Workers' Compensation Guide for

Self-Insuring Employers and their Employees

Ohio | Bureau of Workers' Compensation

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Self-Insuring Employers and Their Employees

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self-insured **Coverage**

The workers' compensation system

The Ohio Bureau of Workers' Compensation (BWC) and the Industrial Commission of Ohio (IC) comprise the Ohio workers' compensation system, which includes state-fund and self-insuring employers.

Under the state-fund program, BWC pays compensation directly to injured workers. Self-insuring employers, which the bureau monitors, pay their own workers' compensation claims. Self-insurance is a privilege granted to employers with proven financial strength and administrative ability to ensure prompt handling of all obligations.

BWC

A governor-appointed administrator and the BWC Board of Directors manage BWC.

BWC has provided injured workers with compensation for work-related injuries, diseases and deaths since 1912. It maintains a central office in Columbus, as well as customer service offices and customer focus centers throughout the state.

BWC's Division of Safety & Hygiene (DSH) performs research to prevent industrial accidents and diseases, and offers employers and their employees safety training and accident-prevention programs.

IC

The IC hears and decides contested claims, and determines whether an injured worker can claim permanent total disability. The governor appoints the three-member IC and the Ohio Senate confirms it. One member represents labor, one represents industry and one represents the public.

Workers' compensation coverage

Ohio law requires employers with one or more employees to obtain workers' compensation coverage. Thus, workers' compensation covers employers either through the state insurance fund or self-insurance for costs associated with work-related accidents, occupational diseases or deaths.

Employers pay the entire cost of workers' compensation. They may not exclude employees from benefits based on age, citizenship, gender, race or relationship. According to the law, employees receive pay from employers for services performed when the relationship between the employer and employee is created by a contract of hire — written, oral, expressed or implied.

Requirements for self-insurance

Employers realize several benefits from self-insurance, including the administration of their own claims and the potential for claims cost savings. To qualify for self-insurance, an employer must meet several requirements, including:

- Possess two-years experience with the state insurance fund;
- Demonstrate a strong financial stability;
- Possess the ability to administer workers' compensation insurance;
- Maintain an account with a financial institution in Ohio, or draw compensation checks from the same account as the payroll checks.

Applying for self-insurance

To apply for self-insurance in Ohio, log on to bwc.ohio.gov. From the Employer tab, hover over Self-Insured tab on the left side of the screen. Open Self-Insured overview, and open Obtain Self-Insurance link. The applicant also may call BWC's self-insured department at 614-644-6292 or 1-800-OHIO BWC, and listen to the options. The applicant also can obtain applications at bwc.ohio.gov.

To apply for self-insurance, complete the:

- *Initial Application by Employers for Authority to Pay Compensation Etc., Directly* (SI-6) — This form requests information regarding the organization's structure, payroll and claims-management locations;
- *Agreement Between Employer and the Ohio Bureau of Workers' Compensation Regarding the Amount of Self-Insured Buyout* (SI-16) — The employer consents to enter into a buyout agreement to pay his or her share of any deficit in the state insurance fund. BWC re-evaluates the need for a buyout on an annual basis;
- *Contract of Guaranty* (SI-38) — This contract ensures any claims liability from a defaulting subsidiary will become the parent organization's responsibility;
- *Claim Reimbursement Election (*SI 44) — The employer may elect to not be reimbursed for overturned claims that result in an overpayment. This election is irrevocable.

This form is optional.

- *Permanent Authorization* (AC-2) — The employer authorizes a third party to represent him or her before BWC or the IC.

Supporting documentation

Besides the forms mentioned above, also submit for review:

- All financial records, documents and data necessary to provide a full financial disclosure (as audited by a certified public accountant). This includes a balance sheet and a profit and loss statement for the current year and the previous four years;
- Organizational plan to administer workers' compensation;
- Proposed plan to inform employees of the change from a state-fund insurer to a self-insurer and procedures employees must follow when filing for compensation and benefits;
- Secretary of State papers providing proof of registration to do business in Ohio;
- Information on your company's risk- and claims-management procedures to establish a safe and more cost-effective workplace, including:
  - Active senior-management leadership;
  - Employee involvement;
  - Return-to-work practices;
  - Communication about employee safety and health;
  - Claims reporting practices;
  - Coordination of safety and health practices;
  - Training;
  - Written and communicated safe work practices;
  - Written safety and health policy;
  - Recordkeeping.

In addition, submit board minutes when there is an organizational merger or a name change of an employer.

Submit completed applications and supporting documentation 90 days in advance of the desired effective date of self-insurance.

Mail completed applications and supporting documentation to: Ohio Bureau of Workers' Compensation, Self-Insured Department, 30 W. Spring St., Columbus, OH 43215-2256. BWC will process applications and documents, and contact the applicant if it has additional questions.

Orientation session

BWC schedules each applicant for a self-insurance orientation session during the 90-day application process. This session explains the self-insurance process, procedures and administrative requirements. All eligible employees will receive an orientation.

Qualification process

After BWC processes all applications and documents, the bureau renders a written decision granting or denying self-insurance. Should the applicant disagree with the decision, he or she should submit an appeal within 20 days to the Self-Insured Review Panel. If approved, BWC assigns the employer a policy number, which is used for identification on all correspondence with BWC. The entire qualification process takes up to 90 days.

Security and bonding

Once an employer becomes self-insured, he or she is responsible for paying assessments to the self-insured guaranty fund for the first three years of self-insurance. The bureau bases any further assessments to the fund on financial analysis and/or inadequacy of the fund.

This fund guarantees claims liabilities are satisfied in the event of an employer's inability to pay them. BWC bases the guaranty fund assessment on the total of an employer's last two full state-fund payroll premiums at base rate, multiplied by 6 percent. The minimum assessment is $5,000 for each of the first three years of being self-insured.

In addition, self-insuring employers must reimburse the disabled workers' relief fund (DWRF) payments on a semiannual basis. This fund is for permanently and totally disabled employees whose workers' compensation benefits have not kept up with inflation.

