

BWC Board of Directors
Medical Services and Safety Committee Agenda

Wednesday, June 15, 2011

William Green Building

Level 2, Room 3

1:00 P.M. – 2:00 P.M.

Call to Order

Jim Matesich, Committee Vice-Chair

Roll Call

Mike Sourek, Scribe

Approve Minutes of May 26, 2011 meeting

Jim Matesich, Committee Vice-Chair

Review and Approve Agenda*

Jim Matesich, Committee Vice-Chair

New Business/ Action Items

1. Motions for Board consideration:
 - A. For Second Reading
 1. 4123-3-23 Limitations on the filing of fee bills
Freddie Johnson, Interim Chief Medical Services & Compliance
 - B. For First Reading
 1. Outpatient Medication Formulary Rule 4123-6-21.3
Johnnie Hanna, Pharmacy Program Director
(possible waive of second reading)

Discussion Items**

1. Medical Services Report
Freddie Johnson, Interim Chief Medical Services & Compliance
John Hanna, Pharmacy Program Director
2. Committee Calendar
Jim Matesich, Committee Vice-Chair

Adjourn

Jim Matesich, Committee Vice-Chair

Next Meeting: Thursday, July 28, 2011

* Agenda subject to change

** 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)

Rule 4123-3-23

Rule Review

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

Citation: R.C. 4123.52

2. The rule achieves an Ohio specific public policy goal.
What goal(s): This rule change is being made to conform with a recent change in statute, and will bring the timeframe for submitting bills to BWC more in line with other payers.

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 e-mailed to the BWC Medical Division's list of stakeholders on May 13, 2011. Stakeholders were given until May 23, 2011, to submit comments. Additionally, on May 12, 2011 this was directly provided to the Ohio Hospital Association. Further discussion of the rule was held with OHA on June 6, 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
Limitations on the Filing of Fee Bills
OAC 4123-3-23

Introduction

OAC 4123-3-23 has provided for many years that fee bills for medical or other services rendered to injured workers must be submitted to BWC or the Industrial Commission within two years of the date of service or 6 months from the date of the final order allowing the claim.

HB 123 will amend Ohio Revised Code 4123.52 effective July 29, 2011 to provide by statute that in general, fee bills for medical or vocational rehabilitation services rendered in a claim must be submitted BWC or the Industrial Commission within one year of the date on which the service was rendered or one year after the date the services became payable under Ohio Revised Code 4123.511(I), whichever is later.

BWC therefore proposes to rescind current OAC 4123-3-23 and replace it with a rule that conforms to the amended statute, and includes several additional provisions/exceptions. This will bring the timeframe for submitting bills to BWC more in line with other payers.

Background Law

As amended by HB 123 effective July 29, 2011, Ohio Revised Code 4123.52 paragraphs (A), (B), and (C) shall provide in relevant part as follows:

Sec. 4123.52. (A) . . . The commission shall not make any modification, change, finding, or award which shall award compensation for a back period in excess of two years prior to the date of filing application therefor. ~~This~~

(B) Notwithstanding division (A) of this section, and except as otherwise provided in a rule that shall be adopted by the administrator, with the advice and consent of the bureau of workers' compensation board of directors, neither the administrator nor the commission shall make any finding or award for payment of medical or vocational rehabilitation services submitted for payment more than one year after the date the services were rendered or more than one year after the date the services became payable under division (I) of section 4123.511 of the Revised Code, whichever is later. No medical or vocational rehabilitation provider shall bill a claimant for services rendered if the administrator or commission is prohibited from making that payment under this division.

(C) Division (B) of this section does not apply to requests made by the centers for medicare and medicaid services in the United States department of health and human services for reimbursement of conditional payments made pursuant to section 1395y(b)(2) of title 42, United States Code (commonly known as the "Medicare Secondary Payer Act").

Proposed Changes

The major substantive changes proposed for the Limitations on the Filing of Fee Bills rule OAC 4123-3-23 are:

- In general, fee bills for medical or vocational rehabilitation services rendered in a claim must be submitted to BWC or the Industrial Commission within one year of the date on which the service was rendered or one year after the date the services became payable under Ohio Revised Code 4123.511(I), whichever is later;
- A self-insuring employer may, but is not required to, negotiate with a provider to accept fee bills from the provider for a different time period;
- The one year limitation does not apply to the following situations, which will still be subject to the two year jurisdictional limitation in Ohio Revised Code 4123.52(A):
 - Requests made by the Centers for Medicare and Medicaid Services for reimbursement of “conditional payments” made pursuant to the Medicare Secondary Payer Act;
 - Fee bills submitted outside the one year timeframe because of BWC or MCO error;
 - Fee bills submitted outside the one year timeframe because the fee bills were initially submitted to and paid by different third-party payer or the injured worker or state or federal program and that payer, injured worker, or program has determined that it is not responsible for reimbursement of the services.
- Requests for additional payments adjustments on fee bills that were initially submitted timely under this rule must be made within one year and seven days of the adjudication of the initial fee bill by the bureau.
- Finally, Paragraph (A) through (C) of the rule applies to bills with dates of service on or after July 29, 2011. Paragraph (D) applies to bills with dates of service on or after September 12, 2011.

Stakeholder Involvement

BWC’s proposed changes to the Limitations on the Filing of Fee Bills rule OAC 4123-3-23 were e-mailed to the following lists of stakeholders on May 13, 2011, with comments due back by May 23, 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 May 12, 2011 this was directly provided to the Ohio Hospital Association. Finally, on June 6, 2011 additional discussion on the rule was conducted with the Ohio Hospital Association.

4123-3-23 Limitations on the filing of fee bills.

