

*** DRAFT - NOT YET FILED ***

4123-6-21.2

Pharmacy and therapeutics committee.

The bureau of workers' compensation pharmacy and therapeutics (P&T) committee is hereby created to advise the administrator and the chief medical officer with regard to issues involving medication therapy for injured workers. A list of physician and pharmacist providers, each holding a professional license in good standing, who have agreed to serve on the P&T committee and who would add credibility and diversity to the mission and goals of the committee shall be developed and maintained by the chief medical officer. Providers may also be nominated for inclusion on the list by provider associations and organizations including but not limited to: deans of Ohio's allopathic and osteopathic medical schools, deans of Ohio's colleges of pharmacy, presidents of Ohio's various allopathic and osteopathic medical associations, the Ohio pharmacists association, the Ohio state medical board, and the Ohio state pharmacy board.

(A) The P&T committee shall consist of the bureau pharmacy program director and not more than thirteen nor less than five voting members who shall be licensed physicians and licensed pharmacists representing the diverse group of providers that provide care to the injured workers of Ohio as administered through the bureau. The committee may create any subcommittees that the committee determines are necessary to assist the committee in performing its duties. Any subcommittee recommendations shall be submitted to the P & T committee.

(B) P&T committee members must meet the following requirements:

- (1) Each provider must be familiar with issues relating to the prescribing or dispensing of medications in the Ohio workers' compensation system.
- (2) Physicians must be a doctor of medicine (MD) or doctor of osteopathic medicine (DO).
- (3) Providers must possess significant clinical or administrative experience in health care delivery, including but not limited to pain management, pharmacy practice, medical quality assurance, disease management and utilization review.
- (4) Providers must have experience with and an understanding of the concepts of evidence based medicine as well as contemporary best practices in appropriate prescribing, dispensing, and monitoring of outpatient medications.
- (5) Providers must not be, or within the previous twenty-four months have been, an

employee of any pharmaceutical manufacturer, pharmacy benefits manager, or any non-governmental firm or entity administering state purchased health care program benefits or pharmaceutical rebates.

- (C) The appointing authority for members of the P&T committee shall be the administrator or the administrator's designee(s), who shall appoint members of the committee from the list of qualified providers developed and maintained by the chief medical officer. Terms of membership for individual members of the P&T committee shall be for one year. Individuals may be reappointed to subsequent terms as determined by the administrator. Vacated terms shall be filled in a like manner as for the full term appointments and shall be for the remaining term of the vacated member.
- (D) The pharmacy program director of the bureau shall be the chairperson of the P&T committee and shall provide notice of meetings to the members and be responsible for the meeting agenda. In addition, the pharmacy program director may be self-designated as an ad hoc member of any subcommittees of the P&T committee; however, the pharmacy program director shall be a voting member of the P&T committee and any subcommittees only in the case of tie votes. The bureau chief medical officer and bureau staff pharmacist may participate in discussions; however, they shall not be voting members.
- (E) The P&T committee shall develop and establish bylaws for the organization and operations of the committee and subcommittees, subject to the requirements of this rule and approval by the administrator.
- (F) The P&T committee may make such recommendations as it deems necessary to address any issue impacting the bureau related to pharmacy or medication therapeutics. The committee shall be responsible to respond to requests for action on any such issue submitted by the bureau's administrator, chief of medical services, chief medical officer or pharmacy director, including but not limited to:
 - (1) Development, approval and annual review of a formulary of approved medications.
 - (2) Development, approval and annual review of a list of non-covered, non-reimbursable medications.
 - (3) Development and approval of prior authorization criteria.
 - (4) Review and approval of proposed medication treatment guidelines.

