Deloitte.

Ohio Bureau of Workers' Compensation Comprehensive Study

Cost Controls: MCO Effectiveness

Report 2.6

Deloitte Consulting LLP
Group 2
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Contents

Executive Summary

Introduction

The objectives of this task were to validate the existing state of workers' compensation Managed Care Organization (MCO) administration in Ohio, to benchmark current MCO systems to other states with respect to MCO regulatory requirements, quality control, dispute resolution, and general administration.

The methodology used for this task involved:

- Review of historical and current BWC-sponsored MCO administration programs,
- Leverage of information assimilated from BWC internal and external studies of MCO performance,
- Research and reporting of relevant industry sources for key performance indicators (KPI),
- Interviews with BWC and MCO process constituents, and
- Review of BWC Medical Services division strategies for program improvement, and commentary on alignment of its SMART (Specific, Measurable, Achievable, Realistic, Time-Bound) objectives for 2008 with our findings and recommendations.

Measurement of MCO effectiveness in Ohio is appropriate at a high level, and must be considered within the context of other BWC-administered medical programs, BWC's oversight and policy-making functions, and with an understanding of considerable enhancements in the Health Partnership Program (HPP) since its inception. Given some distinguishing features of Ohio's program, our ability to make comparisons to other jurisdictions and the insurance carrier community is limited. Other referenced sources also contain idiosyncratic features that complicate head-to-head comparisons.

We encourage readers to also review Deloitte Consulting's Medical Payments Study Report – Section 5.1.2 Task #25; as it contains important companion analyses of medical payment transaction, treatment authorization and alternative dispute resolution processes.

At a high level we offer the following findings and recommendations. Details and rationale for recommended actions are contained in text and exhibits in the report that follows.

Conclusions

Findings

- The HPP, and resulting MCO program establishment has had a positive impact on the overall system over time in conjunction with BWC sponsored initiatives.
- BWC quality assurance programs continue to improve MCO results but replacement of baseline metrics for severity comparison is recommended; i.e. Degree of Disability Management (DoDM) measurements are outdated. Performance of MCOs compared to Ohio DoDM metrics comprises the sole determinant of MCO incentive compensation. All MCOs consistently meet the highest variable compensation threshold. Other MCO administrative payment set-offs and associated metrics are appropriate, and put MCO fees aptly at risk for meeting relevant activity- and results-based performance standards. Activity metrics include allowable timing lag requirements for First Report of Injury (FROI) Timing (Date of Injury to BWC) and FROI Turnaround (MCO Receipt to BWC) and bill submission; results metrics address data accuracy through measurement of error rates by MCOs in FROI and bill electronic data transfers into BWC systems. These represent a good balance of performance metrics that tie MCO compensation to measurable standards in critical process areas. FROI measures for timing and turnaround demonstrate strong continuous improvement over time. BWC should consider establishing more aggressive targets in a progressive format to continually challenge MCOs to meet industry-leading practices in FROI completion and submission. Commercial insurance carriers typically measure their insureds' performance against 2-calendar-day best practice standards.

- Ohio is uncommon among others for MCO administration in the following features:
  - MCOs have primary responsibility for collecting FROI data from injured workers, employers and medical providers, and for verifying information and submitting FROI data to BWC, and
  - MCOs are responsible for provider bill review and payment, subject to BWC review and adjustment.
- Conflict of interest perceptions remain among process constituents over MCO business relationships with vocational rehabilitation (Voc. Rehab) service providers.
- Medical providers perceive a burdensome process for reimbursement. A "Blue Ribbon" panel of preferred providers is currently under consideration by BWC, and supported by the MCO League of Ohio to mitigate this issue for its best performing providers.
- BWC Medical Services Division SMART Objectives, as amended on April 21, 2008, contain appropriate improvement strategies, success measures and implementation timelines.
- MCOs are appropriately held to Utilization Review Accreditation Commission (URAC) standards for Case Management. All MCOs and subcontractors performing case management services must be URAC accredited. Rules of the HPP have historically provided guidance for Utilization Review (UR) but did not specify a designated set of medical treatment protocols until August 2007, with a revision of the MCO Policy Reference Guide that specified the "Official Disability Guidelines" (ODG), as the only BWC approved UR standard. Prior to August 2007 MCOs could use Milliman & Robertson, Interqual, Mercy, Presley Reed, and others but BWC eliminated the approval of these guidelines with the replacement of ODG.
- The number of MCOs participating in the HPP is currently at 23, showing a steady decline from the 57 who initially signed on for the program in 1997. This is a positive, albeit slow trend of attrition to more manageable numbers. Substantial BWC resources are dedicated to audit and oversight of MCOs and economies of scale and more effective program standardization are available in reduced numbers of participating MCOs. Pricing of MCO services are not based in a competitive process, and a "Come One, Come All" approach to all who meet minimum contracting criteria creates an administrative burden for BWC. We recognize that this will require a statutory change to current laws and regulations governing MCO enrollment and contracting but believe further study is warranted. Introduction of expanded competition to the MCO reimbursement structure would also position BWC to evaluate specific service value and pricing, i.e. FROI submission, medical and disability case management rates, UR and clinical editing software, etc. The current "bundled" approach challenges effective pricing of program component services. A more competitive environment would also afford enhanced opportunity for innovation in service delivery and transactional processing, and may attract industry leaders who don't currently participate in Ohio's HPP.
- Fee schedules for all services require formal review and update on a more regular basis. Proposed adjustments in fee schedules are likely to increase medical and ancillary provider satisfaction. Please see Deloitte Consulting's companion report on Medical Payments for more information and analysis of fee schedules.
- The MCO Report Card generated annually by BWC contains appropriate metrics for measurement of both activity-based and results-based standards with the exception of DoDM metrics. As noted above, the DoDM metrics require replacement. Employer and Injured Worker surveys were conducted in all years except 2008.
- BWC's Board of Directors' Public Forums provide important context for the Board of stakeholders' concerns, and are an important component in BWC's transparency initiative.
- Although provider certification is administered by BWC, and performance of providers is tracked on a limited basis by MCOs, there is no sustained, concerted effort to de-certify non-compliant providers.
- The BWC website provides valuable information and "drill-down" functionality to support MCO-related responsibilities and accountabilities for all constituents.
- There are significant bottlenecks in the process related to timely medical treatment authorization for allowable conditions.
- Statutorily-required Independent Medical Exams (IME) at 90 days of injured worker lost time appear to deliver little value to BWC or its constituents.

- The medical Alternative Dispute Resolution (ADR) program appropriately contains a multi-level review and appeal process progressively involving MCOs, BWC, and the Industrial Commission (IC). Limited value is realized in BWC's role in the ADR process as they concur with MCO decisions greater than 95% of the time.

Recommendations

- Encourage the trend of decreasing numbers of participating MCOs through market forces of vendor consolidation to reduce costs associated with BWC's oversight, audit and administration.
- Conduct a formal study to determine the feasibility of introducing more competition into the HPP. If increased competition is determined feasible, statutory changes, rules and regulations development will be required. This study will require significant effort in gathering stakeholder input, establishment of governance standards, business case development, and socialization of intended features among constituent groups.
- Establish the Official Disability Guidelines (ODG) as a replacement for the current DoDM benchmark metrics until such time as credible Ohio-specific data is available. All participating MCOs have access to ODG through BWC's contract.
- Given that the MCO Policy Reference Guide was revised in 2007 to make ODG the only approved set of treatment guidelines, BWC should become more directive with its use as another indicator of MCO performance and should integrate associated measurements in its audit standards.
- The BWC and MCOs are encouraged to undertake an in-depth study of what specific drivers account for average claim cost escalation, and to build a database to broaden management information for more proactive identification and management of emerging trends.
- Re-institute Employer and Injured Worker surveys as part of MCO Report Card measurements and sustain the effort year-to-year.
- Continue BWC Board of Director Public Forums related to Medical Services on a regular basis.
- Study the feasibility of a statutory requirement change to allow MCOs to approve accepted medical conditions and allowance of related medical treatment, subject to BWC oversight and audit. This would require a fundamental shift in BWC responsibilities from involvement in each decision to a concurrent and retrospective auditing model. This has potential to expedite treatment authorization and reduce attendant process delays.
- Increase efforts to gather provider profile information and to de-certify repeated, non-compliant providers.
- Update all fee schedules on a 1-2 year basis.
- Eliminate the statutory mandatory requirement for IMEs at 90 days of lost time.
- Study the feasibility and potential law, rule, and/or policy changes of removing BWC from the ADR process with MCO final decision appeals taken directly to the Industrial Commission. If BWC is removed from the process, MCOs should be required to comply with URAC standards for utilization review.

The Deloitte Consulting team appreciates the considerable time and effort dedicated by HPP constituents, particularly BWC's Medical Services Division and representatives of the MCO League of Ohio over the course of our discovery to help us understand the HPP and related processes.

The Situation

Task Background

RFP Task Reference	RFP Task Description	Task Category
Section 5.1.2 #30, page 14	Conduct a study on the effectiveness of Managed Care Organizations (MCO) in the workers' compensation system. This analysis would include an evaluation of the effectiveness of the use of MCOs, the payments to MCOs relative to the benefits received, the advantages and disadvantages of the MCO approach, the medical cost trends since MCO implementation, and a comparison to industry standards.	**Claims**

As part of the BWC Comprehensive Study the following report comprises Deloitte Consulting's deliverable of Section 5.1.2 Task #30 of BWC's Request for Proposal (RFP):

Background and discovery activities necessary to complete this task included:

- Understanding the evolution and current state of MCO administration at BWC,
- Research of credible sources and metrics for comparison of MCO program performance,
- Documentation and validation of BWC's business processes for MCO administration,
- Identification of industry leading practices,
- Identification of gaps between current and leading practices, and
- Development of improvement recommendations specific to identified opportunities.

Methodology

Completion of our MCO effectiveness analysis involved the following activities:

- Key constituent interviews,
- Data and documentation reviews,
- Industry leading practice comparisons, and
- Benchmarking of other "peer" state standards for MCO administration.

A variety of commercially and publicly available sources were referenced to establish benchmarks for BWC's MCO program effectiveness comparisons.

Deloitte Consulting practitioners met and interviewed BWC's Medical Services Division leadership and MCO specialists to understand MCO and provider enrollment and certification requirements, BWC-based quality control initiatives, annual MCO "Report Card" measurement standards and Alternative Dispute Resolution (ADR) procedures. Additional perspective was gained from discussions with injured worker representatives (attorneys and labor leaders), the MCO League of Ohio, the Industrial Commission and MCO executives.

Primary Constituents

The constituents in this task area include the following:

- **Injured Workers** - Responsible for reporting claims
- **Employers** - Responsible for MCO selection, claim allowance appeals, and for funding of the HPP
- **Medical Providers** - Responsible for treating injured workers and reporting claims to MCOs in compliance with HPP and BWC regulations
- **MCOs** - Responsible for claim intake, provider channeling, utilization review, provider bill review and payment, and medical case management
- **BWC Medical Services Division** – Responsible for management and oversight of MCO programs and IME administration
- **BWC Claims** – Responsible for overall claims administration of indemnity and complex medical-only claims.
- **BWC Internal Audit** - Responsible for BWC program performance measurement

HPP General Overview

MCOs were formally implemented in 1997 as the key component in a newly established Health Partnership Program (HPP). The HPP has evolved in its 11 year history and generally follows established industry standards for managed care with respect to medical bill review and re-pricing, utilization and medical peer review, medical/disability clinical case management, and quality assurance. Ohio's program contains some uncommon features when compared to other jurisdictions that authorize the use of MCOs, including:

MCOs are responsible for direct payment to providers, subject to review, adjustment and reimbursement by BWC.

MCOs are responsible for retrieving and documenting First Report of Injury (FROI) information from injured workers, medical providers and employers.

Below are summarized Deloitte Consulting responses to specific evaluation components of this task as identified in the Comprehensive Study RFP. Supporting documentation and rationale for findings is contained in report sections that follow.

Payments to MCOs relative to the benefits received:

BWC is challenged in managing 23 separate MCOs within the HPP. Ohio's program, unlike most others, requires MCOs to collect initial injury/illness information and submit FROIs to BWC. This appropriately requires a higher level of interaction between the two parties than is found in most other settings. Also, medical bill review is completed by both MCOs and BWC. This is a duplicative activity that impacts efficiency of the overall medical bill payment process. The relatively large number of MCOs compounds the efficiency issue. Please see Deloitte Consulting's Medical Payment Study for more information on medical bill review.

Quality control by BWC requires substantial resources to regularly audit the multiple functions and associated transactions performed by 23 MCOs. Statutory requirements in Ohio yield a non-competitive MCO landscape that places considerable administrative burden on BWC. MCO requirements are bundled such that determining the value of specific services is difficult to quantify. An environment where MCOs compete at a service level on price would afford BWC better options to limit the number of participating firms (thereby reducing its administrative cost), and ensuring the best value for services provided. Seventeen states authorize the use of MCOs; some, like California have over 60; others like Washington acknowledge as few as 6.

The accrued cost of MCO contracts was approximately $161M in FY 2008. BWC would be severely challenged to replace all of the services provided by MCOs in terms of program scale, required services and necessary competencies. The HPP has been institutionalized over the last decade, has experienced continuous

improvement, and has allowed BWC to focus medical management activities in audit and oversight functions. There are however some functions that afford opportunity for improved administration through greater BWC involvement (e.g. Voc. Rehab. and Medical Bill Review and Payment).

Deloitte Consulting does not believe that Ohio could sufficiently replace the current HPP with an alternative model that could deliver equivalent value. We do however encourage BWC to study the feasibility of a law change to introduce more competition to the MCO selection and enrollment process.

Advantages and Disadvantages of the MCO approach (not specific to Ohio):

Advantages associated with the MCO approach include:

- Adoption of leading practice cost control strategies,
- Alignment with other leading practice MCO-allowable jurisdictions,
- Out-sourcing of key clinical management functions,
- Leverage of internal BWC resources toward management and oversight, and shedding of expense related to lower-value, transactional functions.

Disadvantages of MCOs are specific to individual constituent groups given competing interests of some stakeholders related to provider access and reimbursement, treatment authorization, disability duration determination, and managed care interventions. These include:

- Increased bureaucracy to manage MCO-provider-claim payer interactions, and
- Provider resistance to participation due to fee schedules, UR constraints and administrative burdens. Please see Deloitte Consulting's Medical Bill Payment Report for more details.

Medical Cost Trends:

National trends of increased medical costs in workers' compensation include:

- Medical inflation rates exceeding those of general inflation,
- Medical spend increase percentages "flattening" over most recent years,
- An aging serviced workforce and increased life expectancy, and
- Technological advances in diagnostic testing, drug therapies, and medical treatment are generally more costly than replaced services

Moderate increase in the total medical spend for BWC is anticipated in the short-term given fee schedule update proposals, and a $73 million judgment relative to hospital reimbursement for bills back to 2005. New and proposed-new fee schedules will bring Ohio in better alignment with peer jurisdictions. The RBRVS (Resource Based Relative Value Scale) methodology of indexing fees to Medicare fee schedules is a noted industry-leading practice. "Spikes" in annual medical spend numbers present opportunity for "smoothing" over time if all fee schedules are updated on a more regular and predictable basis, i.e. every 1-2 years. Please see Deloitte Consulting's Medical Payments Study Report for more detail on fee schedules.

