

*** DRAFT - NOT YET FILED ***

4123-6-21

Payment for outpatient medication.

- (A) ~~Medication~~ Except as otherwise provided in rule 4123-6-21.6 of the Administrative Code, medication must be for the treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer. The bureau may deny a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of the allowed conditions in a claim.
- (B) Medication may be prescribed by any treating provider authorized by law to prescribe such medication; however, reimbursement for medication shall be denied under the following circumstances:
- (1) Reimbursement for prescriptions written by providers who are not enrolled with the bureau and who refuse to become enrolled shall be denied.
 - (2) Reimbursement for prescriptions written by providers who are enrolled but non-certified shall be denied except in the following situations:
 - (a) The prescription is written by a non-bureau certified provider during initial or emergency treatment of the claimant if the claimant's claim and treated conditions are subsequently allowed.
 - (b) The prescription is written by a non-bureau certified provider who is outside the state or within the state where no or an inadequate number of bureau certified providers exist and the MCO has determined that the treatment to be provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider and has authorized the non-bureau certified provider to continue to provide the treatment.
 - (c) The prescription is written by a non-bureau certified provider for a claimant with a date of injury prior to October 20, 1993, the provider was the claimant's physician of record prior to October 20, 1993, and the claimant has continued treatment with that non-bureau-certified provider.
 - (3) Reimbursement for prescriptions of controlled substances written by Ohio providers who are not enrolled in OARRS and refuse to become enrolled shall be denied if the provider has written prescriptions for controlled substances for the purpose of providing chronic care. For purposes of this

rule:

- (a) "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.
 - (b) "OARRS" means the "Ohio Automated Rx Reporting System" drug database established and maintained pursuant to section 4729.75 of the Revised Code.
 - (c) "Written for the purpose of providing chronic care" means the provider has written three or more prescriptions for controlled substances for the same injured worker in a twelve week period.
- (C) Drugs covered are limited to those that are approved for human use in the United States by the food and drug administration (FDA) and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.
- (D) The bureau may require prior authorization of certain drugs or therapeutic classes of drugs, and shall publish a list of all such drugs or therapeutic classes of drugs for which prior authorization is required.
- (E) Drugs which fall into one of the following categories may be prior authorized by and reimbursed through the bureau's pharmacy benefits manager:
- (1) Compounded sterile parenteral drug products.
 - (a) "Parenteral" drugs are injectable medications. They may include those intended for use by the intrathecal, intravenous, intramuscular, or subcutaneous routes of administration.
 - (b) All compounded sterile parenteral drug products must be prepared and dispensed by a licensed and enrolled pharmacy provider that is able to demonstrate compliance with the standards contained in chapter 797 of the United States pharmacopeia (USP) in effect on the billed date of service.
 - (2) Drug efficacy study implementation (DESI) drugs or drugs that may have been determined to be identical, similar, or related;
 - (3) Extemporaneous compounded prescriptions.

- (a) Reimbursement for non-sterile compounded prescriptions shall only be considered for preparations that contain not less than one nor more than three FDA approved active pharmaceutical ingredients, and that contain only one prescription drug from any specific therapeutic class of drugs (as defined in the edition of the "American Hospital Formulary Service Drug Information" in effect on the billed date(s) of service).
 - (b) Reimbursement for non-sterile compounded prescriptions shall only be considered upon the submission of both:
 - (i) A prior authorization request, and
 - (ii) A copy of the signed prescription that lists all active pharmaceutical ingredients and indicates the usual and customary cost of the prescription.
 - (c) Approval for reimbursement of non-sterile compounded prescriptions will be for an initial period of ninety days with subsequent approvals contingent upon clinical documentation of improvement in both pain and function. Not more than one prescription for a non-sterile compounded prescription will be approved for reimbursement in any thirty day period.
- (F) Drugs which fall into one of the following categories may be approved and reimbursed by an MCO as part of a comprehensive treatment plan submitted by the physician of record or treating physician:
- (1) Drugs for the treatment of obesity;
 - (2) Drugs for the treatment of infertility;
 - (3) Non-compounded injectable drugs not intended for self-administration;
 - (4) Drugs used to aid in smoking cessation;
 - (5) Drugs dispensed to a claimant while the claimant is admitted to a hospital during an approved inpatient admission or during the course of an outpatient visit in a hospital.
- (G) Payment for medications to pharmacy providers shall include both a product cost

component and a dispensing fee component.

(1) Except as provided in this paragraph, product cost component shall be the lesser of the following: maximum allowable cost, if applicable, or the average wholesale price (AWP) of the commonly stocked package size minus nine per cent.