- (5) Review and approval of bureau policies and procedures related to drug utilization review or specific medication issues.
- (6) Review of the bureau's pharmacy providers' professional performance. The P&T committee shall perform peer review according to generally accepted standards of pharmacy practice and may recommend sanctions as well as termination of any pharmacy provider determined to have consistently failed to meet those standards of care.
- (7) Review of the performance of the bureau's pharmacy benefit manager and conduct regarding its management of prescription benefit services for the bureau.
- (G) The P&T committee shall hold at least three meetings annually. The P&T committee and all subcommittees shall keep written records of the agenda and minutes of each meeting. The records of all committees shall remain in the custody of the chief medical officer.
- (H) The P&T committee shall submit an annual report of its activities and recommendations to the administrator. In addition to inclusion in the annual report, all recommendations from the P&T committee and subcommittees shall be submitted to the chief medical officer in a timely fashion upon completion and approval by the respective subcommittees and P & T committee.
- (I) Each member of the P&T committee and its respective subcommittees may be paid such fees as approved by the administrator or the administrator's designee. The expenses incurred by the P&T committee and its subcommittees and the fees of their members shall be paid in the same manner as other administrative costs of the bureau.

Five Year Review (FYR) Dates:

Certification

Date

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*** DRAFT - NOT YET FILED ***

4123-6-21.3

Outpatient medication formulary.

- (A) The administrator hereby adopts the formulary indicated in appendix A to this rule, developed with the recommendation of the bureau's pharmacy and therapeutics committee, effective September 1, 2014.
- (B) The formulary indicated in appendix A to this rule shall constitute the complete list of medications that are approved for reimbursement by the bureau for the treatment of an occupational injury or disease in an allowed claim. Except as otherwise provided in paragraph (F) of this rule, drugs not listed in the formulary are not eligible for reimbursement by the bureau.
- (C) The formulary indicated in appendix A to this rule also contains specific reimbursement, prescribing or dispensing restrictions that have been placed on the use of listed drugs. The formulary will be reviewed annually and updated as necessary. The most current version will be electronically published by the bureau.
- (D) Based upon current medical literature and generally accepted best clinical practices the bureau's pharmacy and therapeutics committee shall evaluate and make recommendations to the administrator regarding the addition, deletion, or modification of coverage of medications listed in the formulary. Requests for pharmacy and therapeutics committee action on a specific drug may be initiated by the bureau's administrator, chief of medical services, chief medical officer, or pharmacy director.
- (E) The bureau shall develop policies to perform an expedited review process for clinically or therapeutically unique medications. The bureau shall also develop policies to address the timely review of new drug products.
- (F) Notwithstanding paragraph (B) of this rule, in cases of medical necessity supported by clinical documentation and evidence of need the bureau may, with prior authorization, reimburse for new drugs approved for use in the United States by the food and drug administration (FDA) on or after the effective date of the formulary, and for new indications approved by the FDA on or after the effective date of the formulary for existing drugs that are not on the formulary, for a period not to exceed one hundred eighty days from the adjudication date of the first prescription for the requested drug.
- (G) Notwithstanding appendix A to this rule, in cases of medical necessity supported by clinical documentation and evidence of need the bureau may, with prior authorization, reimburse for new dosage forms or strengths approved by the FDA

on or after the effective date of the formulary for existing drugs that are on the formulary, for a period not to exceed one hundred eighty days from the adjudication date of the first prescription for the requested drug.

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*** DRAFT - NOT YET FILED ***

4123-6-21.4

Coordinated services program.

The bureau, or a self-insuring employer with a point-of-service adjudication system, may establish a coordinated services program (CSP) that requires an injured worker to obtain prescription medications reimbursed by the bureau or self-insuring employer from a single designated pharmacy and/or prescriber.

(A) Placement in a CSP.

- (1) The bureau or self-insuring employer with a point-of-service adjudication system may review an injured worker for possible placement in a CSP if a review of his or her claim indicates the injured worker meets one or more of the following criteria:
 - (a) Use of three or more different prescribers to obtain prescriptions of the same or comparable medications per three month time frame;
 - (b) Receipt of prescription drugs from more than two different pharmacies per three month time frame;
 - (c) Monthly receipt of three or more prescriptions including refills for drugs identified by therapeutic drug class as a narcotic analgesic per three month time frame;
 - (d) Monthly receipt of more than two concurrent narcotic analgesics in the same therapeutic drug class per three month time frame;
 - (e) Monthly receipt of more than two narcotic analgesics in the same therapeutic drug class, more than one benzodiazepine, and more than one sedative-hypnotics per three month time frame.
- (2) Upon identification of an injured worker meeting one or more of the criteria identified in paragraphs (A)(1)(a) to (A)(1)(e) of this rule, the bureau or self-insuring employer with a point-of-service adjudication system shall obtain a physician review of the injured worker's most recent twelve months history of prescription medications reimbursed by the bureau or self-insuring employer.
- (3) If, based on this physician review, the bureau or self-insuring employer with a point-of-service adjudication system determines that the injured worker's utilization of prescription medications during this period was at a frequency

