

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

**Wednesday, June 15, 2011**  
Level 2, Room 3 (Mezzanine)  
30 West Spring St.  
Columbus, OH 43215

Members Present: James Matesich, Chair  
Peggy Griffith, Vice Chair (arrived 1:19 PM)  
Dave Johnson  
Mark Palmer  
Dewey Stokes  
Nicholas Zuk, *ex officio*

Members Absent: None

Other Directors Present: David Lee Caldwell, Chan Cochran, Kenneth Haffey, Stephen Lehecka, and Robert Smith

Counsel Present: Janyce Katz, Assistant Attorney General

Staff Present: Stephen Buehrer, Administrator  
Donald Berno, Board Liaison  
Johnnie Hanna, Pharmacy Program Director  
Freddie Johnson, Interim Chief, Medical Services

Scribe: Michael J. Sourek, Staff Counsel

**CALL TO ORDER**

Mr. Matesich called the meeting to order at 1:17 PM, and the roll call was taken. All members except Ms. Griffith were present, who arrived at the time noted.

**MINUTES OF MAY 26, 2011 MEETING**

Mr. Matesich asked for any changes to the minutes of May 26, 2011 meeting. With no changes, Mr. Palmer moved to have the minutes of May 26, 2011 be approved through a voice vote. Mr. Zuk seconded the motion. The motion passed with a 5-0 voice vote.

**REVIEW AND APPROVAL OF AGENDA**

Mr. Matesich asked for any changes to the agenda. With no changes, Mr. Johnson moved to have the agenda be approved through a voice vote. Mr. Palmer seconded the motion. The motion passed with a 5-0 voice vote.

**NEW BUSINESS/ACTION ITEMS**

**1. Motions for Board Consideration**

**A. For Second Reading**

**1. 4123-3-23 Limitations on the filing of fee bills**

Mr. Johnson presented the second reading of Rule 4123-3-23, Limitations on the filing of fee bills. Copies of the proposed rule, executive summary, stakeholder feedback and

CSBR are incorporated by reference into the minutes and provided to MSSC prior to the meeting. The proposed rule brings consistency to changes in Ohio Rev. Code Sec. 4123.52 passed under House Bill 123 and effective on July 29, 2011. That statute will change the current 2 year statute of limitation to submit bills for payment medical services, without exception, to 1 year from the date of service or when the bill becomes payable, whichever is later. The current rule has a two year statute of limitations without exception. In 2009, there were 3.6 million invoices submitted, with only 1.8% coming in after 365 days; in 2010 there were 4.6 million invoices submitted, with only 2.3% coming in after 365 days. The Bureau believes only a minimal impact to providers would occur.

Mr. Johnson said the rule was sent to the Ohio Hospital Association (“OHA”) on May 12, 2011 and to numerous interested stakeholders on May 13, 2011. . The last page of the stakeholder grid provided various summaries of the stakeholder responses.

Mr. Johnson reported all of the changes in the proposed rule were presented in last month’s reading. Paragraph (A) noted fee bills must be submitted within one year, or within one year of when a fee bill becomes payable under Ohio Rev. Code Sec. 4123.511(I). Paragraph (B) provided the self insured employer exception to allow for a different time period. Paragraph (C) gave 3 exceptions to the 1 year rule in Paragraph (A) identified in discussions with OHA. The first exception was in Paragraph (C) of Ohio Rev. Code Sec. 4123.52 and concerned the Medicare Secondary Payer Act. The second exception applied to fee bills not timely submitted because of administrative error by the Bureau or a managed care organization (“MCO”). The third exception occurred when a bill was originally submitted to a patient, third party-payer or state or federal program and the patient, payer, or program determined it is not responsible for the cost of the services. The third exception originally did not include “patient,” which was added after receiving feedback from stakeholders. Paragraph (D) placed a limit of 1 year and 7 days of the initial adjudication of a fee bill for an additional payment to be filed. Medical Services staff made a recommendation to change the former wording of “adjustment” to “payment.” The new wording addressed a time limit to receive additional payment for services. The word “adjustment” could have put limitations on the Bureau recouping overpayments from providers. Finally, there were two issues through Paragraphs (A) through (D): timely submission of fee bills, which are addressed specifically in Ohio Rev. Code Sec. 4123.52; and timely submission for additional payment on fee bills, which are only in the rule. Sec. 4123.52’s changes are effective July 29, 2011, and the rule is anticipated to complete JCARR on September 12, 2011. Paragraph (E) of the proposed rule gives the effective dates of: July 29, 2011 for paragraphs (A) through (C), and September 12, 2011 for Paragraph (D).