(A) Except as otherwise provided in this rule, fee bills for medical or vocational rehabilitation services rendered in a claim shall be submitted to the bureau or commission for payment within one year of the date on which the service was rendered or one year after the date the services became payable under division (I) of section 4123.511 of the Revised Code, whichever is later, or shall be forever barred.

(B) A self-insuring employer may, but is not required to, negotiate with a provider to accept fee bills from the provider for a time period other than as set forth in paragraph (A) of this rule.

(C) Paragraph (A) of this rule shall not apply to the following; however, division (A) of section 4123.52 of the Revised Code shall still apply:

(1) Requests made by the centers for medicare and medicaid services in the United States department of health and human services for reimbursement of conditional payments made pursuant to section 1395y(b)(2) of title 42, United States Code (commonly known as the "Medicare Secondary Payer Act");

(2) Fee bills submitted outside the timeframe set forth in paragraph (A) of this rule due to administrative error by the MCO or the bureau;

(3) Fee bills submitted outside the timeframe set forth in paragraph (A) of this rule because the fee bills were initially submitted to a patient, different third-party payer, or state or federal program that reimburses for medical or vocational rehabilitation services and that patient, payer, or program has determined that it is not responsible for the cost of the services.

(D) Requests for additional payment on fee bills that were initially timely submitted under this rule shall be submitted within one year and seven days of the adjudication of the initial fee bill by the bureau or shall be forever barred.

(E) Paragraphs (A) through (C) of this rule shall apply to bills with dates of service on or after July 29, 2011. Paragraph (D) of this rule shall apply to bills with dates of service on or after September 12, 2011.

Effective: _____

To be rescinded

4123-3-23 Limitations on the filing of fee bills.

~~Fee services rendered in a claim shall be filed with the bureau or commission within two years of the date on which the service was rendered or shall be forever barred.~~

~~In cases where the claim was disallowed and by later action is allowed, such fee bills shall be filed within six months from the date of the mailing of the final order allowing the claim or be forever barred. Thus, a fee bill to be timely filed, must be filed either within two years from the date services were rendered or within six months from the date of the mailing of the final order of allowance of claim, whichever period of time is longer, or be forever barred.~~

Effective: 11/28/03

Prior Effective Dates: 1/1/64, 1/9/67, 1/16/78



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 Rule 4123-3-23

Line #	Rule #/Subject Matter	Stakeholder	Draft Rule Suggestions	BWC Response	Resolution
1.	Rule 4123-3-23	Steve Hatton Risk Manager SuperValu Holdings Inc.	This proposal has my full support	Accepted	No change required
2.	Rule 4123-3-23	Sharon Burchfield Cincinnati Children's Hospital Medical Center Injury Management Specialist	I would like this to be 6 months that is what private carriers use insurance purposes less confusing.	When BWC evaluated moving the timeframe a number of options were evaluated and feedback taken. Based on the feedback, it was determined that BWC's objectives could be achieved with a 1 year limitation, with minimum impact to providers. Additionally, this timeframe is in line with Medicare timeline for provider bill submission.	Maintain recommendations
3.	Rule 4123-3-23	(Ms) Marty J. Embry Corporate Claims Manager Direct Energy - US Home Services 3300 Bingle Road Houston, Texas 77055	I believe the injured worker should be protected from a collection or subrogation claim from the vendor should the vendor fail to submit his billing timely. This protection would extend to approve WC claims.	BWC agrees with this comment. This protection is provided in the revision to ORC 4123.52 (B).	No change required

Line #	Rule #/Subject Matter	Stakeholder	Draft Rule Suggestions	BWC Response	Resolution
4.	Rule 4123-3-23	Bridget Viton Patient Accounts Analyst, Southwest General	Please advise if 4123-3-23 Limitations on the filing of fee bills is for all hospital services. If not please specify which services fall under this proposed change. Also does this in any way affect the time limit we have to file an appeal? When would this proposed change take place?	The rule does apply to all workers compensation related hospital services. If a fee bill has been submitted within the required timeframe and paid, appeals relative to the adjudication of the bill is not affected. The rule is being amended to reflect changes in the statute which is effective July, 2011. The rule itself will be affective in September 2011 depending on the JCARR process.	No change required
5.	Rule 4123-3-23	Stephen Duritsch MD Phys Med and Rehab	The proposed changes appear to be reasonable for my specialty practice. A year is fairly standard for a filing deadline and a timeframe that we can live with. I see no major issues.	Accepted	No change required

Line #	Rule #/Subject Matter	Stakeholder	Draft Rule Suggestions	BWC Response	Resolution
6.	Rule 4123-3-23	Nancy_Seymour@acmestores.com	<p>Thank you for the changes proposed in the draft of this rule on filing fee bills. I have always felt that one year was more than enough for a provider to submit a valid bill. The BWC has gone to great lengths to provide all the information a provider needs to bill it correctly the first time.</p> <p>I do, however, disagree with the wording of Section C. The current wording automatically grants an additional 365 days if the provider claims any one of the 3 exemptions and the language does not require the provider to prove their claim. I understand that Medicare conditional payments may need extra time, but the old rule should not take precedence in sections C2 and C3 for providers other than Medicare. Simply give them an additional 30 days and make that extension conditioned on if the provider give written proof as to the reason the bill was not submitted properly in the first place.</p> <p>If a provider refuses to avail himself of the information provided by the BWC and erroneously sends a bill to the BWC, the wrong TPA or self-insurer, we have only 30 days to deny the bill or request more information. Why should a provider be granted 335 additional days to act on that denial or to come up with the additional information when it would take them less than 10 minutes to look up the information on the BWC website and call the claims manager?</p>	<p>BWC understands the party's comments. Providers will have to show the actual existence of the exceptions as provided in paragraph C of the rule revisions. Given the limited circumstances and situations in which this will occur BWC did not feel that further restricting this timeframe is necessary.</p>	<p>No change required</p>