(a) For repackaged brand name medications, the product cost component shall be calculated using the AWP of the original labeler.

(b) For non-sterile compounded prescriptions, the product cost component shall be limited to the lesser of the usual and customary price or the AWP of the commonly stocked package size minus nine per cent for each ingredient.

(c) The maximum reimbursement for any one ~~compounded~~ compounded prescription will be six hundred dollars.

(2) The dispensing fee component for non-compounded prescriptions shall be three dollars and fifty cents.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component of two dollars and fifty cents for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN) per rolling twenty-five days. Exceptions to the single dispensing fee are:

(i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;

(ii) Cases where the physician has changed the dosage;

(iii) Cases where the medication did not last for the intended days supply;

~~(iv) Cases where the medication has been lost, stolen or destroyed;~~

~~(v)~~(iv) Controlled substances (which are limited to two dispensing fees

per twenty-five days).

- (3) The dispensing fee component for non-sterile compounded prescriptions shall be twelve dollars and fifty cents.
 - (4) The dispensing fee component for sterile compounded prescriptions shall be twenty-five dollars.
- (H) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined by the bureau. The bureau shall not reimburse any third-party pharmacy biller that submits pharmacy bills on behalf of a pharmacy provider or that has purchased pharmacy bills from a pharmacy provider for subsequent submission to the bureau for payment. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or the bureau's pharmacy benefit manager's payment system must be used for billing purposes. The pharmacy provider shall:
- (1) Maintain a signature log verifying receipt by the injured worker of applicable covered medications;
 - (2) Include prescriber information within bills submitted electronically to the bureau or the bureau's pharmacy benefits manager for payment. The prescriber information must include the national provider identifier (NPI) or the drug enforcement administration (DEA) number;
 - (3) Not pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services for which payment may be made by the bureau, the bureau's pharmacy benefits manager, or MCO under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;
 - (4) Comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service.
- (I) The bureau may establish a maximum allowable cost for single source or multi-source

medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations" in effect on the billed date(s) of service. The methodology used to determine a maximum allowable cost for a qualified drug product shall be determined by the bureau. For multi-source drugs, the bureau may choose to utilize the maximum allowable cost list of a vendor or develop its own maximum allowable cost list. For single source drugs, the maximum allowable cost shall be the drug's average wholesale price minus nine per cent.

(J) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication for which single source or multi-source medications exist that are pharmaceutically and therapeutically equivalent, as defined in paragraph (I) of this rule, shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price of the dispensed brand name drug minus nine percent. However, the bureau may approve reimbursement of the dispensed brand name drug at the average wholesale price of the drug minus nine per cent if the following circumstances are met:

- (1) The injured worker has a documented, systemic allergic reaction which is consistent with known symptoms or clinical findings of a medication allergy; and
- (2) The injured worker has been prescribed, and has tried, other A code drugs in the therapeutic class and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.

(K) The following dispensing limitations may be adopted by the bureau:

- (1) The bureau may publish supply limitations for drugs which represent the maximum number of days supply that may be dispensed at any one time for a single prescription.
- (2) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.
- (3) Requests submitted that exceed any published days supply limit or maximum quantity limit shall be denied. Denials may be overridden by the bureau in cases where medical necessity and appropriateness have been determined.

(4) Refills requested before seventy-five per cent of any published days supply limit has been utilized will be denied, except in cases where the dosage of a drug has been changed and has a new prescription number. Denials may be overridden by the bureau for the following documented reasons:

~~(a) Previous supply was lost, stolen or destroyed;~~

~~(b)~~(a) Pharmacist entered previous wrong day supply;

~~(e)~~(b) Out of country vacation or travel;

~~(d) Hospital or police kept the medication;~~

~~(e)~~(c) Pharmacy will be closed for more than two days.

~~(f)~~(d) An emergency or disaster, as defined in division (O) of section 4123.511 of the Revised Code, is declared by the governor of Ohio or the president of the United States.

(L) Except as otherwise provided in paragraph (F) of this rule, outpatient medications shall be billed to and reimbursed through the bureau's pharmacy benefits manager. Pharmacy providers must submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the bureau's pharmacy benefits manager's established bill processing system as a condition of provider enrollment or reimbursement. Submission by paper or by tape-to-tape will not be accepted by the bureau or the bureau's pharmacy benefits manager.