or in an amount that was not medically necessary or appropriate under the criteria set forth in paragraphs (B)(1) to (B)(3) of rule 4123-6-16.2 of the Administrative Code, or was potentially unsafe, the bureau or self-insuring employer may place the injured worker in a CSP.

- (4) Notwithstanding paragraphs (A)(1) to (A)(3) of this rule, if the bureau or self-insuring employer with a point-of-service adjudication system determines that an injured worker has been convicted of or pled guilty to an offense under Chapter 2925. of the Revised Code or any other criminal offense related to the misuse of drugs, the bureau or self-insuring employer may place the injured worker in a CSP.
 - (5) Placement in a CSP shall be for an initial period of eighteen months. The bureau or self-insuring employer with a point-of-service adjudication system may place the injured worker in the CSP for additional eighteen month periods in accordance with paragraph (A)(6) of this rule.
 - (6) The bureau or self-insuring employer with a point-of-service adjudication system may evaluate an injured worker's medication utilization at the conclusion of each eighteen month period in the CSP. If the bureau or self-insuring employer determines that the injured worker's medication utilization continues to meet the criteria set forth in paragraphs (A)(1) to (A)(4) of this rule, the bureau or self-insuring employer may place the injured worker in the CSP for an additional eighteen month period.
 - (7) If an injured worker placed in the CSP enters a nursing home, residential care/assisted living facility, or hospice program, the injured worker shall be released from the CSP. If the injured worker is subsequently discharged from the nursing home, residential care/assisted living facility, or hospice program during the CSP period, the bureau or self-insuring employer with a point-of-service adjudication system may place the injured worker back into the CSP.
- (B) Selection of designated pharmacy and/or prescriber.
- (1) An injured worker placed into a CSP pursuant to paragraph (A)(3) or (A)(4) of this rule shall be given the opportunity to select a designated pharmacy from a list of participating pharmacies maintained by the bureau or self-insuring employer. If an injured worker fails to select a designated pharmacy, or selects a designated pharmacy that is unable or unwilling to accept the injured worker, the bureau or self-insuring employer may select a designated pharmacy for the injured worker.

- (2) An injured worker placed in a CSP pursuant to paragraph (A)(3) or (A)(4) of this rule may only change from one designated pharmacy to another in the following circumstances:
 - (a) The designated pharmacy becomes inaccessible to the injured worker due to relocation or incapacity of the injured worker or closing of the designated pharmacy,
 - (b) The designated pharmacy chooses to no longer participate in the CSP or to provide services to the injured worker in accordance with paragraph (D)(4) of this rule.
 - (c) The injured worker requests to be assigned to another designated pharmacy due to personal preference. Not more than one change due to personal preference shall be approved in a rolling twelve-month period.
- (3) An injured worker placed in the CSP pursuant to paragraph (A)(4) of this rule shall be given the opportunity to select a designated prescriber from among those bureau certified providers who meet the definition of physician under paragraph (D) of rule 4123-6-01 of the Administrative Code. If an injured worker fails to select a designated prescriber, or selects a designated prescriber that is unable or unwilling to accept the injured worker, the bureau or self-insuring employer may select a designated prescriber for the injured worker.
- (4) An injured worker placed in a CSP pursuant to paragraph (A)(4) of this rule may only change from one designated prescriber to another in the following circumstances:
 - (a) The designated prescriber becomes inaccessible to the injured worker due to relocation or incapacity of the injured worker or closing of the designated prescriber's practice,
 - (b) The designated prescriber chooses to no longer provide services to the injured worker,
 - (c) The injured worker requests to be assigned to another designated prescriber due to personal preference. Not more than one change due to personal preference shall be approved in a rolling twelve-month period.
- (5) All requests for change of designated pharmacy or designated prescriber must

be submitted in writing to the bureau or self-insuring employer.