BWC Actuarial Division's Comparative Data report of 2008 provides key cost performance measures of Ohio compared to NCCI "State of the Line," studies of 2007. Highlights include:

- For the period 1993 through 2006 continuous improvement in the number of lost-time claims filed is evident across the industry. Although Ohio's is still greater than an NCCI average, BWC's cumulative change for this period is a decrease of 70%, while NCCI subscribers show a cumulative decrease of 48%.
- The average medical cost per claim is greater in Ohio than in NCCI averages, but BWC percentage increases since 2003 are smaller than those among NCCI subscribers, with BWC costs flat 2005-2006 while NCCI subscribers increasing by 7.4%.
- The percentage change in average medical costs on lost-time claims for Ohio is consistently less than NCCI subscribers for '03-'06.

- Medical totals of fiscal year payments have shown a positive downward trend since 2003.
- Pharmacy totals of fiscal year payments peaked in 2005 but have shown marked decreases in 2006 and 2007, with 2007 reaching pre-2003 levels.

Comparison to industry standards:

Ohio appropriately designates URAC standards for Case Management for MCOs to follow in making their medical treatment and return-to-work decisions. Disability duration baseline outcome metrics used to rate MCO performance are outdated and require replacement. BWC-generated annual MCO Report Cards capture appropriate comparative measurements that align with other generally recognized national quality assurance standards.

MCO performance measures are defined as quantitative reports on an organization's functioning. URAC and other credible research bodies have indicated that performance measures can relate to either the process or the outcomes of a system. Ideally, a measure should be based on a recognized best practice that is supported by research. It requires testing and validation to establish performance measures to provide credible information on aspects of care that tie to outcomes, and allow for comparison to like organizations.

URAC has developed working draft principles on performance measures and identified three avenues for collecting and analyzing data. These include:

1) Survey of workers about return to work, activity limitation, injury prevention and outcomes after workers' compensation medical care,

2) A protocol for analyzing data from bills and claims so that reports can be generated to evaluate referrals and treatment patterns, and

3) A chart audit tool is recommended to assess quality of care by providers.

BWC's MCO scorecard has key elements of identified URAC performance measurement principles. BWC current metrics measure performance in specific processes that are known to impact ultimate loss costs (e.g. FROI timing and turnaround). BWC has a history of performing Injured Worker surveys, a key element in URAC recommended performance measures.

Information & Data Gathered

Interviews

Deloitte Consulting practitioners conducted initial and several follow-up interviews with BWC Medical Services Division leadership and staff, and other process constituents to understand the current business process, identify specific challenges, and to validate preliminary assumptions. The following individuals were very helpful in clarifying our multiple questions and responding to requests for data and documentation.

BWC

- Chief Medical Services and Compliance
- Director, Managed Care Operations
- Director MCO Business and Reporting
- Manager Medical Policy
- Provider Relations Manager
- Administrative Staff, Medical Services
- Director Compliance and Performance Monitoring
- ICD-9 Analyst
- Managed Care Services Director
- IRN Administrator
- Director HPP Systems Support

MCO League of Ohio

- Executive Director
- MCO President and Chief Operating Officer
- Managed Care organization Ohio MCO Manager
- MCO Director of Medical Management

Union Representative

- AFL-CIO

In addition to interviews, we attended two BWC Board of Director Public Forums on Medical Issues in April and June that provided important MCO constituent perspectives on current strengths and challenges in MCO administration.

Information/Data Request

Deloitte Consulting requested and received all data and documentation timely. We leveraged existing studies conducted by major workers' compensation research and BWC stakeholder organizations (e.g. the Ohio MCO League's 2007 study by The Kilbourne Company) in favor of redundant data collection in our analysis. Deloitte

Consulting met with BWC Medical Services Division leadership and confirmed that this study would concentrate evaluation efforts in business process assessment. We reference loss trends in this report but have relied on BWC and other credible sources for data underlying our baseline determinations and subsequent trend analyses.

Review & Analysis

Benchmarking

Information from the following sources provided external comparative data for benchmarking of MCO effectiveness and performance in Ohio:

- US Department of Labor, Bureau of Labor Statistics (BLS)
- National Council on Compensation Insurance (NCCI)
- International Risk Management Institute (IRMI)
- Workers' Compensation Research Institute (WCRI)
- American College of Occupational and Environmental Medicine (ACOEM)
- Utilization Review Accreditation Commission (URAC)
- Rand Corporation
- US Chamber of Commerce
- California Commission for Health and Safety and Workers' Compensation
- MCO League of Ohio HPP Report (actuarial study performed by The Kilbourne Company)
- Business Insurance Market Sourcebook data
- BWC Comparative Data Report, January 2008

State Comparisons of MCOs and Choice of Physician

- 30 of 50 states authorize the use of MCOs.
- 35 states allow injured workers to select the treating physician, or Physician of Record (POR), subject to some limitations.
- 16 states require injured workers to treat with a physician in the employer's MCO.

The table below highlights basic state characteristics for MCO authorization and choice of physician. Most states have caveats governing how and when a change in treating physician designation is allowed. For the sake of brevity we have chosen to not identify each state's specific requirements but they are available upon request by BWC.

State Comparisons of MCOs and Choice of Physician

Jurisdiction	State Authorizes Workers' Compensation MCOs Yes (Y)/No (N)	Selection of Treating Physician Employer (ER) or Employee (EE)	Employee Required to Use Physician in Employer's MCO	Employee Allowed to Use Other Physician
Ohio	Y	EE	N	Y
Alabama	Y	ER	Y	
Alaska	N	EE		
Arizona	N	EE / ER		
Arkansas	Y	ER	Y	Y
California	Y	ER	Y	Y
Colorado	N	ER		Y
Connecticut	Y	EE		
Delaware	N	EE		
District of Columbia	N	EE		
Florida	Y	ER	Y	
Georgia	Y	EE		
Hawaii	N	EE		
Idaho	N	ER		
Illinois	N	EE		
Indiana	N	ER		
Iowa	N	ER		
Kansas	N	ER		Y
Kentucky	Y	EE		Y
Louisiana	N	EE		
Maine	Y	ER		
Maryland	N	EE		
Massachusetts	Y	EE / ER		Y
Michigan	N	ER		
Minnesota	Y	EE	Y	
Mississippi	N	EE		
Missouri	Y	ER	Y	Y
Montana	Y	EE		
Nebraska	Y	EE		Y
Nevada	Y	EE	Y	
New Hampshire	Y	EE	Y	
New Jersey	N	ER		

State Comparisons of MCOs and Choice of Physician - continued

Jurisdiction	State Authorizes Workers' Compensation MCOs Yes (Y)/No (N)	Selection of Treating Physician Employer (ER) or Employee (EE)	Employee Required to Use Physician in Employer's MCO	Employee Allowed to Use Other Physician
New Mexico	N	ER		
New York	Y	EE	Y	
North Carolina	Y	EE	Y	
North Dakota	Y	EE	Y	Y
Oklahoma	Y	EE / ER	Y	
Oregon	Y	EE		Y
Pennsylvania	Y	EE		Y
Rhode Island	Y	EE		Y
South Carolina	N	ER		
South Dakota	Y	EE		
Tennessee	Y	EE	Y	
Texas	Y	EE	Y	
Utah	Y	EE	Y	Y
Vermont	N	ER		Y
Virginia	N	EE		
Washington	Y	EE		
West Virginia	Y	EE / ER	Y	
Wisconsin	N	EE		
Wyoming	Y	EE		

Use of the Official Disability Guidelines (ODG)

ODG is an emerging standard of medical treatment protocols for Utilization Review (UR) decisions and expected disability duration determinations throughout the WC Claims industry. BWC and MCO League representatives are in agreement that a higher degree of standardization for disability duration determinations in the HPP is appropriate. Although ODG is the only authorized set of UR treatment protocols, the DoDM metrics in place are outdated and require replacement. The following table indicates states which have implemented formal programs that rely on ODG in various components of managed care. ODG is specified as the exclusive BWC approved UR standard, and ODG disability duration guidelines are suggested as a replacement for DoDM metrics currently in use.

Use of the Official Disability Guidelines (ODG)

Jurisdiction	Current ODG Use	Basis -Law/Rule -Policy -Bargained
Ohio	BWC and MCOs use the Official Disability Guidelines (ODG) - evidence-based treatment guidelines. The ODG is a web-based tool that BWC and MCO staff can easily search and find pertinent information necessary to coordinate everyday issues in claims and medical case management. As of August 2007 ODG is the only BWC-approved set of treatment guidelines.	Policy
California	California uses ODG guidelines for Chronic Pain and Post Surgical Care (Proposed) by the Division of Workers' Compensation (DWC) in a larger data set of treatment guidelines promulgated by the American College of Occupational and Environmental Medicine (ACOEM). CA Labor Code section 4604.5(a) provides that the medical treatment utilization schedule (MTUS) is presumed to be correct on the issue of the extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof. Labor Code section 4604.5(e) provides that treatment for injuries not covered by the MTUS shall be authorized in accordance with other evidence-based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.	Law/Rule
Hawaii	Collectively bargained with The International Brotherhood of Electrical Workers (IBEW) and the Electrical Contractors Association of Hawaii (ECAH).	Bargained
Kansas	The Official Disability Guidelines-Treatment in Workers Compensation (ODG), published by Work Loss Data Institute (WLDI), is to be recognized as the primary standard of reference, at the time of treatment, in determining the frequency and extent of services presumed to be medically necessary and appropriate for compensable injuries under the Kansas Workers Compensation Act, or in resolving such matters in the event a dispute arises.	Law/Rule
Missouri	ODG is used to manage and oversee treatment and expected disability duration for workers' compensation claims.	Policy
North Dakota	The state fund is self-administered by Workforce Safety and Insurance (WSI). WSI chose Work Loss Data Institute's Official Disability Guidelines - Treatment in Workers Comp (ODG) as a resource to manage the treatment and disability duration for workers compensation claims. ODG will enable WSI to use the latest available medical evidence in making treatment decisions to improve outcomes for workers injured on the job.	Policy
Tennessee	Rule requires specific uniform standards -- either from the Official Disability Guidelines (http://www.disabilitydurations.com/) or the American College of Occupational and Environmental Medicine (http://www.acoem.org/) be used in making all utilization review determinations.	Law/Rule

Use of the Official Disability Guidelines (ODG) - continued

Jurisdiction	Current ODG Use	Basis -Law/Rule -Policy -Bargained
Texas	a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning). (f) A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title. http://info.sos.state.tx.us/pls/pub/readtac$ext.tacpage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=2&ch=137&rl=100	Law/Rule

National MCO Case Management Comparative Data

Reimbursement

MCOs are typically reimbursed for case management and utilization review in three ways:

- Per Case/Task Based: Fee includes all services required to be performed until resolution, task completed or mutually agreed upon case closure. This may also include timeframes or other parameters.
- Per Hour: Hourly fee based on professional time to perform case management or utilization review services.
- Flat fee: A fixed fee to manage a case for a closed period of time (e.g. 30, 60 or, 90 days). Flat fee arrangements are common in pricing of Telephonic Case Management services.

Preferred Provider Network Discounts

PPO network costs typically are measured against a percentage of savings. This pricing model is often used for PPO Hospital, Outpatient Care Networks and Out of Network Services. It calculates the amount saved below an applicable fee schedule or Usual, Customary and Reasonable reimbursement rates, and a percentage of savings is shared (e.g. 25%) with the serviced organization. Please see Deloitte Consulting's Medical Payment Study report for more detail.

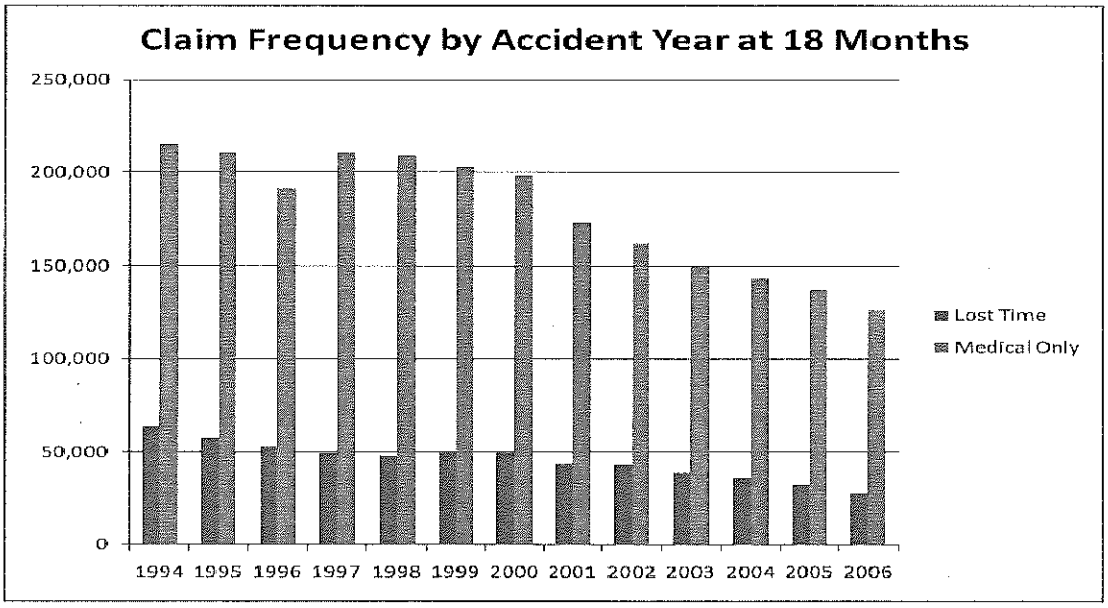
Analysis

BWC's annual medical expenses include cumulative claim costs and appear consistent with larger national trends. Cost controls effected by MCO administration and BWC oversight have mitigated what would have been steeper increases. The following highlight some major cost impact issues that challenge the national workers' compensation insurance industry.