Line #	Rule #/Subject Matter	Stakeholder	Draft Rule Suggestions	BWC Response	Resolution
7.	Rule 4123-3-23	Charles Cataline Senior Director, Health Policy The Ohio Hospital Association 155 East Broad St., FL 15 Columbus, Ohio 43215	OHA recommends adding an exception for instances where a bill paid by another payer is retroactively recouped because the payer determines the services were work-related. OHA also recommends BWC be specific about the amount of time the exceptions in Sec. (C) allow. Based on similar Medicaid and Medicare rules OHA recommends 180 days from the defining circumstance.	<p>BWC discussed with OHA their concerns. Pursuant to that discussion BWC agreed that the potential of a patient paying their own bills and then determining that they should not have paid the same was a possibility. BWC further agree that the injured worker's determination bill should be paid by workers compensation could come after one year and should also be addressed in the rule revisions.</p> <p>Once it was explained that in instances where exceptions as indicated in paragraph C existed, then the provider as with Medicare has 2 years to address the outstanding bill the responder did not feel that the 180 days was necessary.</p>	Change made to paragraph C 3 where the word "patient" was added to the rule.
8.	Rule 4123-3-23	Karen Stombaugh Risk Analyst Momentive Specialty Chemicals Inc. 180 E. Broad St. Columbus, OH 43215	This is a good idea. It matches some of the other insurance carrier's requirements that bar payment long after service date and repeated recovery attempts by billing companies and collection services.	Accepted	No change required

Line #	Rule #/Subject Matter	Stakeholder	Draft Rule Suggestions	BWC Response	Resolution
9.	Rule 4123-3-23	Tradesmen International Rhonda Hollis Injury Counselor 9760 Shepard Road Macedonia, Ohio 44056	I totally agree with the new rule. One year is long enough to submit a bill for payment.	Accepted	No change required
10.	Rule 4123-3-23	Deborah Lee [DebLee21@sbcglobal.net]	I find no problem with the limitation. As a small provider, I attempt to bill as soon as the service is rendered. I would be out of business if I waited a year.	Accepted	No change required
11.	Rule 4123-3-23	Cecilia M. Nigg Workers Comp Acct. Manager	<p>We are a MRI facility and sometimes the patient will present Health Ins at time of service. The patient does not mention this is work related it's after the Health Ins. has paid and we call to collect their co-ins they say this is work related.</p> <p>We cannot submit a claim to MCO or Self Insured if we have no idea this is work related. It could have been that at the time of service the injury is brand new and the patient thinks they can file Health and wait until their claim becomes allowed.</p> <p>Again if we have no clue this is work related then we would not have sent a HCFA to MCO or Self Insured Co.</p> <p>We understand if claim is new and has not been allowed yet or claim is in Hearing status as long as we file a HCFA to MCO or SI Co then it is on file and we will not be denied for timely filing.</p> <p>As you know claims in hearing can go on for over a year depending on all the appeals.</p> <p>Do not change this rule from 2 years to 1 year.</p>	The current language addresses the stakeholders concerns as it states under Paragraph (A) or 1 year after the date the services become payable and also under Paragraph (C) (3)	No change required

Line #	Rule #/Subject Matter	Stakeholder	Draft Rule Suggestions	BWC Response	Resolution
12.	Rule 4123-3-23	Caroline T. Lewin, Ph.D. Clinical Psychologist 218 Collier Ridge Drive Columbus, OH 43235	This revision looks reasonable to me.	Accepted	No change required
13.	Rule 4123-3-23	Scott Dowling 22300 S. Woodland Road Shaker Heights, Ohio 44122	The proposed rule seems fair and reasonable.. The exceptions appear to cover all the possibilities of legitimate delay in billing.	Accepted	No change required
14.	Rule 4123-3-23	Lee Ann Zingg Supervisor, Bill Processing Review	<p>Thank you for the opportunity to respond on the proposal of 4123-3-23 Limitations on the filing of fee bills. This will be a positive change for self insured payers as well as the Bureau. There are several states that currently have Worker’s Compensation regulations on timely submission of medical billings. Mississippi, Michigan, New Mexico, and Oregon are some of the states that have a timely filing statute that assist the payers with ensuring we are paying medical bills timely and appropriately. As a self insured payer Claims Management Inc. timely and accurate payments are imperative to our organization. With this new legislation timely submissions will be needed by the providers and is an issue we sometimes struggle with. We have recently paid bills from services that were performed as far back as 2004.</p> <p>In the states that currently have legislation this allows self insured payers to be effective at paying timely and ensuring that the claimants are receiving the services that they need. Mississippi has a section in their fee schedule that also allows for a payer to reduce</p>	BWC understands the respondent’s suggestion.	

Line #	Rule #/Subject Matter	Stakeholder	Draft Rule Suggestions	BWC Response	Resolution
			<p>the amount owed to the provider if they do not bill timely. This is not something that is widely utilized and this is not something as a payer we would like to see in the Ohio statute, but only for information for your committee.</p> <p>The only suggestion is that the section for self insured payers could possibly be a little clearer as to the ability to apply this regulation. If the section could state that this does apply to self insured employers and they then have the ability to negotiate with the providers. This may assist with helping the providers understand that this regulation does apply to self insured as well.</p> <p>Thank you again for your time and allowing us to submit comments/suggestions.</p>	<p>However, there is no need to included the suggested language as OAC 4123-6-01.1 was specifically placed in chapter 6 BWC rules to inform self-insured employers that all rules as written pertains to self-insured activity unless there is a specific exception stated. In this case the only exception to the 1 year rule is when self-insured employers and providers have negotiated a different payment time. Otherwise the rule is applicable as written.</p>	<p>No change required</p>
15.	Rule 4123-3-23	Carol Fitzpatrick TriHealth/Patient Accounting Bethesda and Good Samaritan Hospitals	<p>I disagree with the change. I believe it should remain 2 yrs as it has been. We have too many patients who don't notify us that it should be Workers Comp or just trying to get the correct information from the patients regarding if they are State Funded, or Self Insured, etc. is sometimes very difficult. Again, it is another cut back that is set out only to hurt the Providers who have already provided the treatment in good faith that they would be reimbursed.</p> <p>Even though you have "exclusions" from the one year filing limitation, anytime one of these occurs it will require documentation etc. to prove why we are past the one year filing limit, and that again puts more work on us and the delay of payments.</p>	<p>The current language addresses the stakeholders concerns as it states under Paragraph (A) or 1 year after the date the services become payable and also under Paragraph (C) (3)</p>	<p>No change required</p>

