

BWC Board of Directors
Medical Services and Safety Committee

Wednesday, February 23, 2011
Level 2, Room 3 (Mezzanine)
30 West Spring St.
Columbus, OH 43215

Members Present: James Hummel, Vice Chair
James Matesich
Thomas Pitts
Nicholas Zuk, *ex officio*

Members Absent: None (2 vacancies)

Other Directors Present: David Caldwell, Kenneth Haffey, Stephen Lehecka, Mark Palmer, Larry Price, Robert Smith, and Dewey Stokes

Counsel Present: Jason Rafeld, BWC General Counsel and Chief Ethics Officer
Pete Mihaly, Legal Counsel

Staff Present: Stephen Buehrer, Administrator
Abe Al-Tarawneh, Superintendent, DSH
Teresa Arms, Director, MCO Business and Reporting
Robert Balchick, M.D., Chief Medical Officer
Donald Berno, Liaison to Board of Directors
Karen Fitzsimmons, Rehab Policy Unit Director
Johnnie Hanna, Pharmacy Program Director
Freddie Johnson, Interim Chief, Medical Services
Michael Rea, Industrial Safety Administrator
Christine Sampson, Pharmacy Program Manager

Scribe: Michael J. Sourek, Staff Counsel

CALL TO ORDER

Mr. Hummel called the meeting to order at 2:40 PM, and the roll call was taken. All members were present.

MINUTES OF DECEMBER 15, 2010 MEETING

Mr. Hummel asked for any changes to the minutes of December 15, 2010. With no changes, Mr. Matesich moved to have the minutes of December 15, 2010 be approved, and Mr. Pitts seconded the motion. The motion passed with a 4-0 unanimous roll call vote.

REVIEW AND APPROVAL OF AGENDA

Mr. Hummel asked for any changes to the agenda. With no changes, Mr. Pitts moved to have the agenda approved, and the motion was seconded by Mr. Matesich. The motion passed with a 4-0 unanimous roll call vote.

NEW BUSINESS/ACTION ITEMS

1. Motions for Board Consideration

A. For Second Reading

1. OSHA/PERRP Cranes and Derricks

Mr. Al-Tarawneh and Mr. Rea presented the second reading of the amendments of Rule 4167-3-04.2 to the Medical Services and Safety Committee ("MSSC"). A copy of the proposed rule, executive summary, and common sense business regulation form ("CSBR") are incorporated into the minutes by reference and were provided to MSSC prior to the meeting.

Mr. Rea reported the Chapter 4167 rules were first adopted in 1992 under House Bill 308. The goal of these rules is to provide on-the-job training and safety protections for public employees. The first reading of this rule was in December 2010. The rule adopts the Occupational Safety and Health Administration ("OSHA") final rule for cranes and derricks. The amendments replace regulations established in 1971 and are a significant rewrite. The proposed rule covers every facet of crane operation, including: training; qualifications; certifications; procedures for working, powering, assembling and disassembling cranes; and addressing power hazards. OSHA led a work group in which Mr. Rea participated. Stakeholder feedback was also sought by the Bureau. Mr. Rea reiterated this proposed rule in no way affects Violations of Specific Safety Requirement rules.

Mr. Matesich inquired if there was any stakeholder feedback. Mr. Rea replied in the negative. Stakeholder feedback was sought from Ohio county engineers, Ohio county commissioners, the Municipal League, and Ohio townships.

Mr. Matesich moved that MSSC recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to amend Public Employment Risk Reduction Program Rule 4167-3-04.2 of the Administrative Code, "Amending the Standards," with the motion consenting to the Administrator amending Rule 4167-3-04.2 as presented at the meeting. Mr. Pitts seconded the motion, and the motion passed with a 4-0 unanimous roll call vote.

B. For First Reading

1. Claimant Reimbursement Rule 4123-6-26

Dr. Balchick, Mr. Hanna, and Ms. Sampson presented the first reading of the Claimant Reimbursement Rule 4123-6-26 to MSSC. A copy of the proposed rule, executive summary, and CSBR are incorporated by reference into the minutes and was provided to MSSC prior to the meeting.