BWC bills the employer dollar for dollar regardless of the injury date. The buyout agreement does not cover this liability.

Renewing coverage

Active, self-insuring employers must renew their self-insurance annually by filing the *Application for Renewal of Authorization to Operate as a Self-Insured Risk* (SI-7) with BWC's self-insured department. BWC reviews the employer's financial strength, program administration and past performance as a self-insurer when considering the renewal application.

BWC mails the renewal application to the self-insuring employer 120 days prior to the renewal month. Return the completed application form no later than 90 days prior to your renewal date.

After approving the company's annual renewal application, BWC mails a *Certificate of Employer's Right to Pay Compensation Directly*, which shows the effective dates of coverage, and a *Findings of Fact* to the self-insuring employer. BWC reissues certificates when it annually renews coverage.

Display the certificate in all Ohio employer locations along with the name, phone number and location of the company employee responsible for the workers' compensation program. If not received by the end of the grace period, contact BWC at once.

BWC will forward any renewal application failing to meet minimum levels of performance as set by BWC to the Self-Insured Review Panel for a final decision.

Report of Paid Compensation

Self-insuring employers pay semiannual assessments based on paid compensation. Complete and return the *Report of Paid Compensation* (SI-40) to BWC by Feb. 28 of each year. Employers must file this report online at ohiobwc.com.

Since BWC bases assessments on this information, the report should reflect consolidated information from the corporate office for all operating locations covered under self-insurance. BWC bills assessments twice a year, in January and July. Make payments by check, payable to the Ohio Bureau of Workers' Compensation, by Feb. 28 and Aug. 31, each year, or pay online by credit card at ohiobwc.com.

Report any compensation paid during the previous calendar year, regardless of the claims' injury dates. Paid compensation includes:

- Living maintenance benefits;
- Compensation benefits;

- Paid wages instead of compensation;
- Funds paid for a violation of a specific safety requirement (VSSR);
- Money paid instead of compensation under a non-occupational accident and sickness program fully funded by the self-insuring employer.

The self-insuring employer may limit reported paid compensation to the amount the law requires. There are additional assessments for self-insuring employers participating in the claims reimbursement fund and the handicap and rehabilitation reimbursement programs.

Self-insuring employers can take credits on their annual report, but only as specified under the Ohio Revised Code sections (4123.93 and 4123.512). Reimbursements for such items as living maintenance and handicaps do not fall into this category.

As for new self-insuring employers, for the first five years of self-insurance, BWC adds the indemnity payments made on the employer's state-fund claims to the amount of paid compensation reported by the self-insuring employer to establish the assessment base.

The bureau does not use DWRF payments or lump sum settlements in claims to calculate assessments. However, self-insuring employers must report lump sum advancements against a permanent total disability payment or against an allowed death benefit. Include all claims in which you paid compensation, including those compensation payments made by third-party administrators, in the paid compensation totals.

BWC bills DWRF payments, which the bureau makes directly to permanently and totally disabled employees in certain situations, to self-insuring employers semiannually. These billings are in addition to the semiannual assessments for premiums.

self-insured **Savings**

Managing workers' compensation costs

BWC offers services designed to improve safety, claims management, detecting fraud and vocational rehabilitation — cost-saving steps that can lower an employer's workers' compensation costs. By working with BWC and taking an active role in managing their injured workers' claims, employers can reduce their workers' compensation costs for their businesses. That's good news for the company's bottom line.

Workplace safety

Workplace safety is a priority at BWC. That's why the bureau's DSH helps employers prevent workplace injuries. No one is happy when a person sustains an injury on the job. It hurts the employee physically, emotionally and financially; lowers the morale of the injured employee's co-workers; raises the employer's premiums while lowering the productivity of an employee; and it raises the overall cost of the workers' compensation system.

DSH services include research, education, publications, local information networks and consulting to help employers prevent workplace injuries. The DSH contact center is an employer's one-stop shop for accessing DSH services.

In addition, employers can obtain the most up-to-date information on occupational safety and health, vocational rehabilitation and workers' compensation by contacting the DSH libraries. The video library, a lending library of occupational safety and health videotapes, has a collection of more than 500 titles.

Employers also can obtain educational guides covering many safety issues, including comprehensive safety manuals for construction and general industry. Visit ohiobwc.com, and click on BWC Library, then Safety publications for ordering information.

The DSH training center provides employers with the knowledge, tools and skills they need to prevent occupational injuries and illnesses. Employers and their employees can receive training on nearly 50 safety and health topics addressing industrial safety, construction safety, industrial hygiene, ergonomics and safety management. To better serve Ohio employers and employees, the training center offers courses in cities around the state.

Each year, the Ohio Safety Congress & Expo provides a forum for the most advanced information in workplace safety practices, technology, products and services. In addition, in conjunction with DSH, area safety councils promote occupational safety and health awareness in their communities through educational meetings, networking and local support.

Access all DSH services by calling 1-800-OHIOBWC and listening to the options; sending a fax to 614-365-4974; visiting BWC's Web site at ohiobwc.com; or by sending an e-mail to safety@bwc.state.oh.us.

Claims management

Unfortunately, work-related injuries occur even in the safest workplaces. It is crucial for employers to take an aggressive and active role in controlling the cost of their workers' compensation claims. When an accident does occur, prompt claim reporting significantly reduces the cost of a claim.

Studies show claims reported within 10 days of occurrence cost nearly 50 percent less than claims reported after 30 days from the occurrence.

Employers can reduce their direct and indirect costs associated with a work-related claim by implementing a pre-injury transitional work program. By including such a program into his or her policies and procedures prior to an injury, the employer can educate his or her work force on early return-to-work processes.

A successful transitional work program can eliminate the need for a claim to result in lost time by bringing the injured worker back to work prior to 100-percent recovery. While proactively communicating with the provider immediately after an injury, the employer can put a process into place to accommodate an injured worker's temporary restrictions. The employer can then progress the injured worker back to his or her original job while reconditioning occurs at the work site.

The self-insuring employer should have a disaster recovery plan to ensure continuity of payments in claims within their statutory time limit.

