DEP Disability Evaluators Panel HANDBOOK

Providing world-class medical examinations and file reviews for Ohio's injured workers and employers

Ohio | Bureau of Workers' Compensation

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Administrator/CEO **Sarah D. Morrison**

Ohio | Bureau of Workers' Compensation
30 W. Spring St.
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Chapter 1 Introduction and Definitions

Welcome to the Ohio Bureau of Workers' Compensation (BWC) Disability Evaluators Panel (DEP). The DEP handbook includes policies and documents DEP physicians (physicians) must acknowledge and follow. This handbook was created to assist DEP physicians in understanding the Ohio workers' compensation system, to set DEP expectations and to serve as a general reference. Questions regarding the DEP handbook, DEP Agreement or DEP expectations should be emailed to DEP Central at: dep@bwc.state.oh.us.

A. OHIO WORKERS' COMPENSATION SYSTEM

The Ohio workers' compensation system is managed by the Ohio Bureau of Workers' Compensation. As the administrative branch of the workers' compensation system, BWC manages claim activity, pays compensation and medical benefits, collects premiums from employers to provide workers' compensation coverage, and administers safety programs to prevent work-related accidents. The Industrial Commission of Ohio (IC) is the adjudicative branch of the workers' compensation system on all claims issues. It hears and decides contested claims issues and determines permanent total disability (PTD).

The BWC and the IC are distinct agencies governed by Ohio Revised Code (ORC) statutes and Ohio Administrative Code (OAC) rules. Headquarters for BWC and the IC are located in Columbus, Ohio. Both agencies maintain local customer service offices statewide.

*The primary legal principles guiding Ohio's workers' compensation system are the concepts of injury, compensability, and causality. As used in the Ohio Workers' Compensation Act, an **injury** must be caused by an external accidental means or be accidental in character and result, and must be received in the course of and arising out of the injured employee's employment.*

The workers' compensation system includes both state-fund and self-insuring employers. State-fund employers pay insurance premiums directly to BWC, which in turn pays indemnity compensation and medical benefits. Self-insuring employers manage their own workers' compensation claims and pay indemnity compensation and medical benefits directly. Ohio Law requires BWC and the IC to monitor self-insuring employers' workers' compensation programs.

B. DISABILITY EVALUATORS PANEL

Purpose: The DEP was established to provide quality, impartial medical examinations (examinations) and medical file reviews (file reviews) to support the claims management process. The DEP is comprised of doctors of medicine, doctors of osteopathy, doctors of chiropractic, doctors of podiatric medicine, doctors of dental surgery and psychologists.

Goal: The DEP's goal is to provide objective, accurate examinations and file reviews that produce concise, timely and justifiable reports that support the claims management process. This goal is consistent with the BWC mission: "To protect Ohio's workers and employers through the prevention, care and management of workplace injuries and illnesses at fair rates."

C. FILE REVIEWS AND EXAMINATIONS

DEP physicians review online and hard copy claim files in order to perform examinations and/or file reviews at the request of BWC and to meet legal requirements. A DEP physician's opinion is a valuable component of the claims management process; therefore, this responsibility must be performed impartially and thoroughly.

A DEP physician is responsible for notifying DEP Central any time the physician is unable to meet the obligation to complete an assigned DEP service (e.g., full schedule, vacation). When unable to complete examinations or

file reviews, the physician must notify BWC by email fourteen (14) days in advance and include the date when the physician can resume examinations and file reviews. DEP Central's email address is: dep@bwc.state.oh.us.

A key component of the DEP process is to ensure examination and file review reports are submitted in a timely manner. The chart below indicates the maximum amount of time from the date of the addendum request, examination date or file review request that the physician has to return a report. Should a physician need additional time to complete a report, the physician shall notify the representative who requested the service.

DEP Requested Service	Time frame (calendar days)
Addendum requests:	
Alternative Dispute Resolution (ADR)	2
All Other Addendum Requests	5
Examinations:	
ADR	5
%PPD, 90-day, 200-week, IME	10
File reviews:	
Medical, drug utilization, %PPD increase	5
Prior authorization	3

1. Addendum Requests

Occasionally, it may be necessary for BWC or the MCO to request a report addendum to clarify conflicting or vague statements, or if the report fails to provide all requested information. In cases in which BWC requests an addendum because of BWC error or because BWC is providing additional information it wants the physician to consider, the physician may bill for the addendum report.

In cases in which BWC or the MCO requests an addendum because of DEP physician error, (e.g., incomplete or illegible report, failure to adequately address all questions, etc) the physician may not bill for the addendum report.

2. Examinations

When an examination is necessary, an appointment will be scheduled. BWC will notify the injured worker, employer and their representatives via a letter of the date, time and place of the examination. An injured worker is normally given a 2-week notice of the examination appointment.

BWC will notify the physician of the date, time and type of examination and include the questions that the physician must address. To allow the physician to prepare for an examination, BWC provides all available, pertinent medical information to the physician in advance of the appointment.

An Examination DEP service consists of an examination of the injured worker and a review of medical records and other documents contained in the injured worker's claim file, report development and submission, and any consultation with BWC or the MCO.

Physicians can perform several types of examinations, which are summarized below. Additional details regarding examinations can be located in Chapter 4 of this Handbook:

a) Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability (%PPD)

A %PPD examination is an examination of an injured worker for the purpose of determining an initial percentage of whole person impairment as a result of the recognized allowed condition(s) in a workers' compensation claim.

A %PPD examination can also be for the purpose of determining if there is an increased percentage award due to the worsening of allowed conditions in the claim or as the result of an additional allowance being recognized in the claim.

b) 90-day and 200-week examinations

A 90-day examination is conducted once an injured worker has received 90-consecutive days of temporary total (TT) compensation. Similarly, a 200-week examination is conducted once an injured worker has received 200 consecutive weeks of TT. These examinations address issues including ongoing compensation, return-to-work barriers and potential solutions, the need for further medical treatment or supportive care, and vocational rehabilitation possibilities.

Most 90-day and 200-week examinations do not require additional diagnostic testing. If diagnostic testing is required, contact the referring party to obtain prior approval.

c) Independent Medical Examinations (IME)

IMEs are either requested by BWC to resolve claims management issues or are required by law for certain occupational diseases. The following are the various types of IMEs:

- Additional allowances (i.e., physical and/or psychological conditions or occupational diseases);
- Claim compensability (e.g., statutory occupational disease);
- Disability management;
- Extent of disability (EOD);
- Indemnity compensation (e.g., TT, wage loss);
- Substantial aggravation termination

d) Alternative Dispute Resolution (ADR) IME

An ADR IME provides additional medical information and/or expert medical opinions to assist in the claims management process when requested medical treatment is in dispute.

3. File Reviews

A File Review DEP service consists of reviewing medical records and other claim documents contained in the injured worker's claim file, report development and submission, and any consultation with BWC or the MCO.

Physicians can perform several types of file reviews, which are summarized below. Additional details regarding file reviews can be located in Chapter 3 of this Handbook.

a) Medical file reviews

A medical file review is a physician review of medical documentation in a claim file to render an impartial opinion on medical questions or issues in an injured worker's claim. Typical issues include appropriate diagnoses, causality and requests for additional allowances.

b) Drug utilization and prior authorization file reviews

A drug utilization review (DUR) is a review to determine if a drug or therapeutic class of drugs being reimbursed by BWC is reasonably related to the allowed conditions in the claim and is medically necessary, safe, and appropriate for treatment of the allowed conditions in the specific claim.

A prior authorization (PA) review is a review to determine if a drug(s) newly prescribed and not previously reimbursed by BWC is reasonably related to the allowed conditions in the claim and is medically necessary, safe and appropriate for treatment of the allowed condition(s).

c) Percent of Permanent Partial Disability (%PPD) Increase file reviews

A %PPD Increase file review is completed to render an impartial medical opinion on the amount of increase, if any, of the whole person impairment percentage above the amount previously determined in a claim. This review results from an application and medical records submitted by the injured worker due to a perceived worsening of allowed condition(s) in the claim, or additional allowances having been recognized in the claim.

D. QUALITY ASSURANCE

BWC nurses perform quality assurance reviews on examination and file review reports to ensure reports are clear, concise, unbiased and complete (i.e., answer with detail all examination and/or file review questions). Predetermined criteria are in place to ensure consistent application of BWC rules, policies, procedures and guidelines. Periodically, BWC's Chief Medical Officer or designee may conduct a review if a quality assurance issue arises.

Feedback on quality assurance issues will be provided to the physician along with recommendations for improvement should BWC identify any issues. If there are significant and/or repeated quality issues with no improvement demonstrated by the physician, BWC may suspend or terminate the physician's DEP Agreement with BWC.

E. BILLING AND REIMBURSEMENT

To be reimbursed, the physician's DEP services must be based on:

- A request for the service by BWC; and
- Completeness in responding to all questions specified in the request.

The amount of reimbursement is based on a fee schedule which can be found in Chapter 6 of this handbook. BWC reserves the right to modify the fee schedule and will give DEP physicians not less than thirty (30) days advance notice.

F. DEP AGREEMENT

The information and chapters contained in the DEP Handbook are incorporated into the DEP Agreement by reference as an appendix. DEP physicians shall comply with all additional requirements contained in the Handbook that are not in the Agreement.

In the event there is a conflict between the contents of this Handbook and the DEP Agreement, the terms and conditions of the agreement shall control.

G. QUESTIONS

Questions about DEP services, expectations, processes and/or reimbursement shall be referred either to DEP Central or BWC Provider Contact Center. All reports for examinations and file reviews shall be faxed to the BWC Customer Service fax number listed below.

BWC DEP Central Unit:
30 W. Spring Street
Columbus, OH 43215
dep@bwc.state.oh.us
Fax: 614-621-1138

BWC Customer Service:
Phone: 800-644-6292
Fax: 866-336-8352

BWC Provider Contact Center:
Phone: 800-644-6292 Option: 0, 3, 0

H. TERMS AND DEFINITIONS

Common terms and definitions that are used in the workers' compensation system can be found on our website by using the links below.

Injured worker glossary of terms: link to BWC web
Medical provider glossary of terms: link to BWC web

Chapter 2 Requirements and Expectations

The DEP process requires DEP physicians to have read, be aware of and adhere to BWC statutes, rules, policies, and customer expectations. In doing so, physicians will be able to efficiently provide DEP services and receive reimbursement.

A. REQUIREMENTS

All DEP physicians must be a BWC-certified provider. BWC assigns each certified provider an identification number that must be used when billing for DEP services. All physicians within a group practice must have an individual provider number. Physicians must immediately notify DEP Central of any changes to their enrollment status or office location(s).

1. **Criteria for Physicians:** Specific criteria must be met by applicants before BWC offers the physician an opportunity to sign a DEP Agreement. BWC-certified providers selected as DEP physicians are required to meet and maintain this criteria.

   Physicians accepted on the DEP serve at the pleasure of BWC and are independent contractors for the performance of DEP services. Once accepted, the DEP physician must continue to meet these criteria during the term of the DEP Agreement, and it is the physician's responsibility to notify BWC within thirty (30) calendar days of any changes that would affect his/her ability to meet these criteria.

   Prior to offering a potential physician a contract to provide DEP services, BWC reviews the applicant's credentials to ensure they have met specific criteria. These criteria include, but are not limited to the following:

   Required Criteria for DEP Applicants

   - Medical Doctor (M.D.), Doctor of Osteopathic (D.O.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D or PsyD), Doctor of Dental Surgery (D.D.S.), or Podiatrist (D.P.M.) licensed in Ohio or a state contiguous to Ohio;

   - Board certified as recognized by the following:

     - A doctor of medicine (M.D.) who has obtained board certification by a specialty board recognized by the American Board of Medical Specialists;

     - A doctor of osteopathic medicine (D.O.) who has obtained board certification by a specialty board recognized by the American Osteopathic Association;

     - A doctor of chiropractic (D.C.) who has obtained diplomate status in orthopedics, neurology, internal disorders, sports medicine, rehabilitation, or occupational health, as recognized by the American Chiropractic Association, or who have obtained the Diplomate of the American Chiropractic Academy of Neurology (D.A.C.A.N.);

     - A psychologist (Ph.D or PsyD) who has three (3) years clinical experience in health psychology or behavioral medicine or one (1) year post doctoral training and two (2) years clinical experience in health psychology of behavioral medicine;

     - A doctor of podiatric medicine (D.P.M.) who has obtained diplomate status, as recognized by the American Board of Podiatric Surgery; or

- A doctor of dental surgery (D.D.S.) who has obtained diplomate status, as recognized by the American Board of Oral and Maxillofacial Surgery.

- BWC-certified provider in the Health Partnership Program;

- Eligible to participate in Medicaid and Medicare programs without sanctions or restrictions by the Centers for Medicare and Medicaid Services (CMS), Ohio Department of Medicaid or other state equivalent;

- DEP Physician warrants and represents that he/she has not been suspended from professional practice or publicly reprimanded by a court or agency of competent jurisdiction within the past five (5) years; that he/she will provide notification to BWC of any criminal indictments, arrests, or convictions of the DEP Physician in any state or federal jurisdiction; that he/she will provide notification to BWC of any pending or prior medical malpractice suits and the outcomes of such suits against the DEP Physician in any state or federal jurisdiction; that he/she is, and for the duration of this Agreement shall be, in compliance with all licensing laws and regulations and with Ohio workers' compensation statutes and rules.

Once a physician has been approved to provide DEP services, it is the responsibility of the DEP physician to notify BWC of any change in their criteria status, as mentioned above. DEP Central Unit will review board certifications annually to ensure board certifications have not expired. If BWC does not receive documentation of renewal (typically a copy of the certificate), and determines during the annual review that the board certification has expired, the physician will be notified by letter of the lapse in board certification and the physician will be suspended from providing any DEP services.

If the DEP physician provides evidence (copy of recertification by the specific certification board) within three (3) months, the physician will be reinstated. If there is no evidence provided within three (3) months, the physician will be reinstated only after evidence of board certification and a new DEP Application has been submitted.

2. **Training for physicians** – Specific training requirements must be met to join the DEP and to maintain eligibility to receive examination and file review referrals. The required training is listed below along with additional details.

   Prior to providing the specific services below, physician applicants shall:

   - All DEP services: successfully complete BWC DEP Handbook/Agreement training;

   - %PPD examinations and file reviews: provide documentation of successful completion of eight (8) hours of training in the *AMA Guides to the Evaluation of Permanent Impairment* currently in use by BWC. Specific training requirements for psychology, vision and dental are listed below;

   - DUR file reviews: successfully complete BWC online training

   Current DEP physicians shall:

   - All DEP services: annually provide documentation of attendance of six (6) hours of workers' compensation related continuing education. This could include, but is not limited to training sponsored by BWC, training related to workplace injuries/illnesses or other BWC approved training opportunities **and**;

   - %PPD examinations and file reviews: every five (5) years provide documentation of successful completion of eight (8) hours of training in the *AMA Guides to the Evaluation of Permanent Impairment* currently in use by BWC. Specific training requirements for psychology, vision and dental are listed below.

%PPD training is not required for the following specialties: otolaryngologists, ophthalmologists, dermatologists, dentists, pulmonologists, cardiologists or internal medicine physicians who perform only %PPD examinations and/or file reviews.

Psychologists shall complete a minimum of four (4) hours of training specifically for psychological conditions in the *AMA Guides to the Evaluation of Permanent Impairment* currently in use by BWC prior to providing %PPD exam and file reviews and every five (5) years thereafter.

3. **Percent Permanent Partial Disability:** When performing impairment examinations, the document or text used by DEP physicians to assist in deriving or justifying impairment percentages must be the document or text adopted by BWC. This document or text shall be referenced in reports including citations to specific tables, figures, or page numbers, to assist reviewers in understanding the justification for the impairment rating.

   BWC has adopted the *AMA Guides to the Evaluation of Permanent Impairment 5th Edition*. DEP physicians shall use the 5th edition unless otherwise specified.