Mr. Hanna provided an overview of the Pharmacy Department. Mr. Hanna began by noting the department was established in 2009 and reports to the Chief Medical Officer. The department oversees outpatient prescription benefits for injured workers ("IWs"). The prescriptions are for home use only. Drugs administered in a physician's office or inpatient drugs in acute care settings are processed by managed care organizations ("MCOs"). Further, the pharmacy program only covers medications for state fund claims, not self insured claims.

Mr. Hanna reported in 2010 the program covered nearly 1.5 million prescriptions in 68,000 claims at a cost of \$130 million. This cost represents 16.3% of all medical expenses paid in 2010. Since 2009, the Bureau has received over \$8.5 million in rebates. The program uses a Maximum Allowable Cost ("MAC") for generic products; in 2010, MAC accounted for over \$66 million in cost reductions from the Bureau's standard Average Wholesale Price. Prescriptions are processed electronically, with electronic payments to pharmacies through a contracted Pharmaceutical Benefits Manager ("PBM.") The PBM uses software with Bureau pricing and dispensing rules. In 2009, a new PBM was selected resulting in 75% reduction in time required for an IW to be reimbursed for out of pocket expenses, from over 30 days to less than 7 days.

Mr. Hanna noted last year a new metric was introduced to evaluate opioid medication dispensing. The PBM created a report that tracks every opioid dispensed to every IW each month, which are about 23,000 IWs. Another recently developed report monitors potentially dangerous doses of acetaminophen prescribed to IWs, which is greater than 4 g/day. The Bureau sends letters to providers when the issue is identified. Finally, a system enhancement was developed through the PBM to identify inappropriate dispensing of antibiotics. The result has been a monthly reduction of 3,500 prescriptions that would have been incorrectly charged to the Bureau at a cost in excess of \$20,000/month.

Mr. Hanna said prescriptions in the Bureau population, as expected, are skewed towards musculoskeletal and pain management medications. Oxycontin represented 12.8% of total program expenditures. The top 25 prescribed individual drugs, out of 3,000 dispensed in 2010, represented 51% of total expenditures. In terms of volume, Vicodin, as expected, is the most prescribed, and Percocet was second. These 2 medications represented 17.7% of the prescription volume, but because both are generic, these 2 drugs only represent 4% of prescription costs. Overall the generic utilization rate was 74%, which compared favorably to the industry standard of 75-80%. The impact of brand name medications is notable when 24 of the 25 top cost drugs are brand name products.

The Bureau's mission is to protect IWs and employers from loss as a result of workplace accidents, and to enhance the general health and well-being of Ohioans and the Ohio economy. To accomplish this mission, Mr. Hanna said the Bureau must provide IWs with high quality cost effective treatment outcomes that enable a prompt return to work. The Pharmacy Department believes this mission is best supported through focusing on the clinical perspective, with medical utilization a key factor. This strategy is built upon two initiatives: improving the utilization of medications and continuously monitoring their impact. The strategy will be a key contributor to driving improved treatments which lead to earlier return to work, and ultimately, lower costs for the employer.

Mr. Hanna indicated in the next few months, there will be 4 rules presented to MSSC for consideration. Each rule enhances medical utilization. The rules concern: improvements to the process of reimbursing injured workers; increasing controls on how and which outpatient medications are reimbursed; the establishment of a drug formulary, and creation of a program permitting IWs at risk for medication problems to be assigned to a specific pharmacy.

Mr. Hummel inquired if the Bureau had a drug formulary. Mr. Hanna replied there was a preferred drug program, not a true formulary. The preferred drugs are listed with dispensing limitations and restrictions, but drugs can be approved by the Industrial Commission if not preferred. Mr. Stokes inquired if there was a requirement of IWs to disclose to physicians all medications prescribed. He provided an example of an IW seeing a general practitioner who prescribes pain medication and another physician prescribing asthma or heart medications that are contraindicated. Mr. Hanna replied the problem is the Bureau is only aware of medications prescribed under the claim, and not the IW's entire profile. If the IW goes to only 1 pharmacy, then the practice described by Mr. Stokes occurs at the pharmacy. Mr. Stokes said he was of the understanding that Oxycontin was off the market. Mr. Hanna replied Oxycodone, the active ingredient in Oxycontin, is an excellent product, but misuse is an issue. There were a number of alternatives to Oxycontin, but when used properly, it was an effective drug. Mr. Hummel noted there were \$130 million in prescriptions paid, and \$8.5 million in rebates. He inquired if rebates were new to the Bureau. Mr. Hanna replied rebates were pursued by the Bureau in 2009. \$4 million in rebates were received in 2009 and \$4.5 million in 2010. Mr. Hummel said the rebates were significant.

