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I. GENERAL

A. Provider Number - A provider, who meets the qualifications to enroll as a Ohio Bureau of Worker's Compensation (BWC) provider, must enroll to receive an individual provider number. The provider must submit the individual provider number as the servicing provider number for billing purposes, unless otherwise noted below.

B. Provider Services - A provider that is eligible to provide services for an injured worker is authorized by law to perform the service being billed and to practice within the scope of the provider's license.

C. Therapy Visits – The maximum time allowable per visit for therapy services with timed procedure codes (i.e., physical medicine, rehabilitation modalities and therapeutic procedures) should be no longer than one (1) hour without prior authorization. If therapy services with timed codes are billed over one (1) hour per day, further medical review and approval shall occur if services were not authorized prior to the payment being made.

D. Maximum Approval Period – Timelines for delivery of medical treatments or services with no specified timeframe on the request shall be no longer than thirty (30) days. Services not rendered in this time must have an update in the injured worker's claim notes as to the rationale for the delayed service delivery. Services that run continuously

over a longer timeframe (e.g., facility placement) shall not receive approval for more than six (6) months.

II. PRACTITIONER SERVICES - The following guidelines are intended to facilitate correct coding and billing processes when used in conjunction with the American Medical Association *"Physicians' Current Procedural Terminology"* (CPT®) book, American Medical Association's monthly *"CPT® Assistant"* publication or the Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System (HCPCS) Level II dental codes.

A. Covered Medical Service Provider
1. Physician of Record
    a. The physician of record is the primary attending physician chosen by the injured worker to direct treatment. The physician of record must be an eligible provider who is a BWC certified provider. The physician of record may or may not be a managed care organization (MCO) panel provider.
    b. An injured worker with a date of injury prior to October 20, 1993, may retain a non-certified provider as a physician of record, if such relationship already exists.
    c. Any request to change a physician of record must be changed to a BWC-certified provider. *(Section II.P.b.)*
2. An injured worker may have only one (1) physician of record at any given time, even in claims where more than one (1) physician treats the injured worker.
3. The MCO may not dispute an injured worker's selection of a physician of record.
4. A physician of record must be a:
    a. Medical Doctor;
    b. Doctor of Osteopathic Medicine;
    c. Doctor of Mechanotherapy;
    d. Doctor of Chiropractic;
    e. Doctor of Podiatry;
    f. Doctor of Dental Surgery; or
    g. Licensed Psychologist (e.g., PhD or PsyD).

B. Physician Assistant
1. The Physician Assistant provides services within the scope of the approved supervision agreement with the Physician Assistant collaborating or supervising physician(s).
2. BWC reimburses the Physician Assistant at eighty-five percent (85%) of the BWC Fee Schedule (https://www.bwc.ohio.gov/provider/services/FeeSchedules.asp). The reduction does not apply to supplies provided by the practitioner. BWC does not reimburse incident to. OAC 4123-6-08.
3. The Physician Assistant may function as an assistant in surgery, in which case, reimbursement depends on both the assistant surgery modifier and the provider type. For example, if the fee for a procedure were $1,000.00, then that procedure billed with assistant surgery modifier -80 would pay twenty percent (20%) of $1,000.00 or $200.00. Since the Physician Assistant receives reimbursement at eighty-five percent (85%) of the BWC Fee Schedule, the fee in this case would be eighty-five percent (85%) of $200.00 or $170.00.
4. BWC cannot directly reimburse a Physician Assistant, but BWC can reimburse the supervising physician with whom the Physician Assistant has an approved supervision agreement. All services provided by a Physician Assistant shall be billed using the Physician Assistant's BWC issued provider number typed into block 25 of

the *Health Insurance Claim Form* (CMS-1500), as the Physician Assistant is the servicing provider. The BWC provider number issued to the supervising physician or physician group must be typed into block 33 of the CMS-1500 to reflect the pay-to-provider.

C. Advanced Practice Nurse
   1. An Advanced Practice Nurse includes Certified Nurse Practitioners and Clinical Nurse Specialists, acting within the scope of the standard care arrangement with their collaborating or supervising physician(s).
   2. BWC reimburses the Advance Practice Nurse at eighty-five percent (85%) of the BWC Fee Schedule. The reduction does not apply to supplies provided by the practitioner. BWC does not reimburse incident to. OAC 4123-6-08.
   3. An Advanced Practice Nurse enrolled with BWC may provide and be reimbursed for assistance in surgery services, in which case reimbursement is based on both the assistant surgery modifier and the provider type. For example, if the fee for a procedure were $1,000.00, then that procedure billed with assistant surgery modifier -80 would pay twenty percent (20%) of $1,000.00or $200.00. Since the Advanced Practice Nurse receives reimbursement at eighty-five percent (85%) of the BWC Fee Schedule, the fee in this case would be eighty-five percent (85%) of $200.00 or $170.00.
   4. A Registered Nurse (CNOR) who is the first assistant in surgery, whom is not an Advanced Practice Nurse, may not enroll as a BWC provider and may not receive reimbursement for assistant surgery services.

D. Independent Social Worker – BWC reimburses an Independent Social Worker at eighty-five percent (85%) of the BWC Fee Schedule.

E. Professional Clinical Counselor - BWC reimburses a Professional Clinical Counselor at eighty-five percent (85%) of the BWC Fee Schedule.

F. Social Worker - BWC reimburses a Social Worker at seventy-five percent (75 %) of the BWC Fee Schedule.

G. Professional Counselor - BWC reimburses a Professional Counselor at seventy-five (75%) of the BWC Fee Schedule.

H. Physical Therapist, Occupational Therapist, Speech Pathologist and Massage Therapist
   1. Physical Therapist, Occupational Therapist, Speech Pathologist and Massage Therapist ***must*** individually enroll with BWC if employed by mixed group practices (i.e., Medical Doctor, Doctor of Osteopathic Medicine, Doctor of Chiropractic, Advanced Practice Nurse, Physician Assistant, Physical Therapist, etc.).
   2. Physical Therapist, Occupational Therapist, Speech Pathologist and Massage Therapist are not required to individually, enroll if employed by therapy groups, home health agencies, skilled nursing facilities or hospitals.

I. Licensed Athletic Trainer
   1. A Licensed Athletic Trainer is eligible for enrollment by BWC.
   2. A Licensed Athletic Trainer ***must*** individually enroll with BWC if employed by mixed group practices (i.e., Medical Doctor, Doctor of Osteopathic Medicine, Doctor of Chiropractic, Advanced Practice Nurse, Physician Assistant, Physical Therapist, etc.).

3. It is not a requirement for a Licensed Athletic Trainer to individually enroll when employed by therapy groups, home health agencies, skilled nursing facilities or hospitals.

J. Non-Physician Acupuncturist
   1. A Non-Physician Acupuncturist ***must*** have a state medical board certificate of registration.
   2. A Non-Physician Acupuncturist is a practitioner BWC reimburses for acupuncture services only.
   3. BWC does not reimburse evaluation and management codes to acupuncturists.

K. Urgent Care Facility
   1. Free-Standing
      a. A freestanding urgent care facility ***must*** enroll as provider type 96.
      b. A freestanding urgent care facility may bill only for physician services.
      c. For reimbursement purposes, BWC shall treat freestanding urgent care centers as any other physician clinic.
      d. BWC shall not reimburse freestanding urgent care centers a facility fee.
   2. Hospital Based
      a. A hospital based urgent care facility ***must*** enroll as a hospital provider type and be assigned a separate provider number. *See Application for Provider Enrollment and Certification* (MEDCO-13) *form at BWC Website: https://www.bwc.ohio.gov/downloads/blankpdf/MEDCO-13.pdf.*
      b. A hospital based urgent care facility must be a part of the hospital cost report in order to receive reimbursement of a facility fee.

L. Ergonomist
   1. To be BWC certified, an ergonomist ***must*** have one of the following certifications:
      a. Certified professional ergonomist;
      b. Certified human factors professional;
      c. Associate ergonomics professional;
      d. Associate human factors professional;
      e. Certified ergonomics associate;
      f. Certified safety professional with ergonomics specialist designation;
      g. Certified industrial ergonomist;
      h. Certified industrial hygienist;
      i. Assistive technology practitioner; or
      j. Rehabilitation engineering technologist.
   2. Ergonomic services must be signed and dated by the actual servicing provider specifying the servicing provider's credentials.
   3. An employer signature is required on the action plan.
   4. An Ergonomist may receive reimbursement for travel and mileage. *See the BWC Fee Schedule for current reimbursement rates.*

M. Covered Vocational Rehabilitation Case Management Provider
   1. To provide and receive payment for vocational rehabilitation case management, including the services provided by an intern, the service provider must be BWC certified and enrolled.
   2. Ohio Administrative Code (OAC) 4123-6-02.2(C)(48) identifies the type of credentials a vocational/medical case manager must maintain. A nationally recognized accreditation committee must have credentialed the provider in one of the following:

a. Certified Rehabilitation Counselor;
b. Certified Disability Management Specialist;
c. Certified Rehabilitation Registered Nurse;
d. Certified Vocational Evaluator;
e. Certified Occupational Health Nurse;
f. Certified Case Manager; or
g. The American Board of Vocational Experts.