4. **DEP physicians as treating physicians:** To be considered an impartial evaluator, the DEP physician cannot have or will not have future benefit, financial or otherwise, in the care provided to the injured worker. Therefore, physicians conducting an examination of an injured worker on behalf of the BWC must not suggest that he/she will provide treatment to an injured worker in the future. Physicians may not accept the injured worker as a patient after conducting an examination of an injured worker on behalf of the BWC except with the written approval of the Administrator.

5. **Use of administrative agents:** DEP physicians are required to provide BWC with the name of any entity used for performing administrative functions for the DEP physician.

   The use of an administrative agent is not required, and the physician is not more or less likely to receive referrals from BWC as the result of his/her use of an administrative agent.

   Physicians can elect to designate an administrative agent to perform the billing of examinations or file reviews in his/her agreement with BWC. Reimbursement for services rendered is the same, regardless if the physician utilizes an administrative agent. BWC does not reimburse services provided by an administrative agent on behalf of a physician.

   BWC has no contractual relationship with any in-state administrative agents. Therefore, if examinations are to be scheduled through the physician's administrative agent, BWC must be notified in advance and be kept updated should the physician's administrative agent change.

   If the physician would prefer for reimbursements to go directly to the administrative agent, the physician must request BWC to do this. BWC, at its discretion, may make arrangements to pay the administrative agent directly.

   It is important to realize that BWC enters into a contract with the DEP physician, not the DEP physician's administrative agent. BWC holds DEP physicians responsible for the actions of their administrative agent. The DEP physician must complete Schedule B, Administrative Agent Authorization and Release, of the DEP Agreement which notifies BWC that an administrative agent has been selected. It is also the responsibility of the DEP physician to notify BWC (in writing signed by the DEP physician) if the administrative agent changes. This notification can be either by letter or by completing a new Schedule B Administrative Agent Authorization and Release.

   BWC selects DEP physicians to conduct examinations and file reviews; therefore, these functions cannot be delegated to the physician's administrative agent. If a physician is unable to perform a DEP service, the physician must notify the local BWC office so that BWC may select an alternate physician.

The following duties are the sole responsibility of the DEP physician and cannot be delegated to the administrative agent:

- Obtaining the history of the injured worker;
- Reviewing the medical records;
- Performing the physical examination;
- Performing the calculations to determine the impairment determination if required; and,
- Dictating and approving final report.

Administrative agents shall be limited to the following activities:

- Scheduling examinations with BWC;
- Transcribing the report
- Billing
- Supporting the physician with tasks such as: office space, office staff support, clerical support, assistance in managing the office, or providing an attendant.

6. **Non-BWC requested examinations and file reviews:** As part of the medical management of injured worker claims, MCOs may request examinations or file reviews. Additionally, employers, third-party administrators, or authorized representatives can also request examinations or file reviews. DEP physicians may perform these examinations if they choose (so long as they comply with the conflict of interest policy in section A.14 of this chapter, below); however, reimbursement is the responsibility of the party requesting the examination or file review. The physician and requesting entity are responsible for working out payment. BWC will not pay for any DEP services the BWC did not request; therefore, do not submit any bills to BWC unless the BWC requested those DEP services.

7. **Reports:** Narrative reports must meet BWC requirements. These requirements vary based on the type of service rendered.

   Occasionally, BWC requests addendum reports to clarify physician findings, outcomes and/or opinions, and to complete reports containing incomplete information. If an addendum is requested, it must be submitted to BWC based on the timeframe outlined in Chapter 1.

   Examination and file review reports are legal documents and cannot be altered or changed in any manner once submitted. All reports must be signed, dated, include the amount of time spent on the examination or file review and have the name of the physician typed or printed along with their signature. Those deemed illegible may be considered inadmissible as medical evidence in the claim and may not be reimbursed by BWC. An electronic capture (scanned copy) of the physician's signature is an acceptable equivalent to a signature, or signature stamp.

   The opinions and recommendations provided by DEP physicians in their reports are used by BWC personnel to resolve issues in an injured worker's claim. These decisions impact the claim in terms of delivery of medical services and compensation payments. Injured workers and their representatives, employers and their representatives, and physicians of record expect prompt resolution of these issues. DEP physicians shall follow the timeframes outlined in Chapter 1 for submission of examination and file review reports.

   Delinquent reports may be cause for suspension and/or removal from DEP.

8. **Concerns:** DEP Central will review all concerns received regarding a DEP physician. In most cases, a concern received by DEP Central is sent to the physician to obtain the physician's viewpoint. BWC closely monitors the number and nature of concerns lodged against a physician. In instances where a consistent pattern is determined, BWC reserves the right to suspend and/or remove a physician from the DEP.

   The physician and the appropriate investigating body will be notified of any concern alleging a serious breach of conduct or ethics. Appropriate action, up to and including removal from the DEP, will be initiated when circumstances warrant.

9. **Customer satisfaction surveys:** BWC may periodically conduct customer satisfaction surveys, either by telephone or by mail. BWC may conduct these surveys randomly or may request information from a specific number of injured workers. The surveys are conducted to gather input about the examination process from the perspective of the injured worker, to identify areas of the process that may be improved, and/or to determine the injured workers' level of satisfaction with the current program.

   Examples of issues that may be addressed include the purpose of the examination, understanding of the BWC referral letter, the BWC scheduling process, or the injured worker's experience at the examination. Examination site issues may include professional appearance of the office and demeanor of staff, time spent waiting to be seen, duration of examination, and explanation of the examination process.

   These surveys are important to BWC's customer satisfaction initiatives and to BWC's external customers. Physicians will be notified annually of the results of all customer satisfaction surveys. Any response or concern noted in the responses requiring immediate investigation will be sent to the physician as part of the DEP Written Concern Process.

10. **Physician selection criteria:** Physicians are selected to perform particular services based on the following criteria:

    - DEP services the physician has indicated he/she is willing to perform, as indicated on his/her application and Agreement.
    - The type of specialty necessary to address the issues and allowed/alleged conditions in a claim.
    - Availability of the physician and history of timely report submission.
    - For examinations, the physician's practice is within the coverage area of the injured worker. If there is not a physician that meets the needs of the injured workers' examination within a coverage area, then BWC may select a provider outside of that area.
    - The goal of BWC is to use as many DEP physicians as possible and will make every effort to schedule examinations and file reviews fairly and equitably.

11. **Bringing medical records and/or diagnostic studies to examinations:** The availability and review of medical records and diagnostic studies by physicians performing examinations is very important to the workers' compensation process. Medical records and diagnostic studies may provide additional information impacting the final conclusion of the physician. However, it is not possible for BWC or the physician to require an injured worker to bring medical records or diagnostic studies to their examinations.

    Periodically, injured workers may bring medical records and diagnostic studies to the examination. If the injured worker brings this information to the examination, the physician must note this and include an interpretation or review of the submitted information in his/her report.

12. **Attending and recording examinations:** During a medical examination requested by BWC or the MCO, the injured worker may choose to have a family member or friend present. If the injured worker is unable to communicate for any reason, an interpreter may be present at no cost to the injured worker or physician. Injured workers' legal or union representatives, employers/employers' representatives and

MCO's representatives may not be present during examinations. Audio or visual recording of examinations is not permitted, and electronic audio or visual recording equipment is not permitted in the examination room or during the examination.

13. **Injured worker appointments, cancellations, no-shows and rescheduling:** Physician selection and scheduling of the injured worker for a BWC authorized examination is the responsibility of BWC. Once scheduled, BWC forwards notices to all parties, including the DEP physician. The physician or his/her office staff may contact the injured worker to confirm the appointment. Physicians must contact the BWC office that requested the examinations when an appointment is rescheduled.

    If the injured worker fails to attend a scheduled examination (whether or not the injured worker was contacted or confirmed by the physician's office) the injured worker is considered a no-show. The BWC office may reschedule the injured worker with the same DEP physician within ten (10) days of the original examination.

    IMPORTANT: If an injured worker fails to appear for their examination, notify the individual at BWC or the MCO that scheduled the examination. DEP physicians shall NOT reschedule with the injured worker directly.

14. **Conflict of interest:** DEP physicians are independent contractors who must avoid conflicts of interest and potential biases when performing any DEP service for BWC. Situations creating conflict of interest include, but are not limited to, when the DEP physician:

    - Is in the injured worker's immediate family;
    - Works with a member of the injured worker's immediate family in the DEP physician's practice or clinic;
    - Is in the immediate family of the injured worker's treating physician/physician of record in the current claim;
    - Previously provided treatment to the injured worker as part of the current or another workers' compensation claim;
    - Performed an examination of the injured worker as part of the current or another workers' compensation claim for BWC, the IC, the employer, or the injured worker in the last 36 months.
    - Completed a file review of the injured worker's current or another workers' compensation claim within the last 12 months for the BWC, the injured worker, or the employer;
    - Is in the same practice or clinic with a provider described above;
    - Has a personal, professional, or contractual relationship with the MCO assigned to the current claim (however, merely being on an MCO's provider panel or network as a treating physician does not in and of itself disqualify a DEP physician from performing examinations or file reviews on injured workers assigned to the MCO);
    - Has a personal, professional or contractual relationship with the injured worker, employer or their representatives;
    - Is the medical director for the MCO managing the current claim, or is a member of the same practice or clinic with the medical director for the MCO managing the current claim; or
    - Has 5% or greater financial interest in the MCO managing the current claim.

    It is the responsibility of the DEP physician to decline to complete an examination or file review when a potential conflict of interest exists. When the DEP physician has identified a potential conflict of interest,

the physician will not examine the injured worker and will return the examination referral packet or file review to BWC with an explanation of the conflict. BWC will then reschedule the examination or file review with an impartial physician.

If a situation occurs that is not described above and the DEP physician believes there is an apparent or potential conflict of interest or an appearance of impropriety, the physician must notify DEP Central. BWC will make a final determination.

Examinations or file reviews of injured workers at the request of BWC are independent. No authorization for treatment of the injured worker is implied or given in BWC's request for a DEP service.

DEP physicians performing examinations for BWC or the MCO may not communicate with the injured worker other than during the examination. DEP physicians may not communicate with representatives of the injured worker or employer regarding the injured worker's claim.

15. **Confidentiality and ethics:** DEP physicians shall not include information obtained during the examination concerning unrelated or other sensitive medical conditions in the examination report without the injured worker's knowledge and consent. DEP physicians must adhere to laws pertaining to confidentiality of medical information, professional standards of conduct, and codes of ethics. Additional information can be obtained in Chapter 7 Policy A.

    Any improper use or access of BWC data by an officer, agent, employee, representative, subcontractor, or signee of the physician will result in the termination of that person's access as well as notification to that person's employer and to the physician. "Improper use or access" is defined as access or use that is not for a legitimate business purpose.

16. **Depositions and testimony:** Medical reports and file reviews, including the report findings and opinions of the DEP physicians, are included in claim files and are accessible by the injured worker, the employer, and authorized representatives for the parties, and other physicians (i.e., the physician of record and any treating physician). This information also may be used during an IC hearing. As a result, any party in the claim can request approval through the IC to depose a DEP physician. The party requesting a deposition is required to provide the reason for the request and to affirm that all costs of the deposition will be paid by the requesting party, including payment of a reasonable fee to the physician who is being deposed. The requesting party will establish the approximate time necessary for the deposition. The IC prohibits a pre-deposition conference between the DEP physician and any party to the claim.

B. EXPECTATIONS

1. **Physician conduct:** BWC wants to provide injured workers with quality, unbiased, professionally performed examinations. To accomplish this, professional communication and conduct between DEP physicians, their staff and injured workers are very important. These are particularly important because an injured worker may see the DEP physician in an adversarial manner and may misinterpret comments, gestures, or behavior by the physician or the staff.

2. **General guidelines for communication and conduct during examinations:**

    - Explain the purpose of the examination and examination procedures.
    - Inform the injured worker that BWC will receive and provide copies of the report to all parties in the claim, including the physician of record or treating physician.
    - Answer the injured worker's questions about the examination process.
    - Refer injured workers to their assigned BWC office regarding any questions about claim status or benefits.

- Refer any requests for medical advice outside the scope of the examination to the physician of record or treating physician.

- Refrain from any comments, gestures, or behavior which could be perceived as derogatory.

- Spend at least 15-20 minutes on average on %PPD examinations and 25-30 minutes on average for all other examinations.

- Provide appropriate gowning and draping during the examination.

- Provide an attendant of the same sex as the injured worker during the examination when the injured worker is the opposite sex from the examining physician and the examination requires the injured worker to disrobe or the physician to palpate the trunk (chest, abdomen, thoracic, lumbar or sacral spine, buttocks, hip, and pelvis), sexual and reproductive organs or rectum. The attendant is not required during the patient history or review.

- Document refusal of the injured worker to allow an attendant to be present during an examination.

- If an attendant of the same sex as the injured worker is not available, and the injured worker is willing to have an attendant of the opposite sex, obtain a signed waiver from the injured worker or document the injured worker's verbal permission for an attendant of the opposite sex to be present during the examination.

- Examination findings can be shared with the injured worker, but opinions or recommendations must be communicated in the examination report.

- At the completion of the examination, ask the injured worker if the injured worker wants to add any information.

3. Examination Sites: The examination site must be safe, clean, comfortable, and permanent. It must be in compliance with the Americans With Disabilities Act (ADA). Unsatisfactory examination sites include, but are not limited to, mobile vehicles and hotel or motel accommodations.

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Chapter 3 File Review Guidelines

A. INTRODUCTION

This chapter provides general guidelines and legal requirements that apply to file reviews requested by BWC. This chapter includes a blank copy of the BWC form necessary to complete each file review type. Physicians shall return the file review report within the timeframe outlined in Chapter 1.

B. GENERAL GUIDELINES

Training for performing specific file reviews may be obtained through the BWC Learning Center. Contact DEP Central for a link and instructions for accessing this training.

The DEP physician's role is to render an objective medical opinion that provides BWC with additional medical documentation to assist with claim determinations. The physician does not make legal decisions, such as allowing or denying the claim or condition, but provides medical evidence, recommendations, and opinions that are the basis for making legal decisions.

The following guidelines shall be followed when completing a file review:

- Consider and accept all allowed conditions in the claim;
- Consider and accept all disallowed conditions in the claim;
- Consider and accept the findings noted by any examining or treating physicians; however, BWC expects physicians to derive their own conclusions when rendering an opinion;
- The review, physician's opinion and file review report must be impartial;
- The physician's conclusion and opinion must be based on medical documentation in the claim file;
- The file review report shall list all claim and medical documentation reviewed and relied upon as the basis for the opinion/conclusion;
- The file review report shall document references, protocols, or treatment guidelines supporting the physician's conclusions in the report;
- Opinions shall be phrased in easily understood terms avoiding the use of medical and legal jargon;
- All questions posed shall be answered as directly as possible. A lack of medical evidence in the claim file shall be noted in the physician's opinion with identification of the medical evidence necessary to render an opinion;
- Responding with a yes or no to questions posed is important; however, there must be a narrative description included to substantiate the physician's opinion;
- Treatment recommendations and opinions shall be based on existing medical evidence;
- If a conclusion cannot be reached, the physician can suggest an Independent Medical Examination;
- All file review reports shall be:
    - Completed on the appropriate form;

- Accurate, comprehensive, typed, signed (including the physician's full name either typed or printed), and dated. Include professional credentials such as Board Certification that support the physician's credibility and expertise;
- Include the amount of time spent on the review, when applicable;
- Faxed to 1-866-336-8352 unless otherwise specified in the referral;
- Returned within the timeframe outlined in Chapter 1.