Mr. Johnson noted all recommendations from the first reading are the same. Last month, concerns were raised by Mr. Pitts and Mr. Matesich regarding Paragraph (B)’s wording. The wording allows self insured employers to potentially negotiate a shorter time period than one year time limit for fee bill filings with a medical provider. Both directors were concerned a shorter time frame could negatively impact providers willing to participate in the system and consequently, injured workers access to quality care. Mr. Johnson indicated that he had a chance to speak with OHA about the concern given they had requested the language change. He stated that OHA believed that this wording would not pose a problem, and that providers wanted the ability to negotiate a shorter time period if appropriate. In light of MSSC’s concerns regarding access to quality care and

participation, the Bureau will monitor and evaluate the impact of this change. If the change results in a negative impact, the Bureau will request further changes in Paragraph (B)'s wording. The Bureau believes the wording will not affect access to quality care, and no other stakeholder recommendations were received on this issue. Overall, the proposed rule will: reduce systemic errors; improve efficiency; eliminate some disconnects between billing codes and filing dates over the currently allowed two year period; provide the Bureau a more just-in-time picture of claims costs; assist self insured employers with budgeting and fiscal planning; and aid in settlements.

Mr. Caldwell inquired if Paragraph (D) of the proposed rule was changed to address only additional payments, and not all +/- adjustments. Mr. Johnson replied in the affirmative. Mr. Matesich appreciated Mr. Johnson's feedback since the first reading; he was pleased the Bureau would monitor the proposed rule to see if the rule impacts access to quality care for injured workers.

Mr. Stokes moved MSSC recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to rescind the current rule 4123-3-23 and adopt new rule 4123-3-23 or the Administrative Code, "Limitations on the Filing of Fee Bills," with the motion consenting to the Administrator rescinding the current rule and adopting new rule 4123-3-23 as presented at the meeting. The motion was seconded by Mr. Palmer, and the motion passed through a unanimous voice 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. A copy of the proposed rule is incorporated by reference into the minutes and provided to MSSC prior to the meeting. The Bureau and MSSC agreed there was a chance a new drug could be approved by the Food and Drug Administration ("FDA") that was not within the formulary and needed by an injured worker. This administrative delay impacts an injured worker's access to the necessary medication. The proposed rule now includes Paragraph (F), which addresses new drugs recently approved by the FDA, or existing drugs that have been approved for new indications. In cases where the injured worker's physician medically documents a unique medical condition recognized in their claim for which only the newly authorized drug, or new indication of an existing drug, is the only appropriate treatment, the Bureau will reimburse the non-formulary medication for up to 180 days while the drug goes through the formulary approval. The attorney stakeholders have been contacted, and there were no objections to this paragraph. Mr. Hanna asked MSSC recommend the Board of Directors approve the proposed rule and waive the second reading.

Mr. Caldwell commented regarding last month's vote. He was part of a political process in serving on the Board of Directors, which he had much experience. He was vocal at last month's meetings, but he was on the losing side of the vote. While not necessary, he was appreciative of Administrator Buehrer meeting with him afterwards, and for Bureau staff researching his concerns. These actions were not necessary, and he wished he could make the motion to waive the second reading. Mr. Matesich asked why 180 days was selected. Mr. Hanna replied the original wording gave 90-120 days; however, the process of adding a drug to the formulary could take longer. Using 90-120 days would require further provisions for an extension. Mr. Matesich inquired if a drug was rejected

from the formulary, would there be a way for an injured worker to be reimbursed for that drug. Mr. Hanna replied in the negative. The injured worker would be given notice that the Bureau would be discontinuing reimbursement of the medication effective 30 days from the date of the letter. The Bureau would not attempt to seek reimbursement from the injured worker for the cost of the medication while the drug was pending approval with the formulary.

Mr. Stokes moved MSSC recommend that the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to revise rule 4123-6-21.3 of the Administrative Code, "Outpatient Medication Formulary," with the motion consenting to the Administrator revising rule 4123-6-21.3 as presented at the meeting and further consenting that MSSC waived the second reading of this rule. The motion was seconded by Mr. Palmer, and the motion passed through a unanimous voice vote.

## **DISCUSSION ITEMS**

### **1. Medical Services Report**

Mr. Johnson and Mr. Hanna presented the Medical Services Report. A copy of the report, titled "Medical Services Division Board Report," is incorporated into the minutes by reference and was provided to MSSC prior to the meeting. Mr. Johnson noted only the introduction and Sections I, II, and III would be discussed. Mr. Johnson covered the introductory section of the report completely and without omission.