N. Covered Vocational Rehabilitation Employment Specialist Provider OAC 4123-6-02.2(C)(17)
1. A covered vocational rehabilitation employment specialist provider provides job placement, job development, job seeking skills training, job club and job coach services.
2. A covered vocational rehabilitation employment specialist provider ***must*** be BWC certified as a type 86 Employment Specialist to provide these services on or after 10/1/15.
3. The criteria for a covered vocational rehabilitation employment specialist provider to be BWC certified as a type 86 include:
    a. Attainment of certification in one of the following:
        i. Certification for American Board of Vocational Experts;
        ii. Certified Rehabilitation Counselor;
        iii. Certified Case Manager;
        iv. Global Career Development Facilitator;
        v. Associate Certified Coach;
        vi. Professional Certified Coach;
        vii. Master Certified Coach;
        viii. Certified Disability Management Specialist;
        ix. Commission on Accreditation of Rehabilitation Facilities accreditation for employment and community services in job development or employment supports; or
    b. Evidence of the completion of three (3) or more courses, seminars or workshops prior to submitting an application for certification, totaling a minimum of eighty (80) hours and approved by BWC or by an entity offering a certification referenced above, in at least two (2) of the following domain areas:
        x. Job development;
        xi. Job placement;
        xii. Career and lifestyle development;
        xiii. Vocational consultation and services for employers;
        xiv. Professional roles and practices; and/or
        xv. Ethic and utilization of community resources.

O. Non-Covered Provider
1. An individual provider is a provider who is ***not*** directly reimbursable by BWC and who ***cannot*** directly enroll with BWC. Examples of these providers include, but are not limited to:
    a. Physician Intern;
    b. Psychology Intern;
    c. Psychology Assistant; or
    d. An out-of-state provider, who provides services in a state that, does not have an Ohio equivalent licensure requirement.

e. The provider is permitted to give services under the direct supervision (i.e., in the presence of the supervisor) of a provider who is licensed and enrolled by BWC to deliver such services. The licensed provider must bill for the services.

2. A network acting as a service coordinating entity only and not meeting qualifications for a provider type recognized by BWC that directly provides goods or medical services to the injured worker is a non-covered provider.
3. Direct manufacturer, supplier of surgical equipment or surgical supplies, is a non-covered provider.

P. Guidelines

1. Provider Signature on Medical Evidence - The following grid identifies provider types whose signature is acceptable on medical evidence.

FORM	PROVIDER TYPE				
	Physician of Record (POR) or treating physician which includes the following: • Medical doctor (M.D.), • Osteopath (D.O.), • Chiropractor (D.C.), • Dentist (D.D.S.), • Mechanotherapist (D.M.T.), • Podiatrist (D.P.M.), • Psychologist, • Ophthalmologist.	Advanced Practice Nurse (A.P.N.) which includes the following: • Certified Nurse Practitioner (C.N.P.), • Certified Nurse Specialist (C.N.S.), Physician Assistant (P.A.)	Licensed Independent Social Worker (L.I.S.W.) Licensed Professional Clinical Counselor (L.P.C.C.)	Audiologist (A.U.D.) Optometrist (O.D.) Physical Therapist (P.T.) Occupational Therapist (O.T.)	Licensed Social Worker (L.S.W.) Licensed Professional Counselor (L.P.C.) All other non-physician providers
Physician's Report of Work Ability (MEDCO-14)	YES	*YES **(see below)**	NO	NO	NO
	*For the first six weeks immediately following the date of injury, an A.P.N. and /or P.A. may independently complete and sign a MEDCO-14 to support payment or non-payment of temporary total disability. Subsequent MEDCO-14s **must** be co-signed by a physician who has examined the injured worker (IW) or has reviewed medical documentation of an A.P.N.'s and /or P.A.'s examination of the IW.				
Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9)	YES	YES	YES	Medical Services Reimbursement YES (**see exception below**) Recommendation for Additional Condition – NO	NO
	Exception: C-9s signed by a P.T. or O.T. for therapy services must be accompanied by a prescription from the POR or treating physician, an A.P.N. or P.A.				

ADR Appeal to the MCO Medical Treatment/Service Decision (C-11)	YES	YES	YES	YES	YES
Indicate causality designation and provide signature on (in the **"Treatment info."** section of the) First Report of an Injury, Occupational Disease or Death (FROI-1)	YES	YES	YES	NO	NO
	NOTE: FROI-1 applications may be filed by anyone, but the causality designation and provider signature in the **"Treatment info."** section as noted can only to be completed by those providers designated above.				

a. General Information Regarding Signatures on Medical Evidence:
   i. An original or stamped signature on an application or medical evidence is acceptable.
   ii. A form with a scanned signature is acceptable, but an electronic signature is not acceptable.
   iii. Medical reports signed by a POR or treating physician's authorized "scribe/designee" are acceptable. The scribe/designee will:
      a) Sign the POR or treating physician's name.
      b) Enters his/her initials next to the POR or treating physician's name.

b. Change of Physicians:
   i. To change a physician of record, the injured worker must submit written notification to the MCO or self-insuring employer on the *Notice to Change Physician of Record* (C-23) or equivalent noting the following:
      a) Name and address of the new physician;
      b) Reason for the requested change; and
      c) Injured worker's signature.
   ii. The *Notice to Change Physician of Record* (C-23) form is on BWC Website: https://www.bwc.ohio.gov/bwccommon/forms/BWCForms/nlbwc/IWForms.asp.

2. Two (2) Physicians Treating At The Same Time (OAC 4123-6-27) - BWC shall not approve medical fees for treatment by more than one (1) physician for the same condition over the same period of time, except where a consultant, anesthesiologist, anesthetist or assistant surgeon is required or where the necessity for treatment by a specialist is clearly shown. The MCO, or in self-insuring employers' claims, the self-insuring employer, shall approve an assistant surgeon in advance, except in cases of emergency.
3. Treatment Of Family Members (OAC 4123-6-06.2) - Except in cases of emergency, BWC shall not reimburse for treatment to an injured worker delivered, rendered or directly supervised by the injured worker or an immediate family member. Furthermore, the physician of record may not be the injured worker or an immediate family member. An immediate family member includes a: spouse, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother, stepsister, father, mother, daughter, son, brother-in-law, sister-in-law, grandparent, spouse of a grandparent or grandchild.
4. Multiple Visits – The provider may bill only one (1) evaluation and management code, per provider/injured worker/date of service. If the injured worker has more

than one (1) claim allowed, the claim involving the primary reason for the evaluation management service shall be billed.

a. A provider may not bill for multiple claims when performing an evaluation and management service.
b. If the injured worker has more than one (1) claim allowed involving different parts of the body, it may be appropriate to bill for services in more than one (1) claim.

5. Reimbursement For In-Home Physician Visits and Physician Mobile Office Visits
   a. In-home physician visits, services shall require prior authorization after the first visit; however, the first and following visits must meet the three (3) prong test outlined in the *"Miller Case Criteria"* (click here) policy.
   The MCO shall approve appropriate in-home physician visits when the injured worker is homebound and unable to access outpatient facilities because of sensory impairment, immobility or transportation problems. An example of this scenario might include an injured worker with a catastrophic condition or an injured worker that requires end of life care. Lack of transportation does not constitute a medical reason for approving in-home physician visits.
   b. The MCO shall grant prior approval according to the plan of care and health care needs of the injured worker. The MCO shall use the CPT® codes for home visits to reimburse the physician. The level of code must reflect current coding documentation standards for the CPT® level of service. Services rendered must only be those services indicated by medically necessary circumstances.
   c. BWC shall reimburse the mobile van or trailer physician visits or services, when the injured worker walks to the van or trailer, as part of a normal office visit according to CPT® levels of service and **shall not be eligible for billing as a home visit**. Mobile offices shall be billed using the appropriate office or other outpatient services CPT® evaluation and management code, with a place of service 15 (mobile unit) and shall be reimbursed at BWC's Non-Facility Fee.
   d. If a physician chooses to make a home visit to an injured worker who does not meet the criteria for a home visit or when determined by BWC and the MCO not to be medically necessary, the physician may not bill the services as a home visit. In these instances, the physician must use established home visit CPT® codes that are in effect on the date of the home visit.
6. Office Based Surgery - BWC follows state licensure requirements for enrollment of providers. The MCO and BWC staff who have knowledge of a physician or other licensed healthcare provider who may not be in compliance with the healthcare provider's licensure requirements in regard to office based surgery or other issues, are encouraged to report this information to the State of Ohio Medical Board or other appropriate licensing Board.
   a. The physician who performs surgery in the physician's office must follow the State of Ohio Medical Board rules. BWC shall reimburse the following the State of Ohio Medical Board licensed providers that perform surgery in the licensed provider's office:
      i. Medical Doctor;
      ii. Doctors of Osteopathic Medicine; and
      iii. Podiatrist.
   b. BWC shall reimburse minor office-based procedures done by State of Ohio licensed Advanced Practice Nurses and Physician Assistants acting within the scope of their practice and under the supervision of a State of Ohio Medical Board licensed provider.
   c. BWC shall reimburse providers of office surgery according to the BWC Fee Schedule at the Non-Facility Fee rate with an office place of service code.