(M) Claimant reimbursement for medications shall be in accordance with rule 4123-6-26 of the Administrative Code. Claimant requests for reimbursement shall comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service. Claimant reimbursement may be limited to the following situations:

(1) Claimants whose ~~claims are not allowed~~ medication is not payable under division (I) of section 4123.511 of the Revised Code on the date of service, but are subsequently allowed later becomes payable;

(2) Emergency situations where an enrolled pharmacy provider with point-of-service capabilities is not available;

(3) Claimants who reside out of the country.

- (N) The bureau may formulate medication utilization protocols for select conditions or diseases consistent with current medical texts and peer reviewed medical literature.

Compliance with the established protocols shall be monitored through the on-line, point-of-service adjudication system. Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's refusal to reimburse for such medications.

- (O) A "pharmacy provider" designation and provider number can be obtained by a provider who meets all the following criteria:

(1) Has a valid "terminal distributor of dangerous drugs" as defined in section 4729.01 of the Revised Code if located within Ohio; or an equivalent state license if located outside of Ohio; and,

(2) Has a valid drug enforcement agency (DEA) number; and,

(3) Has a licensed registered pharmacist in full and actual charge of a pharmacy; and,

(4) Has the ability and agrees to submit bills at the point of service.

All state and federal laws relating to the practice of pharmacy and the dispensing of medication by a duly licensed pharmacist must be observed.

- (P) The bureau may contract with a pharmacy benefit manager to perform drug utilization review and on-line bill processing, maintain a pharmacy provider network and prior authorization program for medications, and provide management reports. The bureau or its vendor may also contract rebate agreements with drug manufacturers. The bureau may utilize other services or established procedures of the pharmacy benefits manager which may enable the bureau to control costs and utilization and detect fraud.

- (Q) The bureau may identify circumstances under which it may consider reimbursement for pharmacist professional services (also known as cognitive services) when payment for such services results in a measurable, positive outcome. The bureau shall be responsible for developing the criteria which will be used to assess the compensability of billed pharmacist professional services. The bureau shall be responsible for developing the structure of the reporting of the measurable outcomes used to justify the payment of pharmacist professional services, which

may included reimbursement for the dispensing fee component. The amount that could be reimbursed for pharmacist professional services shall be determined by the bureau.

- (R) The bureau shall retain a registered pharmacist licensed in the state of Ohio to act as the full-time pharmacy program director to assist the bureau in the review of drug bills. The pharmacy program director may assist the bureau in determining the appropriateness, eligibility, and reasonableness of compensation payments for drug services. The bureau may adopt a drug formulary with the recommendation of the bureau's pharmacy and therapeutics committee established by rule 4123-6-21.2 of the Administrative Code, and may consult with the committee on the development and ongoing annual review of the drug formulary and other issues regarding medications.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

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4123-6-21.1

Payment for outpatient medication by self-insuring employer.

- (A) Medication must be for treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer.
- (B) Medication may be prescribed by any treating provider authorized by law to prescribe such medication.
- (C) Drugs covered are limited to those that are approved for human use in the United States by the food and drug administration (FDA) and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.
- (D) A self-insuring employer may approve and reimburse for various drugs as a part of a comprehensive treatment plan submitted by the physician of record or a treating physician when reasonably related to and medically necessary for treatment of the allowed conditions in the claim, provided that such approval and reimbursement shall not constitute the recognition of any additional conditions in the claim even if such drugs are used to treat conditions that have not been allowed in the claim.
- (E) Payment for medications to pharmacy providers shall include both a product cost component and a dispensing fee component.
 - (1) Except as provided in this paragraph, product cost component shall be the lesser of the following: maximum allowable cost established under paragraph (O) of this rule, if applicable, or the average wholesale price (AWP) of the commonly stocked package size minus nine per cent.
 - (a) For repackaged brand name medications, the product cost component shall be calculated using the AWP of the original labeler.
 - (b) For non-sterile compounded prescriptions, the product cost component shall be limited to the lesser of the usual and customary price or the AWP of the commonly stocked package size minus nine per cent for each ingredient.
 - (c) The maximum product cost component reimbursement for any one compounded prescription will be six hundred dollars.
 - (2) The dispensing fee component for non-compounded prescriptions shall be three

dollars and fifty cents, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider pursuant to rule 4123-6-46 of the Administrative Code.

