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**I. WORKERS' COMPENSATION SYSTEM**

- A. Ohio Workers' Compensation System Summary - The Ohio workers' compensation system consists of two agencies: Ohio Bureau of Workers' Compensation (BWC) and the Industrial Commission of Ohio (IC). Both are governed by the Ohio Revised Code (ORC). 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.
  
- B. State-Fund & Self-Insuring Employer Claims - 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
    - a. BWC, in partnership with private sector managed care organizations (MCO), implemented the Health Partnership Program managed-care program for state-fund employers.
    - b. An Ohio employer has the opportunity to change the employer's MCO during the open enrollment periods that are conducted every two (2) years. The provider may use BWC's website <https://www.bwc.ohio.gov/employer/services/EmployerMCOLookup/nlbwc/employermcolookup0.aspx> to identify an MCO for a particular employer.
    - c. The Health Partnership Program does not affect fee bills for the Marine Fund or Black Lung claims, family caregivers, permanent home and vehicle modifications, BWC examinations or IC examinations. BWC retains responsibility for payment of these services. In addition, BWC's Pharmacy Benefits Manager, handles pharmacy bills for all state-fund claims. For additional Pharmacy Benefits Manager information, please refer to Outpatient Medication, in Chapter 2.
  - 2. Self-Insuring Claims
    - a. The self-insuring employer is responsible for authorizing and determining medical necessity in self-insuring employer claims. Except for emergency situations, the self-insuring employer must approve medical and vocational rehabilitation services in advance. The self-insuring employer is responsible for the payment of all medical bills for the self-insuring employer's employees.
    - b. The treating provider is responsible for:
      - i. Contacting the appropriate self-insuring employer for authorization guidelines;
      - ii. Sending fee bills and medical documentation to the self-insuring employer; and
      - iii. Including the injured worker's social security number and the employer's name on every bill submitted.
    - c. If the provider bills BWC, the bill(s) shall be processed and denied with an explanation of benefits (EOB) and a message. **Example: "EOB 253: Self-insuring employers pay their own bills directly. Re-bill the self-insuring employer."**
    - d. BWC shall not forward the bill to the self-insuring employer. It is the provider's responsibility to bill the appropriate party. A self-insuring employer shall respond to a medical bill within thirty (30) days of receipt by:
      - i. Paying the bill;
      - ii. Denying the bill for an appropriate reason;

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- iii. Requesting additional information to determine reimbursement eligibility for fee bills; or
- iv. Upon receipt of the requested medical documentation, the self-insuring employer has an additional thirty (30) days to pay or deny the bill.
- e. A self-insuring employer may choose to form the self-insuring employer's own Qualified Health Plans to deliver medical services to the self-insuring employer's employees; however, this is not a requirement. If the self-insuring employer with Qualified Health Plans certification denies a bill, then the dispute resolution process will resolve the medical dispute within thirty (30) working days. If the self-insuring employer is not part of a Qualified Health Plan, the injured worker may file a [Motion \(C-86\)](#) form with BWC to request a hearing before the IC.
- f. The provider can ask questions about self-insuring employer claims or file a complaint against a self-insured employer, by calling BWC's Self-Insured Department at 1-800-OHIOBWC (1-800-644-6292).

### II. MCO/BWC SCOPE OF ADMINISTRATIVE SERVICES

#### MCO Managed Claims Matrix of Responsibilities

SERVICE	MCO RESPONSIBILITIES	BWC RESPONSIBILITIES
Provider network	The MCO shall not limit the number of providers on the MCO panel, unless the MCO makes a decision to do so based on objective data that does not discriminate by provider type. Provider networks shall provide a full range of medical services/supplies for injured workers and demonstrate the ability to provide access for specialized services.	All providers shall be offered the opportunity to sign an agreement to meet the terms of BWC to be enrolled with Health Partnership Program. BWC shall certify all providers who comply with the BWC requirements.
Inpatient utilization review	The MCO performs inpatient utilization reviews for all claims for employers selecting the MCO.	BWC provides oversight and monitors performance measures and utilization trends.
Outpatient surgery and high-cost diagnostic utilization review	The MCO performs outpatient utilization reviews for all claims managed by the MCO.	BWC provides oversight and monitors performance measures and utilization trends.
Physical medicine review includes chiropractic	The MCO performs a physical medicine review for all claims for employers selecting the MCO.	BWC provides oversight and monitors performance measures and utilization trends.

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**MCO Managed Claims Matrix of Responsibilities (Continued)**

<b>SERVICE</b>	<b>MCO RESPONSIBILITIES</b>	<b>BWC RESPONSIBILITIES</b>
Peer review	The MCO performs a peer review process for network and non-network utilization review and treatment issues. The MCO has peer review processes for discussing, educating and disciplining providers, who are identified as outliers of normal treatment patterns based on, profiling and utilization trends. The MCO has a 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 the Health Partnership Program. BWC maintains physician peer review processes for initial claim determinations.
Dispute resolution process (medical issues)	The MCO must complete timely dispute resolution processes 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 the MCO's recommended decision.
Dispute resolution process (network issues)	The 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 deactivate and/or decertify providers from Health Partnership Program.
Quality assurance	The MCO must maintain a credentialing committee and quality assurance committee for a network. The MCO must maintain quality assurance standards.	BWC maintains the Health Care Quality Assurance Advisory Committee for workers' compensation general medical policies, as necessary.
Remain at work services for medical only claims (reference <a href="#">OAC 4123-6-19</a> )	The 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.
Remain at work services for medical only claims (reference <a href="#">OAC 4123-6-19</a> )	The 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.

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**MCO Managed Claims Matrix of Responsibilities (Continued)**

<b>SERVICE</b>	<b>MCO RESPONSIBILITIES</b>	<b>BWC RESPONSIBILITIES</b>
Return to work	The MCO is responsible for documenting and implementing a case management plan addressing return to work plans on all lost-time claims where the injured worker has not returned to work, regardless of date of injury. The MCO may send a return to work letter to the injured worker, the employer and the physician that estimates a realistic return to work date, based on the <a href="#">Official Disability Guidelines</a> .	BWC staff claims with the MCO and other parties as needed, making recommendations for case resolution, when the injured worker has not returned to work.
Provider profiling, claims and bill data	The MCO shall capture all pertinent data on both in-network and out-of-network providers and maintain provider profiles, claim records and other data. The MCO shall be required to share aggregate and other data with both employers and BWC.	BWC has complete access to all MCO claim data, paid bill information and provider profiling information. BWC gathers data and completes Health Partnership Program's program analysis and overall monitoring. BWC measures MCO performance based on established performance measures.
Confidentiality	The MCO shall maintain data and individual claim information confidentiality standards.	BWC shall establish confidentiality standards for the MCO and ensure that standards are met. BWC maintains internal data and individual claim information confidentiality standards.
Payment methodology	The MCO may negotiate the MCO's fee schedule(s) with the MCO's network provider(s). The MCO shall not directly benefit financially from reducing fees to providers. Except for hospitals, MCOs shall pay non-panel providers the lesser of the <a href="#">BWC Fee Schedule</a> or billed charges by the provider.	BWC develops and maintains statewide provider fee schedules with stakeholder input. Except for hospitals, BWC pays providers the lesser of the <a href="#">BWC Fee Schedule</a> , MCO fee schedule or provider's billed charges. If the provider is not in the MCO's network, the MCO's fee schedule is not applied.

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**MCO Managed Claims Matrix of Responsibilities (Continued)**

<b>SERVICE</b>	<b>MCO RESPONSIBILITIES</b>	<b>BWC RESPONSIBILITIES</b>
Provider payments	The employer's MCO shall pay all in- and out-of-network provider claims once BWC has paid the MCO. The MCO must maintain standards for timely payment to providers.	Once the fee bill has been approved, BWC shall pay the MCO. BWC must maintain standards for timely payment to the MCO. <i>(Refer to Section VIII.D.2.b.)</i>
Bill review	The MCO performs bill review and clinical editing functions to ensure relatedness, appropriateness, compliance with utilization review and treatment guidelines. The MCO is required to have a nationally recognized clinical editing criteria package.	BWC may perform secondary automated reviews for eligibility, clinical editing compliance, and bill duplication prior to determining the amount that can be reimbursed on each bill.
Retrospective bill audit	The MCO performs detailed retrospective bill audit, as necessary.	BWC is responsible for overall claims audit of the bills paid by the MCO. BWC shall not routinely audit individual claim fee bills, but reserves the right to do so at its discretion.
Provider relations and education	The MCO maintains provider relations and education process specific to workers' compensation issues. The MCO educates providers on the MCO's operations and how to interact with the MCO.	BWC educates the MCO regarding workers' compensation issues, medical policies and Health Partnership Program rules, etc. BWC and stakeholders educate non-network providers on general Health Partnership Program information and requirements.
Treatment standards/guidelines	The MCO maintains national standards for utilization review functions and maintains treatment guidelines. The MCO uses the <a href="#">Official Disability Guidelines</a> to make treatment authorization decisions	BWC utilizes the <a href="#">Official Disability Guidelines</a> as its case management guideline resource and for the Alternative Dispute Resolution process.
Injury prevention	The MCO shall identify safety/injury concerns based on types and frequency of injuries and communicate with the employer. The MCO shall 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 detection	The MCO identifies red flags and cooperates with BWC and employer efforts in provider investigations.	BWC maintains identification, investigation and process functions.

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**MCO Managed Claims Matrix of Responsibilities (Continued)**

<b>SERVICE</b>	<b>MCO RESPONSIBILITIES</b>	<b>BWC RESPONSIBILITIES</b>
Early notification of injury	The MCO shall report injury by electronic notification processes to BWC.	BWC receives injury notification from the MCO and other parties.
Claim determination	N/A	BWC assigns the claim number to each notification, reviews information about injury notifications and determines whether claims can be allowed.
Case coordination	<p>The MCO must interface and coordinate with the customer service teams. The MCO is responsible for triaging claims, performing initial assessment and medical case management referrals.</p> <p>Employers, family members, specialty providers or other sources (community agencies, etc.), should be included as they emerge and are identified in the case.</p>	<p>BWC maintains and performs functions for the overall management of the claim.</p> <p>BWC shares responsibility for successful management of the claim and presents important communication linkages, which include: Claim Service Specialist, Medical Service Specialists, Catastrophic Nurse Advocate, Medical Claim Specialist (MCS/Med only claims) and Disability Management Coordinator.</p>
Medical case management	<p>Medical case management is an essential component in effecting a successful claim outcome.</p> <p>Medical Case Management: Collaboration to assess, plan, implement, coordinate, monitor and evaluate options and services to meet an injured worker's health needs using communication and available resources to promote quality cost-effective outcomes; within the Ohio workers' compensation program. This includes identifying and minimizing potential barriers to recovery, identifying and assessing future treatment needs, evaluating appropriateness and necessity of medical services, authorizing reimbursement for medical services, resolving medical disputes and facilitating successful return to work or claim resolution for injured workers, which can be telephonic and/or on-site depending on the need of the injured workers.</p>	BWC maintains workers' compensation general medical policies. BWC provides oversight and monitors performance measures.