(C) Operation of the CSP.

- (1) An injured worker placed in a CSP pursuant to paragraph (A)(3) or (A)(4) of this rule must obtain covered prescription medications from the injured worker's designated pharmacy. During the period the injured worker is placed in the CSP, the bureau or self-insuring employer shall deny reimbursement for prescription medications obtained from a pharmacy other than the injured worker's designated pharmacy, except in cases of emergency as set forth in paragraph (C)(2) of this rule.
- (2) Emergency prescription fills shall be allowed in the following situations:
 - (a) The injured worker is unable to get to his or her designated pharmacy,
 - (b) The injured worker's designated pharmacy does not have the prescribed medication in stock.
- (3) Emergency prescription fills shall be limited to a four-day supply. Records of dispensing for emergency prescription fills are subject to review by the bureau.
- (4) An injured worker placed in a CSP pursuant to paragraph (A)(4) of this rule must obtain all prescriptions for covered medications from the injured worker's designated prescriber. During the period the injured worker is placed in the CSP, the bureau or self-insuring employer shall deny reimbursement for prescriptions written by providers other than the injured worker's designated prescriber, except:
 - (a) In cases of emergency as defined in paragraph (O) of rule 4123-6-01 of the Administrative Code;
 - (b) With prior authorization, prescriptions written by a specialist in cases where the injured worker has been referred to a specialist for care.

(D) Pharmacies participating in the bureau's CSP.

- (1) The bureau shall maintain a list of pharmacies participating in the bureau's CSP that are eligible for selection by an injured worker as a designated pharmacy. To participate in the bureau's CSP, a pharmacy must meet the following

criteria:

- (a) The pharmacy must be enrolled with the bureau and have a signed agreement with the bureau's pharmacy benefits manager.
 - (b) The pharmacy must enter into a CSP agreement with the bureau.
- (2) Pharmacies participating in the bureau's CSP agree to perform the following monitoring activities:
- (a) For each injured worker in the bureau's CSP for whom the pharmacy is the designated pharmacy, the pharmacy shall conduct a bimonthly review of the injured worker's OARRS report from the Ohio board of pharmacy (or a similar automated prescription monitoring report from the injured worker's state of residence).
 - (b) The pharmacy shall notify the injured worker's prescribing physician of any critical findings discovered in the report. Critical findings are indications of any prescription related activity that could cause harm to the patient, including but not limited to:
 - (i) Duplication of therapy,
 - (ii) Excessive doses of concurrent medications,
 - (iii) Potential drug interactions or potentiation of side effects.
 - (c) The pharmacy shall notify BWC in writing whenever reports are made under paragraph (D)(2)(b) of this rule.
 - (d) BWC may request quarterly documentation of the pharmacy's monitoring activities under paragraphs (D)(2)(a) to (D)(2)(d) of this rule.
- (3) Pharmacies participating in the CSP may receive compensation from the bureau under the CSP agreement for services provided as part of the CSP.
- (4) Pharmacies participating in the bureau's CSP may terminate their CSP agreement with the bureau and discontinue their participation in the bureau's CSP at any time upon not less than thirty days written notice to the bureau. Pharmacies participating in the bureau's CSP may discontinue providing services to an individual injured worker at any time upon not less than thirty

days written notice to the bureau, the injured worker, and the injured worker's authorized representative.

- (5) The bureau may terminate the CSP agreement of a pharmacy participating in the bureau's CSP in accordance with the terms of the CSP agreement.

(E) Pharmacies participating in a self-insuring employer's CSP.

- (1) A self-insuring employer with a point-of-service adjudication system who establishes a CSP shall maintain a list of pharmacies participating in the self-insuring employer's CSP that are eligible for selection by an injured worker as a designated pharmacy. The list of participating pharmacies shall cover a geographic area sufficient to provide the self-insuring employer's injured workers with reasonable access to pharmacy providers.
- (2) Pharmacies participating in a self-insuring employer's CSP shall provide not less than thirty days written notice to an injured worker and the injured worker's authorized representative prior to discontinuing services to the injured worker.