Line #	Rule #/Subject Matter	Stakeholder	Draft Rule Suggestions	BWC Response	Resolution
16.	Rule 4123-3-23	Anna Briant Summit Psychological Associates, Inc. 37 N Broadway Akron, OH 44308	<p>Most insurance companies have the 1 year or shorter timely filing deadline which all provider offices must meet. My only concern with BWC changing theirs or not having provisions in the change for the following scenario:</p> <p>1. Provider has timely submitted claims and is trying to get a DX code added (appropriate to the situation) and BWC denies the addition of the DX code. The patient then contacts their lawyer and then the case goes to litigation. It will take longer than a year for a decision in the lawsuit to be made. Sometimes, we are asked to resubmit afterwards litigation.</p>	When the original bill is submitted within a 12 month period it meets the criteria of timely filing. Refer to Paragraph (A)	No change required
17.	Rule 4123-3-23	Denise K. Evans Workers' Compensation Manager Staffmark	I agree with this change, in most all other states they are required to submit bills within one year or less. This change will allow better tracking and understanding for all parties.	Accepted	No change required
18.	Rule 4123-3-23	Bryn Vallongo Workers' Compensation Administrator The Rudolph/Libbe Companies P.O. Box 716 Toledo, OH 43697	<p>I am responding to proposal of OAC 4123-3-23 in regards to fee bill limitations. I am in agreement with this proposal. Most health insurance plans have a one year limit on when fee bills can submit, and I think it makes sense for the BWC to adopt the same policy. 12 months is a long time to submit a bill, there is really no other place I can think of that allows bills to be received within two years. It is hard to administratively manage claims when bills can be received late, it affects settlements at times.</p> <p>I would love to see this proposal adopted.</p>	Accepted	No change required

Summary of feedback:

- I. **14 out of the 18 comments are in agreement with this Rule. Numbers in the below table reflect the associated comment line on the proceeding grid.**

Providers	4, 5, 10, 12, 13
Employers	1, 2, 3, 6, 8, 9, 17, 18
Professional Organization	
Third Party Administrator	14

8 Provider Comments: one year may be an issue if,

- They do not know that the service should be billed to workers comp
- Potential timing of coverage/allowance litigation through IC.
- Impacts to their appeal rights

8 Employer Comments:

- Paragraph C exceptions – giving too much additional time
- Protection for IW from collections and subrogation if the provider’s or their vendor fails to bill timely.

1 Professional Organization Comment

1 Third Party Administrator Comment

- II. **4 Negative comments. Numbers in the below table reflect the associated comment line on the proceeding grid.**

Providers	11, 15, 16
Employers	
Professional Organization	7
Third Party Administrator	

2011 Common Sense Initiative Checklist (BWC Rules)

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

Rule 4123-6-21.3

Rule Review

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

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

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

What goal(s): This rule allows the bureau to improve the efficiency and safety of treatment for injured workers by implementing a formulary of approved medications. A formulary provides the prescriber with information regarding any restrictions or limitations to the use of an approved medication. The use of a formulary enhances medication safety by allowing for a thorough review of the clinical merits of new medications before they are approved for reimbursement. It also provides a statutory process by which the bureau may remove or limit the inappropriate utilization of medications in keeping with FDA recommendations as well as those found in current clinical literature and best medical practices.

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 e-mailed to the BWC Medical Division's list of stakeholders on April 18, 2011. Stakeholders were given until May 13, 2011, to submit comments. The proposed rule was also discussed in the BWC Pharmacy & Therapeutics 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 Formulary Rule
OAC 4123-6-21.3

Introduction

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

The overarching concern of OAC 4123-6-21, the outpatient medication payment 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 amend rule OAC 4123-6-21.3 as adopted by the BWC Board of Directors on May 27th.

BWC proposes to amend rule OAC 4123-6-21.3 to permit temporary reimbursement of non-formulary drugs which have been clinically documented to be medically necessary. These non-formulary drugs must be either new drug entities recently approved by the FDA or existing drugs that have received a new indication from the FDA. The clinical documentation submitted to the Bureau must demonstrate the existence of a unique condition for which the non-formulary product is the only reasonable therapeutic option for treatment. These drugs may be reimbursed for up to 180 days while the formulary approval process is conducted.

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.”

BWC requests that the proposed rule OAC 4123-6-21.3 be adopted.

Stakeholder Involvement

BWC’s proposed amendment to rule OAC 4123-6-21.3 was e-mailed to the stakeholders who had previously raised concerns about the absence of an emergency type allowance for coverage of a non-formulary product. They have not provided a written response as of this date.

4123-6-21.3 Outpatient Medication Formulary.

(A) The administrator hereby adopts the formulary indicated in appendix A to this rule, developed with the recommendation of the bureau's pharmacy and therapeutics committee, effective September 1, 2011.