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**MCO Managed Claims Matrix of Responsibilities (Continued)**

<b>SERVICE</b>	<b>MCO RESPONSIBILITIES</b>	<b>BWC RESPONSIBILITIES</b>
Independent medical exam	The MCO shall schedule the alternative dispute resolution, independent medical exam, make appropriate referrals for specialist care and obtain second opinions as indicated.	BWC shall perform the independent medical exam, as necessary and as required by statute and rules. This is including but not limited to: <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; or</li> <li>○ Other.</li> </ul> </li> </ul>
<a href="#"><u>Permanent Partial Disability Application for Determination of Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability (C-92)</u></a> form review and exam	In cooperation with BWC, the MCO educates treating physicians on necessary medical documentation for request for increase in the permanent partial disability award.	BWC is responsible for physician education, physician network, scheduling exams, quality assurance on independent medical exam and physician reviews for permanent partial disability awards.
Sub-acute/long term facility/alternative care management (traumatic brain injury care, etc.)	The MCO performs authorization, coordination of care, ongoing monitoring and quality assurance of service level for long-term care needs.	BWC provides oversight and monitors performance measures.
Home and vehicle modifications authorizations	The MCO case manager shall work closely with the BWC Catastrophic Nurse Advocate to ensure coordination of the services. The MCO is responsible for authorizing temporary modifications, such as, home ramps and vehicle scooter lifts.	BWC's Catastrophic Nurse Advocate identifies need for permanent home/vehicle modification as a result of a catastrophic injury. The Catastrophic Nurse Advocate works with the MCO case manager and necessary vendors to ensure coordination of the services.

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**MCO Managed Claims Matrix of Responsibilities (Continued)**

<b>SERVICE</b>	<b>MCO RESPONSIBILITIES</b>	<b>BWC RESPONSIBILITIES</b>
Caregiver services authorization	The MCO performs authorization of professional nursing services (home health agency) and ongoing monitoring.	BWC performs continued authorization for caregiver (spouse, etc.) services and ongoing 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	The 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	The MCO determines feasibility for vocational rehabilitation services. The MCO manages rehabilitation cases in accordance with Ohio Administrative Code (OAC) rules and BWC guidelines. The MCO educates providers and employers about return to work expectations.	BWC determines eligibility for vocational rehabilitation services and may provide rehabilitation referrals. BWC consults with the MCO and may make suggestions on rehabilitation programming. BWC determines and pays compensation such as living maintenance and living maintenance wage loss.
Performance measures	The MCO must meet defined data and reporting requirements.	BWC establishes, with stakeholder input, measurement, analysis, evaluation and reporting functions on the performance of MCO and Health Partnership Program.
MCO contract management	N/A	BWC is responsible for measuring, monitoring and ensuring contract compliance, standards compliance and reporting on outcomes and savings.
Communications about Health Partnership Program	In cooperation with BWC, the MCO educates injured workers/employers/providers on how to interact with the MCO. The MCO prepares provider directory/related information and a toll free inquiry line for customers regarding their network and services.	In cooperation with the MCO, BWC provides high level informational support via its media programs, website, print communications and through its provider contact center at: 1-800-644-6292 option 0,3,0.

### **III. PROVIDER ENROLLMENT AND CERTIFICATION**

- A. Provider Enrollment & Certification Qualifications - All providers who meet minimum credentialing criteria and sign a provider application/agreement, indicating agreement to abide by all Health Partnership Program and medical rules, shall be allowed to participate in Health Partnership Program.
  
- B. There Are Three (3) Categories Of Health Partnership Program Providers:
  - 1. BWC-Certified Provider - A credentialed provider who is approved by BWC for participation in Health Partnership Program 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:
    - a. Is eligible and meets minimum enrollment requirements per Ohio Administrative Code (OAC) [4123-6-02.21](#), but is not approved for certification in the Health Partnership Program;
    - b. Is not eligible for BWC certification; or
    - c. Lapses BWC certification because the provider did not respond to the provider's invitation to recertify.
  - 3. Providers Eligible for Enrollment Only - Provider types ineligible for certification are listed on the [Application for Enrollment – Non-Certification \(MEDCO-13A\)](#) form. For claims with dates of injury prior to October 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.
    - a. The provider may check on the provider's certification status by:
      - i. Contacting the provider's MCO(s);
      - ii. Calling 1-800-644-6292, option 0,3,0;
      - iii. Visiting BWC Online at [www.bwc.ohio.gov](http://www.bwc.ohio.gov) and accessing the Medical Provider section. All BWC-certified providers are listed on the BWC provider look up section.
    - b. Neither the application for certification, nor the provider agreement located within the application may be altered or modified. These actions shall delay certification.

### **IV. PROVIDER ENROLLMENT AND CERTIFICATION APPLICATION AND PROCESSES**

- A. Provider Applications For Enrollment - BWC uses two (2) 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 for [MEDCO-13](#) and ineligible for BWC certification (enrolled only providers, [MEDCO-13A](#) are available at <https://www.bwc.ohio.gov/bwcccommon/forms/BWCForms/nlbwc/ProviderForms.asp>. Please review the provider types noted on each application and complete the appropriate one.
  
- B. Minimum Enrollment Requirements - A provider must meet minimum enrollment requirements (licensure, accreditation, etc.) to be eligible to enroll in BWC's provider

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database. The requirements for certification are noted in Ohio Administrative Code (OAC) [4123-6-02.2](#) and the provider application [MEDCO-13](#).

- C. Verification - BWC shall 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 shall send a verification letter of BWC enrollment and/or certification approval status to the provider, based on the provider type.
- D. How To Change Provider Enrollment Data - 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

- E. Notification Of Changes To Provider Information - The BWC certified provider agrees to notify BWC within thirty (30) days of changes to the provider's:
  - 1. demographic information;
  - 2. provider/[National Provider Identifier](#) numbers;
  - 3. tax identification;
  - 4. ownership information; or
  - 5. change in status regarding credentialing criteria of paragraphs (B) and (C) of [OAC 4123-6-02.2](#).
- F. Notification Of Change To Provider Enrollment Data - The BWC provider shall provide the following information when submitting a written request to change provider enrollment data: :
  - 1. Provider name and any of the above identification numbers;
  - 2. Phone number;
  - 3. Signature of individual who is assigned the specific provider number; and/or
  - 4. Change(s) to address. If there are changes to the address, please specify the:
    - a. Physical location(s);
      - i. A P.O. Box is not accepted as a practice location.
      - ii. An actual street address is needed for each location of the provider's practice.
    - c. Pay-to address; and
    - d. Correspondence address.
- G. Change To Tax Identification Number & Group Affiliation - A change to the tax identification number and group affiliation must be requested in writing. The BWC provider shall specify when the date change shall become effective. See [MEDCO-12](#) form located at <https://www.bwc.ohio.gov/bwcccommon/forms/BWCForms/nlbwc/ProviderForms.asp> to determine if the [MEDCO-12](#) or a new application is appropriate to submit for tax identification changes. In addition, the provider shall submit a [Request for Taxpayer Identification Number and Certification \(W9\)](#) form. Provider status regarding credentialing criteria shall contain the above bulleted information and status update details.

- H. Provider Enrolled As BWC Provider Type 12/Provider Group Practice - This provider type is only eligible to enroll as a provider who receives payment, and shall not bill as a servicing provider. BWC shall require any group enrolling to name a certified provider associated with that group's tax identification number, to submit a [W9](#) for Internal Revenue Service (IRS) purposes to be enrolled. 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 request the provider update BWC with accurate demographic information that shows each location where the provider is working.
- I. Provider Recertification
1. BWC's provider recertification initiative is based on the provider's original certification dates. Periodically, BWC releases recertification applications, which include a summary of the information presently on file for the provider.
  2. If a provider submits a completed recertification application to BWC within ninety (90) days of the initial notice, the provider shall remain certified until BWC issues a final order approving or denying the provider's recertification
  3. If a provider does not submit a completed application within ninety (90) days, the provider certification shall lapse. Once the provider's certification lapses, the provider's bills may not be paid for the dates of service during the period the provider is lapsed. The provider may apply for recertification post lapse by submitting a completed application; however, the provider shall remain lapsed until BWC issues a final order approving or denying the provider's recertification. Once a lapsed provider completes the process, the provider may become recertified and the recertification shall be retroactively applied. There shall be no gap in certification status between initial certification and recertification. The provider's bills for dates of service during the period of lapse may then be paid.
  4. The EOB 448 code addresses non-payment due to non-recertification. EOB 448 code (i.e., payment is denied as provider's certification has lapsed) description - A provider who fails to respond within ninety (90) calendar days of recertification notice or who requests removal from Health Partnership Program shall be put in "lapsed status." There shall be an effective date associated with that status and bills with dates of service prior to the effective date shall pay. Dates of service after the effective date shall be denied unless it is approved by an MCO with override EOB 756 code.
- J. National Provider Identifier
1. BWC prefers the provider use the provider's National Provider Identifier whenever possible for submitting bills.
  2. A National Provider Identifier serves as an alternate identifier that providers can use in Ohio workers' compensation billing.
  3. The federal Health Insurance Portability and Accountability Act (HIPAA) protects the privacy of a injured worker's medical records and other health information maintained by covered entities. BWC is not a covered entity under HIPAA. Therefore, BWC shall continue to accept bills containing only BWC legacy (or current) numbers, as well as bills with both the legacy number and the National Provider Identifier.
  4. BWC has made changes to add National Provider Identifier information to its database to cross-reference BWC provider numbers. This shall 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.

