

# Provider's Billing and Reimbursement Manual

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## A. WORKERS' COMPENSATION SYSTEM

The Ohio workers' compensation system consists of two agencies: The Ohio Bureau of Workers' Compensation (BWC) and the Industrial Commission of Ohio (IC). Both are governed by the Ohio Revised Code. BWC processes claims and pays compensation benefits. BWC also administers safety programs to help prevent work-related accidents and provides rehabilitation services to assist injured workers in returning to gainful employment. The IC resolves disputes over the validity of claims, payment of compensation and medical benefits, and determines permanent total disability (PTD). The workers' compensation system includes both state-fund and self-insuring employers. BWC and the IC monitor self-insuring employers who process their own workers' compensation claims.

### 1. State-Fund Claims

BWC, in partnership with private sector managed care organizations (MCOs), implemented a managed-care program, the Health Partnership Program (HPP) for state-fund employers.

Ohio employers have the opportunity to change their MCO during open enrollment periods, conducted every two years. Providers may identify the MCO for a particular employer by visiting our website at <https://www.ohiobwc.com/provider/services/mcolookup/nlbwc/default.asp>.

**NOTE:** Health Partnership Program (HPP) does not affect fee bills for Marine Fund or Black Lung claims, family caregivers, and BWC/IC examinations. BWC retains responsibility for payment of these services. In addition, BWC's Pharmacy Benefits Manager (PBM), handles pharmacy bills for all state-fund claims. For additional PBM information, refer to Outpatient Medication, Chapter 3.

### 2. Self-Insuring Claims

The self-insuring employer is responsible for authorizing and determining medical necessity in self-insuring employers' claims. Except for emergency situations, the self-insuring employer must approve medical and vocational rehabilitation services in advance.

The provider of record (POR) is responsible for:

- Contacting the appropriate self-insuring employer for authorization guidelines.
- Sending fee bills and medical documentation to the self-insuring employer.
- Including the injured worker's social security number and the employer's name on every bill submitted.

If the provider bills BWC, the bills will be processed and denied with the following explanation of benefits (EOB) and message. **EOB 253: Self-insuring employers pay their own bills directly. Re-bill the self-insuring employer.**

BWC will not forward the bill to the self-insuring employer. It is the provider's responsibility to ensure that the appropriate party is billed. Self-insuring employers are required to respond to a medical bill within thirty (30) days of receipt, either by paying the bill, denying the bill for an appropriate reason, or requesting additional information to determine reimbursement eligibility for fee bills. Upon receipt of the requested medical documentation, the self-insuring employer has an additional thirty (30) days to pay or deny the bill.

Self-insuring employers may choose to form their own Qualified Health Plans (QHP) to deliver medical services to their employees, however, they are not required to do so. Should the self-insuring employer with a certified QHP deny a bill, a dispute resolution process resolves the medical dispute within thirty (30) days. If the self-insuring employer is not part of a QHP, the injured worker may file a C-86 motion with BWC to request a hearing before the Industrial Commission.

For questions about self-insuring employers' claims or to file a complaint against a self-insured employer, please call BWC's Self-Insured Department at 1-800-OHIOBWC.

**B. MCO/BWC SCOPE OF ADMINISTRATIVE SERVICES**

The following is a matrix of responsibilities for MCO-managed claims:

<b>SERVICE</b>	<b>MCO RESPONSIBILITIES</b>	<b>BWC RESPONSIBILITIES</b>
Provider Network	MCO credentials provider network panel based upon the geographic area the MCO wishes to compete within. MCOs will be allowed to limit the number of providers on their panels, but must do so based upon objective data without discrimination by provider type. Provider network must provide full range of medical services/supplies for injured workers and demonstrate the ability to provide access for specialized services.	All providers will be offered the opportunity to sign an agreement to meet the terms of BWC to be enrolled with HPP. BWC will certify all providers who are in compliance with the BWC requirements.
Inpatient utilization review (UR)	MCO performs inpatient UR for all claims for employers selecting an MCO.	BWC provides oversight and monitors performance measures and utilization trends.
Outpatient surgery and high- cost diagnostic utilization review	MCO performs outpatient UR for all claims managed by an MCO.	BWC provides oversight and monitors performance measures and utilization trends.
Physical medicine review includes chiropractic	MCO performs physical medicine review for all claims for employers selecting the MCO.	BWC provides oversight and monitors performance measures and utilization trends.
Peer review	MCO performs peer review process for network and non-network UR and treatment issues. MCO has peer review processes for discussing/educating/disciplining providers who are identified as outliers of normal treatment patterns based on profiling and utilization trends. MCO has credentialing committee and decertification processes for network providers.	Due process and conflict resolution processes must be established by BWC to deactivate and/or decertify providers from HPP. BWC maintains physician peer review processes for initial claim determinations.
Dispute resolution process (Medical issues)	MCO must complete timely dispute resolution process, regarding medical and treatment issues. The MCO must have a medical dispute resolution process that includes one independent level of professional review.	BWC issues final order with MCO's recommended decision.
Dispute resolution process (network issues)	MCO must complete timely dispute resolution processes with credentialing, disciplining and terminating providers from their network.	BWC must establish due process and conflict resolution processes to decertify MCOs and deactivate and/or decertify providers from HPP.
Quality assurance (QA)	MCO must maintain credentialing committee and quality assurance committee for network. MCO must maintain QA standards.	BWC maintains medical policy committee for workers' compensation general medical policies, as necessary.
Remain at Work Services for medical only claims (reference OAC 4123-6-19)	MCO is responsible for identifying injured workers and employers to participate in the remain at work program and developing a case management plan, as appropriate.	BWC monitors return to work data submitted by MCOs.
Return to Work (RTW)	MCO is responsible for documenting and implementing a case management plan addressing RTW plans on all lost-time claims where the IW has not returned to	BWC staffs claims with MCO and other parties as needed, making recommendations for case resolution when the IW has not returned to work .

	work regardless of date of injury (DOI). The MCO may send a RTW letter to the IW, the employer, and the physician estimating a realistic return to work date based on the Official Disability Guidelines (ODG).	
Provider profiling and bill data	MCO will capture all pertinent data on both in-network and out-of-network providers, and maintain provider profiles, claim records and other data. MCOs will be required to share aggregate and other data with both employers and BWC.	BWC will have complete access to all MCO claim data, paid bill information and provider profiling information. BWC gathers data and completes HPP program analysis and overall monitoring. BWC measures MCO performance based on established performance measures.
Confidentiality	MCO will maintain data and individual claim information confidentiality standards.	BWC will establish confidentiality standards for MCOs and ensure that standards are met. BWC maintains internal data and individual claim information confidentiality standards.
Payment methodology	MCOs may negotiate their own fee schedules with their network providers. The MCO will not directly benefit financially from reducing fees to providers. Except for hospitals, MCOs will pay non-panel providers the lesser of the BWC fee schedule or billed charges by the provider.	BWC will develop and maintain a statewide provider fee schedule with stakeholder input. BWC will pay the MCO for payment to the MCO network provider the lesser of the BWC fee schedule, MCO fee schedule or billed charges by the provider. Except for hospitals, BWC will pay the MCO for payment to non-network providers (BWC-certified providers) the lesser of the BWC fee schedule or billed charges by the provider.
Provider payments	The employer's MCO will pay all in- and out-of-network provider claims once BWC has paid the MCO. MCO must maintain standards for timely payment to providers.	Once the fee bill has been approved, BWC will pay the MCO. BWC must maintain standards for timely payment to MCOs.
Bill review	MCO performs bill review and clinical editing functions to ensure relatedness, appropriateness, compliance with UR and treatment guidelines. MCO is required to have a nationally recognized medical bill editing criteria package.	BWC is responsible for overall claims audit of the bills paid by the MCOs. BWC will not routinely audit individual claim fee bills, but, at its discretion, reserves the right to do so based on standard clinical editing criteria in effect on the billed date(s) of service.
Retrospective bill audit	MCO performs detailed retrospective bill audit, as necessary.  MCOs review all inpatient hospital payments of more than \$20,000.	BWC is responsible for overall claims audit of the bills paid by the MCOs. BWC will not routinely audit individual claim fee bills, but reserves the right to do so at its discretion.
Provider relations and education	MCO maintains network provider relations and education process, including information specific to workers' compensation issues. MCO educates providers on the MCO's operations and how to interact with the MCO.	BWC educates MCOs regarding workers' compensation issues, medical policies and HPP rules, etc. BWC and stakeholders educate non-network providers on general HPP information and requirements.
Treatment standards/guidelines	MCO maintains national standards for UR functions and maintains treatment guidelines. MCOs use Official Disability Guidelines (ODG) in making their treatment authorization decisions	BWC utilizes the Official Disability Guidelines (ODG) as its case management guideline resource and for the Alternative Dispute Resolution process.
Injury prevention	MCO will identify safety/injury concerns based on types and frequency of injuries and communicate with the employer. MCO will notify BWC's Division of Safety and Hygiene so it can inform the employer of available services.	BWC maintains safety and hygiene injury prevention programs and employer services functions.
Health-care provider fraud	MCO will cooperate with BWC and	BWC maintains identification, investigation

detection	employer efforts in provider investigations.	and process functions.
Early notification of injury	MCO is required to report injury by electronic notification processes to BWC. MCO is required to report injury to employer.	BWC maintains injury notification process and claim allowance process.
Case management	<p>MCO must interface and coordinate with the customer service teams. The MCO is responsible for implementing URAC Case Management Organization Standards for case management services and achieving full accreditation.</p> <p>The <b>case management plan</b> is action oriented, time bound, and identifies the intervention(s) and resources to be used in order to assist the injured worker to achieve the goals specified within each phase of the plan.</p>	<p>BWC is responsible for claim eligibility determinations. BWC maintains and performs functions for overall management of the claim.</p> <p>BWC shares responsibility for successful management of the claim and presents important communication linkages. These include: the Claim Service Specialist (CSS), Medical Service Specialists (MSS), Catastrophic Nurse Advocate (CNA), Medical Claim Specialist (MCS/Med only claims) and Disability Management Coordinator (DMC).</p> <p>Other sources, such as family members, specialty providers, community agencies, etc. should be included as they emerge and are identified in the case.</p>
Medical case management	Medical case management is an essential component in effecting a successful claim outcome. Because the MCOs share claim operations duties with BWC, it is essential that the roles, responsibilities and activities of the MCOs be clearly defined so that each will be able to interact effectively to reach optimal results.	BWC maintains workers' compensation general medical policies. BWC provides oversight and monitors performance measures.
Independent medical exams (IME) <ul style="list-style-type: none"> <li>Initial Allowances</li> <li>Extent of Disability including: <ul style="list-style-type: none"> <li>200 week;</li> <li>90 day;</li> <li>Other.</li> </ul> </li> </ul>	Medical management practices of MCOs should significantly reduce the need for IMEs overall. MCOs schedule alternative dispute resolution (ADR) IMEs and make appropriate referrals for specialist care and obtain second opinions as indicated.	BWC will perform IMEs, as necessary, and as required by statute and rules.
Permanent partial disability (PPD) (C-92) reviews and exams	In cooperation with BWC, the MCO educates treating physicians on necessary medical documentation for request for increase in PPD award.	BWC is responsible for physician education, physician network, scheduling exams, and quality assurance on IMEs and physician reviews for PPD awards.
Sub-acute/long term facility/alternative care management (traumatic brain injury care, etc.)	MCO performs authorization, coordination of care at appropriate level of setting, and provides ongoing monitoring and quality assurance for long-term care needs and service level.	BWC provides oversight and monitors performance measures.
Home and vehicle modifications authorizations	MCO case manager will work closely with the BWC Catastrophic Nurse Advocate to ensure coordination of the services. The MCO is responsible for authorizing temporary home ramps and vehicle scooter lifts, but no other home or vehicle modifications.	BWC Catastrophic Nurse Advocate (CNA) identifies need for home/vehicle modification as a result of a catastrophic injury. CNA works with MCO case manager and necessary vendors to insure coordination of the services.
Caregiver services authorization	MCO performs authorization of professional nursing services (home	BWC performs continued authorization for caregiver (spouse, etc.) services and ongoing

	health agency) and ongoing monitoring.	monitoring of services for providers authorized prior to 04/01/93 (01/09/95 for spouse caregivers). No new caregiver services are authorized on any claim after 01/09/95.
Out-of-state/out-of-country medical management and provider management	MCO performs medical management, provider payment and provider management services for all claims for employers selecting MCO.	BWC provides oversight functions and monitors performance measures.
Vocational management	MCO provides BWC with initial notification of injured worker eligibility for vocational rehabilitation and determines feasibility for services. MCO manages rehabilitation cases in accordance with Ohio Administrative Code rules and BWC guidelines. MCO educates providers and employers about RTW expectations.	BWC verifies MCO's initial eligibility notification and also may provide rehabilitation referrals. BWC consults with MCO on rehabilitation issues and makes recommendations if injured worker has not RTW thirty (30) days after the optimal RTW date. BWC determines and pays compensation such as Living Maintenance (LM) and LM Wage Loss.
Performance measures	MCO must meet defined data and reporting requirements.	BWC establishes, with stakeholder input, measurement, analysis, evaluation and reporting functions on the performance of MCOs and HPP.
MCO contract management		BWC is responsible for measuring, monitoring and ensuring contract compliance, standards compliance and reporting on outcomes and savings.
Regulatory reporting	MCO must meet defined data and reporting requirements.	BWC performs this function.
Communications about HPP program	In cooperation with BWC, the MCO educates injured workers/employers/providers MCO's operations on how to interact with the MCO. MCO prepares provider directory/related information, and maintains 1-800-inquiry line for IW and employers regarding their network and services.	In cooperation with the MCOs, BWC provides high level informational support via its media programs, print communications and seminars, and through its provider contact center at 1800OHIOBWC, option 0,3,0

### C. ELIGIBLE PROVIDERS

All providers who meet minimum credentialing criteria and sign a provider agreement, indicating agreement to abide by all HPP and medical rules, will be allowed to participate in HPP. There are three (3) categories of HPP providers:

1. **BWC-Certified Provider** - A credentialed provider who is approved by BWC for participation in HPP and signs a provider agreement with BWC. Providers seeking to enroll and become BWC certified, initially, must complete the *Application for Provider Enrollment and Certification* (MEDCO-13), or complete the recertification application made available by BWC to maintain continued BWC certification. The provider agreement is part of the application.
2. **Non-BWC Certified Provider** – A provider who:
  - Is eligible and meets minimum enrollment requirements per Rule 4123-6-02.21 but is not approved for certification in the HPP;
  - Is not eligible for BWC certification; or
  - Lapses BWC certification because they did not respond to their invitation to recertify.