Dr. Balchick presented the first reading of the Claimant Reimbursement Rule 4123-6-26. The rule originally passed in 1997. The rule provides reimbursement to IWs' for out of pocket expenses related to their claim. The proposed rule has important improvements but complex ramifications. A typical example is an IW treated at the emergency room. At that time, there has been no Bureau processing or assessment, The ER will collect insurance information available to the IW. However, when an IW goes to a pharmacy, the IW is faced with three choices: decline service; pay out of pocket; or allow their insurance plan to cover the service which usually requires a co-payment. Under the third option, the IW places the prescription on their group insurance, and the rule proposal allows for reimbursement of the co-pay regardless of the status of the insurance company payment. If the insurance company made a payment, the Bureau would reimburse the health insurer up to the amount that would have been paid under the rules. Shareholder feedback has been requested on the proposed rule, and responses will be presented next month.

Mr. Hummel inquired if an employer's health plan is paying for a prescription, whether the Bureau was reimbursing the employer. Dr. Balchick replied in the affirmative; the proposed rule has a provision to reimburse the IW and the employer's insurer as much as possible. Mr. Price inquired if the stakeholder feedback on the proposed rule could be provided as soon as the feedback was available. Dr. Balchick noted if significant issues are identified, the Bureau may choose to incorporate the suggestions into the second reading. Mr. Hummel inquired if someone may not be totally reimbursed, and Dr. Balchick replied in the affirmative. There were a lot of scenarios. Mr. Hummel asked if the Bureau could pay above the fee schedule. Dr. Balchick replied the Administrator has the authority to reimburse as he determines, but historically, the Bureau has only paid at the fee schedule unless compelled by the Industrial Commission. Mr. Hummel asked for the frequency of co-pays. Dr. Balchick reiterated there was \$240,000 in reimbursements made on 6,800 claims last year; the data did not allow for a breakdown on that number. His estimate was 10%, a small fraction leading to a potential shortfall either to the IW or the insurer. There have been discussions to enhance the system to capture this data. Mr. Mihaly added the statutory authority of the Administrator to reimburse medical expenses

is under Ohio Rev. Code Sec. 4123.66. Paragraph (A) gives the Administrator to adopt rules to fulfill this requirement, and Paragraph (B) indicates if an IW paid what the Bureau would have paid can be reimbursed. This proposed rule handles the issue if the insurer pays what the Bureau would have paid, and if the IW wants the co-pay reimbursed, the proposed rule provides a safety valve to reimburse both to the extent possible. Mr. Pitts asked if the last sentence was redundant and unnecessary, and Dr. Balchick agreed to make the change. Mr. Stokes asked if 25 or 30 drugs reimbursed by the Bureau were brand name. Mr. Hanna replied the top 25 drugs, in terms of cost, comprised 51% of total drug reimbursements in 2010; of the top 25 drugs, in terms of cost, 24 of those drugs were brand name. Mr. Stokes inquired if brand name meant there was no generic alternative. Mr. Hanna replied in the affirmative.

DISCUSSION ITEMS

1. Rehabilitation Services Commission Review

Mr. Johnson and Ms. Fitzsimmons presented an overview of the current relationship between the Bureau and the Rehabilitation Services Commission ("RSC"). A report is incorporated by reference into the minutes and was provided to MSSC prior to the meeting. Ms. Fitzsimmons in her position serves as the primary liaison for and manager of the Cooperative Agreement ("CA") in place between the agencies.