5. A provider wishing to incorporate the National Provider Identifier into the provider's workers' compensation billing must provide and verify the provider's information with BWC's provider relations department. Furthermore, the provider must submit copies of the provider's National Provider Identifier confirmation from the enumerator (Fox Systems Inc.), along with the provider's corresponding BWC provider number to BWC Provider Enrollment fax number (614) 621-1333 or to the following mailing address:

Ohio BWC Provider Enrollment  
P.O. Box 12549  
Columbus, OH 43215-2549
6. Once this process is complete, a provider may bill using either the provider's BWC provider number or a combination of the BWC provider number, the National Provider Identifier and taxonomy code, if applicable. Again, BWC does not require providers to use a National Provider Identifier for billing.
7. A provider seeking additional information on National Provider Identifier registration can [click here](#).
8. Any provider still needing to obtain a National Provider Identifier may do so at <https://nppes.cms.hhs.gov/>.
9. At this time, BWC can only accommodate the National Provider Identifier on forms for the billing processes noted above. BWC has instructed the MCO to identify medical providers using the National Provider Identifier on forms other than bills, attempt to cross-reference the provider information and inform the provider to use its' BWC provider number until the bureau can accommodate National Provider Identifier in other processes.
10. The provider may direct questions about submitting National Provider Identifier information to: 1-800-OHIOBWC (1-800-644-6292), option 0,3,0 weekdays between 8 a.m. and 5:00 p.m. Eastern Time (ET).

### V. REPORTING AN INJURY (BWC Rule – [OAC 4123-6-02.8](#))

#### A. Provider Responsibilities

1. The provider may call the employee's MCO to report an injury or complete and file the *First Report of an Injury, Occupational Disease or Death (FROI)* form online at <https://www.bwc.ohio.gov/bwcccommon/forms/froi/nlbwc/FROI1.asp>. The provider can file the [FROI](#) electronically to receive a claim number immediately.
  - a. Timely reporting of an injury is one of the most important responsibilities a provider has in the Health Partnership Program. By rule, the provider must report the injured worker's injury to the responsible MCO within one (1) working 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 reporting injuries within one (1) working day 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.
  - b. Reporting an injury to the MCO within one (1) working day 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, in general 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.

- c. Timely reporting assists the provider with receiving billing and reimbursement instructions from the MCO and minimizes the possibility in delays of claim authorizations (e.g., for compensation awards, medical benefits, treatment authorizations, etc.). To facilitate claim authorizations, it is important to provide the MCO with accurate information, including the exact International Classification of Diseases (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. Please visit the following BWC ICD reference page to locate more detailed information about the ICD(s).  
<https://www.bwc.ohio.gov/provider/services/ICDforBWC.asp>.
  2. Often, when injured workers first visit a provider or a facility for treatment, the provider is uncertain of the provider's MCO, which complicates reporting the injury. However, injured workers usually know the name of the injured worker's employer. Each state-fund employer either chose or is assigned an MCO, so this information is available from the employer or BWC. If the employer is unable to provide the name of provider's MCO, this information can be accessed on the BWC website at <https://www.bwc.ohio.gov/provider/services/mcolookup/nlbwc/default.asp>. Please contact contact BWC at 1-800-OHIOBWC (1-800-644-6292), if the Internet is inaccessible.
- B. Required Data Elements
1. Required data elements to file a [FROI](#) are located at <https://www.bwc.ohio.gov/bwcccommon/forms/froi/default.asp> on the BWC website. The MCO must collect required data about the injury and may contact the provider for additional information.
  2. If the BWC provider number is submitted to the MCO, BWC shall send the provider who reported the injury or the provider of record a letter that provides the status of the claim and the allowed conditions.

## **VI. ERRONEOUS MCO PAYMENT DENIALS**

- A. MCO Authorization & Determination Responsibilities - The MCO is responsible for authorizing and determining medical necessity of requested treatment for all claims.
- B. Provider Of Record/Treating Physician Responsibilities - The provider of record or treating physician is responsible for contacting the appropriate MCO for authorization of services.
- C. MCO Penalty Payment To Providers
  1. 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.
  2. 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.
  3. The following table of questions and answers, identifies some potential penalty payment situations:

**BWC's Provider Billing and Reimbursement Manual**

<b>Potential Penalty Payment Situations Questions &amp; Answers</b>	
<b>Questions</b>	<b>Answers</b>
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 (1) \$10 payment or three (3) \$10 payments (one (1) for each denied bill)?	The MCO is required to pay "for every instance of erroneous denial," therefore; the MCO shall pay three (3) \$10 penalty payments or \$30 total.
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?	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.
Does the \$10 penalty apply when the IC orders payment of treatment and the MCO denies the bill for lack of prior authorization?	Yes, the MCO is responsible for reviewing hearing orders and paying bills as ordered by the IC.
Is it appropriate to deny an office visit or consultation for lack of prior authorization?	Office visits and consultations (except for chronic pain programs and psychological treatment) do not require prior authorization and therefore will not be denied for lack of prior authorization. The MCO shall utilize a more appropriate explanation of benefits to accurately describe the reason for denial. The MCO shall be required to pay the \$10 penalty payment for any office visit or consultation denied for lack of prior authorization.
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?	Yes, the MCO authorizes specific procedures or treatment plans, not specific procedure codes. No procedure code related to the authorized treatment will be denied for lack of prior authorization; however, it may be appropriate to deny the line item with another explanation of benefits, which accurately describes the reason for denial.

**VII. TREATMENT GUIDELINES**

- A. Treatment Guidelines Section Summary - 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.

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

## **VIII. REIMBURSEMENT GUIDELINES**

- A. Reimbursement Guidelines Section Summary - The information in this section pertains to general reimbursement guidelines for all provider types. Provider type-specific information can be found in Chapter 2 of this manual.
- B. Medical Coding Guidelines
1. Diagnostic Coding Guidelines
    - a. All medical providers shall report the ICD diagnosis code(s) representing the condition(s) being treated during the encounter. The provider shall utilize national correct coding guidelines when reporting diagnoses, using the appropriate code from the ICD code set effective for the date of service. Accurate diagnosis reporting is important as coding may impact the provider's reimbursement and data integrity.
    - b. The provider should not request that additional conditions be added to a claim solely for billing purposes.
    - c. The provider shall contact the appropriate resource, if the provider has questions about whether services are related to a claim.
      - i. The MCO and the employer for state-fund claims; or
      - ii. The provider's bill processing representative for self-insured claims.
    - d. Specific information about the ICD(s) in Ohio Workers' Compensation is available on BWC's ICD reference page:  
<https://www.bwc.ohio.gov/provider/services/ICDforBWC.asp>.
  2. Procedure and Service Coding Guidelines
    - a. The provider 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.
    - b. The provider 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.
    - c. The provider must bill the provider's usual charges for treatment and/or services reported.
    - d. Chapter 2 further clarifies provider type specific details.
- C. Health Partnership Program Billing
1. Forms - To ensure consistent billing processes and maintain quality customer service, all BWC certified MCOs are required to accept the following national and BWC billing forms:
    - a. [American Dental Association Dental Form \(ADA Dental Claim\)](#);
    - b. [Health Insurance Claims Form \(CMS-1500\)](#);
    - c. [Uniform Billing \(UB-04\)](#); and
    - d. [BWC Service Invoice \(C-19\)](#).

*(See Chapter 4 of this manual for detailed billing instructions for each bill form)*

2. Submission
  - a. The provider must submit all bills 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.bwc.ohio.gov/provider/services/837Links.asp>. In addition, the provider may submit bills by mail to the appropriate MCO or self-insured employer.
  - b. In the event of an MCO transition (i.e., merger/acquisition, open enrollment, auto-assignment due to contract termination), all bills must 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 the provider to the MCO.
  - c. The provider may submit bills to the MCO prior to the allowance of injured worker claims. However, the payment shall not be made until the claim is allowed.
  - d. The provider must submit bills for payment within one (1) year of the date on which the service was rendered or one (1) year after the date the service became payable, whichever is later, or shall be forever barred. See <http://codes.ohio.gov/oac/4123-3-23> for details.
    - i. The provider must produce proof of submission in the event of payment denial regarding a timely filing.
    - ii. Proof of timely filing examples (not all inclusive) consist of:
      - a) Documentation from the MCO or BWC, such as, a date stamped bill, notes in the claims management system, a dated bill rejection, phone calls documented in claim file, copy of e-mail or fax from MCO (not provider). *Note: In cases involving an MCO error, the error must be explained and documented in the claim file;*
      - b) When money is recovered from a private insurer, the EOB recovering the money or copy of payment of the EOB from provider allows the provider two (2) years from date of service to submit the bill to the MCO and BWC. There are times when the provider seeks payment from the MCO and BWC when the provider becomes aware that the claim is a workers' compensation claim, but the provider has already received payment from the private insurer. A copy of the payment EOB from the private insurer provides proof of timely filing to extend the billing statute to, two (2) years from the date of service. If the date of service is more than two (2) years from when the provider seeks payment, the bill does not meet the billing statute regardless of the provider just becoming aware that the services were for a workers' compensation claim; or
      - c) When the provider is not aware the services were for a workers' compensation claim and the provider bills the employer or injured worker in error, as long as a copy of the correspondence and copy of any payments made is provided, the billing statute is extended to two (2) years from date of service.
    - iii. No proof of timely filing examples (not all inclusive) consist of:
      - a) Example 1: Notes from the provider's system, notes from the provider's files, dates of phone calls provided by provider, copy of fax transmittal sheet from the provider or copy of electronic submission of bill if the MCO denies receipt of the bill; or

- b) Example 2: When a provider has consistently billed services for an injured worker to the MCO and BWC and has worked with the MCO for prior authorization and then claims to not have known the claim was workers' compensation, the billing statute is not extended.

**D. Reimbursement Review & Payment**

- 1. It is the MCO's responsibility to ensure services and supplies are medically necessary and related to the allowed claim conditions before approving reimbursement.
- 2. 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 the bill shall be processed by the former MCO. It is the newly assigned MCO's responsibility to contact the former MCO in cases where there is not sufficient information to process a bill.