Lost-time claims with dates of injury from Dec. 11, 1967 to Oct. 10, 2006, have a statutory time limit of 10 years from the last payment of medical benefits, compensation paid, or wages paid in lieu of compensation. If no compensation is paid or no wages are paid in lieu of compensation, the statutory limit is six years from the last medical bill payment.

For claims with a date of injury of Oct. 11, 2006, and after, the statutory time limit is five years from the date of last payment of medical benefits, compensation or wages paid in lieu of compensation. If no compensation is paid or no wages are paid in lieu of compensation, the statutory time limit is five years from the date of last medical bill payment.

For more information, contact the return-to-work services department by calling 1-800-OHIOBWC and listening to the options.

Vocational rehabilitation services

These services help the injured worker regain the capability to work again. When employers help one of their workers return to the job after an injury, they get an experienced employee back, which saves them the cost of hiring and training a new employee. Vocational rehabilitation services may include a variety of services designed to increase the injured worker's ability to do the job or a different job if appropriate.

Health care

Self-insuring employers have two options as it relates to their medical management. First, the employer may choose to implement a Qualified Health Plan (QHP) where the employer establishes a network of BWC-certified providers. An employee must first seek treatment for injuries from one of the BWC-certified providers in the employer's network when injured on the job. The QHP also provides an alternative dispute resolution process that addresses medical-management disagreements between the employer and injured worker before BWC sends the matter to the Industrial Commission of Ohio.

Alternatively, the employer may implement a plan that includes a review of treatment requests by a certified medical provider that the employer is challenging to ensure the decision-making process uses medical reasoning.

Fraud detection

Examples of fraud include:

- Injured workers returning to work but still collecting benefits;
- Doctors billing for services they never provided;
- Employers underreporting payroll to reduce their premium.

Fraud is a hidden cost of workers' compensation insurance, with an impact on both employers and injured workers. Industry estimates show that between $80 million and $160 million could be lost to workers' compensation fraud each year in Ohio.

To ensure BWC pays only legitimate claims, the bureau aggressively attacks fraud through its special investigations department. Employers or employees who suspect workers' compensation fraud should call 1-800-OHIOBWC, and listen to the options. Callers may remain anonymous.

self-insured **Claims**

Reporting a claim

BWC understands what a difficult time it can be after sustaining a workplace injury. That's why it wants to make sure the workers' compensation process is as simple and smooth for injured workers as possible. BWC's focus is to provide injured workers with a safe return to work.

Immediately after a workplace injury, there are four things an injured worker should do.

1. Seek medical attention. Be sure to tell the doctor the injury is work related.
2. Tell the employer, and complete an internal accident report.
3. Tell the doctor or emergency room the employer's name and that he or she is a self-insuring employer. Ask the doctor or emergency room to send reports and bills directly to the employer.
4. If the work-related accident results in losing eight or more calendar days of work (a lost-time claim), complete the *First Report of an Injury, Occupational Disease or Death* (FROI) application with the employer.

Claims process

If an employee is injured or contracts an occupational disease on the job, the injured worker may be entitled to medical and compensation benefits.

An injured worker's first step to get benefits is to report the injury to his or her employer so the employer can complete an accident report. In the case of a work-related death, a beneficiary, dependent or friend may file.

If an injured worker loses eight or more calendar days of work as a result of an injury, he or she must complete the FROI application with the employer. Injured workers can obtain this application from their employers or on BWC's Web site, ohiobwc.com.

In addition, the employer must keep a record of all injuries sustained by his or her employees, and notify BWC of all injuries resulting in eight or more calendar days lost time. Upon receipt of a completed FROI application, the self-insuring employer has 30 days to notify BWC of the lost-time claim.

When a work-related injury involves seven or fewer calendar days of lost time (a medical-only claim), the injured worker should notify the employer of the accident and complete the required accident reports. BWC does not require an injured worker, employer or medical provider to file medical-only claim applications with it.

Either party, however, has the option of filing the FROI with BWC. If the option is exercised, the self-insuring employer must provide a list of allowed conditions to BWC. If the employer contests a medical-only claim, the employer must file the claim with BWC.

File claims online via BWC's Web site, ohiobwc.com. Once BWC receives the application, it notifies the injured worker and the employer of the assigned claim number. The claim number is important. The injured worker uses it whenever contacting BWC and the doctors treating the work-related injury.

If needed, the bureau will send the employer a form requesting additional information. Complete and return the form to the BWC customer service office indicated.

The employer should certify or reject the claim by marking the appropriate box in the employer's section of the application. When an employer checks certification and signs the claim application, the employer has certified the information on the application is correct to the best of his or her knowledge. Certification also indicates the employer believes the injury is compensable under the law.

If an employer is not sure of the facts and/or does not agree with the facts on the claim application, the employer should still sign the application and check the rejection box. The employer should attach the reasons for questioning the validity of the claim.

While an employer has the right to appeal any claim, the law penalizes employers who file appeals designed to harass injured employees and delay the claims process.

The self-insuring employer also has the option of checking the clarification box to clarify the exact medical condition he or she is accepting.

Upon receiving the rejected FROI application, BWC forwards the claim to the IC for a hearing. The IC will determine whether the disputed injury or occupational disease is compensable. The IC will schedule a hearing about 45 days from the date it receives your claim file.

Occupational diseases versus accidents

Occupational diseases result from prolonged exposure to substance(s) or repetitive functions common to the workplace but uncommon elsewhere. Disabilities resulting from occupational diseases differ in several ways from those resulting from accidents.

- An accident is the result of a sudden, unexpected single occurrence that happened at a specific time and place. An occupational disease results from an injurious exposure over time that is common to the workplace, but uncommon elsewhere.
- An injury from an accident is usually diagnosed quickly, whereas the positive diagnosis of an occupational disease my take months or even years.
- With few exceptions, injuries from accidents are not unusual in most businesses, but occupational diseases tend to be relatively rare.

An employee should file the FROI application to apply for benefits resulting from an occupational disease within six months from the date of diagnosis or two years after the disability began, whichever is the latest.

