

REQUEST FOR PROPOSALS
by the
STATE OF OHIO
BUREAU OF WORKERS' COMPENSATION
for
RETROSPECTIVE HOSPITAL BILL REVIEW
and
HOSPITAL OVERPAYMENT COLLECTION SERVICES

May 17, 2011

BID # BWCB11007

RFP ISSUED:	May 17, 2011
INQUIRY PERIOD BEGINS:	May 18, 2011
INQUIRY PERIOD ENDS:	June 1, 2011 at 8:00 A.M. EDT
PROPOSAL DUE DATE:	June 16, 2011 by 2:00 P.M. EDT

Proposals received after the due date and time will not be evaluated.

OPENING LOCATION:	Ohio Bureau of Workers' Compensation (BWC) Purchasing Department 30 W. Spring Street, Level 24 Columbus, OH 43215-2256
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TABLE OF CONTENTS

- 1.0 BACKGROUND AND PURPOSE OF REQUEST FOR PROPOSALS**
 - 1.1 BWC General Background
 - 1.2 Purpose of the Request for Proposals
 - 1.3 BWC Inpatient Payment Methodology
 - 1.4 BWC Outpatient Payment Methodology
 - 1.5 MCO Contracts
 - 1.6 BWC Pre-Payment Audits

- 2.0 CALENDAR OF EVENTS**
 - 2.1 Dates

- 3.0 PROPOSAL INQUIRIES AND SUBMISSIONS**
 - 3.1 Questions
 - 3.2 Communication Restrictions
 - 3.3 Proposal Submission
 - 3.4 Changes to this Request for Proposals

- 4.0 GENERAL TERMS AND CONDITIONS**
 - 4.1 General
 - 4.2 Resulting Contract and Term
 - 4.3 Governing Law – Severability
 - 4.4 Compliance with Applicable Laws
 - 4.5 Publicity
 - 4.6 Conditions Precedent
 - 4.7 Equal Employment Opportunity
 - 4.8 Payment and Billing Procedures
 - 4.9 Record Keeping
 - 4.10 Workers’ Compensation Coverage
 - 4.11 General Commercial Liability Insurance
 - 4.12 Vendor’s Liability
 - 4.13 Contract Compliance and Termination
 - 4.14 Default by the Vendor
 - 4.15 Damages
 - 4.16 Subcontracting / Assignment / Delegation
 - 4.17 Drug-Free Workplace
 - 4.18 Confidentiality
 - 4.19 Ohio Elections Law
 - 4.20 Unresolved Finding for Recovery
 - 4.21 Offshore Provision of Services Prohibited
 - 4.22 Declaration Regarding Material Assistance/Non-assistance to a Terrorist Organization
 - 4.23 Debarment
 - 4.24 Conflicts of Interest and Ethics Compliance

- 5.0 SCOPE OF SERVICES FOR RETROSPECTIVE HOSPITAL BILL REVIEW AND COLLECTION OF VENDOR IDENTIFIED OVERPAYMENTS (SECTION A)**
 - 5.1 Review of Hospital Inpatient and Outpatient Bills
 - 5.2 Provider Communication and Appeals
 - 5.3 Collection and Bill Data Reports
 - 5.4 Vendor Reimbursement
 - 5.5 Communication with BWC

6.0 SCOPE OF SERVICES FOR COLLECTION OF OVERPAYMENTS IDENTIFIED BY HOSPITALS ON THEIR CREDIT BALANCE REPORTS (SECTION B)

- 6.1 Bills Eligible for Vendor Review
- 6.2 Process for Collection of Hospital-identified Overpayments and Vendor Reimbursement

7.0 PROPOSAL

- 7.1 Cover Letter
- 7.2 Qualifications, Certifications, Experience and References
- 7.3 Action Plan
- 7.4 Cost/Fee
- 7.5 Disclosure Statement
- 7.6 Financial Ability

8.0 PROPOSAL EVALUATION

- 8.1 Phase 1 – Minimum Requirements
- 8.2 Phase 2 – Evaluation of Content
- 8.3 Phase 3 – Oral Presentation
- 8.4 Contract Negotiations

9.0 AWARD OF CONTRACT

- 9.1 Award Procedure
- 9.2 Contract Execution

APPENDIX A – OHIO ADMINISTRATIVE CODE SECTIONS

- Ohio Administrative Code 4123-6-01 Definitions
- Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services Current Rule Effective Date 02/01/2011
- Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services Previous Rule Effective Date 02/01/2010
- Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services Previous Rule Effective Date 02/01/2009
- Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services Previous Rule Effective Date 01/01/2008
- Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services Previous Rule Effective Date 04/01/2007
- Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services Previous Rule Effective Date 01/01/2007
- Ohio Administrative Code 41236-6-37.2 Payment of Hospital Outpatient Services Current Rule Effective Date 04/01/2011
- Ohio Administrative Code 41236-6-37.2 Payment of Hospital Outpatient Services Previous Rule Effective Date 01/01/2011
- Ohio Administrative Code 41236-6-37.2 Payment of Hospital Outpatient Services Previous Rule Effective Date 09/01/2007
- Ohio Administrative Code 4123-6-45 Audit of Providers' Patient and Billing Related Records

APPENDIX B – BWC POLICIES

- Medical Overpayment Recovery Policy and Procedure
- BWC Sensitive Data Transmission Policy

APPENDIX C – REQUIRED DATA ELEMENTS FOR REPORTING

APPENDIX D – BILLING VOLUMES

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PLEASE READ ALL CONDITIONS AS SET FORTH IN THIS REQUEST FOR PROPOSALS (RFP) FOR
A FULL UNDERSTANDING OF THE REQUIREMENTS

THIS RFP CONSISTS OF TWO SECTIONS:

- A. Retrospective review of hospital inpatient bills and hospital outpatient bills and collection of overpayments identified by these reviews.
- B. Collection of hospital overpayments identified by the hospital on their Credit Balance Report and approved by BWC and collection of other hospital overpayments as identified by BWC.

Each of the two sections will have a distinct scope, process and timeline. Section B does not involve a retrospective bill review.

1.0 BACKGROUND AND PURPOSE OF REQUEST FOR PROPOSALS

1.1 BWC General Background

Under the mandates of the Ohio Revised Code (O.R.C.), the Ohio Workers' Compensation System is the largest exclusive state insurance fund system in the United States, with investment assets of \$20 billion as of December 31, 2010 and annual insurance premiums and assessments of over \$2.1 billion. The Ohio Workers' Compensation System consists of the Ohio Bureau of Workers' Compensation (BWC), responsible for administrative and insurance functions, and the Industrial Commission of Ohio (IC), responsible for claims adjudicative functions. BWC exercises fiduciary authority with respect to the State Insurance Fund (SIF) and related Specialty Funds. These BWC Trust Funds are held for the benefit of the injured workers and employers of Ohio. It is from these trust funds that all claims for both medical and compensation for disability benefits are paid with the exception of self-insured claims.

Self-insuring employers have been granted the status of self-insurance by having proven ability to meet certain obligations set forth in the ORC 4123.35. Self-insuring employers administer their own workers' compensation claims and are monitored by BWC. Presently, BWC processes claims, pays compensation and medical benefits to injured workers and underwrites workers' compensation coverage for employers doing business in Ohio. BWC also offers safety training and accident prevention programs to employers and helps injured employees return to work through rehabilitation programs. The Board of Directors (BOD) oversees BWC's activities and functions as a fiduciary.

1.2 Purpose of the Request for Proposals

BWC is responsible for ensuring correct payments are made to providers for medical services related to compensable workers' compensation claims. While payments are to be based on BWC laws, rules, policies and guidelines, improper payments may sometimes be made in error.

Improper payments on bills can occur for the following reasons:

- Payments were made for services that were later determined to be medically unnecessary or unrelated to the workers' compensation claim;
- Payments were made for services that were incorrectly coded;
- Providers failed to submit documentation to support paid services and goods;
- Billing errors, such as incorrect units of service and charges;
- Other reasons, such as duplicate billing or split billing, payments made above and below the appropriate fees, payments for non-covered services, etc.

BWC is seeking a vendor or vendors to identify and collect overpayments from hospitals as detailed in this RFP.

1.3 BWC Inpatient Payment Methodology

Until 02/01/2010, BWC policy defined hospital inpatient services as a patient admitted to a hospital on recommendation of a physician or dentist, whose inpatient stay continued beyond midnight and/or 23 hours the day of admission. Effective 02/01/2010, Ohio Administrative Code 4123-6-01 includes a new definition of hospital inpatient services. A copy of Ohio Administrative Code 4123-6-01 can be found in Appendix A of this RFP.

Ohio Administrative Code 4123-6-37.1 details BWC's reimbursement methodology for hospital inpatient services. On 01/01/2007, BWC implemented a modified version of Medicare's Inpatient Prospective Payment System (IPPS), and subsequent yearly adjustments to the rule have been adopted. Past and present versions of Ohio Administrative Code 4123-6-37.1 can be found in Appendix A of this RFP.

In addition, for all dates of service, hospitals may be paid at a higher or lower rate negotiated between the Managed Care Organizations (MCO) and hospital; however, relatively few bills have been reimbursed at these negotiated rates.

1.4 BWC Outpatient Payment Methodology

Until 02/01/2010, BWC policy defined hospital outpatient services as a patient who was not an inpatient as defined in the BWC policy cited above and who received outpatient services at a hospital. Outpatient included admission as an inpatient whose inpatient stay did not extend beyond midnight and/or 23 hours of the day of admission except in instances when, on the day of admission, a patient died or was transferred to another inpatient unit within the hospital, to another hospital, or to another state psychiatric facility.

Effective 02/01/2010, Ohio Administrative Code 4123-6-01 includes a new definition of hospital outpatient services. A copy of Ohio Administrative Code 4123-6-01 can be found in Appendix A of this RFP.

Ohio Administrative Code 4123-6-37.2 details BWC's reimbursement methodology for hospital outpatient services. For dates of service through 12/31/2010, BWC reimbursed outpatient services using a retrospective cost plus reimbursement methodology.

BWC adopted a modified version of Medicare's Outpatient Prospective Payment System (OPPS) on 01/01/2011 for dates of service 01/01/2011 and forward. A subsequent adjustment to the rule became effective on 04/01/2011.

Past and current versions of Ohio Administrative Code 4123-6-37.2 can be found in Appendix A of this RFP.

In addition, for all dates of service, hospitals may be paid at a different rate negotiated between the MCO and the hospital; however, relatively few bills have been reimbursed at these negotiated rates.

1.5 MCO Contracts

As part of the Health Partnership Program, the managed care organizations (MCOs) contracted with BWC are required to perform prospective, concurrent and retrospective reviews on hospital inpatient admissions and the subsequent bills related to the admissions.

The BWC-MCO contract requires, at a minimum, prospective and concurrent reviews that take into consideration relatedness of the services to the allowed conditions in the claim, medical necessity and length of stay. Retrospective reviews are required on all non-DRG/MS-DRG inpatient bills with payment amounts greater than or equal to \$20,000 for hospitals with physical locations in Ohio and in states contiguous to Ohio (Indiana, Kentucky, Michigan, Pennsylvania and West Virginia). High level audits are required for inpatient bills with payment amounts between \$20,000 and \$50,000 and entail comparing the core medical documentation to the itemized billed charges. Detailed bill audits are required for inpatient bills with paid amounts greater than \$50,000 and entail review of the entire medical record. MCOs are contractually responsible for facilitating the correction of improper payments identified during retrospective reviews, including recovery of overpayments and submission of adjustments to BWC.

Appeals to medical necessity and relatedness issues must be handled through the ADR process.

As an example, a summary of MCO retrospective reviews submitted for one month showed that 63 bills were reviewed during the timeframe totaling \$3.1M in payments. MCO retrospective review reports showed the following:

	Overpayments	Underpayments
# Bills with incorrect payments	6	2
Total amount identified (includes overpayments identified but not collected)	\$ 30,236	\$ 20,774
Percent of \$3.1M paid on the reviewed bills	0.96%	0.66%

As part of their contract, MCOs are also required to have nationally-recognized clinical editing packages in place to prevent inappropriate payments. At a minimum, BWC requires MCOs to have specific clinical editing criteria in place as outlined in Section 1H(10) of the 2011-2012 MCO Agreement and Chapter 8 of the MCO Policy Reference Guide.

1.6 BWC Pre-Payment Audits

BWC has dedicated staff, including a certified medical coder, to conduct high level pre-payment audits on all inpatient hospital bills with dates of service on or after 01/01/2007. The team's primary focus is to ensure bills contain the correct diagnosis and procedure coding according to the official coding guidelines, which in turn ensures the bills group to the correct DRG/MS-DRG and payment rate. While reviewing the medical documentation for coding purposes, the team also confirms the MCOs' determinations of medical necessity and relatedness of the inpatient stays and appropriateness of MCO-applied EOBs.

Effective 05/02/2011, BWC will significantly reduce the number of pre-payment inpatient hospital bill audits performed.

BWC's bill payment system also includes clinical editing to help prevent inappropriate payments.

BWC does not currently conduct pre-payment audits on outpatient bills.

2.0 CALENDAR OF EVENTS

The time schedule for this project is outlined below, and is subject to change. BWC may change this schedule at any time. If BWC changes the schedule before the Proposal due date, it will do so through an announcement on the State Procurement Web site area for this RFP. The Web site announcement will be followed by an addendum to this RFP, also available through the State Procurement Web site. It is each prospective Offeror's responsibility to check the Web site question and answer area for this RFP for current information regarding this RFP and its calendar of events through award of the Contract. No contact shall be made with agency/program staff until contract award is announced.

2.1 Dates:

RFP Issued	Tuesday, May 17, 2011
Question Period Begins	Wednesday, May 18, 2011
Question Period Concludes	Wednesday, June 1, 2011 (8:00 A.M. EDT)
Questions and Answers Posted by	Friday, June 3, 2011
Proposals Due	Thursday, June 16, 2011 (2:00 P.M. EDT)
Oral Presentation Notification	July 5 or 6, 2011
Oral Presentations (if requested by BWC)	Week of July 18, 2011
Contract Commences:	August 15, 2011

NOTE: These dates are subject to change.

There are references in this RFP to the Proposal due date. Prospective Offerors must assume, unless it is clearly stated to the contrary, that any such reference means the date and time (Columbus, OH local time) that the Proposals are due.

Proposals received after 2:00 p.m. on the due date will not be evaluated.

3.0 PROPOSAL INQUIRIES AND SUBMISSIONS

3.1 Questions

Offerors may make inquiries regarding this RFP any time during the inquiry period listed in the Calendar of Events. To make an inquiry, provide reference(s) to the RFP e.g. (Section number and/or item number, etc.) Unreferenced or incorrectly referenced questions will not be answered; Offerors must use the following process:

1. Access the State Procurement Web site at <http://www.ohio.gov/procure>.
2. From the Navigation Bar on the left, select "Find It Fast".
3. Select "Doc/Bid/Schedule #" as the Type.
4. Enter the RFP Number found on Page 1 of the document. (RFP numbers begin with the letters "BWC")
5. Click "Find It Fast" button.
6. On the document information page, click "Submit Inquiry".
7. On the document inquiry page, complete the required "Personal Information" section by providing:
 - a. First and last name of the prospective Offeror's representative who is responsible for the inquiry.
 - b. Name of the prospective Offeror.
 - c. Representative's business phone number.
 - d. Representative's e-mail address.
8. Type the inquiry in the space provided including:
 - a. A reference to the relevant part of this RFP.
 - b. The heading for the provision under question.
 - c. The page number of the RFP where the provision can be found.
9. Click the "Submit" button.

Offerors submitting inquiries will receive an immediate acknowledgement that their inquiry has been received as well as an e-mail acknowledging receipt of the inquiry. Offerors will not receive a personalized e-mail response to their question, nor will they receive notification when the question has been answered.

