DRAFT - NOT FOR FILING

4123-3-01 Office locations; scope of rules.

(A) Offices of the bureau of workers' compensation shall be located in cities as the administrator establishes and each office will be open during posted hours of operation, holidays excepted, for the receipt and filing of claim applications or any other documents and for the transaction of any business pertinent to the administration of the workers' compensation law.

(B) Any application, form, or document required to be filed with the bureau but received by the industrial commission or managed care organization (MCO) shall be considered filed on the date stamped received by the commission or MCO and shall be forwarded ~~by the commission~~ to the appropriate bureau office or section for processing. Any application, form, or document required to be filed with the commission but received by the bureau or MCO shall be considered filed on the date stamped received by the bureau or MCO and shall be forwarded ~~by the bureau~~ to the appropriate commission office or section for processing.

(C) The rules in this chapter shall govern claims procedures before the bureau, and include related matters applicable to claims procedures before the industrial commission.

(D) Failure to adhere to the rules of the bureau shall be a valid ground for refusal by the bureau to grant the relief sought and may result in further action as may be applicable under each case.

(E) All claims shall be processed in an orderly, uniform and timely fashion.

DRAFT - NOT FOR FILING

4123-3-03 Employers' reports of injuries and occupational diseases.

(A) Every employer shall keep a record of all injuries and occupational diseases resulting in seven days or more of total disability or death and shall report them to the bureau of workers' compensation within one week of acquiring knowledge of such injury or death and within one week after acquiring knowledge of or the diagnosis or death from the occupational disease as required by section 4123.28 of the Revised Code.

(B) Public employers and employers contributing to the private fund of the state insurance fund shall make such reports on the application for benefits or equivalent.

(C) Self-insuring employers shall use the application for benefits or equivalent provided by the bureau of workers' compensation to make the report of injury or occupational disease as required by section 4123.28 of the Revised Code, within the prescribed time limits set forth. Reports of death due to injury and occupational disease shall be on the application for benefits or equivalent.

(D) Self-insuring employers shall make a similar report on the application for benefits or equivalent in claims for injury, involving seven days or less of lost time, wherein it is apparent that there will be permanent partial disability under ~~division (C) of section 4123.57 of the Revised Code and effective August 22, 1986,~~ division (B) of section 4123.57 of the Revised Code. In such cases involving occupational disease, the report shall be on the application for benefits or equivalent.

(E) In order to assist in determining whether the claimant is entitled to an extension of the statute of limitations as set forth in section 4123.28 of the Revised Code, the bureau shall maintain a record of all injuries and occupational diseases reported by each employer.

(F) Each employer shall give a copy of each report to the employee it concerns or his or her surviving dependents as required by section 4123.28 of the Revised Code.

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4123-3-07 Applications for death benefits.

When the death of an employee is the result of an industrial injury or occupational disease, the employee's dependents may file an application for death benefits. To be considered a "dependent", a person must be a member of the family of the deceased employee, ~~or~~ and bear to the employee the relation of surviving spouse, lineal descendant, ancestor, or brother or sister. ~~Generally, lineal descent is descent in a direct or right line, as from father or grandfather to son or grandson, etc. to the remotest degree.~~ An application signed by a person claiming to be a dependent, as described herein, shall be accepted for filing and shall be sufficient to initiate proceedings for workers' compensation benefits and to obtain a ruling on the validity of the claim. If there are no dependents, the application may be filed by the estate of the deceased employee, the attending physician, the funeral director, by a volunteer paying the funeral bill, by a person who authorized the burial and funeral expenses or by the employer, for services rendered because of the injury or occupational disease causing the employee's death.

DRAFT - NOT FOR FILING

4123-3-08 Preparation and filing of applications for compensation and/or benefits.

(A) Preparation and execution of forms.

(1) The "First Report of Injury" form (FROI-1) or equivalent for applying for payment from the state insurance fund due to an injury, occupational disease, or death may be completed by the employee, employer, medical provider, or other interested party. If someone other than the employee submits a FROI-1 or equivalent, the bureau may contact the employee to attempt to verify that the employee wishes to pursue the application. To accept or deny the validity of the claim, the employer may complete and sign the form at the designated point or may use a separate writing, telephone, or other means of telecommunication.

(2) The FROI-1 for applying for payment from a self-insuring employer shall be completed, signed by the employee, and returned to the self-insuring employer. In situations where there is no prescribed form, a notice in writing shall be given in a manner sufficient to inform that a claim for benefits is being presented.

(3) An injured or disabled employee who is a minor (under eighteen years of age) shall file a claim in his or her own name and right. A report of injury signed by such minor employee shall be sufficient to initiate proceedings for compensation and/or benefits.

(4) In the event the injured or disabled employee is unable to complete the first report of injury by reason of physical or mental disability, the report may be completed and filed by the employee's spouse, next friend, the guardian of the employee, or the employee's employer. In claims for death benefits where the dependents are a spouse and one or more minor children, it shall be sufficient for the spouse to make application for benefits on behalf of the spouse and the minor children. In the event a dependent minor child has a guardian of the person other than the spouse of the deceased, such guardian shall execute the report on behalf of such minor child. If there is no spouse surviving, the report on behalf of the dependent minor children, or children who are mentally or physically incapacitated, may be filed by a guardian or next friend of such children.

(5) It shall be the duty of every employer to assist injured or disabled employees in the preparation and submission of reports for compensation and/or benefits. In the event that the employer refuses, neglects or unduly delays the completion of a report, the report may be filed without the part pertaining to the employer having been completed. The fact of refusal or neglect should be noted upon the report or with it by way of separate letter.

(6) In cases where the death of the employee is not the result of injury or occupational disease, an application for accrued compensation may be made as provided in sections 4123.57 and 4123.60 of the Revised Code.

(7) Application for payment of the balance of percentage permanent partial disability compensation, awarded under division (A) of section 4123.57 of the Revised Code prior to the employee's death, shall be made by the injured employee's dependents. The application may be filed whether the death was related or unrelated to an industrial injury or occupational disease.

(B) Certification by the employer.

(1) An employer shall accept or reject the validity of a claim filed against its risk within the time as required by sections 4123.511 and 4123.84 of the Revised Code and the rules of the industrial commission and

bureau of workers' compensation. If the employer fails to comply with the established time limits, the bureau shall take such further action in the claim as provided for by section 4123.511 of the Revised Code and the rules of the industrial commission and the bureau.

(2) If the employer accepts or denies the validity of the claim, the employer may sign the report at the designated point and return the requested information to the bureau, or the bureau may obtain the employer's certification or denial of the claim by a separate writing, by telephone, or by other forms of telecommunication.

If the employer denies the validity of the claim, the employer shall state the reasons for rejecting the validity of the claim.

(3) Certification by the employer in state fund cases shall not be determinative of compensability. Every such claim is subject to administrative review as to compensability.

(4) An employer's certification of a claim may be made by the employer, by an officer of the business entity which is the employer, or by a duly designated representative of the employer. The person certifying a claim for the employer shall indicate in what capacity the person is employed (title). No other person or entity may make such certification. No person may certify his or her own claim, except in cases of a sole proprietor who has obtained coverage as an employee within Chapter 4123. of the Revised Code.

(C) Place and manner of filing applications for benefits.

Any first report of injury shall be accepted for filing in any office of the bureau, MCO, or industrial commission during working hours, and reports may be filed by mail or reported by telecommunication.

(D) Time limitations within which claims must be filed.

(1) Injury claims applying for compensation and/or benefits shall be in writing or by telecommunication as provided for in division (E) of section 4123.84 of the Revised Code, and shall include the specific part or parts of the body alleged to have been injured, the ~~injured worker's~~ claimant's name and address, and the date of injury. Such claims ~~occuring~~ occurring prior to September 29, 2017, shall be forever barred unless ~~said written~~ notice is filed with the bureau of workers' compensation, MCO, or the industrial commission within two years from the date when injured, unless the applicable statute of limitations is extended due to the employer's failure to file a report as required by section 4123.28 of the Revised Code. Such claims occurring on or after September 29, 2017, shall be forever barred unless ~~said written~~ notice is filed with the bureau of workers' compensation, MCO or the industrial commission within one year from the date when injured, unless the applicable statute of limitations is extended due to the employer's failure to file a report as required by section 4123.28 of the Revised Code. Except as provided in paragraph (D)(3) of this rule, any claim or application for compensation and/or benefits for an injury to any part or parts of the body not specified in the original claim will be barred unless ~~written~~ notice of the additional part or parts of the body claimed to have been injured is filed by the claimant with the bureau of workers' compensation, MCO, or the industrial commission within two years of the date when injured for injury claims occurring prior to September 29, 2017, and within one year of the date when injured for injury claims occurring on or after September 29, 2017.

(2) In self-insuring employers' claims, the time limitation is tolled if the employer has provided treatment by a

licensed physician in the employ of the employer or has paid compensation or benefits within the period. "Benefits" means payment by the self-insuring employer to, or on behalf of, an employee for:

(a) A hospital bill;

(b) A medical bill for treatment by a licensed physician, other than a salaried physician in the employ of the self-insuring employer;

(c) An orthopedic or prosthetic device.

(3) The bureau of workers' compensation and the industrial commission have continuing jurisdiction over a claim which meets the requirement of section 4123.84 of the Revised Code, including jurisdiction to award compensation and/or benefits for a condition (or conditions) or disability developing in part or parts of the body not specified pursuant to division (A)(1) of section 4123.84 of the Revised Code, if it is found that the condition (or conditions) or disability was due to and a result of or a residual of the injury to one of the parts of the body set forth in the written notice filed pursuant to division (A)(1) of section 4123.84 of the Revised Code.

(4) Claims for occupational disease must be filed within two years after the disability begins, or within such longer period as does not exceed six months after diagnosis by a licensed physician, as provided in section 4123.85 of the Revised Code, excepting claims enumerated in paragraph (D)(5) of this rule, other than berylliosis, or where the applicable statute of limitations is extended due to the employer's failure to file a report as required by section 4123.28 of the Revised Code. The filing limitation of six months after diagnosis, where it applies, can only lengthen, not shorten, the two-year statute of limitations.

(5) Special statutory provisions (section 4123.68 of the Revised Code) exist as to claims for silicosis, cardiovascular, ~~and~~ pulmonary, or respiratory diseases of fire fighters and police officers, coal miners' pneumoconiosis, asbestosis, berylliosis, radiation illness and all other occupational diseases of the respiratory tract resulting from injurious exposures to dust~~:~~

~~(a) Compensation is payable in silicosis, coal miners' pneumoconiosis, cardiovascular and pulmonary disease of fire fighters and police~~ officers and in all other dust caused diseases of the respiratory tract, except berylliosis, only for temporary total or permanent total disability or death and only if such disability and/or death occurs within eight years after the last injurious exposure.

