

BWC Board of Directors
Medical Services and Safety Committee

Thursday, April 28, 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: Donald Berno, Liaison to Board of Directors
Karen Fitzsimmons, Rehab Policy Unit Director
Johnnie Hanna, Pharmacy Program Director
Freddie Johnson, Interim Chief, Medical Services
Raymond Mazzotta, Chief Operating Officer

Scribe: Michael J. Sourek, Staff Counsel

CALL TO ORDER

Mr. Hummel called the meeting to order at 2:48 PM, and the roll call was taken. All members were present.

MINUTES OF MARCH 24, 2011 MEETING

Mr. Hummel asked for any changes to the minutes of March 24, 2011 meeting. With no changes, Mr. Palmer moved to have the minutes of March 24, 2011 be approved, and Mr. Matesich 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. Pitts. 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. Vocational Rehab Fee Schedule

Mr. Johnson and Ms. Fitzsimmons presented the second reading of the Vocational Rehab Fee Schedule, Rule 4123-18-09. A copy of the proposed rule, executive summary, CSBR, and stakeholder feedback grid are incorporated by reference into the minutes and was provided to Medical Services and Safety Committee ("MSSC") prior to the meeting.

Mr. Johnson noted the proposed rule addresses the reimbursement protocol for all services provided to injured workers in an approved vocational rehabilitation program. Such services included, but were not limited to: vocational case management, occupational rehabilitation, work conditioning, job assessment, and job seeking skills training. The proposed fee schedule represented about 3.5-4.0% of all medical services paid by the Bureau and affected over 3,600 vocational rehabilitation providers, who were either independent or affiliated with a vocational service entity. In 2010, reimbursements made under this fee schedule were over \$32 million. The estimated impact of this proposed fee schedule would increase reimbursements by 1.42% or an estimated \$452,000. The estimated effective date is August 1, 2011. The proposed fee schedule was posted on the Bureau's website, and an overview of the same presented to the Labor Management Government Advisory Council ("LMG"). The proposed fee schedule was also distributed to a wide range of stakeholders. Mr. Johnson noted the proposed fee schedule maintained the following recommendations: a 1.36% payment adjustment factor increase for all rehabilitation service fees; deletion of 1 procedure code and addition of 5 others; and recommendations regarding definitions of certain services for clarity and consistency. Since the first reading, one additional recommendation is being proposed. The team, when reviewing the 77 local codes used in the current fee schedule, identified 5 codes using 1 or 2 hour billable increments. The recommendation is to change the billing increments of those codes to 15 minute increments. There is no change in total billable time available for the codes or the total potential reimbursable amounts. The recommended change will provide more accurate accounting of service time for the related 5 service codes. Each known rehabilitation service provider association was provided notice and a discussion regarding the recommended billable unit change. Mr. Johnson noted that there was consensus around the appropriateness of the changes as evidenced by the stakeholders comments as set forth in the stakeholder feedback grid (see last 3 stakeholder comments). Mr. Johnson concluded the proposed fee schedule met the Bureau's goal of ensuring access to high quality medical care for injured workers by providing a competitive fee schedule that enhances faster recovery and a prompt, safe return to work.

Mr. Matesich inquired if there was any "look back" to the changes or modifications requested by stakeholders that were not adopted by BWC staff. Mr. Johnson replied in the affirmative, as the Bureau conducts quarterly meetings with providers and advisory groups, as well as reviews the fee schedule annually any feedback from stakeholder organizations, or LMG, is constantly revisited and evaluated to determine if the same should be included in the next fee schedule proposal. Mr. Price noted the stakeholder input was the most he had seen. He inquired if the Bureau reviewed each stakeholder comment, and Mr. Johnson replied in the affirmative. Mr. Johnson added Ms. Fitzsimmons and her team looked at all stakeholder comments, and her team made

recommendations. The recommendations were reviewed with Mr. Johnson. Mr. Johnson indicated he does challenge the team with regard to their recommendations, and the stakeholders are notified of the Bureau's position directly. Mr. Price asked if the Bureau followed up with rationale. Mr. Johnson replied "absolutely," that the Bureau attempts to respond to each comment, especially before presentation to MSSC. Mr. Smith inquired as to the status of the follow-up regarding the MCO Vocational Referral Process. Mr. Johnson replied part of this follow-up was contained in the Medical Services Report later in the agenda. Performance metrics were being developed to address alleged biases in the referral system. Mr. Zuk inquired, instead of just listing the stakeholder comments and the Bureau responses, if the Bureau could categorize the comments by the part of the rule being addressed. Mr. Johnson replied this request will be accommodated.