Mr. Johnson noted RSC is a state agency. RSC is charged with working with Ohio citizens with disabilities to achieve employment, independence, and Social Security disability determinations. RSC has 3 business areas: Bureau of Vocational Rehabilitation ("BVR"); Bureau of Services for the Visually Impaired ("BSVI"); and the Bureau of Disability Determination ("BDD"). The RSC area with which the Bureau mostly interacts is BVR. The Bureau provides vocational rehabilitation services to IWs to help facilitate a safe return to work. BVR provides many of the same rehabilitation services as BWC; however RSC's counselors have more expertise in managing cases which require more complex and longer term services, such as individuals with: mental health or developmental disabilities, paraplegia, quadriplegia, or traumatic head injuries.

Mr. Johnson said the CA was formally memorialized and initiated in 1985. The CA sets forth the cash amount which the Bureau will provide to RSC. The Bureau through RSC is able to leverage Ohio dollars for federal dollars at a 21.3% to 78.7% match. Since 2006, the Bureau has allocated \$605,407 allowing for a federal match of \$2.2 million; thus the total funds available are \$2.8 million RSC can use to assist severe IWs. The increase in funds allows the Bureau and RSC to expand service delivery to IWs thereby increasing their employability.

The Bureau and RSC in 2009 reviewed the CA's language resulting in several modifications to the fiscal year 2010 -2011 CA. First, a provision was made for the return to the Bureau of unused funds; before this change, any unused funds were kept by RSC in its general fund. Second, BWC increased the data elements required from RSC to further facilitate the Bureau's effort to perform a full evaluation of the program's activities and return on investment. The data elements also enable the Bureau to identify opportunities for enhancing the BWC/RSC/IW relationship and outcomes. Additional enhancements included: designation of RSC counselors to serve as liaisons for local Bureau service offices; improving the process for determining IWs and RSC consumers eligible to receive services paid under the CA's fund; and development of a "best practices" manual for

counselors at both agencies which provides necessary information of commonalities and differences in laws and policies.

Ms. Fitzsimmons indicated in order to receive services through the CA's fund, an injured worker must meet the Bureau's eligibility criteria. Using a purely systematic approach, the list of Bureau IWs was cross matched with RSC's consumers. The IT departments of both agencies worked together and developed a new cross match. Now, when RSC meets with a consumer, the consumer is asked if they have a Bureau claim; if so, eligibility is verified from the Bureau. Likewise, RSC removes consumers from their rolls once services are provided. Through this CA, an IW may receive services through a Bureau referral, MCO referral, or applying with RSC. Since RSC has more skills in dealing with complex cases, even though there are a relatively small number of IWs who need the special skill set of RSC counselors, the continuum of services afforded by the CA is invaluable.

Ms. Fitzsimmons provided the example of an IW off work due to carpal tunnel syndrome ("CTS") but suffers from unrelated multiple sclerosis ("MS"). A Bureau counselor would refer the case to RSC to evaluate mobility issues and determine a remedy allowing the IW independence in the workplace. The Bureau would most likely offer job placement assistance, and the RSC may purchase a scooter. Another example of this collaboration would be an IW with a vision impairment, which could be addressed by a BSVI counselor. One of the most common services obtained by IWs through RSC is training. RSC and Bureau counselors work together to develop a joint rehabilitation plan, and costs are shared; e.g., RSC pays the tuition, and the Bureau pays for books and supplies. As a result of the collaboration, fewer funds are expended from the BWC surplus fund.

Ms. Fitzsimmons reviewed current challenges in the relationship between RSC and the Bureau. While overall the relationship has been positive, there are efforts to improve outcomes. The primary challenge has been RSC's change in how consumers qualify for RSC services. RSC prioritizes their consumers into 3 categories: Most Significantly Disabled ("MSD"), Significantly Disabled ("SD"), or Other Eligible. Consumers identified as MSD are first eligible for services because of current resource levels. Many IWs are eligible for services, but most are not MSD. The number of IWs accepted for RSC services has declined by 50% since RSC established this prioritization. Consequently a significant portion of Bureau funds under the CA are not being used even though federal funds doubled through the last CA. The Bureau and RSC have been aggressively working to analyze the characteristics of both IWs who have been characterized as MSD and those wait listed. Mr. Johnson emphasized the Bureau was meeting with RSC staff and developing ways to use all funds available.

