor.</p>	<p>reviewing your proposed rule 4123-6-16.2 (Medical treatment reimbursement request), I noticed that in the second paragraph, you refer to "licensed independent clinical counselors". The term we use in our licensure is "licensed professional clinical counselor".</p> <p>Would you please correct that in the rule?</p>	<p>6-01 of the Administrative Code and the following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor</p>		
		<p>Lee Ann Zingg Supervisor, Bill Processing Review Phone 479.621.2763 Fax 479.277.4342 lazingg@cmiw.com Claims Management, Inc. PO Box 1288 Bentonville, AR 72712-1288</p>	<p>However, the MCO's review shall be directed to the treatment being requested, and shall not be construed as approving or denying payment for the specific codes listed by the provider.</p>	<p>As a self insured payer for Worker's Compensation in the state of OH we have reviewed the changes to 4123-6-16.2. We would first like to verify that these changes will apply to self insured payers.</p> <p>The interpretation we have of this statement "However, the MCO's review shall be directed to the treatment being requested, and shall not be construed as approving or</p>	<p>Per 4123-6.01 Medical rules will apply to Self Insured Employers in accordance with 4123-6-.01</p>		Correction adopted

				<p>denying payment for the specific codes listed by the provider” is that if the C-9 contains HCPCS or CPT codes listed does not mean that those codes are allowed for payment under the workers compensation fee schedule. Is that the correct interpretation? If so this is an excellent change. When utilizing the National Correct Coding Initiative Edits (as stated in the fee schedule are applicable), codes are listed on the C-9 are currently being allowed as “approved”. With this change a self insured payer will have the ability to apply the NCCI Edits even when the codes are listed on the C-9 form.</p>			
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2011 Common Sense Initiative Checklist (BWC Rules)

(Note: The below criteria apply to existing and newly developed rules)
OAC 4123-6-21; OAC 4123-6-21.1

Rule Review

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

Citation: R.C. 4123.66; R.C. 4121.441; R.C. 4123.35

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

What goal(s): The proposed changes update reimbursement practices and clinical guidelines for the BWC pharmacy department and self insuring employers, introducing a clinical perspective to BWC's outpatient medication rules that is intended to improve outcomes for injured workers.

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 revisions to OAC 4123-6-21 and OAC 4123-6-21.1 were e-mailed to the Medical Services Division's lists of stakeholders for review and comment on March 15, 2011, with comments due back by April 6, 2011. A draft of proposed rule OAC 4123-6-21 was also discussed at BWC's P&T Committee meeting on March 9, 2011.

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
Outpatient Medication Rules
OAC 4123-6-21 and 4123-6-21.1

Introduction

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

BWC proposes amending its outpatient medication rule, OAC 4123-6-21, to institute a clinical focus to the Bureau's method of operation. These amendments address the clinical issues of patient safety by giving the Bureau and its pharmacy department more control over how medications are reimbursed. In addition, the amendments proposed define the qualifications required of BWC's pharmacy program director to be consistent with those recently adopted in OAC 4123-6-21.2. The overarching concern of the outpatient medication rule can be found in paragraph (A), which allows the Bureau to

. . . deny a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of an allowed condition in a claim...

BWC proposes to revise rule OAC 4123-6-21 to by introducing a clinical perspective that is intended to improve outcomes for injured workers. This increased focus on the treatment being provided to an injured worker will be a part of the determination of whether or not a drug or class of therapeutic drugs is reasonably related to or medically necessary for treatment of an allowed condition in a claim.

Since self-insuring employers are required to pay benefits equal to or greater than BWC, where applicable BWC is proposing to make changes parallel to those proposed in OAC 4123-6-21 in the Chapter 4123-6 self-insuring employers' outpatient medication rule, OAC 4123-6-21.1.

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 therefore."

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, including in paragraph (A)(8) "[d]iscounted pricing for . . . all pharmaceutical services."

Proposed Changes

BWC requests that the proposed changes to rule OAC 4123-6-21 be adopted. The proposed changes to the rule update reimbursement practices and clinical guidelines for the pharmacy department. The proposed changes also address safety issues concerning reimbursement for particular noncertified physicians and utilize the pharmacy benefits manager

to prevent non-sterile drugs from being dispensed to injured workers. The most significant proposed changes to OAC 4123-6-21:

1. Provide that noncertified prescribers who prescribe outpatient medications may not be reimbursed, with three exceptions.
2. Create a separate category for drugs that may be prior authorized by and reimbursed through the bureau's pharmacy benefits management vendor:
 - a. Parenteral drugs (*e.g.*, drugs that are not administered in the body through the digestive tract but rather through intravenous or intramuscular injection) compounded in a physician's office that do not comply with United States Pharmacopeia (USP) standards for preparation of sterile parenteral compounded drug.
3. Add a defined dispensing fee component of three dollar and fifty cents.
4. Define the product cost as the lesser of the average wholesale price minus nine percent, or the maximum allowable cost.
5. Reinforce that BWC does not reimburse third party pharmacy billers.
6. Require pharmacy providers to:
 - Maintain a signature log verifying receipt of applicable covered medications;
 - Include prescriber information, to include the prescriber's national provider identifier (NPI) or the drug enforcement administration (DEA) number, on bills submitted electronically for payment;
 - Not pay or offer to pay any "kickback" to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services;
 - follow all applicable billing procedures as written in the Bureau's billing and reimbursement manual in effect on the billed date of service.
7. Allow the Bureau to determine the maximum allowable cost for single source and multi-source generic drugs.
8. Allow an injured worker to be reimbursed for a brand-name drug where it has been demonstrated that its generic counterpart (and other comparable generic medications within that therapeutic class) has caused allergic reactions or adverse events;
9. Allow the Bureau to deny refills requested before ninety percent of any published days supply limit has been utilized, with overrides for documented exceptions
10. Defines the role and qualifications of the bureau's pharmacy program director consistent with OAC 4123-6-21.2.