7. Unsupervised Physical Reconditioning Program (OAC 4123-6-07(B)(5)) – BWC and the MCO shall not approve reimbursement an unsupervised physical reconditioning program (e.g., services that are provided at a health club, YMCA, spa or nautilus facility) unless it is approved per the specific guidelines when an injured worker is participating in a vocational rehabilitation or remain at work program.
8. Billing Codes
   a. Professional reimbursement is in accordance with the OAC 4123-6-08. Refer to the current BWC Fee Schedule for reimbursement rates http://www.bwc.ohio.gov/provider/services/agreement.asp.
   b. BWC and the MCO shall accept: HCPCS Level I (CPT®) billing codes as established by the American Medical Association. HCPCS Level I codes are descriptive codes for reporting medical services and procedures. Anesthesia CPT® codes (00100-01999) are recognized and required.
      i. HCPCS Level II billing codes as established by the Centers for Medicare and Medicaid Services. HCPCS Level II codes are descriptive codes for reporting durable medical equipment, dental, vision and other services.
      ii. BWC local level billing codes are descriptive terms and identifying codes for services and equipment specific to Ohio workers' compensation. Local codes begin with a "W" or "Z".
9. Telephone Call Codes (99371-99373) - BWC shall continue to recognize and reimburse the discontinued CPT® codes for telephone calls made by the appropriate provider. Please seek guidance in the Medical Documentation Policy. The telephone call codes are not reimbursable on the day of an office visit. During the visit, the time the practitioner spends on the phone with the injured worker present, contacting the employer, etc., must be documented and be included as part of the time component of the office visit. BWC shall not reimburse for new CPT® codes for evaluation and management services provided by telephone, as it is the position of BWC that an injured worker should have the injured worker's care rendered in person.
10. Consultation Codes (CPT® codes 99241-99245 and 99251–99255) - Centers for Medicare and Medicaid Services no longer reimburse for inpatient and outpatient consultation visits. However, to continue to facilitate quality medical care, BWC shall continue to recognize and reimburse the current CPT® consultation codes as noted above.
    a. Consultative services differ from other evaluation and management codes in that a physician provides the physician's opinion regarding the evaluation and management of a specific problem. The physician provides advice after receiving a request to do so. Qualified non-physician practitioners may also provide consultations. Do not report ongoing management following the initial consultation service by the consultant with consultation service codes. Report these services as subsequent visits for the appropriate place of service and level of service.
    b. Consultations require the following:
       i. The referring physician documents a request for an opinion on a specific problem;
       ii. The consultant's opinion is rendered and documented; and/or
       iii. Consultants report-back to the requesting physician.
11. **Anesthesia Billing and Reimbursement Policy *(Located in Section - New-Revised-Updated Policies of the PBRM)***
12. By-Report codes for Professional Services *(See Chapter 3)* for Vocational Rehabilitation By-Report codes

a. By-Report codes are codes for a procedure or service that are not typically covered and BWC shall not routinely reimburse. No set fee is associated with the procedure or service. The provider should give information to the MCO to allow appropriate review.
b. Authorization and payment of By-Report codes require an individual analysis by the MCO prior to submission of the request for approval to BWC Medical Policy. MCO analysis includes:
    i. Researching the appropriateness of the By-Report code in relation to the service or procedure; and
    ii. Appropriate cost comparisons.

13. Reimbursement for Interpretation of Emergency Room X-rays
    a. The MCO shall reimburse the radiologist/specialist in situations where more than one (1) physician such as the emergency room physician provides interpretation of the same emergency room x-ray for the same injured worker, for the same or different dates of service.
    b. The MCO shall also reimburse the emergency room physician for the x-ray interpretation when the interpretation results in treatment of the injured worker. Examples include:
        i. Emergency room physician orders x-ray that results in diagnosis of fracture. Emergency room physician applies cast.
        ii. Emergency room physician orders x-ray. No fracture is visible on x-ray. Emergency room physician diagnoses strain/sprain and orders non-steroidal anti-inflammatory medication for pain.
    a. If an emergency room physician orders an x-ray, does not treat the injured worker based on results of the x-ray and refers the injured worker to a physician specialist for the interpretation and treatment, BWC shall not reimburse the emergency room physician for the interpretation of the x-ray since it did not result in treatment by the emergency room physician.
14. Provider Reimbursement in Multiple Claims
    a. Evaluation and Management Services
        i. General Rule
            a) A provider may receive reimbursement for only one (1) Evaluation and Management service per injured worker per day. Exceptions shall be reviewed on a case-by-case basis.
            b) Example: Evaluation and Management service was provided in the morning, but due to an unforeseen problem, the injured worker had to return later in the day for a reason that would require another complete Evaluation and Management service.
        ii. Injured Worker with Multiple Claims - If a provider is treating an injured worker with multiple claims, the Evaluation and Management services may be billed in one (1) claim only for each visit. The service shall be billed to the claim representing the chief complaint or reason for the visit.
        iii. Multiple Physicians - If multiple physicians of different specialties provide Evaluation and Management services to an injured worker on a single day for conditions allowed in a claim, upon review of documentation, the MCO may make a determination to reimburse each provider for the evaluation and management service, if appropriate.
    b. Osteopathic Manipulative Treatment
        i. Administrative Cost – BWC shall not provide additional reimbursement to cover administrative costs for billing in more than one (1) claim.
        ii. Injured Worker with Two (2) Claims

a) Reimbursement for osteopathic manipulative treatment provided in two (2) claims shall be fifty percent (50%) of the BWC Fee Schedule for each claim.
b) Failure to use the modifiers in both claims shall cause BWC to deny the second bill submitted as a duplicate.

iii. Treatment of Body Regions in Injured Worker with Two (2) Claims

a) If **one (1) body region** is allowed in each of the two (2) claims, each claim may be billed with CPT® 98925. For the primary or most significant claim, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.
If a total of **three (3) or four (4) body regions** are allowed and treated in two (2) claims, two-in-one claim and one-or-two in a second claim, each claim may be billed with 98926. For the primary or most significant claim, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim
b) If a total of **five (5) or six (6) body regions** are allowed and treated in two (2) claims, each claim may be billed with 98927. For the primary or most significant claim, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.

iv. Injured Worker with More Than Two (2) Claims – BWC shall not routinely reimburse for osteopathic manipulative treatment in more than two (2) claims, and if rendered on the same date of service, BWC shall deny it.

c. Chiropractic Manipulative Treatment

i. Administrative Cost – BWC shall not provide additional reimbursement to cover administrative costs for billing in more than one (1) claim.

ii. Injured Worker with Two Claims

a) Reimbursement for chiropractic manipulative treatment provided in two (2) claims shall be fifty percent (50%) of the BWC Fee Schedule for each claim.
b) Failure to use the modifiers in both claims shall cause BWC to deny the second bill submitted as a duplicate.

iii. Treatment of Spinal Regions in Injured Worker with Two (2) Claims

a) If BWC allows **one (1) spinal region** in each of two (2) claims, each claim may be billed with CPT® 98940. For the primary or most significant claim, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.
b) If a total of **three (3) or four** (4) **spinal regions** are allowed and treated in two (2) claims, two-in-one claim and one-or-two in a second claim, each claim may be billed with 98941. For the primary or most significant claim, **modifier PC** must be added to the code. **Modifier SC** must be added to the code in the second claim.
c) If a total of **five (5) spinal regions** are allowed and treated in two (2) claims, each claim may be billed with 98942. For the primary or most significant claim, **modifier PC** must be added to the code. The second claim must be billed with 98942 with modifier **SC** added to the code.
d) If BWC allows **at least one (1) extra spinal region** in each of two (2) claims, each claim may be billed with CPT® 98943. For the primary or most significant claim, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.

iv. Injured Worker with More than Two (2) Claims – BWC shall not routinely reimburse for chiropractic manipulative treatment in more than two (2) claims and if rendered on the same date of service, BWC shall deny it.

d. Physical Medicine Procedures
   i. Reimbursement for physical medicine procedures shall be at the BWC fee.
   ii. CPT® codes 97012 – 97028 are reimbursable in only one claim per date of service as these codes describe treatments to **one or more areas** without time specifications
   iii. CPT® codes 97032 – 97530:
      a) BWC may reimburse in only one (1) claim if a total of fifteen (15) minutes or less are provided; and
      b) BWC may reimburse in more than one (1) claim if the total time units for each service exceed one (1) unit or fifteen (15) minutes.
         i) For each fifteen (15) minutes, one (1) unit may be billed in each claim using the modifier **PT** in the first claim and **ST** in the second claim.
         ii) An example of using CPT® code 97110 – Therapeutic exercises to develop strength and endurance take place for thirty (30) minutes. If the injured worker has two (2) claims, one (1) unit can be billed in each.