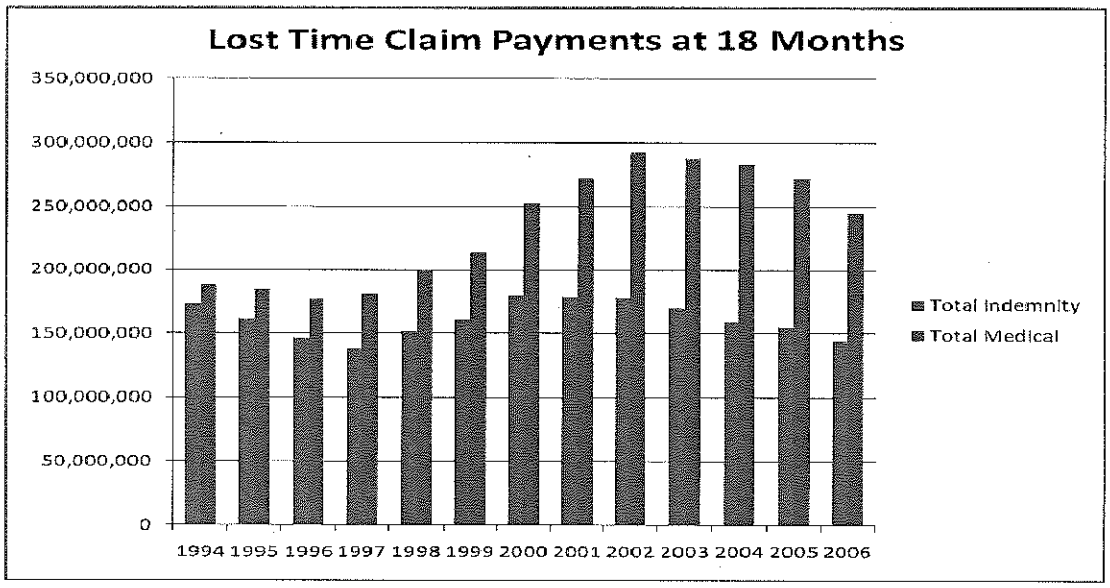
- National trends of medical inflation continue to rise at higher rates than overall inflation.
- Increased allowable conditions, diagnosis and treatment in workers' compensation continue to expand scope of treatment.
- Increased pharmacy costs and expanded utilization of new, expensive drugs (especially in chronic pain management) combine to sustain a multi-year trend of double digit increases in annual costs.
- Specific poor trending health conditions of the US population (e.g. obesity, diabetes, heart disease) combine to drive up workers' compensation medical costs through increased healing periods and compromised return-to-work options.

Ohio Loss Trends

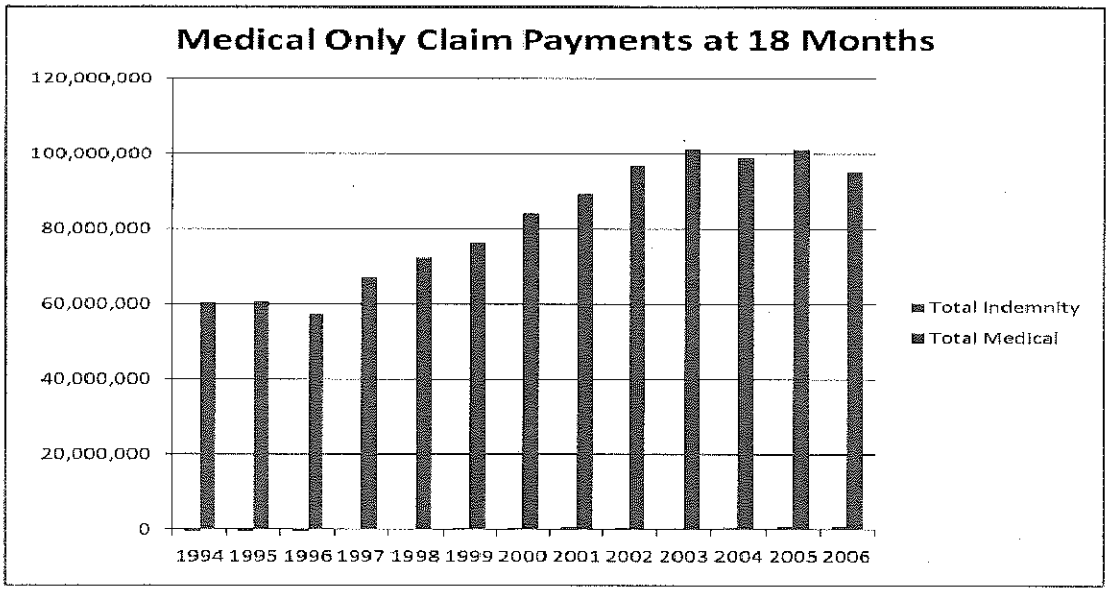
The following charts depict claim frequency and cost trends for public and private employers for accident years 1994-2006. Frequency refers to claim counts and severity reflects paid losses aged at 18 months. Losses include both medical and indemnity expenses under the assumption that MCOs influence both medical and wage-replacement benefit costs through case management efforts. It is important to note that these charts reflect measurement of overall performance of the HPP, and that BWC and MCOs share in responsibility for achieving results. MCOs do not generally impact frequency, i.e. numbers of claims, and frequency improvement is largely attributable to BWC safety initiatives and general industry trends. Severity, i.e. cost of claims, is influenced by both BWC and MCOs. BWC promulgates rules and guidance for cost containment programs and MCOs implement them and are responsible for performing to required criteria.



Consistent with industry trends continuous reduction in frequency is sustained over time.

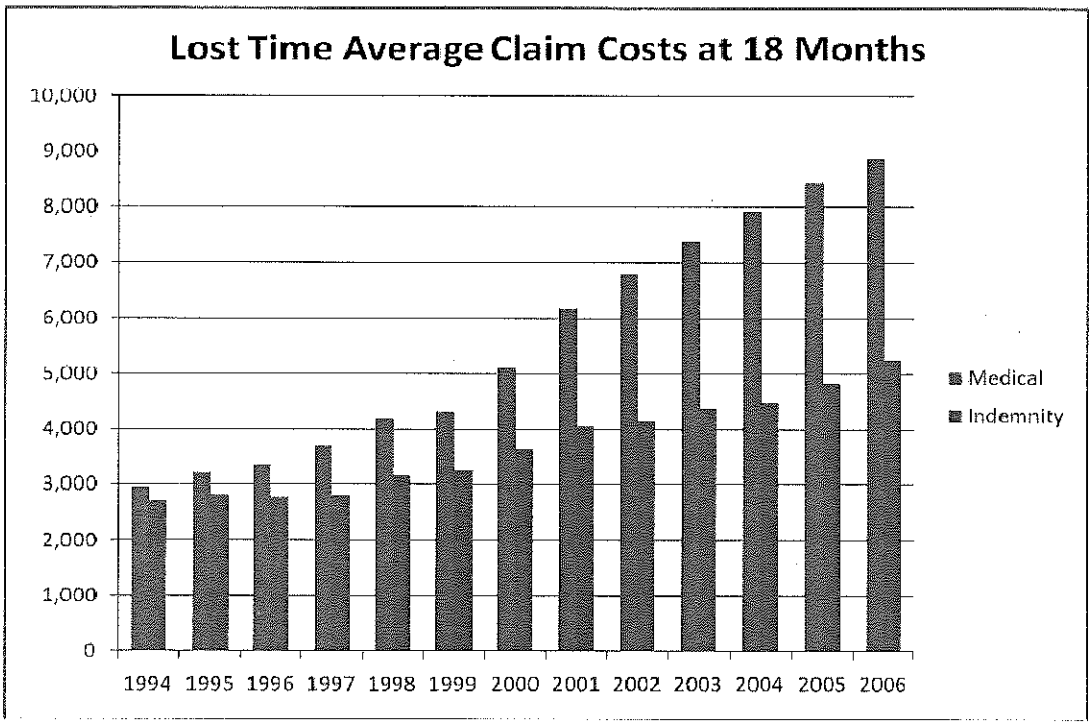


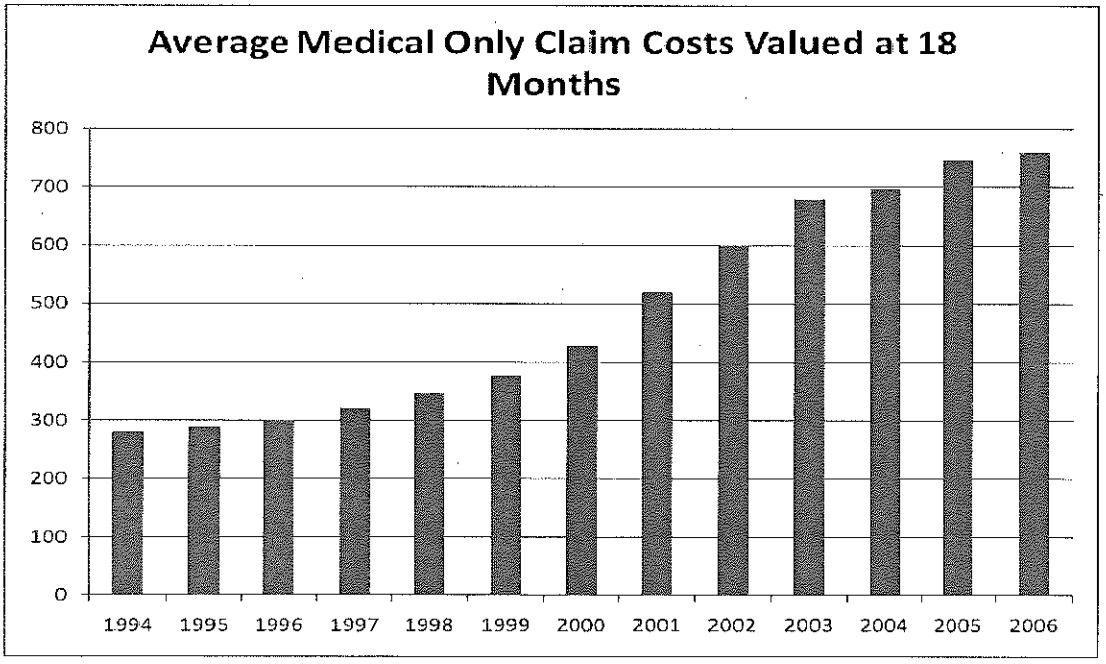
Lost time claim payments reached their highest levels in 2002 and have trended positively since in both medical and indemnity categories.



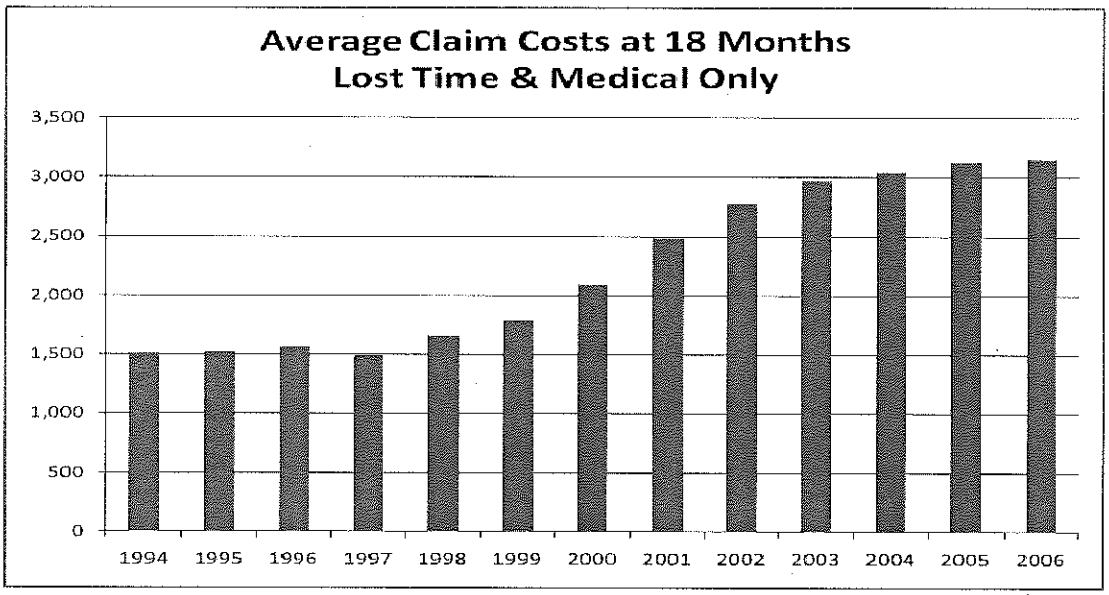
Medical-only claim payments peaked in 2003 and have "flattened" in most recent years.

Note that 2005 and 2006 medical payments will increase as a result of a $73 million judgment for the Ohio Hospital Association for retroactive payment of re-priced inpatient hospital bills.





Annual percentage increases in average costs for Medical Only claims have moderated since 2004. Year over year increases in average claim costs are in large part offset by decreasing frequency (numbers of claims).



Average claim costs for all claims have demonstrated lower percentage increases since 2003 after seven years of consistent significant increase. Average claim costs are relatively "flat" 2005-2006. As noted above; average claim costs should be viewed in the context of decreasing frequency.

All of the above summary observations appear consistent with national trends as published by NCCI for 2007. Please see BWC's Actuarial Department's Data Comparison of January 2008 for more detail.

There are a variety of factors that converge to cause increasing average claim cost. The BWC and MCOs are encouraged to undertake an in-depth study of what specific drivers account for claim cost escalation, and to build a database to broaden management information for more proactive identification and management of emerging trends. A more robust reporting system will yield results in:

- Improved vendor management,
- Improved performance management of BWC Medical Services teams and individuals, and
- Facilitation of better claim workflows for case assignment and escalation.

Specification of ODG's medical treatment protocols as the only BWC accepted standard in 2007 for utilization review is expected to yield a positive impact and needed consistency in managing providers. Auditing for MCO compliance to these guidelines presents opportunity for related performance measurement and adjustable MCO compensation. Expansion of medical procedures and ancillary service fee schedules in recent years is also expected to have a positive impact on costs by limiting "outlier" procedures and corresponding lack of billing controls.

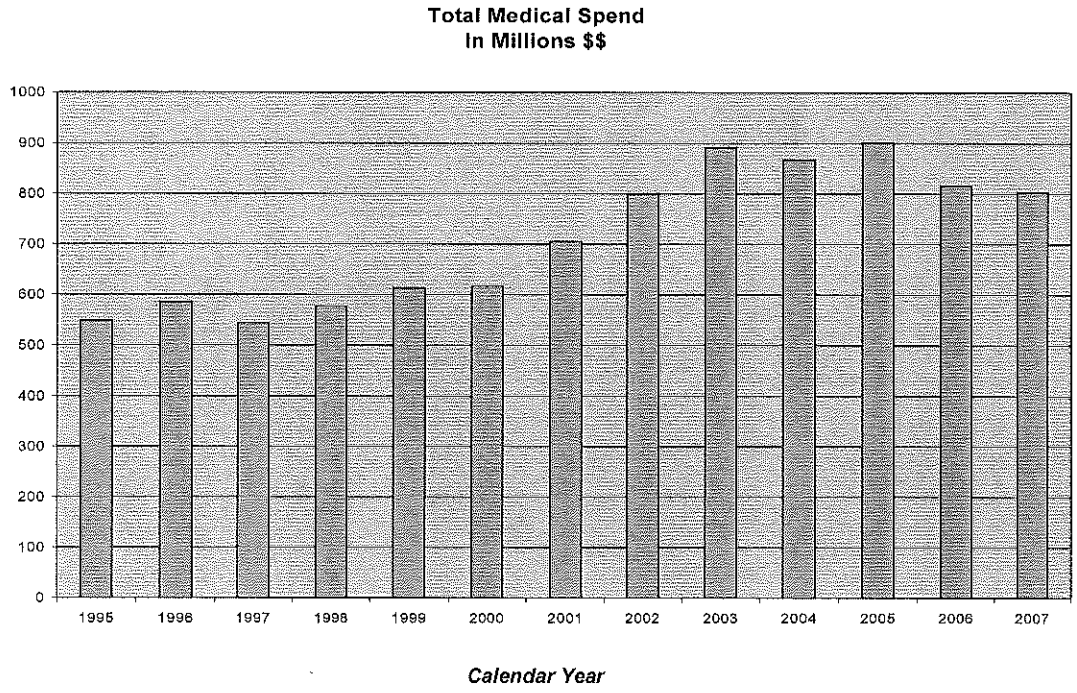
Medical Spend Analysis

The medical spend analysis immediately below shows positive trends in related payment history by calendar year since 2005.