Questions must be received by BWC by June 1, 2011 at 8:00 A.M. EDT. BWC will respond to any or all questions exclusively through the above method; however, responses by BWC will not officially modify the RFP in any way unless a written addendum is issued by BWC.

Offerors may view inquiries and responses using the following process:

1. Access the State Procurement Web site at <http://www.ohio.gov/procure>.
2. From the Navigation Bar on the left, select "Find It Fast".
3. Select "Doc/Bid/Schedule #" as the Type.
4. Enter the RFP Number found on Page 1 of the document. (RFP numbers begin with the letters "BWC")
5. Click "Find It Fast" button.
6. On the document information page, click the "View Q & A" button to display all inquiries with responses submitted to date.

BWC will try to respond to all inquiries within 48 hours of receipt, excluding weekends and State holidays. BWC will not respond to any inquiries received after 8:00 a.m. on the inquiry end date.

Offerors are to base their RFP responses, and the details and costs of their proposed projects, on the requirements and performance expectations established in this RFP for the future contract, not on details of any other potentially related contract or project. If Offerors ask questions about existing or past contracts using the Internet Q&A process, BWC will use its discretion in deciding whether to provide answers as part of this RFP process.

BWC is under no obligation to acknowledge questions submitted through the Q&A process if those questions are not in accordance with these instructions or deadlines.

3.2 Communication Restrictions

In order to ensure fairness and parity among prospective vendors, from the time of the release of this RFP until a vendor is selected and a contract is awarded; vendors shall not communicate with any BWC staff concerning this RFP, except as provided in Section 3.1. If the vendor attempts or undertakes an unauthorized communication, BWC reserves the right to reject that vendor's proposal, without evaluation. BWC shall not be responsible for any vendor's reliance on any information regarding this Request for Proposal or any work hereunder if the information was provided by any source other than through the inquiry process in Section 3.1.

3.3 Proposal Submission

It is absolutely essential that vendors carefully review all elements in their final proposal. Once received by BWC, a proposal cannot be altered. One (1) complete, signed, and sealed original; seven (7) complete, sealed copies; and two (2) electronic copies on CD of your proposal shall be submitted for evaluation. Proposals shall be clearly marked "Ohio Bureau of Workers' Compensation BID No BWCB11007 — Retrospective Hospital Bill Review and Hospital Overpayment Collection Services" on the outside of the envelope. FAX or electronic mail transmissions will not be accepted. All copies must be received by BWC together in one package.

Proposals must be received in the Purchasing Department by **2:00 P.M. EDT on Thursday, June 16, 2011**. Proposals inappropriately addressed or delivered elsewhere risk untimely re-routing to the Purchasing Department. Any proposals received in the Purchasing Department after the deadline will be marked as untimely and will not be opened or evaluated regardless of the reason for late receipt.

If mailing proposals, vendors should allow for sufficient mailing time to ensure timely receipt by the Purchasing Department. All mail and deliveries can be expected to undergo package security screening (amounting to approximately one hour) before receipt in the Purchasing Department. Vendors must anticipate this additional time when arranging for mail or delivery of proposals. If attending the opening, vendors must bring photo identification and should allow for additional time for personal security screening (amounting to approximately twenty minutes) and for package security screening (amounting to approximately one hour) if they are also delivering their proposals in person at that time. Submit complete, signed and sealed copies of the proposal to:

**BY MAIL OR HAND-DELIVERY:
Ohio Bureau of Workers' Compensation
Purchasing Department
30 W. Spring Street, Level 24
Columbus, Ohio 43215-2256**

All material submitted to and accepted by BWC in response to the RFP shall become the property of BWC and will be retained by BWC in accordance with the Ohio Public Records Act and the Ohio Records Retention Act. THE CONTENTS OF THE PROPOSAL ARE SUBJECT TO THE OHIO PUBLIC RECORDS ACT, SECTION 149.43, OF THE OHIO REVISED CODE, UNLESS OTHERWISE EXCEPTED BY LAW. If the proposal includes information that the proposer in good faith believes falls within one of the exceptions to the provisions of the Ohio public records laws, the proposer must put such information in separate sealed envelopes with each copy of the proposal with a note identifying which exception is claimed. Any material not separately sealed and annotated will be released upon a proper public records request. Any proposal that claims that the entire contents of the proposal fall within the exceptions will be disqualified. After a contract is awarded, if BWC determines that the information separately sealed by any proposer appears not to be exempt and may be released upon a proper request, the vendor will be advised of BWC's intent to release the information.

3.4 Changes to this Request for Proposals

All vendors will be notified in the event that BWC finds it necessary to modify one or more portions of this RFP after it has been released. Should BWC issue an addendum to this RFP, additional time may be given to all prospective vendors, if appropriate, to extend the deadline to accommodate needed changes in the proposals.

4.0 GENERAL TERMS AND CONDITIONS

4.1 General

BY SUBMITTING A PROPOSAL, THE VENDOR ACKNOWLEDGES THAT VENDOR HAS READ THIS RFP, UNDERSTANDS IT, AND AGREES TO BE BOUND BY ITS REQUIREMENTS, TERMS, AND CONDITIONS. BWC RESERVES THE RIGHT TO DISQUALIFY ANY PROPOSAL WHICH TAKES EXCEPTION TO OR LIMITS THE RIGHTS OF BWC UNDER THE RFP. BWC RESERVES THE RIGHT TO REFUSE ACCEPTANCE OF ANY PROPOSAL WHICH IS NOT PROPERLY SUBMITTED IN ACCORDANCE WITH THE REQUIREMENTS OF THIS RFP. FURTHERMORE, BWC RESERVES THE RIGHT TO REJECT ANY AND ALL PROPOSALS, INCLUDING THE SELECTED PROPOSAL, AT ANY TIME PRIOR TO EXECUTION OF A CONTRACT. BWC RESERVES THE RIGHT TO CANCEL THIS RFP AT ANY TIME PRIOR TO EXECUTION OF A CONTRACT.

Headings used in this RFP are for convenience only and shall not affect the interpretation of any of the terms and conditions hereof.

In BWC's sole discretion, BWC may waive minor defects that are not material when no prejudice will result to the rights of any other vendors, the public, or BWC.

BWC is not liable for any cost incurred by any vendor in the preparation and submission of any proposal, or in anticipation of the award of a contract. Moreover, BWC is not liable for any cost incurred by any selected Vendor prior to the execution of a contract by all parties. All disbursements made for the contract shall be only for obligations incurred on or after the effective date of the contract.

BWC reserves the right to use any materials or ideas submitted without compensation to the proposer.

4.2 Resulting Contract and Term

Any contract resulting from this RFP shall consist of this RFP and any written addenda issued by BWC, the selected proposal and the executed contract. In the event of conflict, the terms of the RFP shall control.

The term of the contract shall commence on August 15, 2011, contingent upon compliance with any and all conditions precedent as provided for herein, and shall be completed by June 30, 2012 unless modified by mutual agreement of the parties.

The contract may be renewed for two (2) additional one year periods at the sole and exclusive option of BWC. However, in the alternative the contract may be renewed by mutual agreement between the Contractor and BWC for any number of times and for any period of time, so long as the cumulative time of all renewals does not exceed twenty four (24) months. It is expressly understood by the parties that any renewals are contingent upon all necessary funds being made available and forthcoming from the appropriate State agencies, and such expenditure of funds being approved by the Administrator.

BWC shall incur no liability should it choose not to exercise its exclusive option to renew the contract.

4.3 Governing Law - Severability

The validity, construction and performance of any contract resulting from this RFP and the legal relations among the parties to any contract shall be governed by and construed in accordance with the laws of the State of Ohio. If any provision of any contract resulting from this RFP or the application of any such provision shall be held by an Ohio court of competent jurisdiction to be contrary to law, the remaining provisions of the contract shall remain in full force and effect. The parties agree to submit irrevocably to the jurisdiction of Ohio courts.

4.4 Compliance with Applicable Laws

The Vendor agrees to comply with all applicable federal, state, and local laws in the conduct of the work hereunder. The Vendor accepts full responsibility for payment of all taxes and insurance including workers' compensation insurance premiums, unemployment compensation insurance premiums, all income tax deductions, social security deductions, and any and all other taxes or payroll deductions required for all employees engaged by the Vendor in the performance of the work authorized by this contract. BWC does not agree to pay any taxes. Failure to have workers' compensation or other required insurance in accordance with the RFP shall deem any resulting contract voidable at BWC's sole discretion.

4.5 Publicity

Any use or reference to any resulting contract by the selected Vendor to promote, solicit, or disseminate information regarding the scope of the contract is prohibited, unless otherwise agreed to in writing by BWC. BWC agrees to be used as a reference by the successful Vendor in other State of Ohio situations where the Vendor may wish to make a proposal.

4.6 Conditions Precedent

It is expressly understood by the parties that the contract is not binding on BWC until such time as all necessary funds are made available and forthcoming from the appropriate State agencies, and such expenditure of funds is approved by the Administrator after execution of the contract by the Vendor but before execution by BWC. No contract shall be binding upon either party until receipt by the contracting Vendor of a copy of a fully executed contract, and compliance with any and all conditions precedent.

4.7 Equal Employment Opportunity

The Vendor will comply with all state and federal laws regarding equal employment opportunity and fair labor and employment practices, including Ohio Revised Code Section 125.111(B) and all related Executive Orders.

Before a contract can be awarded or renewed, an Affirmative Action Program Verification Form must be submitted to the DAS Equal Opportunity Division to comply with the Ohio affirmative action requirements. Affirmative Action Verification Forms and approved Affirmative Action Plans can be found by contacting the Equal Opportunity Department or viewing the Equal Opportunity Department's web site:

<http://das.ohio.gov/Divisions/EqualOpportunity/AffirmativeActionProgramVerification/tabid/133/Default.aspx>

The State of Ohio encourages the Vendor to purchase goods and services from Minority Business Enterprise (MBE) and Encouraging Diversity, Growth and Equity (EDGE) vendors.

4.8 Payment and Billing Procedures

The proposal shall include the vendor's proposed fee which shall be based on a percentage of the collected overpayment amount on each bill.

The Vendor's fee shall be due and payable within thirty (30) days after receipt of a proper invoice and verification of the recovery check deposit and spreadsheet. Proper invoices should be sent to BWC not more than once per week. Incorrect invoices shall be returned to the Vendor noting areas for correction. When such notification of defect is sent, the required payment date shall be thirty (30) days after receipt of the corrected information.

Section 126.30 of the Ohio Revised Code, and any applicable rules thereto, are applicable to this Agreement and require payment of interest if, upon receipt of a proper invoice, payment is not made within thirty (30) calendar days, unless otherwise agreed in writing. The interest charge shall be at the rate per calendar month which equals one-twelfth of the rate per annum prescribed by Section 5703.47 of the Ohio Revised Code. In the event that BWC does fail to make prompt payment, Vendor is entitled to the interest allowed by law. In no event shall such failure to make prompt payment be deemed a default or breach of contract on the part of BWC.

By signing the contract, the selected vendor agrees to receive payment by means of electronic fund transfers, "EFT". BWC agrees to send to the selected vendor an Authorization Agreement for Automatic Deposit of State Warrants for the selected vendor to complete and to file with the Auditor of State, providing the information needed to enable EFT payment. It is the Vendor's responsibility to complete and to submit the Authorization Agreement for Automatic Deposit of State Warrants.

Payment shall be made to the Vendor, in the Vendor's Federal E.I. number, as provided for in the response to the RFP. The date the EFT payment is issued shall be considered the date payment is made. Payment shall not be initiated before a proper invoice is received by BWC.

BWC shall not be required to pay for or reimburse the Vendor for any onsite audit costs or other expenses incurred or paid by the Vendor in connection with the performance of services under the Agreement. The payment of such expenses is the sole responsibility of the Vendor and not the responsibility of BWC.

4.9 Record Keeping

During the term of this Agreement and until the expiration of three (3) years after final payment under the Agreement, the Vendor shall create, maintain, and provide BWC and/or its duly authorized representatives with access to and the right to examine auditable records of the Vendor that adequately document and fully substantiate the validity of Vendor's billings for work performed under the Agreement.

For each subcontract in excess of \$2,500, the Vendor shall require its subcontractors to agree to the provisions of this section on record-keeping.

4.10 Workers' Compensation Coverage

The Vendor shall submit a copy of the certificate proving that the Vendor and agents are covered by workers' compensation. The Vendor is responsible for ensuring contractually that any subcontractors maintain workers' compensation insurance at all times during the term of the resulting contract. Failure to maintain coverage at any time during the term of any contract shall be deemed a material breach of the contract. Such breach shall render the contract voidable in its entirety at BWC's sole discretion.

4.11 General Commercial Liability Insurance

The Vendor shall carry general commercial liability insurance with limits of not less than \$1,000,000 for any one occurrence. Failure to maintain coverage at any time during the term of any contract shall be deemed a material breach of the contract. Such breach shall render the contract voidable in its entirety at BWC's sole discretion.

Prior to the award of the contract, the selected Vendor shall submit to BWC a copy of the certificate of insurance. The Vendor will furnish a certificate of insurance to BWC for the required coverage from an insurance carrier authorized to do business in Ohio. The certificate must be in a form that is reasonably satisfactory to BWC as to the contents of the policies and the quality of the insurance carriers. The certificate must list BWC as an additional insured. Failure to currently maintain the required coverage amounts will not disqualify a vendor during evaluation. Failure to provide the certificate of coverage will result in the Vendor being deemed non-responsive, and the proposal will be immediately disqualified.

4.12 Vendor's Liability

The Vendor shall hold BWC harmless and indemnify BWC from and against any claims, demands, losses, and causes of action asserted against or incurred by BWC which result from or arise out of the negligent conduct or intentional acts of the Vendor, its agents, employees and subcontractors. The Vendor's entire liability and BWC's remedies for claims it may have related to or arising out of the Agreement for any cause and regardless of the form of action shall include all legal and equitable remedies.

4.13 Contract Compliance and Termination

During the term of this contract, the designated BWC Medical Billing and Adjustments Contract Manager shall be responsible for monitoring the Vendor's performance and compliance with the terms and conditions of the contract. It is specifically understood that the nature of the services to be rendered pursuant to any contract resulting from this RFP are of such a nature that BWC is the sole judge of the adequacy of such services. BWC reserves the right to cancel the contract at any time without cause upon thirty (30) days notice. If BWC's representative observes any infraction(s), such shall be documented and notice conveyed to the Vendor for immediate correction. Continued failures on the Vendor's part to comply with the terms and conditions of the ensuing contract may constitute an event of default. Unremedied infraction(s) persisting beyond thirty (30) days after notice to the vendor may constitute an event of default.

4.14 Default by the Vendor

BWC declares and the Vendor acknowledges that BWC may suffer damages due to the failure of the Vendor to act in accordance with the requirements, terms, and conditions of the contract. BWC declares and the Vendor agrees that such failure shall constitute an event of default on the part of the Vendor. The Vendor agrees that if BWC does not give prompt notice of such a failure, that BWC has not waived any of its rights or remedies

4.15 Damages

Without limiting in any way the Vendor's liability under sections 4.12, 4.13, and 4.14 above, in the event that the Vendor fails to cure a default or breaches any term or condition of the contract, the Vendor agrees to reimburse BWC for any actual and direct losses incurred by BWC. In addition, the Vendor agrees that BWC shall have the right to terminate the contract either in whole or in part, without liability to BWC whatsoever.

4.16 Subcontracting / Assignment / Delegation

The Contractor will not assign any of its rights nor delegate any of its duties and responsibilities under this Agreement without prior written consent of the Bureau. Any assignment or delegation not consented to may be deemed void by the Bureau. However, the Bureau's approval will not serve to modify or abrogate the responsibility of the Contractor for the acts, omissions, nonfeasance, malfeasance, or misfeasance of any and all subcontractors.