(B) The formulary indicated in appendix A to this rule shall constitute the complete list of medications that are approved for reimbursement by the bureau for the treatment of an occupational injury or disease in an allowed claim. ~~Drugs~~Except as otherwise provided in paragraph (F) of this rule, drugs not listed in the formulary are not eligible for reimbursement by the bureau.

(C) The formulary indicated in appendix A to this rule also contains specific reimbursement, prescribing or dispensing restrictions that have been placed on the use of listed drugs. The formulary will be reviewed annually and updated as necessary. The most current version will be electronically published by the bureau.

(D) Based upon current medical literature and generally accepted best clinical practices the bureau's pharmacy and therapeutics committee shall evaluate and make recommendations to the administrator regarding the addition, deletion or modification of coverage of medications listed in the formulary. Requests for pharmacy and therapeutics committee action on a specific drug may be initiated by the bureau's administrator, chief of medical services, chief medical officer, or pharmacy director.

(E) The bureau shall develop policies to perform an expedited review process for clinically or therapeutically unique medications. The bureau shall also develop policies to address the timely review of new drug products.

(F) Notwithstanding paragraph (B) of this rule, in cases of medical necessity supported by clinical documentation and evidence of need the bureau may, with prior authorization, reimburse for new drugs approved for use in the United States by the food and drug administration (FDA) on or after the effective date of the formulary, and for new indications approved by the FDA on or after the effective date of the formulary for existing drugs that are not on the formulary, for a period not to exceed one hundred eighty days from the adjudication date of the first prescription for the requested drug.

Effective: 9/1/11

B2= Stakeholder Feedback Formulary Rule 4123-6-21 3

Stakeholder	Feedback	BWC Response
Sandy Simons Genex Services Wayne, PA	Just a personal comment about the proposed rule -- This is GREAT! Received 4-21-11	Acknowledgement and thanks. Sent 5-9-11
Lora Miller Director of Gov. Affairs and Public Relations Ohio Council of Retail Merchants	Who reviewed the drugs -- the P&T Committee? Received 4-26-11	Yes, the formulary was reviewed by the P&T committee. The list includes all drugs that were approved by BWC for the past 3 years. Sent 4-26-11
Dr. Stephen Duritsch Rehabmed Associates Troy, OH	As I scanned the list, the formulary is fine and is consistent with my normal practice. Received 5-2-11	Acknowledgement and thanks. Sent 5-9-11
Cory Wedding Special Projects Manager Modern Medical Inc. Lewis Center, OH	Does this proposed rule also affect Self Insured employers? Received 5-2-11	This rule and formulary is for state fund claims only. An SI employers would not be precluded from using it, but they are not required to use it. Sent 5-2-11

B2= Stakeholder Feedback Formulary Rule 4123-6-21 3

Stakeholder	Feedback	BWC Response
<p>Dr. Scott Dowling Psychiatry Shaker Heights, OH</p>	<p>I have reviewed the formulary re psychiatric related meds. Generally it is a fine list. Suggestions I would make are:</p> <ol style="list-style-type: none"> 1. Include Aricept with the Alzheimer's meds. Nomedra is approved only for moderate or advanced Alzheimers; Aricept is approved for mild or moderate. Most patients are initially seen in mild or moderate state and only Aricept is approved for treating them. 2. Non barbituate sedatives: psychiatrists often use Trazodone as a non-habituating sedative. There is the single side effect of priapism that seems to scuttle its use by some practitioners.. but there are few reports of this and general usage is great. 3. Non Barb sedative: Halcion should be removed from the list. It has no advantages over others listed, is habituating and has serious side effects. 4. Antianxiety: Please include clonazepam for its ease of use, slow onset (no sudden benzo effect) and acceptability. 5. Antianxiety: Remove Librium.. little used. Other agents better. <p>Received 5-3-11</p>	<p>The medications listed in the formulary include all of those that have been prescribed for injured workers since 2008. Aricept has not been used during this period. We will take this recommendation to the P&T Committee at the June meeting. Both trazadone and clonazepam are on the formulary and as such may be used for out of class or non-FDA listed indications. We will consider the recommendation to delete librium and halcion at the June P&T Committee meeting.</p> <p style="text-align: right;">Sent 5-9-11</p>

B2= Stakeholder Feedback Formulary Rule 4123-6-21 3

Stakeholder	Feedback	BWC Response
Phil Fulton, Vice President Ohio Assn. of Claimants Counsel Columbus	Our concern was that there was no appeal process to challenge a medication not part of the formulary. At the very least, we believe there should be a procedure before the Administrator's designee. Received 5-4-11 Stakeholder asked that his continuing objection be noted. Received 5-13-11	While the P&T Committee, an advisory board made up of clinicians, makes recommendations for the formulary, the formulary itself is adopted by BWC via the Chapter 119 rulemaking process. The rulemaking process is designed to furnish the public with a venue to provide input. A further mechanism such as appeal to an Administrator's designee is unnecessary. Sent 5-13-11.
Bob Kendis, President Ohio Assn. of Claimants Counsel Columbus	I had two concerns. One was that there was no provision for the exception or the rare case where a claimant needs the meds that have not been approved because he is allergic to the approved meds. Second, please consider a process for an emergency exception to the formulary where the situation is unusual and the committee has not met yet to consider the med. This would provide some protection for the injured worker until a more formal decision can be made. Received 5-4-11 ☒	The formulary includes all drugs that were approved by BWC for the past 3 years. It is extremely unlikely that an IW would be allergic to every drug on the formulary in the drug class appropriate for treatment of the IW's allowed conditions. Paragraph (E) of the proposed formulary rule provides that BWC shall develop policies "to perform an expedited review process for clinically or therapeutically unique medications" and to "address the timely review of new drug products." This is meant to cover unusual or emergency situations. Sent 5-13-11
Toni Premier MSS BWC	All of the cardiac meds require prior auth or related claim allowance. All of the pulmonary/asthma meds do NOT. This type of medication is frequently abused within the billing system and they are generally expensive. They also apparently changed their minds about the proton pump inhibitors because they do not need to be claim allowance related either. Received 5-6-11	We will recommend that the pulmonary and asthma drugs be moved into the relatedness category at the June P&T Committee meeting. Recommendations for action to restrict the use of the proton pump inhibitors and histamine-2 receptor antagonists will also be on the agenda at that meeting. Sent 5-9-11

