Proposed Changes

In addition to syntax and grammar changes for clarity and consistency, BWC proposes the following changes:

4123-6-01 Definitions

- Revise language to better clarify definitions.
- Remove the definitions of "Formulary" and "Medical management and cost containment services", which are defined and discussed in rules 4123-6-21.3 and 4123-6-04.3, respectively.

4123-6-01.1 Applicability of medical rules

- Update "industrial injuries" to "work related injuries".

4123-6-02 Provider access to the HPP – generally

- Remove unnecessary word "basic" from phrase "basic credentialing".

4123-6-02.21 Provider access to the HPP – non-certified provider enrollment

- Add language requiring the provider to notify BWC within thirty days of any change in the provider's ownership.
- Remove "and agreement" from the phrase "enrollment application and agreement".

4123-6-02.3 Provider access to the HPP – provider application and certification criteria.

- Add language requiring the provider to report any change in ownership
- Remove the hyphen from "work–related" to "work related" for consistency throughout the Chapter 4123-6 rules.
- Add language requiring providers to interact professionally with BWC, the Industrial Commission, the MCO, injured workers, and their representatives.

4123-6-02.4 Provider access to the HPP – provider and recertification

- Remove "and" from the rule title.

4123-6-02.5 Provider access to the HPP – provider not certified

- Remove redundant language repeated from Ohio Revised Code 4121.443.

4123-6-02.51 Provider access to the HPP – Denial of provider, entity or MCO enrollment certification based on criminal conviction or civil action

- Restructure language to address MCOs, providers and entities.
- Remove MCO restrictions based upon court supervised intervention or treatment in lieu of conviction.
- Add language related to the enrollment, certification or recertification of a provider or entity that mirrors the restrictions based on criminal convictions listed in the appendix to provider credentialing rule 4123-6-02.2.

4123-6-02.6 Provider access to the HPP – selection by an MCO

- Add language clarifying that MCO guidelines for non-panel providers cannot be more restrictive than for MCO panel providers.

4123-6-02.7 Provider access to the HPP – provider decertification procedures

- Add language clarifying that a correction plan must be signed by the provider.
- Revise language regarding documentation when a provider is under a correction plan and entering the correction plan into the provider's certification file.
- Correct a cross-reference in the rule.
- Revise language to cite to the relevant statute regarding immediate revocation or suspension of a provider's certification.

4123-6-02.8 Provider Requirement to notify of injury

- Replace "working" day with "business" day.

4123-6-02.9 Provider access to the HPP – provider marketing

- Add language to clarify the rule applies to enrolled providers as well as certified providers.
- Add language clarifying the entities to which an enrolled or certified provider shall not provide inappropriate inducements to.

4123-6-03.2 MCO participation in the HPP – MCO application for certification or recertification.

- Replace "managed care organization" with "MCO".
- Streamline language referencing the application for certification.

4123-6-03.4

- Relocate language in text to provide better clarity.

4123-6-04.5 MCO scope of services – bureau claims management

- Replace "employee" with "injured worker" for consistency throughout the Chapter 4123-6 rules.
- Revise language to clarify medical payments are not made in a disallowed claim until permitted by statute, or as otherwise provided in Chapter 4123-6 or Chapter 4123-18 of the Administrative Code.

4123-6-04.6 Return to work assessment

- Add language to clarify what constitutes "lost time" and remove unnecessary language.

4123-6-05.3 Employer access to the HPP – certain solicitation practices by MCOs prohibited

- Correct a punctuation error in title.

4123-6-05.4 Employer access to the HPP – payment for referrals prohibited

- Correct a punctuation error in the rule title.

4123-6-07 Services and supplies never covered

- Reformat to provide better clarity
- Remove the term “lounge beds” as unnecessary.
- Remove language elaborating on when seat lift mechanisms may be reimbursed.
- Add language to better define what size hospital bed is not covered and to provide an exception for bariatric mattresses.
- Remove language related to not covering larger mattresses for purposes of accommodating two people.
- Remove unnecessary language related to unsupervised physical reconditioning programs.

4123-6-10 Payment to providers

- Change references to “employees” to “injured workers”.
- Add language requiring a provider to report and return overpayments, and to exercise reasonable diligence to identify and quantify overpayments.

4123-6-14 MCO bill submission to bureau

- Clarify reference to the requirements of BWC’s Provider Billing and Reimbursement Manual.

4123-6-14.1 Records to be retained by MCO

- Rephrase language regarding records related to medical management and billing.
- Rephrase language requiring the MCO to create, maintain and retain records not related to a specific claim and add language specifying types of records included.