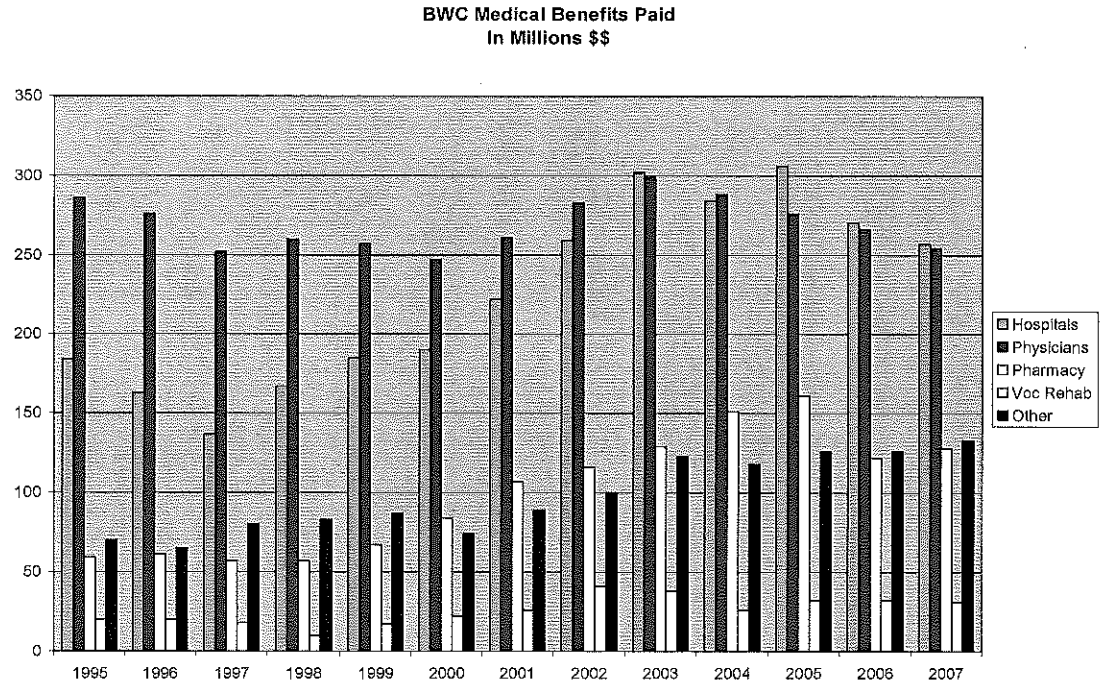
The following charts depict medical payments in annual aggregate and by major categories that fall under the purview of the HPP. All of these categories involve some level of shared responsibility between BWC and MCOs for medical claims administration. Related expenses have trended positively since 2005 reflecting lower frequency of incoming claims, and BWC's implementation of improved cost containment measures related to Pharmacy Benefit Management (PBM), Medical fee scheduling, and Diagnostic Related Grouping (DRG) for in-patient hospital stays.

It is important to note that severity calculations above and medical spend numbers below are under-stated by whatever amount is accumulated within Ohio's $15k Medical Only (and prior $1k and $5k Medical Only) and Salary Continuation programs. Under the $15k Medical Only program employers are allowed to pay up to $15,000 in medical payments without involvement of BWC. The Salary Continuation program allows employers to pay full

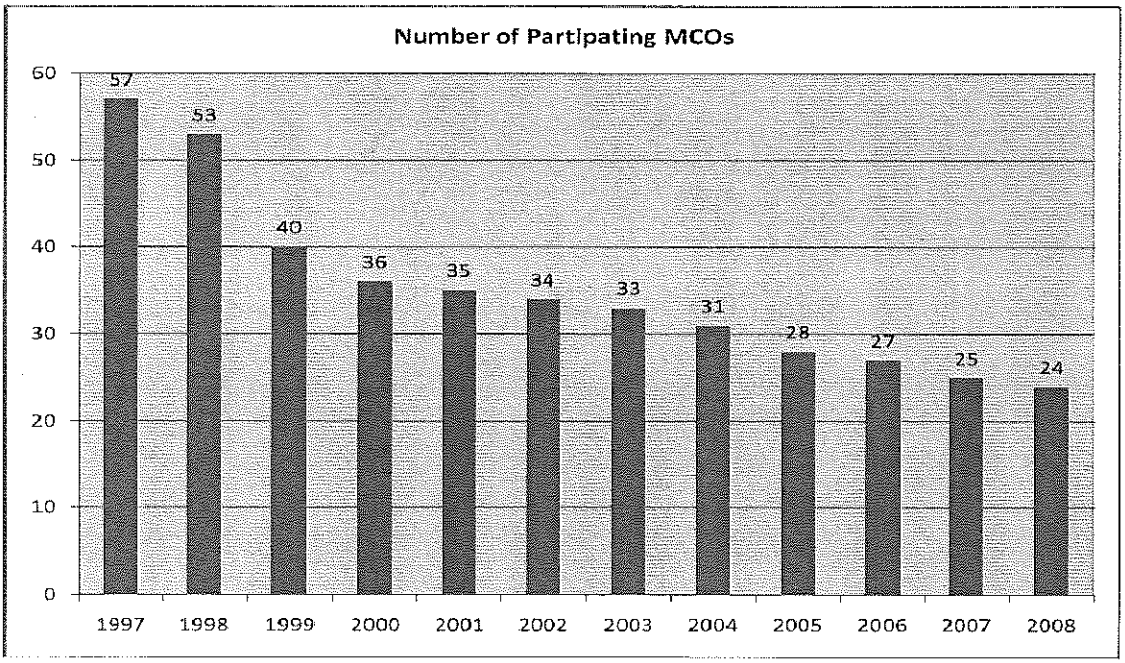
wages for lost-time claimants in lieu of indemnity benefits. Credible data is not available to analyze the effect of these programs. Deloitte Consulting has recommended discontinuance of these programs for multiple reasons as expounded in the Comprehensive Study's Group 1 Tasks. Please see the corresponding Board presentation and report for details.



The mix of types of medical benefits paid shows predictable higher expenses in hospital and physician costs than in pharmacy and vocational rehabilitation consistent with national trends. Pharmacy yields the greatest percentage increases year over year through 2005. Pharmacy Benefit Management programs initiated in 2005 requiring use of generic drugs and other cost containment measures demonstrate significant cost reductions. Note: Pharmacy spend analysis was not included in this study. Hospital expenses from 2005 through 2007 are artificially low due to the Ohio Hospital Association's successful lawsuit to recover $73 million in in-patient and out-patient charges.



MCO Participation



The number of participating MCOs continues to decrease in Ohio and currently stands at twenty three but was at 24 as of July 2008. This trend has a positive impact on BWC administration such that quality control measures are targeted to a smaller group, outcomes are more easily measured, and standardization of program features is enhanced.

MCO Report Cards

MCO Report Cards are developed and reported annually by BWC. Targeted metrics include appropriate integration of both activity-based and results-based standards over which MCOs have direct, first-line control. Scoring in the various categories contained in MCO Report Cards is weighted retrospectively by BWC, i.e. scoring weights by category are determined at year end. Meeting or exceeding DoDM targets comprise the sole current determinant of MCO incentive compensation. All MCOs consistently meet the "well-managed" criteria to earn maximum incentive payments. This points to the need for replacement of disability duration baseline metrics such that MCOs are more challenged to maximize incentive compensation.

The MCO Report Card includes the number of claims with dates of injury March 1, 1997 and later assigned to the MCO as of 12/31 of the prior year regardless of whether the claim is being actively managed by the MCO. This reflects all claims filed after the inception of HPP. As of 12/31/2007, this totaled approximately 2.5 million claims. The steady but declining increase in the number of claims reflected in the Report Cards is due to adding another year's worth of claims to each MCO's total. Given Ohio's statutory requirement of not officially closing claims until six years after the last payment (depending on the date of injury/lost time status this could be as long as 10 years), and significant variations among other states' prescription for claim closing, adequate comparison to peer states did not afford enough value to report. Active managed claims is a "good to have" number as it is a relatively current metric of all active claims in the system. It affords limited value in assessing MCO performance without more data points to identify claim open-to-close ratios and associated timing, but affords an appropriate component determinant of total payments available to MCOs. Ohio is consistent with most other states with a two-year claim filing statute of limitations. Please see Deloitte Consulting's Benefit Comparison companion Comprehensive Study report for more details.

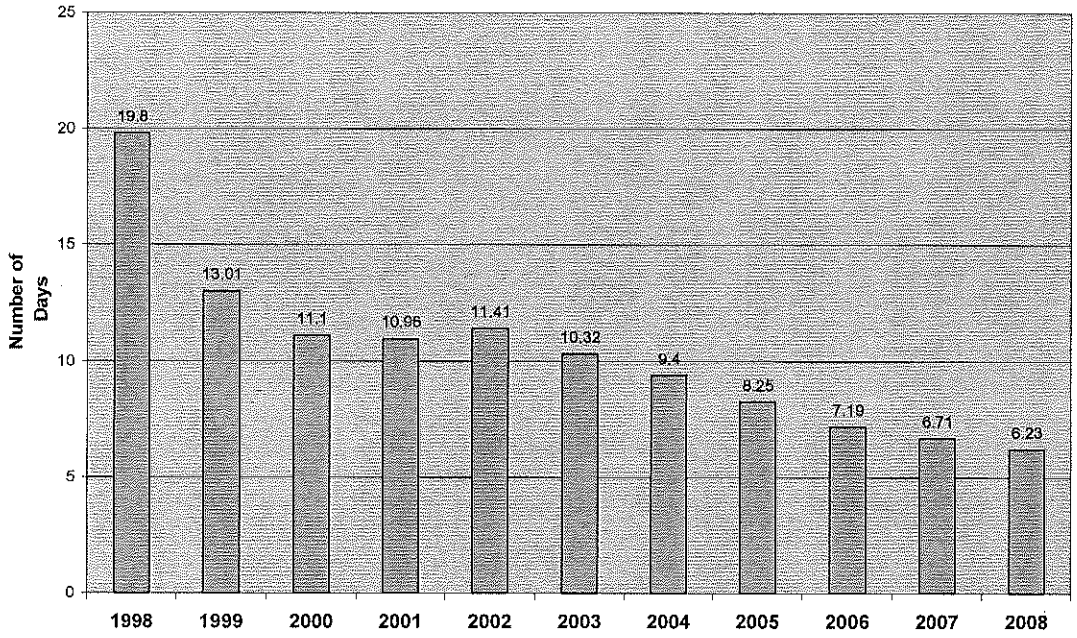
FROI Timing and Turnaround

Ohio is unique in its overall FROI process and distinct from injury reporting in most other jurisdictions. It is the obligation of injured workers to report an injury where it is generally an employer responsibility outside of Ohio. The table below details the typical events / steps in a FROI process both in the Ohio system and in the industry-at-large with corresponding key target timeframes.

Key Events	Key Dates	Ideal Timeframe
Industry at Large		
1. Injury/illness occurs	- Date of Injury/Illness	24 to 48 hours
2. Injured Workers reports injury/illness to employer	- Date of Employee Report to Employer	
3. Employer notifies carrier	- Date Employer Notifies Carrier	
4. Carrier/TPA enters claim into system	- Date Claim Entered	
5. Carrier/TPA makes contacts	- Date Claim Activity Begins	
Ohio		
1. Injury/illness occurs	- Date of Injury/Illness	48 to 72 hours
2. Employee seeks treatment	- Date of Initial Treatment	
3. Physician reports injury to MCO	- Date of Report to MCO	
4. MCO receives, verifies information and reports injury to BWC	- Date BWC Received	
5. BWC receives and notifies employer	- Date BWC Notifies Employer	

First Report of Injury (FROI) timing is a common and effective measurement of a key performance indicator in workers' compensation claims management. FROI timing measures the average number of days between the date of injury and the date the claim is filed with BWC. Timely receipt of injured worker and employer statements and initial medical reports comprise critical claim compensability decision components. Early intervention managed care strategies have a positive impact on ultimate claim outcomes while delayed reporting and claim investigation have negative consequences on medical costs and return-to-work. FROI timing under the HPP has demonstrated strong continuous improvement over time. Claim reporting timing may benefit from an additional measurement of the date of employer knowledge of injury/illness to the date a claim is filed with BWC. Although employers are not statutorily required to report claims to BWC, employer involvement early in the reporting process generally enhances initial claim investigation. FROI timing has continued to improve year over year since HPP inception and but does not yet meet industry leading practice.

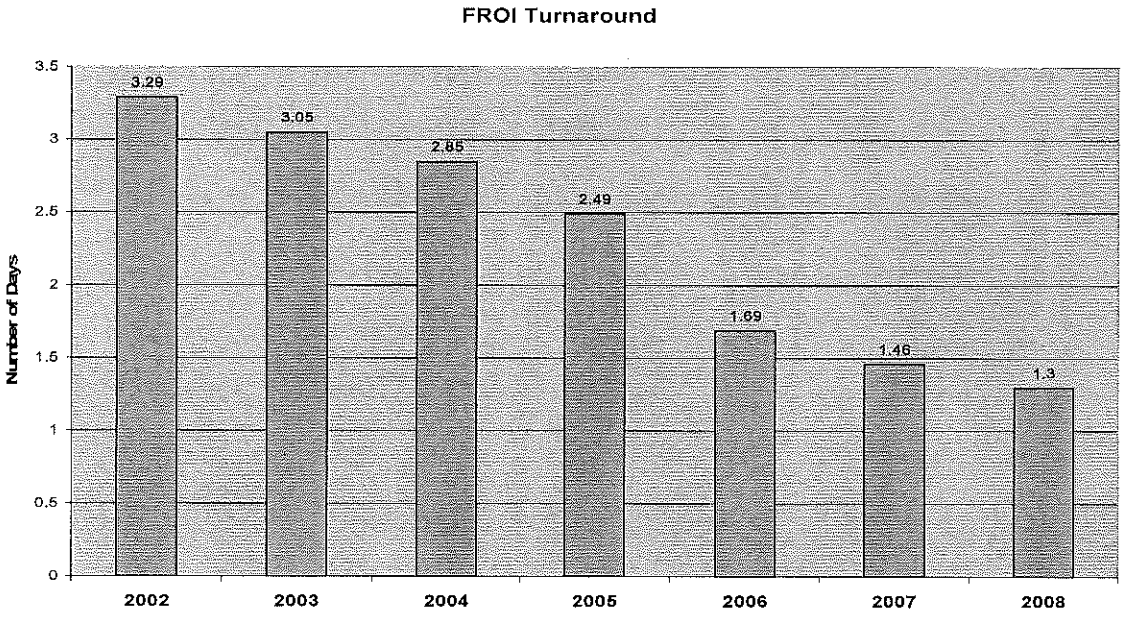
FROI Timing



Note: A definition change of FROI timing occurred in 1999 that accounted for the significant initial reduction. Each year's data measures the prior calendar year's results.