~~(b) If disability or death is from injurious exposure occurring after January 1, 1976, the eight-year limitation shall not apply.~~

~~(c) There must be injurious exposure in this state. In cases of cardiovascular and pulmonary disease of fire fighters and/or police officers, some of this must be after January 1, 1967. In cases of silicosis, asbestosis and coal miners' pneumoconiosis, part of the injurious exposure must be after October 12, 1945.~~

~~(d) In the event of death following continuous total disability commencing within eight years after the last injurious exposure, the requirement of death within eight years does not apply.~~

~~(e) The above provisions govern asbestosis claims except that the eight-year limitation does not apply.~~

~~(f) The above provisions govern berylliosis and radiation claims except that payment of compensation is~~

~~not restricted to temporary total, permanent total disability and/or death, and that exposure in this state is not required for radiation claims. In radiation claims, where disability began prior to November 2, 1959, the general occupational disease provisions apply.~~

~~(g) The above claims, except claims for berylliosis, must be filed within one year after total disability begins or within such longer period as does not exceed six months after diagnosis by a licensed physician. Claims for berylliosis must be filed within the time as provided in paragraph (D)(4) of this rule. If the disability due to the disease began on or after January 1, 1979, or was diagnosed by a licensed physician on or after January 1, 1979, such claims shall be forever barred unless, within two years after the date of disability due to the disease, or within such longer period as does not exceed six months after diagnosis of the occupational disease by a licensed physician, application is made to the industrial commission, the bureau, or to the employer in the event such employer has elected to pay compensation or benefits directly, or the applicable statute of limitations is extended due to the employer's failure to file a report as required by section 4123.28 of the Revised Code.~~

(6) Death claims, alleging that the death is the result of an injury occurring prior to September 29, 2017, must be filed within two years of the death or be forever barred, except as provided in paragraphs (D)(8) and (D)(9) of this rule. Death claims, alleging that the death is the result of an injury occurring on or after September 29, 2017, must be filed within one year of the death or be forever barred.

(7) Where the death is due to an occupational disease ~~and death occurred on or after November 2, 1959~~, the claim must be filed within two years of the death, as provided in section 4123.85 of the Revised Code.

(8) Emergency management claims for injury or death must be filed within one year from the date when injured or from the date of death, or be forever barred. If an injury claim has been filed within the one-year period and the claimant subsequently dies, a death claim must be filed within six months after the death or be forever barred.

(9) Public works relief employees' claims occurring prior to September 29, 2017, must be filed within two years after the date when injured or the date of death, or be forever barred. Public works relief employees' claims occurring on or after September 29, 2017, must be filed within one year after the date when injured or the date of death, or be forever barred.

(10) Militia claims, special contract claims and apprentice claims are governed by the general time limits applicable to injury and occupational disease claims, as provided by sections 4123.84 and 4123.85 of the Revised Code.

DRAFT - NOT FOR FILING

4123-3-09 Procedures in the processing of applications for benefits.

(A) Numbering and recording.

(1) Upon receipt, the bureau will assign a claim number to each initial application for benefits. The bureau shall provide the claim number to the claimant and employer. In cases where a deceased employee has filed, during his or her lifetime, an industrial claim for the injury or disability which is the subject matter of the death claim, the application for death benefits shall be assigned the original claim number.

(2) The claim number should be placed on all documents subsequently filed in each claim and the claim number should be given when inquiry is made concerning each claim.

(B) Initial review and processing of new claims.

Immediately after numbering and recording, all new claim applications, except applications of employees of self-insuring employers, shall be reviewed and processed by the bureau. "Processing on the question of compensability" means making a determination on the validity of the industrial claim.

(1) Uncontested or undisputed claims.

A "contested or disputed claim," as used herein, is where the employer or the bureau of workers' compensation questions the validity of a claim for compensation or benefits. No claim shall be regarded as a contested or a disputed claim requiring a formal (public) hearing, solely by reason of incomplete information, unless every effort has been made to complete the record.

(a) If a state fund claim meets the statutory requirements of compensability, the claims specialist shall have authority to approve such claim for payment of medical bills and temporary total disability compensation or other appropriate compensation. The approval of the claim must contain the description of the condition or conditions for which the claim is being allowed and part or parts of the body affected.

(b) In the processing of initial applications in state fund claims, requesting payment of compensation in addition to medical benefits, the claims specialist may approve temporary total disability compensation over a period not to exceed four weeks, without medical proof in the record, provided that the application has been properly completed and signed, certified by the employer and was otherwise noncontroversial. If medical proof was submitted with the initial application, the above limitation shall not apply. Upon approval of the claim the claimant shall be notified in writing that his or her attending physician's report will be necessary for consideration of any additional payment of compensation and an appropriate form shall be enclosed, with the necessary instructions, for the claimant's convenience.

(2) Contested or disputed claims.

(a) Contested or disputed claims as well as claims requiring investigation shall be referred, immediately after the initial review, to the appropriate office of the bureau from which investigation and determination of issues may be made most expeditiously.

(b) If the bureau or the employer contests the claim application and the claimant is not available for an adjudication due to the claimant's service in the armed services of the United States, the bureau shall continue the matter in accordance with the Servicemembers Civil Relief Act until the claimant is available for adjudication of the claim.

(3) Applications for death benefits.

Immediately after numbering and recording, all applications for death benefits shall be referred to the appropriate office of the bureau from which investigation and determination of issues may be made most expeditiously. Every effort should be made to complete the investigation within the shortest time possible, depending on the facts and circumstances of each particular case, to enable prompt adjudication of such claims by the bureau.

(4) Contested (disputed) applications for workers' compensation benefits filed by employees of self-insuring employers shall be referred to the industrial commission for a hearing.

(C) Proof.

(1) In every instance the proof shall be of sufficient quantum and probative value to establish the jurisdiction of the bureau to consider the claim and determine the rights of the applicant to an award. "Quantum" means measurable quantity. "Probative" means having a tendency to prove or establish.

(2) Proof may be presented by affidavit, deposition, oral testimony, written statement, document, or other forms.

(3) The burden of proof is upon the claimant (applicant for workers' compensation benefits) to establish each essential element of the claim by preponderance of the evidence. Essential elements shall include, but will not be limited to:

(a) Establishing that the applicant is one of the persons who under the act have the right to file a claim for workers' compensation benefits;

(b) That the application was filed within the time period as required by law;

(c) That the alleged injury or occupational disease was sustained or contracted in the course of and arising out of employment;

(d) In death claims, that death was the direct and proximate result of an injury sustained or occupational disease contracted in the course of and arising out of employment; the necessary causal relationship between an injury or occupational disease and death may be established by submission of sufficient evidence to show that the injury or occupational disease aggravated or accelerated a pre-existing condition to such an extent that it substantially hastened death;

(e) Any other material issue in the claim, which means a question that must be established in order to determine claimant's right to compensation and/or benefits.

"Preponderance of the evidence" means greater weight of evidence, taking into consideration all the evidence presented. Burden of proof does not necessarily relate to the number of witnesses or quantity of evidence submitted, but to its quality, such as merit, credibility and weight. The obligation of the claimant is to make proof to the reasonable degree of probability. A mere possibility is conjectural, speculative and does not meet the required standard.

(4) The bureau or commission may, at any point in the processing of an application for benefits, require the employee to submit to a physical examination or may refer a claim for investigation.

(5) Procedure on employer's request for medical examination of the claimant by a doctor of employer's

choice.

The employer may require a medical examination of the employee as provided in section 4123.651 of the Revised Code under the following circumstances:

(a) Such an examination, if requested, shall be in lieu of any rights under paragraph (C)(5)(b) of this rule and in no event will the claimant be examined on the same issue by a physician of the employer's choice more than one time. The exercise of this examination right shall not be allowed to delay the timely payment of benefits or scheduled hearings. Requests for further examinations will be made to the bureau or commission following the provisions of paragraph (C)(5)(b) of this rule. The cost of any examination initiated by the employer shall be paid by the employer including any fee required by the doctor, and the payment of all of the claimant's traveling and meal expenses, in a manner and at the rates as established by the bureau from time to time. If employed, the claimant will also be compensated for any loss of wages arising from the scheduling of an examination.

All reasonable expenses shall be paid by the employer immediately upon receipt of the billing, and the employer shall provide the claimant with a proper form to be completed by the claimant for reimbursement of such expenses.

The employer shall promptly inform the bureau or the commission, as well as the claimant's representative, as to the time and place of the examination, and the questions and information provided to the doctor. A copy of the examination report shall be submitted to the bureau or commission and to the claimant's representative upon the employer's receipt of the report from the doctor.

Emergency treatment does not constitute an examination by the employer for the purposes of this rule. Treatment by a company doctor as the treating physician constitutes an examination for the purposes of this rule. The procedure set forth in paragraph (C)(5)(a) of this rule shall be applicable to claims where the date of injury or the date of disability in occupational disease claims occur on or after August 22, 1986.

(b) If after one medical examination of the claimant under paragraph (C)(5)(a) of this rule, an employer asserts that a medical examination of the claimant by a doctor of the employer's choice is essential in the defense of the claim by the employer, a written request may be filed with the bureau for that purpose. In such request the employer shall state the date of the last examination of the claimant by a doctor of employer's choice on the question pending. If there was no such prior examination, the request must so indicate.

(c) If the claim is pending before the industrial commission or its hearing officers and the question sought to be clarified by such examination is not within the jurisdiction of the bureau (for example: permanent total disability), the request shall be referred, forthwith, to the industrial commission or to the appropriate hearing officer, as the case may be, for further consideration.

(d) If the question sought to be clarified by the requested examination is within the bureau's jurisdiction (for example: temporary total disability in otherwise undisputed claim, allowance of additional condition), the bureau shall immediately act upon the request.

If, upon a review of the claim file the bureau is of the opinion that the request should be denied for the reason that the claimant has been recently examined by a doctor of the employer's choice, or for any other reason indicating that further examination would not be pertinent to the defense of the

claim, based on the facts and circumstances of each particular case, the matter shall be referred, forthwith, to the appropriate district hearing officer for further consideration. In cases of temporary total disability, a medical examination performed within the past thirty days shall be regarded as "recent." If the question involves additional allowance of claim for an additional condition allegedly causally related to the allowed injury or occupational disease, a medical examination performed within the past sixty to ninety days may be regarded as "recent," depending on the nature and type of the condition and/or disability.