(F) Disputes.

- (1) Decisions by the bureau regarding an injured worker's placement in the bureau's CSP, assignment of a designated pharmacy or designated prescriber, or denial of an injured worker's request for change of designated pharmacy or designated prescriber may be appealed to the industrial commission in accordance with section 4123.511 of the Revised Code.
- (2) Decisions by a self-insuring employer regarding an injured worker's placement in the self-insuring employer's CSP, assignment of a designated pharmacy or designated prescriber, or denial of an injured worker's request for change of designated pharmacy or designated prescriber shall indicate that the injured worker has the right to request a hearing before the industrial commission.

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4123-6-21.5

Standard dose tapering schedules.

The bureau hereby adopts the standard dose tapering (weaning) schedules for the prescription medications indicated in appendices A and B to this rule, developed with the recommendation of the bureau's pharmacy and therapeutics committee to safely implement denials for payment of the indicated medications, effective April 10, 2014.

These weaning schedules shall be applied to all denials for payment of the indicated medications by the bureau, self-insuring employers, MCOs, QHPs, and the industrial commission.

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4123-6-23

Jurisdictional principles applicable to payment of bills for medical services rendered by health care providers.

Jurisdictional requirements for payment for medical services rendered by a health care provider are as follows:

- (A) Bills must be filed within the time provided in rule 4123-3-23 of the Administrative Code.
- (B) In claims where the date of injury is on or after December 11, 1967, and prior to August 25, 2006, there is no jurisdiction to consider payment for medical services, if six years or more have elapsed since the date of the last payment of a medical bill and no compensation has been paid, except as provided in the following cases:
 - (1) A bill filed within the six-year period for services rendered within the period can be paid after the six-year period when, except for the time passage, it would have been paid.
 - (2) When an application requesting the payment of medical bills and/or compensation is filed within the six-year period, there is justification to act on the application after the period.
 - (a) Bills for services rendered within the six-year period can be ordered paid and can be paid after the period. However, these bills must be filed no later than two years after the date that services were rendered.
 - (b) Compensation can be ordered paid provided that evidence in the claim supports an award. If compensation is paid, the claim is opened for an additional ten years for the payment of compensation and bills. When there has been a payment of compensation under section 4123.56, 4123.57, or 4123.58 of the Revised Code, the claim is active for ten years from either the date of the last payment of compensation, or ten years from the last payment of a medical bill, whichever is later.
 - (3) Payment for medical services can be made when the claimant has received wages paid by the employer, instead of compensation for total disability. Medical services may be reimbursed when wages have been paid within six years of the date of injury with the employer's knowledge that an allowed claim exists.
 - (4) When a request for authorization of treatment beyond the six-year period is filed

within the six-year period, the authorization for treatment after that period cannot be granted, unless the claim has been opened by the payment of compensation.

- (5) There is no jurisdiction to consider the merits of any application filed after the six-year period, even though supporting evidence for the application was on file within the period.
 - (6) A bill filed within the six-year period that requires reactivation of the claim cannot be paid when an application for reactivation is not filed within the period. This rule also applies to bills filed after the expiration of the six-year period for treatment rendered within that period.
- (C) In claims where the date of injury is prior to December 11, 1967, there is no jurisdiction to consider payment for medical services if ten years or more have elapsed since the payment of compensation or benefits, or, when no compensation has been awarded, ten years have elapsed since the date of injury.
- (D) In claims where the date of injury is on or after August 25, 2006, there is no jurisdiction to consider payment for medical services if five years or more have elapsed since the payment of compensation or benefits. The provisions of paragraph (B) of this rule shall apply to the payment of medical bills in claims where the date of injury is on or after August 25, 2006, except that where those provisions reference six year and ten year time limits, the time limits shall be five years.

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4123.66
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4123-6-29

Request for information by the treating provider.

A provider treating an injured worker may, at any time, make a request in writing, facsimile, or e-mail, in accordance with the bureau's confidentiality and sensitive data requirements, for relevant information concerning conditions, treatment or history for the claim. The request for information shall be accompanied by an appropriate patient release of medical information. A prompt response will be given to this request.