If an employee contracts a disease on or after Aug. 22, 1986, BWC extends the time limit one day for every day the employer delays making a report to the bureau after acquiring the knowledge that an occupational disease involving eight or more days of lost time or death happened. The extensions cannot exceed four years from the date of disability from the occupational disease.

A worker with an occupational disease also may be eligible to receive compensation while seeking other employment if BWC determines the worker should change occupations for medical reasons. This compensation is not to exceed 130 weeks.

BWC may award change of occupation compensation for silicosis, pneumoconiosis, asbestosis, or cardiovascular and pulmonary disease of firefighters or police officers.

Claims decisions

Injured workers can assist the employer with collecting information from their health-care provider. Quickly responding to any inquiries from the self-insuring employers can speed up the claims decision and payment. Keep the employer informed of progress toward recovery and anticipated return-to-work date.

self-insured **Benefits**

Workers' compensation benefits

When a work-related injury or occupational disease causes an injured worker to lose time from work, the self-insuring employer provides benefits and services to help replace lost income, pay related medical expenses and return the injured employee to work. The employer pays benefits according to the laws in effect on the date of injury, or the date of recognition or diagnosis for occupational diseases.

The employer does not cover injuries purposely self-inflicted or caused by the use of alcohol or non-prescription drugs. If the work-related injury is fatal, the employer provides an allowance for funeral expenses and may provide compensation to the decedent's legal dependents.

Medical benefits

If the self-insuring employer allows your claim, the employer will pay for medical services directly related to your workplace injury. There is no dollar limit on benefits, but charges must not exceed the usual, customary and reasonable fees for a geographic area, as established by BWC for physicians and outpatient hospital services.

Health-care services include, but are not limited to, routine physician care, hospitalization, surgery, tests, nursing home care, prescribed medicine, artificial limbs, hearing aids, eyeglasses, special or modified shoes, canes and crutches.

Self-insuring employers may require the use of generic drugs if they use a point of service adjudication system. Employers should provide injured workers with information on how to fill their prescriptions for their workplace injuries.

Except for emergency situations, the employer must approve certain specialized medical services in advance, including, but not limited to, hospital or nursing home stays, surgical procedures, special medical equipment and physical therapy. The employer also must approve in advance nursing services, dental work, weekly injections, elective amputations, acupuncture and home visits by a public health nurse.

Employers must pay medical bills for health-care services for an allowed work-related disability within 30 days of receiving the bill. If the employer questions a medical bill, he or she may request additional medical documentation from the attending physician. Once the employer receives the additional information, he or she has another 30 days to pay or deny the medical bill. Typically, employers use the *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) to approve or deny such requests.

Should the employer with a certified QHP deny a medical bill, the employer's alternative dispute resolution process resolves medical disputes within 30 days. The employer forwards any medical dispute not resolved within 30 days to the IC for resolution. If the employer doesn't have a QHP, the injured worker may file a *Motion* (C-86) to request a hearing before the IC.

Temporary total disability compensation

If an injured worker loses eight or more calendar days of work as a result of a work-related injury, his or her employer pays compensation for lost wages and related medical expenses.

Temporary total disability benefits are usually the first form of compensation awarded. An injured worker cannot work while receiving temporary total.

Temporary total benefits begin on the eighth calendar day following the accident. The employer issues compensation on a weekly or biweekly basis. If an injured worker is off work for 14 consecutive days, the employer will pay the injured worker for the first seven days of missed work. Once the injured worker returns to work, temporary total benefits cease.

The employer awards temporary total benefits based on medical evidence from the attending physician. The physician may furnish this information on a *Request for Temporary Total Compensation* (C-84) or the *Physician's Report of WORKABILITY* (MEDCO-14).

These periodic reports ensure the continuous payment of compensation. The severity of the injury and the length of time off work determine the frequency these reports are required.

After 90 consecutive days, the self-insuring employer may refer the injured worker for an examination to see if he or she still qualifies for temporary total disability, has vocational rehabilitation potential and if he or she is receiving the right medical treatment.

The employer bases an injured worker's weekly rate of compensation upon his or her wages earned at the time of injury. An injured employee's weekly benefit rate cannot exceed the statewide average weekly wage — the average weekly wage for all Ohioans — for the year in which he or she was injured. The Ohio Department of Job and Family Services establishes the rate.

For the first 12 weeks of missed work, an injured worker receives 72 percent of his or her full weekly wage. If the employee sustained an injury on or after Oct. 20, 1983, the employer will issue the injured worker's first 12 weeks of compensation at the rate of 100 percent of his or her net take home weekly wage or 72 percent of the injured worker's full weekly wage, whichever is less. After 12 weeks of missed work, the employer issues temporary total disability benefits at the rate of 66.67 percent of the injured worker's average weekly wage.

Maximum medical improvement

The self-insuring employer has the authority to make initial determinations on all claim actions, including determining whether to continue or terminate temporary total compensation based on evidence of maximum medical improvement (MMI).

MMI occurs when an individual's medical condition has stabilized to the point that providers cannot expect any fundamental functional or physiological change to occur in the condition, despite continued medical treatment and/or vocational rehabilitation. The injured workers' provider of record determines if the injured worker has reached MMI.

The law provides a self-insuring employer can only terminate temporary total benefits if the employee returns to work, the employee's treating physician finds the employee is capable of returning to his former position of employment or other available suitable employment, or the employee's treating physician finds the employee has reached MMI. In any other instance, the self-insuring employer must refer the claim to the IC for determination of continued payment of temporary total compensation.

If the IC decides an injured worker has reached MMI, he or she may still be entitled to other forms of workers' compensation.

Other types of compensation

Other types of disability compensation for work-related injuries include living maintenance, living maintenance wage loss, wage loss compensation, permanent total disability, DWRF, death benefits and permanent partial disability (percentage and scheduled loss impairment).

Living maintenance is payment made to an injured worker instead of temporary total compensation payments while actively participating in an approved vocational rehabilitation program with the goal of returning to work. These payments are not subject to garnishment, levy or attachment.