(e) All reasonable expenses incurred by the claimant in submitting to such examination, including any travel expense that the claimant may properly incur, shall be paid by the employer immediately upon receipt of the billing. Payment for traveling expenses shall not require an order of the bureau or commission, unless there is a dispute. The employer shall provide the claimant with a proper form to be completed by the claimant for reimbursement for traveling expenses. In addition, if ~~the request for such examination is filed on or after January 1, 1979, and~~ the claimant sustains lost wages as a result of such examination, the employer shall reimburse the claimant for such lost wages within three weeks from the date of examination. Expenses incurred by the claimant and wages lost by reason of attending such examination are not to be paid in the claim.

(f) The employer shall make arrangements for such examination within fifteen days from the date of receipt of the order of approval. The examination shall be performed not later than within thirty days from the date of the receipt of approval.

The doctor's report shall be filed with the bureau immediately upon its receipt. Failure of the employer to comply with this rule shall not delay further action in the claim, unless it is established that the omission was due to causes beyond the employer's control.

(6) Procedure for obtaining the deposition of an examining physician. Authority to allow depositions is within the exclusive jurisdiction of the industrial commission. Any such request, if filed with the bureau, shall be referred, forthwith, to the industrial commission for further consideration.

(D) Hearings and orders.

(1) Unless required by law or by the circumstances of the claim, the claim shall be adjudicated without a formal hearing.

(2) Disputed or contested claims shall be set for a formal (public) hearing on the question of allowance before the district hearing officers. A "disputed or contested claim," as used herein, is where the employer or the claimant questions the decision of the bureau regarding a request for compensation or benefits. No claim shall be regarded as a contested or disputed claim requiring a formal (public) hearing, solely by reason of incomplete information unless every effort has been made to complete the record In the event the employer or claimant object to the decision of the bureau, such objection shall be made in writing with rationale and supporting evidence, as appropriate.

(3) The administrator or his or her designee may appear at such hearings to represent the interest of the state insurance fund and/or the surplus fund.

(4) The bureau shall make payment on orders of the commission, and district or staff hearing officers in accordance with law and rules of the bureau and the industrial commission.

(5) If the administrator or his or her designee is of the opinion that an emergency exists which requires an immediate hearing of a claim, he or she may request an emergency hearing. "Emergency," as used herein, means a sudden, generally unexpected occurrence or set of circumstances demanding immediate action. Such request shall be made in accordance with the rule of the industrial commission on emergency hearings as defined in rule 4121-3-30 of the Administrative Code.

(E) Representation of claimants and employers before the bureau. Representation of claimants and employers before the bureau is a matter of individual free choice. The bureau does not require representation nor does it prohibit it. No one other than an attorney at law, authorized to practice in the state of Ohio, shall be permitted to represent claimants for a fee before the bureau.

(F) If the bureau or the parties believe that clarification of issues will facilitate the processing of the claim, the claimant, employer, and their duly authorized representatives, as defined in rule 4123-3-22 of the Administrative Code, shall be given an opportunity to provide additional evidence on questions pertaining to the claim pending before the bureau.

The evidence shall be made a part of the claim file to be considered by the bureau when the determination is made on the issue pending before the bureau.

DRAFT - NOT FOR FILING

4123-3-10 Awards.

(A) Compensation check issuance, delivery and endorsement.

(1) Definition of claimant.

As used in this rule the word "claimant" shall apply to an employee who sustained an injury or contracted an occupational disease in the course of and arising out of employment, to the dependent of a deceased employee, as well as to any person who was awarded compensation under the Ohio Workers' Compensation Act.

(2) Time limit for issuance.

(a) Any order, finding or decision of the bureau, the industrial commission, or its hearing officers wherein payment of compensation is to be made shall be promptly forwarded to the appropriate department of the bureau charged with the duty of making the payment, or in the case of a self-insuring employer to the personnel of such employer charged with the disbursement of funds in industrial claims.

(b) The initial payment of the bureau in payment of compensation under an order shall be issued within the time limits set forth in division (H) of section 4123.511 of the Revised Code. The payment will include compensation accrued and due the claimant at that time. Further payment of compensation due under that order shall be made by the bureau in biweekly installments. In self-insuring employers' claims payment will be made in accordance with applicable laws and rules.

(3) To whom paid.

(a) Awards of compensation shall be made payable only to the claimant as defined in paragraph (A)(1) of this rule, except in cases of lump sum advancements, or where the claimant is an incompetent person or is a minor awarded a lump sum of compensation, or in the case of attorneys fees as provided in paragraph ~~(A)(8)~~ (A)(7) of this rule.

(b) If the claimant is an incompetent person, payment shall be issued payable and shall be mailed to the claimant's legally appointed guardian upon the receipt of documentary proof establishing the existence of such guardianship.

(c) If the claimant is a minor and was awarded a lump sum of compensation, such sum shall be paid to the claimant's legally appointed guardian or in accordance with section 2111.05 of the Revised Code.

(d) If the bureau or the industrial commission determines that it is to the best interest of the claimant that a guardian of the property be appointed to receive the benefits payable, payment shall be withheld until such guardian is appointed.

(4) Delivery of the bureau's payment to claimant and exceptions.

The standard method of delivering payment to a claimant or benefit recipient shall be by electronic fund transfer, as ~~provide~~ provided in paragraph (D) of this rule. Where the bureau issues a check, the bureau's checks payable to a claimant shall be mailed to the claimant's address, as officially recorded in the claim file, except as provided below:

(a) The mailing of the bureau's compensation check to a place requested by the claimant in an authorization to receive workers' compensation payment or equivalent, executed in accordance with paragraph ~~(A)(6)~~(A)(5) of this rule, must be approved by the administrator or the administrator's designee, or by the industrial commission or designee.

(b) Checks for lump sum settlements or lump sum advancements shall be disbursed in accordance with instructions of the bureau or industrial commission, as indicated in the order approving such advancements.

(c) In cases of advancements made by the employer during a period of disability, the bureau's checks shall be delivered in accordance with rule 4123-5-20 of the Administrative Code.

(5) Personal pick-up of the bureau's checks by a claimant and/or by parties other than a claimant.

(a) Provided approval has been given by a member of the industrial commission or designee, the administrator of the bureau of workers' compensation or the administrator's designee, or a hearing officer, a claimant, an attorney for a claimant, or any other person authorized by a claimant, may pick-up a compensation check issued by the bureau.

(b) When a claimant authorizes another person to pick up the claimant's compensation check, the authorization shall be an authorization to receive workers' compensation payment or equivalent. On all types of compensation, other than percentage of permanent partial compensation, the authorization must be filed prior to or at the hearing, or prior to the date of payment of the award of compensation, whether the award of compensation was made at a hearing or without a hearing. For authorization to receive compensation checks in connection with permanent partial disability applications and applications for increases thereof, the authorization must be filed with the application, with the agreement of permanent partial disability, with the election, or with the industrial commission at formal hearing or not later than prior to the date of mailing of the findings resulting from the formal hearing.

(c) The warrant will be made payable to the claimant and sent in care of the attorney/representative identified on the authorization to receive workers' compensation payment or equivalent. The warrant shall be mailed to the address that the claimant indicated on the request, or at a place designated by the administrator.

(d) A person authorized to pick-up the check at the bureau shall furnish adequate identification and sign a dated receipt verifying acceptance of the check.

(e) In self-insuring employers' claims, the claimant and the employer may agree on check delivery or pick-up, such agreement to be based on the same principles as outlined in this rule.

(6) Endorsement of checks and procedure in the event of claimant's death.

(a) An authorization to receive workers' compensation payment or equivalent allowing an attorney or an employee of an attorney to cash or endorse a check on behalf of the claimant is prohibited. Checks payable to claimant's guardian must be endorsed by said guardian in the guardian's official capacity.

(b) When a claimant dies prior to endorsing a compensation check or accessing an electronic benefit payment, no one has the right to endorse and cash such check or access the electronic benefit funds.

~~In order to ensure that the bureau or commission effectively obtains notice of death of a claimant, each~~ Each check payable to a claimant shall bear on the reverse side, immediately above the point specified for endorsement, ~~a~~ the standard printed certification ~~to the effect that the signer or endorser certifies that he or she is the person to whom the check is payable and that the signature is his or her signature~~ explaining the limitations and penalties for false endorsements, as required by the department of administrative services for state warrants and checks.

Checks that cannot be endorsed because the claimant is deceased must be returned to the bureau's benefits payable section, at the address designated by the administrator, by the party handling the claimant's affairs, notifying the bureau of the date of death, if known. Upon receipt of information of claimant's death, payment of compensation shall be terminated and proper entry made in the records of the bureau.

~~(c)~~ (c) ~~Checks that cannot be endorsed because the claimant is deceased must be returned to the bureau's benefits payable section, at the address designated by the administrator, by the party handling the claimant's affairs, notifying the bureau of the date of death, if known. Upon receipt of information of claimant's death, payment of compensation shall be terminated and proper entry made in the records of the bureau.~~

(7) Procedure for a lump sum payment and attorney fees where the claimant is an obligor for child support payments.

(a) If a claimant is entitled to a lump sum payment of one hundred and fifty dollars or greater and the claimant is an obligor for child support payments, prior to issuing the lump sum payment, the bureau shall notify the claimant and the claimant's attorney in writing that the claimant is subject to a support order. The bureau shall hold the lump sum payment for thirty days, pending application by the attorney for attorney fees as provided in paragraph (A)(7)(b) of this rule.

(b) The bureau shall instruct the claimant's attorney in writing to file a copy of the fee agreement signed by the claimant, along with an affidavit signed by the attorney setting forth the amount of the attorney's fee with respect to that lump sum payment award to the claimant and the amount of all necessary expenses, along with documentation of those expenses, incurred by the attorney with respect to obtaining that lump sum award. The attorney shall file the fee agreement and affidavit with the bureau within thirty days after the date the bureau sends the notice under paragraph (A)(7)(a) of this rule.

(i) The attorney shall file a copy of the fee agreement that clearly establishes the fee for the lump sum payment in the claim. The attorney's failure to file a copy of the fee agreement shall be a reason for the bureau to reject the application.

(ii) The attorney shall file an affidavit in the form provided by the bureau. The attorney may complete the affidavit on the form provided by the bureau or in an affidavit that contains at least all of the elements of the form established by the bureau. The affidavit shall be notarized. The attorney's failure to file an affidavit in the form proscribed by the bureau or failure to obtain a notary signature shall be a reason for the bureau to reject the application.

(iii) The attorney fee shall be limited to the fee for obtaining the specific lump sum payment that is the subject of the bureau notice provided in paragraph (A)(7)(a) of this rule. The attorney fee shall be limited to the written fee agreement of the initial lump sum payment of the award. The

bureau will reject a fee application that includes fees from awards other than the subject lump sum payment or that request a fee from future payments of the award after the lump sum payment.