**a. MCO Reimbursement Review**

- i. The MCO is responsible for reviewing the medical documentation to determine if the diagnoses are accurately reported.
  - a) If the MCO determines that the billed diagnosis code is not accurately reported, then EOB 323, *payment is denied as the diagnosis billed does not match the diagnosis code listed in the accompanying reports*, may be applied, which shall result in the denial of the bill. It is the provider's responsibility to correct the coding on the bill and resubmit the bill for payment consideration.

If the MCO determines the diagnosis is accurately reported, not allowed in the claim, but related to the injured worker's work-related injuries, then EOB 776, *payment is being made for a non-allowed, but related condition*, may be applied to the bill to allow for reimbursement. 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](#).

**b. Payment of Bill**

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

**E. Miscellaneous Billing Provisions**

- 1. Payment does not include reimbursement for any sales tax for services and/or items provided to the injured workers, as BWC is exempt from sales tax payment as a State of Ohio government agency.

2. Only medical services provided shall 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.
3. Reimbursement shall not be made for missed appointments.
4. The injured worker is not required to contribute a co-payment or meet any deductibles. The BWC certified provider is responsible for billing the appropriate MCO for reimbursable covered services and shall not, in accordance with the provider agreement, request payment from the injured worker.
5. Balance billing - The health-care provider 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 [ORC 4121.44\(O\)](#)
6. When the 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.
  - a. Services and supplies never covered are defined in [OAC 4123-6-07](#), are found in the fee schedule and flagged as never covered (NC). The injured worker must agree and understand that the services are not payable by workers' compensation.
  - b. Provided by a BWC non-certified provider, except as indicated in [OAC 4123-6-10](#), are the sole obligation of the injured worker.

### F. Additional Considerations

1. 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. The provider will need to bill workers' compensation benefits for services related to compensable conditions before attempting to collect from another payer.
2. Settled Claims
  - a. A claim may be settled for medical and/or indemnity benefits.
  - b. BWC will send a letter to the vocational rehabilitation case manager as applicable, when a settlement is requested. The MCO shall notify the provider when the settlement is filed and finalized. The provider can contact the MCO for any questions about claims and settlement.
  - c. Once the parties agree to the settlement, the claim is placed in a "Settled Pending" status followed by a thirty (30) day hold/pending period. During the thirty (30) day hold/pending period:
    - i. 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" shall 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 the settlement.
    - ii. 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.

- a) A [Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease \(C-9\)](#) form for a date of service on or after the "Effective Settlement Date" shall be dismissed.
  - b) A [C-9](#) for a date of service prior to the "Effective Settlement Date" that is submitted to the MCO within one (1) year from the date of service shall be processed, per MCO contract requirement.
  - c) An appeal to MCO decisions on a [C-9](#) for the date of service prior to the "Effective Settlement Date" is subject to the Alternative Dispute Resolution process.
2. The MCO and BWC shall ensure resolution of all timely submitted bills for services rendered prior to the "Effective Settlement Date." Contact the MCO when a timely submitted bill for services prior to the Effective Settlement Date has not been paid.
- G. 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.
1. Alternative Dispute Resolution appeals are covered in Section XII. Alternative Dispute Resolution appeals relate to medical treatment disputes regarding quality assurance, utilization review, medical necessity and other treatment issues.
    - a. MCO overpayment recovery actions based on an MCO determination that the service(s) is not medically necessary that is appealed by the provider, shall be processed under the Alternative Dispute Resolution appeal process.
    - b. Medical billing disputes where the reason for the bill payment dispute is because the service is not medically necessary shall be processed under the Alternative Dispute Resolution appeal process.
  2. Medical Bill-(*Includes Vocational*) Grievance
    - a. General Considerations
      - i. A medical bill grievance exist when a provider is not satisfied with the amount of payment and the EOB received from an MCO.
      - ii. A medical bill-grievance does not include a dispute of the [BWC Fee Schedule](#) rates.
      - iii. A medical bill-grievance relating to the medical necessity of treatment is handled through the Alternative Dispute Resolution process. (*See Section XII*)
    - b. Process for Handling Medical Bill Grievance
      - i. The provider contacts the MCO to inquire about the reimbursed amount or denial of a medical bill via email, fax, phone or mail.
        - a) It may be necessary to submit the inquiry along with supporting documentation, in writing, to the MCO.
        - b) The provider and MCO should keep detailed notes for their records, including the name and phone number of the person to whom they spoke, fax confirmations, etc.
        - c) 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.
      - iii. The MCO shall acknowledge the inquiry via email, fax, phone or 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.

- iv. 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.
    - a) The conference (i.e., in person or via telephone) shall occur within seven (7) calendar days from the request for the conference.
    - b) The MCO shall document details of all grievance conferences and the outcome.
  - v. The MCO shall issue a written decision within seven (7) calendar days from the date of the conference.
    - a) The MCO's written decision shall be imaged into the injured worker's claim file by the MCO.
    - b) Required elements of the written decision include:
      - i) Identification of specific documentation reviewed at the conference;
      - ii) Date, time, place and person (i.e., MCO and provider) who participated in the conference;
      - iii) The conference method used (e.g., phone, face to face, email); and
      - iv) Information about how the provider can appeal the determination to BWC.
  - vi. If the provider does not agree with the MCO's decision, the provider may contact BWC's Provider Contact Center at 1-800-OHIOBWC (1-800-644-6292), option 0-3-0 or via email at: [feedback.medical@bwc.state.oh.us](mailto:feedback.medical@bwc.state.oh.us) to appeal the billing grievance.
  - vii. The BWC Provider Contact Center shall ask the provider to submit the provider's documentation and grievance conference letter.
    - a) 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.
    - b) The Provider Contact Center shall 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.
  - viii. 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 MCO. BWC's Provider Contact Center shall image the written response into the injured worker's claim file. After BWC's determination is rendered, no additional levels of review shall be considered.
  - ix. If at any point during the medical bill grievance 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 shall notify the Provider Contact Center when payment is released.
3. Overpayment Recovery And Appeal Process
- a. General Considerations
    - i. 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.
    - ii. 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.
    - iii. All paper correspondence shall be mailed to the provider's correspondence address.

- iv. Overpayments to providers resulting from the disallowance of a previously allowed claim or condition shall not be recovered from the provider.
  - v. A provider payment 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.
  - vi. If the MCO authorize 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 shall 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.
  - vii. 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.
  - viii. 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 identification number as the original provider. The MCO shall inform the provider in writing via certified mail that recovery shall 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 shall 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.
  - ix. If a party to the claim files an appeal for services through the Alternative Dispute Resolution process (*see section XII*) or with the IC regarding treatment already rendered, the MCO shall take the following steps:
    - a) 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.
    - b) Bills for service that have already been paid in compliance with Ohio BWC laws and rules shall remain paid. Bills for service that have not been paid shall be pended until appeals through the IC Staff Hearing Officer level are exhausted.
    - c) If the final decision from the Alternative Dispute Resolution 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 shall be denied.
  - x. The MCO shall initiate recovery of overpayments only after all appeal periods have been exhausted.
- b. Process - Discovery of an Overpayment/MCO Notification to Provider
- i. MCO Actions
    - a) 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 shall include instructions regarding the provider grievance conference process, the thirty (30) calendar day time period for provider objections, and instructions regarding when an overpayment shall be referred to Medical Billing and Adjustments for collection.
- b) 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 notes, its attempts to contact the provider.
  - c) The MCO recovery effort shall stop and recovery shall be referred to Medical Billing and Adjustments-Recovery via email at: [MedicalBillPaymentRecovery@bwc.state.oh.us](mailto:MedicalBillPaymentRecovery@bwc.state.oh.us) when any of the following occur:
    - i) The provider has ceased operations;
    - ii) The MCO is unsuccessful in contacting the provider following receipt of the returned certified notice; or
    - iii) The MCO receives no response to the certified letter.
  - d) When referring to Medical Billing and Adjustments-Recovery under the circumstances indicated above, the MCO shall submit supporting documentation including the following:
    - i) Copy of original overpayment recovery request;
    - ii) Copy of certified mail receipt or verification of delivery; and
    - iii) Documentation of all recovery efforts.
  - e) Medical Billing and Adjustments shall review the documentation and determine actions to be taken regarding recovery.
- c. Provider agrees with MCO Overpayment Determination
- i. 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 thirty (30) days from the date of the agreement.
  - ii. If payment of the requested recovery amount is not received within thirty (30) days of the date of initial agreement, the MCO shall refer the overpayment recovery to Medical Billing and Adjustments via e-mail to: [MedicalBillPaymentRecovery@bwc.state.oh.us](mailto:MedicalBillPaymentRecovery@bwc.state.oh.us) for collection of the overpayment.
  - iii. Medical Billing and Adjustments Recovery shall send the provider a demand for recovery. The demand letter shall provide notification that the provider has thirty (30) days from the date of the demand letter to either reimburse BWC for the overpayment or dispute the overpayment determination. The letter shall 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
- i. 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 thirty (30) days from the date of receipt of the MCO notification of overpayment.
  - ii. 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.

- iii. Upon conclusion of the grievance conference, the MCO shall issue a written decision to the provider within seven (7) calendar days. The letter shall contain at least the following:
  - a) The date, time, place and participants in the conference;
  - b) The MCO's rationale for the decision;
  - c) Address for submitting reimbursement to the MCO; and
  - d) Notification that the provider may appeal the MCO's grievance conference decision to BWC management within thirty (30) days of the date of the grievance conference decision by sending their dispute in writing to:

Medical Billing and Adjustments Recovery  
30 West Spring St. L20  
Columbus, OH 43215  
[medicalbillpaymentrecovery@bwc.state.oh.us](mailto:medicalbillpaymentrecovery@bwc.state.oh.us);  
Fax: (614) 621-5294
- iv. If the provider does not appeal the grievance conference decision within thirty (30) days, the MCO shall notify Medical Billing and Adjustments Recovery.
- v. If the provider disputes the MCO's grievance conference decision and submits a timely appeal to Medical Billing and Adjustments recovery, the recovery dispute shall be staffed by the Recovery Manager and the Medical Services Division Chief's designee. The Recovery Manager and the Medical Services Division Chief's designee shall determine whether recovery is appropriate and issue their written decision to the provider within thirty (30) days of receipt of the appeal. The provider shall be notified of the opportunity to appeal the decision to the Administrator's designee within fifteen (15) days of the date of the notification of the decision.
- vi. If the provider timely appeals and provides new documentation not previously presented to prove the Division Chief's designee made an error in the decision, the Administrator's designee shall review and make the final determination and notify the provider of the final decision within thirty (30) days of receipt of the appeal. The notification shall be sent to the provider via certified mail with copies sent electronically to the MCO.
- vii. If the final decision is that an overpayment exist and the provider does not submit repayment, Medical Billing and Adjustments shall refer the overpayment decision to the Attorney General's office for collection.