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4123-6-37

Payment of hospital bills.

- (A) Direct reimbursement will not be made to members of a hospital resident staff.
- (B) Payment for personal comfort items, which include, but are not limited to, telephones, television, and private rooms provided at the patient's request, are not compensable.
- (C) Bureau fees for hospital inpatient services.
 - (1) Bureau fees for hospital inpatient services will be based on usual and customary methods of payment, such as prospective payment systems, including diagnosis related groups (DRG), per diem rates, rates based on hospital cost to charge ratios or percent of allowed charges.
 - (2) Except in cases of emergency, prior authorization must be obtained in advance of all hospitalizations. The hospital must notify the bureau, the injured worker's MCO, QHP, or self-insuring employer of emergency inpatient admissions within one business day of the admission. Failure to comply with this rule shall be sufficient ground for denial of room and board charges by the bureau, MCO, QHP, or self-insuring employer from the date of admission up to the actual date of notification. Room and board charges denied pursuant to this rule may not be billed to the injured worker.
- (D) Bureau fees for hospital outpatient services.
 - (1) Bureau fees for hospital outpatient services, including emergency services, will be reimbursed in accordance with usual and customary methods of payment which may include prospectively determined rates, allowable fee maximums, ambulatory payment categories (APC), hospital cost to charge ratios, or a percent of allowed charges, as determined by the bureau.
 - (2) Treatment in the emergency room of a hospital must be of an immediate nature to constitute an emergency as defined in this chapter. Prior authorization of such treatment is not required. However, in situations where the emergency room is being utilized to deliver non-emergency care, notification will be provided to the injured worker, the hospital, and the provider of record that continued use of the emergency room for non-emergent services will not be reimbursed.
- (E) The bureau may establish the same or different fees for in-state and out-of-state

hospitals based on the above reimbursement methodologies.

(F) Payment will be made for hospital services in accordance with rule 4123-6-10 of the Administrative Code.

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4123-6-37.2

Payment of hospital outpatient services.

(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 May 5, 2014 or after shall be the applicable rate set forth in paragraphs (A)(1) to (A)(6) of this rule as follows multiplied by a payment adjustment factor of 1.0212:

(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)(7) of this rule, multiplied by a bureau-specific payment adjustment factor, which shall be 2.53 for children's hospitals and 1.62 for all hospitals other than children's hospitals, with the following additional adjustments for specific services:

(a) For services reimbursed under the medicare clinical lab fee schedule, the applicable medicare rate specified in this paragraph shall be further multiplied by a 2014 bureau adjustment factor of 1.0175;

(b) For services reimbursed under the medicare physician fee schedule, the applicable medicare rate specified in this paragraph shall be further multiplied by a 2014 bureau adjustment factor of 1.201.

The medicare integrated outpatient code editor and medicare medically unlikely edits in effect as implemented by the materials specified in paragraph (A)(7) 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.

The annual medicare outpatient prospective payment system outlier, hold harmless, and exempt cancer hospital reconciliation processes shall not be applied to payments for hospital outpatient services under this rule.

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 as implemented by the materials specified in paragraph (A)(7) of this rule.

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)(7) of this rule, other than technical corrections, including but not limited to adjustments related to federal budget sequestration pursuant to the Budget Control Act of 2011, 125 Stat. 239, 2 U.S.C. 900 to 907 as amended as of the effective date 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.

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)(7) 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)(7) 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)(7) 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.

Critical access hospitals shall be reimbursed at one hundred 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)(7) 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 not participating in the medicare program.

Reimbursement for outpatient services provided by hospitals and distinct-part units of hospitals that do not participate in the medicare program shall be calculated in accordance with the methodologies set forth in this rule, using a default hospital outpatient cost-to-charge ratio of forty-seven per cent where applicable.

- (6) Reimbursement for outpatient services provided by "new hospitals" as defined in 42 C.F.R. 412.300(b) as published in the October 1, 2013 Code of Federal Regulations shall be calculated in the same manner as provided under paragraph (A)(5) of this rule.

