

Pharmacy and pharmacy benefits manager (PBM) update

BWC has eliminated the Non-Preferred Program as a necessary step in the development of a formulary. We also discontinued the *Non-Preferred Drug Prior Authorization Request* (MEDCO-32).

Also, Erectile Dysfunction/Impotency Drug coverage **now** includes the U.S. Food and Drug Administration's approved daily dosage products for 30-day fills. We will continue to limit products that are FDA approved for use as needed to six dosage units per 30 days.

Pharmacies must submit prescriber information at the point of service for payment.

- o Non-controlled drugs require the prescriber's National Provider Identification.
- o Controlled drugs **now** require the prescriber's Drug Enforcement Administration number.

Additionally, we will approve payment of covered antibiotics in BWC claims with allowed infectious conditions. Submit a *Request for Prior Authorization of Medication Form* (MEDCO-31) to the pharmacy benefits manager (PBM) for consideration. For post-surgical situations, there is a 30-day fill limit. Providers can obtain reimbursement approval two ways.

- o The injured worker can inform the pharmacy of the surgery, and the pharmacy can submit an emergency override at the point of service.
- o Prior to a BWC-approved scheduled surgery, the physician can submit a MEDCO-31 to the PBM. Include the specific date of the surgery for consideration. Additionally, providers can use the form to request pain medication or other post-surgically related medications denied in the claim. A 30-day fill limit applies.

We reimburse for over-the-counter medications (OTC). A physician licensed to prescribe medications must prescribe drugs for BWC to consider reimbursement. The prescription must include OTC written on it, and then the pharmacy will electronically submit the bill for payment.

Compound drug reimbursements

Providers must submit HCPCS code J3490 (unclassified drug) for reimbursement of compounded medication. Reimbursable costs include usual, customary and reasonable expenses for specific doses and volumes of drugs and diluents used to prepare the compound. Reimbursable costs also include prorated expenses for acquisition of drugs (i.e., mailing, storage).

When requested by a managed care organization or BWC, providers must provide an invoice of itemized costs to facilitate proper bill processing. This invoice must include the National Drug Code number for all drugs and diluents used to prepare the final compound.

We negotiate reimbursement for compounded drugs. The reimbursement amount provided by us typically should not be greater than 120 percent of the provider's actual cost of the compounded medication per the itemized invoice and any documented prorated expenses.

Save the dates for upcoming biannual meetings

Please join us from 1:30 to 3:30 p.m. May 11 and Nov. 9, 2011, for medical informational updates. We will hold both meetings in the William Green Building, 30 W. Spring St., Second Floor, Columbus, OH 43215.

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BWC \$15,000 Medical-Only Program revised

Employers enrolled in the \$15,000 Medical-Only Program for claims with a date of injury on or after June 30, 2009, use the BWC fee schedule for medical payments. Employers may access the provider fee schedule at ohiobwc.com. If an employer has questions regarding BWC's fee schedule and/or has general billing questions, he or she should contact provider relations by calling 1-800-OHIOBWC and selecting option 0-3-0.

A certified health-care provider shall accept from an employer who participates in the \$15,000 Medical-Only Program the BWC fee schedule as full payment. The provider shall not charge, assess or otherwise attempt to collect from an employee any amount for covered services or supplies that is in excess of the BWC fee schedule. For claims with a date of injury prior to June 30, 2009, the employer is to pay as billed or according to any provider agreed upon amount.

Alternative dispute resolution update

We have reformed the alternative dispute resolution (ADR) appeal process to eliminate redundancies. Outcomes studies show BWC in agreement with the managed care organization (MCO) Level 1 appeal decisions approximately 97 percent of the time. Reform of the ADR process eliminated the redundant BWC Level 2 of the appeal process via the revision of Rule 4123-6-16.

MCOs have 21 days to perform an independent file review or independent medical examination (IME) and make a final decision. When an IME is required to address the dispute, we temporarily suspend the period until the MCO obtains a completed report. The MCO makes a recommendation based on the physician exam report and sends it electronically to BWC to publish an order. The injured worker or employer may appeal the BWC order to the Industrial Commission of Ohio, as the provider is not a legal party to the claim.