Mr. Palmer inquired if the \$605,000 figure was a fixed dollar amount or was \$2.8 million a cap. Mr. Johnson replied that the Bureau amount was a fixed dollar figure subject to change with each new agreement, which could change the matching amount and the \$2.8 million figure. RSC is charged with working with Ohio's disabled population, and RSC works with agencies other than the Bureau. The Bureau is trying to coordinate and meet the needs of both the Bureau and RSC. Mr. Zuk asked the source of referrals. Mr. Johnson replied that referrals can come from the Bureau or another source, but that an IW has to have an allowed claim and be determined feasible for vocational services. And while IWs may not be feasible for RSC services IWs can still obtain vocational

rehabilitation services from the Bureau. Mr. Pitts went back to the example of the IW having CTS as a recognized workers compensation claim, but also suffering from unrelated MS. He pointed out the Bureau would only address CTS, but not the MS, because MS was not an allowed condition. Mr. Johnson indicated, to an extent that is correct. However, Mr. Johnson noted there was \$2,000 that can be used to treat non-allowed conditions in a vocational rehabilitation program if those non-allowed conditions prevent an effective return-to-work or vocational services. Mr. Price inquired if the federal funds discussed were worth the effort. Mr. Johnson noted historically, the amount of the funds used was 85-90% of the amount available. Since RSC is not accepting as many IWs due to the MSD criteria, only 60-65% of the funds have recently been used. The Bureau believes the return on investment is worth pursuing as funds paid for services to Ohio's IW beyond the \$605,000 are not taken from the worker's compensation surplus fund. By changing the CA, Mr. Johnson reiterated that going forward unspent funds will either be used or roll forward in the RSC BWC fund for use in future years. Mr. Price followed up with a concern: RSC has reduced services by 50% to IWs. Mr. Price wanted assurances that RSC's change in prioritizing is what has impacted IW access. Mr. Johnson replied in the affirmative, and IWs may still be eligible for services through the Bureau independent of their status with RSC; IWs were not losing opportunities for services.

Mr. Hummel inquired where the \$605,000 figure came from. Mr. Johnson replied the figure was used when he joined the Bureau. The figure was \$587,000 in 2005, and there have been discussions with leadership on adjusting the figure. Mr. Hummel asked if there was a mechanism or formula, and Mr. Johnson replied in the negative. Mr. Hummel inquired if the Bureau is keeping the balance of the unused \$605,000. Mr. Johnson indicated the funding is set each year, and the amount for next year has not been determined. In terms of \$605,000 any portion not spent by RSC must be returned to the bureau.

2. Medical Services Report

Mr. Johnson and Ms. Arms presented the Medical Services Report. A copy of the report is incorporated into the minutes by reference and was provided to MSSC prior to the meeting.

MCO 2011-2012 Contract and Key Elements. Mr. Johnson noted the key of the Health Partnership Program ("HPP") is the relationship and partnership of the Bureau and the MCOs. The Bureau determines compensability, pays indemnity and provides oversight and management of the workers' compensation system. The Bureau currently contracts with 17 MCOs to manage the medical component of workers' compensation claims. MCOs also educate employers and IWs on HPP and process claims applications ("FROIs"). MCOs also help employers establish transitional/early return-to-work programs. Finally, MCOs process medical bills and make provider payments. The Bureau monitors MCO performance, such as the effectiveness of the MCOs' return-to-work efforts using the Degree of Disability Management ("DoDM") measure.

Ms. Arms noted the MCO 2011-2012 contract went into effect on January 1, 2011. In aggregate, MCOs will be paid up to \$166.7 million in 2011, which was the same level as 2010; the amount will increase by 2% to \$170 million in 2012. Administrative payments have set offs on predetermined benchmarks. 55% of all MCO payments are made as monthly administrative payments, with the remaining 45% is paid quarterly based on

DoDM scores. The administrative payments considers the MCOs': number of new claims filed; number of bills processed for payment; number of active claims; and number of employers. The DoDM payment is predicated on a percentage of the \$1.968 billion in premiums collected.