If the return to employment represents less pay then the original job as a result of the allowed injury the injured worker may be eligible for wage loss payments. The Bureau has two wage loss options: Living maintenance wage loss, which could be offered after completion of an approved vocational rehabilitation program and wage loss, which has no requirement of vocational rehabilitation participation. An injured worker must meet the eligibility requirements for the type of wage loss requested.

However, if the injured worker's attending physician returns him or her to work with restrictions, the injured worker may also be eligible to receive wage loss compensation. Wage loss is payable in claims when you suffer a reduction in earnings as a direct result of the restrictions caused by the allowed conditions in the claim. Wage loss is payable in medical-only and lost-time claims with a date of injury or diagnosis on or after Aug. 22, 1986. This includes returning to work with the same employer to different job duties, less hours and less pay resulting from the related restrictions or to a different employer.

The employer awards wage loss based on medical evidence from your attending physician furnished on a *Physician's Report of Workability* (Medco-14) or similar form. These reports support the continued entitlement to benefits. Payment of wage loss compensation can begin the day after the date of injury.

The employer pays wage loss at 66.67 percent of the difference between the average weekly wage (AWW) or greater of full weekly wage/AWW if the date of injury is prior to May 15, 1997, and the injured worker's present earnings.

The following information applies to claims with dates of injury on or after Aug. 22, 1986, the injured worker may receive 200 weeks of wage loss and 200 weeks of living maintenance wage loss. Claims with dates of injury on or after Oct. 11, 2006, the injured worker may receive a maximum of 200 weeks of wage loss; however, the employer may extend the 200-week maximum up to 226 weeks if 26 weeks of non-working wage loss is paid. This maximum amount includes both working and non-working wage loss and living maintenance wage loss regardless of which the employer pays first.

Non-working wage loss is limited to 52 total weeks. The first 26 weeks of non-working wage loss are excluded from the 200 week maximum, meaning that if an injured worker receives 200 weeks of working wage loss and/or living maintenance wage loss, he or she is also entitled to the 26 weeks on non-working wage loss, making the total wage loss maximum 226 weeks.

Injured workers who are not at MMI and whose physicians have released them to return to work with restrictions, which their employer cannot accommodate, may be eligible for wage loss, but they may also continue to be eligible for temporary total compensation. Because it is the injured worker's choice to remain on temporary total or to file for wage loss, a release to work with restrictions does not require an injured worker change from temporary total compensation to wage loss.

An injured worker may receive **permanent total disability** when the IC declares him or her permanently and totally disabled due to a work-related injury. The injured worker cannot return to work and receive permanent total disability payments unless the injury re-

The compensation rate for permanent total disability is 66.67 percent of the average weekly wage for the year in which the injury occurred. An award under these circumstances is payable for life. To apply, file an *Application for Compensation for Permanent Total Disability* (IC-2).

DWRF supplements permanent and total disability with annual cost-of-living increases. An injured worker drawing permanent total disability may be eligible to receive benefits from this fund if combined incomes (permanent total disability and disability Social Security) fall below the benefit level established each year.

An employer pays **death benefits** when a death results from a work-related injury or occupational disease. Dependents of the deceased at the time of death may be eligible for benefits.

If the deceased employee would have been entitled to apply for compensation in an existing claim at the time of death, the employer must award compensation to the deceased employee's dependents from the date of the work-related injury or occupational disease to the date of death, provided the dependent applies for compensation and a hearing officer concurs.

The decedent's children receive benefits to age 18. Full-time students in an accredited educational institution receive benefits up to age 25 with proof of enrollment.

Certain documents are required to support death claims, such as the death certificate of the deceased worker. When beneficiaries are entitled to receive benefits, the bureau requires a marriage license for the surviving spouse and requires birth certificates for any dependent children.

The employer may pay funeral expenses only in an allowed death claim. For claims with the date of death prior to April 9, 2003, the maximum amount payable is $3,200 to the person showing proof of payment for funeral expenses or an outstanding bill for funeral expenses. For claims with the date of death on or after April 9, 2003, the maximum amount payable increased to $5,500.

A dependent, beneficiary, friend or funeral director may file a claim by filing the FROI and an *Additional Information for Death Benefits* (C-5).

BWC awards **percentage of permanent partial disability**, also known as C-92, as compensation for remaining impairment that may result from an approved work-related injury. BWC determines the percentage of permanent partial impairment based on the recommendation of an independent medical examiner.

In claims with dates of injury on or after June 30, 2006, the waiting period is 26 weeks from the last payment of compensation or 26 weeks from the date of injury if compensation is not paid.

Every injured worker may file for permanent partial disability. An injured worker may apply for a percentage of permanent partial disability 40 weeks after he or she receives his or her last payment of temporary total compensation, or 40 weeks from the date of injury if compensation is not paid.

To apply for a percentage of permanent partial disability, file an *Application for Determination of Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability* (C-92). Use the same form to apply for an increase of permanent partial disability.

A statewide network of physicians, with offices convenient to most communities, provides medical examinations for permanent partial (percentage) disability applicants. BWC requires a medical exam to determine the extent of permanent damage, if any, the worker's injury has caused.

If an injured worker has received permanent partial (percentage) disability awards totaling 100 percent (collectively) in his or her claims since Oct. 1, 1963, he or she is not eligible to file an application for additional percentage awards.

The processing procedure for increases of permanent partial disability allows BWC to conduct a medical file review before acting on a request for an increase of permanent partial disability. BWC will only schedule the injured worker for an examination in exceptional situations (complex injuries or when a psychological exam is necessary). The physician reviewer also may request an examination.

BWC will consider a request for an increase whether or not it has allowed an additional condition in the claim. If no additional conditions have been added since the last exam, submit medical documentation supporting the increase with the application. Then, BWC may conduct a medical review to make the determination.

If BWC has allowed an additional condition in the claim since the last exam, you only need to submit the C-92, and BWC will schedule an exam.