Where applicable, BWC is also proposing to make changes parallel to those proposed in OAC 4123-6-21 in the Chapter 4123-6 self-insuring employers outpatient medication rule, OAC 4123-6-21.1 (see, *e.g.*, items 3-9 above).

Stakeholder Involvement

BWC's proposed revisions to rules OAC 4123-6-21 and 4123-6-21.1 were e-mailed to the following lists of stakeholders on March 16, 2011 with comments due back by April 8, 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

A draft of proposed rule OAC 4123-6-21 was also discussed at BWC's P&T Committee meeting on March 9, 2011.

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

4123-6-21 Payment for outpatient medication.

(A) Medication must be for the treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer. The bureau may deny a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of the allowed conditions in a claim.

(B) Medication ~~must~~may be prescribed by ~~the physician of record in the industrial claim or by the any~~ treating physician, ~~or by such other treating provider as may be authorized by law to~~ prescribe such medication. Reimbursement for prescriptions written by non-bureau certified prescribers shall be denied except in the following situations:

(1) The prescription is written by a non-bureau certified provider during initial or emergency treatment of the claimant if the claimant's claim and treated conditions are subsequently allowed.

(2) The prescription is written by a non-bureau certified provider who is outside the state or within the state where no or an inadequate number of bureau certified providers exist and the MCO has determined that the treatment to be provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider and has authorized the non-bureau certified provider to continue to provide the treatment.

(3) The prescription is written by a non-bureau certified provider for a claimant with a date of injury prior to October 20, 1993, the provider was the claimant's physician of record prior to October 20, 1993, and the claimant has continued treatment with that non-bureau-certified provider.

(C) Drugs covered are limited to those that are approved for use in the United States by the Food and Drug Administration and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) The bureau may require prior authorization of certain drugs or therapeutic classes of drugs, and shall publish a list of all such drugs or therapeutic classes of drugs for which prior authorization is required.

(E) Drugs which fall into one of the following categories may be prior authorized by and reimbursed through the bureau's pharmacy benefits manager:

(1) Compounded sterile parenteral drug products.

(a) "Parenteral" drugs are injectable medications. They may include those intended for use by the intrathecal, intravenous, intramuscular, or subcutaneous routes of administration.

(b) All compounded sterile parenteral drug products must be prepared and dispensed by a licensed and enrolled pharmacy provider that is able to demonstrate compliance with the standards contained in chapter 797 of the United States pharmacopeia (USP) in effect on the billed date of service.

(2) Drug efficacy study implementation (DESI) drugs or drugs that may have been determined to be identical, similar, or related;

(3) Extemporaneous or simple compounded prescriptions.

(F) Drugs which fall into one of the following categories may be approved and reimbursed by an MCO as part of a comprehensive treatment plan submitted by the physician of record or treating physician:

(1) Drugs for the treatment of obesity;

(2) Drugs for the treatment of infertility;

~~(3) Drug Efficacy Study Implementation (DESI) drugs or drugs that may have been determined to be identical, similar, or related;~~

~~(4) Extemporaneous or simple compounded prescriptions;~~

~~(5) Injectable~~Non-compounded injectable drugs not intended for self-administration;

~~(6)~~(4) Drugs used to aid in smoking cessation;

~~(7)~~(5) Drugs dispensed to a claimant while the claimant is admitted to a hospital during an approved inpatient admission or during the course of an outpatient visit in a hospital.

~~Drugs approved by the MCO under this rule shall not be reimbursed through the bureau's pharmacy benefits management vendor.~~

~~(F)~~(G) Payment for medications to pharmacy providers shall include both a product cost component and a dispensing fee component.

(1) The product cost component shall be the lesser of the following: maximum allowable cost, if applicable, or the average wholesale price of the commonly stocked package size plus or minus a percentage nine percent. ~~The percentage amount added or subtracted from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.~~

(2) The dispensing fee component shall be ~~a flat rate fee, which shall be subject to annual review~~three dollars and fifty cents.

- (a) Only pharmacy providers are eligible to receive a dispensing fee.
- (b) The dispensing fee may include an additional incentive component of two dollars and fifty cents for pharmacy providers that accept assignment.
- (c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN) per rolling twenty-five days. Exceptions to the single dispensing fee are:
 - (i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;
 - (ii) Cases where the physician has changed the dosage;
 - (iii) Cases where the medication did not last for the intended days supply;
 - (iv) Cases where the medication has been lost, stolen or destroyed;
 - (v) Controlled substances (which are limited to two dispensing fees per twenty-five days).

~~(G)~~(H) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined by the bureau. The bureau shall not reimburse any third-party pharmacy biller that submits pharmacy bills on behalf of a pharmacy provider or that has purchased pharmacy bills from a pharmacy provider for subsequent submission to the bureau for payment. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or ~~vendor~~the bureau's pharmacy benefit manager's payment system must be used for billing purposes. The pharmacy provider shall:

- (1) Maintain a signature log verifying receipt by the injured worker of applicable covered medications;
- (2) Include prescriber information within bills submitted electronically to the bureau or the bureau's pharmacy benefits manager for payment. The prescriber information must include the national provider identifier (NPI) or the drug enforcement administration (DEA) number;
- (3) Not pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured

worker ordering or receiving from the provider any medications or other goods or services for which payment may be made by the bureau, the bureau's pharmacy benefits manager, or MCO under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;

(4) Comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service.

~~(H)~~(I) The bureau may establish a maximum allowable cost for single source or multi-source medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication; "Approved Drug Products With Therapeutic Equivalence Evaluations;" in effect on the billed date(s) of service. The methodology used to determine a maximum allowable cost for a qualified drug product shall be determined by the ~~medical policy department and shall be subject to annual review~~ bureau. ~~The~~ For multi-source drugs, the bureau may choose to utilize the maximum allowable cost list of a vendor or develop its own maximum allowable cost list. For single source drugs, the maximum allowable cost shall be the drug's average wholesale price minus nine percent.