15. Valid Modifiers
   a. Effective, January 1, 2015, BWC and the MCO accept all HCPCS and CPT® modifiers on medical bills. The modifiers include ambulance modifiers to allow the provider to indicate the trip's origin and destination.
   b. BWC and the MCO shall continue to accept a small number of proprietary BWC modifiers in addition to the national standard modifiers.
   b. Vocational Rehabilitation Modifiers (W2-W3)
      i. BWC recognizes three (3) levels of vocational rehabilitation case complexity. Complexity Level 1 does not require a modifier and is reimbursed at one-hundred percent (100%) of the unit of service fee. Modifiers for Complexity Levels 2 and 3 and their corresponding levels of reimbursement are as follows:
         a) W2 Complexity Level 2 – One-hundred and three percent (103%) of unit of service fee; and
         b) W3 Complexity Level 3 – One-hundred and four point two percent (104.2%) of unit of service fee.
      ii. Additional information for the Vocational Rehabilitation Fee Schedule is located at http://www.bwc.ohio.gov/provider/services/agreement.asp. Also, see the Vocational Rehabilitation Services in Chapter 3 of this manual.
   c. Modifiers for Reimbursement for Multiple Claims
      i. BWC has four (4) proprietary modifiers used to allow reimbursement for physical medicine treatment in two (2) claims for the same injured worker and date of service:
         a) PC-Primary Claim (osteopathic or chiropractic treatment)
         b) SC-Secondary Claim (osteopathic or chiropractic treatment)
         c) PT-Primary Claim (other physical medicine procedures)
         d) ST-Secondary Claim (other physical medicine procedures)

16. Global Surgical Care for Professional Services ***(Located in Section - New-Revised-Updated Policies of the PBRM)***

III. HOSPITAL SERVICES

A. Eligible Providers - For the purposes of BWC, a hospital is an institution that provides facilities for surgical and medical diagnosis and treatment of bed injured workers under the supervision of staff physicians and furnishes twenty-four (24) hour-a-day care by registered nurses. These facilities must have accreditation from the Joint Commission, Health Care Facilities Accreditation Program or the Commission on Accreditation of Rehabilitation Facilities for rehabilitation hospitals or approved by the Centers for Medicare and Medicaid Services or other organizations with approved deeming authority for Medicare participation.

B. Definitions - BWC provides payment for medically necessary covered inpatient and outpatient services provided to injured workers for treatment of allowed compensable condition(s), subject to MCO or self-insured employer guidelines.
   1. Inpatient (*OAC 4123-6-01(K)(1)*; *OAC 4123-6-37.1*) — An injured worker admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. An injured worker is considered an inpatient if there is a formal order for admission from the physician. The determination of an inpatient stay is not based upon the number of hours involved. If it later develops during the uninterrupted stay that the injured worker is discharged, transferred to another inpatient unit within the hospital, transferred to another hospital, transferred to another state psychiatric facility or expires and does not actually use a bed overnight, the order from the attending physician addressing the type of encounter shall define the status of the stay.
   2. Outpatient (*OAC 4123-6-01(K)(2)*; *OAC 4123-6-37.2*) – The injured worker is not receiving inpatient care as defined above, but receives outpatient services at a hospital. An outpatient encounter cannot exceed seventy-two (72) hours of uninterrupted duration.

C. Prior Authorization & Additional Information
   1. Inpatient Services - The MCO, or the self-insuring employer in self-insuring employer claims, is responsible for authorizing and determining medical necessity for all non-emergency inpatient hospital services. The provider of record or treating physician is responsible for contacting the appropriate MCO or self-insuring employer for authorization guidelines. In cases of emergency, prior authorization is not required. The hospital must notify BWC, the MCO, Qualified Health Plans or the self-insuring employer within one (1) business day of emergency admission.
   4. Outpatient Services - The MCO, or the self-insuring employer in self-insuring employer claims, is responsible for authorizing and determining medical necessity for all outpatient hospital services. The provider of record or treating physician is responsible for contacting the appropriate MCO or self-insuring employer for authorization guidelines. In cases of emergency, prior authorization is not required.
   3. Emergency Department - Treatment in the emergency department of a hospital must be of an immediate nature to constitute an emergency (i.e., per OAC 4123-6-01 definition). **Prior authorization of such treatment is not required**; however, in situations where the emergency department is being utilized to deliver non-emergency care, notification shall be provided to the injured worker, hospital and provider of record that continued use of the emergency department for non-emergent services and shall not be reimbursed by BWC or the MCO.

D. Hospital Inpatient Reimbursement
   1. Overview - BWC reimburses hospital inpatient services using a modified version of Medicare's Inpatient Prospective Payment System. The modifications adopted by BWC are specified in OAC 4123-6-37.1. To view the current and previous hospital

inpatient rules go to https://www.bwc.ohio.gov/basics/guidedtour/generalinfo/ORCandOAC.asp.

2. Interim Bills - BWC shall not process interim bills (i.e., bill types 112 and 113) for interim stays of less than thirty (30) days. For a length of stay of thirty (30) days or greater, the initial interim bill submitted shall be processed according to the applicable reimbursement methodology. Additional interim bills shall be reviewed manually and may result in an adjusted reimbursement amount.
3. Late Charges - Hospital late charges cannot be submitted by hospitals to the MCO or BWC. Instead, the hospital must request adjustment of the initial bill. The hospital must include documentation of the hospital's bill for late charges with the adjustment request. This documentation can be hard or soft copy (e.g., fax, email) of the *Uniform Bill* (UB-04) form or the electronic version of the UB-04 (i.e., EDI.NSF, etc). All submitted requests shall contain clearly identifiable data elements required for bill processing.
4. Provider Types Excluded From BWC's Hospital Inpatient Reimbursement Methodology
   a. The following provider types are not reimbursed as hospitals by BWC:
      i. Skilled nursing facility;
      ii. Skilled nursing facility units in a hospital;
      iii. Skilled nursing facility swing beds;
      iv. Residential care/assisted living facilities; or
      v. Adult day care.
   d. BWC's complete billing guidelines for these provider types are in Chapter 4 of this manual.
5. Appeals - All appeals regarding hospital inpatient or outpatient reimbursement must be directed to the appropriate MCO. If the issue is not resolved to the hospital's satisfaction, the hospital may submit a second level of appeal to BWC. Second level appeals must be directed to the BWC Provider Contact Center, Attn: Hospital Appeals at fax # 614-621-1062. When a hospital is appealing the amount of reimbursement for an inpatient hospitalization, it is the hospital's responsibility to submit the supporting medical documentation for review.
6. Covered Services/Hospital Leave Of Absence - The MCO or self-insuring employer is responsible for authorizing a hospital leave of absence. BWC covers leave of absence from hospitals for catastrophic cases when the injured worker is admitted to learn new techniques and apply new strategies (i.e., involving daily activities) for the injured worker's return home. The leave of absence from the hospital must be medically appropriate and express potential to be beneficial to the injured worker's recuperation. BWC shall reimburse a reduced bed hold rate of fifty percent (50%) of the room and board rate. The leave of absence, when prior authorized, shall be billed using revenue center code 183.
7. Non-Covered Hospital Services OAC 4123-6-37 - Although the MCO or self-insuring employer is responsible for authorizing and determining medical necessity for all hospital services, in most cases, BWC shall not provide reimbursement for the following items:
   a. Convenience Items - Television, telephone, cosmetics, toiletries or other convenience items and goods and services requested by the injured worker solely for convenience are not reimbursable. The injured worker should be billed directly for these services.
   b. Private Rooms

i. BWC shall reimburse hospitals at the semi-private room rate. Private rooms are not covered unless the physician justifies that it is medically necessary. Reimbursement may be considered in the following instances:
   a) The injured worker's condition is such that recovery is jeopardized.
   b) The injured worker's condition may adversely affect other injured workers.

ii. An injured worker who requests a private room because of convenience may be billed the difference between private and semi-private rates. The injured worker who is provided a private room because of the unavailability of semi-private rooms shall not to be billed the difference.