Provider types ineligible for certification are listed on the Application for Enrollment – Non-Certification form (MEDCO-13A). For claims with dates of injury prior to Oct. 20, 1993, the injured worker may continue to be treated by the physician of record (POR) even if the POR is a non-BWC certified provider, if they have

maintained a physician-patient relationship since that date. However, if, for any reason, the injured worker decides to change physicians, a BWC certified-provider must be selected.

Providers may check on their certification status by:

- Contacting their MCO(s);
- Calling 1-800-OHIOBWC, option 0,3,0;
- Visiting BWC Online at [www.ohiobwc.com](http://www.ohiobwc.com) and accessing the Medical Provider section. All BWC-certified providers are listed on the BWC provider look up section.

Neither the application for certification, nor the provider agreement located within the application may be altered or modified. These actions will delay certification.

#### **D. PROVIDER ENROLLMENT AND CERTIFICATION**

BWC uses two provider applications for enrollment into BWC's database. BWC has made changes in provider types eligible for certification. A separate application for provider types eligible (MEDCO-13) and ineligible for BWC certification (enrolled only providers, MEDCO-13A) are available at <https://www.ohiobwc.com/bwccommon/forms/BWCForms/nlbwc/ProviderForms.asp>. Please review the provider types noted on each application and complete the appropriate one.

**A provider must meet minimum enrollment requirements (licensure, accreditation, etc) to be eligible to enroll in BWC's provider database. The requirements for certification are noted in OAC 4123-6-02.2 and the provider application (MEDCO-13).**

BWC will verify a provider's credentials and determine whether minimum enrollment and credentialing criteria have been met, and review the application type for a signed provider agreement. BWC will send a verification letter of BWC enrollment and/or certification approval status to the provider, based on the provider type.

**IMPORTANT:** To change provider enrollment data, please complete the *Request to Change Provider Information Form* (MEDCO-12) or submit the changes, in writing and on letterhead, to:

Ohio Bureau of Workers' Compensation  
Provider Enrollment Unit  
P.O. Box 15249  
Columbus, Ohio 43215-5249  
Fax: 614.621.1333

BWC certified providers agree to notify BWC within thirty (30) days of changes in 1) demographic info; 2) provider/NPI numbers; 3) tax ID or ownership info or change in provider status regarding credentialing criteria of paragraphs (B) and (C) of OAC 4123-6-02.2. When requesting a change to provider enrollment data in writing, please provide the following information:

- Provider name and number;
- Phone number;
- Signature of individual who is assigned the specific provider number;
- If address change, please specify:
- Physical location (P.O. Box is not accepted as a practice location. An actual street address is needed for each location of your practice);
- Pay-to address; and
- Correspondence address.

Changes to tax identification numbers and group affiliations must also be requested in writing. Please specify when the date changes should become effective. See MEDCO-12 form located at <https://www.ohiobwc.com/bwccommon/forms/BWCForms/nlbwc/ProviderForms.asp> to determine if the MEDCO-12 or a new application is appropriate to submit for tax identification changes. A W9 form is required to be submitted also. Provider status regarding credentialing criteria should contain the above bulleted information and status update details.

1. **Providers enrolled as BWC provider type 12 - Provider Group Practice:** This provider type is only eligible to enroll as a provider who receives payment and may not enroll as a servicing provider. BWC will require any group enrolling to name a certified provider associated with that group (TIN) number, and submit a W9 for IRS purposes to be enrolled only. (This provider type is not designed for enrollment of private service coordinators operating private provider networks.) BWC does not require individual providers to be “linked” to group numbers systematically for payment purposes, but requests providers update BWC with accurate demographic information that shows each location where the provider is working.

- a) **Provider recertification**

BWC’s provider recertification initiative is based on the providers’ original certification dates. Periodically, BWC releases recertification applications which include a summary of the information presently on file for the provider.

If a provider does not submit a completed application within ninety (90) days their certification will lapse. Once the provider's certification lapses, bills may not be paid for dates of service post lapse. The provider may apply for recertification post lapse by submitting a completed application. Once a lapsed provider completes the process they may become recertified and the recertification will be retroactively applied, there will be no gap in certification status between initial certification and recertification. During the recertification process, a provider will be in one of several in-process statuses until he or she reaches recertified, denied or lapsed status. The following explanation of benefit (EOB) codes were developed to address non-payment due to non-recertification:

**447 Payment is denied as provider is not eligible for recertification.**

All certified providers must be recertified periodically. A provider who no longer meets the requirements for certification will be put in Denied Recertification status. There will be an effective date associated with that status and bills with date of service prior to the effective date will pay. Dates of service after the effective date will deny unless approved by an MCO with override EOB or 756.

**448 Payment is denied as provider’s certification has lapsed.**

A provider who fails to respond within ninety (90) days or who requests removal from HPP will be put in Lapsed Status. There will be an effective date associated with that status and bills with date of service prior to the effective date will pay. Dates of service after the effective date will deny unless approved by an MCO with override EOB or 756.

2. **National Provider Identifier**

BWC prefers providers use their National Provider Identifier (NPI) when possible for submitting bills.

NPIs serve as an alternate identifier providers can use in Ohio workers’ compensation billing.

The federal Health Insurance Portability and Accountability Act (HIPAA) protects the privacy of patients’ medical records and other health information maintained by covered entities. BWC is not a covered entity under HIPAA. Therefore, the bureau will continue to accept bills containing only BWC legacy (or current) numbers, as well as bills with both the legacy number and the NPI.

The bureau has made changes to add NPI information to its database to cross-reference BWC provider numbers. This will permit BWC to continue processing bills in a way that is accurate and consistent with laws, rules and policies governing payment of workers’ compensation medical benefits.

Providers wishing to incorporate NPI into their workers’ compensation billing must provide and verify their information with BWC’s provider relations department. Providers should submit copies of their NPI confirmation from the enumerator (Fox Systems Inc.) along with their corresponding BWC provider number to the fax number or address below.

**Fax to:**  
BWC Provider Enrollment  
(614) 621-1333

**Mail to:**  
Ohio BWC Provider Enrollment  
P.O. Box 12549  
Columbus, OH 43215-2549.

Once this process is complete, a provider may bill using either his or her BWC provider number or a combination of both the BWC provider number and NPI (and taxonomy code if applicable). Again, BWC does not require providers to use NPIs for billing. [Click here](#) for further information on NPI registration.

Any provider still needing to obtain an NPI may do so at <https://nppes.cms.hhs.gov/>

Please be aware that at this time BWC can only accommodate NPIs on forms for the billing processes noted above. BWC has instructed MCOs to identify medical providers using NPIs on forms other than bills, attempt to cross-reference their information, and then inform the provider to use its BWC provider number until the bureau can accommodate NPI in other processes.

You may direct questions about submitting NPI information by calling 1-800-OHIOBWC, option 0,3,0 weekdays between 8 a.m. and 5:00 p.m.

## **E. REPORTING AN INJURY (BWC Rules 4123-6-02.8)**

### **1. Provider responsibilities**

Prior to HPP, injured workers, providers, and employers filed claims by filing the first Report of Injury (FROI) application. Under HPP it is just as simple. You may call the employee's MCO to report an injury or complete and file the FROI online at [www.ohiohwc.com](http://www.ohiohwc.com). File the FROI electronically and you will receive a claim number immediately.

Timely reporting of an injury is one of the most important responsibilities a provider has in the HPP. By rule, providers must report the injured worker's injury to the responsible MCO within twenty-four (24) hours or one (1) business day of the initial treatment or initial visit. Furthermore, all BWC-certified providers have signed a contract obligating them to adhere to all Ohio workers' compensation laws and rules. Since twenty-four (24) hour reporting is a legal and contractual requirement, non-compliance could result in actions such as loss of BWC certification, removal from an MCO's panel, or both.

Reporting an injury to the MCO within twenty-four (24) hours has a number of advantages, including expediting the processing of the claim. Generally, the sooner a claim is reported, the sooner it can be allowed. However, if a claim is not allowed by BWC for any reason, no payments are issued for either injured worker compensation or payment of medical bills. Additionally, a delay in the payment of medical bills can result if they are received by an MCO prior to the claim being reported.

Timely reporting assists providers with receiving billing and reimbursement instructions from the MCO and minimizes the possibility that claim authorizations (e.g., for compensation awards, medical benefits, treatment authorizations, etc.) will be delayed. To facilitate claim authorizations, it is important to provide MCOs with accurate information, including the exact ICD code(s) for which the injured worker is being treated and an opinion of causal relationship between the reported diagnosis code(s) and the industrial accident.

Often, when injured workers first visit a provider or a facility for treatment, they are uncertain of their MCO, which complicates reporting the injury. However, injured workers usually know the name of their employers. Each state-fund employer either chose or was assigned an MCO, so this information is either available from the employer or BWC. If the employer is unable to provide the name of their MCO, this information is available on the BWC website at <https://www.ohiohwc.com/provider/services/mcolookup/nlbwc/default.asp>. If you are unable to access the Internet, contact BWC at 1-800-OHIOBWC (644-6292).

## 2. Data elements

Data elements that providers should give to an MCO when reporting an injury include:

- a. Injured worker information:**
- Name \*
  - Address \*
  - Telephone number \*
  - Date of birth \*
  - Gender \*
  - Marital status \*
  - Social Security Number \*
  - Occupation \*
- b. Injury information:**
- Type of accident (accident, occupational disease, death) \*
  - Date of injury (date of death, if applicable) \*
  - Will injury likely result in more than seven (7) days off work? (yes or no) \*
  - Accident description (detailed account of how accident happened) \*
  - Date of initial treatment
  - Date last worked and returned to work (estimate return to work if date is unknown)
  - ICD diagnosis codes (specific diagnosis description, including primary ICD Code)
  - ICD Code location (right, left, bilateral)
  - ICD Code site (digits or teeth)
  - Injury description (body part injured, e.g., first joint of left index finger) \*
  - Is diagnosis causally related to the industrial accident? (yes or no) \*
- c. Employer information:**
- Employer name \*
  - Employer address \*
  - Employer telephone \*
- d. Provider information:**
- Initial treating provider name and BWC provider number (may be a hospital or a physician) \*
  - Physician of record name and BWC provider number \*

- \* Indicates data elements required for MCOs to meet the requirement of:
- Submitting seventy percent (70 %) of the initial FROIs to BWC within three (3) business days, and
  - Sending one hundred percent (100%) of the initial FROIs to BWC within five (5) business days.

The remaining data elements, if not available at the time of the first report, must be provided to the MCO no later than five (5) calendar days from the initial treatment.

**Important:** If the BWC provider number is submitted to the MCO, BWC will send the provider who reported the injury or the provider of record (POR) a letter that tells the status of the claim and the allowed conditions.

## F. ERRONEOUS MCO DENIALS

The MCO, or the self-insuring employer in self-insuring employers' claims, is responsible for authorizing and determining medical necessity for all claims. The provider of record or treating physician is responsible for contacting the appropriate MCO or self-insuring employer for authorization of services.

### 1. MCO Penalty Payment to Providers

The MCO shall pay a penalty of \$10.00 to the provider for every instance in which the MCO denies a provider's bill due to lack of prior authorization and prior authorization either had been granted or was not required per standardized prior authorization and/or presumptive authorization guidelines .

Penalty payments shall be paid from funds appropriated by the MCO and not from its provider bank account. The MCO shall issue payment to the provider within fourteen (14) calendar days upon discovery or notification of the inappropriate prior authorization denial.

The following Q&A identifies some potential penalty payment situations:

Q: A provider submitted the same bill three (3) times and all three (3) bills were erroneously denied for lack of authorization. Is the MCO responsible for one \$10 payment or three \$10 payments (one for each denied bill)?

A: The MCO is required to pay "for every instance of erroneous denial," therefore; the MCO should pay three \$10 penalty payments or \$30 total.

Q: Is the provider entitled to the \$10 penalty payment if a bill was denied in error but then the provider resubmitted the bill and the MCO paid the bill?

A: Yes, the MCO is required to pay the \$10 penalty even if the bill was subsequently paid. This payment was meant to offset the provider's administrative burden when they are required to follow up with the MCO or resubmit a bill.

Q: Does the \$10 penalty apply when the Industrial Commission orders payment of treatment and the MCO denies the bill for lack of prior authorization?

A: Yes, the MCO is responsible for reviewing hearing orders and paying bills as ordered by the Industrial Commission.

Q: Is it appropriate to deny an office visit or consultation for lack of authorization?

A: Office visits and consultations (except for chronic pain programs and psychological treatment) do not require authorization and therefore should not be denied for lack of authorization. The MCO should utilize a more appropriate explanation of benefit (EOB) to accurately describe the reason for denial. The MCO will be required to pay the \$10 penalty payment for any office visit or consultation denied for lack of prior authorization.

Q: The MCO authorized a surgical procedure and then denied a line item related to that surgical procedure for lack of prior authorization? Is the MCO required to pay the \$10 penalty?

A: Yes, MCOs authorize specific procedures or treatment plans, not specific procedure codes. No procedure code related to the authorized treatment should be denied for lack of prior authorization; however, it may be appropriate to deny the line item with another EOB which accurately describes the reason for denial.

## **G. TREATMENT GUIDELINES**

Treatment guidelines are based on treatment types and provide uniformity to the system. The parameters work for the majority of injured workers, but there may be exceptions. For those exceptions, the MCO and physician must work together to find the most appropriate course of treatment for the injured worker.