4.17 Drug Free Workplace

The Vendor agrees to comply with all applicable state and federal laws regarding a drug-free workplace. The Vendor shall make a good faith effort to ensure that all of its employees, if working on state property, will not purchase, use or possess illegal drugs or alcohol or abuse prescription drugs in any way.

4.18 Confidentiality

The Vendor, its officers, agents, employees, representatives, subcontractors and assigns shall keep confidential all information obtained in the performance of this Agreement that is confidential under BWC policy or state and/or federal law, including but not limited to employer premium data subject to Ohio Revised Code Section 4123.27 and claim file data subject to Ohio Revised Code Section 4123.88. The Vendor promises not to copy, disclose, publish, or communicate BWC's confidential information.

The Vendor agrees that any confidential information obtained in the performance of this Agreement is for the sole use of the Vendor for the purpose of performing work under the Agreement, and shall be used for no other purpose.

The Vendor shall comply with BWC's Sensitive Data policy shown in Appendix B of this document, and with all electronic data security measures as may be required by Ohio law, Ohio Department of Administrative Services or other state agency Directive, and/or Executive Order of the Governor of Ohio during the term of this Agreement.

The Vendor shall comply with, and shall assist BWC in complying with, all disclosure, notification or other requirements contained in Sections 1347.12, 1349.19, 1349.191, and 1349.192 of the Ohio Revised Code, as may be applicable, in the event computerized data that includes personal information, obtained by the Vendor in the performance of this Agreement, is or reasonably is believed to have been accessed and acquired by an unauthorized person and the access and acquisition by the unauthorized person causes, or reasonably is believed will cause a material risk of identity theft or other fraud.

Any improper use or access of BWC data by an officer, agent, employee, representative, subcontractor, or assign of the Vendor will result in the termination of that person's access as well as notification to that person's employer and to the Vendor. "Improper use or access" is defined as access or use that is not for a legitimate business purpose.

After the Vendor's tasks under this Agreement are completed, and upon expiration of all applicable retention periods under this Agreement and/or state and federal law, the Vendor shall either return to BWC or destroy in a secure manner all confidential data obtained in the performance of this Agreement.

Failure to comply with the provisions of this Section 4.18 shall be deemed a material breach of the Agreement. Such breach shall render the Agreement voidable in its entirety at BWC's sole discretion.

The provisions of this Section 4.18 shall survive the termination of this Agreement.

4.19 Ohio Elections Law

The Vendor hereby certifies that no applicable party listed in Divisions (I), (J), (Y) and (Z) of O.R.C. Section 3517.13 has made contributions in excess of the limitations specified under Divisions (I), (J), (Y) and (Z) of O.R.C. Section 3517.13.

4.20 Unresolved Finding for Recovery

By signing the contract, the selected vendor affirmatively represents and warrants that it is not subject to any unresolved finding for recovery issued by the Auditor of State within the meaning of Ohio Revised Code Section 9.24, or that it has taken the appropriate remedial steps required under Section 9.24 or otherwise qualifies under that section. The Vendor agrees that if this representation and warranty is deemed to be false, the contract shall be declared "void ab initio" as between the parties to this contract and BWC will not pay for any services rendered or goods delivered under the contract. Immediately upon such declaration, any funds paid under this contract shall be immediately repaid by the vendor to BWC or an action for recovery of such payments from the vendor may result.

4.21 Offshore Provision of Services Prohibited

The Vendor affirms to have read and understands Ohio Governor Executive Order 2010-09S and shall abide by those requirements in the performance of this Contract, and shall perform no services required under this Contract outside of the United States. The Executive Order 2010-09S is available at the following website: <http://procure.ohio.gov/pdf/EO2010-09S.pdf>

The Contractor also affirms, understands, and agrees to immediately notify the State of any change or shift in the location(s) of services performed by the Contractor or its subcontractors under this Contract, and no services shall be changed or shifted to a location(s) that are outside of the United States.

If Contractor or any of its subcontractors perform services under this Contract outside of the United States, the performance of such services shall be treated as a material breach of the Contract. The State is not obligated to pay and shall not pay for such services. If Contractor or any of its subcontractors perform any such services, Contractor shall immediately return to the State all funds paid for those services. The State may also recover from the Contractor all costs associated with any corrective action the State may undertake, including but not limited to an audit or a risk analysis, as a result of the Contractor performing services outside the United States.

The State may, at any time after the breach, terminate the Contract, upon written notice to the Contractor. The State may recover all accounting, administrative, legal and other expenses reasonably necessary for the preparation of the termination of the Contract and costs associated with the acquisition of substitute services from a third party.

If the State determines that actual and direct damages are uncertain or difficult to ascertain, the State in its sole discretion may recover a payment of liquidated damages in the amount of one percent of the value of the Contract.

The State, in its sole discretion, may provide written notice to Contractor of a breach and permit the Contractor to cure the breach. Such cure period shall be no longer than 21 calendar days. During the cure period, the State may buy substitute services from a third party and recover from the Contractor any costs associated with acquiring those substitute services.

Notwithstanding the State permitting a period of time to cure the breach or the Contractor's cure of the breach, the State does not waive any of its rights and remedies provided the State in this Contract, including but not limited to recovery of funds paid for services Contractor performed outside of the United States, costs associated with corrective action, or liquidated damages.

4.22 Declaration Regarding Material Assistance/Non-assistance to a Terrorist Organization

The Vendor must complete the Declaration Regarding Material Assistance/Non- Assistance to a Terrorist Organization (DMA) certification as required by the Ohio Department of Public Safety/Ohio Homeland Security. Vendors are required to register at the Ohio Business Gateway, <http://obg.ohio.gov/> to certify that the Vendor does not provide material assistance to any organization on the United States, Department of State's terrorist exclusion list. The completion of this certification is considered a Condition Precedent for Execution of a Contract. Failure to complete the certification may result in the bidder being deemed not responsive and/or may invalidate any Contract award. The current Terrorist Exclusion List can be found on this website: http://www.publicsafety.ohio.gov/links/terrorist_exclusion_list.pdf

4.23 Debarment

The Vendor represents and warrants that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either Ohio Revised Code Section 153.02 or Ohio Revised Code Section 125.25. If this representation and warranty is found to be false, this Agreement will be declared "void ab initio" and Vendor shall immediately repay to BWC any funds paid under this Agreement.

4.24 Conflicts of Interest and Ethics Compliance

The Vendor affirms that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict, in any manner or degree, with the performance of services which are required to be performed under any resulting Contract. In addition, Vendor affirms that a person who is or may become an agent of Vendor, not having such interest upon execution of this Contract shall likewise advise the Bureau in the event it acquires such interest during the course of this Contract.

The Vendor agrees to adhere to all ethics laws contained in Chapters 102 and 2921 of the Ohio Revised Code governing ethical behavior, understands that such provisions apply to persons doing or seeking to do business with the Bureau, and agrees to act in accordance with the requirements of such provisions; and warrants that it has not paid and will not pay, has not given and will not give, any remuneration or thing of value directly or indirectly to the Bureau or any of its board members, officers, employees, or agents, or any third party in any of the engagements of this Agreement or otherwise, including, but not limited to a finder's fee, cash solicitation fee, or a fee for consulting, lobbying or otherwise.

5.0 SCOPE OF SERVICES FOR RETROSPECTIVE HOSPITAL BILL REVIEW AND COLLECTION OF VENDOR IDENTIFIED OVERPAYMENTS (SECTION A)

5.1 Review of Hospital Inpatient and Outpatient Bills

BWC shall identify the total population of bills that are eligible for the vendor to review. The vendor shall review hospital inpatient and outpatient bills, related medical documentation and other information to identify overpayments. The vendor will be granted remote read-only access to BWC's bill payment system and all imaged medical documentation and other documents related to the injured workers' claims.

Overpayments previously identified on the hospital's credit balance report are not eligible for collection under the vendor's scope of services outlined in section 5.0 of this RFP. Overpayments identified on the hospital's credit balance report are covered under the vendor's scope of services outlined in section 6.0 of this RFP. In addition, identification of underpayments is not within the scope of this RFP.

The bills eligible for vendor review vary by service type:

Inpatient bills eligible for review include those with dates of service on or after 01/01/2007 for Ohio and out-of-state hospitals paid at the outlier rate and those paid at the DRG/MS-DRG exempt or outlier rate as defined in the rule. DRG/MS-DRG paid bills eligible for review include those with a BWC receipt date of 05/02/2011 and later. Additional bills, such as those paid at a rate negotiated between the hospital and MCO may also be eligible for review depending on the negotiation language.

The following review criteria are included in the project scope for DRG/MS-DRG exempt and outlier paid inpatient bills:

- Ensuring documentation supports all services and items billed
- Ensuring documentation supports discharge disposition coding
- Identification of billing errors (e.g. duplicates, charges posted to wrong account, etc.)
- Identification of other inappropriate charges and payments (e.g. 30 aspirin given in one day, BWC non-covered services, etc.)

The following review criteria are included in the project scope for DRG/MS-DRG paid inpatient bills:

- Ensuring documentation supports diagnosis coding
- Ensuring documentation supports procedure coding
- Ensuring documentation supports discharge disposition coding
- Ensuring documentation supports other coding that may affect reimbursement (e.g. condition codes)
- Ensuring correct DRG/MS-DRG assignment

The following review criteria are specifically excluded from the project scope for all inpatient bills:

- Ensuring medical necessity of admission, services or supplies billed (MCO responsibility)
- Ensuring services are related to the workers' compensation claim allowances (MCO responsibility)
- Ensuring bill meets the definition of an inpatient service (MCO responsibility)
- Recovering monies associated with bills when incorrect coding does not affect the reimbursement amount.

Outpatient bills eligible for review include those with dates of service on or after 01/01/2011 for Ohio and out-of-state hospitals.

The following review criteria are included in the project scope for outpatient bills:

- Ensuring documentation supports all services and items billed
- Ensuring documentation supports all coding except diagnosis coding
- Identification of billing errors (e.g. duplicates, charges posted to wrong account, etc.)
- Identification of inappropriate charges and payments (e.g. 30 aspirin given in one day, BWC non-covered services, etc.)

The following review criteria are specifically excluded from the project scope for outpatient bills:

- Ensuring medical necessity of admission, services or supplies billed (MCO responsibility)
- Ensuring services are related to the workers' compensation claim allowances (MCO responsibility)
- Ensuring documentation supports diagnosis coding (MCO responsibility)
- Ensuring bill meets the definition of an outpatient service (MCO responsibility)
- Recovering monies associated with bills when incorrect coding does not affect the reimbursement amount.

The vendor will follow the coding advice published in the *Official ICD-9-CM Guidelines for Coding and Reporting, Coding Clinic for ICD-9-CM*, by the American Hospital Association; and *CPT® Assistant*, by the American Medical Association when performing inpatient and outpatient coding reviews.

The vendor shall select specific bills for review from the total population of bills provided by BWC. Hospitals may request that reviews take place onsite. See Appendix A for Ohio Administrative Code 4123-6-45 which details audit of providers' patient and billing related records.

The vendor is responsible for calculating the exact overpayment amount based on the appropriate BWC rule in effect for the date of service. Please note, this will entail the use of past and present rules, Medicare rates, fee schedules, etc.

5.2 Provider Communication and Appeals

The vendor must communicate all overpayment findings in writing to the hospital. Per BWC policy, provider overpayment notices must be postmarked within two years from the BWC payment date. Therefore, the vendor must ensure that hospitals are initially notified within the established timeframe. A copy of the BWC "Medical Overpayment Recovery Policy and Procedure" document is provided for informational purposes and can be found in Appendix B of this RFP.

The vendor must offer a minimum of one level of appeal for hospitals. The appeal review must be conducted by a different person than the original decision-maker. The vendor's appeal responses must be communicated in writing to the hospital.

The vendor's last appeal response shall offer a final appeal to BWC. The vendor shall coordinate the receipt of a hospital's final BWC level appeal and forward the appeal and all related documents (hospital and vendor correspondence, supporting documentation, etc.) to BWC's Medical Bill Payment Recovery Unit. BWC will communicate all final level appeal decisions in writing to the hospital and vendor.

The vendor must offer telephone access with core customer service hours from Monday through Friday, 8:00 a.m. to 5:00 p.m. or similar hours.

5.3 Collection and Bill Data Reports

After appeal opportunities are exhausted, the vendor shall obtain the overpayment check from the hospital. The hospitals' checks must be made payable to Ohio BWC (not the MCO or vendor) and forwarded to BWC for deposit. The vendor shall mail the check and invoice to:

Attention: Carol Wander
BWC Accounts Receivable
30 W. Spring St. 24th Floor
Columbus, OH 43215-2256

The vendor shall submit a bill detail Excel spreadsheet, containing the minimum data elements shown in Appendix C of this RFP, to the specified BWC contact.

5.4 Vendor Reimbursement

Once the invoice, deposit, and spreadsheet are received and verified by BWC, payment to the vendor shall be processed by BWC's Medical Bill Payment Recovery Unit. The normal processing time for these payments is thirty (30) days or less.

The vendor will transfer one hundred percent (100%) of each overpayment recovered to BWC, and will be reimbursed a percentage of the overpayment amount collected from the hospital and deposited to BWC as specified in the contract.

5.5 Communication with BWC

The vendor shall designate a single point of contact to communicate with BWC for routine matters.

At a minimum, the vendor shall submit quarterly reports to BWC summarizing collection data and appeal data.

BWC may periodically request copies of communication between hospitals and the vendor for quality assurance purposes.

6.0 SCOPE OF SERVICES FOR COLLECTION OF OVERPAYMENTS IDENTIFIED BY HOSPITALS ON THEIR CREDIT BALANCE REPORTS (SECTION B)

6.1 Bills Eligible for Vendor Review

Only overpayments identified by the individual hospital and included in the hospital's credit balance report and where the original payment was made by BWC, or the assigned MCO, and not the employer or the employer's third party administrator shall be subject to review and collection by this vendor.

The successful vendor will be granted remote read-only access to BWC's bill payment system and all imaged medical documentation and other documents related to the injured workers' claims.

The vendor shall collect from the hospital only those overpayments which have been approved for collection by BWC.

6.2 Process for Collection of Hospital-identified Overpayments and Vendor Reimbursement

- a) The vendor shall review hospital credit balance reports and BWC billing information as necessary to determine whether BWC is owed a refund.
- b) Once a potential overpayment has been identified, the vendor shall submit an Excel spreadsheet, containing the minimum data elements shown in Appendix C of this RFP, to the specified BWC contact for approval of the collection of the overpayment.
- c) BWC will contact the assigned MCO to verify no collection effort for the particular bill is in process or been completed by the MCO.
- d) BWC will update the original Excel spreadsheet submitted by the vendor with either "approved" or "denied" on each separate invoice listed.
- e) Only those overpayments which are "approved" by BWC may be collected.
- f) The vendor shall obtain the overpayment check from the hospital. The hospitals' checks must be made payable to Ohio BWC (not the MCO or vendor) and forwarded to BWC for deposit. The vendor shall mail the check and invoice to:

Attention Carol Wander
BWC Accounts Receivable
30 W. Spring St. 24th Floor
Columbus, OH 43215-2256

- g) Once the invoice, deposit, and spreadsheet are received and verified by BWC, payment to the vendor shall be processed by BWC's Medical Bill Payment Recovery Unit. The normal processing time for these payments is thirty (30) days or less.
- h) The vendor will transfer one hundred percent (100%) of each overpayment recovered to BWC, and will be reimbursed a percentage of the overpayment amount collected from the hospital and deposited to BWC as specified in the contract. The vendor may also identify underpayments during their audits; however, BWC will not reimburse the vendor for correcting underpayments as BWC will not charge the employer's risks for a task that is ultimately the responsibility of the hospital.

7.0 PROPOSAL

Proposals shall include all components listed in sections 7.1 through sections 7.9 unless otherwise indicated. The information submitted may be used in scoring.