- Medical opinions regarding treatment requests must satisfy the requirements of *Miller v. IC*. The *Miller* case requires that a three-part test (i.e., medical necessity, relatedness and cost effectiveness) be met for treatments and services to be authorized in a workers' compensation claim. Link to Miller Case Criteria Policy

- The file review report is included in the claim file and can be accessed by the injured worker, employer and their authorized representatives;

C. FILE REVIEW TYPES

1. Medical File Review:

a) Definition: A medical file review is a physician review of medical documentation in a claim file to render an impartial opinion on medical questions or issues in a workers' compensation claim. Typical issues include appropriate diagnosis, causality and requests for additional allowances.

b) Typical issues that may require a medical file review include:
- Providing an opinion on causal relationship between a requested medical condition(s) and a workplace accident or illness. This causal relationship may be requested either during the initial investigation of a claim or during a subsequent additional allowance. See Chapter 7, Document I for additional discussion of causality;
- Determining if an alleged condition was pre-existing, and if so, establishing whether the industrial injury or occupational disease aggravated (for claims prior to 08/25/2006) or substantially aggravated (for claims on or after 08/25/2006) the pre-existing condition;
- Determining if the current medical condition or complaint is the result of an aggravation of the original injury, or whether a new and distinct injury has occurred;
- Confirming a medical diagnosis or condition based on medical records.
- Providing an opinion on claim reactivation.

2. Drug Utilization File Review:

a) Definition: A drug utilization review (DUR) is a review to determine if a drug or therapeutic class of drugs being reimbursed by BWC is reasonably related to the allowed conditions in the claim and is medically necessary, safe, and appropriate for treatment of the allowed conditions in the specific claim.

b) Specific guidelines: In addition to the file review general guidelines contained in this chapter, physicians performing DURs shall:
- Follow Ohio State Medical Board Guidelines particularly in regard to pain management (Ohio State Medical Board website: http://www.state.oh.us/med/rules);
- Consider widely accepted uses of medications in addition to FDA-approved indications of drugs for certain conditions;

- Focus on the therapeutic class of drugs and not the specific drug. Your opinion should be whether the therapeutic class of drugs is or is not appropriate;

- Complete the DUR within the timeframe listed in Chapter 1. If the DUR is not completed within the timeframe, the request will be cancelled and the DUR reassigned to another physician;

- If the physician believes there is blatant misuse of narcotics, such as prescribing excessively high quantities or receipt of narcotic prescriptions from multiple claims to the extent that the cumulative would exceed the usual dose limit, the reviewer should notify the requesting party of the concern;

- Indicate when consideration should be given to tapering a drug class or when consideration should be given to a detoxification program; however, because BWC provides in rule for specific tapering schedules for benzodiazepines and opioids, do not list weaning periods for either of these two drug classes.

  https://www.bwc.ohio.gov/downloads/blankpdf/OAC4123-6-21.5.pdf
  https://www.bwc.ohio.gov/downloads/blankpdf/OAC4123-6-21.5Appendix.pdf

- Do not recommend substitution of the drug with another drug. Opinions shall only be whether the class of drug is appropriate;

- For a given injured worker, the physician may be asked to review several claims at one time. Each claim requires a separate DUR to be completed.

3. Prior Authorization File Review:

Definition: Prior authorization (PA) review is a review to determine if a drug(s) newly prescribed and not previously reimbursed by BWC is reasonably related to the allowed conditions in the claim and is medically necessary, safe and appropriate for treatment of the allowed condition(s).

A PA request shall be completed within the timeframe listed in Chapter 1. If the PA is not completed within the timeframe, the request will be cancelled and the PA reassigned to another physician;

4. Percentage of Permanent Partial Disability Increase File Review:

a) Definition: A Percent of Permanent Partial Disability (%PPD) Increase file review is completed to render an impartial medical opinion on the amount of increase, if any, of the whole person impairment percentage above the amount previously determined for a claim's allowed condition(s). This review results from an application and medical records submitted by the injured worker due to a perceived worsening of allowed condition(s) in the claim, or additional allowances having been recognized in the claim.

b) Typical issues addressed in a %PPD file review include:
   - Estimating the percentage of whole person impairment and noting any change from a previous award. These awards are based on the allowed condition(s) in the claim. When the injured worker files the application, the injured worker must submit supporting medical evidence that establishes the worsening of an already allowed condition or provides an impairment rating based on an additional condition being recognized in the claim.

   - This file review may also be required in a situation where the injured worker has had prior claims with impairment determination involving the same body part(s) as those in the current claim. For example, an injured worker with a lumbar strain presenting for an impairment examination in 2014 for a 2012 claim may have had a prior claim in 2007 and received a permanent partial impairment award in 2010. Awarding additional impairment without

consideration of prior awards may lead to cumulative impairments far exceeding the actual impairment present at the time of the evaluation.

- The purpose of this review is to compare the findings and results of previous examinations to the current claim examination to determine the percent of additional impairment of the body part, if any, as a result of the specific injury in the current claim.

- Other issues such as confirmation of diagnosis, causal relationship of the alleged diagnosis to the work-related injury, determination of maximum medical improvement (MMI), or opinions regarding further treatment are not to be addressed. The physician only provides an unbiased, objective medical opinion on the amount of increase to be awarded, if any. If the physician cannot make a determination or if there are inconsistencies in the medical evidence, an examination can be recommended.

c) Specific guidelines: In addition to the file review general guidelines contained in this chapter, physicians performing a %PPD increase file review shall:

- Limit their opinions to the conditions and the associated body part(s) allowed in the claim.

- Use the edition of the AMA's *Guides to the Evaluation of Permanent Impairment* currently in use by BWC to justify their conclusions. Tables and page numbers shall be noted in the file review report.

- Indicate an independent conclusion as to the amount of impairment accepting existing findings of examining and/or treating physicians. These conclusions shall be supported by the AMA's *Guides to the Evaluation of Permanent Impairment* currently adopted by BWC.

D. WRITTEN REPORTS

There is a standard report format that shall be used for all file reviews. The report formats are:

- Medical File Review: MEDCO-21 *Physician Review*

- Drug Utilization Review:
  - MEDCO-34 *Managed Care Organization (MCO) Request for Drug Utilization Review (DUR)*
  - MEDCO-22 *Medication Physician Review*

- Prior Authorization Review: MEDCO-22 *Medication Physician Review*

- Percentage of Permanent Partial Disability Increase Review: C-253 *Report of %PPD Increase Medical File Review*

The top portion of each form will be completed prior to the file review request sent to the physician. The physician shall complete all sections of the form completely and answer all questions posed with details to support the conclusions.

Once completed and signed, the physician must not alter the written opinion. If an error is made in the initial writing of the report, draw a single line through the error and write "error" above it with the physician's initials and date.

If a physician is asked by BWC or the MCO to clarify the review, a second form shall be completed to answer any outstanding questions and/or to provide clarification.

DEP physicians' reports are frequently used in IC hearings and must be legible. If the report is illegible, it **may be excluded** as evidence in the hearing process and may not be reimbursed by BWC.

Standards for non-examining physicians who express an opinion from review of the record: When performing a file review, indicate which reports have been considered, and that the findings demonstrated in the reports of the examining or treating physicians are being accepted.

The Supreme Court has held that a physician who reviews the medical record without conducting an examination of the injured worker is required to expressly accept all the findings of the examining physicians, but not their opinions. The Supreme Court also has held that reviewing physicians are required to consider and note all medical reports on record that may be relevant to the issue that is the subject of the review.

Authority

In *State ex rel. Wallace v. Indus. Comm*., 57 Ohio St.2d 55, 59 (1979) the Supreme Court stated*:*

"Applying the analogy to the hypothetical question, it follows that the non-examining physician is required to expressly accept all the findings of the examining physicians, but not the opinion drawn there from. If a non-examining physician fails to accept the findings of the doctors or assumes the role of the Industrial Commission, the medical opinion that is rendered does not constitute evidence to support a subsequent order of the commission."

Additionally, in *State ex rel. Bowie v. Greater Cleveland Regional Transit Auth.*, 75 Ohio St.3d 458, 460 (1996) the Supreme Court stated:

"We find it imperative, for example, that the doctor review all of the relevant medical evidence generated prior to that time."

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Chapter 4 Examination Guidelines

A. INTRODUCTION

This chapter provides general guidelines and legal requirements that apply to examinations requested by BWC. This chapter includes sample report formats for each examination type. DEP physicians shall return the examination report within the timeframe outlined in Chapter 1.

B. GENERAL GUIDELINES

The DEP physician's role is to render an objective medical opinion that provides BWC with additional medical documentation to assist with the claim management process. The physician does not make legal decisions, such as allowing or denying the claim or condition, but provides medical evidence, recommendations, and opinions that are the basis for making legal decisions.

Examinations consist of reviewing medical records, obtaining a history, performing an examination, generating conclusions and responses to specific questions noted in the referral letter for the examination, and submitting a report justifying conclusions and opinions.

The following guidelines shall be followed when completing an examination:

- Consider and accept all allowed conditions in the claim;
- Consider and accept all disallowed conditions in the claim;
- If a physician is unable to accept the allowed and/or disallowed conditions or unable to complete the examination, immediately contact DEP Central;
- Consider and accept the findings noted by any examining or treating physicians; however, BWC expects the physician to derive his/her own conclusions when rendering an opinion;
- All medical records may not be available and, therefore, may not be provided for the examination. Contact the referring party if you believe there are missing documents that are important for the examination and report;
- If the injured worker brings x-rays or other medical documents to the examination, review and note that in the report;
- Submit with the report the results of any diagnostic tests performed as part of the examination;
- The examination, physician's opinion and examination report must be impartial;
- The physician's conclusion and opinion must be based on the history, physical examination and medical documentation available at the time of the examination;
- The examination report shall document references, protocols, or treatment guidelines supporting the physician's conclusions in the report;
- Opinions shall be phrased in easily understood terms avoiding the use of medical and legal jargon;
- All questions posed shall be answered as directly as possible. A lack of medical evidence in the claim file shall be noted in the physician's opinion with identification of the medical evidence necessary to render an opinion;

- Responding with a yes or no to questions posed is important; however, there must be a narrative description included to substantiate the physician's opinion;

- Treatment recommendations and opinions shall be based on existing medical evidence;

- All examination reports shall be:

    - Accurate, comprehensive, typed, signed (including the physician's full name either typed or printed), and dated. Include professional credentials, such as Board Certification, that support the physician's credibility and expertise;

    - Include the injured worker's name and claim number on each page of the report;

    - Faxed to 1-866-336-8352 unless otherwise specified in the referral;

    - Returned within the timeframe outlined in Chapter 1.

- The examination report is included in the claim file and can be accessed by the injured worker, employer, and their authorized representatives;

- Reference Chapter 6, Section B, for examination no-show or cancellation expectations;

- As part of the examination process, you will be asked to document the amount of time you spend preparing for an examination and the time you spend conducting the examination;

- Organizations other than BWC and MCOs may request examinations as part of the workers' compensation system. The DEP Handbook does not apply to examinations requested by these organizations. BWC only reimburses for examinations requested by BWC. DEP physicians are encouraged to perform examinations for other organizations; however, invoices for those services shall be billed directly to the requesting organization.

C. EXAMINATIONS TYPES

1. Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability (%PPD)

a) Definition: A %PPD examination is an examination of an injured worker for the purpose of determining an initial percentage of whole person impairment as a result of the recognized allowed condition(s) in a workers' compensation claim.

A %PPD examination can also be for the purpose of determining if there is an increased percentage award due to the worsening of allowed conditions in the claim or as the result of additional allowances being recognized in the claim.

b) Typical issues addressed in a %PPD examination:

- The only issue to be addressed in a %PPD examination is the initial or increased percentage of whole person impairment sustained by the injured worker due to the allowed conditions in the claim that were a result of the work-related injury or illness.

- The following issues shall not be addressed in a %PPD examination:
    - Confirmation of the diagnoses;
    - Opinion on causal relationship;
    - Determination of maximum medical improvement;
    - Recommendations for further treatment options;
    - Recommendations for additional conditions.

c) Specific guidelines: In addition to the examination guidelines contained in this chapter, physicians performing %PPD examinations shall:

- List all claim and medical documents reviewed and relied upon as the basis for the opinion/conclusion;
- Limit the examination to the body part(s) recognized in the allowed condition(s) in the claim, or for which the examination was requested;
- Address all allowed condition(s) in the claim, even if the impairment is 0 percent;
- If performing a specialty only examination, address all allowed conditions pertaining to that specialty in the report;
- Use the edition of the AMA's *Guides to the Evaluation of Permanent Impairment* currently in use by BWC to justify their conclusions. Note tables and page numbers used in forming the opinion in the examination report;
- Use the AMA's *Guides to the Evaluation of Permanent Impairment* correctly, particularly noting that certain tables prohibit use of other tables or methods;
- Indicate in the report the actual numeric values of measurements, such as range of motion, performed;
- Correctly perform adding, converting and combining according to the AMA's *Guides to the Evaluation of Permanent Impairment*;
- Refer to or request x-rays when appropriate, as detailed in Chapter 7, Policy C;
- Use the AMA *Guides to the Evaluation of Permanent Impairment*, 5th Edition as the basis for determining impairment. In Chapter 7 are important documents regarding impairment determination for visual loss, mental health and pain which do not follow the 5th Edition;
- If conditions and their associated body parts are identified that are not allowed in the claim, limit the impairment percentage to the best estimate of the allowed condition(s). State in the report that there are additional conditions or diagnoses that are not recognized as allowed conditions in the claim;
- If a condition or finding that would benefit from further examination is identified, discuss this in an addendum paragraph in the report.

d) Special situations: DEP physicians may occasionally receive requests for residual effects or loss of use examination. Residual effects and loss or loss of use examination are performed to determine if an injured worker, as a result of an industrial injury or disease, has either significant on-going symptoms or body parts that are severely restricted functionally.

Residual effects
The %PPD examination for residual effects is used to evaluate an injured worker's condition to justify compensation to the injured worker. This examination also is used to evaluate a permanent partial (scheduled loss) award, which is based on statutory requirements.

The examination considers factors other than the impairment factors considered in the *AMA's Guides to the Evaluation of Permanent Impairment*. These factors may include how the current symptoms, limitations, or difficulties impact the injured worker. Frequently these claims involve amputation of part of the limb or the whole limb.

For example, an injured worker with an amputation at the forearm is granted a loss of use award. Later, the injured worker files for residual effects of the amputation due to the continued *symptoms of pain hypersensitivity, swelling, or breakdown of skin*. The physician is asked to evaluate the injured worker and submit a report. The report should document the symptoms including severity, frequency, treatment, and other important factors regarding the loss addressed by the injured worker; an examination of the injured worker; and an impairment percentage for these symptoms.

This percentage is the physician's best opinion of the percent impairment based on the history, examination, or other information provided. The AMA's *Guides to the Evaluation of Permanent Impairment* may be referenced to justify why the estimated percentage is appropriate. This percentage should be noted in the physician's report as the percentage for residual effects. The impairment percentage for residual effects does not include the amputation impairment and the impairment for the amputation should not be included in the report. It should be noted that the criteria for residual effects may be identical to those used for "pain" impairment in AMA Guides, 5th edition.

Loss or Loss of use

These awards are generally for amputation, loss of vision, loss of hearing or facial disfigurement. The examination is used to document whether an injured worker has sustained a loss or loss of use of a body part from the work-related injury. The examining physician should state if there is loss or loss of use. If there is not loss or loss of use at the time of the examination, the physician should state the extent of loss and provide a whole person impairment percentage in accordance with the edition of the AMA's *Guides to the Evaluation of Permanent Impairment* currently in use by BWC.

"Loss of use" examination is the result of scheduled loss awards to the injured worker as provided in the Ohio Revised Code 4123.57(B). The awards are for loss of or loss of use of a body part prior to treatment. Ankylosis may be considered if the ankylosis is total stiffness or contractures due to scars or injuries which make any of the fingers, thumbs, or parts of either useless.

2. 90-Day and 200-Week Examinations

a) Definition: A 90-day examination is conducted once an injured worker has received 90-consecutive days of TT compensation. Similarly, a 200-week examination is conducted once an injured worker has received 200 consecutive weeks of TT compensation. These examinations address issues including ongoing compensation, return-to-work barriers and potential solutions, the need for further medical treatment or supportive care, and vocational rehabilitation possibilities.

