

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

**Thursday, March 24, 2011**  
Level 2, Room 3 (Mezzanine)  
30 West Spring St.  
Columbus, OH 43215

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

Members Absent: None

Other Directors Present: Kenneth Haffey, Stephen Lehecka, Larry Price, and Robert Smith

Counsel Present: Pete Mihaly, Legal Counsel

Staff Present: Stephen Buehrer, Administrator  
Abe Al-Tarawneh, Superintendent, DSH  
Donald Berno, Liaison to Board of Directors  
Karen Fitzsimmons, Rehab Policy Unit Director  
Johnnie Hanna, Pharmacy Program Director  
Freddie Johnson, Interim Chief, Medical Services  
Kort Grondach, M.D., Member, BWC Pharmacy and Therapeutics Committee

Scribe: Michael J. Sourek, Staff Counsel

**CALL TO ORDER**

Mr. Hummel called the meeting to order at 3:15 PM, and the roll call was taken. All members were present.

**MINUTES OF FEBRUARY 23, 2011 MEETING**

Mr. Hummel asked for any changes to the minutes of February 23, 2011 meeting. With no changes, Mr. Zuk moved to have the minutes of February 23, 2011 be approved, and Mr. Pitts seconded the motion. The motion passed with a 6-0 unanimous roll call vote.

**REVIEW AND APPROVAL OF AGENDA**

Mr. Hummel asked for any changes to the agenda. With no changes, Mr. Matesich moved to have the agenda approved, and the motion was seconded by Mr. Stokes. The motion passed with a 6-0 unanimous roll call vote.

## **NEW BUSINESS/ACTION ITEMS**

### **1. Motions for Board Consideration**

#### **A. For Second Reading**

##### **1. Claimant Reimbursement Rule 4123-6-26**

Mr. Hanna presented the second reading of the Claimant Reimbursement Rule 4123-6-26 to the Medical Services and Safety Committee ("MSSC"). A copy of the proposed rule, executive summary, CSI and stakeholder grid are incorporated by reference into the minutes and was provided to MSSC prior to the meeting.

Mr. Hanna indicated this rule provides for out of pocket and co-pay prescription reimbursement to injured workers ("IWs"), as well as provides how the Bureau may reimburse another health insurer. There were 10 responses from stakeholders. All responses were positive. There were suggestions to have language changed in the rule to allow an IW to be reimbursed regardless of whether a health insurer is reimbursed. These changes were made.

Mr. Matesich moved that MSSC recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to amend Rule 4123-6-26 of the Administrative Code, "Claimant Reimbursement," to reimburse injured workers for certain co-payments for medical services, with the motion consenting to the Administrator amending Rule 4123-6-26 as presented at this meeting. The motion was seconded by Mr. Stokes, and the motion passed with an 8-0 unanimous roll call vote.

#### **B. For First Reading**

##### **1. Vocational Rehab Fee Schedule**

Mr. Johnson and Ms. Fitzsimmons presented the first reading of the Vocational Rehab Fee Schedule, Rule 4123-18-09. A copy of the proposed rule, executive summary, CSBR, and slide show presentation are incorporated by reference into the minutes and was provided to MSSC prior to the meeting. Mr. Johnson and Ms. Fitzsimmons thoroughly covered the information in the slides without omission in the presentation.

Mr. Matesich inquired how the Bureau was measuring results as the Board is now being asked to approve fee adjustments which are projected to increase the cost of vocational rehabilitation services an additional \$500,000. Mr. Johnson replied the Bureau is aggressively putting in place a set of performance metrics regarding the successes/failures of vocational case managers ("VCMs") in returning IWs to work. The Bureau has a hierarchy that it must follow in facilitating vocational rehabilitation: same job, same employer; different job, same employer; and different job, different employer. Most IWs in vocational rehabilitation are in the last category. The Bureau's metrics will examine the success at getting IWs back to work and examine where the Bureau is going. The codes proposed are with the intent of examining services provided in a more detailed manner. The metrics that will be developed by June, 2011 will show each VCMs success at return to work as well as duration of the program. Mr. Matesich asked if there would be metrics in place by June. Mr. Johnson replied the Bureau currently has metrics for return to work and the type of work under the guidelines, duration and lag times that measure achievement/non-achievement. In June, the metrics will be performance measures of the VCMs themselves. Mr. Matesich asked if the Bureau knows the outcomes as of today. Mr. Johnson responded that vocational rehabilitation in 40-42% of

cases leads to a return to work. There is programmatic input, but not on a case-by-case basis based on the VCM, which is a little harder to obtain. Mr. Matesich indicated he would like to see that the additional investment being allocated will show an improvement in performance metrics, a payback on the investment being requested. Mr. Johnson replied that request was a fair expectation. The goal is to ensure access to quality, but efficient, care.