Permanent partial (scheduled losses) disability compensation is payment made to an injured worker for loss of or loss of use of, specific body parts due to a work-related injury or occupational disease. The location of the amputation or ankylosis, a total stiffness of the body part, determines the period of time for which the employer will pay compensation.

The attending physician must document the exact point at which amputation or ankylosis occurred. The employee should file the C-86, and submit supporting medical evidence. There is no waiting period.

The compensation rate is 66.67 percent of the average weekly wage. For injuries occurring on or after Nov. 3, 1989, the employer pays benefits at 100 percent of the statewide average weekly wage, regardless of the injured worker's calculated average weekly wage.

Weeks of compensation allowed for body member(s) lost

Member lost	Number of weeks
Arm	225
Leg	200
Hand	175
Foot	150
Hearing, both ears, total loss	125
Sight, one eye*	125
Thumb (first)	60
Index (second) finger**	35
Middle (third) finger**	30
Big toe	30
Hearing, one ear, total loss	25
Ring (fourth) finger	20
Little (fifth) finger**	15
Any other toe	10

*Loss of sight to both eyes resulting from a work-related injury entitles the disabled employee to permanent total compensation.

**Loss of a metacarpal bone in addition to a finger because of a work-related injury entitles the disabled employee to an additional 10 weeks.

Facial disfigurement is a one-time award if an injured worker experiences a work-related facial or head disfigurement that either impairs, or may in the future, impair opportunities to seek or retain employment. The maximum facial disfigurement award is $10,000. To apply for a facial disfigurement award, file a C-86 with the self-insuring employer.

The IC may grant an award if an injured worker proves the employer **violated a specific safety requirement** (VSSR) established by Ohio law. The injured worker has two years to file for VSSR compensation. To file for VSSR compensation for a non-fatal injury, file an *Application for Additional Award for Non-fatal Injury* (IC-8). For VSSR compensation for a fatal injury, file an *Application Award for Fatal Injury* (IC-9).

Another award, **lump sum advancement**, enables payment of sizable outstanding debts an injured worker may not otherwise be able to pay. It also enables certain large purchases as permitted by workers' compensation law.

Generally, the self-insuring employer grants lump sum advancements only for recipients of long-term benefits, such as permanent total disability, death benefits and, in some cases, permanent partial disability.

The self-insuring employer reduces future compensation payments to offset the amount of the advancement. The bureau reduces permanent total disability benefits for life. The self-insuring employer determines the maximum amount available through lump sum advancement by the biweekly amount of compensation and age of the injured worker. To apply for lump sum advancement, file an *Application for Lump Sum Payment* (IC-32) with the self-insuring employer.

An injured employee also may file an application for a one-time, final **lump sum settlement** or partial settlement of his or her workers' compensation claim. Partial settlement may be for medical benefits only, compensation benefits only or for a particular condition(s).

If an employee settles his or her claim in its entirety, BWC closes it and the self-insuring employer can issue no future payment on that claim. Partial settlement only closes the settled portion of the claim.

Apply for a lump sum settlement by filing a *Self-Insured Joint Settlement Agreement and Release* (SI-42) and *Acknowledgement of the Self-Insured Joint Settlement and Release* (SI-43).

If all parties agree upon the settlement amount, BWC files the settlement agreement with the IC for it to determine if the settlement is fair. A 30-day waiting period follows during which time any party to the settlement can withdraw from the agreement, or the IC can disapprove the agreement.

If the IC fails to review and/or notify the parties of its rejection or agreement, or if none of the parties withdraw consent from the agreement within this 30-day period, the lump sum settlement agreement is deemed approved, and the self-insuring employer issues payment.

Compensation and income

Depending on the employer's policies, the employer's sickness and benefits program may offset an employee's workers' compensation payments. The employee should check with the employer to determine whether he or she also can receive holiday or vacation pay at the same time as workers' compensation.

The Internal Revenue Service does not consider workers' compensation income for tax purposes. However, the Department of Veterans Affairs considers it income with regard to non-service disability pensions. Workers' compensation is subject to child support orders.

self-insured **Information**

IC Hearings and appeals

The self-insuring employer makes all initial and subsequent decisions on workers' compensation claims. For medical issues, the QHP provides two levels of dispute resolution. The self-insuring employer forwards unresolved medical disputes to the IC, regardless of further appeal. The employer must make payment within 21 days of receipt of the order.

Hearings before the IC are informal in nature and do not require legal representation. Parties may choose to have an attorney or other authorized person represent them. The IC gives equal consideration to both parties with or without representation. If you file an appeal with the Court of Common Pleas, it may be necessary to have an attorney.

The employee and employer should bring all evidence relating to the claim, including medical records, written statements of witnesses or other documentation and information on the case, to hearings. Be prepared to furnish two copies of your reports while keeping the originals for yourself.

Call the IC at 800-521-2691 or 614-466-6136, or visit the IC on the Web at www.ic.ohio.gov. to obtain more information about the hearing process.

If the injured worker or employer contests the payment of compensation in a claim, the IC hears the dispute. There are three appeal levels for workers' compensation claims: district hearing officer level, staff hearing officer level and the commission.

District level

If the injured worker contests a self-insuring employer's decision on a workers' compensation claim, an IC district hearing officer hears the appeal. District hearings take place in locations throughout Ohio — at the customer service office nearest the injured worker's residence.

District hearings take place within 45 days of the appeal filing. During the hearing, the district hearing officer will ask both parties to present their views, including any evidence and witnesses. He or she will make a decision within seven days of the hearing.

The district hearing officer bases his or her decision on evidence, which according to workers' compensation law, must be interpreted liberally in the interest of the worker. The IC sends the employer and injured worker a written notice, called an order, of the district hearing officer's decision.

The law guarantees injured workers and employers the right to appeal a district hearing officer's decision to a higher level, the staff hearing officer. The dissatisfied party must appeal the decision within 14 days of receipt of the decision by filing a *Notice of Appeal* (IC-12).