Most 90-day and 200-week examinations do not require additional diagnostic testing. If diagnostic testing is required, contact the referring party to obtain prior approval.

b) Ohio law identifies the primary issues addressed in 90-day and 200-week examinations as:

- Extent of disability/ maximum medical improvement;
- The injured worker's continued entitlement to temporary total compensation;
- Vocational Rehabilitation potential;
- Appropriateness of the medical treatment;
- Alternative treatment options to be considered.

c) Specific guidelines: In addition to the examination guidelines contained in this chapter, physicians performing 90-day and 200-week examinations shall:

- Describe the type of treatment to be considered if a treatment plan is suggested, list duration and frequency of treatment, and expected outcomes;
- Note any medical conditions that may interfere with employment. If the injured worker is unable to return to work (RTW), document which medical condition(s) prohibits RTW and whether the medical condition(s) is allowed in the claim;
- Describe any physical limitations that restrict or prevent the injured worker from returning to his or her former position of employment;
- Comment on the ability of the injured worker to perform the activities of his or her job. This will be helpful in assessing factors preventing RTW;
- Determine if maximum medical improvement has been reached and, if not, when a repeat examination should be considered;
- Consider vocational rehabilitation possibilities if, in your opinion, it would assist with RTW.

3. Independent Medical Examination (IME)

a) Definition: An IME provides BWC with additional medical information and/or expert medical opinions to assist in the claims management process.

b) Typical issues addressed in an IME include:

- Determination of an initial diagnosis or medical justification of an additional claim allowance;
- Causal relationship between the original injury and the alleged condition;
- Appropriateness and/or necessity of the proposed or ongoing medical or psychological health treatment;
- Other medical or indemnity issues identified in the claims management process.
- Ohio Revised Code 4123.68 requires that BWC (prior to awarding compensation) perform an IME to obtain a medical opinion regarding the diagnosis, extent of disability, and other pertinent medical questions connected with the claim for the following occupational diseases:
    - Berylliosis;
    - Asbestosis;
    - Silicosis;
    - Coal miner's pneumoconiosis;
    - Firefighter or police officer filling for cardiovascular or pulmonary diseases;
    - Any other occupational diseases of the respiratory tract resulting from injurious exposure to dust.

4. Alternative Dispute Resolution (ADR) IME

a) Definition: An ADR IME provides additional medical information and/or expert medical opinions to assist in the claims management process when requested medical treatment is in dispute.

b) Typical issues addressed in an ADR IME include:

- The medical necessity or appropriateness of requested medical treatment by a provider and for which authorization for payment was either approved or denied by the MCO;

- Recommendation of alternative treatment options based on best practice medical care

c) Specific guidelines: In addition to the examination guidelines contained in this chapter, physicians performing ADR IMEs shall:

- Have an examination appointment available within 7 calendar days of the request;
- Fax the ADR IME report within 5 calendar days of examination to the MCO that requested the examination;
- Focus on the allowed conditions in the claim and the treatment issues in dispute within the ADR examination report;
- ADR IMEs must address the *Miller Criteria* (reasonably related to the allowed conditions, reasonably necessary for treatment of the allowed conditions, and costs are medically reasonable) in recommendations regarding whether services are medically necessary and appropriate. Link to Miller Case Criteria Policy
- Justify opinions and conclusions by providing specific citations to treatment guidelines (accepted by BWC), peer-reviewed literature, and specialty position statements. Explain how these documents apply to the specific claim;
- ADR IMEs normally do not require additional diagnostic testing. If additional testing is needed, prior approval shall be obtained from the referring party.
- ADR IMEs are a stand-alone examination and may not be combined with any other DEP service.

5. Psychological Examinations

a) Definition: Although psychological examinations follow the guidelines described in this chapter, given the nature of the issues, they present unique circumstances and there is no specific type of psychological examination that would address each circumstance. Therefore, depending on the issues, the psychological examination may be completed as a %PPD, an IME, or an ADR IME.

Be aware that the physician could be asked to examine the IW in multiple claims. Therefore, BWC has developed a policy and special procedures for the situation.

b) Typical issues addressed in a psychological IME are the same as the other examination types listed in this chapter.

c) Specific guidelines: In addition to the examinations guidelines contained in this chapter, physicians performing psychological examinations shall:

- Inform the injured worker that BWC will receive and provide copies of the report to all parties in the claim, including the physician of record or treating physician;
- Base conclusions on the history from the injured worker, mental and/or physical examination of the injured worker, and medical records that are available at the time of examination;
- Rely on any diagnostic testing already performed; however, for examinations being conducted to determine claim allowance or %PPD, the physician may perform a diagnostic test if, in his/her opinion, the test may provide significant evidence to assist in supporting conclusions and responses to issues to be addressed in the examination;

- If a diagnostic study is performed, submit a complete copy of the test results, a copy of the interpretation of the test, and the physician's summary or comments correlating the interpretation of the test with his/her interview and examination of the injured worker with the IME report. BWC and/or other physicians may review diagnostic tests and the reports later in the claim management process;

- Explain and justify opinions and conclusions by providing specific citations to diagnostic criteria, treatment guidelines, peer –reviewed literature, or specialty position statements.

d) Psychological %PPD Examinations – Additional Information

Like other %PPD examinations, those for psychological conditions should consist of a history, review of medical records, summary of treatment with results of treatment, current status of the injured worker, and a mental health examination. The mental health examination should focus on the allowed conditions in the claim and be performed at least to the extent as described in the edition of the *AMA's Guides to the Evaluation of Permanent Impairment* currently in use by BWC.

BWC has adopted the *AMA Guides to the Evaluation of Permanent Impairment, 5th edition*. While this edition of the Guides does not provide impairment percentages for mental or behavioral disorders, the Ohio workers' compensation system requires that a percentage of whole person impairment be provided for each claim of the injured worker when the injured worker applies for this benefit. Therefore, it is required that the physician provide a percentage.

To assist physicians in deriving their impairment percentages, BWC and the IC developed "Percentage of Permanent Partial (%PPD) Impairment for Mental and Behavioral Disorders in the Ohio Workers' Compensation System" based on AMA Guides 4th edition and 5th edition. This document can be found in Chapter 7, Document E.

D. BWC REQUEST FOR REPORT ADDENDUM

Occasionally, it may be necessary for BWC or the MCO to request a report addendum to clarify conflicting or vague statements, if the report fails to provide the requested information, or because BWC or the MCO is providing additional information it wants the physician to consider.

Physicians shall provide a written addendum letter or report within the time frame listed in Chapter 1. Failure to respond within this timeframe may result in suspension or termination of the physician's DEP Agreement.

E. WRITTEN REPORTS

All examination reports shall contain the following data elements in the top portion of the report:

- Injured worker name;
- BWC claim number;
- Date of injury;
- Allowed conditions;
- Disallowed conditions;
- Date of examination; and
- Type of examination

The body of the examination report may differ for each type of examination so a sample report is provided below.

%PPD Examination Report

MEDICAL HISTORY: (history provided by patient including mechanism of injury, treatment and response to treatment, and current status including symptoms, limitations, and current treatment):
REVIEW OF MEDICAL RECORDS: (summary of pertinent medical records provided, including initial examination, report of injury, diagnostic studies; operative reports; consultation reports. This should not include prior impairment examinations):
REVIEW OF MEDICAL RECORDS OR XRAYS BROUGHT IN BY INJURED WORKER:
PHYSICAL EXAMINATION FOCUSED TO THE ALLOWED CONDITIONS: (this should be thorough and consistent with AMA Guides.)
DIAGNOSIS: (physicians impression of conditions)
DISCUSSION: (discuss the allowed condition, treatment, and limitations impacting the injured worker, including return to work and activities of daily living. Discuss any non-allowed condition or other conditions identified during the examination that should be addressed.
IMPAIRMENT PERCENT- AMA GUIDES: (Discussion of derivation of impairment percent for each allowed condition in the claim citing specific tables or pages in the latest edition of the AMA Guides)
FINAL WHOLE PERSON IMPAIRMENT PERCENT FOR ALLOWED CONDITIONS:
I have not provided care for this patient. I have seen this patient one time on _____ for the purpose of evaluating medical impairment. Examination was focused to the allowed condition(s) listed above. (Optional: Present during the examination was _____ of my office staff) Include the amount of time spent preparing for an examination and the time spent conducting the examination

_____ _____

Signature of Physician Date

_____

Printed Name of Physician

90-Day or 200-Week Examination Report & IME Examination Report

PURPOSE OF EXAMINATION: (specify why the examination was requested)
MEDICAL HISTORY: (History provided by patient including mechanism of injury, treatment and response to treatment, and current status including symptoms, limitations, current treatment, and any further planned treatment.)
REVIEW OF MEDICAL RECORDS PROVIDED: (Summary of pertinent medical records provided including initial evaluations; report of injury; diagnostic studies; operative reports; consultation reports; rehabilitation reports.)
REVIEW OF X-RAYS OR MEDICAL RECORDS PROVIDED BY THE INJURED WORKER:
PHYSICAL EXAMINATION: (this should be thorough and consistent with examinations performed by peers within the physician's specialty.)
DIAGNOSIS: (physician's impression of conditions).
DISCUSSION: (Discuss the allowed conditions, treatments, and limitations as impacting the injured worker, including return to work and the activities of daily living. Discuss any non-allowed conditions or other conditions identified during the evaluation that may impede or prolong temporary disabilities.)
RESPONSES TO QUESTIONS FORWARDED ON REFERRAL LETTER FROM BWC: (respond to each question noted in the BWC referral letter. Fully explain opinions and justify conclusions, citing treatment guidelines, position papers, or widely accepted peer review documents.)
I have not provided care for this patient. I have seen this patient one time on _____ for the purpose of an independent medical evaluation. The opinions expressed are based solely on the information provided and cited above. (Optional: Present during the examination was ____ of my office staff.) Include the amount of time spent preparing for an examination and the time spent conducting the examination

_____ _____

Signature of physician Date

_____

Printed Name of physician

ADR IME Report

ISSUE(S) OF DISPUTE: (State the issue that initiated the ADR process)
MEDICAL HISTORY: (History provided by patient including mechanism of injury, treatment and response to treatment, and current status including symptoms, limitations, current treatment, and any further planned treatment.)
REVIEW OF MEDICAL RECORDS PROVIDED: Summary of pertinent medical records provided including initial evaluations: report of injury; diagnostic studies; operative reports; consultation reports; rehabilitation reports.)
REVIEW OF XRAYS OR MEDICAL RECORDS BROUGHT BY INJURED WORKER:
PHYSICAL EXAMINATION:
DIAGNOSTIC STUDIES PERFORMED AND RESULTS:
DIAGNOSIS:
DISCUSSION:
RESPONSES TO QUESTIONS FORWARDED ON REFERRAL LETTER FROM BWC: (somewhere on this report Miller criteria must be addressed.)
I have not provided care for this patient. I have seen this patient one time on _____for the purpose of an independent medical evaluation. The opinions expressed are based solely on the information provided and cited above (Optional: Present during the examination was _____ of my office staff.) Include the amount of time spent preparing for an examination and the time spent conducting the examination

_____ _____

Signature of Physician Date:

_____

Printed Name of Physician

Ohio | Bureau of Workers' Compensation
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Chapter 5 Key Concepts

A. INTRODUCTION

To function effectively in the Ohio workers' compensation system, it is necessary to understand claims management practices and concepts, as well as legal requirements. Two key resources containing system-specific information are:

- *Ohio Industrial Commission and Bureau of Workers' Compensation Laws*
- *Ohio Industrial Commission and Bureau of Workers' Compensation Rules*

These reference manuals can be accessed via www.bwc.ohio.gov under **BWC LIBRARY**, then **Rules, statutes and executive orders** or by clicking on the following link.

This chapter cannot replace these reference manuals, but will highlight laws and rules, and will cite pertinent court cases governing the Ohio workers' compensation system. Understanding this information is essential in adequately performing, and responding appropriately to questions posed in, examinations and file reviews.

B. CLAIMS MANAGEMENT

1. Filling a claim:

Ohio workers' compensation law allows any employee injured in the course of and arising out of employment to file a claim. This legal provision not only covers injuries, but also occupational diseases contracted in the course of and arising out of employment.

Claims are classified as either medical-only (the injured worker is eligible only for medical benefits) or lost-time (the injured worker is eligible for medical benefits and compensation). A claim is classified as a medical-only when seven or fewer days from work are lost due to an occupational injury or disease. A claim is classified as lost time when eight or more days of work have been lost due to an occupational injury or disease.

The statute of limitations for filing workers' compensation claims in Ohio is two years from the date of injury. For occupational disease claims, claims must be filed within two years from the date when disability due to the disease began; or within such longer period that does not exceed six months after a licensed physician diagnosed the disease; or within two years of the date of death due to the disease. Ohio law permits not only injured workers to file claims, but also employers, authorized representatives, and providers. Providers are required to file a workers' compensation claim within one working day of the initial treatment or initial visit of an injured worker.

2. Claim determination:

When a claim is received, BWC designates it with a claim number and assigns it to the appropriate BWC office. After receiving the claim and assigning it a number, BWC is legally obligated to send notification of the filing to all parties in the claim (i.e., injured worker and employer) and the parties' authorized representatives. BWC must provide the parties due process rights in the allowance or disallowance of the claim and its associated medical conditions.

Within 28 days of receiving the claim, BWC is legally mandated to issue a decision regarding the claim. The parties in the claim have 14 days to appeal the order. If any of the parties files an appeal, an IC hearing will be scheduled.

3. Injury, compensability and causality:

The primary legal principles guiding Ohio's workers' compensation system are the concepts of injury, compensability, and causality. As used in the Ohio Workers' Compensation Act, an ***injury*** must be caused by an external accidental means or be accidental in character and result and must be received in the course of and arising out of the injured employee's employment.

Compensability is the legal foundation upon which BWC and the IC base their determinations. For a claim to be compensable, the following criteria, specified by Ohio Revised Code (ORC) 4123.01, must be met and supported by both medical and non-medical evidence:

- An accidental injury or occupational disease exists;
    - The injury or disease must be physical in nature. Psychiatric conditions, stress, exposure or natural deterioration in the absence of a physical injury to the worker are generally not compensable.
    - The injury was sustained in the course of and arising from employment.
- Injuries do not include:
    - Psychiatric conditions, except where the conditions have arisen from a physical injury or occupational disease or in cases of forced sexual conduct.
    - Injury or disability caused primarily by the natural deterioration of tissues, organs, or parts of the body.

As part of determining compensability, all of the evidence gathered during the life of the claim is evaluated to determine a causal relationship between the alleged conditions and the work-related accident or exposure. This process, referred to as determining ***causality***, is essential to deriving reliable conclusions and making appropriate determinations.

Causal relationship is a reasoned medical determination with legal implications that determines if the condition the injured worker (IW) is requesting is compatible with or could result from the mechanism or mode of injury, or could be the result (e.g., flow-through) of a previously allowed condition in the claim.

In deriving an opinion of causality or causal relationship, physician should rely on historical information available to them including that obtained from the injured worker, results of the physician's examination, the results of any studies performed, and the physician's knowledge and expertise. Key factors to consider in deriving an opinion include:

- the alleged mechanism of injury, exposure, or work activity;
- time of onset (direct and proximate cause) or chronological sequence, duration of exposure or activity;
- typical non-occupational disease manifestation;
- common or known conditions which commonly occur as a result of a given exposure;
- other contributing factors such as non occupational activities or medical conditions;
- response when injured worker when away from activity.

Determinations of allowance are made based on these elements:

- Factual information.
- Objective documentation (e.g., diagnostic tests, medical examinations, reports) that support any requests, disputes or allegations.
- Rational explanations and documentation that support legal and medical opinions.
- Any unresolved issues and the need for any additional evidence that have been identified.