FROI Turnaround is a KPI of MCO Report Cards and measures efficiency in submitting claims by tracking the average number of days between the date MCOs receive the FROI notice, and the date they electronically file the claim with BWC. In most other settings employers submit FROIs directly to their claims administrator, eliminating Ohio's interim step of MCO involvement. A two-day (calendar) industry-leading standard is recognized for FROI Turnaround. There are trade-offs to both approaches. In Ohio, MCO involvement has ensured a high degree of complete information in FROI submissions but the extra time in gathering data retards the process. Conversely, employer reports directly to claims administrators often require the administrator to retroactively track down information that was not provided or available at the time of the employer submission.

As with FROI Timing, FROI turnaround demonstrates continuous improvement over time. The last three years reveal a best practice measurement of less than two days.



Each year's data measures the prior calendar year's results.

Injured Worker and Employer Satisfaction Surveys

MCO Report Cards have measured both Employer and Injured Worker satisfaction through surveys in all HPP years with the exception of 2008. The scale for both satisfaction metrics is as follows:

5 Very Satisfied

4 Satisfied

3 Somewhat Satisfied

2 Dissatisfied

1 Very Dissatisfied

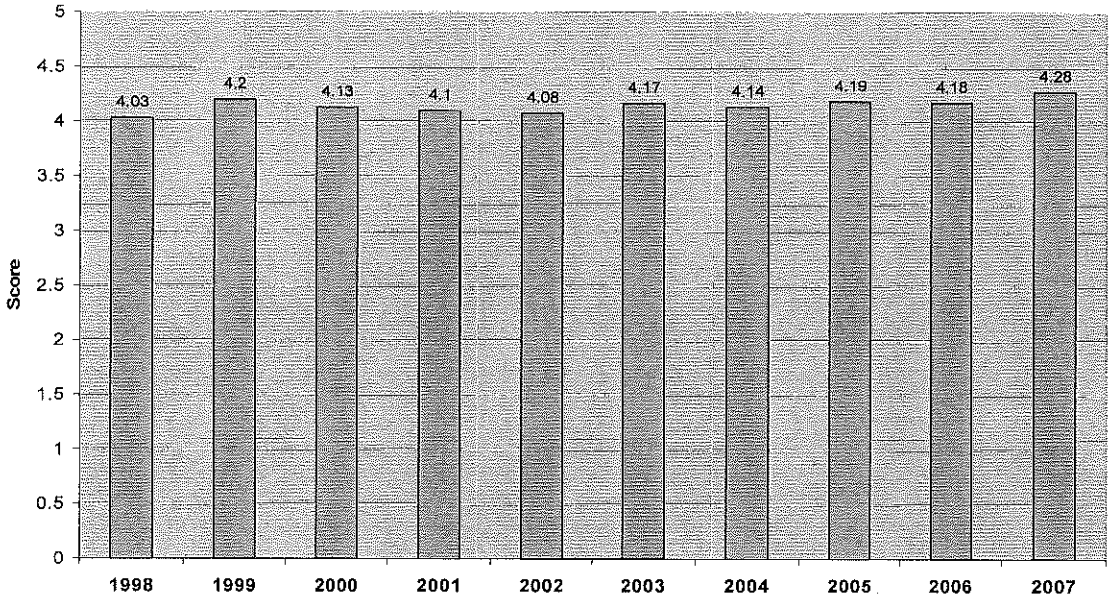
Numbers listed by each year reflect the prior calendar year's experience.

Employer Satisfaction has ranked on average at Satisfied levels for all years surveyed with 2007 showing the strongest performance to date.

Deloitte Consulting recommends that injured worker and employer surveys be re-instated on an annual basis. As the two major serviced populations of BWC, we believe it is important to solicit the "Voice of the Customer," and to respond to systemic issues as they arise. Constituent surveys also promote a high level of transparency that is important in publicly administered programs.

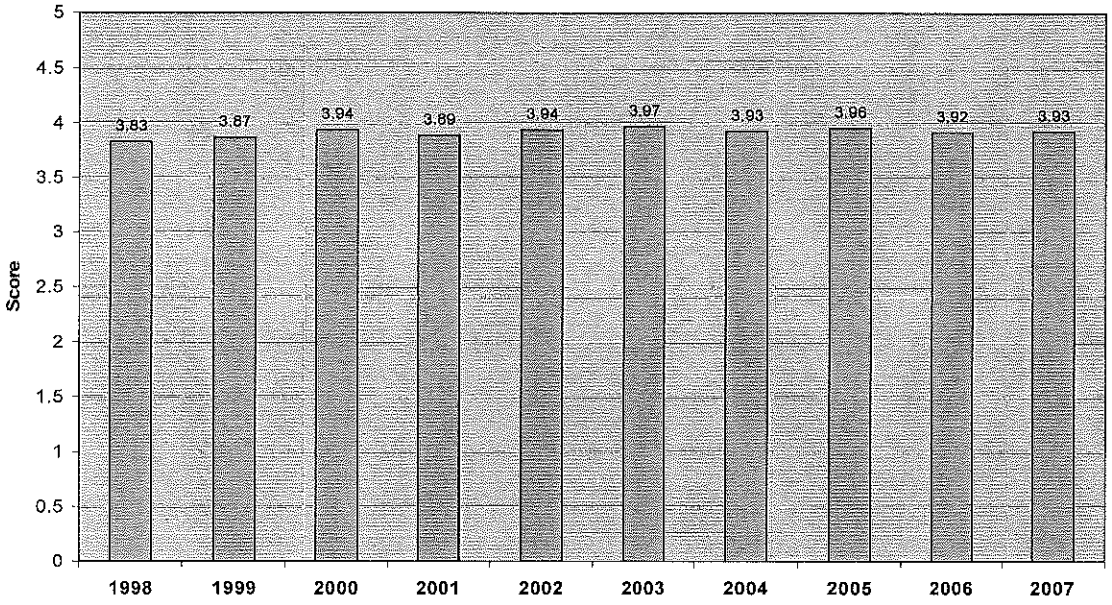
Many major claims administrators, insurers, and MCOs routinely conduct constituent surveys. Oregon, Texas, Montana, Rhode Island and California provide good examples of state administered injured worker surveys.

Employer Satisfaction



Injured Worker Satisfaction has ranked at the high-end of Somewhat Satisfied levels on average for all years surveyed. These scores appear reasonable given inherent claimant survey biases and bureaucratic processes associated with all workers' compensation systems. They do present opportunity for improvement in injured worker outreach programs.

Injured Worker Satisfaction



Vocational Rehabilitation

Given that BWC has recommended in-sourcing of Vocational Rehabilitation referral and management we have compared its desired model with other states. The following table provides detail by state for the role and entity involved in state Vocational Rehabilitation Workers Compensation programs. A few states provide all aspects of service delivery with some or minimal outsourcing.

State Vocational Rehabilitation Provisions*

Jurisdiction	Type of Program	State Vocational Rehabilitation / Other State Entity	State Vocational Rehabilitation Entity Role
Ohio	**Voluntary**	**Rehabilitation Division of Bureau of Workers' Compensation (BWC)**	**Administer (Current)**
Alabama	Mandatory	None Apparent	None Apparent
Alaska	Voluntary	None Apparent	None Apparent
Arizona	Determined by Commission	Industrial Commission	Administer Special Fund
Arkansas	Determined by Commission	Commission	May Authorize Vocational Rehabilitation
California	Voluntary Voucher	Rehabilitation Unit of the Division of Workers Compensation	Administrator
Colorado	Voluntary DOI 7/2/87 +	None Apparent	None Apparent
Connecticut	Voluntary	Workers' Compensation Commission Rehabilitation Services	Delivery of Services
Delaware	Determined by Industrial Accident Board	None Apparent	None Apparent
District of Columbia	Mandatory	Mayor	Monitor (Services provided by Employer)
Florida	Voluntary DOI 10/1/89 +	Bureau of Rehabilitative Services	Coordinator for Insurer Assessment / Some Delivery of Services
Georgia	Mandatory - Catastrophic	None Apparent	None Apparent
Hawaii	Voluntary	Rehabilitation Unit / Dept Labor & Industrial Relations	Administer (Recommend, review, and approve progress)
Idaho	Voluntary	Rehabilitation Division	Administer (Assessment / identification of retraining)
Illinois	Mandatory	None Apparent	None Apparent

State Vocational Rehabilitation Provisions* - continued

Jurisdiction	Type of Program	State Vocational Rehabilitation / Other State Entity	State Vocational Rehabilitation Entity Role
Indiana	Voluntary	Department of Vocational Rehabilitation	Administer
Iowa	Determined by Commissioner	None Apparent	None Apparent
Kansas	Voluntary DOI 7/1/93+	None Apparent	None Apparent (by agreement between parties)
Kentucky	Mandatory	None Apparent	None Apparent
Louisiana	Mandatory	None Apparent	None Apparent
Maine	Mandatory	Workers' Compensation Board	Administer - Office of Rehabilitation may implement and pay plan reject by employer
Maryland	Determined by Office of Education and Voc Rehab	State Department of Vocational Rehabilitation	Delivery of Services (services can also be provided by private vendor)
Massachusetts	Qualification Procedure	Department of Industrial Accidents	Administer
Michigan	Mandatory	Workers Compensation Agency	Administer
Minnesota	Qualification Procedure	None Apparent	None Apparent
Mississippi	Voluntary	Workers' Compensation Commission	Vocational Rehabilitation Determination
Missouri	Voluntary	Division of Workers' Compensation	Administer
Montana	Qualification Procedure	None Apparent	None Apparent - Rehabilitation provider provides certification
Nebraska	Mandatory	None Apparent	None Apparent
Nevada	Mandatory	None Apparent	None Apparent
New Hampshire	Voluntary or Court Order	Vocational Rehabilitation Coordinator	Program Development
New Jersey	Voluntary	DOL and Workforce Development Division of Voc Rehab Services (DVRS)	Administer / Delivery of Services
New Mexico	Voluntary	None Apparent	None Apparent (By agreement between parties)
New York	Voluntary	Board's Rehabilitation Unit	Administer (Direction by State Education)

State Vocational Rehabilitation Provisions* - continued

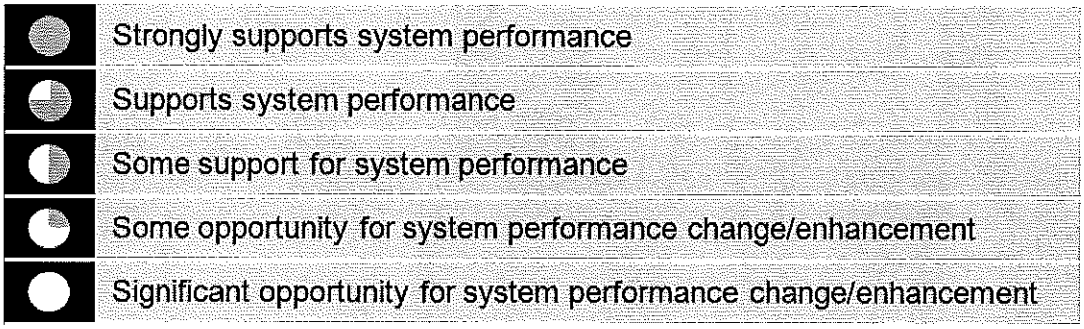
Jurisdiction	Type of Program	State Vocational Rehabilitation / Other State Entity	State Vocational Rehabilitation Entity Role
North Carolina	Voluntary	State Division of Vocational Rehabilitation Services	Delivery of Services
North Dakota	Mandatory	North Dakota Workforce Safety and Insurance	Administer - Delivery of Services Outsourced (Corvel)
Oklahoma	Mandatory - Court Ordered	None Apparent	None Apparent
Oregon	Mandatory - Qualification Procedure	None Apparent	None Apparent
Pennsylvania	Not Apparent	State Board of Vocational Rehabilitation	Administer / Delivery of Services may be outsourced
Rhode Island	Voluntary	Dr. John E. Donley Rehabilitation Center	Delivery of Services
South Carolina	Voluntary - Referral by Commission	Vocational Rehabilitation Department	Delivery of Services
South Dakota	Mandatory	Division of Rehabilitation Services	Delivery of Services
Tennessee	Voluntary	Department of Human Services	Administer
Texas	Voluntary	Department of Assistive and Rehab. Services	Administer
Utah	Voluntary	Labor Commission / Re-employment Program	Administer
Vermont	Mandatory	None Apparent	None Apparent
Virginia	Mandatory - Commission Order	None Apparent	None Apparent
Washington	Mandatory	Dept of Labor and Industries - Private Sector Rehabilitation Service	Administer, Monitor, Quality Assurance
West Virginia	Mandatory	None Apparent	None Apparent
Wisconsin	Qualification Procedure	Division of Vocational Rehabilitation	Evaluation / Certification
Wyoming	Qualification Procedure	Workers' Safety and Compensation Division (Voc. Rehab. Division of Dept. of Employment)	Eligibility (Administer)

* Based on information from State websites, International Risk Management Institute as of July 2007, and U.S. Chamber of Commerce Analysis of Workers' Compensation Laws 2008. In some cases there are additional program nuances that are not noted in program descriptions e.g. "Mandatory unless employer provides certain modified work" is noted as "Mandatory" in an effort to present concise information. In many cases, information was not readily available and noted to be "None Apparent" but does not rule out an existing, structured vocational rehabilitation approach.

Industry Leading Practices

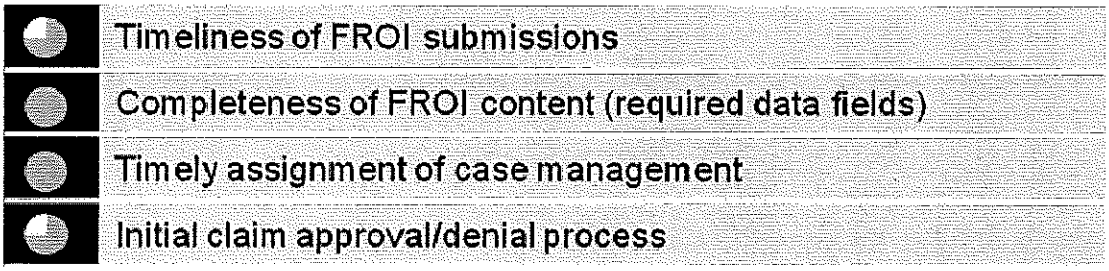
Leading practices in MCO administration and effectiveness measurement are segregated into three over-arching functions: Claim Reporting and Assignment, Quality Control Administration and Medical Dispute Resolution.