### **1. Official Disability Guidelines**

In reviewing medical treatment requests under OAC 4123-6-16.2 and conducting independent reviews of medical disputes under OAC 4123-6-16, the MCO and the bureau shall refer to treatment guidelines adopted by the bureau. The treatment guidelines adopted by BWC are the Official Disability Guidelines (ODG). Ohio providers can take advantage of the BWC negotiated price if they order on the web [www.WorkLossData.com](http://www.WorkLossData.com) or call (800) 488-5548.

## **H. REIMBURSEMENT GUIDELINES**

The information in this section pertains to general reimbursement guidelines for all provider types. Provider type-specific information can be found in Chapter 3 of this manual.

### **1. Medical Coding Guidelines**

#### **a) Diagnostic Coding Guidelines**

- All medical providers must report the ICD diagnosis code(s) representing the condition(s) being treated during the encounter. Accurate diagnosis reporting is important as coding may impact provider reimbursement and data integrity.
- Providers shall utilize national correct coding guidelines when reporting diagnoses, using the appropriate code from the ICD code set effective for the date of service. BWC accepts valid “V” codes as a principal diagnosis on all bills. BWC does not accept “E” codes as a principal diagnosis. E and V codes are accepted as the secondary diagnosis on all bills.
- Non-allowed diagnosis codes are listed under services- “Invalid ICD Code List” on [www.ohiobwc.com](http://www.ohiobwc.com) and are non-allowed diagnosis codes but may be reported by providers on medical bills for billing purposes, if appropriate. For example, an MRI with no findings must be coded to the symptom giving rise to the request for the MRI.
- Any ICD diagnosis code from the ICD code set effective for the date of service may be payable within the first seventy-two (72) hours of an injury if the injured worker’s claim is in allowed status.
- It is the MCO’s responsibility to review the medical documentation to determine if the diagnoses were accurately reported.

**b) Procedure and Service Coding Guidelines**

- Providers shall report the correct procedure or service codes based on treatment and/or services actually provided and shall utilize codes in effect for the date of treatment or service.
- Providers shall utilize correct coding guidelines for treatment or service based on provider type and shall follow billing and reimbursement guidelines established by BWC and the MCO medically managing the claim.
- Providers must bill their usual charges for treatment and/or services reported.
- Chapter 3 further clarifies provider type specific details.

**2. HPP Billing**

**a) Forms**

To ensure consistent billing processes and maintain quality customer service, all BWC-certified MCO’s are required to accept the following national and BWC billing forms:

- American Dental Association (ADA) Dental Form
- CMS-1500
- UB-04
- Service Invoice (BWC billing form C-19)

See Chapter 4 of this manual for detailed billing instructions for each bill form.

**b) Submission**

All bills shall be submitted to the MCO assigned to the claim. The preferred method of submitting bills to the proper MCO is an Electronic Transmission in the ASC X12 837 format. Documentation for the current 837 standard can be requested through a link at: <http://www.ohiobwc.com/provider/services/837Links.asp>. Bills may also be submitted by mail to the appropriate MCO or self-insured employer.

- In the event of an MCO transition (i.e., merger/acquisition, open enrollment, auto-assignment due to contract termination) all bills should be sent to the newly assigned MCO as of the effective date of the transition.
- It is the provider’s responsibility to ensure that the appropriate party is billed. BWC does not forward misdirected bills from providers to MCOs.

- Bills may be submitted to the MCOs prior to the allowance of injured worker claims. However, payment will not be made until the claim is allowed.
- Bills shall be submitted for payment within one (1) year of the date on which the service was rendered or one (1) year after the date the services became payable, whichever is later, or shall be forever barred. See <http://codes.ohio.gov/oac/4123-3-23> for details.

### 3. **Reimbursement Review & Payment**

#### a) **MCO Responsibilities**

It is the MCO's responsibility to ensure services and supplies are medically necessary and related to the allowed claim conditions before approving reimbursement.

Each MCO is responsible for adjudicating all bills for claims currently assigned to that MCO. However, in the event of an MCO transition, if the former MCO receives a bill after the transition date and has sufficient information to process the bill, then it shall be processed by the former MCO. It is the assigned MCO's responsibility to contact the former MCO in cases where there is not sufficient information to process a bill.

#### b) **MCO Reimbursement Review**

- The MCO is responsible for reviewing the medical documentation to determine if the diagnoses were accurately reported.
  - If the MCO determines that the billed diagnosis code was not accurately reported, EOB 323, *payment is denied as the diagnosis billed does not match the diagnosis code listed in the accompanying reports*, may be applied, which will result in the denial of the bill. It is the provider's responsibility to correct the coding on the bill and resubmit for payment consideration.
  - If the MCO determines the diagnosis was accurately reported, not allowed in the claim, but related to the injured worker's work-related injuries, EOB 776, *payment is being made for a non-allowed, but related condition*, may be applied to the bill to allow for reimbursement.
  - Any ICD diagnosis code from the ICD code set effective for the date of service may be payable within the first seventy-two (72) hours of an injury if the injured worker's claim is in allowed status.
- The MCO is responsible for payment of medical services provided in the treatment of work-related allowed compensable conditions and shall review all bills submitted in accordance with OAC 4123-6-04.4 and OAC 4123-6-25.

#### c) **Payment of Bill**

- Within seven (7) days of receiving a bill (or within seven (7) days of the claim's allowance), the MCO will submit the bill electronically to BWC unless:
  - the bill cannot be processed due to missing or invalid data elements; or
  - the bill has been previously paid or is currently in process (i.e. duplicate bill).
- If the bill cannot be processed, the MCO will return the bill to the provider noting the reason for rejection.
- Within seven (7) days of receiving the bill from the MCO, BWC will approve payment and electronically transfer funds to the MCO.
- Within seven (7) days of receiving payment from BWC, the MCO will send the payment and remittance advice to the provider.

#### 4. Miscellaneous Billing Provisions

- Payment does not include reimbursement for any sales tax for services and/or items provided to injured workers as BWC is exempt from sales tax payment as a State of Ohio government agency.
- Only medical services provided will be reimbursed. Unbundling or fragmenting charges, duplicating or over-itemizing coding, or engaging in any other practice for the sole purpose of inflating bills or reimbursement is strictly prohibited. Knowingly and willingly misrepresenting services provided to Ohio injured workers is strictly prohibited.
- Reimbursement will not be made for missed appointments.
- Injured workers are not required to contribute a co-payment or meet any deductibles. BWC certified providers are required to bill the appropriate MCO for reimbursable covered services and shall not, in accordance with their provider agreement, request payment from the injured worker.
- Balance billing. Health-care providers must accept the reimbursement from an MCO, BWC, or the self-insuring employer as payment in full. Neither the injured worker nor the employer may be billed for any difference between the provider's charge and the amount allowed by the MCO, BWC or the self-insuring employer. See R.C. 4121.44(O).

When a provider renders services for conditions that are not covered by workers' compensation, the provider must notify the injured worker that the services are not covered by the MCO, BWC or the self-insuring employer and that the injured worker is responsible for payment. The injured worker must agree and understand that the services are not payable by workers' compensation and the provider may not balance bill an injured worker for the difference between what the BWC or MCO would have paid for a covered service and the billed amount for the non-covered service.

- BWC Non-Certified Provider Services. Unauthorized services provided by a BWC non-certified provider, except as indicated in OAC 4123-6-10, are the sole obligation of the injured worker.

#### 5. Additional Considerations

##### a) **Third Party Payers**

When an injured worker is eligible for public or private insurance and workers' compensation benefits, the MCO, BWC or the self-insuring employer is the primary payer. Providers should bill to workers' compensation benefits for services related to compensable conditions before attempting to collect from another payer.

##### b) **Settled Claims**

- A claim may be settled for medical and/or indemnity benefits.
- BWC will send a letter to the physician of record, and the vocational rehabilitation case manager as applicable, when settlement is requested. Once the parties agree to the settlement, the claim is placed in a "Settled Pending" status followed by a thirty (30) day hold/pend period.
- During the thirty (30) day hold/pend period:
  - All benefits shall suspend. That means bills cannot be paid and adjustments cannot be processed in the BWC billing system. Instead, adjustments for payable bills for dates of service prior to the "Effective Settlement Date" will be processed after the claim is placed in the "Final Settled" status. The "Effective Settlement Date" is the date that BWC mails the approval letter noting that the parties agreed to settlement.
  - Bills for dates of service after the Effective Settlement Date are the responsibility of the injured worker. Providers may not require payment up front from injured workers whose claim is not in Final Settled status.
    - C9s for dates of service on or after the Effective Settlement Date shall be dismissed.
    - C9s for dates of service prior to the Effective Settlement Date that are submitted to the MCO within one (1) year from the date of service shall be processed per MCO contract requirement.
    - Appeals to MCO decisions on C9s for dates of service prior to the Effective Settlement Date are subject to the Alternative Dispute Resolution (ADR) process.

- BWC and the MCOs will ensure resolution of all timely submitted bills for services rendered prior to the Effective Settlement Date. Contact the BWC claims service specialist if a timely submitted bill for services prior to the Effective Settlement Date has not been paid.

#### **6. MCO Grievance Conference/Appeals**

- This section includes the MCO grievance hearing/conference process required by OAC 4123-6-04.4 and sets forth the grievance conference/appeals process for:
  - Medical billing disputes; and
  - MCO overpayment recovery appeals.
- Alternative Dispute Resolution (ADR) appeals are covered in Chapter 1, Section L. ADR appeals relate to medical disputes regarding quality assurance, utilization review, medical necessity and other treatment issues.
  - MCO overpayment recovery actions based on an MCO determination that the service(s) is not medically necessary that are appealed by the provider shall be processed under the ADR appeal process.
  - Medical billing disputes where the reason for the bill payment dispute is because the service is not medically necessary shall be processed under the ADR appeal process.

#### **Medical Billing Disputes**

##### **a) General Considerations**

- A medical billing dispute exists when a provider is not satisfied with the amount of payment and explanation of benefits (EOB) received from an MCO.
- A medical billing dispute does not include a dispute of BWC's fee schedule rates.
- Medical billing disputes relating to the medical necessity of treatment are handled through the ADR process. *See* Chapter 1, Section L.

##### **b) Process for Handling Billing Disputes**

1. The provider contacts the MCO to inquire about the reimbursed amount or denial of a medical bill via email, fax, phone, or mail.
  - It may be necessary to submit the inquiry along with supporting documentation, in writing, to the MCO.
  - The provider and the MCO should keep detailed notes for his/her records, including the name and phone number of the person to whom he/she spoke, fax confirmations, etc.
  - It may be necessary for the provider to request to speak to an MCO supervisor to resolve the issue or to escalate the issue to a grievance conference. Most provider billing inquiries can be handled by the MCO on the phone.
2. The MCO shall acknowledge the inquiry (email, fax, phone, mail) within four (4) calendar days of receipt, and shall resolve or initiate resolution of the inquiry within seven (7) calendar days of receipt per the MCO contract.
3. If the issue is not resolved with the MCO, the provider shall be instructed on how to initiate a medical bill grievance conference with the MCO.
  - The conference may occur in person or via telephone, and shall occur within seven (7) calendar days from the request for the conference.
  - The MCO shall document details of all grievance conferences and the outcome.
4. The MCO shall issue a written decision within seven (7) calendar days from the date of the conference. The MCO written decision shall be imaged into the injured worker's claim file by the MCO.

- Required elements of the written decision include:
    - Identification of specific documentation reviewed at the conference;
    - Date, time, place and persons (MCO and provider) who participated in the conference and the conference method used (phone, face to face, email); and
    - Methods of provider appeal of the decision.
5. If the provider does not agree with the MCO decision, the provider may contact BWC's Provider Contact Center at 1-800-OHIOBWC, option 0-3-0 or via email to: [feedback.medical@bwc.state.oh.us](mailto:feedback.medical@bwc.state.oh.us) to ask for BWC's assistance in resolving the billing dispute.
  6. The BWC Provider Contact Center will ask the provider to document the complaint and will research and track the complaint. The BWC Provider Contact Center may consult with other BWC departments including but not limited to, Medical Policy, Vocational Rehabilitation Policy, Medical Director and/or Legal for input in making a determination.
    - The Provider Contact Center will refer the provider back to the MCO if the MCO did not conduct a medical bill grievance conference or if the MCO did not image the documentation into the injured worker's claim.
  7. If an MCO grievance conference has been conducted and the documentation is imaged in the claim file, BWC's Provider Contact Center shall coordinate a written response to the provider and the MCO and image the response into the injured worker's claim file. After BWC's determination is rendered, no additional levels of review will be considered.
  8. If at any point during the inquiry/dispute process, the MCO or BWC determines that a payment correction is needed, the MCO shall correct or submit an adjustment to BWC within fourteen (14) calendar days of determination. If BWC has reviewed and made a determination to instruct the MCO to pay the provider, the MCO will notify the Provider Contact Center when payment is released.

### **Overpayment Recovery and Appeal Process**

#### **a) General Considerations**

- The recovery of payment made to a provider shall be initiated where payment was made in conflict of law, rule, BWC provider agreement or policy.
- The provider must be notified of the overpayment within five (5) years of the BWC bill system process date except in cases of fraud. If the provider is not timely notified, no recovery shall be ordered.
- All paper correspondence shall be mailed to the provider's correspondence address.
- Overpayments to providers resulting from the disallowance of a previously allowed claim or condition shall not be recovered from the provider.
- 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.
- 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 and shall be responsible for payment of all service rendered prior to and on the day of the notification.
- 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.
- The MCO may recover a provider overpayment from the provider's future payments when the provider agrees or fails to respond to the MCO. 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 via certified mail that recovery will offset future payments due to overpayment and must provide the set-off amount and reference all prior MCO recovery efforts in the case. A list of all the provider locations from which the recovered amount will be deducted shall be specified in the notice. The MCO must identify the amounts recovered on the provider remit when the overpayment is recovered from future payments.