4. Burden of proof

In determining workers' compensation claims, the burden of proof is on the injured worker, not BWC or the IC. Causality is often demonstrated by submitting medical evidence, which is supplied by the injured worker's physician of record or other treating physician. At times, it may be necessary for BWC to obtain additional information, such as results of diagnostic studies, hospital admission notes, emergency room record and/or hospital discharge summary reports or clarification of the injury/description prior to making any recommendations on causality.

If there are questions regarding the existence of causality (e.g., the diagnosis conflicts with the mechanism of injury), BWC may ask a DEP physician to review the claim file. BWC requires DEP physicians to report on and clearly document their findings and support them using medical documentation in the claim file or supplemented by available medical literature.

a. Standard of proof

One of the key concepts in the workers' compensation process to understand is the standard of proof required to establish causality. Ohio Administrative Rule (OAC) 4121-3-09(A)(1) states, "In every instance the evidence shall be of sufficient quantum and probative value to establish the jurisdiction of the commission to consider the claim and determine the rights of the injured worker to an award. Evidence may be presented by affidavit, deposition, oral testimony, written statement, document, or other forms of evidence."

OAC 4123-3-09(C)(1) states: "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."

The injured worker must establish each element of a claim by the preponderance of the evidence. OAC 4123-3-09(C)(3)(e) states "'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 need the required standard."

Examples of standard of proof requirements are supported in the following court cases:

- ***Fox v. Indus. Comm.*, 162 Ohio St. 569 (1955)*:*** It is necessary for the claimant to show by a preponderance of the evidence that a direct and proximate causal relationship exists between his injury and his harm or disability.
- ***Aiken v. Indus. Comm.*, 143 Ohio St. 113 (1944)*:*** The proximate cause of an event is that which in a natural and continuous sequence, unbroken by a new, independent cause, produces that event and without which that event would not have occurred.

- ***Williams v. Mosser, 1997 Constr., 6th Dist. Sandusky No. S-96-051,* 1997 Ohio App. LEXIS 5458. 1997 WL 771565 (Dec. 5, 1997)*:*** It is noted that Black's Law Dictionary defines 'preponderance of the evidence' as 'evidence which is of greater weight or more convincing that the evidence which is offered in opposition to it, evidence which is more credible and convincing to the mind.' Preponderance of the evidence may not be determined by the number of witnesses, but by the greater weight of all evidence, which does not mean the greater number of witnesses but the opportunity for knowledge, information possessed, and manner testifying determines the weight of the testimony."

- ***Mewhorter v. Ex-Cell-O Corp.3rd Dist. Allen No. 1-89-39,* 1990 Ohio App. LEXIS 4040, 1990 WL 131969 (Sept. 7, 1990)*:*** "A direct and proximate cause must exist between the employment and injury and between the injury and the compensable harm."

In sum, the proof or evidence must be of sufficient magnitude based on weight, merit, or credibility, rather than quantity, and with a tendency to establish a causal relationship.

b. Medical evidence standards

Medical evidence standards are derived from court decisions rather than rules. Examples of this are supported by the following court cases.

- ***Fox v. Indus. Comm.,* 162 Ohio St. 569 (1955)*:*** Competent medical evidence is required to prove causation in a workers' compensation case. Medical evidence must show that the injury was or probably was a direct and proximate cause of the harm or disability.

- ***Stinson v. England.,* 69 Ohio St. 3d 451 (1994)*:*** Expert testimony regarding causation must be expressed in terms of probability.

- ***Drakulich v. Indus. Comm.,* 137 Ohio St. 82 (1940)*:*** The testimony of the medical witnesses must show a probability, and not a mere possibility that there was a causal relationship.

- ***Mewhorter v. Ex-Cell-O Corp.3rd Dist. Allen No. 1-89-39, 1990 Ohio App. LEXIS 4040,* 1990 WL 131969 (Sept. 7, 1990):** When medical evidence is necessary to establish proximate cause, such evidence must be based on probabilities. "*The medical evidence offered in this case is conjecture, a mere possibility, and, as such, it is insufficient to establish proximate cause.*" Therefore, using words such as "could be considered related" or "possibly considered related" is not sufficient.

- ***McKees v. Cincinnati Street Co.,* 152 Ohio St. 269 (1949):** Proof of possibility is not sufficient to establish a fact, probability is necessary.

- ***Stacey v. Carnegie-Illinois Steel Corp.,* 156 Ohio St. 205 (1951):** Stated "expert medical opinion evidence must establish a probable and not a mere possibility of such causal connection.

- ***Eberhart v. Flexible Corp.,* 70 Ohio St.3d 649 (1994):** Equivocal medical opinions are not evidence. Such opinions have no probative value. Further equivocation occurs when the doctor repudiates an earlier opinion, renders contradictory or uncertain opinions, or fails to clarify an ambiguous statement. Ambiguous statements however are considered equivocal only while they are unclarified.

In sum, the evidence must support and be consistent with the DEP physician's conclusions. Furthermore, the provider must express his or her opinions so they are not perceived to be ambiguous.

C. ALLOWED CONDITIONS

Allowed conditions are medical diagnoses and the corresponding body part(s) formally recognized in a claim by BWC. Medical benefits are administered for a **specific injury to a specific part of the body**. This fact supports the uniqueness of the workers' compensation system.

As the medical diagnoses of the injury evolve, either becoming more definitive or deteriorating, it may be necessary to allow additional conditions in the claim based on the submission of subsequent medical information. In general, complications or deterioration of the allowed conditions usually become additional allowed conditions only if a new diagnosis develops or if the condition becomes a chronic state. Usually it is not necessary to allow a complication of an injury unless chronicity occurs or the complication results in a specific different diagnosis.

> **Example 1:** A claim is allowed with the initial diagnosis of a sprain/strain. The condition fails to respond to conservative treatment and more definitive diagnostic testing is ordered. The test results indicate a tear, rather than the initial diagnosis of a sprain/strain. Once all medical evidence has been submitted and causality has been established, BWC can issue an order to additionally allow the claim for the tear diagnosis.
>
> **Example 2:** A claim is allowed for a laceration of the left index finger and the finger becomes infected. The treatment of the infection requires a short-term course of antibiotics within the normal healing time of the laceration. The treatment would be paid for under the initial allowed condition of a left finger laceration. However, should osteomyelitis result from the infection, the allowed condition(s) should be amended to reflect the additionally allowed condition of osteomyelitis, which will require a unique course of treatment.

D. DISALLOWED CONDITIONS

Disallowed conditions are conditions that have been determined to be unrelated to the industrial injury or occupational disease. Disallowed conditions are not compensable. BWC will not pay compensation or medical costs associated with the disallowed conditions.

If BWC either determines that medical evidence does not support the alleged condition or that there is no causal relationship between the industrial injury or occupational disease and the alleged condition, the condition will be disallowed. Disallowed conditions, as well as any determination made in the claim, can be appealed to the IC by any party to the claim.

E. INTERNATIONAL CLASSIFICATION OF DISEASES (ICD) CODING SYSTEM

BWC utilizes the diagnosis(es)' narrative description to legally allow claims. You may see ICD-9 or ICD-10 codes assigned to the claim; however, use the narrative diagnosis description when identifying all alleged, allowed, or disallowed medical diagnosis(es)/condition(s) in the claim.

F. AGGRAVATION/SUBSTANTIAL AGGRAVATION OF PRE-EXISTING CONDITION

BWC can recognize a condition which pre-exists the date of the work-related industrial injury or occupational disease as an allowed condition. It is the policy of BWC to provide compensation and benefits for an aggravation or substantial aggravation of a pre-existing condition (based upon the date of the injury) when the injury or occupational disease causing the aggravation is sustained or contracted in the course of and arises out of employment.

For dates of injury prior to August 25, 2006, pre-existing conditions may be allowed if they have been aggravated by the industrial injury or occupational disease. Aggravation of a pre-existing condition is defined as a medical finding that a condition that pre-existed an injury or occupational disease is worsened by the injury or occupational disease and has an adverse impact, no matter how slight. (According to the Ohio Supreme Court, for these dates of service "A work-related aggravation of a pre-existing condition does not have to be of any particular magnitude in order to entitle the claimant to a determination of benefits.")

For dates of injury on or after August 25, 2006, pre-existing conditions may be allowed only if they have been substantially aggravated by the industrial injury or occupational disease. Substantial aggravation of a pre-existing condition is defined as a medical finding that a condition that pre-existed an injury or occupational disease is worsened considerably in amount, value or extent solely because of the injury or occupational disease.

Substantial aggravation of a pre-existing condition must be documented and substantiated by objective diagnostic findings, objective clinical findings or objective test results. Subjective complaints may be included as evidence of a substantial aggravation of a pre-existing condition, but subjective complaints alone, without objective findings, are insufficient to support a substantial aggravation.

Under Ohio law, a pre-existing condition allowed as a substantial aggravation ceases to be compensable once it returns to the level that would have existed without the industrial injury or occupational disease. If such a determination is made as to that condition, BWC will maintain the condition in an allowed but not payable status. The parties to the claim may file a motion to reopen a period of substantial aggravation of a pre-existing condition with supporting documentation.

BWC may obtain an examination or file review from a DEP physician prior to making a determination for additional allowance for an aggravation/substantial aggravation of a pre-existing condition. BWC may obtain an examination or file review from a DEP physician regarding whether a pre-existing condition allowed as a substantial aggravation has returned to the level that would have existed without the industrial injury or occupational disease, or whether a pre-existing condition allowed as a substantial aggravation that has been determined to have returned to the level that would have existed without the industrial injury or occupational disease should be reopened.

Once a claim is allowed for aggravation of a pre-existing condition, it is often difficult to determine what treatment is necessary due to the aggravation versus the treatment that will be necessary due to the pre-existing condition. Often the effects are so intertwined, that virtually no distinction can be made; therefore, all treatment is included in the workers' compensation claim.

The following are examples of pre-existing conditions that have been allowed in claims:

- Aggravation/substantial aggravation of pre-existing arthritis (usually part of body is designated).
- Aggravation/substantial aggravation of pre-existing diabetes.
- Aggravation/substantial aggravation of specific psychiatric conditions.

DEP physicians must note in their reports the part of body affected by the industrial injury in the aggravation/substantial aggravation additional allowance, unless the condition is not specific to a part of the body. Additionally, physicians must document the causal relationship and resulting effects of the injury or occupational disease to the aggravation/substantial aggravation of the pre-existing condition.

G. OCCUPATIONAL DISEASES (ORC 4123.68)

Occupational diseases usually develop over a long period of time and after repeated exposures. To distinguish between an injury and an occupational disease, consider the following:

- An occupational disease generally results from repeated work-related exposure.
- The exposure has a harmful effect on the employee.
- There is a causal relationship between the exposure and the harmful effect that is confirmed by a medical diagnosis.
- The conditions of employment create a greater risk of developing a work-related disease.

- BWC must consider the mechanism or process causing the disease, the type of employment, and any other pertinent information.

ORC 4123.68 provides a list of diseases which are always identified as occupational diseases. These diseases are contracted through industrial processes, including exposure to the following:

- Dust, gases or fumes.
- Chemical or toxic substances.
- Extreme temperature, noise, or pressure changes.
- Physical vibrations, constant pressure and use, physical movement in constant repetition, or radioactive rays.
- Infections and organisms.
- Radiation

The following occupational diseases require an examination prior to awarding compensation or benefits:

- Berylliosis
- Cardiovascular, pulmonary, or respiratory diseases incurred by fire fighters or police officers.
- Silicosis
- Asbestosis
- Coal miners' pneumoconiosis
- Any other occupational diseases of the respiratory tract resulting from injurious exposures to dust.

H. IMPAIRMENT versus DISABILITY

For the purposes of rendering a medical opinion on the injured worker's permanent impairment, it is important to understand the difference between impairment and disability.

Impairment is an alteration of an individual's health status, which reduces functional capability, and is medically assessed by a physician.

The Ohio Supreme Court has defined **medical impairment** as the amount of the injured worker's anatomical and/or mental loss of function caused by the allowed injury.

Disability is "an alteration in an individual's capacity to meet personal, social or occupational demands, or statutory or regulatory requirements".

The Ohio Supreme Court has defined disability as the effect that impairment has on the injured worker's ability to work.

I. TEMPORARY TOTAL DISABILITY (TT)

A disability preventing injured workers from returning to their former positions of employment (i.e., the job held at the time of the injury) results in the payment of TT compensation. BWC pays TT until one or more of the following occur:

- The injured worker returns to work.

- The physician of record submits a written statement that the injured worker is capable of returning to his/her former position of employment.

- It is determined at an IC hearing that the temporary disability has become permanent.

- In claims with dates of injury on or after August 22, 1986, work within the physical capabilities of the injured worker is made available.

- The injured worker has reached maximum medical improvement.

J. PARTIAL DISABILITY

Partial disability is compensated in accordance with ORC 4123.57. There are two types of partial disability:

- **Permanent partial disability**: In accordance with ORC 4123.57(A), prior to awarding compensation, a DEP physician performs a medical examination or file review to determine the percentage of impairment using the *AMA's Guides to the Evaluation of Permanent Impairment* currently adopted by BWC.

- **Scheduled loss:** In accordance with ORC 4123.57(B), scheduled loss awards are statutory awards for either loss (i.e., amputation) or loss of use of a body part as a result of a work-related injury or disease. Possible scheduled loss awards may be for amputation, loss of vision, loss of hearing or facial disfigurement. At times, a DEP physician will perform an examination on the loss of use. In cases where the DEP physician cannot clearly state a complete loss or loss of use, the physician shall provide a percentage.

K. PERMANENT TOTAL DISABILITY (PTD)

There are two standards for permanent total disability. By statute (ORC 4123.58), the loss or loss of use of both hands, or both arms, or both feet, or both legs, or both eyes, or the combination of any two of these body parts, constitutes 'statutory' PTD.

The second type of PTD is demonstrated when it is shown that the injured worker is so disabled as a result of the allowed conditions as to render the injured worker unable to perform any sustained remunerative employment. Additionally, PTD can be based on a combination of allowed conditions and non-medical factors.

The IC has responsibility for conducting medical examinations to determine the permanent impairment in accordance with the edition of the AMA's *Guides to the Evaluation of Permanent Impairment* currently adopted by the IC. The results of these examinations, as well as any vocational or disability factors, are used by the IC hearing officer to reach a PTD determination.

L. MAXIMUM MEDICAL IMPROVEMENT (MMI)

MMI is defined as a treatment plateau (static or well stabilized) at which no fundamental functional or physiological change can be expected in the future in spite of continuing medical or rehabilitative procedures. MMI does not mean that medical or supportive care must be discontinued or is unnecessary, only that it is not anticipated that the condition will improve with further treatment and therefore has become stable.

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Chapter 6 Billing and Reimbursement

A. INTRODUCTION

Physicians are required to use the codes, descriptions and fees specified in this chapter for reimbursement of all DEP services rendered. Furthermore, physicians are required to accept the reimbursement rates stated in this chapter as payment in full. Balance billing the BWC, MCO, employer or injured worker is prohibited.

If it is necessary to exceed the maximum reimbursement rate or units of service stated for either examinations or file reviews, the physician shall obtain prior approval from BWC. This approval may be obtained by contacting DEP Central at 614-995-0451, via email at dep@bwc.state.oh.us, or through the BWC service office requesting the DEP service. The local BWC service office will coordinate approval with the DEP Central Unit.

Each MCO is responsible for establishing reimbursement rates for ADR file reviews it requests. Questions regarding reimbursement of these services shall be directed to the entity who has requested them.

Reimbursement for examinations or file reviews requested by a self-insured employer or its representative must be sent directly to the self-insured employer or the representative for payment. BWC and the MCO will not be responsible for providing an attendant or reimbursing the physician for an attendant for exams performed in a BWC facility.

B. REQUIREMENTS

BWC expects DEP physicians to be fully prepared for each examination prior to the date and time of the examination. Preparation includes a thorough review of claim documents. If an injured worker cancels or no-shows for an examination, and the DEP physician receives less than one (1) full business day notice of the cancellation or no-show, BWC will reimburse the physician for the cancellation or no-show based on the administrative time letter reimbursement listed in this chapter.