(iv) If the attorney claims reimbursement for expenses in the affidavit, the expenses shall be limited to the expenses for obtaining the specific lump sum payment that is the subject of the bureau notice provided in paragraph (A)(7)(a) of this rule. The attorney shall provide itemized expenses and documentation to support the expenses. If the attorney fails to provide the required information on expenses, the bureau may reject that portion of the fee application, but shall process the attorney fee portion of the application.

(v) Where the bureau has paid the attorney fee under paragraph (A)(7)(c) of this rule, the bureau will not honor an authorization to receive workers' compensation payment or equivalent for that award under paragraph (A)(5) of this rule, except in cases of court settlement of the workers' compensation claim.

(vi) Before rejecting an attorney fee affidavit or fee agreement due to noncompliance with any part of this rule, the bureau shall notify the attorney of the noncompliance and provide the attorney an opportunity to submit additional information during the thirty day hold period provided in paragraph (A)(7)(a) of this rule.

(c) Upon receipt of the fee agreement and attorney affidavit, the bureau shall review the affidavit as provided in this rule. If the affidavit complies with this rule, the bureau shall deduct from the lump sum payment the amount of the attorney's fee and necessary expenses and pay that amount directly to and solely in the name of the attorney within fourteen days after the fee agreement and attorney affidavit have been filed with the bureau.

(d) After deducting any attorney's fee and necessary expenses, if the lump sum payment is one hundred fifty dollars or more, the bureau shall hold the balance of the lump sum award in accordance with division (A)(11) of section 3121.037 of the Revised Code.

(B) Medical awards.

Medical awards shall be paid by the bureau within the time limits set forth in rule 4123-6-42 of the Administrative Code.

(C) Rules for self-insuring employers.

Self-insuring employers shall make payment of compensation and benefits within the time as required by law and rules of the bureau.

(1) It is the duty of the employer to pay, in accordance with the act, the amount of compensation due a claimant whose injury or occupational disease has resulted in more than seven days lost time. Payment ~~to~~ shall be made in the manner provided by law and the rules of the bureau.

(2) It is the duty of the employer to pay for necessary medical services rendered by health care providers as a result of an injury or occupational disease for which a claim was recognized by the employer or allowed by the industrial commission.

(3) It is the duty of the employer to pay the amount of compensation and/or benefits due in a compensable

death case, and to make payment to the proper dependents or to such other persons who may be entitled thereto in accordance with the governing statutes and the orders and rules of the bureau. In the event death is the result of a compensable injury or occupational disease, the employer shall also pay the funeral allowance provided by statute at the time of death.

(4) All awards made by self-insuring employers must be at least equal to the amounts specified in the applicable statutes, the rules of the bureau and the industrial commission.

(5) Self-insuring employers shall follow the procedures in paragraph (A)(7) of this rule relating to a lump sum payment and attorney fees where the claimant is an obligor for child support payments.

(D) Electronic payment of compensation and benefits.

(1) Pursuant to section 4123.311 of the Revised Code, this rule describes the bureau's program of electronic payments to:

(a) Utilize direct deposit of funds by electronic transfer for disbursements the administrator is authorized to pay;

(b) Require a payee to provide a written authorization designating a financial institution and an account number to which a payment may be made;

(c) Contract with an agent to supply debit cards for claimants to access payments made to them and credit the debit cards with the amounts specified by the administrator by utilizing direct deposit of funds by electronic transfer;

(d) Enter into agreements with financial institutions to credit the debit cards with the amounts specified by the administrator;

(e) Inform claimants about the bureau's utilization of direct deposit of funds by electronic transfer, furnish debit cards to claimants as appropriate, and provide claimants with instructions regarding use of those debit cards.

(2) For any compensation paid directly to an ~~injured worker or a dependent~~ a claimant, the bureau shall require either an electronic fund transfer into a savings or checking account, or shall issue to the payee an electronic benefits card.

(a) The bureau shall provide to the ~~public~~ claimant notice of the types of compensation or payments paid directly to a benefit recipient that are included in the electronic benefits program.

(b) The bureau shall provide to the ~~public~~ claimant notice of the types of compensation or payments not paid directly to a benefit recipient that are not included in the electronic benefits program. Payments made under an authorization to receive workers' compensation checks are excluded from the electronic benefits program.

(3) The bureau shall notify a benefit recipient of the requirement for electronic payment of benefits and compensation and ask the benefit recipient to provide the financial institution and account to which the bureau shall deposit the compensation or benefits. If the benefit recipient does not have an account or does not respond, the bureau shall issue the payment by a bureau debit card. The debit card shall be used to deliver compensation payments electronically.

(4) The bureau shall contract with a vendor for the debit cards to allow benefit recipients to receive payment without a monthly maintenance fee. The bureau shall issue the debit card only to the benefit recipient.

(5) The bureau shall provide to a benefit recipient who lives in a foreign country an electronic benefit card.

(6) The bureau shall provide notice of electronic payment delivery on the payment remittance of each paper warrant issued to eligible benefit recipients. The notice shall include the two different payment options and shall provide the benefit recipient the opportunity to select between the two electronic payment options.

(7) A benefit recipient may request a waiver of the electronic payment delivery of compensation or benefits under this rule for special circumstances due to hardship in establishing a personal checking or savings account or in accepting the bureau debit card. The request for a waiver shall be referred to the bureau benefits payable department and may be reviewed by the administrator's designee.

DRAFT - NOT FOR FILING

4123-3-15 Claim procedures subsequent to allowance.

(A) Requests for subsequent actions when a state fund claim has not had activity or a request for further action within a period of time in excess of twenty-four months.

(1) The bureau shall consider a request for subsequent action in a claim in the following situations:

(a) Where the employee requests that the bureau or commission modify or alter an award of compensation or benefits that has been previously granted; or

(b) Where the employee ~~request~~ requests that the bureau or commission grant a new award of compensation or to settle the claim; or

(c) Where the claimant ~~request~~ requests that the allowance of a disability or condition not previously considered; or

(d) Where the claimant dies and there is potential entitlement for accrued benefits or payment of medical bills, or the decedent's dependent is requesting death benefits due to relatedness between the recognized injury and death.

(e) Except for a medical issue relating to a prosthetic device or durable medical equipment as designated by the administrator, the bureau, in consultation with the MCO assigned to the claim, shall issue an order on a medical treatment reimbursement request in a claim which has not had activity or a request for further action within a period of time in excess of twenty-four months as follows:

(i) The MCO shall refer a medical treatment reimbursement request in a claim which has not had activity or a request for further action within a period of time in excess of twenty-four months to the bureau for an order when the request is accompanied by supporting medical evidence dated not more than sixty days prior to the date of the request, or when such evidence is subsequently provided to the MCO upon request (via "Form C-9A" or equivalent). The bureau's order shall address both the causal relationship between the original injury and the current incident precipitating the medical treatment reimbursement request in a claim and the necessity and appropriateness of the requested treatment. The employer or the employee or the representative may appeal the bureau's order to the industrial commission pursuant to section 4123.511 of the Revised Code.

(ii) The MCO may dismiss without prejudice, and without referral to the bureau for an order, a medical treatment reimbursement request in a claim which has not had activity or a request for further action within a period of time in excess of twenty-four months when the request is not accompanied by supporting medical evidence dated not more than sixty days prior to the date of the request and such evidence is not provided to the MCO upon request (via "Form C-9A" or equivalent).

(2) Requests which require proof shall conform to the standards required by paragraph (C) of rule 4123-3-09 of the Administrative Code and rules 4123-5-18 and 4123-6-20 of the Administrative Code.

(a) Medical evidence is required to substantiate a request for temporary total disability.

(b) Medical evidence is required to substantiate the allowance of a disability or condition not previously considered.

(3) In state fund cases, upon a request for subsequent action under paragraph (A)(1) of this rule, the bureau shall, upon notification, inform the parties to the claim of the pending action prior to issuing a decision. Upon request, the bureau shall provide a copy of the request and proof to the employer and the claimant, and their representatives, where applicable. Requests in self-insuring employers' cases shall be submitted to the self-insuring employer which shall accept or refuse the matters sought.

(4) The bureau or commission may require the filing of additional proof or legal citations by either party or may make such investigation or inquiry as the circumstances may require.

(5) A state fund employer shall, upon receipt of notification of the request, notify the bureau of any objection to the granting of the relief requested. Such notification must be filed within the time as required by the rules of the bureau and industrial commission.

(6) Such requests shall be determined with or without formal (public) hearing as the circumstances presented require. If the request is within the jurisdiction of the bureau and the matter is not contested or disputed, the bureau shall adjudicate the request in the usual manner. In all other cases, the request shall be acted upon by the industrial commission's hearing officer or as otherwise required by the rules of the commission, depending on the subject matter.

(7) Failure by the employee to furnish information as specifically requested by the bureau or commission shall be considered sufficient reason for the dismissal of the request. If the employer fails to furnish any information requested by the bureau or commission, the request may be adjudicated upon the proof filed.

(B) "Application for Determination of Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability" pursuant to division (A) of section 4123.57 of the Revised Code in state fund and self-insured claims.

(1) An "Application for Determination of Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability" shall be completed and signed by the applicant or applicant's representative and shall be filed with the bureau of workers' compensation. An application for an increase in permanent partial disability must be accompanied by substantial evidence of new and changed circumstances which have developed since the time of the hearing on the original or last determination. The bureau shall dismiss an unsigned application. Except where an additional condition has been allowed in the claim and the request is for an increase in permanent partial disability based solely on that additional condition, the bureau shall dismiss a request for an increase in permanent partial disability filed without medical documentation. Whenever the applicant or applicant's representative leaves a question or questions in the application form unanswered, the bureau shall contact the applicant and applicant's representative to obtain the information necessary to process the application. Should the applicant or applicant's representative inform the bureau that the failure to provide the information necessary to process the application is beyond the applicant's control, the bureau shall take appropriate action to obtain such information.

(2) Upon the filing of the application for either of these requests, the application shall be referred to the bureau for review and processing. The bureau shall send notice of the application to the employer and the employer's representative, unless the employer is out of business. The employer shall submit any proof within its possession bearing upon the issue to the bureau within thirty days of the receipt of the claimant's application.

(3) The bureau shall contact each applicant for a determination of the percentage of permanent partial

disability to schedule an examination by a physician designated by the bureau. If the applicant fails to respond to the bureau's attempt to schedule the examination or fails to appear for the examination, the bureau may dismiss the application as provided in rule 4123-3-15.1 of the Administrative Code. The examining physician shall file a report of such examination, together with an evaluation of the degree of impairment as a part of the claim file. The bureau shall send a copy of the report of the medical examination to the employee, the employer, and their representatives.