H. Special Investigations Department Determination of Overpayment

1. Within fourteen (14) calendar days of notice from the Special Investigations Department and verification of a provider overpayment, Medical Billing and Adjustments 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.
2. The provider may appeal the overpayment notice within thirty (30) days of the date of the overpayment notification to the provider. Notice of appeal shall be in writing and shall be submitted to:

Medical Billing and Adjustments Recovery  
30 West Spring St. L20  
Columbus, OH 43215  
Fax (614) 621-5294  
[medicalbillpaymentrecovery@bwc.state.oh.us](mailto:medicalbillpaymentrecovery@bwc.state.oh.us)

3. 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 thirty (30) 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.
4. If the final decision is that an overpayment exist and the provider does not submit repayment, Medical Billing and Adjustments shall refer the overpayment decision to the Attorney General's office for collection.
5. BWC in its discretion, may 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.
6. BWC may initiate decertification action when providers are certified to the Attorney General's Office for non-payment.

**IX. REQUIRED REPORTS (BWC Rule [OAC 4123-6-20](#))**

- A. Required Reports Summary - The provider undertaking treatment of an injured worker shall submit initial and subsequent reports to the MCO. The OAC authorizes the MCO 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 MCO. In addition, as part of becoming BWC-certified, the provider is contractually obligated to provide medical documents to the MCO. By law, filing a workers' compensation claim authorizes BWC and the MCO to receive medical documents to be used in investigating and determining the claim. Consequently, submitting medical documents to either BWC or an MCO does not require a release signed by the injured worker.
- B. BWC Forms And Medical Documentation - 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 shall list the injured worker's claim number in the top right hand corner of the report(s). The provider shall use the fax numbers in the MCO Directory found at <http://www.bwc.ohio.gov/provider/brochureware/MCOUpdate/default.asp>. This eliminates the need for the provider 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 in *Section IX*.
  1. The provider also assumes the obligation to provide and complete all BWC forms required by the MCO.
  2. A provider may not charge the injured worker, employer, the provider's representatives, MCO, BWC, IC or a self-insuring employer for the costs of completing the required forms or submitting necessary documentation.
- C. Provider Charges For Copies Of Medical Records - Per [OAC 4123-6-20.1](#), a provider may charge a fee for copies of medical records if the provider previously filed copies of medical records with the MCO, BWC or the self-insured employer in self-insured claims, and BWC 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.

- D. Medical Documentation - The provider shall supply medical documentation to the MCO at the time of the treatment request. The MCO shall review and act on (i.e., approve or deny) the [C-9](#) before forwarding it to BWC.
1. If medical data to support treatment necessity is not included within the [C-9](#), such evidence must accompany the [C-9](#) submission as an attachment.
  2. If evidence is incomplete, the MCO shall use BWC's [Request for Additional Medical Documentation for C-9 \(C-9-A\)](#) 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.
- E. Initial Medical Reports – The provider shall also submit initial medical reports to the MCO when the [FROI](#) is submitted, that is, within one (1) working day of the initial treatment or initial visit.
- F. Advantages Of Providing Medical Reports - 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 one (1) working day 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.
- G. Timely Submission Of Medical Reports – The timely submission of medical reports also helps to minimize delays with claim authorizations (e.g., for compensation awards, medical benefits, treatment authorizations, etc.). To facilitate claim authorizations, it is important to provide the MCO with accurate information, including the exact ICD codes for which the injured worker is being treated.
- H. Provider Updates To MCO - 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 injured worker 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 injured worker'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 shall forward progress notes to the MCO.
1. Medical Documentation and Bill Payment
    - a. The MCO shall maintain integrated case management and bill payment systems. The MCO 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/not otherwise classified (NOC) procedures). However, the provider 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. *Example:* For a period not to exceed sixty (60) days following the date of injury, physicians have presumptive approval for providing Evaluation and Management and consultation services when treating soft tissue and musculoskeletal injuries for

allowed conditions in allowed claims. Although the Evaluation and Management service may be rendered without prior authorization, documentation must be submitted to support the components of the Evaluation and Management 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 shall be reconsidered once legible documentation is submitted.*

- b. The MCO must maintain documentation of who determined the medical record to be illegible.
  - c. The provider shall use the fax numbers listed in the [MCO directory](#) to send all medical documentation into the worker's electronic claim file. Both the MCO and BWC shall be able to access all documentation faxed to those numbers. Medical documentation faxed to self-insuring employers is not captured in BWC's electronic claim files. Provider forms are found on the following BWC Website <https://www.bwc.ohio.gov/bwccommon/forms/BWCFORMS/nlbwc/ProviderForms.asp>.
2. Health Insurance Portability and Accountability Act (HIPAA)
- a. The HIPAA privacy and electronic transactions regulations do not directly apply to the MCO and BWC. The MCO, BWC 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.
  - b. 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.
  - c. The MCO and BWC are not "business associates" of providers, since the MCO and BWC 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 providers.
  - d. However, an administrative agent of a Disability Evaluator Panel provider might be considered a "business associate" of the Disability Evaluator Panel provider (but not of BWC) under HIPAA. It is the responsibility of the Disability Evaluator Panel provider to ensure that the Disability Evaluator Panel provider contract with the administrative agent contains the necessary HIPAA privacy safeguards; therefore, the Disability Evaluator Panel provider shall consult with the Disability Evaluator Panel provider's legal counsel and/or HIPAA consultants as to whether the Disability Evaluator Panel provider's 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.
- e. Under the 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 broadly under HIPAA. Therefore, if the provider is currently treating a workers' compensation injured worker and the provider is requesting authorization for treatment, requesting payment for treatment already rendered, 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 would be able to release information to the MCO and BWC. Also, the provider would be able to release information to a self-insuring employer or Qualified Health Plan in a self-insured claim.
  - f. If a treating provider is being asked to disclose protected health information to any of the parties listed in [OAC 4123-6-20\(E\)](#) (BWC, injured worker, employer, MCO, Qualified Health Plan, 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 [Physician's Report of Work Ability \(MEDCO-14\)](#) form for the worker to receive temporary total compensation, etc.), and the provider is persuaded that the requested documentation ***"relates causally or historically to physical or mental injuries relevant to the claim," is "required by the BWC, MCO, Qualified Health Plan, or self-insuring employer", and is "necessary for the injured worker to obtain medical services, benefits or compensation,"*** the provider may disclose the information.

## **X. REQUEST FOR MEDICAL SERVICES**

- A. Submission of Prior Authorization - Requests for medical services that require prior authorization must be submitted by the physician of record or treating physician to the appropriate MCO prior to initiating any non-emergency treatment. The preferred method of submission is the BWC physician's [C-9](#); however, any other physician-generated document may be used if the substitute document contains, at a minimum, the data elements on the [C-9](#). The physician of record should identify additional conditions to be allowed in the claims on the [C-9](#) and should spell out additional conditions with supporting documentation.
- B. Assisting MCO In Medically Managing Injured Worker's Claim - In order to assist the MCO in effectively medically managing the injured worker's claim, it is important for the physician of record/treating physician to comply with the request for medical services guidelines, including *"Presumptive Approval"* and *"MCO Standardized Prior Authorization Table"* policies and procedures.
- C. MCO Authorization Consideration & Expedite Payment - The following guidelines were implemented to help the MCO consider authorization and expedite the payment of medical bills:
  1. The MCO must respond to the physician within three (3) business days with a decision regarding the proposed treatment request. 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.
  2. The MCO shall 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.
3. If the MCO is unable to make a decision within three (3) business days due to the need for additional information, the MCO shall send a request for [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 (10) 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 (10) business days for all active claims. The physician must be notified by fax or phone of the subsequent decision. **Note: In inactive claims - the MCO may dismiss the [C-9](#) (with no Alternative Dispute Resolution appeal rights after the ten (10) days) if the [C-9-A](#) is not returned.**
  4. 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. The MCO shall notify the physician by fax or phone of the subsequent decision.
- D. Medical Service Request Approval & Provider Treatment Initiation - A medical services request shall be considered approved and the provider may initiate treatments when all of these criteria are met:
1. 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 pended;
  2. The physician has documented the medical services request completely and correctly on a [C-9](#) or other acceptable documents;
  3. The physician has proof of submission to the appropriate MCO;
  4. Medical services are for the allowed conditions; and
  5. The claim is in a payable status.
- E. No Response To [C-9](#) In Three (3) Business Days - In instances where there is no response to a [C-9](#) within three (3) business days and the provider initiates treatment, the MCO shall provide concurrent and retrospective review of that treatment.
- F. Discontinue Payment Of 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 injured worker is not responding, the MCO shall notify the parties of decision to discontinue payment of said treatment. Only charges for treatments already rendered shall be paid. If the provider, injured worker or employer wishes to dispute the decision, they may do so via the Alternative Dispute Resolution process.
- G. MCO Authorization Decision Process On [C-9](#) Request - 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 timeframe requirements for each treatment request, including the ability to pend for additional medical documentation/review if necessary.