E. Hospital Outpatient Reimbursement - BWC reimburses hospital outpatient services using a modified version of Medicare's Outpatient Prospective Payment System. The modifications adopted by BWC are specified in OAC 4123-6-37.2.

F. Billing
1. To facilitate accurate calculation of reimbursement in the outpatient prospective payment methodology, hospitals should submit all outpatient charges for one (1) date of service or encounter on the same bill.
   a. In most cases, if charges from one (1) date of service or encounter are submitted on separate bills, the first bill shall pay and subsequent bills shall be denied as potential duplicates.
   b. Exception - Bills containing only therapy charges (e.g. physical, occupational or speech) shall not be denied as duplicates if any previously paid bills for the same date of service or date of service range do not contain therapy charges.
   c. Additional charges may be added to a bill that has been paid or is in process. The hospital and MCO should work together to have the original bill adjusted.
   d. Cycle bills are accepted; however, BWC shall not accept split cycle bills or overlapping dates of service.
2. All hospital services, billed hardcopy, must be submitted on the UB-04 using revenue center codes. For outpatient hospital services, a number of revenue codes require a corresponding CPT® code. Revenue codes requiring a corresponding CPT® code are noted in this chapter. For outpatient services, a date of service is required on each line of the UB-04 for each service rendered. Lines submitted on outpatient bills with a charge of $0.00 are accepted and shall be priced according to the hospital outpatient prospective payment methodology. Professional services may not be billed on the UB-04.
3. A hospitals providing these services must obtain a separate BWC provider number for billing purposes and follow specific billing guidelines for each provider type as set forth in *"BWC's Provider Billing and Reimbursement Manual."* For additional enrollment applications, or if you have questions regarding enrollment with BWC, contact Provider Relations at 1-800-644-6292.

G. Treatment Of Unrelated Illness Or Injury - Treatment for unrelated illness or injury, while the injured worker is hospitalized or receiving hospital outpatient services, including Emergency Department services, is not usually reimbursable by BWC. When such unrelated treatment is requested, the requesting physician must identify which services are necessary due to the industrial illness or injury and which are necessary due to the unrelated condition(s). The hospital may be required to remove unrelated charges from the bill.

H. Documentation Requirements – A hospital must submit documentation to support the diagnosis and procedure codes reported on inpatient and outpatient bills. The MCO is required to validate codes reported by the hospital because coding impacts the reimbursement rates.
   1. Documentation for inpatient services may include:
      a. Admission history and physical;
      b. Emergency department report if applicable;
      c. Operative report if applicable;
      d. Discharge summary and/or progress notes if admission was forty-eight (48) hours or longer in duration;
      e. Discharge note if admission was less than forty-eight (48) hours in duration;
      f. Consultations; and/or
      g. Additional documentation may be requested, including but not limited to temized billing statements, laboratory, radiology and other diagnostic reports.
   2. Documentation for outpatient services may include:
      a. Clinical summary/notes;
      b. Radiology, laboratory, and other diagnostic study reports;
      c. Emergency department reports, if applicable; and/or
      d. Operative reports, if applicable.

I Prospective & Retrospective Hospital Bill Reviews - Prospective and retrospective reviews shall be conducted on hospital bills. Reviews shall include but shall not be limited to the following:
   1. Ensure services are medically necessary for treatment of the allowed claim conditions;
   2. Ensure services are related to allowed claim conditions;
   3. Ensure correct coding;
   4. Identification of billing errors;
   5. Identification of reimbursement errors; and
   6. Overpayments may be recovered according to the medical overpayment recovery policy.

J. Covered & Non-Covered Revenue Codes (Removed. Now published in OAC 4123-6-37.1, Payment for Inpatient Hospital Services and OAC 4123-6-37.2, Payment for Outpatient Hospital Services).

K. Revenue Codes Requiring CPT Codes for Hospital Outpatient Services (Removed. Now published in OAC 4123-6-37.2).

L. Valid Modifiers for Hospital Outpatient Services - BWC recognizes all CPT and HCPCS modifiers for hospital outpatient services in effect on the billed date of service. Per OAC 4123-6-37.2, reimbursement impacts are determined.

IV. AMBULATORY SURGICAL CENTER BILLING AND REIMBURSEMENT POLICY *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

V. TRAUMATIC BRAIN INJURY (TBI) *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

VI. OUTPATIENT MEDICATION PRIOR AUTHORIZATION PROGRAM *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

VII. HOME HEALTH AGENCY SERVICES *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

VIII. NURSING HOME *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

IX. RESIDENTIAL CARE/ASSISTED LIVING FACILITY BILLING REQUIREMENTS POLICY *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

X. TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) & NEURO-MUSCULAR ELECTRICAL NERVE STIMULATION (NMES) - The intent of the BWC *"TENS and NMES"* policy is to implement minimum standards for all vendors supplying TENS and NMES units to Ohio's injured workers and to establish standardized criteria for the medical indications for the use of TENS and NMES.

7. ORC 4752.02(A) - Pursuant to ORC 4752.02(A), no person shall provide home medical equipment services unless they have a valid license or certificate of registration from the Ohio Respiratory Care Board. This includes TENS units. All in-state BWC-certified durable medical equipment providers already have the mandatory license/certificate, as this is required to obtain BWC certification. ORC 4752.02 exempts the following from the licensure/certification requirement:
   - Orthotist;
   - Prosthetist;
   - Pedorthist; and
   - The hospital providing home medical equipment, as an integral part of patient care and not through a separate entity that has its own Medicare or Medicaid provider number from this licensure/registration requirement, is included in this listing.

8. OAC 4123-6-43 - Per TENS rule OAC 4123-6-43, BWC does not reimburse for devices that are labeled by the Food and Drug Administration for over-the-counter use and are identified with the Food and Drug Administration product code "NUH.OTC.TENS."

9. Definitions For TENS & NMES
   - TENS is a device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the injured worker's perception of pain by inhibiting the afferent pain nerve impulses and/or stimulating the release of endorphins.
   2. NMES is a device, which transmits an electrical stimulus to muscle groups and causes the muscle to contract.

D. Required Criteria For TENS & NMES Units - This criteria applies to all vendors supplying TENS and NMES units to Ohio's injured workers:
   1. BWC Minimum Technical & Educational Criteria
      a. **TENS and NMES units Requirements**
         i. Device must produce constant current.
         ii. Device must be restricted to prescription use only; no over-the-counter devices.
      b. **Rationale**
         i. Constant current maintains waveform as it is driven through the skin. It allows the current to be delivered in a uniform pattern, increasing the comfort

level for the injured worker. Breakdown of the waveform may result in increased skin irritation and burning.

ii. Per BWC TENS rule OAC 4123-6-43(D), BWC shall not pay for the rental or sale of devices that are labeled by the Food and Drug Administration for over-the-counter use and are identified with the Food and Drug Administration product code "NUH.OTC.TENS."

iii. Also, as it relates to NUH OTC TENS units, BWC TENS rule OAC 4123-6-43(A)(1) provides that TENS units shall only be purchased for use by the injured worker following a required thirty-day rental period. Because NUH OTC TENS units cannot be rented prior to purchase, the MCOs shall not approve payment for NUH OTC TENS units.

c. **Instruction/Education**

i. Requirements

a) TENS and NMES units supplied by a practitioner must be personally fitted and face-to-face instruction provided when the unit is supplied.

b) Documentation of this instruction must be in the injured worker's record.

c) TENS and NMES units provided by a durable medical equipment supplier must be personally fitted and face-to-face instruction given by a direct employee of the durable medical equipment provider within five (5) business days of the request for the unit, at no additional charge. If the durable medical equipment verifies and documents that the ordering practitioner is supplying the instruction/education, the durable medical equipment is not required to do so.

d) This verification documentation should be available to BWC or the MCO upon request.

ii. Rationale – The injured worker is more apt to use the TENS or NMES unit correctly and to have fewer problems and increased pain relief if given face-to-face instruction rather than if given written or telephonic instruction.

d. **Supplies Requirement**:

i. The injured worker's MCO shall regularly determine the specific TENS supplies needed by the injured worker throughout the timeframe authorized for TENS use.

ii. The TENS provider must receive authorization from the injured worker's MCO prior to the delivery of supplies and/or equipment.

iii. The TENS provider shall then deliver the supplies and bill the injured worker's MCO after authorization is received.

iv. A self-insuring employer may, but is not required to, follow the same procedure as an MCO under this rule; provided, however, that in no event shall a self-insuring employer require an injured worker to submit a written request for TENS supplies and/or equipment.

v. The injured worker's MCO shall retain documentation of the contact with the injured worker substantiating the injured worker need for supplies in accordance with the periods set forth in OAC 4123-6-14.1.

vi. The TENS provider's bill must indicate the actual date of service, reflecting the date that services or supplies were provided.

vii. BWC, the MCO, Qualified Health Plans or self-insuring employer may adjust bills upon audit if the audit discloses the provider's failure to comply with this rule.

viii. The TENS provider shall maintain the following records and make them available for audit upon request:

a) Authorizations of TENS supplies or equipment received from the injured worker's MCO and all other documentation relating to the injured worker need for TENS supplies or equipment received by the provider prior to the delivery of the supplies or equipment, including any requests received from the injured worker, if applicable;
b) Records of the provider's wholesale purchase of TENS supplies or equipment; and
c) Records of delivery of supplies to injured workers and of the delivery or return of TENS units.
d) Upon request, the provider shall supply copies of the record information to the requester at no cost. Failure to provide the requested records may result in denial or adjustment of bills related to these records.

e. **Rationale**
   i. Appropriate amounts of medically necessary supplies shall be provided.
   ii. The billing provider shall not issue supplies unless the injured worker's MCO has provided authorization.