(4) Upon receipt of the examining physician's report, the bureau shall review the medical evidence in the employee's claim file and shall make a tentative order as the evidence at the time of the making of the order warrants. If the bureau determines that there is a conflict of evidence, the bureau shall forward the application, along with the claimant's file, to the industrial commission to set the application for hearing before a district hearing officer.

(5) Where there is no conflict of evidence, the bureau shall enter a tentative order on the request for percentage of permanent partial disability and shall notify the employee, the employer, and their representatives, in writing, of the tentative order and of the parties' right to request a hearing. Unless the employee, the employer, or their representative notifies the bureau, in writing, of an objection to the tentative order within twenty days after receipt of the notice thereof, the tentative order shall go into effect and the employee shall receive the compensation provided in the order. In no event shall there be a reconsideration of a tentative order issued under this division.

(6) If the employee, the employer, or their representatives timely notify the bureau of an objection to the tentative order, the bureau shall refer the matter to a district hearing officer who shall set the application for hearing in accordance with the rules of the industrial commission. Upon referral to a district hearing officer, the employer may obtain a medical examination of the employee, pursuant to the rules of the industrial commission.

(7) Where the application is for an increase in the percentage of permanent partial disability, no sooner than sixty days from the date of mailing of the application to the employer and the employer's representative, the applicant shall either be examined, or the claim referred for review by a physician designated by the bureau. Such period may be extended or the processing of the application suspended by the bureau for good cause shown. If the bureau has determined that the employer is out of business the bureau will not mail the application and may process the application without waiting the sixty day period. The bureau physician shall file a report of such examination or review of the record, together with an evaluation of the degree of impairment, as part of the claim file. Either the employee or the employer may submit additional medical evidence following the examination by the bureau medical section as long as copies of the evidence are submitted to all parties.

(8) After completion of the review or examination by a physician designated by the bureau, the bureau may issue a tentative order based upon the evidence in file. If the bureau determines that there is a conflict in the medical evidence, the bureau shall adopt the recommendation of the medical report of the bureau medical examination or medical review.

(9) The bureau shall enter a tentative order on the request for an increase of permanent partial disability and shall notify the employee, the employer, and their representatives, in writing, of the nature and amount of any tentative order issued on the application requesting an increase in the percentage of the employee's permanent disability. The employee, the employer, or their representatives may object to the tentative order within twenty days after the receipt of the notice thereof. If no timely objection is made, the tentative order shall go into effect. In no event shall there be a reconsideration of a tentative order

issued under this division. If an objection is timely made, the bureau shall refer the matter to a district hearing officer who shall set the application for a hearing in accordance with the rules of the industrial commission. The employer may obtain a medical examination of the employee and submit a defense medical report at any stage of the proceedings up to a hearing before a district officer.

(10) Where an award under division (A) of section 4123.57 of the Revised Code has been made prior to the death of an employee, the bureau shall pay all unpaid installments accrued or to accrue to the surviving spouse, or if there is no surviving spouse, to the dependent children of the employee, and if there are no such children surviving, then to such other dependents as the bureau may determine.

(C) Payment of permanent partial disability pursuant to division (B) of section 4123.57 of the Revised Code (scheduled loss) in state fund and self-insured employer claims.

(1) The bureau or self-insuring employer will determine the payment of scheduled loss for a loss by amputation or for a loss of use upon the motion of a party for such award. To determine the payment of the award, the bureau or self-insuring employer may review the medical evidence in the file, may request additional medical information from the parties, or may refer the ~~injured worker~~ claimant for an examination by a physician designated by the bureau or self-insuring employer.

(2) The bureau shall enter an order on or the self-insuring employer shall make a decision on the payment of scheduled loss ~~for a loss by amputation or for a loss of use~~ and shall notify the employee, the employer, and their representatives, in writing, of the order or decision. The parties have a right to appeal the order or contest the decision pursuant to section 4123.511 of the Revised Code.

(3) Upon an order for the payment of scheduled loss for a loss ~~by amputation or for a loss of use~~, the bureau or self-insuring employer shall calculate such award pursuant to the statutory schedule of division (B) of section 4123.57 of the Revised Code. The bureau or self-insuring employer shall pay the award to the ~~injured worker~~ claimant in weekly payments as provided in division (B) of section 4123.57 of the Revised Code.

(4) Where a scheduled loss has been ordered but not paid prior to the death of an employee, upon application, the award is payable to the surviving spouse, or if there is no surviving spouse, to the dependent children of the employee, and if there are no such children surviving, then to such other dependents as the bureau may determine.

DRAFT - NOT FOR FILING

4123-3-16 Motions.

(A) ~~Form C-86~~ A motion (on form C-86 or equivalent) shall be used to request action from the bureau or commission.

(B) A motion may be submitted by the employee or the employer to seek a determination by the bureau or the commission on any matter not otherwise provided for in this chapter. It is appropriate to file a motion in order to secure allowance of a disability or condition not previously considered in a claim. A motion shall not be used as a substitute for an untimely appeal.

(C) A motion shall fully set forth the question presented together with a succinct statement of the action or relief sought.

(D) A motion shall be accompanied by substantial competent proof conforming to the standards established in paragraph (C) of rule 4123-3-09 of the Administrative Code.

(E) ~~Where required, a motion shall contain citations to the legal authorities relied upon.~~ Except in matters not affecting the rights of the opposite party, the applicant filing a motion shall provide a copy of the motion to the opposite party and the copy of the motion filed with the bureau or the commission shall indicate that a copy has been so provided. When in doubt, the applicant shall provide a copy of the motion to the opposite party.

~~(F)~~ (F) ~~Except in matters not affecting the rights of the opposite party, the applicant filing a motion shall mail~~ a copy of the motion to the opposite party and the copy of the motion filed with the bureau board or the commission shall indicate that a copy has been so ~~mailed~~. When in doubt, the applicant shall ~~mail~~ a copy of the motion to the opposite party.

~~(G)~~ (F) A motion shall bear the signature of the applicant or the applicant's authorized representative.

~~(H)~~ (G) Failure to comply with the provisions of this rule shall be sufficient reason for the dismissal of the motion.

~~(I)~~ (H) Motions shall be adjudicated in the same manner as provided in paragraph (A)(7) of rule 4123-3-15 of the Administrative Code, except motions for allowance of a psychiatric ~~disability~~ or psychological condition (paragraph ~~(J)~~(I) of this rule).

~~(J)~~ (I) Procedure governing motions for allowance of a psychiatric ~~disability~~ or psychological condition:

(1) A motion requesting that a claim be additionally recognized for a psychiatric or psychological condition shall include a ~~typed or printed~~ statement, personally signed and dated by the claimant, ~~setting forth the following declaration: "I am~~ acknowledging the claimant is aware ~~that this~~ the motion is being filed to request that the bureau or commission recognize ~~my emotional problem, nervous condition, or~~ a psychiatric ~~disability~~ or psychological condition as being a result of the injury for which ~~this~~ the claim is allowed.~~"~~

(2) A motion requesting the recognition of an additional condition of a psychiatric or psychological nature shall be accompanied by supporting evidence consisting of a report by a licensed psychiatric specialist, a clinical psychologist, a licensed professional clinical counselor (LPCC), or a licensed independent social

worker (LISW).

(3) The bureau may have the claimant scheduled for an examination by an independent specialist.

(4) If the claimant fails to comply with the bureau's request relating to the motion as provided in paragraphs ~~(J)(1) to (J)(3)~~ (I)(1) to (I)(3) of this rule, the bureau shall refer the motion to the commission with a recommendation to dismiss the motion.

(5) If there is no conflict in the evidence or the motion is not contested or disputed, the bureau shall adjudicate the motion. If there is a conflict in the evidence or the motion is contested or disputed, the bureau shall refer the motion to the commission for further consideration.

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Appendix to rule 4123-3-36
Appendix

ICD-10 Code	Description
S00.211A	Abrasion of right eyelid
S00.212A	Abrasion of left eyelid
S00.251A	Superficial foreign body of right eyelid
S00.252A	Superficial foreign body of left eyelid
S00.261A	Insect bite of right eyelid
S00.262A	Insect bite of left eyelid
T26.01XA	Burn of right eyelid and periocular area nec
T26.02XA	Burn of left eyelid and periocular area nec
T15.81XA	Foreign body in lacrimal punctum - right eye
T15.82XA	Foreign body in lacrimal punctum - left eye
T26.61XA	Acid burn of cornea/conjunctival sac - right eye
T26.62XA	Acid burn of cornea/conjunctival sac - left eye
T15.01XA	Foreign body in cornea - right eye
T15.02XA	Foreign body in cornea - left eye
T15.11XA	Foreign body in conjunctival sac - right eye
T15.12XA	Foreign body in conjunctival sac - left eye
S05.11XA	Contusion of right eyeball
S05.12XA	Contusion of left eyeball
S01.301A	Open wound of right ear
S01.302A	Open wound of left ear
S01.351A	Open bite of right ear
S01.352A	Open bite of left ear
S01.311A	Laceration of right ear
S01.312A	Laceration of left ear
S01.332A	Puncture wound of left ear
S01.331A	Puncture wound of right ear
T20.111A	First degree burn of right ear
T20.112A	First degree burn of left ear
T20.511A	First degree corrosion of right ear
T20.512A	First degree corrosion of left ear
S01.20XA	Open wound of nose
S01.25XA	Open bite of nose
S01.21XA	Laceration of nose
S01.23XA	Puncture of nose
S01.502A	Open wound of oral cavity
S01.552A	Open bite of oral cavity
S01.512A	Laceration of oral cavity
S01.532A	Puncture of oral cavity