Mr. Matesich moved that MSSC recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendations to amend Rule 4123-18-09 of the Administrative Code, "Vocational Rehabilitation Provider Fee Schedule," to review the fee schedule effective August 1, 2011, with the motion consenting to the Administrator amending Rule 4123-18-09 as presented at this meeting. The motion was seconded by Mr. Stokes, and the motion passed with a 6-0 unanimous roll call vote.

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

Mr. Johnson presented the second 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 noted a key role of managed care organizations ("MCOs") is medical management of allowed Bureau claims. Medical treatment must be submitted by a physician of record or eligible treating provider, which is done via Form C-9 ("C-9") before initiating non-emergency treatment. In 2010, there were approximately 171,155 C-9s processed by MCOs on 61,670 claims. One claim had 62 C-9s processed that year.

Mr. Johnson reviewed stakeholder feedback. Mr. Johnson noted the proposal was distributed to a broad range of stakeholders. Mr. Johnson also noted that providers who attended either a June, 2010 or November, 2010 provider stakeholders meeting were provided an overview of the C-9 changes. Stakeholder responses did not require changes in the proposed rule. Many of the comments were addressed in the first reading. The proposed rule will provide: better services; improved simplicity in medical management; address an opportunity for savings; and streamlining of the process by preventing unnecessary and premature appeals.

Mr. Pitts inquired regarding the wording of the proposed rule in paragraph (F)(5) where the wording includes "...or the only allowances in the underlying claim are for substantial aggravation of a pre-existing condition, and the conditions have been determined in a final administrative or judicial determination to be in a non-payable status." Mr. Pitts inquired whether "non-payable status" indicated a return to baseline of a substantially aggravated pre-existing condition. Mr. Johnson deferred to Mr. Mihaly. Mr. Mihaly replied in the affirmative, that the intent of the wording was the Industrial Commission had made a determination that a substantially aggravated pre-existing condition had

returned to baseline and thus, treatment was not payable. Mr. Pitts noted the statute on substantial aggravation and the proposed rule had different wording.

Mr. Matesich moved that MSSC recommend that the Bureau of Workers' Compensation Board of Directors approved the Administrator's recommendation to amend rule 4123-6-16.2 of the Administrative Code, "Medical Treatment Reimbursement Requests," with the motion consenting to the Administrator amending Rule 4123-6-16.2 as presented at this meeting. The motion was seconded by Mr. Palmer, and the motion passed with a 6-0 unanimous roll call vote.

3. Outpatient Medication Reimbursement Rule 4123-6-21

4. Self-insured Outpatient Medication Reimbursement Rule 4123-6-21.1

Mr. Hanna presented jointly the second 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, CSBR, and stakeholder grid are incorporated by reference into the minutes and provided to MSSC prior to the meeting. Mr. Hanna emphasized the proposed rules will improve safety and efficiency in the process. The rule will stop reimbursement for prescriptions from non-certified and non-enrolled BWC providers, and that utilizing properly equipped compounding pharmacies can prevent non-sterile injectable drugs from being dispensed.

Mr. Hanna reviewed the stakeholder responses. For the proposed rule 4123-6-21, there were 11 stakeholder responses; the stakeholder responses concerning proposed rule 4123-6-21.1 did not request any changes. A stakeholder inquired how a pharmacy will know if a provider is enrolled, and the Bureau replied the pharmacy would receive a point of service notification. A stakeholder inquired about drugs that require prior authorization, and the Bureau described the edits of the PBM. A stakeholder inquired regarding the dispensing fee, and the Bureau noted there were no changes. Another stakeholder asked if an intermediary could be paid a dispensing fee, and the Bureau replied in the negative; only the dispensing pharmacy is eligible for the dispensing fee. A stakeholder inquired if an electronic signature log would comply. The Bureau replied an electronic signature log is acceptable if it was a true signature log. A stakeholder asked for a copy of the Maximum Allocable Cost list. The Bureau replied the document was proprietary and could not be disseminated. There were no stakeholder responses to: requirement of a compounding facility in dispensing of injectable drugs to ensure sterility; or use of a brand name drug if a generic causes an allergic reaction. One change made from last month's presentation is the Bureau had proposed in the rule a requirement that a refill denial would be entered if less than 90% of a prescription had been used. However, due to potential inconvenience to injured workers, the refill denial level will remain at 75%.