2. **BWC Medical Necessity Criteria**
   a. TENS for Chronic Pain
      i. Prior authorization by BWC, the MCO or self-insured employer or their agents is required for TENS rental or purchase.
      ii. Payment for a transcutaneous electrical nerve stimulator (i.e., TENS) is covered for the treatment of an injured worker with chronic, intractable pain who meets the following criteria:
         a) Documentation of chronic pain that has been present for three (3) months;
         b) Documentation of the location of pain, duration of time the injured worker has had pain, and the presumed cause of the pain; and
         c) Documentation of other modalities that have been tried and failed.
      iii. A trial rental period at a minimum of one (1) month is implemented to determine the effectiveness of TENS unit. The following documentation must be present in the physician's records at the conclusion of the thirty (30) day trial period to purchase a TENS unit for chronic pain:
         a) Frequency and duration of use of TENS; and
         b) Results of TENS units modulating pain.
   b. TENS for Acute Post-operative Pain
      i. TENS rental is generally limited to thirty (30) days beyond surgery.
      ii. For reimbursement beyond thirty (30) days, the physician must provide medical documentation for justification.
   c. NMES
      i. A NMES device provides an electrical stimulus directly to the muscle or motor nerve of the muscle, causing the muscle to contract. The goal is to stimulate denervated muscle to prevent atrophy or degeneration and to strengthen/train healthy muscles that are at risk of atrophy from immobilization or disuse due to injury. Prior authorization by BWC, the MCO or self-insured employer or their agents is required prior to NMES rental or purchase.
      ii. The MCO Medical Director or an MCO physician consultant is required to review each request for home rental or purchase of NMES based on medical necessity and BWC NMES criteria.
      iii. Reimbursement of NMES devices for home use for the treatment/prevention of muscle atrophy requires the following conditions be met:

a) The injured worker has suffered partial or complete loss of function in one (1) or more muscles because of an injury to a peripheral nerve or nerve root; and
b) Denervation is substantiated by electromyography confirming the nerve injury. The electromyography must demonstrate positive waves and/or fibrillation in the affected muscles.

iv. BWC and the MCO shall reimburse NMES and functional electrical stimulation to enhance walking of injured workers with spinal cord injuries who meet all the following criteria:
a) Diagnosis of paraplegia of both lower limbs;
b) Willingness to use the device on a long-term basis;
c) High motivation, commitment and cognitive ability to use the device for walking;
d) Completion of a physical therapy training program of a minimum of thirty (30) sessions with the NMES unit over a three (3) month period;
e) Intact lower motor units (i.e., L1 and below) both muscle and peripheral nerve;
f) Demonstration of brisk muscle contraction to NMES and sensory perception of electrical stimulations sufficient for muscle contraction;
g) Muscle and joint stability for weight bearing at upper and lower extremities with demonstration of balance and control to maintain an upright support posture independently;
h) Ability to transfer independently and demonstration of standing independently for at least three (3) minutes;
i) Demonstration of hand and finger function to manipulate controls;
j) Minimum of six (6) month post recovery spinal cord injury and restorative surgery; and
k) Absence of hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis.

v. The appropriate HCPCS Level I (CPT®) code to be billed to MCO or the BWC for the required physical therapy with the NMES unit is 97116-gait training.

vi. NMES/functional electrical stimulation for walking is contraindicated for spinal cord injured workers with any of the following:
a) Cardiac pacemakers or cardiac defibrillators;
b) Severe scoliosis or severe osteoporosis;
c) Irreversible contracture;
d) Autonomic dysreflexia; or
e) Skin disease or cancer at the area of stimulation.

E. **OAC 4123-6-43 - Payment Of Transcutaneous Electrical Nerve Stimulators & Neuromuscular Electrical Stimulators**

1. Payment shall be approved for a TENS unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in OAC 4123-6-43 and in this manual.
2. Prior authorization is required to have a prescribed transcutaneous electrical nerve stimulator unit and supplies furnished to the injured worker.
3. Each injured worker who requires a TENS unit shall be provided only one (1) unit at a time.

4. For each TENS unit request approved, the unit shall be rented for a trial period of thirty (30) days before purchase of the TENS unit. This trial period is to evaluate the medical necessity and effectiveness of the TENS treatment.
5. All rental payments for the TENS unit shall be applied to the purchase price.
6. A TENS unit, furnished and purchased for the injured worker, is not the personal property of the injured worker, but remains the property of BWC or self-insuring employer.
7. At its discretion, BWC or self-insuring employer reserves the right to reclaim and recover the TENS unit from the injured worker at the completion of the course of TENS treatment.
8. Once a TENS unit is purchased, BWC or self-insuring employer shall reimburse for repair or replacement, upon the submission of a request from the physician of record or treating provider that includes medical documentation substantiating the continued medical necessity and effectiveness of the unit.
9. Please note that the above criteria listed in OAC 4123-6-43 Payment of Transcutaneous Electrical Nerve Stimulators, also apply to the payment of neuromuscular units (i.e., NMES).

F. **Coding & Reimbursement Of TENS/NMES**

1. BWC shall not separately reimburse for a TENS/NMES fitting and instruction. Fee for TENS and NMES units includes fitting and instruction. Please refer to the most current medical and Professional Provider Fee Schedule for reimbursement rates.
2. Current fee schedules are published at https://www.bwc.ohio.gov/provider/services/agreement.asp.

Code	Description
E0720	TENS unit, 2 lead (rent to purchase)
E0730	TENS unit, 4 lead (rent to purchase)
E0731	Form fitting conductive garment, TENS or NMES
A4595	All supplies for TENS and NMES except lead wires and batteries, per month
E0745	NMES unit (rent to purchase)
A4557	Lead wires, per pair

XI. LOW LEVEL LASER THERAPY - BWC's review of the medical literature determined there is inadequate evidence to support the medical effectiveness of low level laser therapy for the treatment of musculoskeletal disorders. See the BWC position paper on our Web site, https://www.bwc.ohio.gov/downloads/blankpdf/PositionLaserTherapy.pdf.

XII. OTHER BWC CERTIFIED PROVIDER SERVICES

A. Billing From All Other BWC Certified Providers - Billing from all other BWC certified providers, including, but not limited to, ambulance, durable medical equipment supplier, orthotist, prosthetist and traumatic brain injury facilities must be submitted to the MCO on a CMS-1500 using the appropriate HCPCS Level I (CPT®) or HCPCS Level II codes or BWC local level codes.

B. Medical Services Request – A physician of record or treating provider must submit a request for medical services because these services require prior authorization. Please refer to Signature on Medical Evidence Grid, in section II.P.1.