S01.80XA	Open wound of jaw (other part of head)
S01.81XA	Laceration of jaw (other part of head)
S01.83XA	Puncture wound of jaw (other part of head)
S01.85XA	Open bite of jaw (other part of head)
T20.12XA	First degree burn of lip
T20.52XA	First degree corrosion of lip
T20.13XA	First degree burn of chin
T20.53XA	First degree corrosion of chin
T20.15XA	First degree burn of scalp
T20.55XA	First degree corrosion of scalp
T20.19XA	First degree burn of face/head/neck – multiple sites
T20.59XA	First degree corrosion of face/head/neck – multiple sites
S31.109A	Open wound of abdominal wall
S31.119A	Laceration of abdominal wall
S31.139A	Puncture wound of abdominal wall
S31.159A	Open bite of abdominal wall
T21.10XA	First degree burn of trunk nos
T21.19XA	First degree burn of trunk nec
T21.50XA	First degree corrosion of trunk nos
T21.59XA	First degree corrosion of thunk nec
T21.11XA	First degree burn of chest wall
T21.51XA	First degree corrosion of chest wall
S31.000A	Open wound of pelvis/lower back
S31.010A	Laceration of pelvis/lower back
S31.030A	Puncture wound of pelvis/lower back
S31.050A	Open bite of pelvis/lower back
S31.501A	MALE- Open wound of perineum
S31.511A	MALE - Laceration of perineum
S31.531A	MALE - Puncture wound of perineum
S31.551A	MALE - Open bite of perineum
S31.502A	FEMALE - Open wound of perineum
S31.512A	FEMALE - Laceration of perineum
S31.532A	FEMALE - Puncture wound of perineum
S31.552A	FEMALE - Open bite of perineum
S31.20XA	MALE - Open wound of penis
S31.25XA	MALE - Open bite of penis
S31.21XA	MALE - Laceration of penis
S31.23XA	MALE - Puncture wound of penis
S31.30XA	MALE - Open wound of scrotum and testes
S31.31XA	MALE - Laceration of scrotum and testes
S31.33XA	MALE - Puncture of scrotum and testes
S31.35XA	MALE - Open bite of scrotum and testes
S31.40XA	FEMALE - Open wound of vagina and vulva
S31.41XA	FEMALE - Laceration of vagina and vulva
S31.43XA	FEMALE - Puncture of vagina and vulva

S31.45XA	FEMALE - Open bite of vagina and vulva
S41.001A	Open wound of right shoulder
S41.002A	Open wound of left shoulder
S41.011A	Laceration of right shoulder
S41.012A	Laceration of left shoulder
S41.031A	Puncture wound of right shoulder
S41.032A	Puncture wound of left shoulder
S41.051A	Open bite of right shoulder
S41.052A	Open bite of left shoulder
T22.151A	First degree burn of right shoulder
T22.152A	First degree burn of left shoulder
T22.551A	First degree corrosion of right shoulder
T22.552A	First degree corrosion of left shoulder
S20.229A	Contusion of interscapular region
S41.101A	Open wound of right axilla
S41.102A	Open wound of left axilla
S41.111A	Laceration of right axilla
S41.112A	Laceration of left axilla
S41.131A	Puncture wound of right axilla
S41.132A	Puncture wound of left axilla
S41.151A	Open bite of right axilla
S41.152A	Open bite of left axilla
T22.141A	First degree burn of right axilla
T22.142A	First degree burn of left axilla
T22.541A	First degree corrosion of right axilla
T22.542A	First degree corrosion of left axilla
T22.191A	First degree burn of right arm – multiple sites
T22.192A	First degree burn of left arm – multiple sites
T22.591A	First degree corrosion of right arm – multiple sites
T22.592A	First degree corrosion of left arm – multiple sites
T22.121A	First degree burn of right elbow
T22.122A	First degree burn of left elbow
T22.521A	First degree corrosion of right elbow
T22.522A	First degree corrosion of left elbow
S51.801A	Open wound of right forearm
S51.802A	Open wound of left forearm
S51.811A	Laceration of right forearm
S51.812A	Laceration of left forearm
S51.831A	Puncture wound of right forearm
S51.832A	Puncture wound of left forearm
S51.851A	Open bite of right forearm
S51.852A	Open bite of left forearm
S50.851A	Superficial foreign body of right forearm
S50.852A	Superficial foreign body of left forearm
S61.501A	Open wound of right wrist
S61.502A	Open wound of left wrist
S61.511A	Laceration of right wrist

S61.512A	Laceration of left wrist
S61.531A	Puncture wound of right wrist
S61.532A	Puncture wound of left wrist
S61.551A	Open bite of right wrist
S61.552A	Open bite of left wrist
S61.401A	Open wound of right hand
S61.402A	Open wound of left hand
S61.411A	Laceration of right hand
S61.412A	Laceration of left hand
S61.431A	Puncture without foreign body of right hand
S61.432A	Puncture wound without foreign body of left hand
S61.451A	Open bite of right hand
S61.452A	Open bite of left hand
S60.551A	Superficial foreign body of right hand
S60.552A	Superficial foreign body of left hand
T23.151A	First degree burn of right palm
T23.152A	First degree burn of left palm
T23.551A	First degree corrosion of right shoulder
T23.552A	First degree corrosion of left shoulder
S61.001A	Open wound of right thumb
S61.002A	Open wound of left thumb
S61.200A	Open wound of right Index finger
S61.201A	Open wound of left Index finger
S61.202A	Open wound of right middle finger
S61.203A	Open wound of left middle finger
S61.204A	Open wound of right ring finger
S61.205A	Open wound of left ring finger
S61.206A	Open wound of right little finger
S61.207A	Open wound of left little finger
S61.011A	Laceration of right thumb
S61.012A	Laceration of left thumb
S61.210A	Laceration of right index finger
S61.211A	Laceration of left index finger
S61.212A	Laceration of right middle finger
S61.213A	Laceration of left middle finger
S61.214A	Laceration of right ring finger
S61.215A	Laceration of left ring finger
S61.216A	Laceration of right little finger
S61.217A	Laceration of left little finger
S61.031A	Puncture wound of right thumb
S61.032A	Puncture wound of left thumb
S61.230A	Puncture wound of right index finger
S61.231A	Puncture wound of left index finger
S61.232A	Puncture wound of right middle finger
S61.233A	Puncture wound of left middle finger
S61.234A	Puncture wound of right ring finger
S61.235A	Puncture wound of left ring finger
S61.236A	Puncture wound of right little finger
S61.237A	Puncture wound of left little finger

S61.051A	Open bite of right thumb
S61.052A	Open bite of left thumb
S61.250A	Open bite of right index finger
S61.251A	Open bite of left index finger
S61.252A	Open bite of right middle finger
S61.253A	Open bite of left middle finger
S61.254A	Open bite of right ring finger
S61.255A	Open bite of left ring finger
S61.256A	Open bite of right little finger
S61.257A	Open bite of left little finger
T23.141A	First degree burn of multiple fingers with thumb – right
T23.142A	First degree burn of multiple fingers with thumb – left
T23.541A	First degree corrosion of multiple fingers with thumb – right
T23.542A	First degree corrosion of multiple fingers with thumb – left
S31.819A	Open wound of right buttock
S31.829A	Open wound of left buttock
S31.811A	Laceration of right buttock
S31.821A	Laceration of left buttock
S31.813A	Puncture wound of right buttock
S31.823A	Puncture wound of left buttock
S31.815A	Open bite of right buttock
S31.825A	Open bite of left buttock
S71.001A	Open wound of right hip
S71.002A	Open wound of left hip
S71.011A	Laceration of right hip
S71.012A	Laceration of left hip
S71.031A	Puncture wound of right hip
S71.032A	Puncture wound of left hip
S71.051A	Open bite of right hip
S71.052A	Open bite of left hip
S71.101A	Open wound of right thigh
S71.102A	Open wound of left thigh
S71.111A	Laceration of right thigh
S71.112A	Laceration of left thigh
S71.131A	Puncture wound of right thigh
S71.132A	Puncture wound of left thigh
S71.151A	Open bite of right thigh
S71.152A	Open bite of left thigh
T25.131A	First degree burn of right toe
T25.132A	First degree burn of left toe
T25.531A	First degree corrosion of right toe
T25.532A	First degree corrosion of left toe
T24.191A	First degree burn of right leg – multiple sites
T24.192A	First degree burn of left leg – multiple sites
T24.591A	First degree corrosion of right leg – multiple sites
T24.592A	First degree corrosion of left leg – multiple sites
L57.8	Solar dermatitis nec (other skin changes due to chronic exposure to nonionizing radiation)

DRAFT - NOT FOR FILING

4123-3-18 Appellate procedure.

(A) Administrative appeals.

(1) The right of an administrative appeal is limited to the claimant, the dependents of a deceased worker, the employer, and the administrator, where the administrator or the administrator's representative appeals on behalf of the state insurance fund and/or the surplus fund.

(2) The above named eligible appellants may appeal decisions of the district hearing officers, or staff hearing officers.

(3) Decisions of district hearing officers are appealable to the staff hearing officers. Decisions of the staff hearing officers are appealable to the industrial commission.

(4) Appeals shall be filed in accordance with rule 4121-3-18 of the Administrative Code.

(5) Appeal applications shall be signed by the party appealing or by authorized representative on behalf of such party. The same applies to the administrator when filing an appeal.

(6) Such applications may be filed with any office of the bureau or of the industrial commission.

(7) The same time limits apply to appeals filed from the decision of the staff hearing officers to the industrial commission.

(8) Appellate review and determination of claims being within the exclusive jurisdiction of the industrial commission, the conduct of hearings and other incidental matters are governed by the rules of the industrial commission.

(9) The bureau's legal division shall act as attorney in appeals filed by the bureau on behalf of the state insurance fund; it may also act as a representative of the administrator in appeals filed by the bureau on behalf of the surplus fund. As a party to the proceedings, the bureau's legal division shall be entitled to proper notice of any action taken by the appellate body on appeals filed by the bureau.

(10) The bureau shall make payment of an award of compensation in a claim at the earliest time provided in division (H) of section 4123.511 of the Revised Code, except that, in all cases of a determination made under division (A) of section 4123.57 of the Revised Code for percentage permanent partial disability compensation, no payment shall be made to the claimant until a final decision on reconsideration allows such compensation.

(11) In all other cases, if the decision of the district hearing officer is appealed by the employer or the administrator, the bureau shall withhold medical benefits during the course of appeal to the staff hearing officer, but where the staff hearing officer rules in favor of the claimant, medical benefits shall be paid by the bureau immediately upon the receipt of the order, regardless of whether or not further appeal is taken. In self-insuring employers' claims, payment shall be made in accordance with applicable laws and rules.

(12) Payments of an award of compensation and/or benefits made by the bureau pursuant to a decision of a staff hearing officer shall commence immediately upon the bureau's receipt of the order.

(B) Appeals to court.