- H. Self-Insuring Employer Decision Process On [C-9](#) Request – A self-insuring employer is 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 shall be granted. A self-insuring employer is not required to follow BWC's "Presumptive Approval" or "MCO Standardized Prior Authorization Table" located at BWC Website:  
<https://www.bwc.ohio.gov/provider/services/authrequirements/default.asp>.
- I. Information Supporting Request & Authorization - Information used to support requests and authorization for mental health services can also be submitted on the [C-9](#).
- J. Request For Progress Notes - Ohio law protects the confidentiality of the mental health provider's progress notes; therefore, the MCO cannot request copies of this document. A request for copies of the progress notes with the deletion of any non-claim related information is also prohibited. However, a detailed summary of the progress notes can be requested via a [Mental Health Notes Summary \(MEDCO-16\)](#) form, which can be used to support the [C-9](#).
- K. Authorization Granted For Specific Number Of Session Or Period Of Time - Authorization shall be granted for either a specific number of sessions or period of time. **The MCO is 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. Medical Prior Authorization Requirements - "Presumptive Approval" and "MCO Standardized Prior Authorization Table" are located at BWC Website:  
<https://www.bwc.ohio.gov/provider/services/authrequirements/default.asp>).
  2. Request for Medical Services Disclaimer
    - a. A disclaimer 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.
    - b. A disclaimer shall not be used when authorizing treatment for allowed claims and conditions that are within the statute of limitations.
    - c. The MCO 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 and the 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.***"
  3. Provider Compliance
    - a. The provider 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 in section "b" on this page. Reimbursement shall be at seventy-five percent (75%) of the applicable fee schedule for non-emergency treatment delivered, rendered, or directly supervised by the physician of record 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.
- b. The “just cause” or excused reasons to submit a retroactive [C-9](#) noted in [OAC 4123-6-16.3](#) include:
    - i. The treatment requested was emergency treatment;
    - ii. The provider was not aware that services were for a workers' compensation claim;
    - iii. The provider was non-BWC certified and had no established relationship with the injured worker;
    - iv. The provider was initially BWC certified within six (6) months prior to the treatment request;
    - v. The treatment requested was for a pending claim allowance or additional allowance with BWC or IC;
    - vi. The treatment provided was within BWC's presumptive authorization guidelines, or does not require prior authorization per the “*Provider Billing and Reimbursement Manual*”;
    - vii. The treatment request was submitted retroactively due to BWC or MCO error; and/or
    - viii. Other documented justification as deemed sufficient by BWC.
  - c. A provider who does not agree with the discounted reimbursement may utilize the grievance hearing procedure for disputed bill payments found in *Section VIII.G.2.b.vii.* of this manual.
  - d. [OAC 4123-6-02.7](#) Provider Decertification Procedures is BWC's progressive compliance rule. Beginning January 1, 2013, provider rule infractions shall be monitored by the MCO and reported to BWC. The MCO shall send a written notice to the provider after each infraction. The provider is 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 and enrollment termination could occur. If decertification/termination occurs, the provider must wait two (2) years before reapplication is considered. The program works as follows:
    - i. After BWC receives from an MCO report of three (3) or more of the same, or five (5) differing OAC violations over six (6) months, BWC shall send the provider written notice that they are in BWC's progressive compliance monitoring (“First Notice”).
    - ii. Two (2) or more subsequent infractions over the next twelve (12) months result in a second BWC written notice (“Second Notice”) and requires the provider to submit a correction plan within thirty (30) days. Refusal to submit a correction plan shall result in a move to decertify/terminate.
    - iii. 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) shall result in a move to decertify/terminate.
    - iv. Any provider who receives two “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/termination.
  - e. You may access BWC's Rules and Statutes on our website at: <http://www.bwc.ohio.gov/basics/guidedtour/generalinfo/ORCandOAC.asp>.

4. [C-9](#) Approved Service Timeframes
  - a. Approved [C-9](#)s set forth timeframes for the delivery of services and is noted on the [C-9](#). 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. If services cannot be completed within the approved timeframe, the MCO must be notified. The MCO shall update any approved authorization timeline changes and place a note in the claim. 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.
  - b. Approval of [C-9](#)s submitted by a Physical Therapist or Occupational Therapist 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](#).

## **XI. ADDITIONAL ALLOWANCES**

- A. Submitting Evidence To Support [C-9](#) Request - 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.
- B. Supporting Documentation For Additional Allowance - The medical documentation, mechanism of injury and time sequence must support the additional allowance. Relevant information includes but is not limited to:
  1. Clinical examination and diagnostic test findings;
  2. Current treatment plan;
  3. ICD code for requested diagnosis with location (right, left, bilateral), level (L5-S1, C1-C3), and/or site (digits, teeth, or body part) when applicable;
  4. 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). The **causality statement must** indicate whether the recommended condition is as follows:
    - 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) - 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) - 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.
- d. 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. *Also, see section XVI. for Substantial Aggravation of a pre-existing condition.*
  - e. A flow-through from the previously allowed condition - A flow through condition must be indirectly caused by the previously allowed condition or the injury or treatments for them that 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.
5. A psychiatric condition(s) must be requested on a [Motion \(C-86\)](#) form submitted by the injured worker/authorized representative. BWC shall not consider allowance of a psychiatric condition(s) submitted on a [C-9](#).
  6. Once a final decision has been rendered on the requested/recommended condition(s), BWC shall notify the MCO of the final decision and the MCO shall notify the treating physician of the status of the request/recommendation.

## **XII. MEDICAL TREATMENT DISPUTES (BWC Rule [OAC 4123-6-16](#))**

- A. Alternative Dispute Resolution - All MCOs are required to have an Alternative Dispute Resolution process. The Alternative Dispute Resolution is intended to handle medical disputes regarding quality assurance, utilization review, medical necessity and other treatment and provider issues. The provider, employer and their representative, injured worker and the injured worker's representative, may initiate Alternative Dispute Resolution for MCO-managed claims by contacting the injured worker's MCO in writing, detailing the issue with the MCO's decision, within fourteen (14) calendar days of receipt of written notice of an MCO determination. These are guidelines and not deadlines. Neither the Alternative Dispute Resolution rule nor case law provides any consequence if an Alternative Dispute Resolution appeal is filed untimely. Providers are encouraged to use the MCO [ADR Appeal to the MCO Medical Treatment/Service Decision \(C-11\)](#) form 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.bwc.ohio.gov/bwcccommon/forms/BWCFORMS/nlbwc/ProviderForms.asp>.
- B. Appeal Letter - The appeal letter or [C-11](#) must be signed by the appellant or the appellant's representative, 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.
- C. Medical Dispute Resolution - The MCO 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 ORC 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 the MCO's 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 Alternative Dispute Resolution process and in such cases the MCO shall submit its recommended Alternative Dispute Resolution decision to BWC electronically within seven (7) days after receipt of the independent medical examination report. Following completion of the independent review and/or examination, the MCO shall forward the MCO's recommended decision to BWC. BWC shall 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 representative). By law, the MCO and provider are not parties to the claim; therefore, the MCO and provider cannot appeal any BWC order, including those regarding medical issues.

- D. MCO Defer Consideration Of Dispute Pending Appeal - The MCO may defer consideration of a dispute when there is a pending appeal before BWC or the IC and the MCO has previously conducted a peer review for a [C-9](#) that is the "same as or similar to" the one received. Once the previous treatment request has been resolved, the MCO may resume the Alternative Dispute Resolution process and may proceed in accordance with [OAC 4123-6-16\(C\)\(4\)](#). The previous peer-to-peer review or an Alternative Dispute Resolution independent medical examination 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 Alternative Dispute Resolution independent medical examination.
- E. Prohibited Use Of Alternative Dispute Resolution - Per [ORC 4121.441\(A\)\(1\)\(a\)](#) and [OAC 4123-6-16\(H\)\(1\)](#), the Alternative Dispute Resolution 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/Third Party Administrator appeals of approved authorizations shall be exempt from the dispute resolution process if the requested services fall within presumptive authorization, pathways, or guidelines.
- F. Bills Submitted On Treatment Request Currently In The Alternative Dispute Resolution Process - Bills submitted on treatment requests currently in the Alternative Dispute Resolution process shall be denied by the MCO. If the services are later authorized, the MCO shall adjust the denied bills to reimburse the approved services. The provider does not need to re-bill the services.

### **XIII. RETURN TO WORK**

- A. Benefits To Early & Successful Return To Work - Early and successful return to work benefits everyone. The cost of any disability goes far beyond the measurable cost for medical care and compensation payments injured workers may encounter:
  - 1. Loss of self-esteem;
  - 2. Depression;
  - 3. Secondary symptoms; and/or
  - 4. A complete change in their life style.
- B. Injured Worker Requiring Additional Medical Care - Most injured workers return to work without any assistance, but some injured workers require additional medical care

resulting in longer recovery and time away from work. Some require intensive return to work and vocational services to return to productive employment. It is the MCO and BWC's responsibility to recognize these differences and plan the best course for the individual worker.

- C. [Official Disability Guidelines](#)- The [Official Disability Guidelines](#) data assists the MCO and BWC in working with the employer, injured worker and physician to set expectations for return to work. The BWC certified provider must understand the basis and goals of the return to work strategy and the [Official Disability Guidelines](#) to help set return to work expectations of the injured worker. In addition, the provider has to manage treatment with the anticipated return to work date in mind and release the injured worker to work (with restrictions, if necessary) as soon as medically feasible.
1. Remain at Work - Remain at work services are available for the injured worker who has 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.
  2. 30-Day Return to Work Assessments – The MCO manages 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 [Official Disability Guidelines](#), BWC shall become directly involved in reviewing the case. BWC and MCO staff shall 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 take advantage of return to work interventions.
  3. Transitional Work
    - a. Transitional work helps businesses offer the injured worker strategies to return the injured worker to work as soon as safely possible and before the injured worker is 100% recovered. The service uses real job-related tasks to accommodate the injured worker's medical restrictions for an agreed upon, specified time period and gradually return the injured worker to his or her original duties.
    - b. 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. The employer can help by opening the channels of communication among the injured worker, the doctor, the employee's immediate supervisor, BWC and their MCO. This increases the odds the injured worker shall stay connected to the job and recover more quickly.
  4. Vocational Rehabilitation - If a return to work to the same job, at the original employer is not possible, vocational rehabilitation services is an excellent tool to help an injured worker identify skills and abilities to secure a new job with the original or another employer. Training programs and employer incentives are also possible to assist with return to work.”
- D. [Physician's Report of Work Ability \(MEDCO-14\)](#)
1. Purpose
    - a. The [MEDCO-14](#) is a tool to manage an injured worker's lost time claim and assist the injured worker to return to work.
    - b. The [MEDCO-14](#) allows the physician to document a complete summary of the injured worker's disability status and provides relevant information enabling the MCO case manager, BWC claims team, and the employer to understand the injured worker's:

- i. Progress from disability to work ability;
  - ii. Ability or inability to perform any work;
  - iii. Capabilities and restrictions, if applicable;
  - iv. Barriers and reasons for delay in the injured worker's ability to return to the injured worker's current job; and/or
  - v. Plan of treatment and vocational issues that need to be addressed to help the injured worker in returning to work.
- c. The MCO, BWC and the self-insured employer uses 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 the injured worker's former position of employment without restrictions, the information will assist in the determining whether the injured worker is entitled to an indemnity benefit.
2. Requirements
- a. It is a **requirement** that the [MEDCO-14](#) be completed by the treating physician, when an injured worker's status is evaluated or re-evaluated by a physician and one of the following apply:
    - i. The injured worker is temporarily not released to any work, including the former position of employment;
    - ii. The injured worker is not released to the former position of employment, but may return to available and appropriate work with restrictions; or
    - iii. 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.
  - b. If two physicians are treating an injured worker concurrently, both physicians treating the injured worker are required to complete and submit the [MEDCO-14](#), unless the form submission exceptions are met.
  - c. It is **not a requirement** that the treating physician complete the [MEDCO-14](#) when an injured worker's status is evaluated or re-evaluated by a physician and one of the following apply:
    - i. The injured worker has been awarded permanent total disability; or
    - ii. The injured worker has returned to work without restrictions within seven (7) days of the injury; or
    - iii. The treating physician has released the injured worker to full-duty work, the injured worker has returned to work and the treating physician is treating the injured worker periodically.
  - d. The provider can visit the BWC website to view the informational video and document that will assist the provider with completing the form. This information is available in the [Education/Training](#) section of the Medical Providers page and the [OAC 4123-6-20](#) obligation to submit medical documentation and reports.
  - e. Equivalent physician-generated document/statement - The [MEDCO-14](#) form is the preferred form. However, the MCO and BWC shall 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](#).
  - f. 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 11/18/15). **Both the name and date of the medical report are required** in order to discern which document on file contains the equivalent response.

**XIV. ~~APPLICABLE BWC LAWS AND RULES~~ (MOVED TO PREAMBLE)**

**XV. MEDICAL CODING REQUIREMENTS ON FROI**

ICD Coding - International Classification of Diseases, Clinical Modification (ICD-CM) - BWC requires the provider to identify all applicable ICD(s) on the [FROI](#) application, treatment plans and subsequent reports. The provider must bill the condition(s) treated, regardless of the ICD condition allowed in the claim. Additionally, all diagnosed conditions should be:

1. Determined by a qualified practitioner;
2. Be causally related to the occupational injury or illness; and
3. Updated as medical conditions in the claim change.

**XVI. PROVIDER COMMUNICATION**

- A. BWC E-Business System - BWC's e-business system allow BWC to provide BWC customers with consistent, customized, streamlined service twenty-four (24) hours a day, seven (7) days a week. Log onto [www.bwc.ohio.gov](http://www.bwc.ohio.gov) to find out how fast, efficient and easy it is to have all of the provider's workers' compensation information and services readily available for providers. BWC e-business system allows providers to:
1. View basic claims information, including ICD codes, claim status, date of injury, accident description, BWC and MCO claim notes and the assigned MCO.
  2. Verify BWC-certified the provider with Provider Lookup.
  2. Determine the MCO for a particular employer with BWC Employer/MCO Lookup.
  3. View the [BWC Fee Schedule](#).
  4. Download various BWC forms to print, complete, and mail, fax or drop off, including the [FROI](#), [C-9](#) and [MEDCO-14](#). In addition, if the provider files a [FROI](#) electronically, the provider will receive a claim number immediately.
  5. Look-up an injured worker's claim history.
  6. Access information twenty-four (24) hours a day, seven (7) days a week.
  7. Access the BWC library. The provider can take a guided tour to learn more about processes and policies. Also, the provider can find answers to frequently asked questions and definitions for workers' compensation terms in the provider glossary.
  8. Access the medical bill payment look-up. A servicing or pay-to provider can view medical bill payment information. A bill search can be customized to verify receipt of the provider bills from the MCO to BWC, and provider payments made to the MCO.
  9. Access the online *Provider Billing & Reimbursement Manual (BRM)* to download, view or print reimbursement policies/procedures and updates.
  10. Access claim documents. The provider who meets BWC's security criteria can access claim documents, a repository of imaged documents from individual claim files.
  11. View provider education/training section, including video presentations of information relevant to a new provider doing business with BWC and other educational offerings.
- B. Ensuring Confidentiality - To ensure confidentiality, the provider must create a primary account before accessing injured worker information. The provider can create secondary users from this account so that each of provider's employees or vendor employees can have individual passwords. Customers who prefer dealing with a person shall 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 (1-800-644-6292) or e-mail the Provider Relations department at [Feedback.medical@BWC.state.oh.us](mailto:Feedback.medical@BWC.state.oh.us).

**XVII. SENSITIVE DATA POLICY**

- A. Sensitive Data Policy Summary - Due to heightened security awareness and state law, BWC has established a Sensitive Data Policy. To prevent unauthorized disclosure of BWC sensitive information this policy prohibits the electronic transmission of Sensitive Data without encryption (i.e., password protection or encrypted/secure email).
- B. Proper Sensitive Data Format In Non-Secure Emails - All claims information, including injured worker claim number and name are considered sensitive and must be masked if used in email format (e.g., John Smith, claim 09-123456 would be acceptably emailed as John S., 09-xxx456).
- C. Email Encryption - BWC currently uses Zixmail for email encryption. If you receive an electronic document from BWC or the MCO not using their encryption, it shall be password protected if sensitive data is included. BWC and/or the MCO shall provide you with the password that shall generally be used. Once you open a document and respond to the message, the document shall remain password protected when the changes are saved.
- D. Secured Fax Transmission - 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 (e.g., name and claim number/SSN) that ensures to the MCO or BWC that the provider is involved in this injured worker's care, or a signed consent may be needed before the case can be discussed.

**XVIII. FRAUD**

- A. Workers' Compensation Fraud Definition - 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 an injured worker who is not entitled to receive those payments.
  - 1. Examples of workers' compensation fraud under [ORC 2913.48](#) include (but, are not limited to) the:
    - a. Injured worker going back to work, but still collect lost-time benefits;
    - b. Injured worker claiming to have been injured in the course of his or her employment when in fact the injured worker was injured elsewhere;
    - c. Injured worker faking an injury at work;
    - d. Provider billing for services not rendered;
    - e. Provider billing for a more expensive level of service than provided (i.e., 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"*;
    - f. Provider attempting to bill uncovered expenses to the workers' compensation claim;
    - g. Employer under reporting the employer's premiums;
    - h. Employer misrepresenting the manual classification of the employer's injured worker to secure a lower premium rate;
    - i. Employer altering, forging or creating workers' compensation certificates to falsely show correct coverage;
    - j. Employer providing false information when that information is needed to determine the employer's actual premium or assessment; and/or

- k. Employer failing to secure or maintain workers' compensation coverage with the intent to defraud BWC.
- 2. In addition, [ORC 4121.444](#):
  - a. Prohibits a person, health-care provider and MCO from obtaining or attempting to obtain by deception, payments under the workers' compensation law to which they are not entitled.
  - b. Authorizes monetary penalties and decertification for a person, health-care provider and MCO 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.
- B. BWC Special Investigations Department - To ensure only legitimate claims are paid, BWC is aggressively attacking fraud through the BWC Special Investigations Department. The Special Investigations Department has investigative personnel located in each service office, its own automated detection team and 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.
- C. Reporting Fraud - If a provider suspects fraud, please 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 the BWC Website at: [www.bwc.ohio.gov](http://www.bwc.ohio.gov).
- D. Unethical Marketing
  - 1. BWC occasionally receives complaints that suggest that a small number of BWC certified providers have attempted to use what appears to be false, misleading, or deceptive marketing to injured workers. Examples of false, misleading, or deceptive marketing practices that violate [OAC 4123-6-02.9](#) include, but are not limited to:
    - a. Offering free services to injured workers. Providers are prohibited from offering free services or other things of value to injured workers in return for the injured worker selecting the provider for treatment reimbursable by BWC.
    - b. Informing injured workers that their contact information was obtained from BWC this information is not made accessible to the public per BWC's confidentiality policy.
    - c. Telling injured workers that reimbursement of compensation shall 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, injured workers have free choice of BWC certified providers when seeking treatment.
  - 2. 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.

**XIX. [REQUEST FOR TEMPORARY TOTAL COMPENSATION \(C-84\) FORM](#)**

- A. [C-84](#) Requirements : 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. The injured worker may complete the [C-84](#) online at

<https://www.bwc.ohio.gov/worker/forms/TempTotalCompensation/Default.aspx>.

Temporary total compensation shall not be paid without the completed and signed form from the injured worker

- B. [MEDCO-14](#) : Effective August 2012, the provider no longer complete this [C-84](#) form to certify temporary total compensation. The provider now completes the [MEDCO-14](#). The provider is encouraged to remind the injured worker to complete and sign the [C-84](#) before the provider sends it to the BWC.

## **XX.CLAIM REACTIVATION**

- A. [OAC 4123-3-15](#) : 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 [www.bwc.ohio.gov](http://www.bwc.ohio.gov) or by contacting the assigned MCO.
- B. Inactive Claim - 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.
- C. Prescription Medication – 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.bwc.ohio.gov](http://www.bwc.ohio.gov) or call 1-800-OHIOBWC (1-800-644-6292).
- D. Initiating A Claim Reactivation - An inactive claim must be reactivated in order to receive payment for services rendered. To initiate a claim reactivation review the provider must submit to the MCO:
  - 1. A completed a [C-9](#) or equivalent thoroughly documenting the treatment requested and how the treatment relates to the original workplace injury.
  - 2. A [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.
  - 3. 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.
- E. MCO Response & Referral - The MCO has sixteen (16) business days to respond to the treatment request and refer the request for claim reactivation to BWC. During this time, the MCO may:
  - 1. Request submission of additional documentation via [C-9-A](#) or equivalent. A provider will have up to ten (10) business days to submit the requested information; or
  - 2. Dismiss the [C-9](#) request on an inactive claim when there is no supporting medical evidence or the medical evidence is dated more than sixty (60) days prior to the date of the request. A [C-9](#) dismissed in this manner cannot be appealed through the Alternative Dispute Resolution process. However, the MCO may reconsider the treatment or medical bill issue upon submission of the requested documentation; or
  - 3. Refer the request to BWC for review.
- F. BWC Responsibility - BWC will have up to twenty-eight (28) days from receipt of the MCO's referral of the request to complete a causality investigation and issue a BWC Order.
  - 1. A party to the claim may appeal the BWC Order to the IC.
  - 2. Upon receipt of the final BWC or IC claim reactivation decision (i.e., all appeals are exhausted), BWC shall update the claim and notify the MCO who will notify the provider of the final decision and/or pay the previously denied medical bill.