B2= Stakeholder Feedback Formulary Rule 4123-6-21 3

Stakeholder	Feedback	BWC Response
<p>Alan B Levy, MD Chair, Psychiatric Practice Committee Ohio Psychiatric Physicians Assn.</p>	<p>Thank you for making your proposed formulary available online for review. As a psychiatrist, I noticed 2 omissions which would potentially compromise patient care. While Lithium is an approved medication for mood stabilization, there are some patients who cannot tolerate the immediate-release form of this medication and can only take a controlled release form such as Eskalith CR or Lithobid. I would ask that you consider adding one or both of these long-acting forms of Lithium. Secondly, Adderall (and Adderall XR) was left off the formulary for treatment of ADHD. I would ask that Adderall be permitted as some patients respond preferably to this compound. Received 5-11-11</p>	<p>In our formulary, unless otherwise specifically restricted, all dosage forms of a drug are included. Restrictions and limitations on dosage form or quantity will be noted in the last column for each drug. To your specific questions, since Lithobid is an extended-release form of lithium carbonate, it is allowed. Eskalith and Adderall are both listed on the formulary. Sent 5-13-11</p>

Medical Services Division Board Report

The Medical Services Division (Medical Services) coordinates BWC's health-care services through a network of providers and managed care organizations (MCOs). In order to effectively coordinate health-care services, Medical Services works with and actively supports Customer Services, Pharmacy and other internal business units in setting claims policies and claims management approaches. The goal is to ensure and/or support prompt, quality, cost-effective health care for injured workers to facilitate their early, safe and sustained return to work, quality of life and claim resolution. To realize this goal, the division uses claims management pricing and payment strategies that benefit injured workers and employers while ensuring that those benefits are related to the workers' compensation injury or injuries.

To achieve the above business goals, the Medical Services Division has a focus of 5 business objectives:

1. Develop, maintain and execute quality and cost-effective medical, vocational rehabilitation and pharmaceutical benefits plans and associated fee schedules;
2. Develop and support the appropriate managed-care processes, including contract management and training;
3. Establish and maintain a quality pool of medical and vocational service providers to make certain injured workers have access to quality, cost-effective and timely care;
4. Establish, maintain and implement claims, medical and vocational policies, rules and training to direct handling of claims from inception to resolution.
5. Evaluate and process medical bills, guaranteeing proper and timely payment consistent with benefits plan criteria.

The Medical Services report for this month highlights a few activities related to the 1st, 2nd, 3rd and 5th business objectives.

I. Develop, maintain and execute quality and cost-effective medical, vocational rehabilitation and pharmaceutical benefits plans and associated fee schedules;

Fee Schedule Development

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

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 annually reimburses over 70,000 providers for medical services rendered to Ohio's injured workers. An equitable and competitive fee for the right medical service is essential to maintain a quality provider network across the wide range of necessary provider disciplines.

Medical Services Division Board Report

In April Medical Services began our annual fee schedule development for all of our reimbursement schedules which utilizes Medicare reimbursement methodologies as the foundation of the schedule. We have engaged in this process since 2007. Included in your materials is a fee schedule history chart which provides a summary overview of past fee schedule development timelines and estimated impact of their adoption. Four of the five schedules utilize Medicare reimbursement methodologies as the foundation from which the Ohio BWC schedules are developed.

1. The Professional Providers and Medical Services Fee Schedule,
2. The Hospital Inpatient Fee Schedule,
3. The Hospital Outpatient Fee Schedule, and
4. The Ambulatory Surgical Centers Fee Schedule.

Medical Services staff has been at this time focusing on the Professional Providers and Medical Services Fee Schedule development. Our internal staff has reviewed over 13,000 reimbursement codes called common procedure terminology codes or CPT codes for short reference. You will hear more about our development methodology, as well as the meaning and application of CPT codes as we are planning to present in July to this Board, BWC's annual recommendations for changes to the fee schedule.

Medical Services utilizes the services of a consultant to analyze related Medicare reimbursement methodologies and changes which serves as the foundation for BWC's development of the Hospital Inpatient and Outpatient, as well as the Ambulatory Surgical Centers fee schedules. Currently, our consultant is focused on analyzing the proposed Medicare Hospital Inpatient rule which was made available in early May. Additionally, she is in the process of analyzing BWC's inpatient bill data from the previous year to develop specific recommendations for updates to the next inpatient fee schedule, which we are planning to present to this Board as part of the September meeting agenda.

Medical Services is constantly engaging providers and others in gathering data and information which we are able to utilize in developing appropriate benefit plans and fee reimbursement levels. As part of that effort, BWC in May met with the executive director and another representative of the Ohio Association of Ambulatory Surgical Centers (ASCs) to begin early discussions on potential updates to the next ASC fee schedule, which has a target effective date of April 1, 2012. Specifically, given ASCs do not present cost data to Medicare which assists us in establishing an appropriate adjustment level to the Medicare base rate, BWC and the ASC are working together to address that data deficiency. At the meeting we discuss ASCs' ability to provide quality data and cost data. We also requested procedural and service data to determine if there was opportunity to expand the types of services that may be safely performed in the ASC setting.