In order for a physician to be reimbursed for an untimely cancellation or no-show, the physician shall either complete the bottom portion of the exam notice or submit a letter containing the information (injured worker name, claim number, and date and time of scheduled examination) regarding the cancellation or no-show. This notification acknowledging an injured worker failure to show for a scheduled examination or that the examination was cancelled with less than one (1) full business day notice to the physician shall be faxed to BWC at 1-866-336-8352.

BWC currently limits a DEP physician's reimbursement to a maximum of one hundred eighty-five thousand six hundred twenty-five dollars ($185,625.00) per fiscal year cumulative for all DEP services performed. This cap applies whether a physician performs examinations, file reviews or a combination of the two services. If a physician exceeds the maximum reimbursement during the fiscal year, BWC will subtract the overage amount from the next fiscal year reimbursement allotment. Diagnostic testing is not counted towards the annual maximum**.**

BWC reserves the right to modify the DEP fiscal year reimbursement cap with not less than thirty (30) days advance notice.

C. REIMBURSEMENT FEE SCHEDULE

1. File Reviews

a) Units of Service (UOS) – Ten (10) minutes equals one (1) UOS

b) Amount of time – Physicians shall accurately report the amount of time spent completing a file review

c) Medical File Review – This reimbursement rate is for rendering a medical opinion based on review of a claim file. The reimbursement rate includes review of the claim file, completion and submission of a report and any consultation with BWC staff. Billing for one medical file review shall not exceed three (3) hours or eighteen (18) UOS without prior approval by BWC.

W1110	Medical File Review	$22.50/UOS

d) Drug Utilization File Review – This reimbursement rate is for rendering a medical opinion regarding medical necessity and appropriateness of medications BWC is reimbursing based on review of a claim file and pharmacy reimbursement reports. The reimbursement rate includes review of the claim file, completion and submission of a report and any consultation with BWC staff. Billing for one drug utilization file review shall not exceed three (3) hours or eighteen (18) UOS without prior approval by BWC.

W1116	Drug Utilization File Review (first claim)	$22.50/UOS
W1117	Drug Utilization File Review (second claim same date of service)	$22.50/UOS
W1118	Drug Utilization File Review (third claim same date of service)	$22.50/UOS
W1119	Drug Utilization File Review (fourth claim same date of service)	$22.50/UOS

e) Prior Authorization File Review – This reimbursement rate is for rendering a medical opinion regarding newly prescribed medications not yet being reimbursed by BWC. The reimbursement rate includes review of the claim file, completion and submission of a report and any consultation with BWC staff. Billing for one prior authorization file review shall not exceed three (3) hours or eighteen (18) UOS without prior approval by BWC.

W1615	Prior Authorization Drug File Review; 10 minutes = 1 unit of service	$22.50/UOS

f) Percent Permanent Partial Impairment Increase (%PPD) File Review – This reimbursement rate is for rendering a medical opinion based on review of a claim file using edition of the *AMA Guides to the Evaluation of Permanent Impairment* currently adopted by BWC to determine the adequacy of medical evidence to support an increase in a permanent partial disability award. The reimbursement rate includes review of the claim file, completion and submission of a report and any consultation with BWC staff. Billing for one %PPD file review shall not exceed thirty (30) minutes or three (3) UOS without prior approval.

W1115	Increase Percent Permanent Partial Impairment (%PPD) File Review	$22.50/UOS
W1157	%PPD File Review (second claim, same day)	$22.50/UOS
W1158	%PPD File Review (third claim, same day)	$22.50/UOS
W1159	%PPD File Review (fourth claim, same day)	$22.50/UOS

g) Toxicology File Review – This reimbursement rate is for rendering a medical opinion based on specific questions posed to a DEP physician. The reimbursement rate includes review of the claim file, completion and submission of a report and any consultation with BWC staff. Billing for a toxicology file review shall not exceed six hundred dollars ($600.00) without prior approval by BWC.

W1606	Toxicology File Review	$600.00

2. Examinations

a) 90-Day Examinations - This reimbursement rate is for completion of a 90-day examination, review of claim documents, completion and submission of a report, and any consultation with BWC staff.

W1170	90-Day Examination	$421.88

b) Independent Medical Examinations - This reimbursement rate is for completion of an independent medical examination or 200-week examination, review of claim documents, completion and submission of a report and any consultation with BWC staff.

W1600	Independent Medical Examination	$421.88
W2902	Addendum (10 minutes equals 1 unit of service maximum 4 UOS).	$22.50/UOS

c) Percent Permanent Partial Impairment Examinations (%PPD) – This reimbursement rate is for completion of an examination and rendering a medical opinion based on the edition of the *AMA Guides to the Evaluation of Permanent Impairment* currently adopted by BWC to determine the percentage of permanent partial impairment. The reimbursement rate includes completion of an examination, review of claim documents, completion and submission of a report, and any consultation with BWC staff.

W1120	Percent Permanent Partial Impairment Examination (%PPD)	$191.25
W1165	%PPD Examination (second claim same day)	$191.25
W1166	%PPD Examination (third claim, same day)	$191.25
W1167	%PPD Examination (fourth claim, same day)	$191.25

d) Percent Permanent Partial Impairment Increase Examinations (%PPD) – This reimbursement rate is for completion of an examination and rendering a medical opinion based on the edition of the *AMA Guides to the Evaluation of Permanent Impairment* currently adopted by BWC to determine an increase in the percentage of permanent partial impairment. The reimbursement rate includes completion of an examination, review of claim documents, completion and submission of a report, and any consultation with BWC staff.

W1130	Percent Permanent Partial Impairment Increase Examination (%PPD)	$191.25
W1126	%PPD Examination (second claim same day)	$191.25
W1127	%PPD Examination (third claim, same day)	$191.25
W1128	%PPD Examination (fourth claim, same day)	$191.25

e) Multi-Claim Psychological Examination – This reimbursement rate is for the completion of a multi-claim psychological examination. The reimbursement rate includes completion of the examination, review of claim documents, completion and submission of a report, and any consultation with BWC staff. The DEP physician shall write one report, addressing each claim separately, and shall determine which claim to assign each W code. W1604 has a maximum reimbursement of one (1) hour or 6 UOS.

W1603	Multi-Claim Psychological Examination – first claim	$421.88
W1604	Multi-Claim Psychological Examination, subsequent claims, same injured worker, same day	$22.50/ UOS

f) Asbestosis / Mesothelioma Examinations or File Reviews – This reimbursement rate is for the completion of an examination or file review when the alleged condition being requested is asbestosis

or mesothelioma. The reimbursement rate includes completion of the examination (when requested), review of claim documents, completion and submission of a report, and any consultation with BWC staff.

W1109	Asbestosis or Mesothelioma Examination or File Review	$600.00

g) Alternative Dispute Resolution Examination (ADR IME) - This reimbursement rate is for the completion of an examination when there is a dispute regarding a request for treatment under the Health Partnership Program. The reimbursement rate includes completion of the examination, review of claim documents, completion and submission of the report, and any consultation with BWC and/or MCO staff.

Z1600	ADR IME	$506.25

h) Administrative Time and Letters - This reimbursement rate is for the completion of administrative paperwork associated with scheduling an examination and reviewing claim documentation where the injured worker cancels with less than one (1) full business day notice or no-shows for an examination.

W1111	C-92 Administrative Time Letter	$75.00
W1162	C-92 Administrative Time Letter (second claim same day)	$75.00
W1163	C-92 Administrative Time/ Letter (third claim same day)	$75.00
W1164	C-92 Administrative Time Letter (fourth claim same day)	$75.00
Z1601	ADR Administrative Time Letter	$75.00
W1171	All Other Examination Administrative Time Letter	$75.00

i) Addendum – This reimbursement rate shall be used when BWC requests a report addendum because of BWC error or because BWC is providing additional information it wants the DEP physician to consider. Billing for one (1) addendum report shall not to exceed forty (40) minutes or four (4) UOS without prior approval by BWC.

W2902	Addendum	$22.50/UOS

3. Diagnostic Testing

The DEP physician must request prior authorization to conduct diagnostic testing from the BWC service office that has requested the examination. BWC will only consider authorizing diagnostic testing when it is absolutely necessary, and physicians should rarely need to request it.

However, BWC does allow reimbursement for x-rays performed in conjunction with a %PPD examination under certain defined circumstances without prior BWC approval. Additional details can be found in Chapter 7, Policy C.

If the additional testing exceeds the maximum reimbursement rate or a diagnostic test other than those listed in the reimbursement rate schedule is necessary, the physician must request prior approval from DEP Central. Contact information for DEP Central can be found in Chapter 1, Section G.

The DEP physician must perform all diagnostic testing. However, if the physician cannot provide the completed service (i.e., technical and professional components), he or she is responsible for making separate arrangement (i.e., contract) and for reimbursement to those separate providers. The physician must bill for the technical and professional components of the diagnostic test using the appropriate diagnostic “W” codes listed in this chapter.

All bills for approved diagnostic testing completed in conjunction with any BWC ordered examination must be submitted by the examining physician and will be reimbursed to the examining physician according to the diagnostic reimbursement rate schedule contained in this chapter. It is the responsibility of the examining physician to reimburse the testing facility. The injured worker cannot be billed directly for these tests.

Visual Field Testing by Ophthalmologists - Ophthalmologists performing permanent partial impairment or independent medical examinations may perform **formal** testing of visual fields without obtaining prior authorization from BWC. Testing that is considered appropriate include the Goldmann, Octopus, or Humphrey methods. The test should include unilateral or bilateral evaluation and the physician must include testing results and interpretation with their report.

This testing would be considered appropriate for any allowed condition in a claim that may impair the visual field of the injured worker. Results should be applied to the impairment determination process consistent with the edition of the *AMA Guide to the Evaluation of Permanent Impairment* currently in use by BWC. Gross or confrontation visual field testing is part of the traditional examination and not included in this testing.

The testing will be identified as "Static/kinetic perimetry" and billed using Code W1160 on the C-19 billing invoice. Reimbursement is $70.85 regardless of whether unilateral or bilateral visual fields are tested.

Psychiatrists and psychologists may perform diagnostic testing if medically indicated or necessary to support examination findings; however, recent results in the claim file may be sufficient and additional diagnostic testing may not be necessary.

BWC will allow mental health physicians to perform psychological testing without prior authorization. Tests that can be performed include the Minnesota Multiphasic Personality Indicator (MMPI), the Psychological Assessment Inventory, or the Million Multi-Axial Clinical Assessment. Performance of the test will be allowed for any mental health impairment evaluation (%PPD) or an IME.

The DEP physician shall submit the diagnostic test summary with interpretation from the evaluating psychiatrist or psychologist with the written report. The physician's summaries or comments shall correlate the interpretation of the test with his/her interview and evaluation of the injured worker.

The following codes and reimbursement rates must be used when billing for approved diagnostic tests as part of an examination.

W1003	Prosthetic Clinic Consult OT/PT Evaluation	$105.99
W1131	Radiological examination – skull; complete, minimum of four views, with or without stereo	$115.00
W1132	Radiological examination – chest; complete, minimum of four views	$77.00
W1133	Radiological examination – spine, cervical; complete, including oblique and flexion, and/or extension studies.	$117.00
W1134	Radiological examination – spine, thoracic; complete, including oblique, minimum of four views.	$106.00
W1135	Radiological examination – spine, lumbosacral; complete, including bending views.	$113.00
W1136	Radiological examination – upper extremity, complete.	$208.00
W1137	Radiological examination – lower extremity, complete.	$155.00
W1138	Electrocardiogram – routine ECG with at least 12 leads, with interpretation and report.	$42.00
W1139	Cardiovascular stress test; using maximal or submaxial treadmill or bicycle exercise, continuous ECG monitoring and/or pharmacological stress; with physician supervision, interpretation, and report.	$250.00
W1140	Bronchospasm evaluation; spirometry pre and post bronchodilator	$71.00
W1141	Basic comprehensive audiometry (pure tone, air and bone, and speech; threshold and discrimination).	$61.00
W1142	Spirometry; including graphic record, total and time vital capacity; expiratory flow rate measurement(s) and/or maximal voluntary ventilation.	$55.00

W1143	Pulmonary stress testing, simple or complex.	$160.00
W1144	Gases, blood; pH, pC02, p02, simultaneous	$60.00
W1145	Carbon monoxide diffusing capacity, any method	$43.00
W1146	Electromyography, two extremities and related paraspinal areas.	$239.00
W1147	Nerve conduction, velocity and/or latency study; motor each nerve.	$99.00
W1148	Computerized axial tomography – head or brain, without contrast material.	$386.00
W1149	Magnetic resonance (e.g., proton) imaging – brain (including brain stem); without contrast material.	$717.00
W1150	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method	$53.00
W1151	Computerized axial tomography – head or brain, without contrast material, followed by contrast material(s) and further sections.	$601.00
W1152	Computerized axial tomography – thoracic spine, without contrast material, followed by contrast material(s) and further sections.	$692.00
W1153	Computerized axial tomography – lumbar spine, without contrast material, followed by contrast material(s) and further sections.	$697.00
W1154	Magnetic resonance (e.g., proton) imaging – spinal canal and contents; cervical with contrast.	$913.00
W1155	Magnetic resonance (e.g., proton) imaging – spinal canal and contents; thoracic with contrast.	$913.00
W1156	Magnetic resonance (e.g., proton) imaging – spinal canal and contents; lumbar with contrast material	$902.00
W1160	Static/kinetic Perimetry; extended examination of visual field (Goldman) with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry (Octopus program or Humphrey visual field analyzer)	$70.85
W1161	Psychological testing – included psycho-diagnostic assessment of personality, psycho-diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities; (e.g., WAIS-R, Rorscharch, MMPI) with interpretation and report, per hour.	$89.00
W1168	Lung Volumes	$32.19
W1169	Neuropsychological Testing- one (1) hour = 1 unit of service.	$100.00
W1226	CT thorax without contrast material	$426.80
W1228	CT without contrast material followed by contrast material(s) and further sections	$608.94
W1245	Prosthetic Clinic Consult MD Evaluation	$175.83
W1255	Prosthetic Clinic Consult include MD, OT/PT, CPO all inclusive	$419.34
W1256	Prosthetic Clinic Consult MD, OT/PT Evaluation	$281.82
W1601	B-reading, interpretation only, of chest x-ray	$50.00
W1760	Prosthetic Clinic Consult Prosthetic Evaluation; 1 unit is 15 minutes; maximum 4 billable units.	$45.84
W2903	High Resolution CT Scan (HRCT) of chest, interpretation	$200.00
W2904	High Resolution CT Scan (HRCT) of chest, technical component	$426.80

D. BILLING INSTRUCTIONS

The DEP physician shall submit all *Service Invoices* (C-19) for in-state (Ohio and within 50 miles of its border in the contiguous states) with the corresponding examination and/or file review report, but no later than ninety (90) days after the conclusion of the requested DEP service. C-19's submitted for reimbursement prior to BWC's receipt of the examination and/or file review report will not be paid until BWC receives the report.

BWC may deny reimbursement for a C-19 in whole or in part when the physician submits an incomplete report, fails to submit a report, or performs an unauthorized service. Periodic audits may be completed to detect inappropriately billed services. Discrepancies found on billing audits may be referred to BWC's Special Investigations Department for further review and action, if necessary.

C-19s must be completed and signed by the physician rendering the DEP service. Physicians shall submit one (1) C-19 per examination or file review. BWC may return improperly completed C-19 forms. Diagnostic tests performed on the date of service shall be included on the C-19 used to bill for the examination.

All completed C-19s must be mailed or faxed to BWC Medical Billing & Adjustments at:

BWC Medical Billing & Adjustments
30 W. Spring Street, 20th floor
Columbus, OH 43215
Fax number: 614-621-1398

a. General C-19 information

1. C-19s are furnished free of charge and may be obtained by calling BWC Forms and Publications at 1-800-644-6292 or visiting www.bwc.ohio.gov and going to the forms section of the medical providers page.