~~(J)~~(J) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication for which ~~has an~~ applicable maximum allowable cost price single source or multi-source medications exist that are pharmaceutically and therapeutically equivalent, as defined in paragraph (I) of this rule, shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price ~~plus or minus the bureau established~~ percentage of the dispensed brand name drug minus nine percent. However, the bureau may approve reimbursement of the dispensed brand name drug at the average wholesale price of the drug minus nine percent if the following circumstances are met:

(1) The injured worker has a documented, systemic allergic reaction which is consistent with known symptoms or clinical findings of a medication allergy; and

(2) The injured worker has been prescribed, and has tried, other A code drugs in the therapeutic class and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.

~~(K)~~(K) The following dispensing limitations may be adopted by the bureau:

~~(1) The bureau may publish a list of drugs identifying those drugs that are considered "chronic" medications. Drugs not identified as "chronic" medications shall be considered "acute" medications.~~

~~(2) The bureau may publish supply limitations for acute and chronic drugs which represent the maximum number of days supply that may be dispensed at any one time for a single prescription.~~

~~(3)~~(2) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

~~(4)~~(3) Requests submitted that exceed any published days supply limit or maximum quantity limit shall be denied. Denials may be overridden by the bureau in cases where medical necessity and appropriateness have been determined.

~~(5)~~(4) Refills requested before ~~seventy-five~~ninety per cent of any published days supply limit has been utilized will be denied, except in cases where the dosage of a ~~noncontrolled~~-drug has been ~~increased~~changed and has a new prescription number.

Denials may be overridden by the bureau for the following documented reasons:

- (a) Previous supply was lost, stolen or destroyed;
- (b) Pharmacist entered previous wrong day supply;
- (c) Out of country vacation or travel;
- (d) Hospital or police kept the medication.

~~(K)~~(L) ~~Through internal development or through vendor contracts, an online point of service adjudication system may be implemented. Upon implementation, pharmacy~~ Except as otherwise provided in paragraph (F) of this rule, outpatient medications shall be billed to and reimbursed through the bureau's pharmacy benefits manager. Pharmacy providers may be required to ~~submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the bureau's pharmacy benefits manager's established bill processing system as a condition of provider enrollment or reimbursement. Submission by paper or by tape-to-tape may be refused upon implementation of an online point of service system~~ will not be accepted by the bureau or the bureau's pharmacy benefits manager.

~~(L)~~(M) ~~Claimant reimbursement for medications shall not exceed the bureau's established rate for the medication regardless of the price paid by the claimant~~ be in accordance with rule 4123-6-26 of the Administrative Code. Claimant requests for reimbursement shall comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service. ~~Upon implementation of a point of service system, claimant~~ Claimant reimbursement may be limited to the following situations:

- (1) Claimants whose claims are not allowed on the date of service, but are subsequently allowed;
- (2) Emergency situations where an enrolled pharmacy provider with point-of-service capabilities is not available;

(3) Claimants who reside out of the country.

~~(M)~~(N) The bureau may formulate medication utilization protocols for select conditions or diseases consistent with one or more of the following current medical texts and peer reviewed medical literature:

~~(1) Compendia consistent of the following:~~

~~(a) "United States Pharmacopoeia—Drug Information";~~

~~(b) "American Medical Association Drug Evaluations";~~

~~(c) "Drug Facts and Comparisons"; or,~~

~~(2) Peer reviewed medical literature.~~

Compliance with the established protocols shall be monitored through the on-line, point-of-service adjudication system. Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's refusal to reimburse for such medications.

~~(N)~~(O) A "pharmacy provider" designation and provider number can be obtained by a provider who meets all the following criteria:

(1) Has a valid "terminal distributor of dangerous drugs" as defined in section 4729.024729.01 of the Revised Code if located within Ohio; or an equivalent state license if located outside of Ohio; and,

(2) Has a valid drug enforcement agency (DEA) number; and,

(3) Has a licensed registered pharmacist in full and actual charge of a pharmacy; and,

(4) Has the ability and agrees to submit bills at the point of service. All state and federal laws relating to the practice of pharmacy and the dispensing of medication by a duly licensed pharmacist must be observed.

~~(O)~~(P) The bureau may contract with a ~~vendor~~pharmacy benefits manager to perform drug utilization review and on-line bill processing, maintain a pharmacy provider network and prior authorization program for medications, and provide management reports. The bureau or its vendor may also contract rebate agreements with drug manufacturers, ~~and be responsible for maintaining a drug formulary~~. The bureau may utilize other services or established procedures of

the ~~vendor~~pharmacy benefits manager which may enable the bureau to control costs and utilization and detect fraud.

~~(P)~~(Q) The bureau may identify circumstances under which it may consider reimbursement for pharmacist professional services (also known as cognitive services) when payment for such services results in a measurable, positive outcome. The bureau shall be responsible for developing the criteria which will be used to assess the compensability of billed pharmacist professional services. The bureau shall be responsible for developing the structure of the reporting of the measurable outcomes used to justify the payment of pharmacist professional services, which may include reimbursement for the dispensing fee component. The amount that could be reimbursed for pharmacist professional services shall be determined by the ~~bureau's medical policy department~~bureau.

~~(Q)~~(R) The bureau shall ~~secure the services of~~ retain a registered pharmacist licensed in the state of Ohio to act as the full-time pharmacy program director to assist the bureau in the review of drug bills. ~~The bureau may employ a staff pharmacist on a full or part-time basis or may contract for such services.~~ The ~~pharmacist~~pharmacy program director may assist the bureau in determining the appropriateness, eligibility, and reasonableness of compensation payments for drug services. The bureau may ~~consult~~adopt a drug formulary with the recommendation of the bureau's pharmacy and therapeutics committee, which shall be a subcommittee of the stakeholders' health care quality assurance advisory committee established by rule ~~4123-6-22~~4123-6-21.2 of the Administrative Code, and may consult with the committee on the development and ongoing annual review of the drug formulary and other issues regarding medications.