- If a party to the claim files an appeal for services through the ADR process (see section L) or with the Industrial Commission (IC) regarding treatment already 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 Industrial Commission (IC) Staff Hearing Officer (SHO) level are exhausted.
  3. If the final decision from the ADR process or the IC 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) 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.
- MCOs shall initiate recovery of overpayments only after all appeal periods have been exhausted.

**b) Process - Discovery of an Overpayment/MCO Notification to Provider**

• **MCO Actions**

1. Within fourteen (14) calendar days of discovery and verification of provider overpayment, the MCO shall send written notice by certified mail to the provider informing the provider of the overpayment and the requirement for provider repayment. The notice shall contain rationale for the repayment, including identification of the specific documents supporting the rationale. The notice must include instructions regarding the provider grievance conference process, the forty-five (45) calendar day time period for provider objections, and instructions regarding when an overpayment will be referred to MB&A for collection.
2. 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 and shall document in the claim file, its attempts to contact the provider.
3. 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](mailto:MedicalBillPaymentRecovery@bwc.state.oh.us) when any of the following occur:
  - a) The provider has ceased operations;
  - b) The MCO is unsuccessful in contacting the provider following receipt of the returned certified notice; or
  - c) The MCO receives no response to the certified letter.
4. When referring to MB&A Recovery under the circumstances indicated above, the MCO shall submit supporting documentation including the following:
  - Copy of original overpayment recovery request;
  - Copy of certified mail receipt or verification of delivery;
  - Documentation of all recovery efforts.
5. MB&A will review the documentation and determine actions to be taken regarding recovery.

**c) Provider agrees with MCO Overpayment Determination**

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.

2. If payment of the requested recovery amount is not received within forty-five (45) calendar days of the date of initial agreement, the MCO shall refer the overpayment recovery to MB&A via e-mail to: [MedicalBillPaymentRecovery@bwc.state.oh.us](mailto:MedicalBillPaymentRecovery@bwc.state.oh.us) for collection of the overpayment.
3. MB&A Recovery will send the provider a demand for recovery. The demand letter shall provide notification that the provider has forty-five (45) calendar days from the date of the demand letter to either reimburse BWC for the overpayment or dispute the overpayment determination. The letter will also include details supporting the overpayment determination, instructions for submitting payment to BWC, consequence for non-payment, and provider appeal remedies.

d) **Provider disputes MCO Overpayment Determination**

1. If the provider does not agree with the MCO overpayment determination, the provider may dispute the decision by filing a written appeal with the MCO within forty-five (45) calendar days from the date of receipt of the MCO notification of overpayment.
2. If timely appealed, the MCO shall schedule a **grievance conference** within fourteen (14) calendar days of receipt of the provider's appeal. The MCO shall notify the provider of the date, time and location of the conference, the issue and statement of facts. The conference shall be limited to the stated issue in the letter.
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:
  - The date, time, place and participants in the conference;
  - The MCO's rationale for the decision;
  - Address for submitting reimbursement to the MCO;
  - 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 by sending their dispute in writing to:
    - Email box: [medicalbillpaymentrecovery@bwc.state.oh.us](mailto:medicalbillpaymentrecovery@bwc.state.oh.us);
    - Fax: (614) 621-5294; or
    - Mail: MB&A Recovery, 30 West Spring St. L20, Columbus, OH 43215
4. If the provider does not appeal the grievance conference decision within forty-five (45) calendar days, the MCO shall notify MB&A Recovery.
5. 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 Recovery 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 shall be notified of the opportunity to appeal the decision to the Administrator's designee within forty-five (45) calendar days of the date of the notification of the decision.
6. If the provider timely appeals the decision, the Administrator's designee shall 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 the provider via certified mail with copies sent electronically to the MCO.
7. If the final decision is that an overpayment exists and the provider does not submit repayment, MB&A shall refer the overpayment decision to the Attorney General's office for collection.

7. **Special Investigations Department Determination of Overpayment**

a) Within fourteen (14) calendar days of notice from the Special Investigations Department of a provider overpayment, MB&A Recovery Manager shall notify the provider by certified mail of the overpayment and the requirement for provider repayment. The notice shall contain rationale for the repayment, including identification of the specific documents supporting the rationale. The notice shall include instructions regarding the provider appeal process.

b) The provider may appeal the overpayment notice within forty-five (45) calendar days of the date of the overpayment notification to the provider. Notice of appeal shall be in writing and shall be submitted to:

- \* Email box: [medicalbillpaymentrecovery@bwc.state.oh.us](mailto:medicalbillpaymentrecovery@bwc.state.oh.us);
- \* Fax: (614) 621-5294; or
- \* Mail: MB&A Recovery, 30 West Spring St. L20, Columbus, OH 43215

c) If the provider timely appeals, the Administrator's designee shall determine whether recovery is appropriate and issue a final written decision to the provider within forty-five (45) calendar days of receipt of the appeal. Notification shall be sent to the provider via certified mail with copies sent electronically to the Special Investigation Division.

d) If the final decision is that an overpayment exists and the provider does not submit repayment, MB&A shall refer the overpayment decision to the Attorney General's office for collection.

e) BWC may, in its discretion, refer provider overpayments identified by the Special Investigations Department directly to the Attorney General's office for collection without following the process set forth above.

#### **8. Retrospective Bill Review of Inpatient Hospital Bills**

MCOs will perform retrospective reviews on all inpatient hospital bills which were:

- 1) paid the previous month;
- 2) paid to hospitals with physical locations in Ohio or in states contiguous to Ohio (Indiana, Kentucky, Michigan, Pennsylvania or West Virginia); or
- 3) were not paid at a DRG rate. (Note: Bills paid at the DRG rate contain EOB 302).

High level bill audits will be conducted for inpatient bills with paid amounts between \$20,000 and \$50,000, using core medical documentation and itemized charges. For high level bill audits, the MCO shall ensure the following documents are imaged or shall request the missing documents from the hospital and ensure they are imaged upon receipt:

- Admission history & physical;
- Emergency department report if patient was admitted through E.R.;
- Operative report if bill contains O.R. charges & patient had surgery;
- Discharge summary if admission was  $\geq$  48 hours in duration;
- Discharge note if admission was  $<$  48 hours in duration

In addition, the MCO shall request the itemized charges for the admission. Itemized charges are not to be routinely forwarded to BWC for imaging

Detailed bill audits will be conducted for inpatient bills with paid amounts greater than \$50,000 or when there are findings identified during a high level bill audit. The MCOs should review the entire medical record and itemized charges while conducting the detailed audit.

If the entire medical record is not imaged in the repository, the MCO must request the remaining documents from the hospital. The MCO must comply with the hospital's preferred method of providing the information. The MCO shall establish and utilize contacts at each hospital when arranging or requesting record reviews.

To document the request for information, the MCO shall create an *MCO Request for Medical Documentation Fax*. The fax shall first list all of the related documents already imaged in the claim file, itemized by document name and date of the report to prevent duplication of documentation. The fax shall also briefly document the conversation with the hospital contact, including the name, department, telephone number and fax number of the hospital contact; the hospital's preferred method of submission; and the MCO contact name, telephone number, fax number and/or address where the information should be sent. The MCO shall fax the *MCO Request for Medical Documentation Fax* to the hospital.

Hospitals have twenty-one (21) calendar days from receipt of the MCO's request to provide the records requested by the MCO on the *MCO Request for Medical Documentation Fax*.

If the hospital does not supply the requested information during this timeframe, the MCO shall contact the hospital contact person, within 7 calendar days after the due date, to inquire as to why the MCO has not received the documentation. The MCO shall have a verbal discussion with the contact or a supervisor in the same department and the MCO shall document the hospital's response in its *MCO Inpatient Hospital Retrospective Review Report*.

The MCO is not required to send the entire medical record to BWC for imaging into the claim file; however, the MCO shall maintain the records as part of their audit file. BWC may request copies of the records for quality reviews. If the review is conducted on site at the hospital, the MCO shall either make copies of the documents that result in findings or at least make a specific note of the document name, page number and other identifying information.

The MCO will also perform retrospective reviews on selected DRG-priced bills after BWC has additional data from DRG-priced bills.

#### **I. REQUIRED REPORTS (BWC Rule 4123-6-20)**

Providers undertaking treatment of an injured worker are required to submit initial and subsequent reports to the MCO. The Ohio Administrative Code authorizes MCOs to medically manage workers' compensation claims on the behalf of BWC. Therefore, all laws, rules, and policies concerning submission of medical documents to BWC also pertain to the MCOs. In addition, as part of becoming BWC-certified, providers are contractually obligated to provide medical documents to the MCOs. By law, filing a workers' compensation claim authorizes BWC and the MCOs to receive medical documents to be used in investigating and determining the claim. Consequently, submitting medical to either BWC or an MCO does not require a release signed by the injured worker.

The provider shall forward all BWC forms and medical documentation supporting treatment for both medical-only and lost-time claims to the appropriate MCO. These documents should list the injured worker's claim number in the top right hand corner of the report(s). Providers shall use the fax numbers provided in the MCO Directory found at <http://www.ohiobwc.com/provider/brochureware/MCOUpdate/default.asp>. This eliminates the need for providers to fax medical documentation to BWC. BWC maintains a Medical Repository system, to house these medical documents in the injured worker's electronic claim file. BWC Forms are listed at the end of this section. MCOs are required to review and act on (approve or deny) the C-9 before forwarding to BWC.

**The provider also assumes the obligation to provide and complete all bureau forms required by the MCO. A medical provider may not charge the injured worker, employer, or their representatives, or the MCO, BWC, IC, or a self-insuring employer for the costs of completing the required forms or submitting necessary documentation.**

However, according to OAC [4123-6-20.1](#), a provider may charge a fee for copies of medical records if the provider had previously filed copies of medical records with the bureau or MCO, or with the SI employer in SI claims, and the bureau had provided access to such medical records electronically. The provider's fee shall be based on the actual cost of furnishing such copies, not to exceed twenty-five (25) cents per page. In addition, per OAC 4123-6-45, providers may charge BWC \$.05 per page for copying medical records in cases where BWC's Special Investigations Department requests records specifically for auditing purposes after having unsuccessfully attempted to obtain the information through the Medical Repository.

Providers must supply medical documentation to MCOs at the time of treatment request. If medical data to support treatment necessity is not included within the C-9 form, such evidence must accompany the C-9 submission as an attachment or obtained via the C-9-A form process. (This is the BWC form to request additional information). The provider must return the form C-9-A and any additional supporting documentation to the MCO within ten (10) business days.

Providers must also submit initial medical reports to the MCO when the First Report of Injury (FROI) is submitted, that is, within twenty-four (24) hours or one (1) business day of the initial treatment or initial visit.

Providing medical reports (i.e., Emergency Room Report, Physician Statement, Specialist Report, Operative Report, Diagnostic Report, X-ray, MRI, CAT Scan, Accident Report, Physician’s Office Progress Notes) to the MCO within twenty-four (24) hours has a number of advantages, including assisting BWC in expediting the processing of the claim. The MCO is responsible for gathering and providing medical evidence to support the initial decision in a timely manner. In most cases, the sooner the MCO sends initial medical documentation to the customer care team, the sooner the claim can be allowed.

Timely submission of medical reports also minimizes the possibility that claim authorizations (e.g., for compensation awards, medical benefits, treatment authorizations, etc.) will be delayed. To facilitate claim authorizations, it is important to provide MCOs with accurate information, including the exact ICD codes for which the injured worker is being treated.

In some instances it is necessary for the provider to update the MCO throughout the delivery of care, during the treatment plan. Such instances include IW non-compliance with treatment plan or missed appointments, negative/lack of response to treatment, changes in outcome or goals of treatment, diagnostic testing results, specialist/consultation results, hospital discharge summaries, emergency room reports, operative reports or other situations that indicate a need to alter a treatment plan/plan of care or concurrently monitor the patient's care. In such situations, the provider must submit the update to the MCO within five (5) days of delivery of service or request by MCO. Within five (5) days following completion of an approved treatment plan, or discontinuance of plan, the provider is required to forward progress notes to the MCO.

**1. Medical documentation and bill payment**

The MCOs are required to maintain integrated case management and bill payment systems. MCOs shall not deny payment for previously approved treatment because medical documentation was not attached to a provider invoice, unless such documentation is necessary to price the service (e.g. unclassified/NOC procedures). However, providers must submit medical documentation in cases where services billed do not correspond to treatment that was requested and approved or if the MCO needs information to show what services were provided. For example, for a period not to exceed sixty (60) days following the date of injury, physicians have presumptive approval for providing E/M and consultation services when treating soft tissue and musculoskeletal injuries for allowed conditions in allowed claims. Although the E/M service may be rendered without prior authorization, documentation must be submitted to support the components of the E/M service. To justify payment for the service reported, the documentation must be legible and specific in describing the service provided. If the medical record is determined to be illegible by at least two (2) reviewers, the MCO may deny the line item with **EOB 472: Payment is denied as the medical documentation provided is not legible. Payment for these services will be reconsidered once legible documentation is submitted.**

The MCO must maintain documentation of who determined the medical record to be illegible.

**Forms indexed in BWC’s Medical Repository**

<b>Document Type</b>	<b>Description</b>	<b>Rationale</b>
C-140	Initial Application for Wage Loss Compensation	Includes medical restrictions outlined by physician.
C-9	Physician’s Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease	Imaged after responded to by MCO.
C-63	Additional Information Request	A letter asking for additional medical information.
C-86	Motion	This is a request for additional medical conditions.
C-92/C-92A	Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability	Determination of % of medical disability – medical information is attached.
C-92EXA	C92/C92A Exams	Determination of % of medical disability – medical information is attached.