7.1 Cover Letter

A cover letter in the form of a standard business letter that shall be signed by an individual authorized to legally bind the Vendor must be provided. The letter shall provide the name, telephone number and e-mail address of a contact person with authority to answer questions regarding the proposal. The letter shall also provide a statement that the proposal remains valid for the term of the proposed contract.

7.2 Qualifications, Certifications, Experience, and References

The vendor shall submit a table of organization for all employees involved in this project. Employee qualifications or certifications should be included.

The vendor shall submit information related to current and/or previous project experience:

- Projects in process or completed within the last three years related to auditing of medical bills and/or collection of overpayments. Please specify the types of bills audited (hospital, physician, etc.)
- Information to demonstrate the project outcomes
- A minimum of three references for bill audit and/or collection projects, including company name, contact person, title, address and telephone number

7.3 Action Plan

Note: The vendor's proposed action plan is only required for the services outlined in section 5.0 (retrospective hospital bill review and collection of vendor-identified overpayments). An action plan is not required for section 6.0 (collection of overpayments identified on hospital credit balance reports).

The vendor shall submit a description of the method that will be utilized to select the bills to be reviewed from the BWC selected population. The proposal shall indicate the estimated number or percentage of bills that are expected to be reviewed for each bill type (inpatient and outpatient) and an estimate of overpayments the vendor would expect to recover (e.g. percentage and/or dollar amount).

The proposal shall include a detailed description of the proposed work plan, including all required processes, tasks and timelines. The timelines must include how the vendor will meet the two year limit for sending provider overpayment notifications. The vendor shall describe their hours of availability for customer service inquiries.

The proposal shall include a sample of the vendor's initial overpayment notice.

The proposal shall indicate the vendor's ability to conduct onsite audits as requested by the hospital.

7.4 Cost/Fee

The proposal shall include the vendor's proposed fee which shall be based on a percentage of the collected overpayment amount on each bill.

7.5 Disclosure Statement

The Vendor must provide a completed IRS Form W-9 and a disclosure statement concerning its organizational structure, including subsidiary or parent corporations and/or organization and ownership information

7.6 Financial Ability

BWC may request that an Offeror submit audited financial statements for up to the past three (3) years if BWC is concerned that an Offeror may not have the financial ability to carry out the Contract. If BWC believes the Offeror's financial ability is not adequate, BWC may reject the Proposal despite its other merits. To maintain fairness in the evaluation process, all information sought by BWC will be obtained in a manner such that no Offeror is provided an unfair competitive advantage.

8.0 PROPOSAL EVALUATION

A selection committee composed of BWC personnel will evaluate the proposals. The composition of the committee will remain consistent for all responses. The selection committee will be responsible for documenting and tabulating the scores for all responses.

BWC's approach to evaluation of the responses to this proposal will consist of the following three phases:

8.1 Phase 1 - Minimum Requirements

The first phase of the evaluation process consists of a review of all proposals received to ensure that each proposal meets the minimum administrative and professional requirements identified in section 7.0 of this RFP.

8.2 Phase 2 – Evaluation of Content

Proposals that have met minimum requirements will undergo detailed evaluation based on a point scale rating of the content. The evaluators will assign a score, from zero to the maximum score available, based on the vendor's response to the requirements.

- A. Retrospective review of hospital inpatient bills and hospital outpatient bills and collection of overpayments identified by these reviews.

Category	Maximum Points
Qualifications, certification and experience	45 points
Action plan	30 points
Cost/fee	25 points

- B. Collection of hospital overpayments identified by the hospital on their Credit Balance Report and approved by BWC and collection of other hospital overpayments as identified by BWC.

Category	Maximum Points
Qualifications, certification and experience	60 points
Cost/fee	40 points

8.3 Phase 3 – Oral Presentation

BWC reserves the right to request an oral presentation from up to three of the top scoring vendors from Phase 2 of the evaluation process. The presentation should focus on the scope of the project as presented in this RFP. This will also give the evaluation team an opportunity to meet key personnel from the vendor's organization and to ask questions about the vendor's proposal and presentation. Information acquired during the oral presentation may be used to revise or confirm prior scoring.

8.4 Contract Negotiations

The final phase of the evaluation process may be contract negotiations. Negotiations will be scheduled at BWC's convenience. The selected Vendor(s) are expected to negotiate in good faith.

Negotiations may be conducted with any Vendor who submits a competitive proposal, but BWC may limit discussions to specific aspects of the RFP. Any clarifications, corrections, or negotiated revisions that may occur during the negotiations phase will be reduced to writing and incorporated in the RFP or the Vendor's proposal, as appropriate. Any Vendor whose response continues to be competitive will be accorded fair and equal treatment with respect to any clarification, correction, or revision of the RFP, and

will be given the opportunity to negotiate revisions to its proposal based on the amended RFP. Should the evaluation process have resulted in a top-ranked proposal, BWC may limit negotiations to only that Vendor and not hold negotiations with any lower-ranking Vendor. If negotiations are unsuccessful with the top-ranked Vendor, BWC may then go down the line of remaining Vendors, according to rank, and negotiate with the next highest-ranking Vendor. Lower-ranking Vendors do not have a right to participate in negotiations conducted in such a manner.

If BWC decides to negotiate with all the remaining Vendors, or decides that negotiations with the top-ranked Vendor are not satisfactory and negotiates with one or more of the lower-ranking Vendors, BWC will then determine if an adjustment in the ranking of the remaining Vendors is appropriate based on the negotiations. The Contract award, if any, will then be based on the final ranking of Vendors, as adjusted.

Auction techniques that reveal one Vendor's price to another or disclose any other material information derived from competing proposals are prohibited. Any oral modification of a proposal will be reduced to writing by the Vendor as described below.

Following negotiations, BWC may set a date and time for the submission of best and final proposals by the remaining Vendor(s) with which BWC conducted negotiations. If negotiations were limited and all changes were reduced to signed writings during negotiations, BWC need not require the submissions of best and final proposals.

If best and final proposals are required, they may be submitted only once; unless BWC makes a written determination that it is in BWC's interest to conduct additional negotiations. In such cases, BWC may require another submission of best and final proposals. Otherwise, discussion of or changes in the best and final Proposals will not be allowed. If a Vendor does not submit a best and final proposal, the Vendor's previous proposal will be considered the Vendor's best and final proposal.

It is entirely within BWC's discretion whether to permit negotiations. A Vendor must not submit a proposal assuming that there will be an opportunity to negotiate any aspect of the proposal. BWC is free to limit negotiations to particular aspects of any proposal, to limit the Vendors with whom BWC wants to negotiate, and to dispense with negotiations entirely.

BWC generally will not rank negotiations. The negotiations will normally be held to correct deficiencies in the top-scoring Vendor's proposal. If negotiations fail with the top-scoring Vendor, BWC may negotiate with the next Vendor in ranking. Alternatively, BWC may decide that it is in BWC's interests to negotiate with all the remaining Vendors to determine if negotiations lead to an adjustment in the ranking of the remaining Vendors.

From the opening of the proposals to the award of the Contract, everyone working on behalf of BWC to evaluate the proposals will seek to limit access to information contained in the proposals solely to those people with a need to know the information. They will also seek to keep this information away from other Vendors, and the evaluation committee will not be allowed to tell one Vendor about the contents of another Vendor's proposal in order to gain a negotiating advantage.

Before the award of the Contract or cancellation of the RFP, any Vendor that seeks to gain access to the contents of another Vendor's proposal may be disqualified from further consideration.

Negotiated changes will be reduced to writing and become a part of the Contract file open to inspection to the public. The written changes will be drafted and signed by the Vendor and submitted to BWC within five (5) business days. If BWC accepts the change, BWC will give the Vendor written notice of BWC's acceptance. The negotiated changes to the successful offer will become a part of the Contract.

If a Vendor fails to provide the necessary information for negotiations in a timely manner, or fails to negotiate in good faith, BWC may terminate negotiations with that Vendor.

9.0 AWARD OF CONTRACT

9.1 Award Procedure

The overall point score for those proposals scored through all three phases will determine the selected Vendor. All Vendors shall be notified by letter of the selection decision. No information will be released by BWC until the official announcement of the award. All offers tendered in response to this RFP shall remain open for a period of ninety (90) days from the date upon which proposals submitted in response hereto are due.

The selected Vendor may be contracted for the services identified in Section A (Section 5.0), Section B (Section 6.0), or both. BWC shall evaluate and score Section A (Section 5.0) and Section B (Section 6.0) of this RFP separately, and BWC reserves the right to award both sections to the same Vendor or to split the award between two different Vendors as appropriate based on BWC's evaluation and scoring.

BWC reserves the right to reject any and all proposals received in response to this RFP. The evaluation committee may waive minor defects that are not material when no prejudice will result to the rights of any other vendors, the public, or BWC.

If BWC awards a contract pursuant to this RFP, and the Vendor is unable or unwilling to perform the work within a reasonable time after the contract award under the terms and conditions of the RFP, BWC reserves the right to deem the inability or unwillingness to perform the work to be a withdrawal of that Vendor's proposal and BWC may evaluate any remaining proposals for award of the contract.

If the selected Vendor changes its business organization or identity from that described in its proposal before the contract is signed by both parties or before work pursuant to the contract commences, that change may be deemed a material change in circumstances by BWC (for example, if the vendor was selected based in part on its experience, corporate structure, financial responsibility or conflicts of interest, which factors have changed). BWC may withdraw the contract award or BWC may declare the contract void ab initio and BWC may select the next highest scoring Vendor for a contract under this RFP.

9.2 Contract Execution

BWC will provide the successful Vendor a contract for execution based on the draft attached to this RFP. If the Vendor fails to execute such contract within a reasonable time, BWC reserves the right to reject the proposal and award the contract to the next highest scoring Vendor until a contract is negotiated, or BWC decides not to contract.

SAMPLE – AGREEMENT – SAMPLE
Between
OHIO BUREAU OF WORKERS' COMPENSATION
And
NAME OF SELECTED VENDOR

This is an Agreement by and between NAME OF SELECTED VENDOR, (hereinafter referred to as the "Vendor"), having offices at ADDRESS OF SELECTED VENDOR, and the State of Ohio, Bureau of Workers' Compensation (hereinafter referred to as the "Bureau"), having offices at 30 W. Spring Street, Columbus, Ohio 43215, entered into the day, month, and year set out below.

Whereas, the Bureau issued a Request for Proposals ("RFP") # BWCB11007 for Retrospective Hospital Bill Review and Hospital Overpayment Collection Services, and the Vendor submitted the best responsive and responsible response to the Request for Proposals;

Now, therefore, the parties hereto mutually agree to perform the contract in accordance with the Request for Proposals and the Vendor's Proposal, which are hereby incorporated by reference as if fully rewritten. Furthermore the parties agree that if there is any conflict between the Request for Proposals and the Vendor's Proposal, the Request for Proposals controls.

CONDITIONS PRECEDENT: It is expressly understood by the parties that the contract is not binding on BWC until such time as all necessary funds are made available and forthcoming from the appropriate State agencies, and such expenditure of funds is approved by the Administrator after execution of the contract by the Vendor but before execution by BWC. No contract shall be binding upon either party until receipt by the contracting Vendor of a copy of a fully executed contract, and compliance with any and all conditions precedent.

TERM AND RENEWAL: The term of the contract shall commence on August 15, 2011, contingent upon compliance with any and all conditions precedent as provided for herein, and shall be completed by June 30, 2012 unless modified by mutual agreement of the parties.

The contract may be renewed for two (2) additional one year periods at the sole and exclusive option of BWC. However, in the alternative the contract may be renewed by mutual agreement between the Contractor and BWC for any number of times and for any period of time, so long as the cumulative time of all renewals does not exceed twenty four (24) months. It is expressly understood by the parties that any renewals are contingent upon all necessary funds being made available and forthcoming from the appropriate State agencies, and such expenditure of funds being approved by the Administrator.

OHIO ELECTIONS LAW: Contractor hereby certifies that no applicable party listed in Divisions (I), (J), (Y) and (Z) of O.R.C. Section 3517.13 has made contributions in excess of the limitations specified under Divisions (I), (J), (Y) and (Z) of O.R.C. Section 3517.13.

CONFLICTS OF INTEREST AND ETHICS COMPLIANCE CERTIFICATION: Contractor affirms that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict, in any manner or degree, with the performance of services which are required to be performed under any resulting Contract. In addition, Contractor affirms that a person who is or may become an agent of Contractor, not having such interest upon execution of this Contract shall likewise advise the Bureau in the event it acquires such interest during the course of this Contract.

Contractor agrees to adhere to all ethics laws contained in Chapters 102 and 2921 of the Ohio Revised Code governing ethical behavior, understands that such provisions apply to persons doing or seeking to do business with the Bureau, and agrees to act in accordance with the requirements of such provisions; and warrants that it has not paid and will not pay, has not given and will not give, any remuneration or thing of value directly or indirectly to the Bureau or any of its board members, officers, employees, or agents, or any third party in any of the engagements of this Agreement or otherwise, including, but not limited to a finder's fee, cash solicitation fee, or a fee for consulting, lobbying or otherwise.

NAME OF SELECTED VENDOR

Tax ID # _____

BWC Risk # _____

Signature

Printed Name

Printed Title

Date

**STATE OF OHIO, BUREAU OF
WORKERS' COMPENSATION**

Signature

Printed Name

Printed Title

Date

Ohio Administrative Code 4123-6-01 Definitions

As used in the rules of this chapter and Chapter 4123-7 of the Administrative Code:

(A) "Health partnership program" or "HPP" means:

The bureau of workers' compensation's comprehensive managed care program under the direction of the chief of medical services as provided in sections 4121.44 and 4121.441 of the Revised Code.

(B) "Qualified health plan" or "QHP" means:

A health care plan sponsored by an employer or a group of employers which meets the standards for qualification under section 4121.442 of the Revised Code and is certified as a qualified health care plan with the bureau.

(C) "Managed care organization" or "MCO" means:

A vendor as defined under section 4121.44 of the Revised Code who has contracted with the bureau to provide medical management and cost containment services as provided in sections 4121.44 and 4121.441 of the Revised Code. As used in these rules, a managed care organization is not a health care provider.

(D) "Physician" means:

A doctor of medicine, doctor of osteopathic medicine or surgery, or doctor of podiatric medicine who holds a current, valid certificate of licensure to practice medicine or surgery, osteopathic medicine or surgery, or podiatry under Chapter 4731. of the Revised Code; a doctor of chiropractic who holds a current, valid certificate of licensure to practice chiropractic under Chapter 4734. of the Revised Code; a doctor of mechanotherapy who holds a current, valid certificate of licensure to practice mechanotherapy under Chapter 4731. of the Revised Code and who was licensed prior to November 3, 1985; a psychologist who holds a current, valid certificate of licensure to practice psychology under Chapter 4732. of the Revised Code; or a dentist who holds a current, valid certificate of licensure to practice dentistry under Chapter 4715. of the Revised Code. A physician licensed pursuant to the equivalent law of another state shall qualify as a physician under this rule.

(E) "Physician of record" or "attending physician" means:

For the purposes of Chapters 4121. and 4123. of the Revised Code, the authorized physician chosen by the employee to direct treatment.

(F) "Practitioner" means:

A physician, or a physical therapist, occupational therapist, optometrist, or any other person currently licensed and duly authorized to practice within his or her respective health care field.

(G) "Health care provider" or "provider" means:

A physician or practitioner, or any person, firm, corporation, limited liability corporation, partnership, association, agency, institution, or other legal entity licensed, certified, or approved by a professional standard-setting body or by - medicare or medicaid to provide medical services or supplies, including, but not limited to a qualified rehabilitation provider.

(H) "Credentialing" or "recredentialing" means:

A process by which the bureau validates or reviews the application of a provider for certification or recertification.

(I) "Certification" or "recertification" means:

A process by which the bureau approves a provider or MCO for participation in the HPP.

(J) "Provider application and agreement" means:

A bureau form which requests background information and documentation necessary for credentialing and which, if completed and signed by the provider and approved by the bureau, constitutes a written, contractual agreement between the bureau and the provider.