~~(R)~~ The bureau will publish line by line billing instructions in a health care provider billing and reimbursement manual. ~~At least thirty days written notice will be given prior to required changes in billing procedures.~~

Replaces: 4123-6-21

Effective: 10/1/05

Prior Effective Dates: 1/27/97, 1/1/03

March 15, 2011

Dear Interested Parties:

We are seeking feedback from you and your members on BWC's proposed revisions to Ohio Administrative Code (OAC) rules 4123-6-21 and 4123-6-21.1 (see attached). We are revising the existing outpatient medication rule (4123-6-21) to update reimbursement practices and clinical guidelines for the pharmacy department. The revisions to the self-insuring employers outpatient medication rule (4123-6-21.1) aligns the changes in the outpatient medication rule with those that govern self-insuring employers.

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 revisions and determine whether to accept them. If approved by the board, we will submit the revised rules to the Joint Committee on Agency Rule Review for final review and incorporation into the OAC.

How to submit feedback

- We have created an e-mail box for you to provide your feedback. Please submit your comments to 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 **April 6, 2011**. We appreciate your timely review and response.

We will give your insights and suggestions serious consideration. We plan to submit the rule proposals to the BWC Board of Directors' Medical Services & Safety Committee for a first reading on March 24, 2011. We will then present it to the committee for a second reading and possible vote on April 28, 2010.

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,

Johnnie L. Hanna, R.Ph., MBA
Pharmacy Program Director

2011 Common Sense Initiative Checklist (BWC Rules)

(Note: The below criteria apply to existing and newly developed rules)
OAC 4123-6-21; OAC 4123-6-21.1

Rule Review

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

Citation: R.C. 4123.66; R.C. 4121.441; R.C. 4123.35

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

What goal(s): The proposed changes update reimbursement practices and clinical guidelines for the BWC pharmacy department and self insuring employers, introducing a clinical perspective to BWC's outpatient medication rules that is intended to improve outcomes for injured workers.

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 revisions to OAC 4123-6-21 and OAC 4123-6-21.1 were e-mailed to the Medical Services Division's lists of stakeholders for review and comment on March 15, 2011, with comments due back by April 6, 2011. A draft of proposed rule OAC 4123-6-21 was also discussed at BWC's P&T Committee meeting on March 9, 2011.

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
Outpatient Medication Rules
OAC 4123-6-21 and 4123-6-21.1

Introduction

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

BWC proposes amending its outpatient medication rule, OAC 4123-6-21, to institute a clinical focus to the Bureau's method of operation. These amendments address the clinical issues of patient safety by giving the Bureau and its pharmacy department more control over how medications are reimbursed. In addition, the amendments proposed define the qualifications required of BWC's pharmacy program director to be consistent with those recently adopted in OAC 4123-6-21.2. The overarching concern of the outpatient medication rule can be found in paragraph (A), which allows the Bureau to

. . . deny a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of an allowed condition in a claim...

BWC proposes to revise rule OAC 4123-6-21 to by introducing a clinical perspective that is intended to improve outcomes for injured workers. This increased focus on the treatment being provided to an injured worker will be a part of the determination of whether or not a drug or class of therapeutic drugs is reasonably related to or medically necessary for treatment of an allowed condition in a claim.

Since self-insuring employers are required to pay benefits equal to or greater than BWC, where applicable BWC is proposing to make changes parallel to those proposed in OAC 4123-6-21 in the Chapter 4123-6 self-insuring employers' outpatient medication rule, OAC 4123-6-21.1.

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 therefore."

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, including in paragraph (A)(8) "[d]iscounted pricing for . . . all pharmaceutical services."

Proposed Changes

BWC requests that the proposed changes to rule OAC 4123-6-21 be adopted. The proposed changes to the rule update reimbursement practices and clinical guidelines for the pharmacy department. The proposed changes also address safety issues concerning reimbursement for particular noncertified physicians and utilize the pharmacy benefits manager

to prevent non-sterile drugs from being dispensed to injured workers. The most significant proposed changes to OAC 4123-6-21:

1. Provide that noncertified prescribers who prescribe outpatient medications may not be reimbursed, with three exceptions.
2. Create a separate category for drugs that may be prior authorized by and reimbursed through the bureau's pharmacy benefits management vendor:
 - a. Parenteral drugs (*e.g.*, drugs that are not administered in the body through the digestive tract but rather through intravenous or intramuscular injection) compounded in a physician's office that do not comply with United States Pharmacopeia (USP) standards for preparation of sterile parenteral compounded drug.
3. Add a defined dispensing fee component of three dollar and fifty cents.
4. Define the product cost as the lesser of the average wholesale price minus nine percent, or the maximum allowable cost.
5. Reinforce that BWC does not reimburse third party pharmacy billers.
6. Require pharmacy providers to:
 - Maintain a signature log verifying receipt of applicable covered medications;
 - Include prescriber information, to include the prescriber's national provider identifier (NPI) or the drug enforcement administration (DEA) number, on bills submitted electronically for payment;
 - Not pay or offer to pay any "kickback" to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services;
 - follow all applicable billing procedures as written in the Bureau's billing and reimbursement manual in effect on the billed date of service.
7. Allow the Bureau to determine the maximum allowable cost for single source and multi-source generic drugs.
8. Allow an injured worker to be reimbursed for a brand-name drug where it has been demonstrated that its generic counterpart (and other comparable generic medications within that therapeutic class) has caused allergic reactions or adverse events;
9. Allow the Bureau to deny refills requested before ninety percent of any published days supply limit has been utilized, with overrides for documented exceptions
10. Defines the role and qualifications of the bureau's pharmacy program director consistent with OAC 4123-6-21.2.

Where applicable, BWC is also proposing to make changes parallel to those proposed in OAC 4123-6-21 in the Chapter 4123-6 self-insuring employers outpatient medication rule, OAC 4123-6-21.1 (see, *e.g.*, items 3-9 above).