Section I. Mr. Johnson covered the materials from the last paragraph on page 1 through the second paragraph on page 2 completely and without omission.

Section II. In light of the Governor's concerns over pill mills, Mr. Johnson said the Bureau is attempting to improve medical outcomes through the following two prescription medication initiatives. Mr. Johnson covered the section Enhancing Drug Utilization Review Process ("DUR") completely and without omission. Mr. Hanna presented the section on Medication Therapy Management Program – Pilot Project. The Bureau is grounded in protecting injured workers and employers from loss, and protecting Ohio and the Ohio economy. Pharmacist driven Medication Therapy Management has been used by insurance companies and employers for some time, but the process has never been applied to a chronic pain program or to a workers' compensation program. The Bureau is engaging in this pilot through a partnership with the University of Toledo ("UT") to determine if either would be feasible. A final proposal is being developed. A similar program was done by UT for the City of Toledo; if the proposal is 10% as successful as the City of Toledo's program, the Bureau would see \$15 million in savings per year. The program's key is to ensure injured workers receive appropriate medication therapy under current clinical standards and best practices. The proposal calls for increased communication between pharmacies and prescribers with the goal of focusing on the medication regimen. It is anticipated the proposal, by having additional pharmacist input, will decrease overall medication cost and decrease lost time.

Section III. Provider Development Activity, Mr. Johnson covered two topics: Dental Provider Recruitment Initiative and the May 11, 2011 Provider Meeting. The Dental Provider Recruitment Initiative section was covered completely and without omission. Additionally, the Bureau has been responsive in addressing what barriers are present for dentists to participate. With regard to the May 11, 2011 Provider Meeting, Mr. Johnson

said objective of the meeting is to keep Bureau service partners informed about changes to rules and/or Bureau policies to ease their adoption of the same. There were 10 provider associations present giving a wide cross-section. Medical Services was fortunate to have Administrator Buehrer provide comments and updates. Medical Services and Pharmacy staff also partnered to provide updates on recent and relevant policy and rule changes including recent treatment authorization request and outpatient medication rule changes.

Developing Provider Performance Measurements. Mr. Johnson reported the Bureau is developing performance metrics for both medical service and vocational rehabilitation providers. Through contract negotiations between the Department of Administrative Services (“DAS”) and labor unions representing state employees, the Workplace Injury Labor Management Approved Provider Committee (“WILMAPC”) was established. The program provides an option to a state agency employee who has been injured at work to receive 100% of their salary 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, the state employee will receive 100% of their salary. In return, approved panel providers agreed to be measured. The Bureau is using the WILMAPC as a pilot for the Bureau’s broader initiative with the intent of developing a Blue Ribbon Panel for all Bureau providers. The providers are being categorized into different buckets of performance, with certain types of incentives and disincentives to certain behaviors identified. WILMAPC is ultimately trying to improve return to work outcomes from medical providers. The first year of the WILMAPC has been completed, and the Bureau is compiling the data; once completed, DAS will send letters to the participating providers who have opportunities for improvement or were unacceptable. If no appeals are taken, the provider will be removed from the WILMAPC’s approved panel. As the Bureau completes its analysis, the Bureau will be setting forth its strategy steps for the full development and rollout of the Blue Ribbon provider concept for the workers’ compensation environment. The Bureau anticipates that this strategy will be developed and submitted for approval to the Administrator in late fall, 2011.

Mr. Matesich inquired regarding providers who were rated unacceptable, or room for improvement, and whether those providers were given guidance. Mr. Johnson replied what happened each quarter is that the provider scores were posted onto a secure DAS website. The providers know from these scores where they were deficient. Further, at the end of the year, providers are notified where there are opportunities for improvement. If the provider failed in an appeal to remain on the panel, the provider would be removed by the end of the year. Mr. Matesich inquired if the scores represented a self policing type of evaluation. Mr. Johnson replied in the affirmative, but preferred to soften the words “self-policing.” The test and performance metric is to evaluate what the Bureau expects the provider to achieve. The performance metric is the policing tool, but whether providers choose to improve is entirely up to them.

## **2. Committee Calendar**

Mr. Matesich and Mr. Berno agreed to split Customer Service reports into a Customer Services Report and Safety Services Report. The Committee Calendar will reflect a report each quarter for Medical Services, Customer Services and Safety Services. Mr. Matesich

believed the change will alleviate time constraints that had occurred in some recent meetings.

**ADJOURNMENT**

Mr. Johnson moved to adjourn the meeting at 2:04 PM. The motion was seconded by Mr. Stokes. The meeting adjourned with a unanimous voice vote.