- (7) 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, 2013 Code of Federal Regulations;

- (b) Department of health and human services, centers for medicare and medicaid services' "42 CFR Parts 405, 410, 412, and elsewhere. Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals; final rule", 78

Fed. Reg. 74825 - 75200 (2013).

(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
 - (a) For hospitals the department of health and human services, centers for medicare and medicaid services maintained hospital-specific cost-to-charge ratio information on as of January 1, 2014, based on the hospitals' submitted cost report (CMS-2552-96), the hospital's allowable billed charges multiplied by the hospital's reported cost-to-charge ratio (from the outpatient provider specific file in use by medicare on January 1, 2014) multiplied by a payment adjustment factor of 1.16, not to exceed sixty per cent of the hospital's allowed billed charges.
 - (b) For hospitals the department of health and human services, centers for medicare and medicaid services did not maintain hospital-specific cost-to-charge ratio information on as of January 1, 2014, the hospital's allowable billed charges multiplied by the applicable FY14 urban or rural statewide average outpatient cost-to-charge ratio set forth in table 11 of the federal rule referenced in paragraph (A)(7)(b) of this rule (the Ohio average cost-to-charge ratio shall be used for hospitals outside the United States) multiplied by a payment adjustment factor of 1.16, not to exceed sixty per cent of the hospital's allowed billed charges; or
- (2) The rate negotiated between the hospital and the QHP or self-insuring employer in accordance with rule 4123-6-46 of the Administrative Code.

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 9/1/07, 1/1/11, 4/1/11, 4/1/12, 4/1/13, 5/5/14

*** DRAFT - NOT YET FILED ***

4123-6-37.3

Payment of ambulatory surgical center services.

Unless an MCO has negotiated a different payment rate with an ambulatory surgical center pursuant to rule 4123-6-08 of the Administrative Code, reimbursement for ambulatory surgical center services with a date of service of May 5, 2014 or after shall be equal to the lesser of the ambulatory surgical center's allowable billed charges or the fee schedule amount indicated in appendix A to this rule, developed with provider and employer input and effective May 5, 2014.

Five Year Review (FYR) Dates:

Certification

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*** DRAFT - NOT YET FILED ***

4123-6-38.2

Payment of nursing home and residential care/assisted living services.

- (A) Payment to a nursing home or residential care/assisted living facility for the care of a claimant who sustained an injury or contracted an occupational disease in the course of and arising out of employment shall be made only when the need for such care is the direct result of the allowed conditions in the claim.
- (B) Payment will be made only for care provided in nursing homes and residential care/assisted living facilities meeting the qualifications specified in paragraphs (C)(20) and (C)(33) of rule 4123-6-02.2 of the Administrative Code.
- (C) Nursing home or residential care/assisted living facility care must be pre-authorized, except when a nursing home or residential care/assisted living facility is used immediately following an approved or emergency hospitalization.
 - (1) The allowed per diem rate for a claimant shall be no greater than the bureau's fee schedule or the rate negotiated between the nursing home or residential care/assisted living facility and the bureau, MCO, QHP, or self-insuring employer.
 - (2) Nursing home care shall be provided on a semiprivate bed basis, unless a situation exists when the use of a private room is medically necessary due to the allowed industrial condition. In these cases, the use of such a private room must be pre-authorized, except in cases of emergency, as defined in rule 4123-6-01 of the Administrative Code, or where the claimant's condition would be endangered by delay.
 - (3) Fee bills for prescription medication provided to claimants in nursing homes and residential care/assisted living facilities for the treatment of the allowed industrial injury or occupational disease shall be submitted by the providing pharmacy in compliance with the rules of this chapter of the Administrative Code.

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Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 2/14/05, 2/1/10

*** DRAFT - NOT YET FILED ***

4123-6-42 **Interest on late payments for equipment, materials, goods, supplies or services in state insurance fund, public work relief employees' compensation fund, coal workers pneumoconiosis fund, and marine industry fund claims.**

(A) Payment is made for equipment, materials, goods, supplies, or services incurred by the claimant in connection with claims against the state insurance fund, public work relief employees' compensation fund, coal workers pneumoconiosis fund, or marine industry fund in accordance with section 126.30 of the Revised Code. For the purpose of this rule, the required payment date is the date on which payment is due under the terms of a written agreement between the bureau, or its agent, and the provider. Payment will be made either thirty days after the bureau, or its agent, receives a proper invoice for the amount of the payment due, or thirty days after the final adjudication allowing payment of an award to the claimant, whichever is later.