Stakeholder Involvement

BWC's proposed revisions to rules OAC 4123-6-21 and 4123-6-21.1 were e-mailed to the following lists of stakeholders on March 16, 2011 with comments due back by April 8, 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

A draft of proposed rule OAC 4123-6-21 was also discussed at BWC's P&T Committee meeting on March 9, 2011.

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

4123-6-21.1 Payment for outpatient medication by self-insuring employer.

(A) Medication must be for treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer.

(B) Medication ~~must~~may be prescribed by ~~the physician of record in the industrial claim or by the treating physician, or by such other~~any treating provider ~~as may be~~ authorized by law to prescribe such medication.

(C) Drugs covered are limited to those that are approved for use in the United States by the food and drug administration (FDA) and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) A self-insuring employer may approve and reimburse for various drugs as a part of a comprehensive treatment plan submitted by the physician of record or a treating physician when reasonably related to and medically necessary for treatment of the allowed conditions in the claim, provided that such approval and reimbursement shall not constitute the recognition of any additional conditions in the claim even if such drugs are used to treat conditions that have not been allowed in the claim.

(E) Payment for medications to pharmacy providers shall include both a product cost component and a dispensing fee component.

(1) The product cost component shall be the lesser of the following: maximum allowable cost established under paragraph (O) of this rule, if applicable, or the average wholesale price of the commonly stocked package size ~~plus or minus a percentage~~nine percent. ~~The percentage amount added or subtracted from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.~~

(2) The dispensing fee component shall be ~~a flat rate fee determined by the bureau~~three dollars and ~~subject to annual review~~fifty cents, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider pursuant to rule 4123-6-46 of the Administrative Code.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component of two dollars and fifty cents for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN), or other proprietary code that serves to group together pharmaceutically equivalent products (defined as products that contain the same active ingredients in the same strengths, dosage

forms, and routes of administration), per rolling twenty-five days. Exceptions to the single dispensing fee are:

- (i) Cases where the physician has prescribed a second round of medication within the twenty-five day period
- (ii) Cases where the physician has changed the dosage;
- (iii) Cases where the medication did not last for the intended days supply;
- (iv) Cases where the medication has been lost, stolen or destroyed;
- (v) Controlled substances (which are limited to two dispensing fees per twenty-five days);
- (vi) Cases where the self-insuring employer determines the limitations of this paragraph to be unnecessary under the specific circumstances.

(F) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined in paragraph (E) of this rule, unless the self-insuring employer has negotiated a payment rate with the provider pursuant to rule 4123-6-46 of the Administrative Code. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(G) The pharmacy provider shall:

- (1) Maintain a signature log verifying receipt of applicable covered medications;
- (2) Include prescriber information within bills submitted electronically to the self-insuring employer or its vendor for payment. The prescriber information must include the national provider identifier (NPI) or the drug enforcement administration (DEA) number;
- (3) Not pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services for which payment may be made by the self-insuring employer or its vendor or QHP under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;
- (4) Comply is required to follow all applicable line by line with all applicable billing instructions as published contained in the bureau's health care provider billing and

~~reimbursement manual in effect on the billed date(s) of service. At least thirty days written notice will be given prior to required changes in billing procedures.~~

(H) Claimant reimbursement for medications shall be in accordance with rule 4123-6-26 of the Administrative Code and shall at least be equal to the bureau's established rate for the medication, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider utilized by the claimant pursuant to rule 4123-6-46 of the Administrative Code, in which case the claimant reimbursement shall be at least the rate negotiated with the provider. Claimant requests for reimbursement shall comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service. Requests for reimbursement must be paid within thirty days of receipt of the request.

(I) Self-insuring employers must obtain a drug utilization review from a physician before terminating payment for current medications, as follows:

(1) Before terminating payment for current medications, the self-insuring employer shall notify all parties to the claim (including authorized representatives) and the prescribing physician, in writing, that a physician drug review is being performed, or has been performed, regarding the necessity and appropriateness of the continued use of current medications (by therapeutic drug class).

(2) The written notice shall inform all parties to the claim (including authorized representatives) and the prescribing physician that they have twenty-one days from receipt of the notice to provide additional information and/or medical documentation to justify the need for continued use of the medications (by therapeutic drug class).

(3) The self-insuring employer shall provide all medically related information regarding the medications to an independent physician reviewer for review and opinion as to the necessity or appropriateness of the medications. If the self-insuring employer has obtained an independent physician reviewer's report prior to sending the notice required by paragraph (I)(1) of this rule and subsequently receives additional information and/or medical documentation pursuant to paragraph (I)(2) of this rule, the self-insuring employer shall provide the additional information and/or medical documentation to the independent physician reviewer and obtain an addendum. The independent physician reviewer's report (and addendum, if applicable) shall address the medical rationale, necessity and appropriateness of the drug treatment in the control of symptoms associated with the allowed conditions in the claim.

(4) When the independent physician reviewer's report (and addendum, if applicable) indicates the drug treatment is not medically necessary or appropriate for treatment or in the control of symptoms associated with the allowed conditions in the claim, the self-insuring employer may terminate reimbursement for the medications (by therapeutic drug class) effective as of the date of receipt of the independent physician reviewer's report, or addendum if one is obtained, or in the case that a drug is in a therapeutic class that

requires a "weaning-off" period, such other date as agreed to by the prescribing physician and self-insuring employer.

(5) In the event the self-insuring employer terminates reimbursement for the medications as set forth in paragraph (I)(4) of this rule, the self-insuring employer or its authorized representative shall provide all parties to the claim (including authorized representatives) and the prescribing physician with a copy of the independent physician reviewer's report (and addendum, if applicable) and the self-insuring employer shall notify the employee and the employee's representative in writing of its decision to terminate. The employer's notification to the employee and employee's representative shall indicate that the employee has the right to request a hearing before the industrial commission.

(6) In the event there is a dispute as to whether the drug treatment is medically necessary or appropriate for treatment of the symptoms associated with the allowed conditions in the claim, the disputed matter shall be adjudicated in accordance with paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.