For performance assessments, the following scoring method applies:



Claim Reporting and Assignment

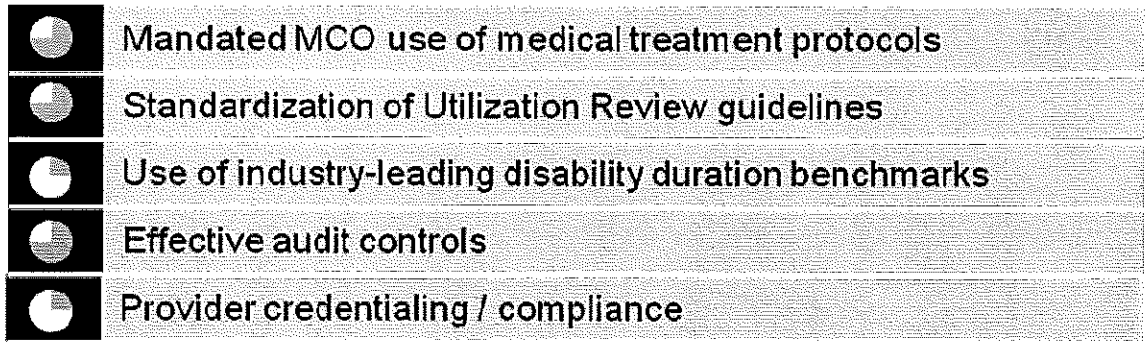
Claim Reporting and Assignment, although not a typical MCO function in other jurisdictions is included due to its importance in overall claim service and cost control. Initial actions taken by MCOs and claim administrators are key to providing appropriate treatment, effective assignment of resources, and are known to impact ultimate loss costs. MCOs in Ohio are meeting industry leading practices with respect to quality of information contained in initial claim submissions. This is important to proactive management of claims by both BWC and MCOs.



- Timeliness of FROI submissions combines FROI Timing and FROI Turnaround to reflect the total length of time between date of injury and completed FROI receipt by BWC. Timing lags continue to improve in both timing and turnaround and there is continued room for improvement.
- Completeness of FROI content meets industry leading practices.
- Timely assignment of case management is based on our review of contractual standards, and not an in-depth analysis of actual assignment times.
- Initial claim approval/denial process scoring reflects effective processing of in-coming claims and initially accepted conditions. Improvement opportunities exist in expediting allowance of expanded diagnoses.

For Quality Control BWC provides strong guidance to MCOs and audits activities and results in an effective manner. BWC has appropriately required MCOs (and subcontractors) to be fully accredited with URAC for Case Management. As noted elsewhere in this report, development is needed in provider credentialing programs and in update of current disability duration benchmarks.

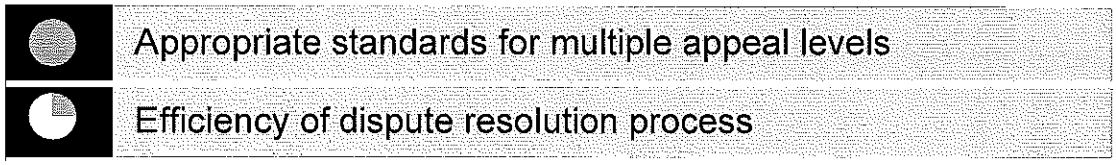
Quality Control Administration



- BWC specifies ODG as the only approved set of nationally recognized medical treatment protocols for rendering UR decisions. This change was made in 2007 but BWC has not formally integrated resulting measures into MCO performance systems.
- Opportunity exists to increase consistency in UR decisions through installment of formal BWC audit procedures.
- DoDM metrics are outdated and require replacement.
- BWC audits MCOs on other appropriate measures over which MCOs have direct control. Fewer participating MCOs would allow more efficient and effective use of BWC audit and oversight resources.
- Provider credentialing requires a more stringent approach to provider profiling, and a more formal approach to decertification for non-compliance with HPP standards.

Medical Dispute Resolution

The medical dispute resolution or Alternative Dispute Resolution (ADR) process contains appropriate multiple review and appeal levels. BWC concurs with final MCO decisions in greater than 95% of escalated cases indicating strong adherence by MCOs to stated policies concerning allowable conditions and UR guidelines. However, the exceptionally high degree of concurrence by BWC yields limited effectiveness in the overall appeal process.



- Industry standards are met for the ADR process, clinical review, and levels of appeal.
- Limited value is realized through BWC's involvement in the ADR process.

Conclusions

Findings

In total, MCOs are effective in meeting stated HPP goals in providing managed care services to injured workers in Ohio. Significant improvements continue in the overall HPP with respect to critical claims management actions known to positively impact loss costs. Improvements in timeliness of claim reporting, technology enablement of routine, transactional functions, fee scheduling, overall transparency and significant inclusion of process constituents in the study of alternative methods has established a strong trend in continuous process improvement.

BWC and MCOs are appropriately focused on improving medical service delivery and on institutionalizing effective cost controls. Challenges remain in easing administrative burdens on providers, improving the timing of allowable condition authorizations, tightening provider compliance, and standardizing UR and disability duration determination guidelines across all MCOs. The Medical Services Division is in the process of addressing all of these concerns under various SMART objectives.

Following are specific findings that impact MCO effectiveness and BWC administration and oversight of medical programs.

- The HPP, and resulting MCO program establishment has had a positive impact on the overall system over time in conjunction with BWC sponsored initiatives. Managed care nationally has achieved significant cost reductions in workers' compensation over the last ten years and BWC would be challenged to replicate (i.e. in-source) all of the functions currently performed by MCOs. There are however some functions that afford opportunity for improved administration through greater BWC involvement, (e.g. Voc. Rehab and Medical Bill Review and Payment).
- MCOs do not compete on a price-of-service basis in the HPP. The associated bundling of services (e.g. FROI submission, telephonic and field-based case management) makes it difficult for BWC to value these services and to compare them one to another or to other out-of-state MCO arrangements.
- Quality assurance programs continue to improve MCO results through MCO internal reviews and BWC audit and oversight. One key measurement and component of MCO incentive compensation is Degree of Disability Management (DoDM). DoDM baseline metrics are outdated and require replacement for severity comparison. Although DoDM contains Ohio-specific data, they are over 10 years old and the 2008 MCO scorecard shows all participating MCOs exceeding the "well managed" benchmark.
- Conflict of interest perceptions remain among process constituents over MCO business relationships with vocational rehabilitation (Voc. Rehab.) service providers. BWC has made recommendations to ultimately bring the Voc. Rehab referral and management functions in-house to alleviate this concern, and to make more effective use existing BWC resources.

  Significant redundancies exist in activities performed by BWC Disability Management Coordinators and MCOs' Voc. Rehab staff. BWC's Rehabilitation Redesign Project has four objectives:

  1) Enrich service delivery,
  2) Increase successful return to work,
  3) Strengthen BWC Disability Management Coordinators expertise and provision of staff support, and
  4) Reduce administrative costs.

  Six distinct recommendations are aligned to support these objectives:

  1: Strengthen the qualifications and training for BWC Disability Management Coordinators,
  2: Expand quality assurance oversight for both internal and external processes,
  3: Fortify internal controls throughout all administrative and service processes,
  4: Evaluate certification requirements and recommend appropriate changes to qualifications/credentials for service providers,

5: Develop a data and information analysis process which supports meaningful services, cost and outcomes analysis, and
6: Develop a model for transferring to Disability Management Coordinators eligibility and feasibility determination responsibilities. (Action on this recommendation is postponed per stakeholders input).

This appears to be an appropriate approach for BWC to undertake in addressing both conflict of interest concerns related to business relationships, and to resolving redundant process issues. We encourage continued analysis of stakeholder feedback and revision of plans as necessary. BWC's proposed program would be consistent with many other state programs. Aspects of Vocational Rehabilitation (eligibility and referral) are commonly in-sourced to leverage existing state resources,

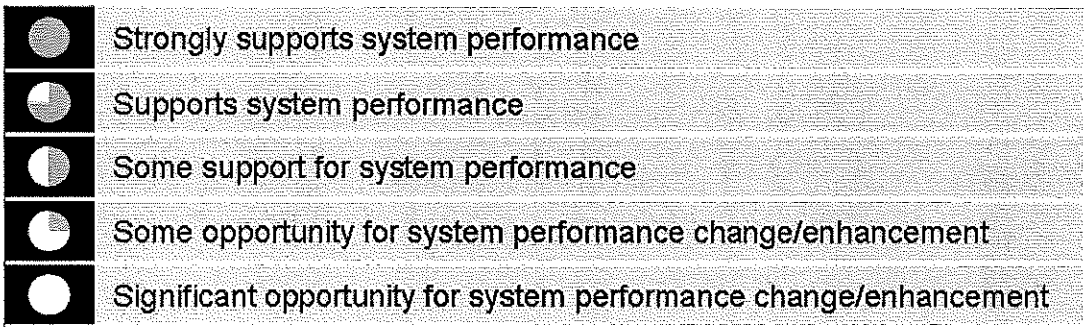
- Medical providers perceive a burdensome process for reimbursement. This assumption is made based on anecdotal information gleaned from interviews with MCO and BWC representatives, and on direct testimony from providers at two BWC Board of Directors' Public Forums on Medical Issues. A "Blue Ribbon" panel of preferred providers is currently under consideration by BWC to mitigate this issue for its best performing providers. The MCO League has expressed its support of this effort. Options exist to provide added compensation and/or reduced administrative burden associated with C-9 (Physician's Request for Medical Service or Recommendation of Additional Conditions for Industrial Injury or Occupational Disease) submissions. Formal credentialing of such a panel will require a moderate effort to define criteria for participation, supplement current provider quality determinations by MCOs and/or BWC, and additional audit functions for BWC.
- BWC Medical Services Division SMART Objectives, as amended on April 21, 2008, contain appropriate improvement strategies, success measures and implementation timelines that are responsive to the most critical system needs. Deloitte Consulting met with SMART Objective team leaders and significant progress is noted on a majority of BWC initiatives.
- MCOs are appropriately held to URAC Case Management standards. All MCOs (and subcontractors) must be URAC accredited in Case Management. BWC rules require MCOs to be compliant with multiple standards in other functions (but do not require formal URAC certification).
- Prior to August 2007, MCOs were afforded flexibility to use a variety of medical treatment protocols to make UR decisions. This lack of standardization had the potential to result in inconsistent UR decisions regarding accepted or denied care with all other claim and claimant characteristics being equal. This is a common scenario among state systems. BWC revised the MCO Policy Reference Guide in 2007 to specify that the "Official Disability Guidelines," as published by the Work Loss Data Institute, comprise the exclusive approved set of treatment guidelines. Some states have become more prescriptive in definition of UR tools (e.g. California's adoption of ACOEM protocols as "presumptively correct"). No UR product is perfect and tradeoffs between consistency in process and appropriateness of treatment decisions at a medical procedure level are major considerations in deciding whether to mandate a specific set of tools. Injured workers, BWC, providers, and MCOs are likely to benefit from this consistent approach across the HPP. BWC is afforded another important MCO performance metric in measurement of compliance with ODG UR standards. Since all MCOs are now required to reference the same standards in making decisions of allowed care, outliers are more easily identified and dealt with, and performance measures are consistent across the landscape.
- The number of MCOs participating is currently at 23, showing a steady decline from the 57 who initially signed on for the program in 1997. This has a positive impact on program administration as BWC audit resources are less dispersed and able to concentrate quality control efforts across a smaller sample. This has been a slow trend of attrition and 23 is still a high number to manage. Introduction of a more competitive process has the potential to reduce both the costs of service and the number of participating MCOs, both to BWC's advantage. Consistency in process is enhanced with fewer MCOs, and competition would allow BWC to value specific services, evaluate better for cost-efficiency, and invite more innovation in program design.
- Fee schedules for all services require formal review and update on a more regular basis. Proposed adjustments in fee schedules are likely to increase medical and ancillary provider satisfaction. Please see the accompanying Medical Payments Study Report – Section 5.1.2 Task #25 for more details.
- The MCO Report Card generated annually by BWC contains appropriate metrics for measurement of both activity-based and results-based standards. As noted above, the DoDM metrics require an update or replacement. Employer and Injured Worker surveys were conducted in all years except 2008.

- BWC's Board of Directors' Public Forums provide important context for stakeholders' concerns, and are a visible sign of BWC's commitment to transparency.
- Although provider certification is administered by BWC, and performance of providers is tracked on a limited basis by MCOs, there is no sustained, concerted effort to de-certify non-compliant providers. This is particularly important given Ohio's status as an "Employee Choice" state, whereby claimants are free to select any certified provider of their choice. BWC recognizes that provider credentialing processes require development. A BWC internal Medical Billing Payment Process Audit of March 2008 highlighted the issue as a significant process gap and the Medical Services Division has two related SMART objectives studying alternatives and enhancements.
- The BWC website provides valuable information and "drill-down" functionality to support MCO-related responsibilities and accountabilities for all constituents. Specific content is appropriately segregated and directed to injured workers, providers and employers.
- There are significant bottlenecks in the process related to timely medical treatment authorization for allowable conditions. BWC makes allowable condition determinations on which MCOs must rely for subsequent treatment approval and provider reimbursement. Often these allowable conditions are based on initial diagnoses, and in many cases definitive diagnoses are not reached until specialist referrals and diagnostic testing is completed. For example, an initial diagnosis of a knee sprain may be updated to an ACL tear upon definitive diagnostic testing results. BWC allows "presumptive authorization" of most routine medical treatment and diagnostic testing by providers for the first sixty days following an injury, Thereafter, providers must request authorization for any treatment that doesn't directly relate to narrowly-defined, determined diagnoses and allowable conditions. Providers are denied reimbursement until BWC updates the allowable condition and then providers must submit revised C-9 forms.
- Statutorily-required Independent Medical Exams (IME) at 90 days of injured worker lost time appear to deliver little value to BWC or its constituents. In order to forgo these IMEs an employer must sign a waiver. This requirement was made law over a decade ago when return-to-work strategies were not institutionalized and employers required reassurance that injured workers required off-work status. IMEs are typically used in the industry today to render opinions on the course of treatment and disability duration determinations, most often when appropriateness of medical treatment or permanency impairment is disputed. Deloitte Consulting maintains that if there is no dispute with medical treatment plans or work status then there is no good reason to conduct an IME. We also believe that employers should not have a voice in deciding whether an IME is conducted or not. IMEs are conducted by both MCOs and BWC under a variety of circumstances but BWC assumes full responsibility for arranging and funding the statutory 90-day exams. In total, all IMEs conducted by BWC comprise a significant expense in the system at approximately $23 million in 2007. The 90-day statutory IME requirement represents over 10% of BWC's annual spend at $2.35 million and creates an unnecessary burden on injured workers and on BWC where no dispute exists. The 90-day timeline is arbitrary and BWC should consider a program that allows for IMEs on an "as needed" basis.
- The medical Alternative Dispute Resolution (ADR) program appropriately contains a multi-level appeal process progressively involving MCOs, BWC, and the Industrial Commission (IC). Limited value is realized in BWC's role as they concur with MCO decisions greater than 95% of the time. Considerable resources are dedicated to reviewing and rendering decisions, with minimal return on investment. Please see Deloitte Consulting's Medical Payments Study Report – Section 5.1.2 Task #25 for more detail.