Changes in facility outpatient reimbursements

BWC moved from a retrospective cost-plus reimbursement methodology to a prospective payment methodology for hospital outpatient services beginning with dates of service on Jan. 1, 2011. We selected a prospective payment methodology because of its two main principles:

- o We establish the rates and policies in advance;
- o The rates remain constant during the effective period.

The prospective payment methodology that we adopted is a modified version of Medicare's Outpatient Prospective Payment System (OPPS).

As indicated in Ohio Administrative Code 4123-6-37.2, reimbursement for hospital outpatient services is 197 percent of the 2010 Medicare OPPS reimbursement rate for all Ohio hospitals and all BWC-certified hospitals, regardless of location.

There are two exceptions:

- o We reimburse children's hospitals at 253 percent of the Medicare OPPS reimbursement rate;
- o We reimburse critical access hospitals, as designated by Medicare, at 101 percent of Medicare reasonable cost, plus the BWC payment adjustment factor for all payable line items.

Our Web site contains a page dedicated to this new methodology. Providers can find current and proposed rules, a brief video explaining the change and many other tools and resources at <http://www.ohiobwc.com/provider/services/outpatientpay.asp>.

BWC needs ICD-9-CM E causation codes submitted on FROI

Federal mandate requires BWC to submit an ICDM-9-CM E causation codes (external cause of injury) quarterly report to Medicare of all claims for Medicare eligible injured workers. We ask that providers submit an E code with the *First Report of an Injury, Occupational Disease and Death* (FROI) for all claims. We have included a field for this E code for providers to report on both the paper and online FROI.

Transcutaneous electrical nerve stimulator (TENS) update

Revised Ohio Administrative Code rule 4123-6-43, removes the responsibility for the injured worker's signature on monthly written requests for supplies. The managed care organization (MCO) now must provide regular authorization to the injured worker's selected TENS supplier for the specific supplies he or she needs.

The supplier must receive the authorization from the MCO prior to providing and billing for the supplies and/or equipment. Self-insured employers may but do not have to follow the same procedure. However, they are prohibited from requiring injured workers to submit a written request for TENS supplies.

Provider data updates

All providers must inform BWC of any changes in their provider data within 30 days of the revisions. This includes updates in Medicare numbers for hospitals. The *Request to Change Provider Information* (MEDCO-12) or notice with provider letterhead is acceptable. All updates regarding payment address changes require the provider's signature. Fax updates to provider enrollment at 614.621.1333.

Global surgery time frame changes and modifier add-on to emergency department bills

Effective Aug. 1, 2010, we shortened the post-operative period for all major surgeries from 90 days to 60 days.

Also effective Aug. 1, 2010, we appended the modifier 54 (intra-operative care only) to all procedures performed in the emergency department (ED) that have a global period.

We did this because another provider normally performs the ED follow-up (post op period). The provider rendering the post op care must bill the surgical procedure with the -55 modifier or S code for suture removal, as appropriate.

When faxing, remember!

Always use the 1 when faxing information to BWC before the 800 or 866 number. This ensures we receive your information correctly.

Did you receive a settlement letter notice?

Please do not require payment from the injured worker up front, as settlement is not yet approved/completed at the time your office receives the notice. Check ohiobwc.com, or ask the injured worker to find out if the claim is settled. Bills for services rendered prior to the settlement date may be billed after the date of final settlement. Bills for services rendered after the settlement are not payable by BWC.

Fee schedule update

We update five fee schedules annually and notify provider associations to relay this opportunity to respond with feedback to members. These five fee schedules include:

- Hospital outpatient;
- Hospital inpatient;
- Ambulatory surgical centers;
- Vocational rehabilitation services;
- Professional provider fee schedule.

We also invite the public to respond via our website when we propose revisions and send notices to the BWC list serv (see below). Please see ohiobwc.com for a complete listing of all current and proposed fee schedules.

The professional provider fee schedule undergoes a full annual review in October. We also revise it in January, so we can add new and deleted codes into the BWC system. The January 2011 revisions included the addition of several S codes for reimbursement of services. These include personal and infection control items, which the previous fee schedules did not specifically identify. In addition, we updated acceptable urine drug screen codes and changed home-health services hourly W codes to 15-minute unit increments. Please bill accordingly.