If, however, the district hearing officer is making a judgment as to the percentage of permanent partial disability, neither party can appeal the decision. Either the employer or employee may apply for reconsideration, using an *Application for Reconsideration* (IC-88), within 10 days of receiving the hearing officer's decision.

Staff level

Staff hearings take place within 45 days after filing an appeal of the district-level decision. The procedure is much the same as a district hearing. In cases of appeal to a decision awarding compensation, the self-insuring employer must verify he or she paid compensation.

The staff hearing officer (SHO) will make a decision within seven days of the hearing. The IC sends the injured worker and the employer written notice of the SHO's decision.

Each party has 14 days from receiving the SHO's decision to file an appeal to the next level, the commission, by submitting the IC-12.

Commission level

After thoroughly studying the staff-level decision, the IC either agrees to hear the appeal or refuses the appeal. If the commission accepts an appeal, it will hold a hearing within 45 days of the employer or injured worker filing the appeal. The commission issues a decision within seven days of the hearing. If the commission refuses to hear the appeal, the SHO's decision becomes final.

Beyond the commission

The employer or injured worker may file an appeal of final commission decisions that do not settle questions of extent of disability to the Court of Common Pleas within 60 days from receipt of the commission order. Neither party, however, may file an appeal of commission decisions, which decide questions of extent of disability, to the Court of Common Pleas. Injured workers and employers can only challenge these decisions in mandamus, a formal legal document ordering or prohibiting some action.

Payments during appeals

The employer will make compensation payments for allowed claims pending appeal outcomes. If the decision of the district hearing officer is favorable to the injured employee, the employer pays compensation, regardless of further appeal. The employer does not make medical payments until ordered by the SHO. The employer must make these payments within 30 days of receipt of the SHO order.

If the IC awards compensation, and the employer or employee appeals to the Court of Common Pleas, payment continues during the appeal period until the court makes a final decision.

Claim file review

BWC can divulge information contained in a workers' compensation claim file only to the employer, employee or a duly appointed representative. The appointed representative must have written authorization from either the employer or injured worker to inspect the file. The self-insuring employer is required, upon request, to make your claim file available for review at a reasonable place and time (not to exceed 72 hours). To obtain authorization forms for an appointed representative, log on to ohiowbwc.com, and click on BWC Library, Forms and then Employer or Injured worker. You may also contact BWC's customer contact center at 30 W. Spring St., Columbus, OH 43215-2256, or call 1-800-OHIOBWC, and listen to the options.

Injured workers, employers and their appointed representatives can review files in customer service offices or online by logging on to ohiobwc.com and clicking on either Injured Workers and then Claim Info, or Ohio Employers and then Claim Info.

Armed services-related disabilities

BWC may reimburse self-insuring employers who have employees with pre-existing armed service-related disabilities that have caused additional disability. There is no limitation of nature of pre-existing condition. To apply, file a C-86.

Employer-sponsored fitness activities

Employees may waive any rights to workers' compensation claims for injuries or diseases arising from employer-sponsored fitness or recreational activities. You can obtain a waiver form, *Waiver of Workers' Compensation Benefits for Recreational or Fitness Activities* (C-159), which is effective for two calendar years, by logging on to ohiobwc.com and clicking on BWC Library and then Forms, or by calling 614-752-8843, or 1-800-OHIOBWC and listening to the options. You also may obtain this form by writing to BWC, Office Services Department, 30 W. Spring St., Columbus, OH 43215-2256.

Questions

BWC's self-insured department monitors the activity of all self-insuring employers in Ohio. It ensures self-insuring employers pay all workers' compensation benefits fairly, promptly and in accordance with Ohio's laws.

While it is necessary to first contact your employer with any questions you may have regarding your claim, the self-insured department is available to address your specific questions concerning self-insured issues. The self-insured department also accepts and processes complaints filed against self-insuring employers. You must submit supporting documentation with your complaint.

Employers with specific questions concerning self-insured issues also may contact the self-insured department.

When contacting the self-insured department, employers need to include their self-insured policy number, and employees should have their claim number available. Both employers and employees may call the self-insured department's special services unit at 614-466-8222 or 1-800-OHIOBWC, and listen to the options, or send a fax to 614-466-0149. This service is available from 8 a.m. to 4:45 p.m. each workday.

The self-insured department is located at 30 W. Spring St., Columbus, OH 43215-2256.

Contact information

Customer service offices

Call your local BWC customer service office for policy and claims information, as well as help managing your workers' compensation claims.

Cambridge
61501 Southgate Road
Cambridge, OH 43725
Claims: 740-435-4200
Employer services: 740-435-4210
Imaging fax: 866-281-9351

Canton
400 Third St., S.E.
Canton, OH 44702-1102
Claims: 330-438-0638
Employer services: 330-471-0937
Toll free: 800-713-0991
Imaging fax: 866-281-9352

Cleveland
615 Superior Ave. W., Sixth Floor
Cleveland, OH 44113-1889
Claims: 216-787-3050
Employer services: 216-787-3060
Toll free: 800-821-7075
Imaging fax: 866-336-8345

Columbus
30 W. Spring St., 11th floor
Columbus, OH 43215-2256
Claims: 614-728-5416
Employer services: 614-752-4538
Imaging fax: 866-336-8352

Dayton
3401 Park Center Drive
Dayton, OH 45414
Claims: 937-264-5000
Employer services: 937-264-5217
Imaging fax: 866-281-9356

Garfield Heights
4800 E. 131 St.
Garfield Heights, OH 44105
Claims: 216-584-0100
Employer services: 216-584-0115
Toll free: 800-224-6446
Imaging fax: 866-457-0590

Governor's Hill
8650 Governor's Hill Drive
Cincinnati, OH 45249-1369
Claims: 513-583-4400
Employer services: 513-583-4403
Imaging fax: 866-281-9357

Hamilton
1 Renaissance Center
345 High St.
Hamilton, OH 45011
Claims: 513-785-4500
Employer services: 513-785-4510
Imaging fax: 866-336-8343

Lima
2025 E. Fourth St.
Lima, OH 45804-4101
Claims: 419-227-3127
Employer services: 419-227-4116
Toll free: 888-419-3127
Imaging fax: 866-336-8346