Mr. Hummel inquired about the rationale for the bullet point on page 2 of the Executive Summary: "Not pay or offer to pay any 'kickback' to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods and services." Mr. Hanna replied the clause is in place with other vendors, and the wording was included at the request of the Legal Department.

Mr. Matesich moved that MSSC recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to amend Rule 4123-6-21 of the Administrative Code, "Payment for Outpatient Medication," with the motion consenting to the Administrator amending Rule 4123-6-21 as presented at this meeting. The motion was seconded by Mr. Pitts, and the motion passed with a 6-0 unanimous roll call vote.

Mr. Hummel inquired if any further presentation was needed regarding Rule 4123-6-21.1, and Mr. Hanna replied in the negative. Mr. Matesich moved that MSSC recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to amend Rule 4123-6-21.1 of the Administrative Code, "Payment for Outpatient Medication by Self-Insuring Employer," with the motion consenting to the Administrator amending Rule 4123-6-21.1 as presented at this meeting. The motion was seconded by Mr. Pitts, and the motion passed with a 6-0 unanimous roll call vote.

B. For First Reading

1. Outpatient Medication Formulary Rule 4123-6-21.3

Mr. Hanna presented the first reading of the Outpatient Medication Formulary Rule 4123-6-21.3. Copies of the proposed rule, executive summary, and CSBR are incorporated by reference into the minutes and provided to MSSC prior to the meeting.

Mr. Hanna noted the proposed formulary would be managed by the Bureau's Pharmacy and Therapeutics Committee ("P & T"). The P & T is responsible for the monitoring of medication utilization in keeping with Food and Drug Administration regulations and good clinical practice. The Bureau, between 2008 and 2011, has reimbursed injured workers for 28,000 National Drug Codes contained within 397 drug classifications, and 1321 generic entities. A formulary would provide enhanced treatment and improve medication safety for injured workers for their allowed conditions. Non-formulary medications would not be reimbursed. The formulary would prevent reimbursement of "me too" copies of therapeutic duplicates. An example is MS Contin when compared to Oxycontin. The use of MS Contin has the same therapeutic use as Oxycontin and differs only in the amount used and side effects profile, but the cost of MS Contin is about ½ the cost of Oxycontin. The proposed rule has been distributed to stakeholders in the employer, labor and medical communities, P & T, and Bureau business partners. Stakeholder feedback is due back on May 13, 2011.

Mr. Zuk inquired for the result if a doctor prescribed a medication, the pharmacy checks the medication, and the medication was not in the formulary. Mr. Hanna replied the pharmacy would indicate to the injured worker that the medication was not covered. The injured worker or the pharmacy would notify the physician of the medication's status. The pharmacy could offer alternatives that are covered in the formulary. Mr. Zuk requested confirmation that the injured worker would not be "left hanging." Mr. Hanna replied that situation should not happen because of the large size of the initial formulary; as the formulary is narrowed over time, communication will be made with prescribing providers and pharmacies. Mr. Hanna added the Bureau is developing an online formulary look-up application similar to the Ohio Department of Job and Family Services Medicare Formulary, where a provider may go online to see if a medication is covered. Mr. Hummel stated that many BWC rules have an override process, and asked Mr. Hanna if that would be the case here. Mr. Hanna replied there would not be any overrides in this

formulary. Mr. Hanna also noted a formulary had never been pursued by the Bureau before, and extensive feedback was expected from stakeholders. Mr. Hummel asked if not having a formulary would be considered an odd practice, and Mr. Hanna confirmed the statement.