(1) A "proper invoice" includes but is not limited to the claimant's name, claim number, date of injury or occupational disease, employer's name, provider's name and address and assigned payee number, a description of the service provided, the procedure code for the service provided, the date provided, and the amount of the charge. If more than one item has been included in the invoice, each item is to be considered separately to determine if it is a proper invoice.

(2) If the bureau or its agent determines that an invoice is improper, the bureau or its agent shall send notification to the provider through the MCO at least fifteen days prior to what would be the required payment date if the invoice did not contain an error. The notice shall describe the error and the additional information needed to correct the error. The required payment date shall be redetermined upon receipt of a proper invoice.

(3) If an invoice is for payment of either a condition not allowed in a claim, or for a claim that is not allowed, the payment date is thirty days after final adjudication of allowance of the condition or claim. As defined in section 126.30 of the Revised Code, "final adjudication" is the date that the decision of the bureau, industrial commission, or court becomes final, with no further right of appeal. If any section of the Revised Code contains a faster timetable for payments, however, such provisions shall not be superseded by this rule.

(B) Interest shall be paid based on division (E) of section 126.30 of the Revised Code. Any interest charges payable under section 126.30 of the Revised Code are to be paid by the bureau of workers' compensation.

Five Year Review (FYR) Dates:

Certification

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Prior Effective Dates:	2/12/97, 2/1/10

*** DRAFT - NOT YET FILED ***

4123-6-44

Bureau fees for provider services rendered by in-state and out-of-state providers.

Bureau fees for in-state or out-of-state providers will be established by the administrator of workers' compensation with the assistance of the bureau's medical management and cost containment division. The bureau may establish different fees for in-state and out-of-state providers. The methods of payment may include rates based on resource based relative value scale (RBRVS), percent of allowed charges, or usual, customary and reasonable fee maximas, as determined by the bureau's medical management and cost containment division. Rates will be reviewed at least annually by the bureau to determine the need for appropriate adjustment.

Payment for provider services will be made in accordance with rule 4123-6-10 of the Administrative Code.

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Prior Effective Dates:	2/16/96, 2/1/10

*** DRAFT - NOT YET FILED ***

4123-6-45.1

Records to be retained by provider.

- (A) A health care provider shall create, maintain, and retain sufficient records, papers, books, and documents in such form to fully substantiate the delivery, value, necessity, and appropriateness of goods and services provided to injured workers under the HPP or of significant business transactions. The provider shall retain such records for a minimum period of three years from the date of payment for said goods or services, or three years from the date of referral to a certified or non-certified provider, or until any initiated audit or investigation is completed, whichever is longer. The provider shall create and maintain the records at the time the goods or services are delivered or within seven days from the date the service was rendered.
- (B) The provider shall retain records documenting the following minimum information concerning the goods or services provided to injured workers:
- (1) Date the service was provided;
 - (2) Description of service, treatment or product provided;
 - (3) Record of patient appointments, if appropriate;
 - (4) Dates where injured worker canceled or failed to appear for a scheduled examination, treatment, or procedure;
 - (5) Treatment plans;
 - (6) Subjective and objective complaints, if the provider is the practitioner or physician of record;
 - (7) Injured worker's progress, if the provider is the practitioner or physician of record;
 - (8) Wholesale purchase records, if goods, products, or prescriptions are delivered;
 - (9) Delivery records, if goods, products, or prescriptions are delivered by way of a third party;
 - (10) The identity and qualifications of any individual involved in the delivery of health care or billing for services to injured workers on behalf of the provider

billing for the services.

- (C) A provider's failure to create, maintain, and retain such records shall be sufficient cause for the bureau to deny payment for goods or services, to declare overpaid previous payments made to the provider, or to decertify the provider.

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Certification

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