(K) "Recertification application and agreement" means:

A bureau form sent to bureau certified providers as part of the provider recertification and recertification process which requests background information and documentation necessary for recertification and which, if completed and signed by the provider and approved by the bureau, constitutes a written, contractual agreement between the bureau and the provider.

(L) "Bureau certified provider" means:

A credentialed provider who has completed and signed a provider application and agreement or recertification application and agreement with the bureau and is approved by the bureau for participation in the HPP.

(M) "Non-bureau certified provider" means:

A provider who has not completed and signed a provider application and agreement or recertification application and agreement with the bureau and is not approved by the bureau for participation in the HPP, or whose certification has lapsed and has not been reinstated pursuant to rule 4123-6-02.4 of the Administrative Code.

(N) "Employee" means:

As used in the rules of this chapter, the term "employee" includes the terms "injured worker" and "claimant" and all employees of employers covered under HPP.

(O) "Emergency" means:

Medical services that are required for the immediate diagnosis and treatment of a condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency, but is necessary to determine whether an emergency exists.

(P) "Medical management and cost containment services" means:

Those services provided by an MCO pursuant to its contract with the bureau, including return to work management services, that promote the rendering of high-quality, cost-effective medical care that focuses on minimizing the physical, emotional, and financial impact of a work-related injury or illness and promotes a safe return to work.

(Q) "Medically necessary" means:

Services which are reasonably necessary for the diagnosis or treatment of disease, illness, and injury, and meet accepted guidelines of medical practice. A medically necessary service must be reasonably related to the illness or injury for which it is performed regarding type, intensity, and duration of service and setting of treatment.

(R) "Authorization" or "prior authorization" means:

Notification by the MCO, that a specific treatment, service, or equipment is medically necessary for the diagnosis and/or treatment of an allowed condition, except that the bureau reserves the authority to authorize or prior authorize the following services: caregiver services, home and van modifications, and return to work management services pursuant to paragraph (D) of rule 4123-6-04.6 of the Administrative Code.

(S) "Dispute resolution" means:

Procedures for the resolution of medical disputes prior to filing an appeal under section 4123.511 of the Revised Code.

(T) "Provider outcome measurement" means:

A medical management analysis tool used by the bureau or MCO which at a minimum, utilizes line item detail from a medical bill and employee specific information including, but not limited to, demographics, diagnosis allowances return to work and remain at work statistics, and other data regarding treatment to evaluate a health care provider on the basis of cost, utilization and treatment outcomes efficiency and compliance with bureau requirements.

(U) "Utilization review" means:

The assessment of an employee's medical care by the MCO. This assessment typically considers medical necessity, the appropriateness of the place of care, level of care, and the duration, frequency or quality of services provided in relation to the allowed condition being treated.

(V) "Treatment guidelines" means:

Guidelines of medical practice developed through consensus of practitioner representatives that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions.

(W) "Formulary" means:

A list of medications determined to be safe and effective by the food and drug administration which the bureau shall consider for reimbursement. The list shall be regularly reviewed and updated by the bureau to reflect current medical standards of drug therapy.

(X) "Medication" means:

The same as drug as defined by division (D) of section 4729.01 of the Revised Code.

(Y) "Injury" means:

For the purposes of the rules of this chapter and Chapter 4123-7 of the Administrative Code only, an injury as defined in division (C) of section 4123.01 of the Revised Code or an occupational disease as defined in division (F) of section 4123.01 of the Revised Code.

(Z) "Return to work services" means:

Services to support an injured worker in returning to employment where the injured worker is experiencing difficulty as a result of conditions related to an allowed lost time claim.

(AA) "Remain at work services" means:

Services to support an injured worker or employee in continued employment where the injured worker is experiencing difficulties performing a job as a result of conditions related to an allowed medical only claim.

(BB) "Transitional work" means:

A work-site program that provides an individualized interim step in the recovery of an injured worker with job restrictions resulting from the allowed conditions in the claim. Developed in conjunction with the employer and the injured worker, or with others as needed, including, but not limited to the collective bargaining agent (where applicable), the physician of record, rehabilitation professionals, and the MCO, a transitional work program assists the injured worker in progressively performing the duties of a targeted job.

(CC) "Hospital" means:

An institution that provides facilities for surgical and medical diagnosis and treatment of bed patients under the supervision of staff physicians and furnishes twenty-four hour-a-day care by registered nurses.

(1) For the purposes of the rules of this chapter of the Administrative Code relating to hospitals, "inpatient" means:

An injured worker is considered to be an inpatient when he or she has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. An injured worker is considered an inpatient if there is a formal order for admission from the physician. The

determination of an inpatient stay is not based upon the number of hours involved. If it later develops during the uninterrupted stay that the injured worker is discharged, transferred to another inpatient unit within the hospital, transferred to another hospital, transferred to another state psychiatric facility or expires and does not actually use a bed overnight, the order from the attending physician addressing the type of encounter will define the status of the stay.

(2) For the purposes of the rules of this chapter of the Administrative Code relating to hospitals, "outpatient" means:

The injured worker is not receiving inpatient care, as "inpatient" is defined in paragraph (CC)(1) of this rule, but receives outpatient services at a hospital. An outpatient encounter cannot exceed seventy-two hours of uninterrupted duration.

(DD) "Urgent care facility" means:

A facility where ambulatory care is provided outside a hospital emergency department and is available on a walk in, non-appointment basis.

Effective: 2/1/10

Prior Effective Dates: 2/16/96, 9/5/96, 1/1/99, 1/1/01, 3/29/02, 2/14/05

Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services
Current Rule (effective 02/01/2011)

(A) HPP.

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-10 of the Administrative Code, reimbursement for hospital inpatient services with a discharge date of February 1, 2011, or after shall be as follows:

(1) Reimbursement for hospital inpatient services, other than outliers as defined in paragraph (A)(3) of this rule or services provided by hospitals subject to reimbursement under paragraph (A)(4) of this rule, shall be calculated using the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system, multiplied by a 2011 bureau adjustment of 1.0315 and further multiplied by a payment adjustment factor of 1.20, according to the following formula:

$(\text{MS-DRG reimbursement rate} \times 1.0315) \times 1.20 = \text{bureau reimbursement for hospital inpatient service.}$

(2) In addition to the payment specified by paragraph (A)(1) of this rule, hospitals operating approved graduate medical education programs and receiving additional reimbursement from medicare for costs associated with these programs shall receive an additional per diem amount for direct graduate medical education costs associated with hospital inpatient services reimbursed by the bureau. Hospital specific per diem rates for direct graduate medical education shall be calculated annually by the bureau effective February first of each year, using the most current cost report data available from the centers for medicare and medicaid services, according to the following formula:

$1.20 \times [(\text{total approved amount for resident cost} + \text{total approved amount for allied health cost}) / \text{total inpatient days}] = \text{direct graduate medical education per diem.}$

Direct graduate medical education per diems shall not be applied to outliers as defined in paragraph (A)(3) of this rule or services provided by hospitals subject to reimbursement under paragraph (A)(4) of this rule.

(3) Reimbursement for outliers as determined by medicare's inpatient prospective payment system outlier methodology shall be calculated using the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system. multiplied by a 2011 bureau adjustment of 1.0315 and further multiplied by a payment adjustment factor of 1.80, according to the following formula:

$(\text{MS-DRG reimbursement rate} \times 1.0315) \times 1.80 = \text{bureau reimbursement for hospital inpatient service outlier.}$

(4) Reimbursement for inpatient services provided by hospitals, distinct-part units of hospitals designated by the medicare program as exempt from the medicare inpatient prospective payment system, and hospitals enrolled or certified by the bureau as psychiatric hospitals shall be determined as follows:

(a) For Ohio hospitals who submitted a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2009 state fiscal year, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported facility inpatient cost-to-charge ratio (from schedule B, line 101 of the hospital cost report) plus twelve percentage points, not to exceed seventy per cent of the hospital's allowed billed charges.

(b) For Ohio hospitals who did not submit a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2009 state fiscal year and for out-of-state hospitals, reimbursement shall be equal to sixty-one per cent of the hospital's allowed billed charges.

(5) For purposes of this rule, the "applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate" or "value" shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 et seq. as amended, excluding 42 U.S.C. 1395ww(d)(4)(D) and 42 U.S.C. 1395ww(m), as implemented by the following materials, which are incorporated by reference:

(a) 42 C.F.R. Part 412 as published in the October 1, 2010 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' "42 C.F.R. Parts 412, 413, 415, et al. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system changes and FY2011 rates; provider agreements and supplier approvals; and hospital conditions of participation for rehabilitation and respiratory care services; medicaid program: accreditation for providers of inpatient psychiatric services; final rule." 75 Fed. Reg. 50041-50681 (2010).

(B) QHP or self insuring employer (non-QHP):

A QHP or self-insuring employer may reimburse hospital inpatient services at:

(1) The applicable rate under the methodology set forth in paragraph (A) of this rule;

or

(2)

(a) For Ohio hospitals who submitted a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2009 state fiscal year, the hospital's allowable billed charges multiplied by the hospital's reported facility inpatient cost-to-charge ratio (from schedule B, line 101 of the hospital cost report) plus twelve percentage points, not to exceed seventy per cent of the hospital's allowed billed charges;

(b) For Ohio hospitals who did not submit a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2009 state fiscal year and for out-of-state hospitals, sixty-one per cent of the hospital's allowed billed charges; or

(3) The rate negotiated between the hospital and the QHP or self-insuring employer in accordance with rule 4123-6-46 of the Administrative Code.

Effective: 2/1/11

Prior Effective Dates: 1/1/07, 4/1/07, 1/1/08, 2/1/09, 2/1/10

Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services
Previous Rule (effective 02/01/2010)

(A) HPP.

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-10 of the Administrative Code, reimbursement for hospital inpatient services with a discharge date of February 1, 2010, or after shall be as follows:

(1) Reimbursement for hospital inpatient services, other than outliers as defined in paragraph (A)(3) of this rule or services provided by hospitals subject to reimbursement under paragraph (A)(4) of this rule, shall be equal to one hundred twenty per cent of the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system.

(2) In addition to the payment specified by paragraph (A)(1) of this rule, hospitals operating approved graduate medical education programs and receiving additional reimbursement from medicare for costs associated with these programs shall receive an additional per diem amount for direct graduate medical education costs associated with hospital inpatient services reimbursed by the bureau. Hospital specific per diem rates for direct graduate medical education shall be calculated annually by the bureau effective February first of each year, using the most current cost report data available from the centers for medicare and medicaid services, according to the following formula: $1.20 \times [(total\ approved\ amount\ for\ resident\ cost + total\ approved\ amount\ for\ allied\ health\ cost) / total\ inpatient\ days] = direct\ graduate\ medical\ education\ per\ diem$. Direct graduate medical education per diems shall not be applied to outliers as defined in paragraph (A)(3) of this rule or services provided by hospitals subject to reimbursement under paragraph (A)(4) of this rule.

(3) Reimbursement for outliers as determined by medicare's inpatient prospective payment system outlier methodology shall be equal to one hundred seventy-five per cent of the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system.

(4) Reimbursement for inpatient services provided by hospitals and distinct-part units of hospitals designated by the medicare program as exempt from the medicare inpatient prospective payment system shall be determined as follows:

(a) For Ohio hospitals who submitted a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2008 state fiscal year, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported facility inpatient cost-to-charge ratio (from schedule B, line 101 of the hospital cost report) plus twelve percentage points, not to exceed seventy per cent of the hospital's allowed billed charges.

(b) For Ohio hospitals who did not submit a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2008 state fiscal year and for out-of-state hospitals, reimbursement shall be equal to sixty-two per cent of the hospital's allowed billed charges.

(5) For purposes of this rule, the "applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate" or "value" shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 et seq. as amended, excluding 42 U.S.C. 1395ww(d)(4)(D), as implemented by the following materials, which are incorporated by reference:

(a) 42 C.F.R. Part 412 as published in the October 1, 2009 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' "42 C.F.R. Parts 412, 413, 415, et al. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; and Changes to the Long-Term Care Prospective Payment System and Rate Years 2010 and 2009 Rates; "74 Fed. Reg. 43754 (2009).

(B) QHP or self insuring employer (non-QHP):

A QHP or self-insuring employer may reimburse hospital inpatient services at:

(1) The applicable rate under the methodology set forth in paragraph (A) of this rule; or

(2)

(a) For Ohio hospitals who submitted a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2008 state fiscal year, the hospital's allowable billed charges multiplied by the hospital's reported facility inpatient cost-to-charge ratio (from schedule B, line 101 of the hospital cost report) plus twelve percentage points, not to exceed seventy per cent of the hospital's allowed billed charges;

(b) For Ohio hospitals who did not submit a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2008 state fiscal year and for out-of-state hospitals, sixty-two per cent of the hospital's allowed billed charges; or

(3) The rate negotiated between the hospital and the QHP or self-insuring employer in accordance with rule 4123-6-46 of the Administrative Code.

Effective: 2/1/10

Prior Effective Dates: 1/1/07, 4/1/07, 1/1/08, 2/1/09

Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services
Previous Rule (effective 02/01/2009)

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-08 of the Administrative Code, reimbursement for hospital inpatient services with a discharge date of February 1, 2009, or after shall be as follows:

(A) Reimbursement for hospital inpatient services, other than outliers as defined in paragraph (C) of this rule or services provided by hospitals subject to reimbursement under paragraph (D) of this rule, shall be equal to one hundred twenty per cent of the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system.

(B) In addition to the payment specified by paragraph (A) of this rule, hospitals operating approved graduate medical education programs and receiving additional reimbursement from medicare for costs associated with these programs shall receive an additional per diem amount for direct graduate medical education costs associated with hospital inpatient services reimbursed by the bureau. Hospital specific per diem rates for direct graduate medical education shall be calculated annually by the bureau effective January 1 of each year, using the most current cost report data available from the Centers for Medicare and Medicaid Services, according to the following formula:

$1.20 \times [(total\ approved\ amount\ for\ resident\ cost + total\ approved\ amount\ for\ allied\ health\ cost) / total\ inpatient\ days] = direct\ graduate\ medical\ education\ per\ diem.$

Direct graduate medical education per diems shall not be applied to outliers as defined in paragraph (C) of this rule or services provided by hospitals subject to reimbursement under paragraph (D) of this rule.

(C) Reimbursement for outliers as determined by medicare's inpatient prospective payment system outlier methodology shall be equal to one hundred seventy-five per cent of the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system.

(D) Reimbursement for inpatient services provided by hospitals and distinct-part units of hospitals designated by the medicare program as exempt from the medicare inpatient prospective payment system shall be determined as follows:

(1) For Ohio hospitals who submitted a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2007 state fiscal year, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported facility inpatient cost-to-charge ratio (from schedule B, line 101 of the hospital cost report) plus twelve percentage points, not to exceed seventy per cent of the hospital's allowed billed charges.

(2) For Ohio hospitals who did not submit a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2007 state fiscal year and for out-of-state hospitals, reimbursement shall be equal to sixty-two per cent of the hospital's allowed billed charges.

(E) For purposes of this rule, the "applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate" or "value" shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 as amended, excluding 42 U.S.C. 1395ww(d)(4)(D), as implemented by the following materials, which are incorporated by reference:

(1) 42 C.F.R. Part 412 as published in the October 1, 2008 Code of Federal Regulations;

(2) Department of health and human services, centers for medicare and medicaid services' "42 C.F.R. Parts 411, 412, 413, 422, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Payments for Graduate Medical Education in Certain Emergency Situations; Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Updates to the Long-Term Care Prospective Payment System; Updates to Certain IPPS-Excluded Hospitals; and Collection of Information Regarding Financial Relationships Between Hospitals; Final Rule," 73 Fed. Reg. 48434-01 (2008);

(3) Department of health and human services, centers for medicare and Medicaid services' "Medicare Program; Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates: Final Fiscal Year 2009 Wage Indices and Payment Rates Including Implementation of Section 124 of the Medicare Improvement for Patients and Providers Act of 2008," 73 Fed. Reg. 57888-01 (2008).