C. Durable Medical Equipment
1. BWC follows HCPCS Level II to report durable medical equipment E0100-E9999. Durable medical equipment is defined as equipment which:
   a. Can withstand repeated use;
   b. Primarily and customarily serve a medical purpose;
   c. Generally is not useful to a person in the absence of illness or injury;
   d. Is appropriate for use in the home; and
   e. Does not include disposable items.
2. The following reusable items are examples of durable medical equipment:
   a. Hospital beds;
   b. Mattresses for hospital beds;
   c. Walkers;
   d. Wheelchairs;
   e. Breathing machines;
   f. Crutches;
   g. Bedside commodes; and
   h. Seat-lift mechanism.
3. BWC considers a seat-lift mechanism to be medically necessary for injured workers who require a mobility aid to stand from a seated position due to physical limitations that are reasonably related to the industrial injury (i.e., disease). BWC reimburses the seat-lift mechanism, (i.e., E0627, E0628 or E0629) when the MCO determines it is medically necessary and appropriate to the industrial injury. BWC does not reimburse the chair (i.e., furniture).
4. BWC shall not reimburse for equipment, used primarily and customarily for non-medical purposes, because it does not qualify as durable medical equipment. Pursuant to OAC 4123-6-07, the following items are never covered by BWC:
   a. **Home furniture** including, but not limited to: reclining chairs, non-hospital beds, water beds, lounge beds (e.g., Adjust-A-Sleep Adjustable Bed, Craftmatic Adjustable Bed, Electropedic Adjustable Bed, Simmons Beautyrest Adjustable Bed);
   b. **A mattress** for a non-hospital bed;
   c. **Home exercise equipment** including but not limited to such equipment as treadmills and exercise bikes; and

d. **Home whirlpools** including built-in whirlpools and pumps, portable hydrotherapy pools, jacuzzi tubs, portable saunas and spas and TheraSaunas are not considered to be medically necessary. When a request is received for a built in hot tub/whirlpool, the MCO shall call the provider to advise that BWC covers the "over tub whirlpool" (i.e., E1300) if determined to be medically necessary and appropriate to the industrial injury.

5. Specific features of durable medical equipment that have been determined by the MCO to be features that are not medically necessary or do not have a reasonable relationship to the allowed conditions in the claim shall not be reimbursed. Examples include:
   a. Heavy duty/bariatric piece of equipment, unless the injured worker meets the weight requirements;
   b. Limited reimbursement of a hospital bed mattress to a single size mattress, or the size that is required by the injured worker determined by the injured worker's weight, height and medical condition. BWC shall not reimburse a provided for a double, queen or king size mattress to accommodate two (2) people; or
   c. BWC shall not reimburse a provider for a "deluxe" model if the standard model provides the features that are medically necessary for the injured worker.
6. BWC considers durable medical equipment to be purchased when rental has reached the BWC purchase fee. BWC does not accept a provider's percentage reduction from the rental fees already paid which result in BWC payment of additional monies for the purchase of the equipment beyond the BWC purchase fee.

D. **Equipment Used As Part Of A Surgical Procedure**

1. Equipment used as part of a surgical procedure (i.e. implantable devices, surgical hardware) must be billed by the facility where the procedure takes place (i.e., ambulatory surgical center or hospital) or by the physician if done in the physician's office.
2. BWC and the MCO shall not reimburse the manufacturer or supplier of the equipment when the equipment is used as part of a surgical procedure.
3. Replacement batteries for implanted devices shall be reimbursed to the attending provider or durable medical equipment supplier.
4. Examples of equipment used as part of a surgical procedure include, but are not limited to: implantable neurostimulator pulse generator, implantable neurostimulator electrodes, implant hardware, implantable infusion pump and implantable intraspinal catheter.

XIII. SERVICES APPROVED AND REIMBURSED BY BWC RATHER THAN BY THE MCO

A. Caregiver Services *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

B. Home & Vehicle Modifications *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

C. Prosthetics/Artificial Appliances

1. All eligible prosthetic/artificial appliance and repair thereof, whether for state fund claims or self-insured claims, are paid from the surplus fund.

a. **For MCO managed claims,** the MCO receives the C-9 request for authorization and approves or denies the request. If the request is approved, the provider submits the bill to the MCO**.**
b. **In self-insured claims,** BWC is responsible for processing requests for artificial appliance and travel expenses associated with the artificial appliance in **all self-insured claims**. When an artificial appliance is needed in a self-insured claim, the physician/provider must send a request for the artificial appliance and/or request for repair, as well as the subsequent bills, to the appropriate BWC Customer Service Team. The BWC Customer Service Team must submit the bill from the provider to Medical Billing and Adjustments.

2. The provider must ensure that the following information is available for processing an artificial appliance request. Processing may be delayed if the following information is not included with the request:
   a. Written evidence that an artificial appliance has been determined to be medically necessary for the injured worker from one (1) of the following:
      i. The Ohio State University hospital amputee clinic;
      ii. The Opportunities for Ohioans with Disabilities agency;
      iii. An amputee clinic approved by the administrator or the administrator's designee; and
      iv. A prescribing physician approved by the administrator or the administrator's designee.
   b. Dated and signed prescription for the item being requested including the manufacturer, brand name and model number;
   c. Recent physical examination that includes a functional assessment with current and expected ability, impact upon activities of daily living, assistive devices utilized and co-morbidities that impact the use of the prescribed artificial appliance;
   d. Clinical rationale for requested artificial appliance, replacement part(s) or repair(s) and a description of any labor involved;
   e. Coding description for the artificial appliance or repair utilizing the HCPCS (i.e., If a miscellaneous code is requested, all component items bundled in the miscellaneous code shall be listed along with a complete description and itemization of charges;
   f. As appropriately required by the appendix to OAC 4123-6-08, a copy of the manufacturer's invoice for items requested under a miscellaneous HCPCS code; and
   g. Copy of any warranties related to the requested artificial appliance.
3. It is the prosthetist's responsibility to assure that any prosthetic device/artificial appliance fits properly for three (3) months from the date of dispensing. Any modifications, adjustments or replacements within the three (3) months are the responsibility of the prosthetist who supplied the item and BWC shall not reimburse for those services. The provision of these services by another provider shall not be separately reimbursed.

D. Interpreter Services *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

E. Catastrophic Case Management Plan *(Previously Called Life Care Plan) (LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

XIV. EXPOSURE OR CONTACT WITH BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS WITH OR WITHOUT PHYSICAL INJURY *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

XV. CHRONIC PAIN *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

XVI. UTILIZING PRESCRIPTION MEDICATION FOR THE TREATMENT OF INTRACTABLE PAIN

A. Purpose - The purpose of this policy is to provide to Ohio physicians treating Ohio injured workers, BWC personnel, MCO, BWC's Disability Evaluators Panel drug file reviewers and independent medical examiners and injured workers, their employers and their respective representatives:

1. The rules for prescribing narcotic medication in the treatment of intractable pain according to the State of Ohio Medical Board of OAC 4731-21-02;
2. The expectations of the type of medical evaluation and documentation necessary to support and facilitate using prescription medication for the treatment of intractable pain in injured workers in the Ohio Workers' Compensation System;
3. The key elements that may be necessary in the claim file to assist BWC personnel and physicians performing reviews to determine whether the use of prescription medications in the claim meet statutory requirements;
4. The rationale and process for BWC claims management personnel to use to obtain when necessary the information needed to support or deny the use of prescription medications for the treatment of intractable pain and to facilitate the use of prescription medication, when necessary and appropriate for treatment, to obtain necessary information when insufficient information is available in the claim file, and to deter use of prescription medications when there is lack of proof of medical necessity and appropriateness.

B. Issues Important To Ohio Workers' Compensation - Issues important to Ohio Workers' Compensation include:
1. Lack of strict claims management guidelines regarding criteria to support use or to deny authorization of prescription medication in the treatment of intractable pain;
2. Concern for overuse and excessive prescribing of prescription pain medications for some injured workers as been identified by BWC personnel, pharmacists, physicians, employers and other parties, as it impacts the well being of the injured worker, potential for inappropriate use and distribution, social implications, and financial costs to the system.
3. Variance in interpretation and application of the State of Ohio Medical Board of OAC Chapter 4731-21 by physicians performing claims management services for BWC and BWC personnel, which ultimately impacts authorization/denial decisions regarding use of prescription medications.
4. Lack of use of prescription medication, particularly opioids, by physicians who are treating chronic intractable (non-malignant, benign) pain in some of Ohio's injured workers has been identified as a pattern as opposed to appropriate utilization.
5. Appropriate use, careful surveillance and escalating vigilance with longer-term higher doses is required.

C. Statutes - Statutes regarding the use of prescription medication for the treatment of intractable pain have changed considerably both nationally and in Ohio.