(J) Self-insuring employers may deny initial requests for a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for the treatment of the allowed conditions in a claim.

(K) Self-insuring employers may utilize medication utilization protocols formulated by the bureau for select conditions or diseases consistent with ~~one or more of the following~~ current medical texts and peer reviewed medical literature:

~~(1) Compendia consistent of the following:~~

~~(a) "United States Pharmacopoeia—Drug Information";~~

~~(b) "American Medical Association Drug Evaluations";~~

~~(c) "Drug Facts and Comparisons"; or,~~

~~(2) Peer reviewed medical literature.~~

Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's or self-insured employer's refusal to reimburse for such medications.

(L) Through internal development or through vendor contracts, self-insuring employers may implement a point-of-service adjudication system. Upon implementation, a self-insuring employer may require pharmacy providers to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the established bill processing system as a condition of reimbursement, and may refuse submission by paper or by tape-to-tape. Self-

insuring employers utilizing a point-of-service adjudication system may refuse to reimburse any third-party pharmacy biller that submits pharmacy bills on behalf of a pharmacy provider or that has purchased pharmacy bills from a pharmacy provider for subsequent submission to the self-insuring employer for payment.

(M) Self-insuring employers utilizing a point of service adjudication system may require prior authorization of drugs or therapeutic classes of drugs which appear on the bureau's published list of drugs or therapeutic classes of drugs for which prior authorization is required.

(N) Self-insuring employers utilizing a point-of-service adjudication system may apply the following dispensing limitations, adopted by the bureau, to medications approved and reimbursed by the self-insuring employer:

~~(1) The bureau may publish a list of drugs identifying those drugs that are considered "chronic" medications. Drugs not identified as chronic medications shall be considered "acute" medications.~~

~~(a) Acute medications may be limited by the self-insuring employer to a thirty-four day supply.~~

~~(b) Chronic maintenance medications may be limited by the self-insuring employer to a one hundred two day supply.~~

~~(2)~~ The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

~~(3)~~⁽²⁾ Requests submitted that exceed either the days supply limit or maximum quantity limit shall be denied; provided, however, that the pharmacy provider may still fill the prescription up to the days supply limit or maximum quantity limit, as applicable. Denials may be overridden by the self-insured employer in cases where medical necessity and appropriateness have been determined.

~~(4)~~⁽³⁾ Refills requested before ~~seventy-five~~ninety per cent of the days supply has been utilized will be denied, except in cases where the dosage of a ~~noncontrolled~~ drug has been ~~increased~~changed and has a new prescription number. Denials may be overridden by the self-insured employer for the following documented reasons:

(a) Previous supply was lost, stolen or destroyed;

(b) Pharmacist entered previous wrong day supply;

(c) Out of country vacation or travel;

(d) Hospital or police kept the medication.

(O) Self-insuring employers utilizing a point-of-service adjudication system may apply the maximum allowable cost list of the point-of-service adjudication system vendor ~~to~~for multi-source medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations:" in effect on the billed date(s) of service. For single source drugs, self-insuring employers utilizing a point-of-service adjudication system may utilize as a maximum allowable cost the drug's average wholesale price minus nine percent.

(P) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication for which has an applicable maximum allowable cost price ~~single source or multi-source medications exist that are pharmaceutically and therapeutically equivalent, as defined in paragraph (O) of this rule,~~ shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price ~~plus or minus the bureau established percentage of the dispensed brand name drug minus nine percent.~~ However, the self-insuring employer or its vendor may approve reimbursement of the dispensed brand name drug at the average wholesale price of the drug minus nine percent if the following circumstances are met:

(1) The injured worker has a documented, systemic allergic reaction which is consistent with known symptoms or clinical findings of a medication allergy; and

(2) The injured worker has been prescribed, and has tried, other A code drugs in the therapeutic class and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.

~~(P)~~(Q) A self-insuring employer has sufficient grounds to refuse to pay for the dispensing of drugs and other medications when a pharmacy provider fails to observe any state or federal law relating to his or her professional licensure or to the dispensing of drugs and other medication.

Prior Effective Date: 2/1/10

KORT M. GRONBACH, M.D.