Medical Services Division Board Report

II. Develop and support the appropriate managed-care processes, including contract management and training

1. Enhancing Drug Utilization Review Process (DUR)

In order to simplify the DUR referral process and to ensure that BWC is paying for the proper medicines for the allowed industrial injury, BWC has created a referral form that has specific criteria for drug review referrals, as well as to focus the review on pertinent medical documents in the file to support the reviewer. The form creates a consistent statewide standard for the DUR program as well as to streamline the process. Feedback and responses have been positive when shared with the MCO Medical Directors, MCO Quality of Care Committee and BWC Field Operations. The form is in the final review stage and we anticipate implementation in the next quarter to allow time for training and communication with BWC and MCO staff as well as the overall provider community.

2. Medication Therapy Management Program - Pilot Project

This project is to initiate a pharmacy based Medication Therapy Management (MTM) pilot project directed at treatment of chronic pain. The intent of this project is to demonstrate the effectiveness of a pharmacy based medication therapy management program in improving outcomes in both the fiscal as well as clinical dimensions of the BWC pharmacy program.

Chronic pain treatment was chosen due to its prevalence in the workers compensation environment. Unlike with commercial insurance where pain related drugs represent less than 10% of total prescription costs, over 50% of the Bureau's pharmacy benefit costs are for pain management drugs. More importantly an injured worker's return to work is nearly always predicated upon effective pain management. It would seem that a successful MTM program directed at improving the treatment of chronic pain presents us with the potential for a double win in both the fiscal as well as clinical dimensions.

Presently we are in the process of finalizing an agreement to permit data transfer to the University of Toledo. This data will permit the biostatistician attached to the project to project outcomes and return on investment from the project. We anticipate that the project will be initiated by late Fall.

III. Establish and maintain a quality pool of medical and vocational service providers to make certain injured workers have access to quality, cost-effective and timely care

Provider Development Activity

1. Dental Provider Recruitment Initiative

Analysis of BWC's participating dentists showed a total of 2,045 dentists in the system. That number reflected 1,785 dentists within Ohio, with 989 actively enrolled and 781

Medical Services Division Board Report

certified. As a result of the low numbers this provider group was identified as a key group to implement a recruitment strategy. Thus, in February, 2011, BWC mailed approximately 6,000 fliers to non-BWC certified dentists licensed in Ohio. The goal we have as a measure of success is to increase the number of certified dentist by a minimum of 20%.

By mid-May, the team had completed a follow-up with 5 counties where there were no network dentists and 8 counties which had no BWC certified dentists. As of June, the team had completed follow-up with 600 providers and a plan to execute on 150 additional contacts prior to the end of the month. The outreach efforts to date have resulted in 34 newly certified dentists. The provider relations staff will continue to outreach, as well as create a communication plan with newly certified dentists to assist them into the workers compensation system.

2. May 11, 2011 - Provider Meeting

The Medical Provider Stakeholder/Interested Party biannual meeting was held on May 11, 2011. The objective of this meeting, which occurs twice a year, is to keep BWC service provider partners informed about changes to rules and/or bureau policies to ease their adoption of the same. This meeting affords BWC the opportunity to create a stronger partnership with the provider community thereby enhancing the Provider Relations' business unit's outreach and recruitment efforts.

We had over 55 attendees signed in with a cross section of provider associations well represented. There were 10 associations signed in which included:

1. International Association of Rehabilitation Providers (IARP)
2. Ohio Association of Rehabilitation Facilities (OARF)
3. Ohio Orthotic/Prosthetic Assn.
4. Ohio Physical Therapy Assn.
5. Ohio State Chiropractic Assn.
6. Ohio Psychological Assn.
7. Ohio Society of Anesthesiologists
8. Ohio Podiatric Medical Assn.
9. Ohio State Medical Assn.
10. Ohio Dental Assn.

In addition, there were 34 independent providers and six MCOs in attendance.

The Administrator provided comments and updates. Medical Service and the Pharmacy staff provided updates on recent and relevant policy and rule changes including such items as the recent treatment authorization request and outpatient medication rules change. Additionally, overviews of project activities such as Dental providers recruitment, provider recertification, performance measurement development, the International Classification of Diseases v10 project, just to name a few were covered.

Medical Services Division Board Report

The next meeting is scheduled for November 9, 2011 from 1:30 -3:30 pm in the William Green Building.

Developing Provider Performance Measurements

1. Medical Providers Measurement Development (WILMAPC)

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

In summary, the program provides an option to a state agency employee who has been injured at work to receive 100% of their salary¹ or the current workers compensation indemnity rate during a lost time claim. Where an injured employee selects a provider from the WILMAPC approved provider panel to manage their workers' compensation claim they will receive 100% of their salary. If an injured worker opts to select a provider outside the panel, they will have their claim managed under the workers' compensation system exclusively and receive the standard workers' compensation indemnity benefit for a lost time claim. A webpage is provided on DAS's website which provides program details and is used by injured workers to locate an approved provider to address their workers compensation medical needs.

The approved provider panel has approximately 11,000 providers. Providers can also go to the DAS webpage where a detail description of each provider performance metrics is found. As the program has progressed, provider awareness and desire to participate has continued to grow. This is evidenced by the fact that a number of providers who were not initially invited to join the panel have requested inclusion and have been included on the panel. The fact that providers are willing to be subjected to the measurement is viewed as a positive in relation to the identification of the appropriate measures and the validation of the same. Since its inception, the panel has managed about 1,100 state agency workers compensation claims. Initial results of program data indicate that approximately 750 different providers were involved in the care of workers in those claims.

Providers are being measured on 4 key metrics. The four metrics are:

1. Absence Duration 40%
2. Release Return to work (RTW) 30%
3. Relapse Rate 20%
4. Average Medical Costs 10%.

¹ 100% of salary reflect program of salary continuation or occupational injury leave.