Mr. Hummel asked once the data is collected at the VCM level, what exactly the Bureau would do with the data. A VCM could be determined to be good, another not so good. Mr. Johnson indicated that, based on the previous presentation on the MCO vocational rehabilitation referral patterns and the Deloitte study, the Bureau would look at the assignment of cases and utilize the data elements to provide IWs a selection of VCMs with this information. The goal is to have an aggregation of data and develop a VCM report card, so IWs know what VCMs are performing at what level. Mr. Hummel asked if fees could be tied to performance. Mr. Johnson replied a goal is to eventually set up the fee schedule, stratify providers, and provide remuneration for services provided. The slippery slope however, is having the right mixture. The Bureau does not want a fee schedule based solely on return to work metrics or IWs may return to work before they are ready. Likewise the Bureau does not want to terminate services that may be useful, citing the example of a broken leg with a football player would have different costs than a bank employee.

Mr. Zuk inquired if career counseling is a psychological service. Ms. Fitzsimmons replied in the affirmative under the CPT definitions, but the services are not psychological services. Mr. Zuk asked if the fee was the same as psychological counseling. Ms. Fitzsimmons replied the fee is comparable for in person time; however, the research and report writing is significantly less. Mr. Zuk asked if licensed social workers and counselors are the provider of the services, and Ms. Fitzsimmons replied in the affirmative.

## **2. C-9 Rule 4123-6-16.2 -- Medical Treatment Reimbursement Requests**

Mr. Johnson presented the first reading of the C-9 Rule 4123-6-16.2, Medical Treatment Reimbursement Requests. A copy of the proposed rule, executive summary, CSBR, and stakeholder grid are incorporated by reference into the minutes and was provided to MSSC prior to the meeting.

Mr. Johnson reported the C-9 is a key report to managed care organizations (“MCOs”) in performing medical management of a claim. A C-9 is required for reimbursement of services and must be submitted by a provider prior to initiating non-emergency treatment. In 2010, there were 171,155 C-9 forms processed on 61,670 claims. One claim had 62 C-9s processed that year. Mr. Johnson noted C-9s initiate the Alternative Dispute Resolution (“ADR”) process. In 2006, there was a quality improvement committee set up that led to improvements in time and efficiency through reforms. One of the common issues raised was that the C-9 form was vague and resulted in communications challenges. The communication challenges resulted in delays in approving treatment as the MCOs had to issue a C-9A to gather more clarification and information. The rule proposal encourages and facilitates communication between providers and MCOs and better collaboration between the Bureau and MCOs. Stakeholder feedback had been sought from such interested parties as: Healthcare Quality Assurance and Advisory

Committee (“HCQAAC”), the Ohio Association of Justice (“OAJ”), and employer organizations. Furthermore, the rule proposal was discussed with IARP, OARF, and OPTA. There have been 18 stakeholder responses received to date.

Mr. Johnson went through the proposed changes in this rule. First, the rule adds eligible treating providers who may submit C-9 requests, so long as there is a prescription for the requested treatment. Physical therapists and occupational therapists may request treatment via a C-9, but the request will not be valid longer than 30 days unless supported by a prescription. The Bureau recognized physicians of record may indicate a need for physical or occupational therapy, but may not understand the type of therapy needed. This change of allowing the physical or occupational therapist make the request avoids bills being denied because the disconnect that can exist between the submitted C-9 requesting medical treatment and the procedure codes billed by the physical or occupational therapist services provider. Another change in the rule is that even where there is a prescription the same cannot be for more than 6 months. This change will create a quicker, more efficient methodology to have services started faster, as well as a free flow of information between the MCO and a provider while ensuring crosschecks and protocols for evaluation and determination of the need for those services remain in place.

Another recommended change provides BWC the ability to request CPT/HCPCS codes on the C-9. Mr. Johnson noted that there was a difference in what the MCOs are to do relative to the request for treatment versus CPT/HCPCS codes. Decisions on C-9s are related to what treatment is specifically requested and the claim allowances; MCOs are not to use the CPT/HCPCS codes on the C-9 requests as the decision point. The MCOs must look at the treatment requested as it relates to the allowed conditions.

Mr. Johnson pointed out that another recommended change simply reflects the changes in the claim reactivation rule, which expanded the time before a claim can go inactive for no claim activity from 13 months to 24 months.