Effective: 2/1/09

Prior Effective Dates: 1/1/07; 4/1/07, 1/1/08

Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services
Previous Rule (effective 01/01/2008)

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-08 of the Administrative Code, reimbursement for hospital inpatient services shall be as follows:

(A) Reimbursement for hospital inpatient services, other than outliers as defined in paragraph (C) of this rule or services provided by hospitals subject to reimbursement under paragraph (D) of this rule, shall be equal to one hundred fifteen percent of the applicable diagnosis related group (DRG) reimbursement rate for the hospital inpatient service under the medicare program.

(B) In addition to the payment specified by paragraph (A) of this rule, hospitals operating approved graduate medical education programs and receiving additional reimbursement from medicare for costs associated with these programs shall receive an additional per diem amount for direct graduate medical education costs associated with hospital inpatient services reimbursed by the bureau. Hospital specific per diem rates for direct graduate medical education shall be calculated annually by the bureau effective October 1 of each year, using the most current cost report data available from the Centers for Medicare and Medicaid Services, according to the following formula:

$1.15 \times [(\text{total approved amount for resident cost} + \text{total approved amount for allied health cost}) / \text{total inpatient days}] = \text{direct graduate medical education per diem.}$

Direct graduate medical education per diems shall not be applied to outliers as defined in paragraph (C) of this rule or services provided by hospitals subject to reimbursement under paragraph (D) of this rule.

(C) Reimbursement for outliers shall be determined as follows:

(1) For hospitals with a 2006 total inpatient cost-to-charge ratio as reported to Ohio medicaid, outliers shall be defined as hospital inpatient stays in which the hospital's allowable billed charges multiplied by the hospital's 2006 total inpatient cost-to-charge ratio as reported to Ohio medicaid is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to the hospital's allowable billed charges multiplied by the hospital's 2006 total inpatient cost-to-charge ratio as reported to Ohio medicaid, not to exceed sixty percent of the hospital's allowable billed charges;

(2) For hospitals without a 2006 total inpatient cost-to-charge ratio as reported to Ohio medicaid and out-of-state hospitals, outliers shall be defined as hospital inpatient stays in which sixty percent of the hospital's allowable billed charges is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to sixty percent of the hospital's allowable billed charges.

(D) Reimbursement for inpatient services provided by hospitals and distinct-part units of hospitals designated by the medicare program as exempt from DRG-based reimbursement shall be determined as follows:

(1) For Ohio hospitals with a 2006 total inpatient cost-to-charge ratio as reported to Ohio medicaid, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio plus twelve percentage points, not to exceed seventy percent of the hospital's allowed billed charges.

(2) For Ohio hospitals without a 2006 total inpatient cost-to-charge ratio as reported to Ohio medicaid and out-of-state hospitals, reimbursement shall be equal to sixty-six percent of the hospital's allowed billed charges.

(E) For purposes of this rule, the "applicable diagnosis related group (DRG) reimbursement rate" or "value" shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 as amended, as implemented by the following materials, which are incorporated by reference:

(1) 42 CFR Part 412 as published in the October 1, 2007 Code of Federal Regulations;

(2) Department of Health and Human Services, Centers for Medicare and Medicaid Services' "42 CFR Parts 411, 412, 413, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule." Federal Register, Volume 72, Number 162, Pages 47129-48175, August 22, 2007, as updated in CMS Manual System, Pub.100-04, Medicare Claims Processing, Transmittal 1374, November 7, 2007.

Effective: 1/1/08

Prior Effective Dates: 1/1/07; 4/1/07

Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services
Previous Rule (effective 04/01/2007)

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-08 of the Administrative Code, reimbursement for hospital inpatient services shall be as follows:

(A) Reimbursement for hospital inpatient services, other than outliers as defined in paragraph (C) of this rule or services provided by hospitals subject to reimbursement under paragraph (D) of this rule, shall be equal to one hundred fifteen percent of the applicable diagnosis related group (DRG) reimbursement rate for the hospital inpatient service under the medicare program.

(B) In addition to the payment specified by paragraph (A) of this rule, hospitals operating approved graduate medical education programs and receiving additional reimbursement from medicare for costs associated with these programs shall receive an additional per diem amount for direct graduate medical education costs associated with hospital inpatient services reimbursed by the bureau. Hospital specific per diem rates for direct graduate medical education shall be calculated annually by the bureau effective October 1 of each year, using the most current cost report data available from the Centers for Medicare and Medicaid Services, according to the following formula:

$1.15 \times [(\text{total approved amount for resident cost} + \text{total approved amount for allied health cost}) / \text{total inpatient days}] = \text{direct graduate medical education per diem.}$

Direct graduate medical education per diems shall not be applied to outliers as defined in paragraph (C) of this rule or services provided by hospitals subject to reimbursement under paragraph (D) of this rule.

(C) Reimbursement for outliers shall be determined as follows:

(1) For hospitals with a 2004 total inpatient cost-to-charge ratio as reported to Ohio medicaid, outliers shall be defined as hospital inpatient stays in which the hospital's allowable billed charges multiplied by the hospital's 2004 total inpatient cost-to-charge ratio as reported to Ohio Medicaid is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to the hospital's allowable billed charges multiplied by the hospital's 2004 total inpatient cost-to-charge ratio as reported to Ohio medicaid, not to exceed sixty percent of the hospital's allowable billed charges;

(2) For hospitals without a 2004 total inpatient cost-to-charge ratio as reported to Ohio medicaid and out-of-state hospitals, outliers shall be defined as hospital inpatient stays in which sixty percent of the hospital's allowable billed charges is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to sixty percent of the hospital's allowable billed charges.

(D) Reimbursement for inpatient services provided by hospitals and distinct-part units of hospitals designated by the medicare program as exempt from DRG-based reimbursement shall be determined as follows:

(1) For Ohio hospitals with a 2004 total inpatient cost-to-charge ratio as reported to Ohio medicaid, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio plus twelve percentage points, not to exceed seventy percent of the hospital's allowed billed charges.

(2) For Ohio hospitals without a 2004 total inpatient cost-to-charge ratio as reported to Ohio medicaid and out-of-state hospitals, reimbursement shall be equal to sixty-six percent of the

hospital's allowed billed charges. For purposes of this rule, the "applicable diagnosis related group (DRG) reimbursement rate" or "value" shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 as amended, as implemented by the following materials, which are incorporated by reference:

(a) 42 CFR Part 412 as published in the October 1, 2006 Code of Federal Regulations;

(b) Department of Health and Human Services, Centers for Medicare and Medicaid Services' "42 CFR Parts 409, 410, 412, 413, 414, 424, 485, 489, and 505 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Fiscal Year 2007 Occupational Mix Adjustment to Wage Index; Health Care Infrastructure Improvement Program; Selection Criteria of Loan Program for Qualifying Hospitals Engaged in Cancer-Related Health Care and Forgiveness of Indebtedness; and Exclusion of Vendor Purchases Made Under the Competitive Acquisition Program (CAP) for Outpatient Drugs and Biologicals Under Part B for the Purpose of Calculating the Average Sales Price (ASP)." Federal Register, Volume 71, Number 160, Pages 47869-47918, August 18, 2006;

(c) Department of Health and Human Services, Centers for Medicare and Medicaid Services' "42 CFR Parts 409, 410, 412, 413, 414, 424, 485, 489, and 505 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Correction." Federal Register, Volume 71, Number 191, Pages 58286-58287, October 3, 2006;

(d) Department of Health and Human Services, Centers for Medicare and Medicaid Services' "Medicare Program; Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates: Final Fiscal Year 2007 Wage Indices and Payment Rates After Application of Revised Occupational Mix Adjustment to Wage Index" Federal Register, Volume 71, Number 196, Page 59885-60043 October 11, 2006.

Effective: 4/1/07

Prior Effective Dates: 1/1/07

Ohio Administrative Code 4123-6-37.1 Payment of Hospital Inpatient Services
Previous Rule (effective 01/01/2007)

(A) Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-08 of the Administrative Code, reimbursement for hospital inpatient services, excluding outliers as defined in paragraph (B) of this rule, shall be equal to one hundred fifteen percent of the applicable diagnosis related group (DRG) reimbursement rate for the hospital inpatient service under the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 as amended.

(B) Reimbursement for outliers shall be determined as follows:

(1) For hospitals with a reported cost-to-charge ratio, outliers shall be defined as hospital inpatient stays in which the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio, not to exceed sixty percent of the hospital's allowable billed charges;

(2) For hospitals without a reported cost-to-charge ratio, outliers shall be defined as hospital inpatient stays in which sixty percent of the hospital's allowable billed charges is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to sixty percent of the hospital's allowable billed charges.

Effective: 1/1/07

Ohio Administrative Code 4123-6-37.2 Payment of Hospital Outpatient Services
Current Rule (effective 04/01/2011)

(A) HPP:

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-10 of the Administrative Code, reimbursement for hospital outpatient services with a date of service of April 1, 2011 or after shall be as follows:

(1) Except as otherwise provided in this rule, reimbursement for hospital outpatient services shall be equal to the applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system as implemented by the materials specified in paragraph (A)(6) of this rule, multiplied by a bureau-specific payment adjustment factor, which shall be 2.53 for children's hospitals and 1.97 for all hospitals other than children's hospitals, with the following additional adjustments for specific services:

For services reimbursed under a medicare ambulatory payment classification, excluding drugs, biological, devices reimbursed via pass-through, and reasonable cost items, the applicable medicare rate specified above shall be further multiplied by a 2011 bureau adjustment factor of 1.0025;

For services reimbursed under the medicare clinical lab fee schedule, the applicable medicare rate specified above shall be further multiplied by a 2011 bureau adjustment factor of 1.0175;

For services reimbursed under the medicare physician fee schedule, the applicable medicare rate specified above shall be further multiplied by a 2011 bureau adjustment factor of 1.3078.

(a) The medicare integrated outpatient code editor and medicare medically unlikely edits in effect as implemented by the materials specified in paragraph (A)(6) of this rule shall be utilized to process bills for hospital outpatient services under this rule; however, the outpatient code edits identified in table 1 of appendix A to this rule shall not be applied.

(b) The annual medicare outpatient prospective payment system outlier reconciliation process shall not be applied to payments for hospital outpatient services under this rule.

(c) For purposes of this rule, hospitals shall be identified as critical access hospitals, rural sole community hospitals, essential access community hospitals and exempt cancer hospitals based on the hospitals' designation in the medicare outpatient provider specific file in effect implemented by the materials specified in paragraph (A)(6) of this rule.

(d) For purposes of this rule, the following hospitals shall be recognized as "children's hospitals": nationwide children's hospital (Columbus), Cincinnati children's hospital medical center, shriners hospital for children (Cincinnati), university hospitals rainbow babies and children's hospital (Cleveland), Toledo children's hospital, children's hospital medical center of Akron, and children's medical center of Dayton.

In the event the centers for medicare and medicaid services makes subsequent adjustments to the medicare reimbursement rates under the medicare outpatient prospective payment system as implemented by the materials specified in paragraph (A)(6) of this rule, the "applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system" as specified in this paragraph shall be determined by the bureau without regard to such subsequent adjustments.

(2) Services reimbursed via fee schedule. These services shall not be wage index adjusted.

(a) Services reimbursed via fee schedule to which the bureau-specific payment adjustment factor shall be applied.

(i) Except as otherwise provided in paragraphs (A)(2)(b)(ii) and (A)(2)(b)(iii) of this rule, hospital outpatient services reimbursed via fee schedule under the medicare outpatient prospective payment system shall be reimbursed under the applicable medicare fee schedule in effect as implemented by the materials specified in paragraph (A)(6) of this rule.

(b) Services reimbursed via fee schedule to which the bureau-specific payment adjustment factor shall not be applied.

(i) Hospital outpatient vocational rehabilitation services for which the bureau has established a fee, which shall be reimbursed in accordance with table 2 of appendix A to this rule.

(ii) Hospital outpatient services reimbursed via fee schedule under the medicare outpatient prospective payment system that the bureau has determined shall be reimbursed at a rate other than the applicable medicare fee schedule in effect as implemented by the materials specified in paragraph (A)(6) of this rule, which shall be reimbursed in accordance with table 3 of appendix A to this rule.

(iii) Hospital outpatient services not reimbursed under the medicare outpatient prospective payment system that the bureau has determined are necessary for treatment of injured workers, which shall be reimbursed in accordance with tables 4 and 5 of appendix A to this rule.

(3) Services reimbursed at reasonable cost. To calculate reasonable cost, the line item charge shall be multiplied by the hospital's outpatient cost to charge ratio from the medicare outpatient provider specific file in effect as implemented by the materials specified in paragraph (A)(6) of this rule. These services shall not be wage index adjusted.

(a) Services reimbursed at reasonable cost to which the bureau-specific payment adjustment factor shall be applied.

(i) Critical access hospitals shall be reimbursed at one hundred and one per cent of reasonable cost for all payable line items.

(b) Services reimbursed at reasonable cost to which the bureau-specific payment adjustment factor shall not be applied.

(i) Services designated as inpatient only under the medicare outpatient prospective payment system.

(ii) Hospital outpatient services reimbursed at reasonable cost as identified in tables 3 and 4 of appendix A to this rule.

(4) Add-on payments calculated using the applicable medicare outpatient prospective payment system methodology and formula in effect as implemented by the materials specified in paragraph (A)(6) of this rule. These add-on payments shall be calculated prior to application of the bureau-specific payment adjustment factor.

(a) Outlier add-on payment. An outlier add-on payment shall be provided on a line item basis for partial hospitalization services and for ambulatory payment classification reimbursed services for all hospitals other than critical access hospitals.

(b) Rural hospital add-on payment. A rural hospital add-on payment shall be provided on a line item basis for rural sole community hospitals, including essential access community hospitals; however, drugs, biological, devices reimbursed via pass-through and reasonable cost items shall be

excluded. The rural add-on payment shall be calculated prior to the outlier add-on payment calculation.

(c) Hold harmless add-on payment. A hold harmless add-on payment shall be provided on a line item basis to exempt cancer centers and children's hospitals. The hold harmless add-on payment shall be calculated after the outlier add-on payment calculation.

(5) Providers without a medicare provider number.

(a) Providers without a medicare provider number shall be reimbursed for hospital outpatient services at forty-seven per cent of billed charges for all payable line items.

(6) For purposes of this rule, the "applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system " and the medicare outpatient prospective payment system " shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 et seq. as amended, as implemented by the following materials, which are incorporated by reference:

(a) 42 C.F.R. Part 419 as published in the October 1, 2010 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' "42 CFR Parts 410, 411, 412, 413, 416, 419, and 489 medicare program: hospital outpatient prospective payment system and CY 2011 payment rates; payments to hospitals for graduate medical education costs; physician self-referral rules and related changes to provider agreement regulations; payment for certified registered nurse anesthetist services furnished in rural hospitals and critical access hospitals; final rule, "75 Fed. Reg. 71800 - 72580 (2010).

(B) QHP or self-insuring employer (non-QHP):

A QHP or self-insuring employer may reimburse hospital outpatient services at:

(1) The applicable rate under the methodology set forth in paragraph (A) of this rule;

or

(2) For Ohio hospitals that annually report a total outpatient cost-to-charge ratio to Ohio medicaid, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio as set forth below plus sixteen percentage points, not to exceed sixty percent of the hospital's allowed billed charges.

(a) To assist QHPs and self-insuring employers in determining reimbursement under this paragraph, the bureau shall make available to QHPs and self-insuring employer the hospital's most recently reported cost-to-charge ratio not later than thirty days following the bureau's receipt of the hospital's most recently reported cost-to-charge ratio from Ohio medicaid.