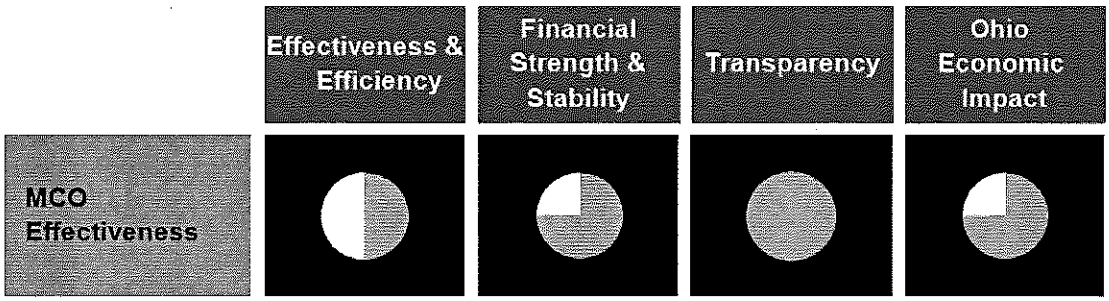
Performance Assessment

We assessed the performance of the Ohio workers' compensation system compared to these four overarching themes: Effectiveness & Efficiency; Financial Strength & Stability; Transparency; and Ohio Economic Impact. Each broad study element (Ohio Benefit Structure; Pricing Process; Cost Controls; Financial Provisions; and Actuarial Department Functions & Resources) is reviewed with these themes in mind to develop a performance assessment of the current state. Our performance assessment is made on each element in the context of its contribution to supporting the overarching themes.

For these performance assessments, the following scoring method applies:



Based on this scoring method, here is the performance assessment for the Cost Controls area of MCO Effectiveness:



Peers and Industry Standards Considered

Peers: State Comparisons - All for MCO participation, choice of physician, & Voc Rehab provisions;
OH, CA, HI, KS, MO, ND, TN, TX for use of ODG

Referenced Standards: State Laws, URAC, US Dept. of Labor, NAIC

Commercial Sources: WCRI, IRMI, Rand Corporation, ODG, U.S. Chamber of Commerce

- Effectiveness & Efficiency - The HPP continues to improve performance in multiple functions but opportunities exist in improving performance measurement standards and metrics, allowable condition determination timing and process, Voc. Rehab service delivery, and medical bill review processes.
- The HPP supports Ohio's Financial Strength and Security. Please see companion actuarial studies of the larger Comprehensive Study.
- Transparency in total strongly supports system performance. Multi-media communications and resources, and Board of Director Public Forums demonstrate strong commitment to transparency in operations.
- The HPP supports a reasonable impact to Ohio's economy. Please see companion actuarial studies of the larger Comprehensive Study.

Recommendations

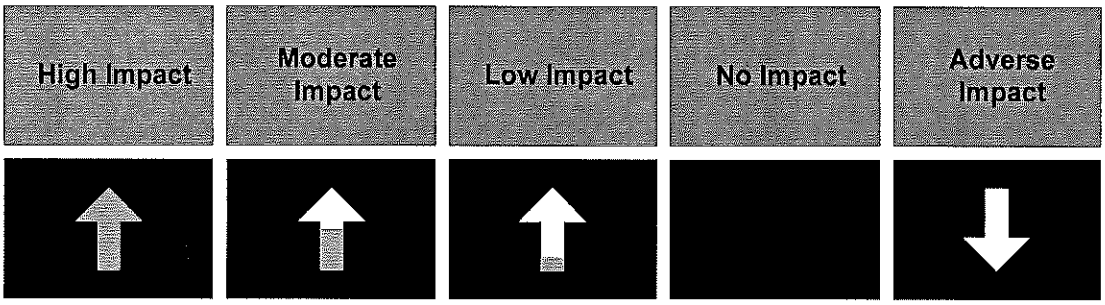
The following comprise Deloitte Consulting's recommendations for increasing effectiveness of MCOs in Ohio. The HPP is well established and has experienced a sustained trend of continuous improvement in major business processes since its inception. Our recommendations are made in this context and we recognize that BWC has many of these recommended solutions already under study and in various stages of implementation.

- Encourage the trend of decreasing numbers of participating MCOs through market forces of vendor consolidation to reduce costs associated with BWC's administration, and to enhance consistency in process. Fewer MCOs will allow BWC to better concentrate oversight and audit functions to enhance quality and increase standardization across the HPP.
- Study the feasibility of price-of-service competition among MCOs. We recommend that BWC conduct a formal study to determine the feasibility of introducing competition into the HPP. If competition is determined feasible, statutory changes, and rules and regulations development will be required.
- Explore feasibility and rule changes required to eliminate BWC from the ADR process, with final MCO decisions appealed directly to the IC.
- Seek legislative change to eliminate the statutory requirement of required IMEs at 90 days of lost time.
- Allow MCOs to approve accepted medical conditions and allowance of related medical treatment, subject to BWC oversight and audit. This will require statutory changes and BWC is encouraged to advance a corresponding legislative reform agenda. This has the potential to significantly reduce delays in treatment approval and C-9 re-submissions by providers. BWC's "Proactive Allowance" program is designed to accelerate approval of related diagnosis and expanded medical conditions but still requires Physicians of Record (POR) to substantiate rationale to MCOs, who then submit to BWC for approval. Shifting of these responsibilities would require BWC to implement new MCO audit standards. If undertaken BWC should consider audit compliance results in annual MCO Report Cards and in weighted incentive compensation.
- Establish the Official Disability Guidelines (ODG), as published by the Work Loss Data Institute, as a replacement for the current DoDM and Ohio Specific Disability Durations (OSDD) benchmark metrics until such time as credible Ohio-specific data is available. Any development of OSDD has to take into account the effects of data issues related to the Salary Continuation program in which BWC does not adequately capture data. Although DoDM contains Ohio-specific data, they are over 10 years old and the 2008 MCO scorecard shows all participating MCOs exceeding the "well managed" benchmark. BWC needs to "move the bar" such that expected outcomes are updated and MCOs are challenged to reach full incentive compensation. Deloitte Consulting believes regularly updated national ODG benchmarks are preferable to 10-year old, Ohio-specific data in establishment of MCO performance metrics. We recommend that BWC adopt a national standard of disability duration guidelines as its benchmarking source until such time as Ohio-specific data is credible and available. We suggest that ODG is an appropriate interim standard given that BWC and all MCOs have access to the product. Significant improvements have been institutionalized in care management and return-to-work strategies over the last decade to favor current national statistics over aged Ohio-specific data in establishment of MCO targets and related incentive compensation. ODG offers a range of expected outcomes by decile and BWC can work with constituents to determine where targets should be within the scale. We expect that the number of ICD-9 diagnosis codes reported by ODG will be sufficient to meet Ohio's needs.
- Having specified ODG's medical treatment protocols as the only BWC approved UR tool set in 2007, BWC should integrate its use into the overall MCO performance measurement and compensation system.
- Re-institute Employer and Injured Worker surveys as part of MCO Report Card measurements and sustain the effort year-to-year.
- Encourage that BWC Board of Director Public Forums related to Medical Services continue on a regular basis. These provide additional "voice of the customer" venues to supplement other BWC customer outreach programs (e.g. surveys, stakeholder meetings).
- Sustain SMART objective team efforts to gather provider profile information, establish standard credentialing criteria, and de-certify repeated, non-compliant providers. BWC's Medical Services Division has two SMART objective teams working on potential solutions; one to develop a methodology for identification of utilization outliers, and another to develop appropriate sanctioning standards for non-compliance. Both reports are pending.

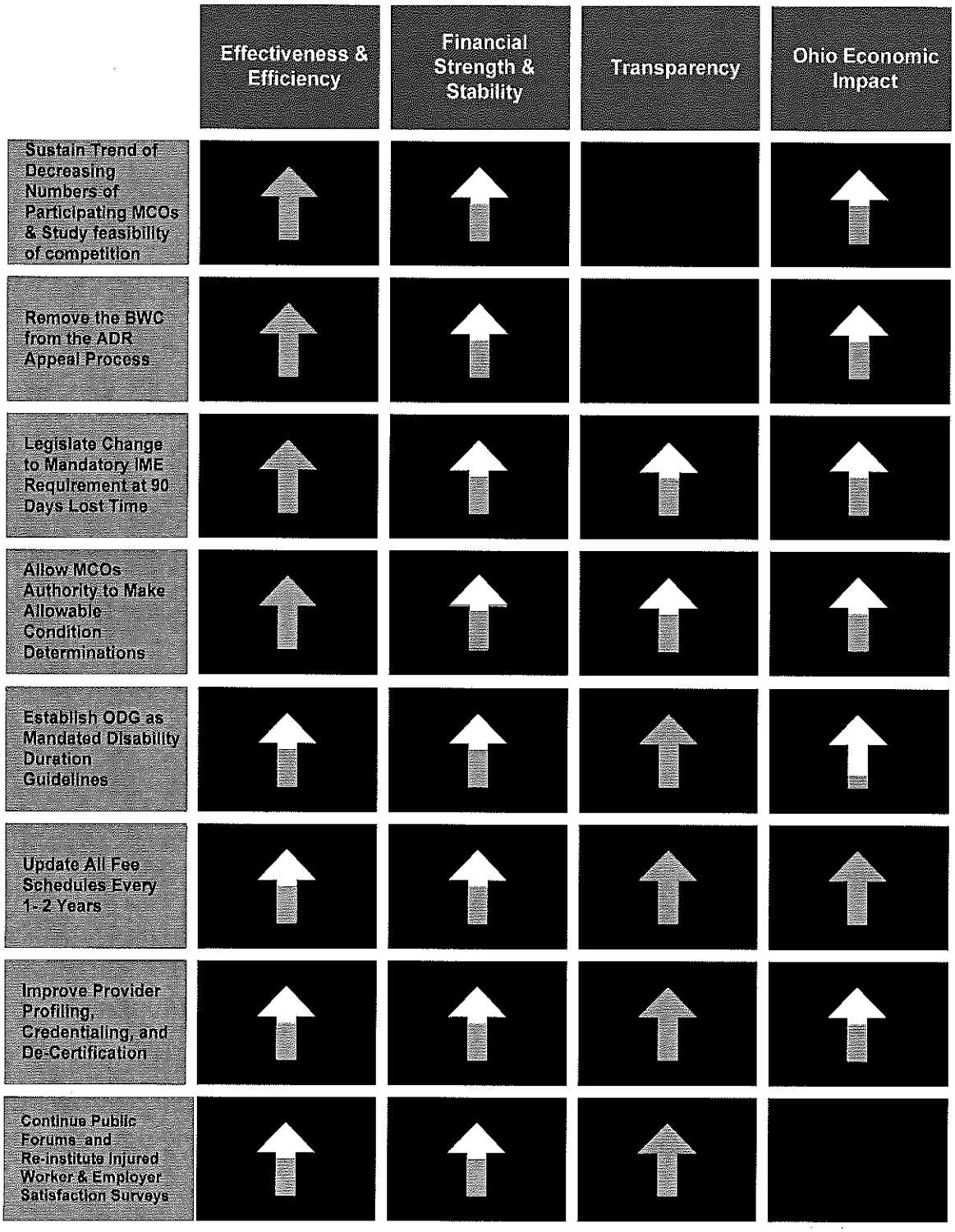
- Update all fee schedules on a 1-2 year basis. Proposed updates in Professional Provider schedules (last updated in 2004) will logically increase the annual medical spend. Indexing to Medicare's Resource-Based Relative Value Scale (RBRVS), and application of Ohio-specific conversion factors for specific medical services, ensures that Ohio is in-line with national standards and industry leading practices. Please refer to Deloitte Consulting's companion report of the Medical Payments Study.
- In collaboration with MCOs, build a database and commission a comprehensive study to determine specific causes of increasing average medical costs, per claim, and quantify their respective contribution margins. Based on this analysis determine and prioritize actions to take to mitigate this trend.

Impact

Our recommendations are provided for each area in priority order. The impact of each recommendation as it relates to each of the four overarching themes is also provided, using the following scoring method:



These indicators show how much impact each recommendation has relative to each theme area. For example, while a recommendation might have a high impact in one theme area, such as Effectiveness & Efficiency, it might have low impact or no impact on the area of Transparency.



The Deloitte Consulting team remains available to clarify or amplify any issues raised in this report. We express our appreciation for BWC process constituents' time, effort and guidance in completing this integral task of our comprehensive study.

Appendix A – Deliverable Matrix

Group 2 Study Elements

Ohio Benefit Structure
Award Categories
1) Compensation Types
2) Benefit and Compensation Levels
3) Number of Benefit Types

Pricing Process
Statewide Rate Level
1) Administrative Cost Calculation

Cost Controls
MCO Effectiveness
Medical Payments to Providers

Financial Provisions
Loss Reserves
1) Current Actuarial Audit Reserve Methodology
2) Independent Review
3) Expected Payments Established by Independent Actuarial Consultant
4) Loss Reserve Margins and Discount Factor
5) Performance Assessment Implications
Net Asset Level
1) Methods for Setting Net Asset Targets
2) Risk Margins
3) Disclosure
Excess Insurance and Reinsurance
1) Cost Effectiveness, Catastrophic Events, and Rate Stability

Ohio Benefit Structure Areas

Award Benefit Types	Tasks Involved
1) Compensation Types	23. Conduct a study of the benefits and compensation paid by the BWC compared to industry peers. This study would include an analysis of all compensation types and their application by the BWC.
2) Benefit and Compensation Levels	
3) Number of Benefit Types	

Pricing Process Areas

Statewide Rate Level	Tasks Involved
1) Administrative Cost Calculation	27. Conduct a study on the administrative cost calculation used in employer rates. This evaluation should include a review of the allocated and unallocated loss adjustment expenses of the BWC.

Cost Controls Areas

MCO Effectiveness	Tasks Involved
MCO Effectiveness	30. Conduct a study on the effectiveness of Managed Care Organizations (MCO) in the workers' compensation system. This analysis would include an evaluation of the effectiveness of the use of MCOs, the payments to MCOs relative to the benefits received, the advantages and disadvantages of the MCO approach, the medical cost trends since MCO implementation, and a comparison to industry standards.

Medical Payments to Providers	Tasks Involved
Medical Payments to Providers	25. Conduct a study on the medical payments to providers in Ohio and provide a comparison to industry peers. This study should recommend changes/improvements to BWC's medical payment structure in line with industry standards.

Financial Provisions Areas

Loss Reserves	Tasks Involved
1) Current Actuarial Audit Reserve Methodology	21. Review the actuarial audit reserves established by the BWC's independent actuarial consultant to establish objective quality management principles and methods by which to review the performance of the workers' compensation system.
2) Independent Review	
3) Expected Payments Established by Independent Actuarial Consultant	15. Evaluate the methodology and reasonability of the expected payments established by the BWC's independent actuarial consultant.
4) Loss Reserve Margins and Discount Factor	
5) Performance Assessment Implications	21. See above.

Net Asset Level	Tasks Involved
1) Methods for Setting Net Asset Targets	26. Conduct a study on the amount of surplus/net assets that should be held by the BWC. This study should compare the BWC to industry standards and recommend appropriate methods of setting target surplus for the BWC and the appropriate discount rate.
2) Risk Margins	
3) Disclosure	

Excess Insurance and Reinsurance	Tasks Involved
1) Cost Effectiveness, Catastrophic Events, and Rate Stability	31. Conduct an evaluation on the excess insurance or reinsurance requirements for the BWC including the need for excess coverage or reinsurance in the event of a catastrophic event. This evaluation should include the cost effectiveness of excess coverage or reinsurance, the ability of the BWC to handle a catastrophic event, and the stability in rates provided by excess insurance or reinsurance coverage. This study should include an evaluation of reinsurance requirements and a possible reinsurance program for the BWC.