Join BWC's E-mail listserv for providers and interested parties

We're building an e-mail list of providers and interested parties to receive our *Provider Update* and other medical information electronically. To assist our efforts, we request providers send us the applicable information below to the e-mail address Provlistserv@bwc.state.oh.us, or call us at 1-800-644-6292, and select option 0-3-0.

1. Provider/Interested party name, title, board specialty (i.e., John Smith, M.D., board certified family practice 1999)
2. Address, phone number where we can reach you
3. Name of group/organization you are affiliated with, practice specialty (Smith Family Practice – family medicine office)
4. Address and phone number (if it's different than above)
5. Your e-mail address

Ohio Administrative Code 4123 rules update

We are mandated to review and update all of our Ohio Administrative Code medical rules as needed, at least every five years. We also make revisions in between as needed. We completed our most recent five-year review in 2009. At that time, we incorporated the Chapter 7 self-insuring employer rules into the Chapter 6 rules for simplification. Please click on *Rules and statutes* located at the bottom of the home page on ohiobwc.com to find BWC Rules governing this system.

Be sure to review Chapter 6, which includes the Inpatient hospital reimbursement update (Rule 4123.6-37.1), updates to definitions for both inpatient and outpatient

stays (Rule 4123-6-01), enrollment and credentialing criteria (Rule 4123-6-02.2) and the requirement of directly providing services you were certified as is found in Rule 4123-6-02 (i.e.: no subcontracting). Find these and many other revisions within these rules. We share rules with BWC's provider stakeholder associations, interested parties and the provider list serv.

Request for Temporary Total Compensation (C-84)

The injured worker now must sign and complete the C-84 form to provide information regarding work status, disability dates, his or her employer's name, light-duty work availability and receipt of other benefits. We encourage the physician to remind the injured worker to complete and sign the front page of the C-84 before he or she sends it to the BWC. We will not pay temporary total compensation without the completed and signed form from the injured worker.

Claim reactivation update

The inactive claim period changed from 13 months to 24 months on Oct. 12, 2010. The claim reactivation policy ensures timely and appropriate benefit payments on inactive claims. These are claims that have had a lapse of activity in which BWC has paid no medical or compensation for more than **24 months**.

We review inactive claims to make sure the requested treatment/services are appropriate based on the allowed conditions in the claim. This review also allows us to offer the same level of BWC/managed care organization communication and investigation on inactive claims that we have on new claims.

We deny bills with EOB 265: Payment is denied because the claim is inactive.

Required reports submission

The provider assumes the obligation to provide and complete all BWC forms required by the managed care organization (MCO) or BWC. A medical provider **may not charge** the injured worker, employer or their representatives, or the MCO, BWC, the Industrial Commission of Ohio, or a self-insuring employer for the costs of completing the required forms or submitting necessary documentation. This includes the *Request for Medical Information* (C-30) See BWC Rules 4123-6-20 and 4123-6-20.1.

Medco-16 and C-9 form updates

We have revised the *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) to include the CPT code and servicing provider information. Please provide this information if known.

By request of the Industrial Commission of Ohio, no longer use the C-9 form to request additional conditions in self-insured claims. BWC uses this area of the C-9 to look at additional conditions through its proactive allowance policy, which is not applicable to self-insuring employers. To assist these injured workers employed by self-insuring companies, please provide any documentation that would show causality and why the condition should be added to the claim, just as you currently do.

Psychological services providers may use the *Mental Health Note Summary* (Medco-16) in lieu of a written summary of mental health services.

BWC website security update

In late 2010, BWC made changes to our website in four areas to ensure injured worker information was protected. These changes include:

- Deleted injured worker Social Security number on the claim documents window;
- Deleted accident location on the injury/illness information window;
- The break out on the claims parties contact information window gives only contact name and phone number (Note: MCO and employer may be accessed under Employer/MCO lookup);
- Deleted Injured Worker Demographics Information service offering.

Providers who are listed on the claim as treating providers or the provider of record (POR) may still access this information.