(b) For Ohio hospitals that do not annually report a total outpatient cost-to-charge ratio to Ohio medicaid and out-of-state hospitals, reimbursement shall be equal to fifty-six per cent of the hospital's allowed billed charges; or

(c) The rate negotiated between the hospital and the QHP or self-insuring employer in accordance with rule 4123-6-46 of the Administrative Code.

Effective: 4/1/11

Prior Effective Dates: 9/1/07, 1/1/11

Ohio Administrative Code 4123-6-37.2 Payment of Hospital Outpatient Services
Previous Rule (effective 1/1/2011)

(A) HPP:

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-10 of the Administrative Code, reimbursement for hospital outpatient services with a date of service of January 1, 2011 or after shall be as follows:

(1) Except as otherwise provided in this rule, reimbursement for hospital outpatient services shall be equal to the applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered, multiplied by a bureau-specific payment adjustment factor, which shall be 2.53 for children's hospitals and 1.97 for all hospitals other than children's hospitals.

(a) The medicare integrated outpatient code editor and medicare medically unlikely edits in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered shall be utilized to process bills for hospital outpatient services under this rule; however, the outpatient code edits identified in table 1 of appendix A of this rule shall not be applied.

(b) The annual medicare outpatient prospective payment system outlier reconciliation process shall not be applied to payments for hospital outpatient services under this rule.

(c) For purposes of this rule, hospitals shall be identified as children's hospitals, critical access hospitals, rural sole community hospitals, essential access community hospitals and exempt cancer hospitals based on the hospitals' designation in the medicare outpatient provider specific file in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered.

(2) Services reimbursed via fee schedule. These services shall not be wage index adjusted.

(a) Services reimbursed via fee schedule to which the bureau-specific payment adjustment factor shall be applied.

(i) Except as otherwise provided in paragraphs (A)(2)(b)(ii) and (A)(2)(b)(iii) of this rule, hospital outpatient services reimbursed via fee schedule under the medicare outpatient prospective payment system shall be reimbursed under the applicable medicare fee schedule in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered.

(b) Services reimbursed via fee schedule to which the bureau-specific payment adjustment factor shall not be applied.

(i) Hospital outpatient vocational rehabilitation services for which the bureau has established a fee, which shall be reimbursed in accordance with table 2 of appendix A of this rule.

(ii) Hospital outpatient services reimbursed via fee schedule under the medicare outpatient prospective payment system that the bureau has determined shall be reimbursed at a rate other than the applicable medicare fee schedule in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered, which shall be reimbursed in accordance with table 3 of appendix A of this rule.

(iii) Hospital outpatient services not reimbursed under the medicare outpatient prospective payment system that the bureau has determined are necessary for treatment of injured workers, which shall be reimbursed in accordance with tables 4 and 5 of appendix A of this rule.

(3) Services reimbursed at reasonable cost. To calculate reasonable cost, the line item charge shall be multiplied by the hospital's outpatient cost to charge ratio from the medicare outpatient provider specific file in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered. These services shall not be wage index adjusted.

(a) Services reimbursed at reasonable cost to which the bureau-specific payment adjustment factor shall be applied.

(i) Critical access hospitals shall be reimbursed at one hundred and one per cent of reasonable cost for all payable line items.

(b) Services reimbursed at reasonable cost to which the bureau-specific payment adjustment factor shall not be applied.

(i) Services designated as inpatient only under the medicare outpatient prospective payment system.

(ii) Hospital outpatient services reimbursed at reasonable cost as identified in tables 3 and 4 of appendix A of this rule.

(4) Add-on payments calculated using the applicable medicare outpatient prospective payment system methodology and formula in effect as of the calendar quarter immediately prior to the calendar quarter in which the hospital outpatient service was rendered. These add-on payments shall be calculated prior to application of the bureau-specific payment adjustment factor.

(a) Outlier add-on payment. An outlier add-on payment shall be provided on a line item basis for partial hospitalization services and for ambulatory payment classification (APC) reimbursed services for all hospitals other than critical access hospitals.

(b) Rural hospital add-on payment. A rural hospital add-on payment shall be provided on a line item basis for rural sole community hospitals, including essential access community hospitals; however, drugs, biological, devices reimbursed via pass-through and reasonable cost items shall be excluded. The rural add-on payment shall be calculated prior to the outlier add-on payment calculation.

(c) Hold harmless add-on payment. A hold harmless add-on payment shall be provided on a line item basis to exempt cancer centers and children's hospitals. The hold harmless add-on payment shall be calculated after the outlier add-on payment calculation.

(5) Providers without a medicare provider number.

(a) Providers without a medicare provider number shall be reimbursed for hospital outpatient services at forty-seven per cent of billed charges for all payable line items.

(6) For purposes of this rule, the "applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system " and the medicare outpatient prospective payment system " shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 et seq. as amended, as implemented by the following materials, which are incorporated by reference:

(a) 42 C.F.R. Part 419 as published in the October 1, 2009 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' 42 CFR Parts 410, 416, and 419 Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Final Rule 74 Fed. Reg. 60315 - 61012 (2009).

(B) QHP or self-insuring employer (non-QHP):

A QHP or self-insuring employer may reimburse hospital outpatient services at:

(1) The applicable rate under the methodology set forth in paragraph (A) of this rule; or

(2) For Ohio hospitals that annually report a total outpatient cost-to-charge ratio to Ohio medicaid, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio as set forth below plus sixteen percentage points, not to exceed sixty percent of the hospital's allowed billed charges.

(a) To assist QHPs and self-insuring employers in determining reimbursement under this paragraph, the bureau shall make available to QHPs and self-insuring employer the hospital's most recently reported cost-to-charge ratio not later than thirty days following the bureau's receipt of the hospital's most recently reported cost-to-charge ratio from Ohio medicaid.

(b) For Ohio hospitals that do not annually report a total outpatient cost-to-charge ratio to Ohio medicaid and out-of-state hospitals, reimbursement shall be equal to fifty-six percent of the hospital's allowed billed charges; or

(c) The rate negotiated between the hospital and the QHP or self-insuring employer in accordance with rule 4123-6-46 of the Administrative Code.

Proposed Effective Date: 1/1/11

Replacing: 4123-6-37.2

Prior Effective Dates: 9/1/07

Appendix – A (continued)

Ohio Administrative Code 4123-6-37.2 Payment of Hospital Outpatient Services
Previous Rule (effective 09/01/2007)

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-08 of the Administrative Code, reimbursement for hospital outpatient services shall be as follows:

(A) For Ohio hospitals that annually report a total outpatient cost-to-charge ratio to Ohio medicaid, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio as set forth below plus sixteen percentage points, not to exceed sixty percent of the hospital's allowed billed charges.

In determining reimbursement under this paragraph, the bureau shall initially utilize the hospital's 2005 cost-to-charge ratio as reported to Ohio medicaid. However, as subsequent cost-to-charge ratios are reported to Ohio medicaid by the hospital, the bureau shall thereafter utilize the hospital's most recently reported cost-to-charge ratio not later than thirty days following the bureau's receipt of the hospital's most recently reported cost-to-charge ratio from Ohio medicaid.

(B) For Ohio hospitals that do not annually report a total outpatient cost-to-charge ratio to Ohio medicaid and out-of-state hospitals, reimbursement shall be equal to fifty-six percent of the hospital's allowed billed charges.

Effective: 9/1/07

Ohio Administrative Code 4123-6-45 AUDIT OF PROVIDERS' PATIENT AND BILLING RELATED RECORDS

(A) Providers' patient and billing related records, including but not limited to those records described in rule 4123-6-451 of the Administrative Code, may be reviewed by the bureau or the MCO to ensure workers are receiving proper and necessary medical care, and to ensure compliance with the bureau's statutes, rules, policies, and procedures.

(1) Based on division (B)(16)(c) of section 4121.121 of the Revised Code, provider records may be reviewed before, during, or after the delivery of services. Reviews may be random, with no unreasonable infringement of provider rights, or may be for cause. Reviews may include the utilization of statistical sampling methodologies and projections based upon sample findings. Records reviews may be conducted at or away from the provider's place of business.

(2) Based on division (B)(17) of section 4121.121 of the Revised Code, legible copies of providers' records may be requested. Providers shall furnish copies of the requested records within thirty calendar days of receipt of the request. The bureau shall establish a schedule for payment of reasonable costs for copying records, which shall be published in the health care provider billing and reimbursement manual.

(3) Original records shall not be removed from the provider's premises, except upon court order or subpoena issued by the bureau pursuant to section 4121.15 or 4123.08 of the Revised Code.

(B) Upon any finding of improper or unnecessary medical care, the administrator shall, if requested by the provider, appoint a subcommittee of the stakeholders' health care quality assurance advisory committee to review and advise the administrator as provided in paragraph (K) of rule 4123-6-22 of the Administrative Code. The administrator may sanction, suspend, or exclude a health care provider from participation in the workers' compensation system based on rule 4123-6-17 of the Administrative Code.

(C) The bureau or the MCO may deny payment for services or declare as overpaid previous payments to providers who fail to provide records or access to records to either the bureau or the MCO. The bureau may decertify a health care provider that fails to provide records requested pursuant to Chapters 2913., 4121., and 4123. of the Revised Code.

Effective: 1/15/99

Prior Effective Date: 2/12/97

Medical Overpayment Recovery Policy and Procedure

In accordance with Section 4123.32(D) of the Ohio Revised Code (ORC) and applicable sections of the Ohio Administrative code (OAC), BWC is establishing the following Provider Overpayment Recovery Policy and Procedure to govern the actions of BWC, Managed Care Organizations (MCOs) and medical providers regarding the recovery of provider payments made in error.

I. Policy

A. The recovery of provider payment from providers shall be initiated where payment was made to providers in conflict of law, rule, BWC provider agreement or policy.

B. Provider overpayment recovery and MCO overpayment recovery is subject to a time limitation as follows:

The provider or MCO must be notified of the overpayment within two (2) years of the BWC bill system process date. If the provider or MCO is not notified of the recovery demand within such two (2) year time period, no recovery shall be ordered. This two (2) year limitation does not apply to payments where the provider or MCO was aware of the overpayment or became aware within two (2) years of receipt of payment.

C. The provider may request review of the recovery decision by the MCO pursuant to the Bill Grievance process. Subsequent review may be requested of BWC Medical Services Division Chief's designee and, upon request, final review by the Administrator's designee.

D. Provider payments made as a result of MCO or BWC error and where the provider rendered services and sought reimbursement in good faith shall not be recovered from the provider. BWC shall initiate recovery from the MCO of any overpayment made as a result of MCO error unless overpayment is recovered from the provider. An MCO payment error exists when payment is made to a provider which is inconsistent with current health care provider payment standards and industry practices or in conflict with law, rule, or the MCO contract. The MCO may request review of the recovery decision by BWC Medical Services Division Chief's designee and, upon request, final review by the Administrator's designee.

II. Procedure

A. The MCO is not responsible for re-payment, and shall not recover from the provider, overpayments resulting from the disallowance of a previously allowed claim or condition. If the MCO authorizes services in error, the MCO shall inform the provider immediately by phone and in writing that service was authorized in error and that the provider will not be paid for any service rendered after the date of notification. The MCO may not withdraw authorization for services that were already authorized and rendered. The MCO shall be responsible for payment of all service rendered prior to and on the day of the notification.

MCOs shall initiate recovery of overpayments only after all appeal periods have been exhausted. All paper correspondence shall be mailed to the provider's correspondence address.

B. If a party to the claim files an appeal for services through the ADR process or with the Industrial Commission regarding treatment which has already been rendered, the MCO shall take the following steps:

1. Within two (2) business days of learning of the appeal, the MCO shall inform the provider by phone and in writing that services are now under appeal and may be subject to non-payment.

2. Bills for service that have already been paid in compliance with Ohio BWC laws and rules shall remain paid. Bills for service that have not been paid shall be pended until appeals through the IC SHO level are exhausted.
3. If the final decision from the ADR process or the Industrial Commission allows provider reimbursement for the treatment, bills shall be paid. If the final decision denies the provider reimbursement and the overpayment was due to MCO error, the MCO shall be responsible for reimbursement to the provider or BWC from the MCO administrative account for services authorized and rendered on or before the date the MCO notified the provider of the pending appeal. If no MCO error occurred, pended bills will be denied.

C. Discovery of an Overpayment and Initial Notification

1. Within fourteen (14) calendar days of discovery and verification of provider overpayment, the MCO shall send written notice to the provider informing the provider of the overpayment and the requirement for provider repayment. The notice shall contain a complete and specific rationale for the repayment, including identification of the specific documents supporting the rationale. The notice must include instructions regarding the provider grievance conference process and the forty-five (45) calendar day time period for provider objection.
2. Within fourteen (14) calendar days of the date of original MCO overpayment notification to the provider, the MCO shall contact provider by means other than letter to verify the notification letter was received and discuss whether the provider disputes overpayment.
3. If the MCO's attempts to contact the provider are unsuccessful, an overpayment notification letter shall be sent via certified mail. If the certified letter is returned to the MCO, the MCO shall attempt to contact the provider during the next fourteen (14) calendar days to continue recovery efforts.
4. In the event the provider has ceased operations, the MCO recovery effort will stop and recovery will be referred to Medical Billing and Adjustments-Recovery (MB&A Recovery) via email at MedicalBillPaymentRecovery@bwc.state.oh.us.

D. Provider agrees with the initial overpayment notification from the MCO

1. If the provider agrees with the MCO determination of provider overpayment, the MCO and provider shall further agree on the method and time period for repayment (e.g. provider submitting check or MCO taking payment from future reimbursement). In no case, shall the time period for repayment extend beyond forty-five (45) calendar days from the date of the agreement.

After the overpayment is collected, the MCO shall send the request for adjustment with supporting documentation to MB&A via email at HPP.Adjustments@bwc.state.oh.us or fax to 614-752-6555 within fourteen (14) calendar days. Each state holiday falling within the fourteen (14) calendar day period shall extend the deadline by one (1) calendar day.

2. If payment of requested recovery amount is not received within forty-five (45) calendar days of date of initial agreement, MCO shall contact and send a follow-up letter to provider restating the terms of repayment.

E. Before a bill adjustment is submitted to BWC by the MCO, the overpayment must be recovered by the MCO and deposited into the MCO's provider account.

F. Recovery from Provider's future payments

The MCO may recover provider overpayment from provider's future payments. If recovery of funds is designated from such future payments, the repayment can be taken from any provider location operating under the same Tax ID number as the original provider. The MCO shall inform the provider in writing that recovery will offset future payments due to overpayment and must provide the set-off amount and reference all prior MCO recovery efforts in this case. A list of all

the provider locations from which the recovered amount will be deducted shall be specified in this notice. The MCO must identify the amounts recovered on the provider remit when the overpayment is recovered from future payments.

After the overpayment is collected, the MCO shall send the request for adjustment with supporting documentation to MB&A via email at HPP.Adjustments@bwc.state.oh.us or fax to 614-752-6555 within fourteen (14) calendar days. Each state holiday falling within the fourteen (14) calendar day period shall extend the deadline by one (1) calendar day.

G. No response from provider to MCO request for overpayment recovery

1. If provider does not respond to the MCO's request for recovery within ninety (90) calendar days of date of notification letter sent via certified mail, or subsequent follow-up letter as referenced in section D.2, MCO shall notify MB&A Recovery and submit supporting documentation via e-mail, and track and document the information accordingly (see section I of this procedure). The information must include the following:

- a. Copy of original overpayment recovery request
- b. Copy of 2nd overpayment recovery request sent via certified mail
- c. Copy of certified mail receipt or verification of delivery
- d. Documentation of all recovery efforts

2. Documentation review by MB&A Recovery

- a. Upon receipt of complete overpayment information, MB&A Recovery will research, review, and determine the appropriateness of recovery. If the MCO information is incomplete, MB&A Recovery will notify the MCO. The MCO must provide the complete information within seven (7) calendar days of notification.
- b. If BWC determines that recovery shall not be made, MB&A Recovery will notify MCO. The MCO must then notify the provider of the decision.
- c. If MB&A Recovery determines that recovery shall be made, MB&A Recovery will send provider a demand for recovery. The demand letter shall provide notification that the provider has forty-five (45) calendar days from date of letter to either reimburse BWC for the overpayment or dispute overpayment determination. The letter will also include details supporting the overpayment determination, instructions for submitting payment to BWC, consequences for non-payment, and provider appeal remedies.