Medical Services Division Board Report

After each quarter of performance, BWC calculates the rates after a 90 day run out period and the results are published for each of the providers to review on a DAS secure website. BWC in May provided to the WILMAPC group the 1st year composite provider performance results. The table below provides an overview of the results of providers' 1st year performance with the number of claims reflected with respect to each of the performance categories. The 1st year performance indicated that pursuant to the provider measurement approximately 7.3% or 103 would potentially be removed from the panel for unacceptable performance.

Performance Category	Providers	Claims
Exceptional	56	516
Acceptable	1045	397
Opportunity for Improvement	208	397
Unacceptable	103	116

Once the results for the first year has been reviewed and fully analyzed, BWC will be setting forth our next strategy steps for full development and rollout of a Blue Ribbon provider concept for the workers compensation environment as a whole. We anticipate that this strategy will be developed and submitted for approval to the administrator in late fall of 2011.

IV. Evaluate and process medical bills, guaranteeing proper and timely payment consistent with benefits plan criteria

Other Administrative Actions

1. ICD-10

The International Classification of Diseases (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. Every health condition can be assigned to a unique category and given a code. Effective October 1, 2013, the ICD-9 coding system will become obsolete as the general health industry will adopt ICD-10. The US Department of Health and Human Services has mandated the replacement of the ICD-9 code sets used by the medical community to be replaced by ICD-10. Although HIPAA is requiring ICD-10 reporting for all entities, Ohio BWC is exempt from this mandate. However, if we decide not to convert, this would leave BWC as a separate health provider without health industry support. If BWC continued to use the ICD-9 coding system, it would be an additional cost for providers as they would be required to carry two dual systems for bill processing. In addition, we would be unable to receive electronic data from providers, there would be a lag time in processing claims/bills, and our current fee schedule methodology would be unusable.

ICD-10 will radically change the way injury coding is currently done and will require very significant efforts to implement. In anticipation of the extensive work that will be necessary

Medical Services Division Board Report

to convert from ICD-9 to ICD-10, BWC has created a cross-enterprise project team and approach. The team has begun its work on this large-scope project and has recommended that the ICD-10 conversion be broken into five phases. The first phase, which began on January 1, 2011, consists of claimant eligibility file conversion, EDI (Electronic Data Interchange) transaction set migration, PDD (Procedures/Drug/Diagnosis) file conversion, ICD coding process change, bill process change, and several other sub-projects. Phase 1 is scheduled to conclude by October, 2011.

2. Encoder

The management of workers' compensation claims requires an automated process to assign appropriate International Classification of Disease (ICD) codes based on the accident description submitted on the First Report of Injury (FROI). In addition to automated ICD Processing, other medical coding features are also desired, specifically the automated coding of procedure codes through the Current Procedural Terminology (CPT) and Health Care Procedure Coding System (HCPCS). BWC is in the process of issuing an RFP for a vendor to provide a comprehensive software package to automate medical coding during the processing of injured worker claims. The software solution will involve integration with BWC's existing processes and software applications. The current vendor, McKesson Health Solutions, has informed BWC that they will not support the ICD-10 software and will no longer provide these services as of June 30th, 2012.

3. National Correct Coding Initiative (NCCI)

The National Correct Coding Initiative (NCCI) was developed by the Centers for Medicare and Medicare Services (CMS) to prevent payments from being made due to inappropriate CPT and HCPCS code assignment; eliminate unbundling of services; detect incorrect or inappropriate reporting of combinations of CPT and HCPCS codes; and curtail improper coding practices that lead to inappropriate increased payment.

NCCI edits are performed on every possible pairing of CPT and HCPCS codes. They were developed and continue to be enhanced using coding conventions defined in the American Medical Association's CPT manual; national and local policies and edits; coding guidelines developed by national societies; analysis of standard medical and surgical practice; and review of current coding practice.

In order to be compatible in the workers compensation environment, Ohio BWC plans to customize several of the Medicare NCCI edits. Once that process is complete, communication to our providers will occur regarding an expected implementation date. The edits will be then be applied to the bills submitted for payment. It is anticipated that OBWC will grant a 60 day grace period before denials begin.

12 - Month Medical Services & Safety Calendar

	June 2011	Notes
6/15/11	1. Amendments to Formulary Rule	
	2. Limitation on filing of fee bills (2nd read)	
	3. Medical Services Report	
	July 2011	
7/28/11	1. Medical & Service Provider Fee Schedule (1st read)	
	2. Lock in Pharmacy Rule (1st read)	
	3. Customer Services and Safety Report	
	August 2011	
8/25/11	1. Inpatient Hospital Fee Schedule (1st read)	
	2. Medical & Service Provider Fee Schedule (2nd read)	
	3. Lock in Pharmacy Rule (2nd read)	
	4. Medical Services Report	
	September 2011	
9/29/11	1. Inpatient Hospital Fee Schedule (2nd read)	
	2. Customer Services and Safety Report	
	October 2011	
10/27/11	1. Committee Charter review (1st read)	
	2. Inpatient Hospital Fee Schedule (2nd read)	
	3. Formulary Update	
	4. 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 and Safety 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	
Date TBD	1. Customer Services and Safety Report	
	2. Formulary Update	
	February 2012	
Date TBD	1. Medical Services Report	
	March 2012	
Date TBD	1. Vocational Rehab fee schedule (1st read)	
	2. Customer Services and Safety Report	
	April 2012	
Date TBD	1. Vocational Rehab fee schedule (2nd read)	
	2. Formulary Update	
	3. Medical Services Report	
	May 2012	
Date TBD	1. Customer Services and Safety 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	Sept/Oct			

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	Oct/Nov			

* 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	Oct/Nov			

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	Jan/Feb	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	Jul/Aug			

* Emergency rule to add new codes