**XXI. SUBSTANTIAL AGGRAVATION OF PRE-EXISTING CONDITION (Also see section XI. Additional Allowances)**

- A. Date Of Injury Claims On Or After 8/25/06 : A claim with a date of injury 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 like and firmly established and solidly based through presentation of objective diagnostic findings, objective clinical findings or objective test results.
- B. Complaint - A subjective complaint 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. A subjective complaint must be accompanied by supporting objective diagnostic finding, objective clinical finding, 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.
- C. Substantially Aggravated Pre-Existing Condition Returned - 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.
- D. Independent Medical Exam - When a request to allow a claim for substantial aggravation of a pre-existing condition is filed, an independent medical exam **may** be necessary to assist BWC in making an appropriate determination; however, an exam is not required, especially when the evidence mandated by law supports the request. BWC Claims Service Specialists should staff the claim with the nurse and/or other members of their team to determine if an exam or file review is appropriate.
- E. Types Of Medical Evidence/Documentation -The following types of medical evidence/documentation may be submitted and/or gathered for decisions involving a substantially aggravated pre-existing condition(s):
  - 1. 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;
  - 2. Lab reports, X-rays, MRI, CT reports other diagnostic tests pertaining to the condition prior to the injury;
  - 3. Documentation of current medication including dosage and frequency for substantially aggravated pre-existing condition (i.e. insulin or pain medication);
  - 4. Documentation of medication, including dosage and frequency for substantially aggravated pre-existing condition that the injured worker was receiving prior to the date of injury;
  - 5. Any objective physician examination findings of substantially aggravated pre-existing condition prior to injury and subsequent to injury;
  - 6. Physical Therapist and Occupational Therapist records prior to and subsequent to the injury;
  - 7. Emergency Room reports; and/or
  - 8. Accident reports.

- F. Request For Medical Treatment - The MCO must consider requests for medical treatment when a final BWC or 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 process.
- G. Substantially Aggravated Pre-Existing Condition Only Condition Allowed In Claim - 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 or IC decision has determined that the condition has returned to a level that would have existed without the injury.

**XXII. 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 [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 the evaluation and/or treatment is part of an authorized detoxification or substance abuse program.

**XXIII. \$15,000 MEDICAL-ONLY PROGRAM**

- A. \$15,000 Medical-Only Program Summary - Ohio employers can participate in BWC's \$15,000 Medical-Only Program, designed to offer the employer the opportunity to pay the first \$15,000 of medical and pharmacy bill payments for the employer's employees' work-related injuries in medical only claims.
- B. Employer Notification - A participating employer will notify the provider that the employer is responsible for the first \$15,000 of the employer's employee's alleged work-related injuries in medical only claims. The \$15,000 maximum applies only to medical only claims with a date of injury on or after September 10, 2007. For a date of injury prior to September 10, 2007, the employer in the program still has the opportunity to pay up to:
  - 1. \$1,000 Medical Only Program: Claim is Medical-Only with date of injury 7-1-95 through 6-29-06;
  - 2. \$5,000 Medical-Only Program: Claim is Medical-Only with date of injury 6-30-06 through 9-9-07;
  - 3. \$15,000 Medical-Only Program: Claim is Medical-Only with date of injury 9-10-07 and after.
- C. Provider Responsibilities
  - 1. Bill the employer directly for services related to injuries covered by the \$15,000 Medical-Only Program.
  - 2. An employer pays the provider directly for the injured worker's medical care up to \$15,000.
    - a. The employer will use the [BWC Fee Schedule](#) for medical payments for claims with a date of injury on or after June 30, 2009 and enrolled in the Medical-Only Program. The employer may access the provider fee schedule on our website at [www.bwc.ohio.gov](http://www.bwc.ohio.gov). If an employer has questions regarding the [BWC Fee Schedule](#) and/or has general billing questions, the employer should be directed to contact BWC Provider Relations by calling 1-800-OHIOBWC (1-800-644-6292) option 0-option 3-option 0.

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- b. A certified health care provider shall accept the [BWC Fee Schedule](#) as full payment from an employer who participates in the Medical-Only Program. The provider shall not charge, assess or otherwise attempt to collect from an injured worker any amount for covered services or supplies that is in excess of the [BWC Fee Schedule](#).
  - c. The employer must pay as billed or according to any provider agreed upon amount for claims with a date of injury prior to June 30, 2009.
  3. The MCO may not act as an agent of the employer and may not process the bills on behalf of the employer.
  4. If the MCO receives a [C-9](#) for a claim in the Medical-Only Program, the MCO may dismiss without prejudice and notify the provider and employer. An employer cannot deny or allow a [C-9](#); however, the [C-9](#) 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](#) 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.
  5. The provider shall bill in the same manner and on forms that the provider use to bill the MCO or BWC.
  6. A provider cannot bill a state-fund employer directly outside of the \$15,000 Medical-Only Program.
- D. Exceeding the \$15,000 Maximum
1. The employer will pay that portion of the bill that will bring their payment to the \$15,000 maximum.
  2. The employer will then inform the provider to bill the MCO or BWC for the remainder of the bill.
- E. 15,000 Maximum is Reached or Claim is Removed from Med-Only Program
1. The employer should notify BWC, the injured worker and the provider, that the MCO or BWC will be responsible for processing all bills after a specific date of service.
  2. The employer will forward proof of bill payment to BWC, including copies of bills paid, upon written request from BWC.
  3. 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.
  2. If BWC has issued a claim number, BWC will process the bill and inform the provider that it cannot be paid while the \$15,000 Medical-Only Program covers the claim. In this case, the provider will receive the following EOB code on the provider's 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.**
  3. In the event of duplicate payments, the provider should refund duplicate payments directly to the employer.

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- F. 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.

### XXIV. DISABILITY EVALUATORS PANEL (DEP)

- A. DEP Summary - The DEP is a statewide panel of physicians and medical professionals who perform objective, impartial medical examinations and medical file reviews for BWC to support claims management. Evaluations requested by BWC include medical examinations required by statute at ninety (90) days of consecutive temporary total disability and two hundred (200) weeks of temporary total disability; occupational disease allowance; and permanent partial disability. 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:
1. Licensure without restrictions;
  2. Specialty board certification; professional and general liability and workers' compensation coverage; and
  3. Agreement to BWC's performance requirements, fees and peer reviews of evaluation reports.
- B. How To Apply For DEP - To apply for the DEP the provider may access the [Disability Evaluator Application \(MEDCO-30\)](#) at the forms page of our website. For additional information, call BWC's Contact Center at 800OHIOBWC (1-800-644-6292), option 0-3-0, or email the DEP Central Unit at: [DEP@bwc.state.oh.us](mailto:DEP@bwc.state.oh.us). Providers may access the ["Disability Evaluators Panel Handbook"](#) outlining billing codes, fees and instructions on BWC's website under the Medical Providers page located at <http://www.bwc.ohio.gov/downloads/blankpdf/DEPhandbook.pdf>.

### XXV. ASSISTANCE

- A. BWC Claims Offices - To continuously improve service to our customers, BWC has thirteen (13) customer service offices. To find a BWC Claims Office by zip code, visit the following <https://www.bwc.ohio.gov/bwccommon/services/officelocator/default.asp>

#### BWC Claims Offices

<b>Cambridge</b> 61501 Southgate Road Cambridge, OH 43725-9114 (800) 644-6292 (866) 336-8352 Fax	<b>Canton</b> 339 East Maple St., Suite 200 North Canton, OH 44720 (800) 713-0991 (866) 336-8352 Fax
<b>Columbus</b> 30 West Spring Street, L-11 Columbus, OH 43215-2256 (614) 728-5416 (866) 336-8352 Fax	<b>Cleveland</b> 615 West Superior Avenue West Cleveland, OH 44113-1889 (216) 787-3050 (866) 336-8352 Fax
<b>Garfield Heights</b> 4800 East 131st Street	<b>Dayton</b> 3401 Park Center Drive, Suite 100

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Garfield Heights, OH 44105-7132 (216) 584-0100 (866) 336-8352 Fax	Dayton, OH 45414-2577 (800) 644-6292 (866) 336-8352 Fax
<b>Cincinnati-Governor's Hill</b> 8500 Governor's Hill Drive Cincinnati, OH 45249-1369 (800) 644-6292 (866) 336-8352 Fax	<b>Lima</b> 2025 East Fourth Street Lima, OH 45804-4101 (800) 644-6292 (866) 336-8352 Fax
<b>Mansfield</b> The Tappan Building 240 Tappan Drive North Mansfield, OH 44906-1367 (419) 747-4090 (866) 336-8352Fax	<b>Portsmouth</b> 1005 Fourth Street Portsmouth, OH 45662-4315 (800) 644-6292 (866) 336-8352 Fax
<b>Toledo</b> PO Box 794 One Government Center, Suite 1236 Toledo, OH 43604-0794 (800) 644-6292 (866) 336-8352 Fax	<b>Youngstown</b> 242 Federal Plaza West Youngstown, OH 44503-1206 (330) 797-5500 (866) 336-8352Fax
<b>Central (Medical Claims, Special Claims)</b> 30 West Spring Street, L-23 Columbus, OH 43215-2256 (800) 644-6292 (866) 336-8352 Fax	

- B. Fax Documents – Please allow up to 48 hours for indexing before re-faxing a document. This will reduce the number of duplicate documents BWC receives.
- C. Contact For Billing Questions - Direct all billing questions to the injured worker's MCO for Health Partnership Program managed claims.
- D. BWC General Customer Service Number – Call 1-800-OHIOBWC (1-800-644-6292) for forms, claims and employer information, or options to reach a representative for medical and pharmacy, injured worker claim information, fraud, Ombuds office, employer policy or safety service information. Also the provider may log on to the BWC website at [www.bwc.ohio.gov](http://www.bwc.ohio.gov).

**XXVI. GLOSSARY** - For a list of workers' compensation terms and definitions relating to providers, refer to [www.bwc.ohio.gov](http://www.bwc.ohio.gov) under "glossary."