(1) The claimant or the employer may appeal an order of the industrial commission made under division (E) of section 4123.511 of the Revised Code in any injury or occupational disease case, other than a decision as to the extent of disability to the court of common pleas of the county in which the injury was inflicted or in which the contract of employment was made if the injury occurred outside the state, or in which the contract of employment was made if the exposure occurred outside the state. If no common pleas court has jurisdiction for the purposes of an appeal by the use of the jurisdictional requirements described in this division, the appellant may use the venue provisions in the Rules of Civil Procedure to vest jurisdiction in a court. If the claim is for an occupational disease, the appeal shall be to the court of common pleas of the county in which the exposure which caused the disease occurred. Like appeal may be taken from an order of a staff hearing officer made under division (D) of section 4123.511 of the Revised Code from which the commission has refused to hear an appeal. ~~The~~ Except as otherwise provided in paragraph (B)(2) of this rule, the appellant shall file the notice of appeal with a court of common pleas within sixty days after the date of the receipt of the order appealed from or the date of receipt of the order of the commission refusing to hear an appeal of a staff hearing officer's decision under division (D) of section 4123.511 of the Revised Code. The filing of the notice of the appeal with the court is the only act required to perfect the appeal.

(2) Either the claimant or the employer may file a notice of intent to settle the claim within thirty days after the date of the receipt of the order appealed from or of the order of the commission refusing to hear an appeal of a staff hearing officer's decision. The claimant or employer shall file notice of intent to settle on the appropriate form with the administrator of workers' compensation, and the notice shall be served on the opposing party and the party's representative. The filing of the notice of intent to settle extends the time to file an appeal to one hundred and fifty days, unless the opposing party files an objection on the appropriate form within fourteen days after the date of the receipt of the notice of intent to settle. The party shall file the objection with the administrator, and the objection shall be served on the party that filed the notice of intent to settle and the party’s representative.

~~(2)~~ (3) "Notice of Appeal" stating the names of the claimant and the employer, the number of the claim, the date of the decision appealed from and the fact that the appellant appeals from such order must be filed with the industrial commission and with the court of common pleas within ~~sixty days after the date of the receipt of the decision appealed from or the date of receipt of the order of the commission refusing to permit further appeal~~the timeframes provided in paragraphs (B)(1) and (B)(2) of this rule.

~~(3)~~ (4) Such appeal or any other action filed from a decision of the industrial commission in a claim in which an award of compensation has been made shall not stay the payment of compensation under such award or payment of compensation for subsequent periods of total disability during the pendency of the appeal.

DRAFT - NOT FOR FILING

4123-3-20 Additional awards by reason of violations of specific safety requirements.

~~An application for an additional award of compensation founded upon the claim that the injury, occupational disease, or death resulted from the failure of the employer to comply with a specific requirement for the protection of health, lives, or safety of employees, must be filed, in duplicate, within two years of the injury, death, or inception of disability due to occupational disease. Such applications must be completed in the manner established by the industrial commission.~~ The determination of awards by reason of violation of specific safety requirements being within the exclusive jurisdiction of the industrial commission, such applications, if filed with the bureau, shall be referred~~, forthwith,~~ to the industrial commission for further consideration.

DRAFT - NOT FOR FILING

4123-3-22 Inspection of claim files.

(A) Authorizations for representation shall be in writing and signed by the authorizing party. When the authorization is on behalf of the employee, it shall be filed on an "~~Authorization of Representation of Injured Worker~~ Claimant Authorized Representative" form or equivalent. There shall be a separate authorization filed with the bureau for each claim to which the authorization is to extend. When the authorization is on behalf of the employer, a blanket authorization may be filed with the bureau.

(B) An authorization may be cancelled by the filing of a notice to that effect with the bureau or by filing a new authorization by another representative. In either event, the party should notify the former representative of the party's action.

(C) The inspection of claim files shall be limited to:

(1) The parties and/or their duly authorized representatives as outlined in paragraphs (A) and (B) of this rule;

(2) Any other person authorized, in writing, by either the employee or the employer; such authorization having been executed within one year prior to its use;

(3) Members of the general assembly when in the course of their duties as such;

(4) The governor, a select committee of the general assembly, a standing committee of the general assembly, the auditor of state, the attorney general, or the designee of any, in the pursuance of any duty imposed by Chapters 4121. and 4123. of the Revised Code.

(5) Duly authorized employees of governmental agencies whose official duties require the information contained in the claim files;

(6) Such other persons as are specifically authorized by a member of the commission or the administrator pursuant to the provisions of section 4123.88 of the Revised Code.

DRAFT - NOT FOR FILING

4123-3-31 Disabled workers' relief fund: claimant's payments.

(A) On and after August 22, 1986, all persons, without regard to date of injury, who are receiving compensation for permanent and total disability which, when combined with disability benefits received pursuant to the Social Security Act, is less than three hundred forty-two dollars per month adjusted annually as provided in division (B) of section 4123.62 of the Revised Code, shall be eligible to participate in the disabled workers' relief fund. For purposes of this rule, this amount shall be referred to as the "DWRF qualifying figure."

(B) Each person who has satisfied the requirements of paragraph (A) of this rule shall receive from the disabled workers' relief fund a monthly amount equal to either the difference between the DWRF qualifying figure and such amount as the person is receiving per month as disability benefits from the social security administration or the difference between the DWRF qualifying figure and such amount as the person is receiving under the workers' compensation laws for permanent total disability, whichever calculation results in the lower DWRF payment. ~~The following is an example of the computations to be performed pursuant to this rule.~~

~~$800.00~~	~~DWRF qualifying figure~~
~~- 400.00~~	~~permanent total disability benefits~~
~~$400.00~~	
~~$800.00~~	~~DWRF qualifying figure~~
~~- 300.00~~	~~disability social security benefits~~
~~$500.00~~	
~~$400.00 = DWRF payment~~	

(C) For purposes of this rule, in the case of individuals who have received a commutation of permanent total disability benefits pursuant to the provisions of section 4123.64 of the Revised Code, payments from the disabled workers' relief fund shall be calculated as if such commutation had not been made.

~~(D) This rule shall only apply to DWRF payments for August 22, 1986, and thereafter, and shall have no effect on DWRF payments for any periods prior to August 22, 1986.~~

DRAFT - NOT FOR FILING

4123-3-34 Settlement of state fund claims.

(A) The procedures of this rule shall apply to the settlement of state fund injury and occupational disease claims.

(B) The employer or the claimant shall file an application for approval of settlement agreement on the appropriate form with the administrator of workers' compensation. Each application shall include the signature of the claimant and the employer, except as follows:

(1) A claimant may file an application without an employer's signature in the following situations:

(a) The employer is no longer doing business in Ohio;

(b) The claim no longer is in the employer's industrial accident or occupational disease experience as provided in division (B) of section 4123.34 of the Revised Code and the claimant no longer is employed with that employer; or,

(c) The employer has failed to comply with section 4123.35 of the Revised Code.

(2) If a claimant files an application without an employer's signature, and the employer still is doing business in this state, the bureau shall send written notice of the application to the employer immediately upon receipt of the application. If the employer fails to respond to the notice within thirty days after the notice is sent, the application need not contain the employer's signature.

(C) Each settlement application shall:

(1) Include a list of the claim numbers and body parts affected in all claims filed by the claimant with the administrator of workers' compensation or the industrial commission.

(2) Set forth the reason the proposed full and final settlement is deemed desirable by the claimant and state the amount of the requested settlement.

(D) Settlement may be requested for a portion of a claim, one or more claims, or a combination of claims, provided that the claimant is not required to enter into a settlement agreement for every claim that has been filed with the bureau by the claimant.

(E) The administrator shall utilize whatever methods the administrator determines to be appropriate, consistent with general insurance principles, to evaluate a claim for settlement. When a settlement agreement has been approved by the administrator, a notice of approval shall be sent to the claimant, the employer, and their representatives, informing them of their rights to withdraw consent to the settlement agreement within thirty days. If written notice of the withdrawal of consent is not filed within the thirty day period, the settlement agreement is final. ~~An injured worker's~~ A claimant's refusal to endorse a settlement check issued as a result of an agreement reached pursuant to these procedures does not alter the finality of the settlement. The administrator may reopen a settled claim for purposes of conducting a fraud investigation.

(F) The administrator shall also send the notice of approval to the industrial commission within five days from the date of the bureau order of approval. The staff hearing officer shall determine, within the time set forth in paragraph (E) of this rule, whether the settlement agreement is or is not a gross miscarriage of justice. If the staff hearing officer determines within that time period that the settlement agreement is clearly unfair, the staff hearing officer shall issue an order disapproving the settlement agreement. If the staff hearing officer determines that the settlement agreement is not clearly unfair, or fails to act within the time limits, the

settlement agreement is approved.

(G) The effective date of the settlement is the date the notice of approval of settlement agreement is mailed. Once the thirty day waiting period has passed as set forth in paragraphs (E) and (F) of this rule, the agreed settlement shall be final and cannot be appealed to the industrial commission or to court.

(H) When a settlement application is filed in a claim in which an application for violation of specific safety requirement has been granted or is pending, the administrator shall refer the claim to the industrial commission for disposition of the application for violation of the specific safety requirement. If the application for the specific safety requirement has been granted and the employer is no longer doing business, or is otherwise not making the payments required by any award for violation of any specific safety requirement, the administrator may approve a final settlement without referring the claim to the industrial commission, provided the administrator identifies any settlement amounts that may be attributed to the award for violation of specific safety requirement. The administrator need not refer to the industrial commission any claim in which the ~~injured worker~~ claimant has voluntarily withdrawn an application for violation of a specific safety requirement, provided no portion of the settlement amount is attributed to any violation of a specific safety requirement.

(I) The administrator may offset settlement amounts due the claimant by overpayments owed by the claimant or, where the claimant is also an employer, unpaid premiums owed by a claimant, as the administrator determines appropriate.

(J) The representative's signature for either the claimant or the employer satisfies the requirements for paragraphs (B) and (C) of this rule. When required, the claimant's or employer's signature must be on one of the settlement application documents.

(K) A settled claim may be used as a defense to a claim for the same or similar conditions. A self-insuring employer shall not settle disabled workers' relief fund liability in state fund claims without the administrator's approval.

(L) An employer or claimant who files a notice of intent to settle authorized under section 4123.512 of the Revised Code shall file on the appropriate form with the administrator of workers' compensation prior to filing an application for approval of settlement agreement. If the opposing party does not object within fourteen days of receipt of the notice, the administrator will proceed with the settlement process under this rule.

DRAFT - NOT FOR FILING

4123-3-36 Immediate allowance and payment of medical bills in claims.

(A) In accordance with division (A) of section 4123.511 of the Revised Code the administrator has established a program to immediately allow specific medical conditions which have a historical record of being allowed whenever included in a claim and having low medical costs.

The medical conditions that the administrator has determined to be included in the program are indicated in the appendix to this rule.