DELETED	Deleted Document	To be used by indexers for documents not included in the list.
FROI	First Report of Injury	Primary injury/benefit claim form.
MED	Medical Documents	Medical information that does not fit in the stated categories including Independent Medical Examinations and peer reviews.
MEDCO-14	Physician's Report of Work Ability	Form used by physicians for work restriction
MEDCO-21	Physician Review	Forms used by physicians for work restriction
REHAB	Rehabilitation Notes	Contains medical documents – supports rehab plan.
C-1	For payment of Comp or Med Benefits	FROI replaced this form, but a few still come in. Inactive Form.
C-1A	Attending Physician's Report	Inactive Form.
C-2	App for Death Benefits	Inactive Form.
C-3	App for Medical Benefits Only	Inactive Form.
C-5	Death Benefits	Inactive Form.
C-50	SI Claim Application	Inactive Form.
C-6	Accrued Compensation	Inactive Form
C-85A	App to Reactivate Claim	Form has medical information attached. Inactive Form.
ODI	Occupational Disease APP	Inactive Form.
ODI-22	SI Occupational Disease APP	Contains medical documents – supports rehab plan. Inactive Form.

**NOTE:** Medical documentation faxed to self-insuring employers is not captured in the Medical Repository.

## 2. HIPAA

The final HIPAA privacy and electronic transactions regulations do not directly apply to BWC and the MCOs. BWC and the MCOs (and self-insuring employers' workers' compensation programs) do not qualify as "covered entities" under the HIPAA regulations, since they do not meet the definitions of a "health plan", "health care clearinghouse" or "health care provider" as defined in the rules. In fact, workers' compensation programs are specifically *excluded* from the definition of a "health plan" under the HIPAA regulations.

Under the final HIPAA privacy and electronic transactions regulations, covered entities, including providers, may have "business associates" who perform some tasks or functions for or on behalf of the covered entity (e.g., legal, accounting, etc.) that involve the use or disclosure of health information. In general, covered entities must enter into "business associate agreements" with these "business associates" in which the "business associate" agrees to safeguard the privacy of the information.

BWC and its MCOs are not "business associates" of providers, since BWC and the MCOs generally do not perform any functions "for or on behalf of" providers. This applies to both treating providers and to BWC's Disability Evaluator Panel (DEP) providers.

**However, an administrative agent of a DEP provider might be considered a "business associate" of the DEP provider (but not of BWC) under HIPAA.** It is the responsibility of the DEP provider to ensure that his/her contract with the administrative agent contains the necessary HIPAA privacy safeguards; therefore, DEP providers should consult their own legal counsel and/or HIPAA consultants as to whether their administrative agent contracts are (or need to be) HIPAA compliant.

Under HIPAA, protected health information may be released by providers in a workers' compensation claim (1) for treatment, payment or health care operations purposes; (2) under a HIPAA exemption for the

release of information in compliance with state workers' compensation laws; (3) under a valid HIPAA authorization; and (4) under a valid administrative or judicial order, subpoena, discovery, or other lawful process which meets HIPAA requirements.

Under the final HIPAA privacy regulations, covered entities may use and disclose protected health information for treatment, payment, and health care operations purposes. "Payment" and "Treatment" are defined fairly broadly under HIPAA. Therefore, to the extent that a provider is currently treating a workers' compensation claimant, and the provider is

- requesting authorization for treatment,
  - requesting payment for treatment already rendered, or
  - providing information with regard to the allowance of a workers' compensation claim, or the allowance of an additional condition in an existing claim,
- the provider should be able to release information to BWC or an MCO (or to a self-insuring employer or Qualified Health Plan [QHP] in a SI claim).

If a treating provider is being asked to disclose protected health information to any of the parties listed in **O.A.C. 4123-6-20(D)** (BWC, injured worker, employer, MCO, QHP, or self-insuring employer) for a purpose other than for treatment, payment, or health care operations (e.g., the initial investigation of a claim, the completion of a C-84 form for the worker to receive temporary total compensation, etc.), and the provider is persuaded that the requested documentation "**relat[es] causally or historically to physical or mental injuries relevant to the claim**", is "**required by the bureau, MCO, QHP, or self-insuring employer**", and is "**necessary for the claimant to obtain medical services, benefits or compensation**," the provider may disclose the information.

## **J. REQUEST FOR MEDICAL SERVICES**

Requests for medical services that require prior authorization must be submitted by the physician of record (POR) or treating physician to the appropriate MCO prior to initiating any non-emergency treatment. The preferred method of submission is the BWC Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9) form; however, any other physician generated document may be used, provided that the substitute document contains, at a minimum, the data elements on the C-9 form. PORs should identify additional conditions to be allowed in the claims on the C-9 form and should spell out additional conditions with supporting documentation.

In order to assist the MCO in effectively medically managing the injured worker's claim, it is important for the POR/treating physician to comply with the request for medical services guidelines, including presumptive approval and standardized prior authorization policies and procedures.

The following guidelines were implemented to help the MCO consider authorization and expedite the payment of medical bills:

- The MCO must respond to the physician within three (3) business days with a decision regarding the proposed treatment request. **Note:** For services provided under the Presumptive Authorization Guidelines, the MCO is required to notify the provider within three (3) business days acknowledging receipt of the C-9 and that a review was completed to ensure that services being rendered are medically necessary for the claim allowance.
- The MCO must return fax of the authorized, denied or pended medical services request back to the physician within the required three (3) business days. If faxing is not feasible, the MCO is required to call the physician in order to communicate the decision and follow-up in writing via mail. The MCO shall assign a tracking number to each treatment reimbursement decision made by the MCO and publish that tracking number on all copies of the decision distributed by the MCO.
- If the MCO is unable to make a decision within three (3) business days due to the need for additional information, the MCO will send a request for Additional Medical Documentation C-9 form (C-9-A) to the provider. The provider must return the form C-9-A and any additional supporting documentation to the MCO within ten business days. The MCO has five (5) business days from the date additional information is received to make a subsequent decision. The MCO must render a decision to allow or

deny the medical services request if the physician does not provide the MCO with any requested documentation within ten business days for all active claims. The physician must be notified by fax or phone of the subsequent decision. **Note:** for inactive claims the MCO may dismiss the C-9 (with no ADR appeal rights) after the ten (10) days if the C-9-A is not returned

- If the MCO is unable to make a decision within three (3) business days due to the need for a medical review and the physician is notified, the medical review must take place and a decision granted within the five (5) business day period. Again, the physician must be notified by fax or phone of the subsequent decision.

A medical services request will be considered approved and the provider may initiate treatments when all of these criteria are met:

- The MCO fails to communicate a decision to the physician within three (3) business days of receipt of an original medical services request or five (5) business days if the request was pending;
- The physician has documented the medical services request completely and correctly on a C-9 or other acceptable document;
- The physician has proof of submission to the appropriate MCO;
- Medical services are for the allowed conditions;
- The claim is in a payable status.

In instances when a C-9 is not responded to within three (3) business days and the provider initiates treatment, the MCO will provide concurrent and retrospective review of that treatment.

If it is found before, after or during delivery, that any treatment, approved or not approved within three (3) business days, is not medically indicated or necessary, not producing the desired outcomes, or patient is not responding, the MCO will notify the parties of decision to discontinue payment of said treatment. Only charges for treatments already rendered will be paid. If the provider, IW or employer wishes to dispute the decision, they may do so via the Alternative Dispute Resolution process.

The MCO shall authorize, deny, or pend a provider's proposed *retroactive* treatment request (submitted on a C-9 or other appropriate form) within **thirty (30) calendar days** from the MCO's Request for Medical Services request Receipt Date.

When processing a C-9, or other acceptable document, that includes retroactive and future treatment request(s) the MCO must follow the normal three (3) business day time frame requirements for each treatment request, including the ability to pend for additional medical documentation/review if necessary.

**NOTE: Self-insuring employers are required to approve or deny the C-9, or any other physician generated document that contains the data elements on the C-9 form, within ten (10) days of receipt of the request. If the self-insuring employer fails to respond to the request, the authorization for treatment will be granted. Self-insuring employers are not required to follow BWC's Presumptive Approval or Standard prior authorization tables.**

Information used to support requests and authorization for mental health services can also be submitted on the C-9 form.

**Important:** Ohio law protects the confidentiality of the mental health providers' progress notes; therefore, MCOs cannot request copies of this document. Requests for copies of the progress notes with the deletion of any non-claim related information is also prohibited. However, a detailed summary of the notes can be requested via a MEDCO-16 form, which can be used to support the C-9.

Authorizations are to be granted for either a specific number of sessions or period of time. **MCOs are prohibited from authorizing "continuous" or "indefinite" mental health treatment.** Once the authorized

limits have been reached, a new C-9 and a detailed summary must be resubmitted to the MCO for re-evaluation of the treatment.

## 1. Presumptive Approval

In general, BWC requires prior authorization for non-emergency treatment and services through the submission of a C-9 form or its equivalent, to the MCO.

There are specific instances, however, when services are provided within the first 60 days from the date of injury, that physicians have presumed approval to provide treatment and services for specific work-related injuries – soft tissue and musculoskeletal injuries – the most common BWC injuries, if specific criteria are met.

Presumptive Approval guidelines are meant to further BWC's goal of expediting early treatment management for **allowed conditions** in **allowed claims**. By eliminating wait time for authorizations, you may immediately schedule diagnostic testing and other procedures covered under the presumptive approval criteria at the time of the office visit. Quicker treatment means faster recovery, lower disability costs and injured workers returning to gainful employment.

### **Presumptive Approval Criteria (all criteria must be met)**

- a) Treatment is for a soft tissue or musculoskeletal injury (such as sprains, strains, superficial injuries and contusions, per the International Classification of Diseases (ICD) manual) for allowed conditions in allowed claims and includes only the following treatment(s):
  - A maximum of twelve (12) physical medicine visits per injured worker claim which may include any combination of osteopathic manipulative treatment, chiropractic manipulative treatment, and physical medicine and rehabilitation services performed by a provider whose scope of practice includes these procedures, including, but not limited to, doctor of chiropractic, doctor of osteopathic medicine (DO), doctor of allopathic medicine (MD), physical therapist, occupational therapist, athletic trainer or massage therapist;
  - Diagnostic studies, including x-rays, CAT scans, MRI scans and EMG/NCV. **Note:** medical necessity for the allowed conditions is always the driver for services. Surgical diagnostics, such as arthroscopic procedures, are not included unless it is an emergency. (MCO case managers may advise providers when they identify procedures that do not appear to be medically necessary but as long as a provider follows commonly accepted treatment guidelines when treating allowed conditions in a claim, the bill will be paid);
  - Up to three (3) soft tissue or joint injections involving the joints of the extremities (shoulder including acromioclavicular, elbow, wrist, finger, hip, knee, ankle and foot including toes) and up to three (3) trigger point injections. NOTE: Injections of the paraspinal region, including epidural injections, facet injections, and sacroiliac injections are not included in the presumptive approval guidelines;
  - E/M services and consultation services.
- b) All of the following are completed prior to initiating treatment noted above:
  - The First Report of Injury (FROI) is filed with the MCO;
  - The C-9 form (Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease) is filed with the MCO. The MCO will notify the provider within three (3) business days acknowledging receipt of the C-9 and that a

review was completed to ensure that services being rendered are medically necessary for the claim allowance. When the claim or condition for which treatment is being requested is not yet in an allowed status, the MCO may use disclaimer language notifying the provider that services will not be paid if the claim is not allowed;

- The MCO is notified within twenty-four (24) hours of treatment if the injured worker will be off work for more than two (2) calendar days.

## 2. Standardized Prior Authorization Table

In general, BWC requires prior authorization for non-emergency treatment and services through the submission of a C-9 form or its equivalent, to the MCO.

“Emergency” services are “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.” OAC 4123-6-01(O).

Following is the Standardized Prior Authorization Table for prior authorization requirements. The table does not include items meeting the presumptive approval criteria.

Service	Prior Authorization Required	No Prior Authorization Required
Physical medicine services, including chiropractic/osteopathic manipulative treatment and acupuncture	Yes	
Psychological services	Yes	
Dental	Yes	
Evaluation and Management services	Yes for psychological consults or chronic pain program consults	All other evaluation and management services
Diagnostic Testing	Yes with exceptions noted in next column	Basic x-rays and urine screens as noted in Chapter 3 under chronic pain
DME	Yes if purchase price is equal or greater than \$250.00  Yes for DME rentals anticipated to or having the probability to exceed eighty percent (80%) of the purchase price of the DME.	DME purchase price is less than \$250.00.
Home/Vehicle Modifications	Yes	
Home Health Agency Services	Yes	
All inpatient and outpatient hospital services treatment and ambulatory surgery center services	Yes unless for emergency services. Emergency inpatient hospitalization may be through the emergency department or by direct admission.	
In-Home Physician Services	Yes after first visit	First visit
Injections	Yes	
Non-emergency ambulance (medical transportation) services	Yes	
Orthotic	Yes if greater than \$250	

Prosthetic or Artificial Appliance and/or Repair	Yes if greater than \$250	
Skilled Nursing Facility (SNF)/Extended Care Facility (ECF)	Yes	
TENS and NMES units	Yes for both rental and purchase	
TENS and NMES monthly supplies	Yes with a maximum of six (6) months per authorization	
Vision and Hearing Services	Yes if greater than \$100	Vision and Hearing Services less than or equal to \$100
Vocational Rehabilitation – all vocational rehabilitation services, in or out of plan	Yes unless meets the “No PA Required” criteria	Transitional work on-site therapy services provided by an occupational therapist or physical therapist that fall under the presumptive authorization criteria. <b>Note:</b> Occupational Rehabilitation/Comprehensive (work hardening) requires CARF accreditation.

### 3. Request for Medical Services Disclaimer

Disclaimers may only be used on a C-9, or any other physician generated request for treatment, when the claim or the condition for which the treatment is being requested is not yet in an allowed status. Disclaimers shall not be used when authorizing treatment for allowed claims and conditions that are within the statute of limitations.