2. The *Service Invoice* (C-19) is the only acceptable reimbursement form when requesting reimbursement for DEP services (examinations, file reviews or diagnostics).

3. Physicians must always indicate (V) "Other Vendor" for "Bill Type" on the invoice. Marking any other "Bill Type" may result in denial of reimbursement.

4. Physicians must always use the codes specified in this chapter. Any procedure code other than that assigned to the service may result in denial or incorrect reimbursement.

5. The assigned code for each type of examination or file review must be used even if the reimbursement rate is the same for several codes. This allows BWC to collect and report data on the number of examinations, diagnostic tests and file reviews that have been completed.

6. Physicians who want payment for services sent to their group practice must place their group number in Box 14 of the C-19 and their individual physician number in Box 11. The reimbursement will be sent to the address on file for the pay-to-provider number listed on the C-19.

7. Physicians who want payment for services to be sent to their individual practice must place their individual provider number in Box 11 on the C-19. The reimbursement will be sent to the address on file associated with the pay-to number listed on the C-19.

8. For physicians who have contracted with an administrative agent, the administrative agent may complete the C-19. The administrative agent will place its provider enrollment number in Box 14, the individual physician enrollment number of the physician in Box 11, and the physician's address in Box 28. The reimbursement will be sent to the address on file for the administrative agent.

b. Instructions for completing a C-19 - Use the 2 digit month, 2 digit date, 2 digit year (MM/DD/YY) when entering dates on the C-19 (e.g., August 14, 2015, should be entered as: 08/14/15).

1. Bill type: Always indicate (V) "Other Vendor" for "Bill Type" on the invoice. Marking any other "Bill Type" will result in denial of reimbursement.

2. Claim number: Enter the BWC claim number.

3. Injured worker Social Security number: Not required.

4. Date of Injury: Enter the injured worker's date of injury.

5. Injured worker name: Enter the injured worker's last name, first name and middle initial.

6. Injured worker address: Not required.

7. Referring physician provider number: Not required.

8. Referring physician name: Not required.

9. Prior authorization number: Not required.

10. Patient account number: Not required.

11. Provider number:

    a. Group providers – Enter the BWC provider number of the treating physician and continue to Block 12.

    b. Individual physicians – Enter the 11-digit assigned BWC provider number and skip to items 13 and 14.

12. Provider name: Group providers only – Enter the provider name that corresponds to the provider number listed in Block 11.

13. Check here if payment is to be made to the claimant: Not applicable to DEP services.

14. Group payee number: Group providers only – Enter the BWC provider number to which payment is to be made. Block 11 must contain the treating provider's number.

15. Service date: Enter the date service was rendered.

16. Place of service: Not required.

17. Procedure code: Enter the appropriate W code for the service rendered.

18. Modification code: Not required.

19. Diagnostic code (ICD-10-CM): Not required.

20. Description of service: Enter the description of the procedure code. Abbreviations of the description of service are acceptable.

21. Charges: Enter the reimbursement amount for the service that was rendered based on the reimbursement rates documented in this chapter.

22. Units of service: Enter the units of service rendered for each detail line.

23. Tooth number: Enter tooth number(s), if applicable.

24. Provider signature: Enter an authorized signature.

25. Date: Enter the date the bill was signed.

26. Total charge: Add together all charges in Column 21 and enter the total amount in this Box 26.

27. Remarks: Not required unless this is a self-insured claim. If self-insured enter the employer's name.

28. Payee name, address, city, state, ZIP code and telephone number: Enter the name, address, zip code and telephone number of the physician to whom payment is to be made.

Ohio | Bureau of Workers' Compensation
30 W. Spring St.
Columbus, OH 43215-2256

Governor **John R. Kasich**
Administrator/CEO **Sarah D. Morrison**
www.bwc.ohio.gov
1-800-644-6292

Chapter 7 Additional Policy Information

A. INTRODUCTION

This chapter contains additional policy information pertaining to BWC rules and the legal requirements for Ohio workers' compensation.

B. ADDITIONAL POLICY INFORMATION

- Policy A: Maintenance and Destruction of Medical Records
- Policy B: Asbestosis Related Disease Examinations
- Policy C: Diagnostic Radiology Performed during a %PPD Examinations
- Policy D: %PPD Impairment for Loss of Vision
- Policy E: %PPD Impairment for Mental and Behavioral Disorders
- Policy F: %PPD Impairment for Pain
- Policy G: %PPD Impairment General Information

POLICY A: Maintenance and Destruction of Medical Records

The purpose of this policy is to ensure DEP physicians and their designees protect the confidential information of injured workers. DEP physicians shall only disclose confidential claim file information to an entity legally entitled to receive it, in accordance with the confidentiality provisions of the DEP Agreement.

BWC defines confidential information as legally protected information relating to data, such as any injured worker data that contains a name or any other identifier and which described anything about, done by or done to a person. This includes, but is not limited to medical information or information regarding whether the person has a workers' compensation claim.

BWC holds DEP physicians responsible for the methods in which their designees maintain and destroy injured workers' medical records. It is important DEP physicians adhere to the following:

- The DEP physician is responsible for actions of his/her staff and any other agents including Administrative Agents in the performance of DEP services. This includes, but is not limited to, securing and proper maintenance, utilization, and destruction of all claim records (whether provided by BWC to the DEP physician or generated by the DEP physician) by the physician, the physician's staff, the physician's Administrative Agent, or any other agent of the DEP physician for the performance of DEP services. DEP physician is responsible and liable for any costs incurred by BWC as a result of any loss, misuse, or improper destruction of such claim records by the physician, the DEP physician's staff, the physician's Administrative Agent, or any other agent of the DEP physician.

- The DEP physician must maintain records created by the DEP physician and submitted to BWC for a period of three (3) years following the submission of the final report to BWC. Records may be maintained as a hardcopy record or by electronic means so long as the records are accessible and maintained in a safe, secure manner.

- Claim records provided by BWC to the DEP physician, physicians' staff, physicians' Administrative Agents, or other agents for the performance of DEP services must be properly destroyed after sixty (60) days and by not later than ninety (90) days after submission of the physicians' created report (evaluation report or file review) to BWC. The DEP physician is responsible for ensuring claim records are properly destroyed by cross-cut shredding or incineration. Claim documents transmitted electronically to the DEP physician for file review may be deleted after submission of the physicians' file review report.

POLICY B: Asbestosis Related Disease Examinations

The current DEP examination procedure, in addition to review of evidence submitted by the injured worker, injured worker representatives, or physician of record and/or treating physician or attorney, includes use of pulmonary diffusion study and lung volumes (spirometry), which in select cases may assist in confirming or denying the asbestosis-related disease as follows:

- Chest x-ray of good/adequate quality (ILO film quality 1 to 2) with interpretation by an independent B-reader from the BWC list of B-readers and in some cases High Resolution Computed tomography (CT) Scan. The examining physician may review and interpret the chest x- ray and High Resolution Computed tomography (CT) Scan, but a separate B reading from an independent B reader and High Resolution Computed tomography (CT) Scan report is also required.

- Spirometry, according to the criteria recommended by the American Thoracic Society. Testing may include carbon monoxide diffusion capacity, adjusted for blood carbon monoxide level if necessary and total lung volumes performed at the discretion of the examining physician when performed at the time of spirometry. Interpretation of the results and discussion must be included in the report.

- Modification of questions to be asked to assist in the claim management of asbestos- related conditions.

The evaluation will require the use of DEP physicians to perform evaluations and NIOSH Certified, BWC-certified B-readers to interpret x-rays. Due to a relatively small number of pulmonary specialists who perform these examinations, the examiner pool will be increased by the use of board certified occupational medicine physicians as necessary. All physicians shall meet the DEP acceptance criteria requirements contained in Chapter 2. Preference will be given to the pulmonary specialists and occupational medicine physicians who have the capability to perform and/or interpret the following diagnostics:

- Spirometry

- Chest X-ray

- High Resolution computed tomography (CT) Scan (prior-authorization from DEP Central Unit required)

B-Readers: BWC will utilize only B- readers who are NIOSH-certified, BWC-certified physicians who are board certified in radiology and/or pulmonary medicine.

Based on review of the medical literature of asbestosis-related diseases and review of Ohio Workers' Compensation statutes and rules, examination reports of injured workers alleging asbestosis-related diseases shall include the following:

- Medical history describing pertinent symptoms present and absent, date of onset, severity, and treatment to date;

- Past medical history describing any other exposure to other fibrogenic physical or chemical agent, other medical conditions that can cause pulmonary disease such as auto-immune disorders, post pulmonary infections, cardiac disease, past chest surgery or trauma or other underlying pulmonary disorders or cigarette smoking that should be considered as causing similar symptoms or findings;

- Occupational history including type of job, duration of employment exposure, interval between exposure and onset of symptoms, use of any personal protective equipment while employed, and any periodic employer examinations performed (periodic asbestosis evaluations);

- Physical examination that includes auscultation in the upright (straight back) position with full inspiration for end or peak inspiratory crackles (rales) at the midaxillary line (lateral) and posterior basilar lung fields bilaterally that are persistent and fail to clear with coughing and deep breathing plus any other associated findings or lack of findings;

- Spirometry performed according to guidelines of the American Thoracic Society. Results and interpretation of results should be included in the report. Include whether the findings are or are not consistent with asbestosis-related exposure.

- Chest x-ray taken at the time of the examination with interpretation report by a B-reader from the BWC list of B-readers which includes a description of any changes of the lung and pleura so that all asbestosis-related abnormalities can be evaluated.

- A statement, with justification, of whether there is clinical evidence of an asbestosis-related change and which change.

- A statement of the causal relationship of any asbestosis-related changes to the workplace.

- A statement providing an opinion of the last and also most significant exposure contributing to the asbestosis-related condition if present.

At the time of spirometry, physicians may elect to perform a diffusion capacity and/or measurement of lung volumes if the spirometry results reveal the FVC < 82% predicted or FEV1 < 82% predicted. These additional studies must be performed at the time of spirometry. The injured worker may not be asked to return later for these studies. Charges for these studies must be submitted by the DEP physician using the fee schedule listed in Chapter 6.

POLICY C: Diagnostic Radiology Performed during a %PPD Examinations

The *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition* recommends the use of a recent x-ray when determining the percentage of permanent impairment for a select number of conditions. Many injured workers may appear for an examination without x-rays, and if x-rays have been performed and are contained in the claim documents those x-rays may be greater than six (6) months old.

BWC shall authorize performance of x-rays by the DEP physician for claims with the allowed conditions listed below if the injured worker does not bring an x-ray to the examination or the claim documents included for the examination do not contain an x-ray performed within the past six (6) months:

- Intra-articular fracture or dislocation of the hip or acetabulum, knee, ankle, hindfoot, or midfoot;
- Shaft fracture of the femur, tibia, or metatarsal;
- Impairment determinations after joint replacement of the upper or lower extremity;
- Ligamentous instability of the ankle, os calcis fracture, or loss of tibia-os calcis angle;
- Degenerative or Osteoarthritis of hip, knee, ankle, hindfoot, or midfoot;
- Intra-articular fracture or dislocation of the shoulder, elbow, or wrist (carpal bones);
- Compression fracture of vertebral body;
- Spondylolisthesis;
- Status post spinal fusion surgery;
- Fracture with allowed complication of nonunion or malunion;
- Limb length inequality secondary to trauma.

In addition, PA and lateral chest x-ray may be indicated for allowed occupational diseases of the respiratory system such as asbestosis, silicosis, and/or pneumoconioses.

Other diagnostic radiological studies such as MRI, CT scans, myelogram, arthrograms, or bone scans are rarely indicated when performing examinations. The DEP physician must obtain prior approval from BWC to perform these diagnostic studies.

POLICY D: %PPD Impairment for Loss of Vision

In the Ohio Workers' Compensation System compensation for loss of vision is based on loss of sight of “an eye” as required by Ohio statutes rather than the percent of impairment derived from the *AMA Guides to the Evaluation of Permanent Impairment* which is used for most other organ systems. This document is intended to provide a method and the rationale for determination the loss of vision sufficient to meet the administrative and legal needs of the Ohio Workers' Compensation System. It is important to remember that in the administrative process, the applicable laws and rules supersede other methods such as the *AMA Guides to the Evaluation of Permanent Impairment*.

Ohio Revised Code:

Partial disability compensation for loss of vision in Ohio is provided in Ohio Revised Code (ORC) 4123.57(B) which states:

> "For the permanent partial loss of sight of an eye, the portion of one hundred twenty-five weeks as the administrator in each case determines, based upon the percentage of vision actually lost as a result of the injury or occupational disease, but, in no case shall an award of compensation be made for less than twenty-five percent loss of uncorrected vision. "Loss of uncorrected vision" means the percentage of vision actually lost as the result of the injury or occupational disease."

This paragraph specifically instructs the determination to be based on the percentage of loss of uncorrected vision as a result of the injury or occupational disease. There is no award unless there is twenty-five percent loss of uncorrected vision. This paragraph is also focused to loss of sight of “an eye” (singular) and not of both eyes or the visual system as a whole. Since the determination is based on loss without correction of vision, aphakia and pseudophakia should be considered in the loss when appropriate.

AMA Guides to the Evaluation of Permanent Impairment, 4th Edition

This edition of the *AMA Guides to the Evaluation of Permanent Impairment,* evaluated permanent impairment by considering the corrected visual acuity for near and distant vision, visual field perception, and ocular motility with diplopia. *AMA Guides to the Evaluation of Permanent Impairment, 4th Edition* allowed the physician to combine an additional five percent (5%) to ten percent (10%) impairment for ocular or adnexal conditions that interfere with visual function and not reflected in the visual acuity, visual field, or ocular motility impairment. Examples of the abnormalities include media opacities, corneal or lens opacities, or abnormalities that caused symptoms such as epiphora, photophobia, or metamorphopsia. Up to ten percent (10%) impairment could also be considered for scars or cosmetic defects as long as they were not considered in other chapters or by other physicians.

Table 3 "Loss (in %) of Central Vision in a Single Eye" provides a table to determine the percent loss of central vision in a single eye using the measured Snellen rating for distant and near vision. The table also provides values for each combination of near and distant vision with and without allowance for monocular aphakia and pseudophakia.

Table 5 "Loss of Monocular Visual Field" provides percent loss using the total lost degrees derived from the measurement of visual fields. Figure 3 "Percentage Loss of ocular Motility of One Eye in Diplopia Fields" is used to determine the loss due to ocular motility if appropriate.

To determine the loss for each eye, the loss of vision is combined with the loss due to visual fields and any loss due to diplopia. To determine the impairment for the visual system (both eyes), the impairment for each eye is determined and combined using Table 7 "Visual System Impairment for Both Eyes". The impairment from Table 7 can be converted to whole person impairment using Table 6.

Using this method total loss of vision of one eye is twenty-five percent (25%) impairment of the visual system and 24% whole person impairment. However, as described in the section above, the Ohio Workers' Compensation System is focused by statute to the loss of vision in the eye.

AMA Guides to the Evaluation of Permanent Impairment, 5th Edition

AMA Guides to the Evaluation of Permanent Impairment, 5th Edition has focused more on the visual system and performance of activities of daily living. The process has been revised with the creation of the Functional Vision Score (FVS) which is based on the assessment of the visual acuity and visual field. In this process near vision measurements are optional and losses for diplopia and aphakia have been removed. The visual field determination is recalculated and a different formula is used to determine visual impairment.

In this edition, the measured best-corrected visual acuity is converted using Table 12-2 to a Visual Acuity Score for each eye. These are combined to provide a Functional Acuity Score using Table 12-3. If there are visual field deficits, these are determined and converted to a Visual Field Score (VFS) for each eye according to Table 12-5. Using Table 12-6, the Visual Field Scores for each eye are then combined to yield the Functional Field Score. The Functional Acuity Score and the Functional Field Score are combined to yield the Functional Vision Score. Subtracting the Functional Vision Score from 100 yields the impairment rating for the visual system. This can then be converted using Table 12-10 to whole person impairment. If needed, Near Vision (Reading Acuity) can be estimated by Table 12-11.