1. The State of Ohio Medical Board has established standards and procedures for physicians regarding the diagnosis and treatment of intractable pain. These rules are contained in OAC Chapter 4731-21.
2. The State of Ohio Medical Board of OAC 4731-21-02 pertains to "utilizing prescription drugs for the treatment of intractable pain".
3. Since these rules provide the legal authorization and criteria for use of the prescription drugs for treatment of intractable pain, they must also be followed by physicians providing opinions for authorization of payment of such medications in claims in either file reviews or independent medical evaluations for BWC.
4. According to OAC 4731-21-01 "Definitions" of the State of Ohio Medical Board OAC rules:
   a. "Intractable pain" means a state of pain that is determined, after reasonable medical efforts have been made to relieve the pain or cure its cause, to have a cause for which no treatment or cure is possible or for which none has been found. "Intractable pain" does not include pain experienced by an injured worker with a terminal condition. "Intractable pain" does not include the treatment of pain associated with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition."
   b. To comply with this definition, reasonable medical efforts should have been made to relieve the pain or cure its cause and that the pain has a cause for which no treatment or cure is possible or at least none has been found. Therefore, intractable pain is considered only after reasonable medical efforts have been made to diagnose the cause of the pain and adequate and appropriate medical treatment has been provided to treat the cause. Many medical conditions seen in a BWC injured worker could be considered "intractable pain" (e.g., but not limited to, complex regional pain syndrome I or the chronic pain frequently associated with lumbar procedures, such as, postlaminectomy syndrome). Due to wide variance of symptoms and treatment over the clinical course of a condition, not all injured workers with these allowed conditions in the claim meet the definition of "intractable pain".
5. OAC 4731-21-02 provides the guidelines or expectations of physicians managing intractable pain with prescription drugs. OAC 4731-21-02(A) requires:
   a. An initial evaluation that includes complete medical, pain, alcohol and substance abuse histories;
   b. Assessment of the impact of pain on physical and psychological functions;
   c. Review of previous diagnostic studies and previously utilized therapies;
   d. An assessment of coexisting illnesses, diseases or conditions; and
   e. An appropriate physical examination.
6. The medical diagnosis must be documented that indicates the intractable pain along with the signs, symptoms, and causes of the pain. An individual treatment plan must be documented and specify the medical justification of the treatment of intractable pain with prescription drugs on a protracted basis, the intended role of prescription drug therapy within the overall plan, and other medically reasonable treatment for relief of the intractable pain that have been offered or attempted without adequate or reasonable success. The response to the treatment must be documented along with modifications to the treatment plan. OAC 4731-21-02(A)(4)(a) states that the diagnosis of intractable pain can be made only after having the injured worker "evaluated by one (1) or more other practitioners who specialize in the treatment of the anatomic area, system, or organ of the body perceived as the source of the pain." The prescribing physician is to maintain a copy of the report of the evaluation.

The evaluation is not required, if the injured worker has been evaluated and treated within a "reasonable period of time," by one (1) or more, other practitioners who specialize in the anatomic area, system, or organ perceived to be the source of pain and the treating practitioner is satisfied that he or she can rely on the evaluation to meet the requirements of the Rule. The practitioner is required to obtain and maintain a copy of the records or report on which he/she relied to meet the requirements of an evaluation by a specialist. The last paragraph of OAC 4731-21-02(A) requires an informed consent be present and retained in the medical record informing the injured worker of the risks and benefits of receiving prescription drug therapy and of available treatment alternatives.

7. OAC 4731-21-02(B)(1) requires that the practitioner see the injured worker at "appropriate periodic intervals to assess the efficacy of treatment, assure that prescription drug therapy remains indicated, evaluate the injured worker's progress toward treatment objectives, and note any adverse drug effects." OAC 4731-21-02(B)(2) also requires ongoing assessment of functional status, the pain intensity, and its interference with activities of daily living, quality of life, and social activities. If there is evidence or behavioral indications of drug abuse, the practitioner may obtain a drug screen. According to OAC 4731-21-02(B)(3), "It is within the practitioner's discretion to decide the nature of the screen and which type of drug(s) to be screened." Results of the screening must be documented in the injured worker's medical record.
8. OAC 4731-21-02(C) requires immediate consultation with an addiction medicine or substance abuse specialists if the practitioner believes or has reason to believe the injured worker is suffering from addiction or drug abuse.
   9. Based on the above statutory and regulatory documents described, the use of prescription medication for the treatment of chronic intractable pain is acceptable in Ohio on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions so long as the treating physician complies with the State of Ohio Medical Board rules. Based on Ohio Supreme Court decision, it is also required that the authorization of payment for services be reasonably related, reasonably necessary for treatment of the allowed injury, and that the costs are medically reasonable. To support the reasonably necessary requirement, practitioners are expected to provide medical documentation to support intractable pain and the need to use prescription medication for the treatment of intractable pain when present. Medical records must also reflect or explain how the intractable pain and its treatment are reasonably related to the allowed injury in the claim.
10. Key elements expected to be present in the medical file include but are not limited to:
    a. Reasonable medical efforts (e.g., diagnostic study, consultation, and treatment) have been performed to relieve the pain, identify the source, and cure its cause.
    b. No other treatment or cure is possible or none has been found.
    c. The initial evaluation by the treating practitioner meets the requirements of OAC 4731-21-02. This is not intended to be point-by-point specific, but that the medical records do document sufficient history, pain description, relatedness of the pain to the allowed condition in the claim, alcohol and substance abuse history, assessment of physical and psychological function, diagnostic studies and treatment performed, and an appropriate physical examination.
    d. Appropriate consultation has been performed by either consultation or previous treating specialist, as defined by OAC 4731-21-02 within a

reasonable period, not to exceed six (6) months from the beginning of such treatment.

e. Medical records provide appropriate documentation to support continued use of the medication consistent with OAC 4731-21-02. This includes adequate monitoring of the injured worker on a periodic basis to determine the continued need for prescription medication.

11. BWC expects practitioners to perform or receive authorization as part of the treatment guidelines for the following services:
    a. Periodic office visitation to monitor treatment compliance, results, physiologic and psychological functioning;
    b. In certain claims, it may be necessary to obtain periodic urine drug testing to determine drug abuse based on evidence or behavioral indications of addiction as described in OAC 4731-21-02(B)(3 (i.e., This most likely would be no more); frequent than quarterly);
    c. In all claims receiving medications for intractable pain, checking the Ohio Automated Rx Reporting System report is advisable; and
    d. Referral to an addiction medicine specialist or substance abuse specialist for consultation and evaluation (most likely each case would need to be evaluated for treatment) if the practitioner believes or has reason to believe the injured worker is suffering from addiction or drug abuse as described in OAC 4731-21-02(C).
12. Since there is no specific allowance of "chronic intractable pain", BWC personnel involved with claim management determinations and physicians performing file reviews or independent medical evaluations for BWC should consider the following criteria in regard to the use of prescription medication to treat chronic intractable pain:
    a. That the medical records meet the definition of "intractable pain" as defined by the State of Ohio Medical Board particularly in relation to reasonable medical efforts to determine the source and treat the cause of the pain have been documented;
    b. That a second opinion from an appropriate specialist has been performed;
    c. That the medical records provide a reasonable relationship of the symptoms to the allowed conditions in the claim; and
    d. That the use of such medication is reasonably necessary to help manage the symptoms experienced by the injured worker.

13. If the above criteria are met, even though there is no allowance for chronic intractable pain on the claim, then BWC may authorize reimbursement for prescription medication used in the treatment of chronic intractable pain.
14. In claim management, many, if not most, cases would be a continuation of or "flow-through" of treatment of a condition that is presumed to be the cause of pain and for which the injured worker has received appropriate diagnostic testing, treatment, and evaluations. Many individuals considered to have "chronic intractable pain" shall have obvious limitation of activity and difficulty controlling pain following treatment of the allowed condition. Other claims shall be more difficult to assess. There may be issues of:
    a. Need for additional diagnostic testing;
    b. Need for specialist consultation;
    c. Uncertainty of diagnosis or relationship to the allowed conditions in the claim; or

d. Medical records do not support the apparent need for continued treatment in which case, it can be anticipated that some employers may also request an independent medical evaluation of injured workers for the purpose of justification of ongoing treatment in many of these cases.

15. In questionable cases or those requested by the employer, an independent medical evaluation performed by a specialist is appropriate to determine issues such as:
    a. Recommendations for any additional testing to identify the source of the pain;
    b. Other treatment that should be considered;
    c. Specialty consultation that may be beneficial;
    d. Provide description of the pain and impact on daily living, functioning etc.;
    e. Clarify relationship of symptoms (pain) to the allowed conditions or work injury;
    f. Determine the apparent need for continued treatment; and
    g. Other issues as deemed necessary.
16. In most non-catastrophic workers' compensation cases, the presumed source of pain shall be limited to the musculoskeletal system. Appropriate independent medical evaluating specialists shall be limited to orthopedists, hand surgeons for the upper extremity, neurosurgeons, physical medicine and rehabilitation specialists, and possibly occupational medicine and pain specialists depending on the nature of the issue.
17. Treating physicians who consistently fail to provide appropriate medical records or follow the State of Ohio Medical Board rules shall be referred to Disability Evaluators Panel Central or Provider Relations along with the specific claim numbers of injured workers being treated.
18. The provider can access the complete BWC position paper including references, at the following BWC Website:
    https://www.bwc.ohio.gov/provider/services/medpositionpapers.asp.

XVII. SPINAL DECOMPRESSION THERAPY *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*

XVIII. SMOKING DETERRENT PROGRAMS *(LOCATED IN SECTION - NEW-REVISED-UPDATED POLICIES OF THE PBRM)*