Pricing Process Areas – continued

Ancillary Funds	Tasks Involved
1) Coal Workers Pneumoconiosis	7. Review and make written recommendations with regard to the Coal-Workers Pneumoconiosis Fund. This review would include a complete analysis of the rating program. This analysis should compare the methodology used in BWC's rating calculation to industry standards the actuarial standards of practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries.
2) Marine Industry Fund	10. Review and make written recommendations with regard to the Marine Industry Fund. This analysis should compare the methodology used in BWC's rating calculation to industry standards and the Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries.
3) Disabled Workers' Relief Fund	13. Review and make written recommendations with regard to the Disabled Workers' Relief Funds. This analysis would include a complete analysis of the funds including but not limited to the loss information, payroll information, and other rating calculations. This analysis should compare the methodology used in BWC's rating calculation to industry standards and the Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries.

Appendix B – Data & Documentation

An inventory of key BWC and other source reference documents used in our analysis is highlighted below.

Constituent Sources

BWC

- Memorandum. MCO League Actuarial Report.
- Medical Services Division Smart Objectives, as amended April 21, 2008.
- Medical Billing Payment Process Audit March 2008.
- Agreement between Ohio Bureau of Workers Compensation and MCO: Final 12/06/07.
- MCO Report Cards, 2000 to 2008.
- BWC Annual Reports for Fiscal Years 2003 – 2007.
- Disability Evaluator Panel (DEP) Report *(Draft for Discussion Purposes Only).*
- Draft BWC 2008 Proposed Professional Provider Fee Schedule.
- BWC Actuarial Division Comparative Data report of January 2008.

MCO League of Ohio

- The Ohio Health Partnership Program: A Review of the First Nine Years (1997-2006).
- The Ohio Health Partnership Program: An Independent Actuarial Study Conducted by the Kilbourne Company, November 2007.
- 10 Years at BWC, 2005.
- Additions to the MCO Workload since the inception of HPP, Prepared September 2006.
- Understanding Ohio's Health Partnership Program (HPP) 1997-2008.
- % Change in MCO Policy Guidelines Chapter 1 to 10.

External Benchmarking Sources

Benchmarking Sources

- Workers Compensation State Laws. **International Risk Management Institute**. December 2007.
- Physician Choice/Workers Compensation MCOs. **International Risk Management Institute.** December 2007.
- Workers Compensation Medical Fee Schedules. **International Risk Management Institute.** December 2007.
- Pay-for-Performance in California's Workers' Compensation Medical Treatment System. An Assessment of Options, Challenges, and Potential Benefits. **Rand Working Paper**. August 2007.
- Provider Credentialing Standard Language and Revisions for Public Comment. **URAC**. May 2008.
- Workers' Compensation Utilization Management Standard Language and Revisions for Public Comment. **URAC**. May 2008.
- Current Recognition of Best Practices Organizations. **NAIC's** Compendium of State Laws on Insurance Topics. 2007.
- Summary of Workers' Compensation Laws. Medical Benefits. **U.S. Chamber of Commerce** 2007.
- Table 5a. Medical Benefits Provided by Workers' Compensation Statutes. **US Department of Labor.** In effect January 1, 2006.
- Multi-State Benchmarks CA, FL, IL, MA, MD, MI, NC, PA, TN, WI. **Workers' Compensation Research Institute.** 2008.
- Market Sourcebook data, Business Insurance 2007.
- NCCI "State of the Line" report of 2007.

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4123-6-32
Appendix

What BWC Wants You to Know About Lumbar Fusion Surgery

(Applies to all workers considering lumbar fusion, regardless of diagnosis)

Ohio Bureau of Workers' Compensation wants you to have the highest quality of care. That can only occur if you know how lumbar fusion surgery may affect your health and recovery. BWC is providing the following instructional form to aid in the process. BWC requires your physician to discuss this information before the surgery, so you can make the best informed decision. In preparation, please study this form, and discuss the information with your healthcare team. Afterwards, you, your physician of record, and your operating surgeon should sign the form. **THIS IS NOT A SURGICAL CONSENT FORM.**

Studies have shown the following post-operative outcomes:

- General Lumbar Fusion Outcomes

  a. The chance of an injured worker no longer being disabled 2 years after lumbar fusion is 32%.

  b. More than 50% of workers who received lumbar fusion through the Washington workers' compensation program felt that both pain and functional recovery were no better or were worse after lumbar fusion.

  c. Smoking at the time of fusion greatly increases the risk of failed fusion

  d. Pain relief, even when present, is **NOT** likely to be 100%

  e. The use of spine stabilization hardware (metal devices) in Washington workers nearly doubled the chances of having another surgery

  f. Lumbar fusion for the diagnoses of disc degeneration, disc herniation, and/or radiculopathy in work comp setting is associated with significant increase in disability, opiate use, prolonged work loss, and poor return to work status.

- Ohio Specific Lumbar Fusion Outcomes Study: (2 year follow-up – 1450 total patients)

a. Back pain patients treated with fusion were able to return to work (activity) only 26% of the time, workers treated non-surgically were able to return to work (activity) 67% of the time.

b. Re-operation rate was 27% in fused patients

c. Complications occurred in 36% of fused patients

d. Narcotic use increased 41% in fused patients, and continued for over 2 years in 76% of fused patients

e. 17 of the fused patients died during the course of the study and 11 non-surgical patients

- National/International Lumbar Fusion Statistics

  a. Surgical fusion outcomes are **NOT** better than cognitive therapy and exercise

  b. Surgical fusion for previous herniated disk is **NOT** better than non-operative treatment

  c. Surgical satisfaction was reportedly high even in injured workers with ongoing pain and no improvement in function observed

  d. Some patients described less pain, improvement of 1 or 2 points on a 10 point pain scale, but any functional benefit of having a fusion was not demonstrated

- Opioid use has been associated with significant long term morbidity and mortality in both surgical and non-surgical patients. Back pain patients are at risk for long term opioid use. Fusion patients have greater narcotic/opioid usage than non-operative patients.

What is expected of you if you proceed to have lumbar fusion surgery:

If the BWC/MCO authorizes your surgery, your surgeon will continue to see you at least every two months for six months after surgery. As your surgeon, I expect you to actively participate in your recovery and rehabilitation plan both prior to and following your surgery.

By signing this form, we (the injured worker, physician & surgeon), attest that we have discussed the information presented here, we understand this information, and we wish to proceed with the fusion surgery. **We also understand that this information does NOT take place of, and is separate and distinct from, any surgical form that we will complete prior to surgery.**

_____ _____

Injured Worker

Date:___/____/_____

Physician of Record

Date:____/_____/_____

_____

Operating Surgeon

Date:____/_____/_____

4123-6-32 Payment for lumbar fusion surgery.

Effective January 1, 2018, reimbursement for lumbar fusion surgery for treatment of allowed conditions in a claim resulting from an allowed industrial injury or occupational disease shall be limited to claims in which current best medical practices as implemented by this rule are followed.

This rule governs the bureau's reimbursement of lumbar fusion surgery to treat a work related injury or occupational disease. It is not meant to preclude, or substitute for, the surgeon's responsibility to exercise sound clinical judgment in light of current best medical practices when treating injured workers.

A provider's failure to comply with the requirements of this rule may constitute endangerment to the health and safety of injured workers, and claims involving lumbar fusion surgery not in compliance with this rule may be subject to peer review by the bureau of workers' compensation stakeholders' health care quality assurance advisory committee (HCQAAC) pursuant to rule 4123-6-22 of the Administrative Code or other peer review committee established by the bureau.

(A) Prerequisites to consideration of lumbar fusion surgery.

Authorization for lumbar fusion shall be considered only in cases in which the following criteria are met:

(1) Conservative care.

(a) Except as otherwise provided in paragraph (A)(1)(c) of this rule, the injured worker must have had at least sixty days of conservative care for low back pain, with an emphasis on:

(i) Physical reconditioning;

(ii) Avoidance of opioids, when possible; and

(iii) Avoidance of provider catastrophizing the explanation of lumbar MRI findings.

(b) The injured worker's comprehensive conservative care plan may include, but is not limited to, one or more of the following:

(i) Relative rest/ice/heat;

(ii) Anti-inflammatories;

(iii) Pain management / physical medicine rehabilitation program;

(iv) Chiropractic / osteopathic treatment;

(v) Physical medicine treatment as set forth in rule 4123-6-30 of the Administrative Code;

(vi) Interventional spine procedures / injections.

(c) The requirement of a trial of at least sixty days of conservative care prior to consideration of lumbar fusion surgery may be waived with prior approval from the MCO in cases of:

(i) progressive functional neurological deficit;

(ii) spinal fracture;

(iii) tumor;

(iv) infection;

(v) emergency / trauma care; and/or

(vi) other catastrophic spinal pathology causally related to the injured worker's allowed conditions.

(2) The operating surgeon requesting authorization for lumbar fusion surgery must have personally evaluated the injured worker on at least two occasions prior to requesting authorization for lumbar fusion surgery.

(3) The injured worker must have undergone a comprehensive evaluation, coordinated by both the injured worker's physician of record or treating physician and the operating surgeon, in which all of the following have been documented:

(a) Utilization and correlation of all of the following tools:

(i) Visual analog scale (VAS);

(ii) Pain diagram;

(iii) Oswestry low back disability questionnaire.

(b) A comprehensive orthopedic / neurological examination, including documentation of all of the following categories:

(i) Gait;

(ii) Spine (deformities, range of motion, palpation);

(iii) Hips and sacroiliac joints;

(iv) Motor;

(v) Sensation;

(vi) Reflexes;

(vii) Upper motor neuron signs.

(c) Diagnostic testing.

(i) Lumbar X-rays (including flexion/extension views), lumbar MRI, or lumbar CT (with or without myelography) must be performed;

(ii) Electromyography (EMG) / nerve conduction study (NCS) may be performed if questions still remain during surgical planning.

(d) Discussion and consideration of opportunities for vocational rehabilitation.

(e) Review of current and previous medications taken.

(i) If opioid management is in process, review for best practices;

(ii) Consider impact of surgery on opioid load.

(f) Health behavioral assessment (pre-surgical).

Biopsychosocial factors that may affect treatment of the injured worker's allowed lumbar conditions are considered modifiable conditions that may change the need for surgery or improve surgical outcomes if appropriately addressed, and must be addressed if identified in the assessment.

(g) Accounting and assessment of the following co-morbidities to stratify additional associated risks:

(i) Smoking;

(ii) Body mass index (BMI);

(iii) Diabetes;

(iv) Coronary artery disease;

(v) Peripheral vascular disease.

The co-morbidities indicated above are considered modifiable conditions that may improve surgical outcomes if appropriately addressed, and must be addressed if identified in the assessment.

(h) The injured worker, the physician of record or treating physician, and the operating surgeon must have reviewed and signed the educational document, "What BWC Wants You to Know About Lumbar Fusion Surgery," attached as an appendix to this rule.

(B) Authorization for lumbar fusion surgery where the injured worker has no prior history of lumbar surgery.

(1) Authorization for lumbar fusion shall be considered in cases where the injured worker has no prior history of lumbar surgery only when the injured worker remains highly functionally impaired despite a trial of at least sixty days of conservative care as provided in paragraph (A)(1)(a) of this rule (unless waived with prior approval by the MCO pursuant to paragraph (A)(1)(c) of this rule) and one or more of the following are present:

(a) Mechanical low back pain with instability of the lumbar segment and no history of lumbar surgery.

(b) Spondylolisthesis of twenty-five per cent or more with one or more of the following:

(i) Objective signs/symptoms of neurogenic claudication;

(ii) Objective signs/symptoms of unilateral or bilateral radiculopathy, which are corroborated by neurologic examination and by MRI or CT (with or without myelography);

(iii) Instability of the lumbar segment.

(c) Lumbar radiculopathy with stenosis and bilateral spondylolysis.

(d) Lumbar stenosis necessitating decompression in which facetectomy of greater than or equal to fifty per cent or more is required.

(e) Primary neurogenic claudication and/or radiculopathy associated with lumbar spinal stenosis in conjunction with spondylolisthesis or lateral translation of three mm or greater or bilateral pars defect.

(f) Degenerative disc disease (DDD) associated with significant instability of the lumbar segment.

(g) Spinal stenosis, disc herniation, or other neural compressive lesion requiring extensive, radical

decompression with removal of greater than fifty per cent of total facet volume at the associated level.

The surgeon must document why the surgical lesion would require radical decompression through the pars interarticularis (critical stenosis, recurrent stenosis with extensive scarring, far lateral lesion).

(2) For purposes of this paragraph, instability of the lumbar segment is defined as at least four mm of anterior/posterior translation at L3-4 and L4-5, or five mm of translation at L5-S1, or eleven degrees greater end plate angular change at a single level, compared to an adjacent level.

(C) Request for lumbar fusion surgery where the injured worker has a history of prior lumbar surgery.

(1) If a trial of at least sixty days of conservative care as provided in paragraph (A)(1)(a) of this rule has failed to relieve symptoms (or has been waived with prior approval by the MCO pursuant to paragraph (A)(1)(c) of this rule) and the injured worker has had a prior laminectomy, discectomy, or other decompressive procedure at the same level, lumbar fusion should be considered for approval only if the injured worker has one or more of the following:

(a) Mechanical (non-radicular) low back pain with instability at the same or adjacent levels.

(b) Mechanical (non-radicular) low back pain with pseudospondylolisthesis, rotational deformity, or other condition leading to a progressive, measureable deformity.

(c) Objective signs/symptoms compatible with neurogenic claudication or lumbar radiculopathy that is supported by EMG/NCS, lumbar MRI, or CT and detailed by a clinical neurological examination in the presence of instability of three mm lateral translation with at least two prior decompression surgeries at the same level.

(d) Evidence from post laminectomy structural study of either:

(i) One hundred per cent loss of facet surface area unilaterally; or

(ii) Fifty per cent combined loss of facet surface area bilaterally.

(e) Documented pseudoarthrosis or nonunion, with or without failed hardware, in the absence of other neural compressive lesion.

(2) For purposes of this paragraph, instability of the lumbar segment is defined as at least four mm of anterior/posterior translation at L3-4 and L4-5, or five mm of translation at L5-S1, or eleven degrees greater end plate angular change at a single level, compared to an adjacent level.

(D) Lumbar fusion surgical after care.

Both the physician of record or treating physician and the operating surgeon must follow the injured worker until the injured worker has reached maximum medical improvement (MMI) for the allowed lumbar conditions.

(1) In the first six months post-operatively, the injured worker must be seen by both the physician of record or treating physician and the operating surgeon at least every two months to monitor the injured worker's progress, rehabilitation needs, behavioral patterns or changes, and return to work willingness and/or status.

During this period, the physician of record or treating physician and the operating surgeon shall

determine the following:

(a) Fusion status;

(b) Pain and functional status;

(c) MMI status of injured worker;

(d) Residual level of functional capacity;

(e) Appropriateness for vocational rehabilitation.

(2) From six months to one year post-operatively, if the injured worker continues to experience significant functional impairment despite the lumbar fusion, the following actions are recommended:

(a) Pain and functional status (repeat VAS / pain diagram / Oswestry)

(b) Repeat baseline orthopedic / neurological examination;

(c) Repeat health behavioral assessment;

(d) Revisit appropriate diagnostic imaging.

(e) Coordinate with MCO to develop a plan of care / return to functional status.