DISCUSSION ITEMS

1. Medical Services Report

Mr. Johnson 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. The report was completely covered without omission. The comments that follow are supplemental information provided by Mr. Johnson, or inquiries by Board of Directors members present. Mr. Hummel complimented Mr. Johnson at the conclusion of the presentation.

Medical Providers Measurement Development (WILMAPC): Mr. Johnson noted that, in June 2011, if a provider is rated “unacceptable” through their performance score, the provider would be asked to leave the panel. Mr. Hummel inquired if the provider, if asked to leave the panel, would still be Bureau certified. Mr. Johnson replied in the affirmative, as the provider had to be certified to serve on the panel. Mr. Johnson added that as a result of the WILMAPC pilot, the intent is to by September, 2011, have the strategy for full development and implementation of a “blue ribbon” panel for presentation to and approval by the Administrator. The blue ribbon panel would be applicable for any and all workers’ compensation claims, thus eliminating the need for programs such as the incentive of 100% salary continuation under the current WILMAPC program.

Provider Recertification: Mr. Johnson explained why there were 2 different numbers for enrolled providers and certified providers. Mr. Johnson replied if an injured worker chooses to go to an uncertified provider the Bureau would not pay for office visits. Any licensed provider is allowed to treat an injured worker one time or on an emergency basis. For example an initial evaluation by a licensed provider who is not certified to provide workers’ compensation services would be paid, but an injured worker would have to continue treatment with a certified provider for further services to be paid. Thus, any provider servicing an injured worker would be enrolled in order to receive reimbursement, which results in the higher number of enrolled to certified providers. Mr. Johnson noted that 500 certification packets being sent initially sounds like a small number, as does 2500-3500 being released by the end of third quarter. However, infrastructure and information technology changes are required to make the system automated. The packets will continue to be issued until the recertification of all providers is completed.

Mr. Zuk inquired if the recertification process addresses issues concerning abuse of medications, such as the issue pending out of the Portsmouth area. Mr. Johnson replied the short answer was in the negative. The recertification process focused on provider credentialing and the ability of a provider to provide services to injured workers. Tracking measures being developed will help identify potential problem providers. If there are concerns in the provider certification process, background checks can be obtained. Mr. Mazzotta added Mr. Zuk’s concerns are also being addressed by the Pharmacy Program’s initiatives. Mr. Hummel inquired as to what is involved in recertification. Mr. Johnson indicated the providers certified the longest are being addressed first. The Bureau sends

the provider a certification packet. If no response to the packet is received in 60 days, a follow-up letter is sent. If after 90 days no response is made, the provider is suspended until the packet is returned. Once the packet is returned, a review is done, and if further information is required, appropriate follow-up is done. Mr. Hummel asked if the recertification packet just asks a series of questions. Mr. Johnson replied in the affirmative.

Dental Provider Recruitment Initiative: Mr. Johnson noted he had received calls from various plaintiff attorneys notifying him that a Bureau certified dentist cannot be located in the county where an injured worker resides. This problem leads to increased Bureau costs because the Bureau pays travel reimbursement if the medical treatment travel exceeds 45 miles for the injured worker. The Health Care Quality Assurance Advisory Committee currently has a dental member, and the member assisted with having the recruitment request published on the Ohio Dental Association's website.

May 11, 2011 Provider Meeting: Mr. Hummel inquired if these meetings are well attended. Mr. Johnson replied they had not been in the past. The Bureau is aggressively marketing this meeting, and Administrator Buehrer's discussion of key issues for providers should increase attendance.

National Correct Coding Initiative (NCCI): Mr. Johnson reported the edits put in place on January 1, 2011 have been estimated to save the Bureau \$417,000 as of March 31, 2011.

2. Committee Calendar

Mr. Hummel noted Mr. James Harris, former Chair of MSSC, had indicated the Committee Calendar had no mention of the word "safety" anywhere. Mr. Matesich commented the Customer Services Reports typically have a safety component. Mr. Berno agreed, the issue appeared to be one of terminology and would be addressed.

ADJOURNMENT

Mr. Matesich moved to adjourn the meeting at 3:55 PM, seconded by Mr. Pitts. The meeting adjourned with a 6-0 unanimous roll call vote.