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Employment

ADENA REGIONAL MEDICAL CENTER, Chillicothe, Ohio

Staff Pain Medicine Physician and Anesthesiologist, July 2006 to present

OHIO STATE BOARD OF PHARMACY, Columbus, Ohio

Medical Practice Consultant and Expert Witness, April 2010 to present

STATE OF OHIO BUREAU OF WORKERS COMPENSATION, Columbus, Ohio

Pain Physician member Prescribing & Treating committee, 2010 to present

Education

UNIVERSITY OF CINCINNATI, Cincinnati, Ohio

Fellowship, Pain Medicine, June 2006

Residency, Anesthesiology, June 2005

MOUNT CARMEL MEDICAL CENTER, Columbus, Ohio

Transitional Year, June 2002

ROSS UNIVERSITY SCHOOL OF MEDICINE, Dominica, West Indies

Doctor of Medicine, June, 2001

THE OHIO STATE UNIVERSITY, Columbus, Ohio

Bachelor of Science, Nutrition, September 1993

Qualifications

AMERICAN BOARD OF ANESTHESIOLOGY

Board Certified Pain Medicine, 2007

Board Certified Anesthesiology, 2006

THE OHIO PRESCRIPTION DRUG ABUSE TASK FORCE, Columbus, Ohio

Representative for the Ohio State Medical Association, 2010

Physician leader for the Governor's task force

ROSS COUNTY DRUG ABUSE COALITION, Chillicothe, Ohio

Physician member on Pain Medicine, May 2010 to present

THE OHIO STATE MEDICAL ASSOCIATION, Columbus, Ohio

Prescription Drug Abuse Advisory Committee, May, 2010 to present

ADENA REGIONAL MEDICAL CENTER, Chillicothe, Ohio

Medical Director, Hopewell Myofascial Pain Program, 2007-2008

CME and Palliative Care Committee, 2009 to present

Ethics committee, 2010 to present

THE OHIO SOCIETY OF ANESTHESIOLOGIST

Chair, Subcommittee on Pain Medicine 2011 to present

Subcommittee on Resident Relations, 2006 to 2008

Resident Component Executive Board and Government Affairs, 2005

Resident Component Executive Board, Secretary and Treasurer, 2002

Resident Delegate to ASA House of Delegates, 2002, 2003, and 2005

THE GREATER CINCINNATI PAIN SOCIETY, Cincinnati, Ohio

Executive board, CME Director, and Secretary 2004-2006

CHI PHI FRATERNITY ALUMNI ASSOCIATION, Columbus, Ohio

Advisory Board, 1996 to present

-Currently Vice President

Housing Trustee, 1996 to 2009

UNIVERSITY OF CINCINNATI, DEPARTMENT OF ANESTHESIOLOGY

Education Committee, 2004-2006

Chief Resident, 2004-2005

Resident Advisory Committee, 2004-2005

Executive and Clinical Competence Committee, 2004-2005

Teaching

OHIO UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE

Clinical Assistant Professor, Pain Medicine & Anesthesiology, 2008 to Present

ADENA SENIOR HEALTH FAIR

Pain Management of Shingles, lecture 2010

ROSS COUNTY MEDICAL SOCIETY

Clinical Management of Chronic Pain, lecture, 2008

ST. JUDE MEDICAL

Consultant/Lecturer, Neuromodulation for Chronic Pain States, 2009 to present

MEDTRONIC

Consultant/Lecturer; The Role of Intrathecal Baclofen in Spasticity,
Functional Anesthetic Discography, 2008 to 2010

UNIVERSITY OF CINCINNATI, DEPARTMENT OF ANESTHESIOLOGY

Clinical instructor of Anesthesiology, 2003 to 2006

Epidural Role in the Operative Patient, Grand rounds, 2006

Platelet Function and Dysfunction, Grand rounds, 2005

Professional

American Society of Interventional Pain Physicians, and Ohio Chapter

American Society of Anesthesiologist, and Ohio Chapter

Ohio State Medical Association, Ross County Medical Society

Personal

Works a small family tree farm with wife and three children having a special interest in developing sustainable wildlife habitat. Member and volunteer with St. Mary church and school in Lancaster. Tactical Physician involved with training exercises and call-outs for Fairfield County S.W.A.T. Active Mason, Lancaster lodge #57, F & A.M.

CHRONIC PAIN MANAGEMENT AND THE ISSUES OF OPIOID ABUSE AND DIVERSION

Kort M. Gronbach, M.D.

Prevalence of Pain

- 1 out of every 4 Americans suffer from recurrent pain (day-long bout of pain/month)
- 1 in 5 individuals over the age of 65 report pain persisting for more than 24 hours in the preceding month
 - 6 in 10 report pain persisting > 1 year
 - About 20% general population in developed countries suffer chronic pain.
 - Chronic pain = pain in 3-6 months of the previous 6-12 months
- Given the accepted estimate of 20% population dealing with some form of chronic pain, this gives Ohio 2.3 million people in chronic pain.
- Pain is considered the 5th vital sign and the responsibility of due attention from providers
- Patients suffering in pain have an expectation of just and unprejudiced care.

Multimodal Treatment



Domains for Pain Management Outcome: The 4 A's

- **Analgesia**
- **Activities of Daily Living**
- **Adverse Events**
- **Aberrant Drug-Taking Behaviors**

Principles of Responsible Opioid Prescribing

- **Patient Evaluation**

- Pain assessment and history
- Directed physical exam
- Review of diagnostic studies
- Analgesic and other medication history
- Personal history of illicit drug use or substance abuse
- Personal history of psychiatric issues
- Family history of substance abuse/psychiatric problems
- Assessment of co-morbidities
- Accurate record keeping

Initial Visits

- Initial comprehensive evaluation
- Risk assessment
- Prescription monitoring assessment
- Urine drug test
- Opioid treatment agreement
- Opioid consent form
- Patient education

Medical Records

- **Maintain accurate, complete, and current medical records**
 - Medical Hx & PE
 - Diagnostic, therapeutic, lab results
 - Evaluations/consultations
 - Treatment objectives
 - Discussion of risks/benefits
 - Tx and medications
 - Instructions/agreements
 - Periodic reviews
 - Discussions with and about patients

FSMB Model Policy

Basic Tenets

- Pain management is important and integral to the practice of medicine
- Use of opioids may be necessary for pain relief
- Use of opioids for other than a legitimate medical purpose poses a threat to the individual and society
- Physicians have a responsibility to minimize the potential for abuse and diversion
- Physicians may deviate from the recommended treatment steps based on good cause
- Not meant to constrain or dictate medical decision-making

Epidemic in Rx Drug Abuse and Diversion

- For the first time, in 2007 unintentional drug poisoning deaths exceeded motor vehicle traffic fatalities as the leading cause of injury death in Ohio.
- 4 Ohioans die every day due to unintentional drug poisoning
- 350% increase in the number of deaths from 1999 to 2008
- Opioids were involved in at least 37% of all drug poisoning deaths in 2008 in Ohio
- 400% increase between 1998 and 2008 of substance abuse treatment admissions for those aged 12 and over reporting abuse of prescription pain relievers

Prevalence of Misuse, Abuse, and Addiction

- Out of the total pain patient population:
 - 40% Misuse
 - 20% Abuse
 - 2-5% Addiction

Factors Contributing to Opioid Overuse/Abuse

- Overaggressive marketing of opioid analgesics
- Poor medical judgment
- Underuse of tools to assess and monitor patients at risk
- Off-label use of opioid analgesics
- Addiction
- Criminal intent – black market opioids

Conclusion

- Use of opioids may be necessary for pain relief
- Balanced multimodal care
 - Use of opioids as part of complete pain care
 - Anticipation and management of side effects
 - Judicious use of short and long acting agents
 - Focus on persistent and breakthrough pain
 - Maintain standard of care
 - H&P, F/U, PRN referral, functional outcomes, documentation
- Treatment goals
 - Improved level of independent function
 - Increase in living
 - Decreased pain

Presentation to Medical/Safety Committee

I. PTD and Death Claim Transfers

In order to ensure proficiency and consistency of claims management and better service to our customers, BWC recently centralized/regionalized certain complex claim types. Specifically, death claims are centralized and managed by our Columbus Service Office and PTD claims are regionalized and managed by our Dayton and Youngstown Service Offices. In each of these offices specialized team (s) have been assigned these more complex claims types.