Other changes in the contract reflect the Bureau's key performance indicators. In the first quarter of 2012, Ms. Arms reported a new metric, Measure of Disability ("MoD"), would be introduced to replace DoDM. The MoD metric will improve measurement of MCO activity by more accurately measuring effectiveness of the MCO medical case management. MoD measures a much larger population of claims than DoDM, and uses updated benchmarks developed using Ohio specific data. Additionally MoD will measure actual return-to-work dates instead of release to return-to-work dates. Finally, claims would be weighted in correlation to their severity.

Ms. Arms indicated the 2011-2012 MCO contract also tightened performance benchmarks and added 2 new measures. First, any MCO receiving a qualified SAS 70 opinion will receive a 15% set off of their next month's administrative payment, and the MCO will be placed at capacity until the MCO has implemented an action plan to resolve any audit deficiencies. Second, any MCO that materially fails to timely submit requested audit and/or compliance materials will receive a 1% set-off per day until the materials have been provided. Third, the benchmark for the FROI Turnaround has been lowered to 2.50 calendar days from 3.00 calendar days. Finally, the benchmark for submission of provider of record and case manager/case contact information has been raised to 92.50% from 90%. Both of the latter benchmarks are needed for timely decision making by the Bureau.

HSQIU. Mr. Johnson noted on November 1, 2009, the Alternative Dispute Resolution process eliminated the level 2 review by the Bureau. This allowed the Bureau to better utilize limited resources of critical nursing and administrative support services for furthering the Bureau's goal of ensuring prompt, effective medical care to IWs.

While the Bureau has strong quantitative metrics to measure MCO performance, HSQIU gives an opportunity to address performance management, which is to greatly enhance the Bureau's qualitative review of MCO performance. This was a recommendation of the 2009 Comprehensive Study. The treatment authorization audit process is in the research and analysis phase and staff is identifying audit tools. The HSQIU will use 9 nurses and 3 claims staff with an intent to audit the quality of 179,000 treatment approvals and denials, as well as whether the decisions were within the law, specifically the Miller criteria. The goal of HSQIU will be to increase the quality of services to IWs.

State Agency Provider Panel. Mr. Johnson indicated this program was developed by the Department of Administrative Services ("DAS") and Ohio's labor unions representing state employees. Both groups share a common goal of ensuring injured employees receive effective and efficient care resulting in a timely, safe return to work. These groups believe an effective provider panel will help employers develop an effective partnership with providers and help state employees receive the best medical care. This program, identified as Workplace Injury Labor Management Approved Provider Committee ("WILMAPC") is consistent with the 2009 Comprehensive Study recommendations to improve provider performance. The Bureau is providing expertise to the project, with the goal of a developing a blue ribbon panel concept in terms of certified performance

metrics. The Bureau has developed 4 performance measures: release to work, duration of disability, relapse, and cost. Cost is weighted the least, with the other categories weighted higher. Cost is weighted less to avoid an unintended consequence of an injured employee receiving the appropriate care based on cost. An example given was that the costs for treatment of a broken leg for a service business employee will be much different than that of a professional football player. Presently, 11,000 providers have been approved for this panel, and the panel continues to grow. The Bureau has calculated 2 quarters of scores and posted them on the DAS website. After the third quarter ends in March, 2011, a determination will be made whether to renew a provider on the panel or provide 90 days for improvement.

Reimbursement/Fee Schedules. Mr. Johnson noted MSSC had been provided a status of all fee schedules in tabular form along with a historical chart of the last few years. The documents show what changes have been made, and what changes are being proposed.

3. Committee Calendar

Mr. Hummel noted MSSC had a full calendar the next two months, and he requested more than one and one-half hours be scheduled for these meetings.

ADJOURNMENT

Mr. Matesich moved to adjourn the meeting at 4:03 PM, seconded by Mr. Pitts. The meeting adjourned with a 4-0 unanimous roll call vote.