Finally, there are 3 additional reasons being recommended to the rule which would permit an MCO to deny a C-9 without prejudice. MCOs can only approve, deny, or pend for further information a request a C-9 request when there is no reason to dismiss as set forth in the rule. However, the Bureau recognized it is better to dismiss a C-9 without prejudice in some instances rather than deny the request. First, a C-9 will be dismissed when the underlying claim is disallowed, dismissed, or is for substantial aggravation of a pre-existing conditions in non-payable status. Submitting a C-9 for services in these instances has no reason to go to the ADR process. Second, were services are never covers pursuant to statute or rule a C-9 for the same would be dismissed. For example, the Bureau would never purchase a Jacuzzi. Finally, a C-9 will be dismissed if an MCO has requested supplemental documentation and no response received. However, if a provider responds, the appropriate approval or denial of the C-9 must be made. If the C-9 is dismissed for complete lack of response, the IW would work with the provider to obtain the necessary information.

Mr. Johnson concluded the initial presentation by reiterating that the recommended changes will encourage better communication between providers and MCOs; better and quicker responses; improved simplicity in the process; save state resources; and streamline services.

Mr. Pitts inquired on circumstances where a dismissal may be appropriate in treatment for a substantial aggravation of a pre-existing condition. Mr. Pete Mihaly representing legal gave an example reflected in Senate Bill 7 provisions that a substantial aggravation of a pre-existing condition will have treatment no longer reimbursed if it is determined the condition returned to its prior level before injury. Mr. Pitts inquired about an example of an IW with degenerative joint disease of the knee whom underwent a total knee replacement. An employer is contesting further payment because there is no longer a joint, and thus there is no longer further obligation. Mr. Johnson indicated he would have to look into the issue further. Mr. Pitts had concerns that the language of the rule was not as clear as needed and that MCO could make requests for further information by phone without imposing time limits. Mr. Johnson pointed out that the were parameters which did not allow for the MCOs dismiss claims inappropriately under this guise that the response was inappropriate or non-responsive. It was pointed out that the rule required the use of the C-9A form, which address Mr. Pitt's concerns.

### **3. Outpatient Medication Reimbursement Rule 4123-6-21**

#### **4. Self-Insured Outpatient Medication Reimbursement Rule 4123-6-21.1**

Mr. Hanna presented jointly the first reading of the Outpatient Medication Reimbursement Rule 4123-6-21 and the Self-Insured Outpatient Medication Reimbursement Rule 4123-6-21.1. Copies of the each proposed rule, executive summary, and CSI are incorporated by reference into the minutes and provided to MSSC prior to the meeting.

Mr. Hanna began noting both rules provide guidelines of how the Bureau and self-insured employers reimburse outpatient medications. There have been concerns regarding reimbursement of these medications to non-certified providers and non-sterile injectable drugs dispensed to IWs. The most significant change in the rules is non-certified providers may not be reimbursed for these medications unless: the date of injury of the claim is prior to October 20, 1993, the provider was the IW's physician of record before that date, and the IW has continued treatment with that provider. Out of state, out of country, or intrastate providers in underserved areas, may be reimbursed for these medications if they are non-certified. The rules address compounded medications that are dispensed intrathecal, intravenously, intramuscular, or subcutaneously. In order to company with U.S. pharmacopeia standards, these medications must be properly dispensed at a compounding facility. Further, in accordance with the Ohio Hospital Association case, the rules provide a specific dispensing fee of \$3.50 and the product cost is the lesser of the maximum allowable cost or the average wholesale price +/-9%. The dispensing fee may only be paid to the dispensing pharmacy and not a third party. There are recordkeeping requirements to these pharmacies, such as signature logs and prescription information. Finally, the rules provide for brand name drugs, if there is a generic equivalent, to be used, only if an IW has an allergic reaction caused by a generic equivalent, consistent with industry standards.

Mr. Hanna indicated the proposed rules have been distributed to a wide array of healthcare, labor and business stakeholders. Stakeholder feedback is due April 6, 2011. The primary difference between the two rules is many self-insured employers do not have a pharmaceutical benefit manager. Additionally, a self-insured employer may have

a more liberal reimbursement policy than the Bureau, but the self-insured employer cannot have a more restrictive policy.

Mr. Hummel inquired if there was an issue with non-sterile drugs being dispensed to IW. Mr. Hanna replied in the affirmative. There are prescriptions compounded in a physician's office that could not be done in a hospital. Mr. Hummel inquired how the Bureau would know if the compounded prescription was done in a sterile setting. Mr. Hanna indicated the rule requires a compounding medication pharmacy or other suitable facility must fill the prescription.

## **DISCUSSION ITEMS**

### **1. Overview of Pain Management**

Dr. Grondach presented a slide show presentation on pain management that is incorporated by reference into the minutes and provided to MSSC prior to the meeting. Dr. Gronbach thoroughly covered the slides in the presentation without omission.