~~(1)The administrator used historical statistical criteria to determine the appropriate specific medical conditions to include in the program. The criteria included but was not limited to the following:~~

~~(a) Number of claims for the medical condition;~~

~~(b) Per cent of claims for the medical condition disputed;~~

~~(c) Per cent of claims for the medical condition appealed;~~

~~(d) Per cent of claims for the medical condition disallowed; and~~

~~(e) Average cost for the medical condition per claim.~~

~~(2) The medical conditions that the administrator determined to be included are attached as appendix A to this rule.~~

(B) Upon the initial filing of a claim, the administrator shall investigate the claim and issue an order on the claim as required by section 4123.511 of the Revised Code. The administrator shall consider all of the necessary evidence and relevant laws and rules for the determination of the allowance of a claim. For any medical condition identified in appendix A to this rule, however, the administrator may grant immediate allowance of the medical condition and may make immediate payment of the medical bills relating to that condition, regardless of the receipt of the medical reports for that medical condition or the employer's certification of the claim.

(C) The employer retains the right to contest the immediate allowance and payment of a medical condition in a claim under this rule. If the employer appeals the allowance and payment and the claim is disallowed, the payment for the medical treatment provided prior to the date of the disallowance of that claim shall be charged to and paid from the surplus fund created under section 4123.34 of the Revised Code. The administrator shall not seek reimbursement of the payment from the ~~injured worker~~ claimant or the provider.

DRAFT - NOT FOR FILING

4123-3-37 Lump sum advancements.

(A) The administrator of the bureau of workers' compensation, under special circumstances, may commute an award of compensation to a lump sum payment when the administrator determines that the advancement is advisable for the purpose of providing the injured worker or the surviving spouse financial relief or for furthering the injured worker's rehabilitation.

(1) The bureau may grant a lump sum advancement to an injured worker only from an award of compensation made pursuant to section 4123.58 of the Revised Code or from division (A) or (B) of section 4123.57 of the Revised Code.

(2) The bureau may grant a lump sum advancement to a surviving spouse only from an award of death benefits made pursuant to section 4123.59 of the Revised Code. However, the advancement shall not exceed the amount of death benefits payable to the surviving spouse over a two-year period.

(3) The bureau shall not grant a lump sum advancement to a surviving dependent from an award of compensation made pursuant to division (B) of section 4123.57 of the Revised Code.

(4) The bureau shall not grant a lump sum advancement in a claim where the allowance of the award of compensation made pursuant to section 4123.58 of the Revised Code or from division (A) or (B) of section 4123.57 of the Revised Code is on appeal under section 4123.511 of the Revised Code or an appeal to court.

(5) The industrial commission has exclusive jurisdiction over an application for a lump sum advancement for the payment of attorney fees incurred in securing an award. The bureau shall refer such applications to the industrial commission to adjudicate.

(B) An injured worker or the surviving spouse shall file an application requesting a lump sum advancement with the bureau.

(1) The application shall be fully completed and notarized.

(a) The injured worker or surviving spouse shall provide proof that there are special circumstances for the lump sum advancement and that the lump sum advancement is advisable for the purpose of providing financial relief or for furthering the injured worker's rehabilitation.

(b) The bureau may dismiss an application for a lump sum advancement where the injured worker or surviving spouse has not provided proof of special circumstances and proof of financial relief or for furthering the injured worker's rehabilitation.

(2) The bureau shall review the application and utilize whatever methods the bureau determines to be appropriate, consistent with general insurance principles, to evaluate the claim for a lump sum advancement.

(3) For a lump sum advancement from an award of compensation made pursuant to section 4123.58 of the Revised Code or from an award of death benefits pursuant to section 4123.59 of the Revised Code, if the bureau determines that the lump sum advancement is advisable, the bureau shall calculate the net present value of the lump sum advancement on the remaining compensation payable to the injured worker or benefits payable to the spouse. The bureau shall determine the amount of the biweekly rate reduction

and the terms of such reduction. The administrator shall fix a specific time for the reduction of the biweekly rate of compensation to offset the lump sum advancement depending upon the time period that the injured worker or surviving spouse has selected for the offset of the lump sum advancement, when applicable. Once an injured worker or surviving spouse has selected a time period for the offset of the lump sum advancement, the injured worker or surviving spouse may not change the time period. The bureau shall include the net present value of the lump sum advancement in determining the reduction of the biweekly rate of compensation.

(4) For a lump sum advancement of an award made pursuant to division (A) or (B) of section 4123.57 of the Revised Code, if the bureau determines that the lump sum advancement is advisable, the bureau shall calculate the net present value of the lump sum advancement on the remaining weeks of compensation payable to the injured worker and in determining the amount to be paid to the injured worker for the lump sum advancement.

(5) In determining the net present value of a lump sum advancement, the bureau shall use the discount factor as periodically established by the bureau.

(6) The bureau shall issue an order approving or disapproving the application. If the bureau approves the application, the order shall advise the injured worker or surviving spouse of the amount of reduction of compensation and the terms of the lump sum advancement.

(C) Maximum rate reduction in compensation.

(1) No lump sum advancement shall be approved that will result in a rate reduction of more than one-third of the biweekly rate of compensation, except where the advancement is for compensation under division (A) or (B) of section 4123.57 of the Revised Code. The bureau shall not include an advancement for attorney's fees in accordance with section 4123.06 of the Revised Code in the calculation of the maximum rate reduction limitation.

(2) The bureau may approve no more than two concurrent lump sum advancements in a claim in addition to an advancement for attorney fees that the industrial commission has granted in accordance with section 4123.06 of the Revised Code.

(3) Upon the recoupment of the lump sum advancement in accordance with the terms of the order and agreement, the bureau shall remove the rate reduction due to the lump sum advancement and reinstate the injured worker's rate of compensation or the surviving spouse's benefits.

(D) The lump sum advancement warrant shall include the claimant or the surviving spouse as a payee, except where the warrant is for the payment of attorney's fees in accordance with section 4123.06 of the Revised Code, in which case the attorney shall be named as the only payee on the warrant.

DRAFT - NOT FOR FILING

4123-3-38 Surplus fund charge of qualified motor vehicle accident claims.

(A) Pursuant to section 4123.932 of the Revised Code and when an employer satisfies all of the requirements of this rule, the bureau shall charge to the surplus fund created under division (B) of section 4123.34 of the Revised Code any compensation and benefits related to a compensable workers' compensation claim based on a motor vehicle accident involving a third party. This rule applies only to claims arising on or after July 1, 2017.

(B) Eligibility requirements.

(1) This rule does not apply to self-insuring employers, state agencies, or a state institution of higher education, including its hospitals.

(2) This rule applies to private state fund employers and public employer taxing district employers that pay premiums into the state insurance fund.

(a) The employer must have had active workers' compensation coverage on the date of injury of the claim.

(b) The employer must be current with respect to all payments due the bureau, as defined in paragraph (A)(1)(b) of rule 4123-17-14 of the Administrative Code.

(c) The employer must be current on the payment schedule of any part-pay agreement into which it has entered for payment of premiums or assessment obligations.

(C) If an employer believes the bureau should charge a claim to the surplus fund under this rule, the employer may file an application with the bureau requesting the bureau determine whether the claim is to be charged to the surplus fund. The bureau will not review or consider charging a claim to the surplus fund under this rule unless the employer files an application in accordance with this rule.

(D) The employer's application to charge a claim to the surplus fund shall include all of the following:

(1) Evidence that the claim is based on a motor vehicle accident involving a third party. "Motor vehicle" has the same meaning as in section 4501.01 of the Revised Code.

(2) Evidence that the ~~third party involved in the motor vehicle accident was issued a citation for violation of any law or ordinance regulating the operation of a motor vehicle arising from the accident on which the claim is based. The employer does not need to prove that the third party was convicted of the citation.~~ following circumstances apply to the claim:

(a) **The third party involved in the motor vehicle accident was issued a citation for violation of any law or ordinance regulating the operation of a motor vehicle arising from the accident on which the claim is based. The employer does not need to prove that the third party was convicted of the citation.**

(i) The employer does not need to prove that the third party was convicted of the citation.

(ii) The employer does not need to prove that the insurance accepts complete liability for the motor vehicle accident, but only that the insurance accepts liability for some portion of the accident and pays costs associated therewith.

(b) If there is evidence that the third party was not issued a citation arising from the accident, the employer shall provide evidence that the third party involved in the motor vehicle accident was primarily liable for the accident on which the claim was based and that any form of insurance maintained by the third party or uninsured or underinsured motorist coverage as described in section 3937.18 of the Revised Code covers damages caused by the motor vehicle accident which gave rise to the claim.

(i) "Primarily liable" means that the third party involved in the motor vehicle accident is more than fifty per cent liable for purposes of section 2315.33 of the Revised Code.

(ii) The employer does not need to prove that the insurance accepts complete liability for the motor vehicle accident, but only that the insurance accepts primary liability for the accident and pays costs associated therewith.

~~(3) Evidence that any form of insurance maintained by the third party or uninsured or underinsured motorist coverage as described in section 3937.18 of the Revised Code covers damages caused by the motor vehicle accident which gave rise to the claim. The employer does not need to prove that the insurance accepts complete liability for the motor vehicle accident, but only that the insurance accepts liability for some portion of the accident and pays costs associated therewith.~~

(E) Within one hundred eighty days after the bureau receives the employer's application, the bureau shall determine whether the claim shall be charged to the surplus fund under this rule.

(1) If the bureau believes the employer has not provided all of the information necessary for the bureau to make the determination, the bureau shall contact the employer for the employer to provide the additional evidence required prior to denying an application.

(2) If the bureau determines that the employer failed to establish that the bureau should charge the claim to the surplus fund under this rule, the bureau shall deny the application with an explanation of the reasons for the denial.

(3) If the bureau fails to make a determination within the time required, the application shall be deemed approved and the bureau shall charge the claim to the surplus fund.

(F) If the bureau determines that the employer's claim shall be charged to the surplus fund created under division (B) of section 4123.34 of the Revised Code or if the application is deemed approved because the bureau failed to make a determination within the time provided for in paragraph (E) of this rule, the bureau shall charge all of the costs of the claim to the surplus fund.

(1) If the bureau previously included the costs of the claim in the calculation of the employer's experience in a prior policy year, the bureau shall adjust the employer's experience in the prior policy year, subject to the limitation provided in paragraph (F)(2) of this rule.

(2) In accordance with paragraph (C)(2) of rule 4123-17-17 of the Administrative Code, the bureau shall limit any adjustments in an employer's account which result in changes to the amount of premium due from an employer for a policy year to the annual or adjustment periods ending within twenty-four months immediately prior to the date the employer filed its application under this rule.

(G) The bureau's denial of an employer's application to charge a claim to the surplus fund under this rule is appealable to the adjudicating committee under section 4123.291 of the Revised Code.

DRAFT - NOT FOR FILING