4123-6-15 Confidentiality of records

- Change “employee” to “injured worker” for consistency throughout the Chapter 4123-6 rules.
- Remove “his or her” and rephrase.

4123-6-16 Alternative dispute resolution for HPP medical issues.

- Change “employee” to “injured worker”
- Relocate language related to independent medical examinations from rule 4123-6-04.3 to this rule and rephrase.

4123-6-16.2 Medical treatment reimbursement requests

- Add language clarifying that BWC reserves the authority to require authorization or prior authorization for services.

4123-6-16.3 Reimbursement of retroactive medical treatment reimbursement requests

- Correct a cross-reference to the Administrative Code.

4123-6-17 Bureau refusal to certify or recertify, action to decertify a provider or MCO – standards and procedures for adjudication hearings

- Remove language requiring an adjudication order be sent certified mail, as this requirement was redundant to language in Ohio Revised Code 119.09.

- Simplify language regarding attorney fees.

4123-6-18 Data gathering and reporting

- Correct a cross-reference to the Ohio Revised Code.

4123-6-20 Obligation to submit medical documentation and reports

- Change “claimant” to “injured worker”.
- Reformat for clarity.
- Add “or other bureau forms” to reports that may be requested by BWC.
- Add “allowance” as a purpose for the required reports.

4123-6-20.1 Charges for copies of medical reports

- Change title to more clearly reflect the subject matter of the rule.
- Rephrase and simplify language

4123-6-21 Payment for outpatient medications

- Change “claimant” to “injured worker”.
- Add language clarifying when BWC may require prior authorization of drugs,
- Simplify the language regarding prescriptions for compounded drug products.
- Remove language requiring a pharmacy provider to maintain a signature log verifying receipt by the injured worker as redundant to Ohio Board of Pharmacy requirements.
- Update language to prohibit the pharmacy provider from providing anything of value to “any other person, firm or corporation” as an inducement for their business.
- Remove language mandating how the maximum allowable cost of single source drugs is determined.
- Add and update language regarding at what point a refill of drugs scheduled and not scheduled by the DEA may be obtained.
- Clarify the language regarding when a denial of a drug may be overridden by BWC with supporting documentation.
- Remove language indicating the bureau may formulate medication utilization protocols for select conditions or diseases.

4121-6-21.1 Payment for outpatient medication by self-insuring employer

- Remove a requirement that an enrolled pharmacy provider must be used to dispense drugs in self insured claims.
- Simplify language regarding compounded prescriptions and allowable cost.
- Remove the language requiring a signature log verifying receipt of medications as redundant to Ohio Board of Pharmacy requirements.
- Add language to prohibit the pharmacy provider from providing anything of value to “any other person, firm, or corporation” as an inducement for their business.
- Remove language requiring claimant requests for reimbursement to comply with BWC’s Provider Billing and Reimbursement Manual.
- Add language allowing the self-insuring employer to terminate without a physician drug review medications that have been removed from the BWC formulary.
- Remove language permitting self-insuring employers to utilize protocols formulated by BWC for medications.

- Clarify language that permits a self-insuring employer to contract with a pharmacy benefits manager.
- Change references to “point of service adjudication system” to “pharmacy benefits manager”.
- Add language regarding dispensing limitations to mirror BWC ’s dispensing limitations pursuant to 4123-6-21.
- Add language requiring the self-insuring employer to approve or deny a prior authorization request for medications within three business days.

Proposed Rules To Be Rescinded

BWC proposes that the following rules be rescinded:

4123-6-04.3 MCO scope of services - MCO medical management and claims management assistance.
4123-6-04.4 MCO scope of services - fee bill review and audit process
4123-6-06.1 Employee access to medical services – education by MCO and employer

Proposed New Rule

4123-6-04.3 MCO scope of services – MCO medical management and claims management assistance

This rule merges portions of current rules 4123-6-04.3, 4123-6-04.4 and 4123-6-06.1 and addresses the MCOs’ scope of services and responsibilities, including:

- Medical management and cost containment;
- Education of employees and employers;
- The reporting of injuries to BWC and employers;
- Reviewing bills for treatment;
- Maintaining a grievance hearing procedure regarding bill disputes;
- Referring requests in inactive claims to BWC; and
- Providing medical management and return to work management in a claim as long as the employer remains assigned to the MCO.

Proposed No Change Rules

BWC proposes that the following rules be submitted with no changes for this five year rule review period:

4123-6-03.7 MCO participation in the HPP – bureau’s authority to decertify, to refuse to certify or recertify an MCO
4123-6-3.9 MCO participation in the HPP – MCO disclosure of relationship
4123-6-03.10 Conflict of interest
4123-6-16.1 HPP medical treatment guidelines
4123-6-19 Remain at work services