Mr. Pitts inquired where an IW should go if a provider is uncomfortable with providing long term opiate prescriptions. Dr. Grondach replied the best avenue would be to seek a new provider, particularly in a pain management practice. Dr. Grondach saw the medical/legal issues involved in closing a practice that is illegally dispensing medications as a high propensity of the patients do have chronic pain. These patients had been receiving not very good treatment, but they do need to receive some treatment. Unfortunately, pain management is a practice area that is not very large. Mr. Pitts inquired if there are not many providers, as a whole, these providers would prescribe a large percentage of opiate prescriptions. Dr. Grondach concurred; without knowing his practice, and writing only pain medication prescriptions, his practice on paper would not look very good. In order to look at the quality of the practice, one has to look deeper. Most of Dr. Grondach's colleagues are conservative specialists who work with a primary physician in occupational health. The doctors who are doing a good job manage pain and investigate the root cause of the pain. The doctors who do nothing but prescribe narcotics is where the trouble lies.

In describing the prevalence of misuse, abuse and addiction, Dr. Grondach said misuse was the case of the Good Samaritan. Someone – like a friend, neighbor, or coworker – provides a pill to the person in pain to see if it helps. Dr. Grondach indicated this would not lead to the patient being discharged from his practice. Mr. Smith asked for clarification, such as a person working on a roof at his brother's house and the person's arm began to hurt. The brother gave him a Vicodin, and there was no criminal/bad intent in doing so. Dr. Grondach concurred. With regard to abuse, Mr. Pitts noted the underlying pathology is that pain is chronic and it is not going to go away; people do become dependent on the medication. Dr. Grondach agreed, but this issue is not abuse. Most drugs, such as antihypertensives, will work great forever; however, this is not true of all drugs, including opiates. Opiates are very effective if the drug is necessary, but opiates only help the pain; opiates do not cure the pain. The issue is as bodies get used to opiates, a tolerance develops that differs by person. At some point in long term use of opiates, there will be a physical dependency, and the individual will become sick if dropped from a practice. The sickness will last a few days, up to a couple of weeks. This issue is a physical dependency, not an abuse. The body has become used to the drug. Addiction is a neurological issue, and there is usually a strong family and personal

history. Dr. Grondach admits the key is to be very careful in these situations, and education is important. Opiates are not the first choice in treatment in these situations. This field of neurochemistry is an evolving field of study. Addiction is the small portion of individuals who have predisposed and will lose control whatever opiate they are prescribed. The time on the medication or the dose does not matter, and the individual will be out of control. The same is true for alcoholism. As a final comment, Mr. Hanna noted if the Bureau pays for narcotics on 24,000-27,000 claims per month, and 2-5% of population is at risk for addiction, that means 500-1,000 injured workers are at risk for addiction.

## **2. Customer Services Report**

Ms. Kilmeyer and Mr. Al-Tarawneh presented the Customer Services Report. A copy of the report is incorporated into the minutes by reference and was provided to MSSC prior to the meeting. The reports were completely covered without omission.

PTD and Death Claim Transfers. To follow-up with an inquiry from Mr. Pitts when this topic was previously discussed, Ms. Kilmeyer reported PTD claims would be transferred upon the Industrial Commission granting PTD by order, and death claims would be transferred upon filing. Death claims are transferred early in the process is to provide for the assigned team in the Columbus Service Office the opportunity to use their skill sets in investigating the compensability and dependency of the claimants. Mr. Hummel believed the PTD and death claim reassignment as a great idea, and he inquired to the response. Ms. Kilmeyer replied this initiative was a labor and management collaboration which developed the idea. A CSS could go years without ever processing a death claim. The reassignments were believed to improve accuracy and efficiency.

Virtual Nurse Pool. Mr. Hummel asked how nurses were assigned previously. Ms. Kilmeyer replied ideally there was one nurse assigned to each team. However, nurses did not have to be physically present in the service office they covered to staff medical issues. Through time and attrition, there not as many nurses employed with the agency as previously and the pool concept was developed to use resources more efficiently and make more prompt determinations.

Ohio Safety Congress and Expo ("OSC 2011"). Mr. Al-Tarawneh noted 4,100 registrants for OSC 2011. Mr. Hummel asked if the Board of Directors were all registered, and Mr. Berno confirmed. Mr. Hummel asked how this number compared with expectations. Mr. Al-Tarawneh responded the goal was to have 4,100 by March 25, 2011.

## **3. Committee Calendar**

Mr. Hummel inquired if MSSC would like to take a field trip to the Ohio Center of Safety and Health. With general consensus received from the directors present, Mr. Berno agreed to make the necessary arrangements.

## **ADJOURNMENT**

Mr. Matesich moved to adjourn the meeting at 4:59 PM, seconded by Mr. Pitts. The meeting adjourned with a 6-0 unanimous roll call vote.