MCOs may use the following disclaimer language only when responding to a C-9 or any other physician generated request for treatment:

***"This medical payment authorization is based upon a claim or additional condition that is currently being adjudicated by BWC/IC as of the date of the MCO's signature. If the claim or additional condition is ultimately disallowed, the services /supplies to which this medical payment authorization applies may not be covered by BWC and may be the responsibility of the injured worker."***

### 4. Provider Compliance

Providers submitting a C-9 after treatment has been provided may be subject to payment reduction. Per OAC 4123-6-16.3 *Reimbursement of retroactive medical treatment reimbursement requests*, effective January 1, 2013, BWC is authorized to reduce reimbursement for retroactive treatment requests not meeting excused reasons noted below. Reimbursement will be at seventy-five percent (75%) of the applicable fee schedule for non-emergency treatment delivered, rendered, or directly supervised by the POR or eligible treating provider. Only individuals eligible to submit a C-9 are subject to this payment reduction. Retroactive medical treatment reimbursement requests submitted within seven (7) calendar days of treatment initiation or prior to the date of the next encounter with the injured worker, whichever is earlier, are not subject to this payment reduction.

The “just causes” or excused reasons to submit a retroactive C-9 noted in the Rule include:

- (1) The treatment requested was emergency treatment;
- (2) The provider was not aware that services were for a workers' compensation claim;
- (3) The provider was non-BWC certified and had no established relationship with the injured worker;
- (4) The provider was initially BWC certified within six (6) months prior to the treatment request;
- (5) The treatment requested was for a pending claim allowance or additional allowance with BWC or the Industrial Commission;
- (6) The treatment provided was within BWC's presumptive authorization guidelines, or does not require prior authorization per BWC's Provider Billing and Reimbursement Manual;
- (7) The treatment request was submitted retroactively due to BWC or MCO error,
- (8) Other documented justification as deemed sufficient by BWC.

Providers disagreeing with the discounted reimbursement may utilize the grievance hearing procedure for disputed bill payments found in Section H.6. above.

OAC 4123-6-02.7 Provider Decertification Procedures, is BWC's progressive compliance rule. Beginning January 1, 2013, provider rule infractions will be monitored by MCOs and reported to BWC. MCOs will send a written notice after each infraction to the provider. Providers are encouraged to discuss any notices with the issuing MCO in order to avoid further reportable rule infractions. A rule infraction could lead to a provider submitting a correction plan. If the infractions continue, decertification could occur. If decertification occurs the provider must wait two (2) years before reapplication is considered.

The program works as follows:

- After BWC receives from an MCO reports of three (3) or more of the same, or five (5) differing Ohio Administrative Code violations over six (6) months, BWC will send the provider written notice that they are in BWC's progressive compliance monitoring ("First Notice").
- Two (2) or more subsequent infractions over the next twelve (12) months result in a second BWC written notice ("Second Notice") and require the provider to submit a correction plan within thirty (30) days (refusal to submit a correction plan results in a move to decertify).
- Two (2) or more violations of the same provision within the following twelve (12) months (starting the calendar month after the submission of the correction plan) result in a move to decertify.
- Any provider who twice receives a First Notice of violation, but did not progress to the Second Notice and then violates the same provision within three (3) years of the date of the initial First Notice, shall receive written notification from BWC of the violation and notice of proposed decertification.

You may access BWC's Rules and Statutes on our website at:

<http://www.ohiobwc.com/basics/guidedtour/generalinfo/ORCandOAC.asp>

## 5. C-9 Approved Service Timeframes

Approved C-9s set forth timeframes for the delivery of services and are noted on the C-9 form. Timelines for approvals of routine diagnostics (x-rays, CAT scans, MRI scans and EMG/NCV) are generally no longer than two (2) weeks. Timelines for approvals of other medical treatments or services with no specified timeframe on the request are generally no longer than thirty (30) days. Services not able to be or not rendered in this time must have an update in IW claim notes as to the rationale for the delayed service delivery. Services that run continuously over a longer timeframe (such as facility placement) are generally not being approved for more than six (6) months at a time.

Approval of C-9s submitted by a PT or OT shall be valid for no longer than thirty (30) days unless the approval specifies a longer period and such longer period is supported by the prescription accompanying the C-9.

## K. ADDITIONAL ALLOWANCES

When the C-9 is submitted with a recommendation for an additional condition, in addition to checking "yes" or "no" to the question of causality, the physician must attach medical evidence that supports the recommendation. The medical documentation, mechanism of injury, and time sequence must support the additional allowance.

Relevant information includes but is not limited to:

- Clinical examination and diagnostic test findings;
- Current treatment plan;
- ICD diagnostic code for requested diagnosis with location (right, left, bilateral), level (L5-S1, C1-C3), and/or site (digits, teeth, or body part) when applicable;
- A **causality statement** explaining how the mechanism of injury resulted in the requested diagnosis (i.e., is the diagnosis causally related to the industrial injury).

1. The **causality statement must** indicate whether the recommended condition is:

- a) A direct and proximate result of the industrial injury;
  - A direct condition must be directly and proximately caused by the injury, and generally has appeared immediately or close in time after the injury. A direct condition would not be present prior to, or pre-exist, the injury.

- b) The aggravation of a pre-existing condition (for claims with date of injury prior to August 25, 2006).
    - Aggravation of a Pre-Existing Condition (applies to claims with date of injury prior to August 25, 2006): an aggravation of a pre-existing condition does not have to be of any particular magnitude in order to qualify as an aggravation. An aggravation of a pre-existing condition having some real adverse effect, even if that effect was relatively slight, would qualify as an aggravation. However, an aggravation of a pre-existing condition that was so negligible as to not be of any consequence would not qualify as an aggravation. Either objective or subjective evidence alone is sufficient for proof, but some real adverse effect must be shown. An aggravated condition must be present prior to, or pre-exist, the injury, and the aggravation of the condition must be proximately caused by the injury.
  - c) The substantial aggravation of a pre-existing condition (for claims with date of injury on or after August 25, 2006).
    - Substantial Aggravation of a Pre-Existing Condition (applies to claims with date of injury on or after August 25, 2006): A substantial aggravation of a pre-existing condition must be considerable in amount, value, or the like and firmly established and solidly based through presentation of objective diagnostic findings, objective clinical findings, or objective test results. Subjective complaints must be accompanied by supporting objective diagnostic findings, objective clinical findings or objective test results. A substantially aggravated condition must be present prior to, or pre-exist, the injury, and the substantial aggravation of the condition must be proximately caused by the injury. (*See* also section U. for Substantial Aggravation of a pre-existing condition).
  - d) A flow-through from the previously allowed conditions.
    - Flow Through Condition: A flow through condition must be indirectly caused by the previously allowed conditions or the injury or treatments for them, and generally has developed later and was not originally alleged in the initial injury. It is not directly caused by the injury or treatments for them, and generally has developed later and was not originally alleged in the initial injury. It is not directly caused by the injury, but must still be proximately caused by the injury. A flow through condition would not be present prior to, or pre-exist, the injury.
2. A psychiatric condition(s) must be requested on a Motion (C-86) submitted by the injured worker/authorized representative. BWC will not consider allowance of a psychiatric condition(s) submitted on a C-9.
  3. Once a final decision has been rendered on the requested/recommended condition(s), BWC will notify the MCO of the final decision, and the MCO will notify the treating physician of the status of the request/recommendation.

**L. MEDICAL DISPUTES (BWC Rule 4123-6-16)**

All MCOs are required to have an Alternative Dispute Resolution (ADR) process. ADR is intended to handle medical disputes regarding quality assurance, utilization review, medical necessity and other treatment and provider issues. Providers, employers and their representatives, and injured workers and their representatives may initiate ADR for MCO-managed claims by contacting the injured worker's MCO in writing, detailing the issue with the MCO decision, within fourteen (14) calendar days of receipt of written notice of an MCO determination. These are guidelines and not deadlines. Neither the ADR rule nor case law provides any consequences if an ADR appeal is filed untimely. Providers are encouraged to use the MCO Medical Treatment/Service Decision Appeal form (C-11) to expedite the identification of the issue in dispute and improve efficiency and avoid processing delays. For a copy of the C-11 please log onto <https://www.ohiobwc.com/bwccommon/forms/BWCForms/nlbwc/ProviderForms.asp>.

The appeal letter or C-11 must be signed by the appellant or their representatives, or by the provider. A signature from the provider's non-professional staff member, with signature authority, is acceptable as long as the staff member signs the provider's name and initials.

MCOs must have a medical dispute resolution process that includes one independent level of professional review. The independent level of review shall consist of a peer review conducted by an individual or individuals licensed pursuant to the same section of the Revised Code as the health care provider who would be providing the service requested. However, if the MCO has already obtained one or more peer reviews during previous disputes involving the same or similar treatment, the MCO may obtain a different perspective review from a licensed physician who falls outside the peer-to-peer review criteria pursuant to OAC 4123-6-16 (C) (2). The MCO must complete and submit their recommended decision to BWC within twenty-one (21) days of the MCO's receipt of the written medical dispute. If the MCO recommends that the injured worker be scheduled for an independent medical exam, this recommendation shall toll the MCO's timeframe for completing the ADR process and in such cases the MCO shall submit its recommended ADR decision to BWC electronically within seven (7) days after receipt of the independent medical examination report. Following completion of the independent review and or exam the MCO will forward their recommended decision to BWC. BWC will then issue an order per ORC 4123.511, which may be appealed to the IC by any party to the claim (i.e., injured worker, employer, or their representatives). By law, MCOs and providers are not parties to the claim; therefore, they cannot appeal any BWC order, including those regarding medical issues.

The MCO may defer consideration of a dispute when there is a pending appeal before the bureau or industrial commission and the MCO has previously conducted a peer review for a C-9 that is "same as or similar to" the one received. Once the previous treatment request has been resolved, the MCO may resume the ADR process, and may proceed in accordance with paragraph (C) (4) of ADR Rule 4123-6-16. The previous peer-to-peer review or an ADR IME must be within twelve (12) months of the current C-9 decision. The previous treatment request must have been ultimately denied based on the peer-to-peer review or an ADR IME.

Per Senate Bill 7 and OAC 4123-6-16 (H) (1), the ADR process shall NOT be used to resolve disputes concerning medical services rendered that have been approved through standard treatment guidelines, pathways, or presumptive authorization guidelines.

This means all Employer/TPA appeals of approved authorizations will be exempt from the dispute resolution process if the requested services fall within presumptive authorization, pathways, or guidelines.

#### **1. Bills Submitted on Treatment Requests Currently in the ADR Process**

Bills submitted on treatment requests currently in the ADR process shall be denied with the appropriate ADR denial EOB code. If the services are later authorized, the MCO shall use the appropriate EOB code and request an adjustment on the denied bills. The MCO should use the following, appropriate EOBs on bills submitted for treatment requests currently in the ADR process include:

***EOB 537:*** MCO Alternative Dispute in process for services requested. Services are not payable at this time.

***EOB 538:*** Treatment reimbursement approved by MCO Alternative Dispute process (no appeal) - adjustment done to process previously disputed services.

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at MCO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 537 EOB. If the services are later authorized at the MCO level, and the decision is not appealed to the BWC, the MCO may use the 538 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.

***EOB 539:*** MCO decision on ADR issue was appealed to the BWC. Services are not payable at this time.

***EOB 540:*** Treatment reimbursement approved by BWC (final determination) - adjustment done to process previously disputed services.

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at BWC level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 539 EOB. If the services are later authorized at the BWC level, and the decision is not appealed to the DHO, the MCO may use the 540 EOB (along with any other pertinent EOBs) to

request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.

**EOB 541:** BWC decision on ADR issue appealed to DHO. Services are not payable at this time.

**EOB 542:** Treatment reimbursement approved by DHO (final determination) - adjustment done to process previously disputed services.

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at the DHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 541 EOB. If the services are later authorized at the DHO level, and the decision is not appealed to the SHO, the MCO may use the 542 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.

**EOB 543:** DHO decision on ADR issue appealed to SHO. Services are not payable at this time.

**EOB 544:** Treatment reimbursement approved by SHO (final determination) - adjustment done to process previously disputed services.

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at the SHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 543 EOB. If the services are later authorized at the SHO level the MCO may use the 544 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills.

## **M. RETURN TO WORK**

Early and successful return to work (RTW) benefits everyone. The costs of any disability go far beyond the measurable costs for medical care and compensation payments. Injured workers may encounter:

- Loss of self-esteem;
- Depression;
- Secondary symptoms;
- A complete change in their life style.

Most injured workers return to work without any assistance, but some injured workers require more medical care resulting in longer recovery and time away from work. Some require intensive RTW and vocational services to return to productive employment.

BWC's efforts recognize these differences and plan the best course for the individual worker. The ODG guideline date assists BWC and MCOs in working with the employer, injured worker and physician to set expectations for RTW. As a critical player in the HPP design, providers must understand the basis and goals of the RTW strategy and the –ODG guidelines help set RTW expectations of the injured worker. In addition, providers have to manage return office visits and treatment with the anticipated RTW date in mind and release injured workers to work (with restrictions, if necessary) as soon as medically feasible.

- **Remain at Work:**  
Remain at work services are available for IWs who have experienced a work- related injury but remain at work. These services assist the worker to deal with difficulties in remaining at work by providing early intervention to minimize the number of days an employee is off work due to an injury.
- **30-Day Return to Work Assessments:**  
MCOs manage each claim with the goal of an anticipated return-to-work date. If an injured worker has not returned to work within thirty (30) days after benchmark as outlined in the ODG , BWC will become directly involved in reviewing the case. BWC and MCO staff will work together to ensure the injured worker is on a successful path toward a safe return to work. The goal is to make it easier for injured workers to streamline the process and take advantage of return to work interventions.

- **Transitional Work:**

Transitional work helps businesses offer injured employees' strategies to return them to work as soon as safely possible and before the worker is 100% recovered. The service uses real job-related tasks to accommodate the workers' medical restrictions for a specified time period, generally no more than three (3) months and gradually return them to their original duties.

Transitional work services may include strategies such as purchasing tools and equipment, modifying the work area, adjusting job tasks or allowing employees to work part-time. Employers can help by opening the channels of communication among the employee, the doctor, the employee's immediate supervisor, BWC and their managed care organization (MCO). This increases the odds the worker will stay connected to the job and recover more quickly.