Logan
P.O. Box 630
1225 W. Hunter St.
Logan, OH 43138-0630
Claims: 740-385-5607
Employer services: 740-385-9848
Toll free: 800-385-5607
Imaging fax: 866-336-8348

Mansfield
240 Tappan Drive, N., Suite A
Mansfield, OH 44906-8051
Claims: 419-747-4090
Employer services: 419-529-4528
Imaging fax: 866-336-8350

Portsmouth
P.O. Box 1307
1005 Fourth St.
Portsmouth, OH 45662-1307
Claims: 740-353-2187
Employer services: 740-353-3419
Imaging fax: 866-336-8353

Toledo
P.O. Box 794
1 Government Center, Suite 1136
Toledo, OH 43697-0794
Claims: 419-245-2700
Employer services: 419-245-2474
Imaging fax: 866-457-0594

Youngstown
242 Federal Plaza W.
Youngstown, OH 44503
Claims: 330-797-5500
Employer services: 330-797-5010
Toll free: 800-551-6446
Imaging fax: 866-457-0596

TTY/TDD Ohio Relay Service
Statewide 800-292-4833

By calling 1-800-OHIOBWC, you can reach key information areas and customer service representatives ready to respond to inquiries. The number is effective nationwide, and in Canada and Mexico. Automated information is available from 7 a.m. to 7 p.m.

1-800-OHIOBWC options
Option 1: Injured worker information
Option 2: Employer information
Option 3: Medical and pharmacy providers
Option 4: To report fraud
Option 9: For service in Spanish
Option 0: Customer contact center

Publications

BWC offers a variety of free publications and forms to help employers, employees and other interested parties become more familiar with Ohio's workers' compensation system. To view, print or order publications, log on to ohiobwc.com, and click on BWC Library and then BWC publications. To view, print or order forms, log on to ohiobwc.com, select BWC Library and then Forms. You also may order forms and publications by calling 1-800-OHIOBWC and listening to the options or by writing to: BWC, Office Services Department, Level B-2, 30 W. Spring St., Columbus, OH 43215-0581.

To view or print a manual specifically targeting self-insuring employers log on to ohiobwc.com, select Ohio Employers, then Self-Insured and then SI claims procedural guide.

Glossary

Allowed condition — A condition recognized as a direct result of an industrial injury or occupational disease.

Commission level — The third level of three IC appeal levels for workers' compensation claims.

Compensation — Money paid by the self-insuring employer to an employee or dependent (in allowed death claims) for lost wages due to a work-related injury or occupational disease.

Disabled Workers' Relief Fund (DWRF) — A fund for permanently and totally disabled employees whose workers' compensation benefits have not kept up with inflation.

District level — The first of three IC appeal levels for workers' compensation claims.

Division of Safety & Hygiene (DSH) — The division, a non-compliance organization, helps employers maintain a safe workplace through a variety of safety and health consulting services.

Facial disfigurement — A one-time benefit to an injured worker who has experienced a work-related facial or head disfigurement that either impairs, or may in the future impair, opportunities to seek or retain employment.

Industrial Commission of Ohio (IC) — The adjudicative branch of the Ohio workers' compensation system.

Living maintenance — The payment(s) made to an injured worker instead of temporary total compensation payments while he or she is actively involved in an approved vocational rehabilitation program.

Lost-time claim — A claim filed when an employee loses eight or more calendar days from his or her job due to an industrial injury or occupational disease.

Lump sum advancement — An advancement of future compensation given to an employee to enable payments of sizable outstanding debts or certain large purchases, as permitted by workers' compensation law.

Lump sum settlement — A one-time, final or partial settlement of a workers' compensation claim.

Maximum medical improvement (MMI) — Occurs when an individual's medical condition has stabilized to the point that no fundamental, functional or physiological change can be expected in the condition, despite continued medical treatment and/or vocational rehabilitation.

Medical benefits — Fees paid for medical services arising from an allowed work-related injury or occupational disease.

Medical-only claim — A claim filed when an employee loses seven or fewer calendar days from his or her job due to an industrial injury or occupational disease.

Non-complying employer — Employers who have either allowed their coverage to lapse or who have failed to provide workers' compensation coverage as required by Ohio law.

Occupational disease — A disease contracted in the course of employment.

Ohio Bureau of Workers' Compensation (BWC) — The administrative branch of the Ohio workers' compensation system.

Permanent partial (percentage) — Compensation that may be paid in claims where there is continuing impairment.

Permanent partial (scheduled losses) — Compensation provided when an employee loses specific body part(s) or suffers loss of function due to a work-related injury or occupational disease.

Permanent total — Compensation provided when the IC declares an employee permanently and totally disabled due to a work-related injury or occupational disease.

Policy number — Self-insuring employers have a policy number of 2000__-_. The __-_ designates the specific location of a self-insuring employer.

Qualified Health Plan (QHP) — A parallel managed-care system to the Health Partnership Program that provides access to high-quality, cost-effective medical care for injured workers that will facilitate an early return to work or return the injured worker to a functional lifestyle. QHP allows self-insuring employers greater flexibility to address individual needs and resources.

Vocational rehabilitation services — A variety of services and programs available to assist an injured worker with returning to gainful employment.

Self-insurance — A privilege granted to employers with sufficient financial ability to pay workers' compensation claims directly and administrative ability to manage a workers' compensation program.

Staff level — The second of three IC appeal levels for workers' compensation claims.

Statewide average weekly wage — The average wage of Ohioans, which BWC uses to establish the minimum and maximum levels of workers' compensation.

Temporary partial — A disability determination on cases where injury occurred prior to Aug. 22, 1986, in which an employee is no longer temporarily and totally disabled, but is not yet fully recovered.

Temporary total — Compensation awarded for a temporary disability that prevents an employee from returning to his or her job position at the time of injury.

Wage loss — Compensation available in claims filed for injuries occurring on or after Aug. 22, 1986, where an employee suffers wage loss due to a work-related injury.