H. Provider Disputes MCO Overpayment Determination

1. If the provider does not agree with the MCO overpayment determination, the provider may dispute the decision. Provider notification of appeal must be made to the MCO within forty-five (45) calendar days from the date of receipt of the MCO notification of overpayment. Provider appeal must be in writing. If the provider does not appeal the MCO's determination, the MCO shall notify MB&A Recovery as detailed in section G.

2. If the provider timely appeals the MCO's determination, the MCO shall schedule a grievance conference in accordance with the "MCO's Grievance Hearings with Providers Policy" as set forth in the MCO Policy Reference Guide (MCOPRG).

3. Upon conclusion of the grievance conference, the MCO shall issue a written decision to the provider within seven (7) calendar days. The letter shall contain at least the following:

- a. The date, time, place and participants in the conference,
- b. The MCO's rationale for the decision,
- c. Address for submitting reimbursement to MCO,
- d. Notification that the provider may appeal the MCO's grievance conference decision to BWC management within forty-five (45) calendar days of the date of the grievance conference decision letter by sending their dispute in writing to:

E-mail box: MedicalBillPaymentRecovery@bwc.state.oh.us or

Fax: (614) 621-1059 or

Mail: MB&A Recovery
30 W. Spring St., L20
Columbus, OH 43215

- e. If the provider does not appeal the grievance conference decision within forty-five (45) calendar days, the MCO shall notify MB&A Recovery as detailed in section G.
4. If the provider disputes the MCO's Grievance Conference decision and submits a timely appeal to MB&A Recovery, the recovery dispute will be staffed by the MB&A Manager and the Medical Services Division Chief's designee. They shall determine whether recovery is appropriate and issue their written decision to the provider within forty-five (45) calendar days of receipt of the appeal. The provider will be notified of the opportunity to appeal their decision to the Administrator's designee within forty-five (45) calendar days of the date of the notification of the decision through the any of the methods identified in section H.3.c.
5. If the provider appeals the BWC management decision:

The Administrator's designee will review and make the final determination and notify the provider of the final decision within forty-five (45) calendar days of receipt of the appeal. The notification shall be sent to provider via certified mail with copies sent electronically to the MCO.

I. Tracking and Documentation:

1. Due to the potential of recovery for multiple claims for the same provider, provider recovery information shall not be imaged into the IW's claim nor notes be placed into the IW's claim record. MCOs shall maintain a distinct and separate file for each overpayment recovery case. The file shall contain all relevant documents and communications. Upon request by BWC, the MCO shall provide a copy of the requested recovery file to BWC within seven (7) calendar days.
2. MCOs shall identify and track the status of recovery adjustments.
3. MB&A Recovery will track all recovery actions through to resolution.

J. Recovery of overpayments due to MCO error:

1. Upon BWC verification of an MCO error in treatment authorization or bill payment, MB&A Recovery shall notify the MCO via e-mail.
2. If the MCO agrees with the determination by MB&A Recovery, the MCO shall make payment from the MCO's administrative account to either the provider or to BWC, as directed by BWC, within fourteen (14) calendar days of the BWC notification.
3. If the MCO does not agree with the determination by MB&A Recovery, the MCO may dispute the determination by responding to the e-mail from MB&A Recovery within fourteen (14) calendar days of receipt.
4. The dispute will be considered by MB&A Recovery and staffed with other BWC subject matter experts as needed.
5. The Medical Services Division Chief's designee (designee) shall review the MCO appeal and notify the MCO of the decision via email within forty-five (45) calendar days of receipt of the appeal.
6. If the MCO agrees with the decision by the designee, the MCO shall make payment from the MCO's administrative account to either the provider or to BWC, as directed by BWC, within fourteen (14) calendar days of the designee notification.

7. If the MCO does not agree with the decision by the designee, the MCO may appeal the decision to Administrator's Designee by responding within fourteen (14) calendar days by email at MedicalBillPaymentRecovery@bwc.state.oh.us.
8. The Administrator's Designee shall review the appeal, and inform the MCO of the decision within fourteen (14) calendar days of receipt of the appeal via email, and copy the Director, Compliance/Performance Monitoring and the Director, MCO Business & Reporting. MCO must submit documentation supporting completion to BWC Compliance/Performance Monitoring.

SENSITIVE DATA TRANSMISSION POLICY

1.0 Purpose

To prevent unauthorized disclosure of BWC sensitive information.

2.0 Scope

This policy covers the responsibilities of every employee entrusted with transmitting BWC sensitive data of any type (i.e., e-mail, files, medical documents or reports).

3.0 Policy

Employees must, at all times, exercise utmost caution when handling BWC sensitive information especially when transmitting any type of sensitive data. BWC sensitive information is any information that if made public, would:

- be unlawful,
- compromise BWC's ability to carry out its functions,
- expose BWC customer (s) or employee (s) confidential information (e.g. social security numbers, medical records, employer financial data, banking information, driver's license numbers, confidential internal communications, etc.), or
- jeopardize the safety of BWC's employees.

*Please refer to the Sensitive Data Chart, Section 3.2.

3.1 Employee Responsibilities

3.1.1 Include a disclosure statement on all transmitted information: Portions of this message may be confidential under an exemption to Ohio's public records law or under a legal privilege. If you have received this message in error or due to an unauthorized transmission or interception, please delete all copies from your system without disclosing, copying, or transmitting this message.

3.1.2 Transmitting sensitive data to another BWC employee is allowed only if the data is sent from/to another BWC e-mail address.

3.1.3 Never transmit BWC sensitive data via e-mail to any entity outside of BWC unless the document is password protected.

3.1.4 Transmitting BWC sensitive data via RightFax is allowed only if the recipient is a Fax machine and includes the disclosure statement listed in 3.1.1.

3.1.5 Never RightFax sensitive data to another e-mail address or computer outside of BWC unless the document is password protected and includes the disclosure statement listed in 3.1.1.

3.1.6 Transmitting sensitive data via normal Fax is allowed but must contain the disclosure statement listed in 3.1.1.

3.1.7 If anyone receives sensitive data from an external party that is not protected, immediately contact the sender and notify them **not to send sensitive data unless it is protected**.

3.1.8 Transmitting sensitive data via an approved VPN is allowed.

3.1.9 Transmitting sensitive data via File Transfer Protocol (FTP) using at least 128 bit encryption with PGP or GPG is allowed.

3.1.10 Transmitting sensitive data to the MCO Share point portal is allowed.

3.1.11 When password protecting a document, never send that password in the same e-mail as the document and do not use the password as part of the document name. To ensure that passwords are not sent via e-mail, please consider the following format for each recipient type:

- a. MCO – their MCO Number
- b. Provider – their Provider Number
- c. Employer – their Policy Number
- d. Claimant - their Claim Number
- e. TPA/Legal Representatives – Representative ID
- f. Others - Any password (The recipient must be called with the password).

3.1.12 If sensitive data of any kind has been misplaced, lost or stolen, follow the procedures outlined in the BWC Sensitive Information and Portable Storage Device Theft/Loss Procedure located on the Infrastructure and Technology BWCWeb page.

3.2 Sensitive Data Charts

Injured Worker Sensitive Data Chart

Data Element	Sensitive or Non-sensitive	Data Element	Sensitive or Non-Sensitive	Data Element	Sensitive or Non-Sensitive
Name	Sensitive	Name and Any Banking Information/Credit Card Information	Sensitive	Claim Number and Any Banking Information/Credit Card Information	Sensitive
Name and SSN	Sensitive	SSN and ANY data element	Sensitive	Phone Number and ANY data element	Sensitive
Name and Claim Number	Sensitive	Claim Number	Sensitive	Address and ANY data element	Sensitive
Name and Address	Sensitive	Claim Number and Address	Sensitive	Claim Status and ANY data element	Sensitive
Name and Phone Number	Sensitive	Claim Number and Phone Number	Sensitive	ICD-9 Codes and ANY data element	Sensitive
Name and Claim Status	Sensitive	Claim Number and Claim Status	Sensitive	Medical Records Created in the Course Of Treatment and ANY data element	Sensitive
Name and ICD-9 Codes	Sensitive	Claim Number and ICD-9 Codes	Sensitive	Medical Records created to establish entitlement to benefits and ANY data element	Sensitive
Name and Medical Records Created in the Course Of Treatment	Sensitive	Claim Number and Medical Records Created in the Course Of Treatment	Sensitive	Payments and ANY data element	Sensitive
Name and Medical Records created to establish entitlement to benefits	Sensitive	Claim Number and Medical Records created to establish entitlement to benefits	Sensitive	HIV and ANY data element	Sensitive
Name and Payment	Sensitive	Claim Number and Payment	Sensitive	Psych Conditions and ANY data element	Sensitive
Name and HIV	Sensitive	Claim Number and HIV	Sensitive	Drivers License and ANY data element	Sensitive
Name and Psych Conditions	Sensitive	Claim Number and Psych Conditions	Sensitive	Banking Information/ Credit Card Information and ANY data element	Sensitive
Name and Drivers License	Sensitive	Claim Number and Drivers License	Sensitive	IW Name, Employer Name, Accident Information	Sensitive

Employer Sensitive Data Chart

Data Element	Sensitive or Non-sensitive	Data Element	Sensitive or Non-Sensitive	Data Element	Sensitive or Non-Sensitive
Coverage Status	Non-Sensitive	Manual Numbers	Non-Sensitive	Rating Plan and Premium Amounts	Sensitive
Coverage Status and Payroll Reported	Sensitive	Manual Numbers and Payroll Reported	Sensitive	Rating Plan and Security Deposit	Sensitive
Coverage Status and Premium Amounts	Sensitive	Manual Numbers and Premium Amounts	Sensitive	Rating Plan and Reserves	Non-Sensitive
Coverage Status and Manual Number	Non-Sensitive	Manual Numbers and Security Deposit	Sensitive	Rating Plan and Banking/Credit Card Information	Sensitive
Coverage Status and Security Deposit	Sensitive	Manual Numbers and Rating Plan	Non-Sensitive	Reserves	Non-Sensitive
Coverage Status and Rating Plan	Non-Sensitive	Manual Numbers and Reserves	Non-Sensitive	Reserves and Payroll Reported	Sensitive
Coverage Status and Reserves	Non-Sensitive	Manual Numbers and Banking/Credit Card Information	Sensitive	Reserves and Premium Amounts	Sensitive
Coverage Status and Banking/Credit Card Information	Sensitive	Security Deposit and ANY data element	Sensitive	Reserves and Security Deposit	Sensitive
Payroll Reported and ANY data element	Sensitive	Rating Plan	Non-Sensitive	Reserves and Banking/Credit Card Information	Sensitive
Premium Amounts and ANY data element	Sensitive	Rating Plan and Payroll Reported	Sensitive	Banking/Credit Card Information and ANY data element	Sensitive
Number of Employees and ANY data element	Sensitive	Federal Tax ID and ANY data element	Sensitive	Employer Policy Number	Non-sensitive

Provider Sensitive Data Chart

Data Element	Sensitive and Non-Sensitive
Provider Number	Sensitive
DEA Provider Number	Sensitive

Other Sensitive Data Chart

Data Element	Sensitive or Non-Sensitive
SIU Open Investigations data and ANY data element	Sensitive
Internal IG Open Investigations and ANY data element	Sensitive
Cyber Crime Open Investigations and ANY data element	Sensitive
BWC Employee HR Personal Information (i.e. SSN, Address)	Sensitive
IT Source Code and Security Records	Sensitive
Safety Reports that include Trade Secrets or Proprietary Information	Sensitive
MCO Application and related documentation	Sensitive
MCO Financial and auditing information	Sensitive

4.0 Enforcement

Any employee who violates this policy is subject to disciplinary action in accordance with the BWC Disciplinary Policy and associated Work Rules

Rev. 4/09

Appendix – C

REQUIRED DATA ELEMENTS FOR REPORTING
(Spreadsheet Format)

BILL IDENTIFICATION

CAMBRIDGE INVOICE NUMBER
SERVICING BWC PROVIDER NUMBER
PAY-TO BWC PROVIDER NUMBER
HOSPITAL NAME
MCO NUMBER
BWC CLAIM NUMBER

LINE ITEM DETAIL

INVOICE LINE SEQUENCE
ORIGINAL CHARGES
CORRECT CHARGES
ORIGINAL AMOUNT PAID
AMOUNT RECOVERED
ORIGINAL DATE OF SERVICE FROM
CORRECT DATE OF SERVICE FROM
ORIGINAL DATE OF SERVICE TO
CORRECT DATE OF SERVICE TO
ORIGINAL REVENUE CODE
CORRECT REVENUE CODE
ORIGINAL PROCEDURE/CPT CODE
CORRECT PROCEDURE/CPT CODE
ORIGINAL MODIFIER(S)
CORRECT MODIFIER(S)
ORIGINAL UNITS OF SERVICE
CORRECT UNITS OF SERVICE

OTHER INFORMATION

ORIGINAL INFORMATION - OTHER CODING
CORRECT INFORMATION – OTHER CODING
ORIGINAL TYPE OF BILL IP/OP
CORRECT TYPE OF BILL IP/OP
CATEGORY/REASON FOR RECOVERY
DECRPTION OF REASON FOR RECOVERY (IF NEEDED)

DATA ELEMENTS MAY BE SUBJECT TO CHANGE

Appendix – D

BILLING VOLUMES

INPATIENT BILL VOLUMES BASED ON PAID DATE:

	Number of Paid Bills in Calendar Year 2010	Total Hospital Charges	Total Reimbursed
DRG/MS-DRG	3,998	\$ 154,110,313.24	\$ 58,910,103.40
DRG/MS-DRG Exempt	849	\$ 35,618,286.05	\$ 21,056,555.20
Outlier	208	\$ 34,144,655.05	\$ 12,394,696.59
TOTAL	5,055	\$ 223,873,254.34	\$ 92,361,355.19

OUTPATIENT BILL VOLUMES BASED ON PAID DATE:

TOTAL NUMBER OF BILLS PAID IN CALENDAR YEAR 2010	TOTAL AMOUNT PAID IN CALENDAR YEAR 2010
242,407	\$ 165,196,365

HOSPITAL CREDIT BALANCE RECOVERY VENDOR:

Reason Given for Recovery	Number Of Invoices
1 - Hospital credited charges	65
2 - Employer in \$1K or \$5K and previously paid bill	18
3 - Bill contained 2 lines with same revenue code but different CPT codes	68
4 - Same payment made by 2 different MCOs	46
5 - Two dates of service billed; medical records substantiate only one	32
6 - Same bill, different bill type (inpatient vs. outpatient)	11
7 - Other	11
Pre-transition no info located regarding reason for recovery	2
GRAND TOTAL THROUGH 3/12/2011	253

Calendar Year	Amt BWC Recouped Through CDR Efforts	Amount Paid to CDR	Net Savings for BWC
2006	\$ 102,333.93	\$ 15,350.09	\$ 86,983.84
2007	\$ 177,561.12	\$ 26,634.25	\$ 150,926.87
2008	\$ 42,613.52	\$ 6,282.10	\$ 36,331.42
2009	\$ 13,393.26	\$ 2,017.01	\$ 11,376.25
2010	\$ 38,837.47	\$ 5,825.63	\$ 33,011.84
TOTAL THROUGH 3/12/2011	\$ 374,739.30	\$ 56,109.08	\$ 318,630.22