## 1. Physician's Report of Work Ability (MEDCO-14)

### a) Purpose

The Physician's Report of Work Ability (MEDCO-14) is a tool to manage an injured worker's lost time claim and assist the injured worker to return to work.

The Medco-14 form allows the physician to document a complete summary of the injured worker's disability status and provides relevant information enabling the claims team and employer to understand the injured worker's:

1. Progress from disability to work ability;
2. Ability or inability to perform any work;
3. Capabilities and, if applicable, restrictions;
4. Barriers and reasons for delay in the injured workers' ability to return to their current job; and/or
5. Plan of treatment and vocational issue(s) that need to be addressed to help the injured worker in returning back to work.

BWC, MCOs, and self-insured employers use the information to determine if action steps may be taken to remove barriers and/or delays to return the injured worker to work. If an injured worker has not been released to his/her former position of employment without restrictions, the information assists in the determining whether an injured worker is entitled to an indemnity benefit.

### b) Requirements

A MEDCO-14 is **required** to be completed for evaluation and management services, when an injured worker's status is evaluated or re-evaluated by a physician and one of the following apply:

- The injured worker is temporarily not released to any work, including the former position of employment; or
- The injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions; or
- The injured worker has previously not been released to any work or has been placed under work restrictions and is now being released to full duty work without restrictions.

A MEDCO-14 is **not required** to be completed for evaluation and management services, when an injured worker's status is evaluated or re-evaluated by a physician and one of the following apply:

- The injured worker has been awarded permanent total disability; or
- The injured worker has already returned to work without restrictions.
- The injured worker is seen for manipulation treatments and other therapies, when an evaluation and management service is **not** performed, unless, in the course of treatment or therapy, the injured worker's work status changes

### c) Equivalent physician-generated document/statement

The MEDCO-14 form is the preferred form. However, BWC will recognize an equivalent physician-generated document if the equivalent physician-generated document contains, at a minimum, all of the data elements required on the MEDCO-14.

**d) Referencing Medical Notes**

If medical information has been submitted that answers a question on the MEDCO-14, it is sufficient to indicate the name and date of the medical report that contains the equivalent information in response to the question on the MEDCO-14, e.g. office note 5/18/11. **Both the name and date of the medical report are required** in order to discern which document on file contains the equivalent response.

In summary, the equivalent form or statement must contain the same information being requested on the MEDCO-14.

**N. APPLICABLE BWC LAWS AND RULES**

BWC laws and rules are applicable to any provider treating an Ohio injured worker, regardless of whether the service is rendered in Ohio or another state.

Rules related to the provision of medical services are located in Ohio Administrative Code chapter 4123-6. Statutes governing the Ohio Workers' compensation system are located in Ohio Revised Code chapters 4121 and 4123.

Chapter 4123-6 of the Ohio Administrative Code (OAC) is available at <http://www.ohiobwc.com/basics/guidedtour/generalinfo/ORCandOAC.asp#six>.

Applicable chapters of the Ohio Revised Code (ORC) may be found at <http://codes.ohio.gov/orc/4121> and <http://codes.ohio.gov/orc/4123>.

**O. MEDICAL CODING REQUIREMENTS**

**1. Primary ICD - International Classification of Diseases, Clinical Modification (ICD-CM)**

BWC requires the identification of a primary ICD on the *First Report of Injury, Occupational Disease or Death* (FROI) application, treatment plans, and subsequent reports. Although a claim may have multiple ICD codes, only one primary diagnosis can be identified per claim. The provider must bill the condition(s) treated, regardless of the primary ICD. Additionally, the primary diagnosis should be:

- Determined by the physician of record;
- Identified for allowed conditions only;
- Updated as medical conditions in the claim change.

**2. Procedure Coding**

Providers are required to use the Centers for Medicare and Medicaid Services' Health Care Common Procedure Coding System (HCPCS) to report procedures and/or services provided to injured workers. This system is comprised of HCPCS Level 1 procedure codes from the AMA's Current Procedural Terminology (CPT®) book, including additional definitions in CPT® Assistant, and HCPCS Level 2 codes and HCPCS Level 3 codes.

**a) HCPCS Level 1**

BWC and MCOs accept current HCPCS Level I (CPT®) billing codes. HCPCS Level I (CPT®) billing codes are established by the American Medical Association (AMA). HCPCS Level I Codes are descriptive codes for reporting medical services and procedures. Anesthesia CPT® codes (00100-01999) are recognized and required.

**b) HCPCS Level 2**

BWC and MCOs accept current HCPCS Level II billing codes as established by Centers for Medicare & Medicaid Services (CMS). Level II codes are descriptive codes for reporting durable medical equipment, dental, vision and other services.

**c) HCPCS Level 3**

BWC and MCOs accept current HCPCS Local Level III billing codes. Local Level III codes are descriptive terms identifying codes for services and equipment specific to Ohio workers' compensation. They are published in Chapter 2 of this manual.

### **3. Hospital Services**

All hospital bills should include revenue center codes. Certain outpatient hospital services require CPT® codes. For outpatient services, a date of service is required on each line of the UB-04 for each service rendered. Professional services may NOT be billed on the UB-04.

For additional information on hospital services, including covered revenue center codes and revenue codes requiring CPT® codes, please refer to Chapter 3 of the *Billing & Reimbursement Manual*.

### **4. Outpatient Medications**

Outpatient medications are reported using National Drug Codes. Catamaran serves as the sole drug bill processor for state-fund, Black Lung and Marine Industrial Fund employers' claims. Catamaran does not process bills for self-insured or federal workers' compensation claims. For information on Outpatient Medication, refer to Chapter 3 of your *Billing & Reimbursement Manual*.

## **P. PROVIDER COMMUNICATION**

BWC's e-business system allows us to provide our customers with consistent, customized, streamlined service twenty-four (24) hours a day, seven (7) days a week. Log onto [www.ohiobwc.com](http://www.ohiobwc.com) to find out how fast, efficient and easy it is to have all of your workers' compensation information and services at your fingertips. With our e-business system, you can:

- View basic claims information, including International Classification of Diseases (ICD) codes, claim status, date of injury, accident description, BWC and MCO claim notes, and the assigned MCO.
- Verify BWC-certified providers with Provider Lookup;
- Determine the managed-care organization (MCO) for a particular employer with BWC Employer/MCO Lookup;
- View the BWC Fee Schedule;
- Download various BWC forms to print, complete, and mail, fax, or drop off, including the First Report of Injury (FROI), Physician's Report/Treatment Plan for Industrial Accident or Disease (C-9) and Physician's Report of Work Ability (MEDCO-14). In addition, if you file a FROI electronically you receive a claim number immediately;
- Look-up an injured worker's claim history;
- Access information twenty-four (24) hours a day, seven (7) days a week.
- BWC library - Take a guided tour to learn more about processes and policies. Find answers to frequently asked questions and definitions for workers' compensation terms in the provider glossary.
- Medical bill payment look-up - Servicing or pay-to providers can view medical bill payment information. Bill searches can be customized to verify receipt of your bills from the managed care organization (MCO) to BWC, and provider payments made to MCOs.
- Billing and reimbursement - Access the online *Provider Billing & Reimbursement Manual (BRM)* to download, view or print reimbursement policies/procedures and updates.
- Claim documents - Providers who meet BWC's security criteria can access claim documents, a repository of imaged documents from individual claim files.
- View Provider Education/Training section-including video presentations of information relevant to new providers doing business with BWC and other educational offerings.

To ensure confidentiality, you must create a primary account before accessing injured worker information. You can create secondary users from this account so that each of your employees or vendor employees can have individual passwords. Customers who prefer dealing with a person will always have the option of doing so. To get more information about e-business provider services, or for help creating a BWC provider e-account (user ID and password), call 1-800-OHIOBWC or e-mail the provider relations department at [Feedback.medical@BWC.state.oh.us](mailto:Feedback.medical@BWC.state.oh.us).

## **Q. SENSITIVE DATA POLICY**

Due to heightened security awareness and state law, BWC has incorporated a new Sensitive Data Policy. To prevent unauthorized disclosure of BWC sensitive information this policy prohibits the electronic transmission of Sensitive Data without encryption (password protection).

Proper sensitive data format in emails : All claims information, including injured worker claim number and name are considered sensitive and must be masked if used in email format (John Smith, claim 09-123456 would be acceptably emailed as John S., 09-xxx456. )

If you receive an electronic document from BWC or the MCO it will be password protected if sensitive data is included. BWC and/or the MCO will provide you with the password that will generally be used. Once you open a document and respond to the message, the document will remain password protected when the changes are saved.

Please note that a faxed transmission to a phone number is considered secure and is an accepted means of communication of sensitive data. Please have identifying injured worker information (name and claim number/SSN) that ensures to BWC or the MCO that you are involved in this injured worker's care, or a signed consent may be needed before the case can be discussed.

## **R. FRAUD**

Workers' compensation fraud is defined by BWC, to a large extent, as an intentional act or series of acts resulting in payments (or could have resulted in payments) to a person who is not entitled to receive those payments. Examples of workers' compensation fraud include (but, are not limited to);

- Injured workers who go back to work, but still collect lost time benefits.
- Injured workers who claim to have been injured in the course of their employment when in fact they were injured elsewhere.
- Injured workers who fake an injury at work.
- Providers who bill for services not rendered.
- Providers who bill for a more expensive level of service than provided. This process is sometimes referred to as "upcoding." (Note: BWC utilizes AMA CPT© Assistant Guidelines, which are based on accepted industry standards, when reviewing medical reports and documentation.)
- Providers who attempt to bill uncovered expenses to the workers' compensation claim.
- Employers who under report their premiums.
- Employers who misrepresent the manual classification of their employees to secure a lower premium rate.

Senate Bill 7 (SB7) expanded the definition of workers' compensation fraud to include altering, forging or creating workers' compensation certificates to falsely show correct coverage, providing false information when that information is needed to determine an employer's actual premium or assessment, and failing to secure or maintain workers' compensation coverage with the intent to defraud the bureau. It also:

- Prohibits persons, health-care providers, managed care organizations (MCOs) from obtaining or attempting to obtain by deception payments under the workers' compensation law to which they are not entitled.
- Authorizes monetary penalties and decertification for persons, health-care providers and MCOs for obtaining or attempting to obtain by deception payments under the workers' compensation law to which they are not entitled and specifies procedures for enforcing these provisions.

To ensure only legitimate claims are paid, BWC is aggressively attacking fraud through its Special Investigations Department. The Special Investigations Department has investigative personnel located in each service office, its own automated detection team as well as a team that specializes in health-care fraud investigations. Individuals and corporations convicted of workers' compensation fraud can expect to receive penalties that range from a misdemeanor (\$1,000 fine and up to six (6) months incarceration) to a felony (fines ranging from \$2,500 - \$15,000 and from six (6) months to five (5) years incarceration), restitution and an order to reimburse BWC for its investigative costs.

If you suspect fraud, call the Special Investigations Department at 1-800-OHIOBWC (1-800-644-6292) or complete the online fraud report in the Medical Providers section of our website [www.ohiobwc.com](http://www.ohiobwc.com).

### **1. Unethical Marketing**

BWC has received an increasing number of complaints from injured workers, MCOs, and providers that suggests that a small number of BWC-certified providers have attempted to obtain significant profit opportunities by use of false, misleading, or deceptive marketing to injured workers. Examples of false, misleading, or deceptive marketing practices that violate guidelines listed in the BWC Provider Billing and Reimbursement Manual, include, but are not limited to:

- Attempting to influence injured workers to be examined by a specific physician or to select a certain physician either as a physician of record (POR) or as a treating physician. Ohio Administrative Code 4123-6-06.2 states that an injured worker may choose as the primary attending physician, or POR, an eligible provider who is a:

- BWC-certified provider that is an MCO panel provider;
- BWC-certified provider that is not an MCO panel provider.

Note: Injured workers with dates of injury prior to October 20, 1993 may retain a non-certified provider as a POR if such relationship already exists.

Offering free services to IWs. Per OAC 4123-6-02.9, providers are prohibited from offering free services or other things of value to IWs in return for the IW selecting the provider for treatment reimbursable by BWC.

- Telling injured workers that reimbursement of compensation will be suspended if they choose not to see a specific physician.

ORC 4123.53 states that benefits may be suspended should an injured worker fail to attend a BWC scheduled examination. However, IWs have free choice of BWC certified providers when seeking treatment.

BWC-certified providers shall maintain the highest level of ethical standards and shall not use, or promote the use of, advertising matter, promotional materials, or other representation, however disseminated or published, that is false, misleading, or deceptive to an injured worker being treated for an injury or an occupational disease.

### **S. REQUEST FOR TEMPORARY TOTAL COMPENSATION (C-84) FORM**

#### **Injured Worker signature and completion of C-84/equivalent form required**

The injured worker is required to sign and complete the C-84/equivalent form to provide information regarding work status, disability dates, his or her employer's name, light-duty work availability and receipt of other benefits. Effective August 2012, physicians no longer complete this form to certify temporary total compensation, physicians now complete the MEDCO-14 form. The physician is encouraged to remind the injured worker to complete and sign the C-84 form before he or she sends it to the BWC. Injured workers may complete the C-84 online at <http://www.ohiobwc.com/>. Temporary Total compensation will not be paid without the completed and signed form from the injured worker.

### **T. CLAIM REACTIVATION**

Per OAC 4123-3-15, claims for which no medical or compensation has been paid for more than twenty-four (24) months become inactive. Claim status and diagnosis information can be found on [ohiobwc.com](http://ohiobwc.com) or by contacting the assigned MCO.

If the claim is inactive, the office visit and/or services rendered will not be payable by workers' compensation unless BWC reactivates the claim. If the claim is not reactivated, the injured worker will be responsible for payment.

**Prescription Medications** – If prescription medications are denied because the claim is inactive, contact BWC to request a claim reactivation review.

For questions about claim reactivation, log onto [www.ohiobwc.com](http://www.ohiobwc.com), or call 1-800-OHIOBWC.