While this system may more accurately reflect an individual's ability to function and perform activities of daily living using both eyes (visual system), it may well underestimate or not adequately reflect the loss of vision required by Ohio statutes. In particular, the tables are based on "best-corrected" visual acuity, there is no consideration of near vision, and there is no allowance for aphakia.

Discussion:

Ohio statutes are specific for the determination of loss of vision due to work-related injuries or illnesses. The loss must be for "uncorrected vision" and an award can be given for claims when the loss exceeds twenty-five percent (25%). While advances in treatment of these injuries and illnesses may ultimately result in less loss of vision after treatment or with corrective lenses, these treatments cannot be considered in deriving a percent loss of vision.

While each edition of the AMA Guides may have its strengths and more accurately reflect the impact of a condition on function of the visual system or performance of the activities of daily living, these are not the issues to be addressed in visual loss for Ohio Workers' Compensation. Yet, it is imperative that physicians provide to all parties in the claim their objective findings at the time of examination and some estimate of the loss of vision. Additionally, it is important that the evaluations document adequate findings so the report may be relied upon in the future as evidence in the event there are changes to the current statutes.

POLICY E: %PPD Impairment for Mental and Behavioral Disorders

The purpose of this section is:

- To define the legal requirements of the Workers' Compensation System of Ohio for opinions provided by DEP mental health specialist examiners;

- To provide DEP mental health specialists a process to use consistent with the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition (Guides)* and justification to provide an impairment percentage for mental health conditions.

- To examine different approaches to the application of the *Guides* that will assist the DEP physician in quantifying functional limitations.

Section 14.3 "A Method of Evaluation Psychiatric Impairment" states "Percentages are not provided to estimate mental impairment in this edition of the *Guides*. Unlike cases with some organ systems, there are no precise measures of impairment in mental disorders. The use of percentages implies a certainty that does not exist. Percentages are likely to be used inflexibly by adjudicators, who then are less likely to take into account the many factors that influence mental and behavioral impairment. In addition, the authors are unaware of data that show the reliability of the impairment percentages."

The mental and behavioral specialist's basis for estimating impairment and functional capability is derived from the clinical history, mental status examination, review of records, and any testing performed. These findings are then incorporated in the multiaxial system of the classification of mental and behavioral disorders:

Axis I: Clinical disorders and other conditions that are the focus of treatment
Axis II: Personality and developmental disorders
Axis III: General medical conditions or physical disorders.
Axis IV: Psychosocial and environmental stressors
Axis V: Global assessment of functioning

"Axis V is a rating of the injured worker's global functional capacity and, like disability, is related directly to the effects of impairments." Impairment is determined by assessing the examinee's capability in four functional areas:

- Activities of daily living - Self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social and recreational activities, and occupational activity.

- Social functioning - An individuals' capacity to interact appropriately, communicate effectively, and get along with others.

- Concentration, persistence, and pace - The ability to sustain focused attention long enough to permit completion of tasks commonly found in the workplace.

- Adaptation - The ability to appropriately react to stressful circumstances including the workplace. These stresses may include attendance, making decisions, scheduling or completing tasks, and interacting with supervisors and coworkers.

Limitations of these activities must be caused by the specifically allowed mental disorder to qualify as impairment, and the quality of these functions is judged by whether it is performed independently, appropriately, effectively and in a sustained manner.

The DEP physician's opinion shall be justified by citing specific examples of functional ability or lack thereof in these areas. Specific reference with examples to each of these categories will strengthen the DEP physician's opinion.

The history, mental status examination, testing, and specific observations in the above functional categories are then used to classify the functional capacity of the examinee according to Table 14-1 on page 363.

Table 14-1 Classes of Impairments Due to Mental and Behavioral Disorders

The *Guides* state “in the ordinary individual, extreme impairment in only one area or marked limitation in two or more spheres would be likely to preclude the performance of any complex task, such as one involving recreation or work, without special support or assistance, such as that provided in a sheltered environment. An individual impaired to a moderate degree in all four categories of functioning would be limited in the ability to carry out many, but not all, complex tasks. Mild and moderate limitations reduce overall performance but do not preclude some performance."

To assess impairment severity, several factors shall be considered including:

- the effect of treatment,
- the effect of structured settings or modification of the environment;
- the variability and unique characteristics of the mental disorders;
- an assessment of the workplace function; and
- the effects of common mental and behavioral conditions such as substance abuse, personality disorders, somatoform pain disorders, and malingering.

Justification of impairment percentages for Table 14-1:

The DEP physician shall provide an estimate of the percentage of whole person impairment for the allowed mental health condition in the claim. Otherwise, the request for permanent partial impairment and compensation cannot be provided to the injured worker.

The *AMA Guides to the Evaluation of Permanent Impairment, 4th Edition* provided numeric impairment percentages that were found in the *2nd Edition of the AMA Guides*. Using those percentages and providing space in which to indicate the degree of impairment in each of the four functional areas under consideration the chart looks like this (Table 1):

Table 1: Classification of Impairment due to Mental and Behavioral Disorders

Classes of Impairment	Class 1 No Impairment	Class 2 Mild Impairment	Class 3 Moderate Impairment	Class 4 Marked Impairment	Class 5 Extreme Impairment
% of Impairment	0-5%	10-20%	25-50%	51-75%	>75%
Description of Impairment Severity	No impairment noted	Impairment levels are compatible with most useful functioning	Impairment levels are compatible with some, but not all, useful functioning	Impairment levels significantly impede useful functioning	Impairment levels preclude useful functioning
Activities of Daily Living					
Social Functioning					
Concentration					
Adaptation					

The Central and Peripheral Nervous System in Chapter 13, Table 13-8, of the *Guides,* 5th Edition offers another classification of Emotional or Behavioral Disorders. While the description and percentages for the categories are somewhat different, they at least provide information that may be used to provide a numeric estimate of impairment. These percentages and description of the Classes are shown below in Table 2.

Table 2: Criteria for Rating Impairment Due to Emotional or Behavioral Disorders Table 13-8

Class 1 **0-14% Impairment of the Whole Person**	**Class 2** **15-29% Impairment of the Whole Person**	**Class 3** **30-69% Impairment of the Whole Person**	**Class 4** **70-90% Impairment of the Whole Person**
Mild limitation of activities of daily living and daily social and interpersonal functioning	Moderate limitation of some activities of daily living and some daily social and interpersonal functioning	Severe limitation in performing most activities of daily living, impeding useful action in most daily social and interpersonal functioning	Severe limitation of all daily activities, requiring total dependence on another person.

Finally, the type of treatment and the frequency of treatment may also be also considered in determining the degree of impairment or assist the DEP physician by providing a check point for other estimates. Class 1 might require no treatment; Class 2 might require medication and monthly or biweekly counseling sessions; Class 3 requires periodic supervision; Class 4 assisted living or day care; Class 5 institutionalization.

By considering these different clinical descriptions and impairment methods, mental health professionals have several methods that may assist them in justifying their estimates of whole person impairment for mental health conditions that are specifically allowed in workers' compensation claims.

Guidelines specific to mental health providers include the following:

- The report must provide an estimate of the whole person percent impairment based only on the specific allowed mental health conditions in the claim.
- Please cite the *AMA Guides* to justify your conclusions and explain your reasoning.
- BWC allows the mental health evaluator to perform without prior authorization one psychological test (preferably the MMPI-2) for impairment evaluations. Reimbursement for the test requires the DEP physician to submit the following with the report:
    - A complete copy of the test be submitted with the report;
    - The interpretation of test be included with the report; and
    - The DEP physician's summary or comments correlating the interpretation of the test with his/her interview and evaluation of the injured worker must be stated in the report in a designated section.

The examination report shall be consistent between your history, examination, any testing performed, review of medical records, and your impairment estimate. If there are inconsistencies, provide an explanation and reasoning for your opinion that justify your conclusion.

POLICY F: %PPD Impairment for Pain

***AMA Guides to the Evaluation of Permanent Impairment, 5th Edition (Guides)* – Chapter 18**

The text itself provides several statements regarding the credibility of the process including acknowledgement that pain is subjective; that pain cannot be validated or objectively measured; that there is frequently lack of association between complaints and well defined biological abnormalities; and that to a certain extent pain has been addressed in the impairment in other chapters.

The text also introduces several decisions or terms that are controversial, not well accepted, or at best vague. This includes the decision of whether a given pain condition is well accepted within the medical community and vagueness about when Chapter 18 should and should not be used such as "any injury to the nervous system". Other potential controversial decisions are whether a condition is "ratable" or "un-ratable", whether the impact of pain is "encompassed" in the conventional impairment or whether additional "pain-related impairment" is appropriate. Even when the DEP physician believes additional "pain-related impairment" may be appropriate, the DEP physician must then decide whether the pain-related impairment is the result of a slight increase in burden due to pain or substantial increase in burden due to pain.

The process recommended by the *Guides* to be followed is also burdensome and may not truly provide objective evidence of impairment. If the DEP physician decides that there is a substantial increase in burden due to pain, the DEP physician then must perform a "formal pain assessment" which consists of a self-reported questionnaire scored by the DEP physician, an assessment of the credibility of the examinee by the DEP physician, and an assessment of the pain behavior exhibited by the examinee and interpreted by the DEP physician. The results of the "formal pain assessment" are used to create a pain-related impairment score which does not represent impairment, but rather is used to determine an impairment severity class that lacks any percent of impairment.

The pain severity class also indicates criteria which are never directly assessed or considered such as use of medication or modifications to the injured worker's normal activities. In fact, the questionnaire addressing activities of daily living raises issues as to whether it is assessing the Ohio Supreme Court's definition of impairment ("the amount of the claimants' anatomical and/or mental loss of function caused by the allowed condition") or the Supreme Court's definition of disability ("the effect the impairment has on the claimant's ability to work").

Another issue is whether to award the three percent (3%) pain-related impairment when the maximum impairment allowed for a Diagnosis Related Estimate (DRE) category in the spine has already been awarded. The *Guides*, Chapter 15, in the discussion of lumbar spine DRE categories states, "Each category includes a range to account for the resolution or continuation of symptoms and their impact on the ability to perform ADL." According to Chapter 18, the system to rate pain impairment "assesses pain intensity, emotional distress related to pain, and ADL deficits secondary to pain. ADL deficits are given the greatest weight." According to the *Guides*, the “discretionary” three percent (3%) is capped for consistency with other features of the *Guides*, and is to be combined (page 283) with other conventional impairment rating to form the final whole person impairment rating.

Also, if the injured worker is given a discretionary impairment award in another chapter of the *Guides*, a second discretionary award based on the individual’s pain is not given." As a result of these statements, it is the BWC position that the three percent (3%) for the impact on Activities of Daily Living and Pain described in the spine and pain chapters are one and the same. To provide two or more three percent (3%) impairments for the injured worker would be providing multiple impairments for the same reason or for the same limitations.

The authors of Chapter 18 state: the procedure "permits administrative agencies to count "conventional" impairment ratings and pain-related impairment ratings on an equal footing, to discount pain-related impairment ratings, or to disregard them entirely". The authors also indicate it is the decision of the administrative agency as to whether individuals with "un-ratable" pain-related impairments should be compensated. Therefore, they have provided wide leniency on methods of implementation for agencies that would still allow the agency to comply with the chapter.

The United States Department of Labor for the Federal Workers’ Compensation System has instructed examiners for its programs (Black Lung, Marine Fund, etc.) as follows:

"For OWCP purposes, this chapter (Chapter 18) should be applied in the following manner:

a. The physician measures organ function according to other chapters in the Guides and establishes an impairment percentage;

b. If the conventional impairment adequately encompasses the burden produced by pain, the formal impairment rating is as determined above;

c. If pain-related impairment appears to increase the burden of the individual's condition slightly, the examiner can increase the percentage found in step (a) by up to three percent (3%);

d. If pain-related impairment appears to increase the burden of the individual's condition substantially, the examiner can increase the percentage found in step (a) by three percent (3%)."

Procedure for pain evaluation for BWC

BWC requires physicians performing impairment evaluations for BWC to follow the process outlined below (the process is very similar to that implemented by the United States Department of Labor):

- Perform impairment evaluation examinations according to Chapters 1-17 AMA *Guides, 5th Edition.*

- While obtaining history, perform informal pain assessment addressing pain related issues such as ongoing pain symptoms; character, frequency, location, and intensity of pain; current treatment and medications used and frequency, past pain treatment, impact on Activities of Daily Living, and impact on current work activities.

- Determine conventional body system impairment rating using AMA *Guides, 5th Edition*. If the DEP physician believes that the conventional body system impairment percentage adequately encompasses the impact of the allowed condition(s) due to pain, the DEP physician provides the conventional impairment percentage. The DEP physician uses as justification for this opinion information from the medical records provided, the history and the injured worker's examination, his/her ability to work and perform activities of daily living, and use of medication, that additional pain impairment is not indicated.

- If the DEP physician believes that the conventional body system impairment percentage derived in Chapter 1-17 is not adequate to encompass the impact of pain, that the pain is due to an allowed condition(s), and that the pain is consistent with accepted pain syndromes, the DEP physician should state this in the report and justify by using information such as the severity of pain, limitations, impact on activities of daily living, and medication usage. The DEP physician should award one to three percent (1-3%) impairment, which is combined, with the impairment from the conventional body system impairment. Other than stating that the pain is medically acceptable and related to the allowed conditions in the claim, no other statement of credibility is necessary. Note: Only one three percent (1%) discretionary impairment (e.g., Spine or Pain) can be awarded per individual since both impairments are granted primarily for impact on ADLs.

- If the DEP physician finds or the injured worker alleges/describes additional burden of pain that is not consistent with accepted pain syndromes or not related to the allowed conditions of the claim, the DEP physician should state this in the report. He/she shall then state that additional Pain Impairment does not apply and provide a reason such as the symptoms are not due to the allowed conditions, inconsistent with other aspects of the evaluation, inconsistent anatomical distribution, etc. He/she then provides the conventional impairment percent.

- DEP physicians may use pain drawings, analog scales, or a copy of Table 18-4 "Ratings Determining Impairment Associated with Pain" to assist them. These assessment documents may be submitted with their report, but is not required above a narrative explanation that reflects a thorough evaluation and justification for the DEP physician's opinion.

POLICY G: %PPD Impairment General Information

In some cases, BWC may ask you limit your examination to specific conditions. For example, the conditions in a claim may require examination by different specialists (e.g., there are both physical and psychological conditions in the claim). In your report, be certain to indicate the conditions that you evaluated.

We have developed consistent language for reducing an award for percentages granted in the same claim or for the same part of body in a different claim.

We have created a standard question regarding apportionment of a prior %PPD impairment rating. The need to apportion a prior award occurs when an injured worker has received a %PPD impairment rating in a claim for multiple parts of the body and one or more (but not all) of the parts of the body are the same as in the claim for which we ask you conduct an exam.

You must subtract the portion of the prior award that is for the overlapping part(s) of body from the current percentage. Sometimes it is not possible to rely on the *Guides to the Evaluation of Permanent Impairment 5th Edition (Guides)* to apportion a prior award. For example, a hearing officer may not have based the medical evidence to grant a %PPD impairment rating on the *Guides*. The hearing officer may have chosen a percent that was within the range of supporting medical evidence. In those cases, you must use your expertise and best judgment in apportioning the prior award.

We acknowledge there is a difference in the standards for an impairment rating between Ohio Rule and the *Guide*. In Ohio, we must process the %PPD application if it is timely filed, even if the injured worker is not at maximum medical improvement (MMI) or medically stable at the time of the examination. This differs from the standard of an injured worker being MMI according to the *Guides*.

When we request this DEP service, you must provide a -%PPD impairment. If you cannot determine the %PPD impairment at the time, you must report zero percent (0%). You must report zero percent (0%) even if the reason you cannot determine the amount of impairment is that in your opinion the injured worker is not MMI or medically stable.