This transition began 12/27/2010 and all claims movement was completed by 1/21/2011.

PTD Claims: Approximately 24,500 PTD claims were reassigned to our Dayton and Youngstown Offices.

Death Claims: Approximately 4,300 death claims (with active dependent benefits) were reassigned statewide to our Columbus Office.

In order to accomplish this centralization/regionalization of certain complex claim types and ensure adequate caseload size and span of control statewide, internal caseload leveling and virtual claims management support has been utilized.

II. Virtual Nurse Pool

In our world of ever-changing staffing levels, the primary mission is to support the BWC enterprise effort. The optimal goal is to provide excellent internal and external customer service.

By leveraging the available statewide resources, four nurse pools will be created. Each service office will be assigned to one of the four nurse pools. All medical referrals will be sent to the respective nurse pools and work will be completed based on priority triage requirements. For consistency, compliance, and equitable workload distribution the four nurse pools will be managed by Injury Management Supervisors that have RN licensure.

Phase one of this transition plan will begin on 4/25/2010.

Ohio Safety Congress and Expo, OSC 2011, March 29-31, 2011

Next week, March 29 through 31, BWC will be hosting the 81st Ohio Safety Congress and Expo (OSC) at the Greater Columbus Convention Center. Since its inception, OSC has been a highly informed educational event celebrating safety by Ohio's employers, workers, trade organizations, unions, and BWC. It is a time in which Ohio's public, private, and self-insured employers send their employees and purchasing representative to receive quality professional development and continuing education credit, to network, and to learn about the latest advances in safety gear, personal protective equipment, and industrial and construction equipments from vendors from all over the world.

The 2011 OSC will feature several well-recognized speakers, 150 educational sessions, and over 200 vendors. The general sessions will feature Administrator Stephen Buehrer, John Howard, Director of the National Institute of Occupational Safety and Health, and David Rife, from White Castle, as keynote speakers. The program for educational sessions this year is delivered in staggered tracks over two days. This is based on feedback from past OSC participants. The program will provide the same variety of sessions and topics while lessening the participants' overall time away from their businesses. The staggered tracks will allow participants enough time to switch between the different tracks and more time to spend on the Expo floor.

So far we have over 3,200 registered participants. We wish to thank all the external volunteers who worked with us very diligently to put the OSC program together. We also wish to thank OSC's vendors whose contributions continue to pay for the operational costs of this event.

BWC-NIOSH Workshop, March 15, 2011

On March 15, 2011 BWC and NIOSH held a workshop at the NIOSH Alice Hamilton Laboratories in Cincinnati. Attendees from the majority of NIOSH's locations nationwide participated in the workshop through video-conference. BWC presented to the attendees on topics related to BWC safety services and programs as well as recent projects dealing with data analysis of injury and claim data. NIOSH presented on several recently-completed as well as on-going research projects in the areas of occupational safety and health, epidemiology, ergonomics, workers' compensation economics, outreach programs, and training and education. Part of the workshop involved exchanging ideas relative to potential future project collaborations that can benefit the trucking, wholes sale and retail, agriculture, and manufacturing sectors.

Date	March 2011	Notes
3/24/11	1. Claimant Reimbursement Rule 4123-6-26 (2nd read)	
	2. Vocational Rehab fee schedule (1st read)	
	3. Outpatient Medication Reimbursement Rule (1st read)	
	4. SI Outpatient Medication Reimbursement Rule (1st read)	
	5. C-9 rule changes (1st read)	
	6. Best Practices in Pain Management	
	7. Customer Services Report	
	April 2011	
4/28/11	1. Vocational Rehab fee schedule (2nd read)	
	2. Outpatient Medication Reimbursement Rule (2nd read)	
	3. SI Outpatient Medication Reimbursement Rule (2nd read)	
	4. C-9 rule changes (2nd read)	
	5. Formulary Rule (1st read)	
	6. Medical Services Report	
	May 2011	
5/26/11	1. Formulary Rule (2nd read)	
	2. Lock in Pharmacy Rule (1st read)	
	3. Customer Services Report	
	June 2011	
6/15/11	1. Medical & Service Provider Fee Schedule (1st read)	
	2. Lock in Pharmacy Rule (2nd read)	
	3. Medical Services Report	
	July 2011	
7/28/11	1. Medical & Service Provider Fee Schedule (2nd read)	
	2. Customer Services Report	
	August 2011	
8/25/11	1. Inpatient Hospital Fee Schedule (1st read)	
	2. Medical Services Report	
	September 2011	
9/29/11	1. Inpatient Hospital Fee Schedule (2nd read)	
	2. Customer Services Report	
	October 2011	
10/27/11	1. Committee Charter review (1st read)	
	2. Inpatient Hospital Fee Schedule (2nd read)	
	3. Medical Services Report	
	November 2011	
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	
	December 2011	
12/14/11	1. Conform Fee Schedules with new Medicare rates	
	2. Ambulatory Surgical Center Fee Schedule Rule (2nd read)	
	3. Outpatient Hospital Fee Schedule (2nd read)	
	4. Medical Services Report	
	January 2012	
1/xx/12	1. Customer Services Report	
	February 2012	
2/xx/12	1. Medical 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	+10%	\$677,000
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	N/A	N/A
2011	Mar/Apr	June, 2011	+1.42%	+\$452,122

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	N/A	N/A
2011	Jan (final)			

* Emergency rule to add new codes