**Inactive claims must be reactivated in order to receive payment for services rendered. To initiate a claim reactivation review the provider must submit to the MCO:**

- A completed *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9)* form or equivalent thoroughly documenting the treatment requested and how the treatment relates to the original workplace injury.
- The C-9 or equivalent must be accompanied by current medical documentation dated not more than sixty (60) days prior to the date of the request.
- It is not necessary that the request specifically include the verbiage "claim reactivation" as a request for medical treatment on an inactive claim is handled as a request for claim reactivation.

**MCOs have 16 business days to respond to the treatment request and refer the request for claim reactivation to BWC. During this time, MCOs may:**

- Request submission of additional documentation via *Request for Additional Medical Documentation for C-9 (C-9-A)* form or equivalent. A provider will have up to ten (10) business days to submit the requested information; or
- Dismiss the C-9 request on an inactive claim when there is no supporting medical evidence or the medical evidence is dated more than 60 days prior to the date of the request. A C-9 dismissed in this manner cannot be appealed through the Alternative Dispute Resolution (ADR) process. However, the MCO may reconsider the treatment or medical bill issue upon submission of the requested documentation; or
- Refer the request to BWC for review.

**BWC will have up to 28 days from receipt of the MCO's referral of the request to complete a causality investigation and issue a BWC Order.**

- A party to the claim may appeal the BWC Order to the Industrial Commission.
- Upon receipt of the final BWC/IC claim reactivation decision (i.e., all appeals are exhausted), BWC will update the claim and notify the MCO who will notify the provider of the final decision and/or pay the previously denied medical bill.

**U. SUBSTANTIAL AGGRAVATION OF PRE-EXISTING CONDITION (See also section K. Additional Allowances)**

Claims with a date of injury (DOI) on or after 8/25/06 may be allowed for substantial aggravation of a preexisting condition. A substantial aggravation of a pre-existing condition must be considerable in amount, value, or the like and firmly established and solidly based through presentation of objective diagnostic findings, objective clinical findings, or objective test results.

Subjective complaints may be evidence of a substantial aggravation, but they are insufficient to support allowance of a substantial aggravation without objective diagnostic findings, objective clinical findings, or objective test results. Subjective complaints must be accompanied by supporting objective diagnostic findings, objective clinical findings, or objective test results. A substantially aggravated condition must be present prior to, or pre-exist, the injury, and the substantial aggravation of the condition must be proximately caused by the injury.

Once the substantially aggravated pre-existing condition has returned to a level that would have existed without the injury, no compensation or benefits are payable for the condition. Therefore, a claim will always be *allowed* for aggravation of a pre-existing condition once the condition has become a claim allowance; however, compensation and benefits are not be payable once this condition is returned to the pre-injury state.

When a request to allow a claim for substantial aggravation of a pre-existing condition is filed, an independent medical exam (IME) **may** be necessary to assist BWC in making an appropriate determination; however, an exam is not required, especially when the request is supported by the evidence mandated by law. Claims Service Specialists (CSSs) should staff the claim with the nurse and/or other members of their team to determine if an exam or file review is appropriate.

The following types of medical evidence/documentation may be submitted and/or gathered for decisions involving a substantially aggravated pre-existing condition(s):

- Lab reports, X-rays, MRI, CT reports or any other diagnostic tests that may document the current status of the substantially aggravated pre-existing condition;

- Lab reports, X-rays, MRI, CT reports other diagnostic tests pertaining to the condition prior to the injury;
- Documentation of current medication including dosage and frequency for substantially aggravated pre-existing condition (i.e. insulin or pain medication);
- Documentation of medication including dosage and frequency for substantially aggravated pre-existing condition that IW was receiving prior to the date of injury;
- Any objective physician examination findings of substantially aggravated pre-existing condition prior to injury and subsequent to injury;
- PT, OT records prior to and subsequent to injury;
- Emergency Room reports;
- Accident reports.

The managed care organization (MCO) must consider requests for medical treatment when a final BWC/IC decision has determined that the substantially aggravated pre-existing condition has returned to a level that would have existed without the injury and other conditions are allowed in the claim. If the request is denied and an appeal is filed, the issue will go through the Alternative Dispute Resolution (ADR) process.

If the substantially aggravated pre-existing condition is the only condition allowed in the claim, treatment requests will be dismissed without prejudice once a final BWC/IC decision has determined that the condition has returned to a level that would have existed without the injury.

#### **V. PSYCHIATRIC CONDITION**

BWC may approve and/or reimburse for psychiatric evaluations and/or treatment when an injured worker's:

- Psychiatric condition is allowed in the claim;
- Psychiatric condition is allowed in the claim and the injured worker or provider previously paid for an examination performed to provide evidence to support the Motion (C-86);
- Evaluation and/or treatment is part of an approved vocational rehabilitation or catastrophic treatment plan;
- Evaluation is part of an authorized pre-admission evaluation for an approved chronic pain program;
- Evaluation and/or treatment is part of an authorized chronic pain program; or
- Evaluation and/or treatment is part of an authorized detoxification or substance abuse program.

#### **W. THIRD-PARTY PAYERS**

When an injured worker is eligible for public or private insurance and workers' compensation benefits, the MCO, BWC or the self-insuring employer is the primary payer. Bill services related to compensable conditions to workers' compensation before attempting to collect from another payer.

#### **X. \$15,000 MEDICAL-ONLY PROGRAM**

Ohio employers can participate in BWC's \$15,000 Medical-Only Program, designed to offer employers the opportunity to pay the first \$15,000 of medical and pharmacy bill payments for their employees' work-related injuries.

Participating employers will notify providers that they are responsible for the first \$15,000 of their employee's alleged work-related injuries. The \$15,000 maximum applies only to claims with a date of injury (DOI) on or after September 10, 2007. For DOI prior to September 10, employers in the program still have the opportunity to pay up to:

- \$1,000 Medical Only Program: Claim is Medical-Only with DOI 7-1-95 through 6-29-06;
- \$5,000 Medical-Only Program: Claim is Medical-Only with DOI 6-30-06 through 9-9-07;
- \$15,000 Medical-Only Program: Claim is Medical-Only with DOI 9-10-07 and after.

##### **1. Provider Responsibilities**

- Bill the employer directly for services related to injuries covered by the \$15,000 Medical-Only Program.
- An employer pays providers directly for the injured worker's medical care up to \$15,000.
  - For claims with a DOI on or after June 30, 2009 and enrolled in the Medical-Only Program, the employer will use the BWC Fee Schedule for medical payments. Employers may access the provider fee schedule on our website at [www.ohiobwc.com](http://www.ohiobwc.com). If an Employer has questions

regarding BWC's Fee Schedule and/or has general billing questions, they should be directed to contact Provider Relations by calling 1-800-OHIOBWC option 0-option 3-option 0.

- A certified health care provider shall accept from an employer who participates in the Medical-Only Program the BWC Fee Schedule as full payment. The provider shall not charge, assess, or otherwise attempt to collect from an employee any amount for covered services or supplies that is in excess of the BWC Fee Schedule.
- For claims with a DOI prior to June 30, 2009, the employer is to pay as billed or according to any provider agreed upon amount.
- The MCO may not act as an agent of the employer and may not process the bills on behalf of the employer.
- If the MCO receives a C-9 form (Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease) for a claim in the Medical-Only Program, it may dismiss without prejudice and notify the provider and employer. An employer cannot deny or allow a C-9 form; however, the C-9 form does provide notice to the employer of the services that may be rendered in a claim by a treating provider. The employer may review the C-9 form for the treating diagnosis and requested services for the injured worker. The employer can also use the information to decide if the claim will remain in the Medical-Only Program, based on anticipated cost of requested services and treatment.
- Bill in the same manner and on forms that the provider uses to bill the MCO or BWC.
- A provider cannot bill a state-fund employer directly outside of the \$15,000 Medical-Only Program.

## **2. Exceeding the \$15,000 Maximum**

- The employer will pay that portion of the bill that will bring their payment to the \$15,000 maximum.
- The employer will then inform the provider to bill the MCO or BWC for the remainder of the bill. Contact the assigned provider representative to make arrangements for special processing of this bill.

## **3. \$15,000 Maximum is Reached or Claim is removed from Medical-Only Program**

- The employer should notify BWC, the injured worker and the provider that MCO or BWC will be responsible for processing all bills after a specific date of service.
- The employer will forward proof of bill payment to BWC, including copies of bills paid, upon written request from BWC.
- After a claim has been removed from the Medical-Only Program for any reason, medical management and all bills received will be handled by the MCO. The MCO will be responsible for processing all bills regardless of date of service after the claim's termination from the program. BWC **will not** mediate fee disputes between employers and providers. If BWC and the employer both pay a bill, the employer is responsible for recovering the payment. BWC will not recover duplicate payments unless it is proven that the employer followed program requirements and the error was on the part of BWC. A BWC claim must be filed and allowed before the MCO or BWC can consider these medical bills for payment. The same process applies when a claim is removed from the program.
- The MCO will continue to process bills related to medical-only claims filed in the normal manner when an employer has not elected to participate in the \$15,000 Medical-Only Program.

If BWC has issued a claim number, BWC will process the bill and inform the provider that it cannot be paid while the claim is covered by the \$15,000 Medical-Only Program. In this case, providers will receive the following Explanation of Benefits (EOB) code on their BWC Remittance Advice:

**210 BWC cannot reimburse these services, as this claim is part of the \$15,000 Medical-Only Program. Submit medical bills to the injured worker's employer.**

Refund duplicate payments directly to the employer.

## **4. Injured Worker Loses More Than Seven Work Days**

If over seven (7) days of work are lost, the injury is no longer eligible for this program and the claim is filed with BWC. This process automatically changes the claim to lost-time and removes it from the \$15,000 Medical-Only Program.

## Y. DISABILITY EVALUATORS PANEL (DEP)

The DEP is a statewide panel of physicians and medical professionals who perform medical examinations and medical file reviews for BWC to ensure that qualified medical specialists perform objective, impartial evaluations to support claims management. Evaluations requested by BWC include medical examinations required by statute at ninety (90) days of consecutive temporary total disability (TTD) and two hundred (200) weeks of TTD; occupational disease allowance; and permanent partial disability (PPD). Other evaluations are done for clarification of disability issues or medical disputes within claims. The DEP is open to providers who meet BWC's acceptance criteria as a qualified medical specialist and who sign a written contract for performance of medical examinations and medical file reviews. Acceptance criteria include:

- Licensure without restrictions;
- Specialty board certification;
- Active clinical practice within specialty;
- Professional and general liability and workers' compensation coverage; and
- Agreement to BWC's performance requirements, fees and peer reviews of evaluation reports.

To apply for the DEP you may access the DEP application (MEDCO-30) at the forms page of our website. For additional information, call BWC's Contact Center at 800OHIOBWC, option 0-3-0, or email the DEP Central Unit at: [DEPcentral@bwc.state.oh.us](mailto:DEPcentral@bwc.state.oh.us). Providers may access the DEP handbook outlining billing codes, fees and instructions on BWC's website under the Medical Providers page located at <http://www.ohiobwc.com/downloads/blankpdf/DEPhandbook.pdf>

## Z. ASSISTANCE

To continuously improve service to our customers, BWC has 13 customer service offices. To find a service office by zip code, visit the following

<https://www.ohiobwc.com/bwccommon/services/officelocator/default.asp>.

### BWC Service Offices

#### Cambridge

61501 Southgate Road, Suite 2  
Cambridge, OH 43725-9114  
(740) 435-4200  
(866) 281-9351 Fax

#### Columbus

30 West Spring Street, L-11  
Columbus, OH 43215-2256  
(614) 728-5416  
(866) 336-8352 Fax

#### Garfield Heights

4800 East 131<sup>st</sup> Street, Suite A  
Garfield Heights, OH 44105-7132  
(216) 584-0100  
(866) 457-0590 Fax

#### Governor's Hill

8500 Governor's Hill Drive, L-4  
Cincinnati, OH 45249-1369  
(513) 583-4400  
(866) 281-9357 Fax

#### Canton

400 Third Street SE, Suite 2  
Canton, OH 44702-1102  
(330) 438-0638  
(866) 281-9352 Fax

#### Cleveland

615 West Superior Avenue, L-6  
Cleveland, OH 44113-1889  
(216) 787-3050  
(866) 336-8345 Fax

#### Dayton

3401 Park Center Drive, Suite 100  
Dayton, OH 45414-2577  
(937) 264-5000  
(866) 281-9356 Fax

#### Lima

2025 East Fourth Street  
Lima, OH 45804-4101  
(419) 227-3127  
(866) 336-8346 Fax

**Mansfield**

The Tappan Building  
240 Tappan Drive North, Suite A  
Mansfield, OH 44906-1367  
(419) 747-4090  
(866) 336-8350 Fax

**Portsmouth**

1005 Fourth Street  
Portsmouth, OH 45662-4315  
(740) 353-2187  
(866) 336-8353 Fax

**Toledo**

One Government Center, Suite 1236  
Toledo, OH 43604-0794  
(419) 245-2700  
(866) 457-0594 Fax

**Youngstown**

242 Federal Plaza West, Suite 200  
Youngstown, OH 44503-1206  
(330) 797-5500  
(866) 457-0596 Fax

**Central (Medical Claims, Special Claims)**

30 West Spring Street, L-23  
Columbus, OH 43215-2256  
(800) 644-6292  
(866) 336-8352 Fax

**For HPP managed claims, direct all billing questions to the injured worker's MCO**

**Call 1-800-OHIOBWC (1-800-644-6292) for:**

Forms, claims and employer information, or options to reach a representative for medical and pharmacy, IW claim information, fraud, Ombuds office, employer policy or safety service information. Also you may log on to our website at [www.ohiobwc.com](http://www.ohiobwc.com).

**AA. GLOSSARY**

For a list of workers' compensation terms and definitions relating to providers, refer to [ohiobwc.com](http://ohiobwc.com) under "[glossary](#)" and the CPT® manual.