- (a) Only pharmacy providers are eligible to receive a dispensing fee.
 - (b) The dispensing fee may include an additional incentive component of two dollars and fifty cents for pharmacy providers that accept assignment.
 - (c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN), or other proprietary code that serves to group together pharmaceutically equivalent products (defined as products that contain the same active ingredients in the same strengths, dosage forms, and routes of administration), per rolling twenty-five days. Exceptions to the single dispensing fee are:
 - (i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;
 - (ii) Cases where the physician has changed the dosage;
 - (iii) Cases where the medication did not last for the intended days supply;
 - ~~(iv) Cases where the medication has been lost, stolen or destroyed;~~
 - ~~(v)~~(iv) Controlled substances (which are limited to two dispensing fees per twenty-five days;
 - ~~(vi)~~(v) Cases where the self-insuring employer determines the limitations of this paragraph to be unnecessary under the specific circumstances.
 - (3) The dispensing fee component for non-sterile compounded prescriptions shall be twelve dollars and fifty cents.
 - (4) The dispensing fee component for sterile compounded prescriptions shall be twenty-five dollars.
- (F) The pharmacy provider is required to bill medication at their usual and customary

charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined in paragraph (E) of this rule, unless the self-insuring employer has negotiated a payment rate with the provider pursuant to rule 4123-6-46 of the Administrative Code. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(G) The pharmacy provider shall:

- (1) Maintain a signature log verifying receipt of applicable covered medications;
- (2) Include prescriber information within bills submitted electronically to the self-insuring employer or its vendor for payment. The prescriber information must include the national provider identifier (NPI) or the drug enforcement administration (DEA) number;
- (3) Not pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services for which payment may be made by the self-insuring employer or its vendor or QHP under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;
- (4) Comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service.

(H) Claimant reimbursement for medications shall be in accordance with rule 4123-6-26 of the Administrative Code and shall at least be equal to the bureau's established rate for the medication, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider utilized by the claimant pursuant to rule 4123-6-46 of the Administrative Code, in which case the claimant reimbursement shall be at least the rate negotiated with the provider. Claimant requests for reimbursement shall comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service. Requests for reimbursement must be paid within thirty days of receipt of the request.

(I) Self-insuring employers must obtain a drug utilization review from a physician before terminating payment for current medications, as follows:

- (1) Before terminating payment for current medications, the self-insuring employer shall notify all parties to the claim (including authorized representatives) and the prescribing physician, in writing, that a physician drug review is being performed, or has been performed, regarding the necessity and appropriateness of the continued use of current medications (by therapeutic drug class).
- (2) The written notice shall inform all parties to the claim (including authorized representatives) and the prescribing physician that they have twenty-one days from receipt of the notice to provide additional information and/or medical documentation to justify the need for continued use of the medications (by therapeutic drug class).
- (3) The self-insuring employer shall provide all medically related information regarding the medications to an independent physician reviewer for review and opinion as to the necessity or appropriateness of the medications. If the self-insuring employer has obtained an independent physician reviewer's report prior to sending the notice required by paragraph (I)(1) of this rule and subsequently receives additional information and/or medical documentation pursuant to paragraph (I)(2) of this rule, the self-insuring employer shall provide the additional information and/or medical documentation to the independent physician reviewer and obtain an addendum. The independent physician reviewer's report (and addendum, if applicable) shall address the medical rationale, necessity and appropriateness of the drug treatment in the control of symptoms associated with the allowed conditions in the claim.
- (4) When the independent physician reviewer's report (and addendum, if applicable) indicates the drug treatment is not medically necessary or appropriate for treatment or in the control of symptoms associated with the allowed conditions in the claim, the self-insuring employer may terminate reimbursement for the medications (by therapeutic drug class) effective as of the date of receipt of the independent physician reviewer's report, or addendum if one is obtained, or in the case that a drug is in a therapeutic class that requires a "weaning-off" period, such other date as agreed to by the prescribing physician and self-insuring employer.
- (5) In the event the self-insuring employer terminates reimbursement for the medications as set forth in paragraph (I)(4) of this rule, the self-insuring employer or its authorized representative shall provide all parties to the claim (including authorized representatives) and the prescribing physician with a copy of the independent physician reviewer's report (and addendum, if applicable) and the self-insuring employer shall notify the employee and the employee's representative in writing of its decision to terminate. The

employer's notification to the employee and employee's representative shall indicate that the employee has the right to request a hearing before the industrial commission.

(6) In the event there is a dispute as to whether the drug treatment is medically necessary or appropriate for treatment of the symptoms associated with the allowed conditions in the claim, the disputed matter shall be adjudicated in accordance with paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.

(J) Self-insuring employers may deny initial requests for a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for the treatment of the allowed conditions in a claim.

(K) Self-insuring employers may utilize medication utilization protocols formulated by the bureau for select conditions or diseases consistent with current medical texts and peer reviewed medical literature.

Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's or self-insured employer's refusal to reimburse for such medications.

(L) Through internal development or through vendor contracts, self-insuring employers may implement a point-of-service adjudication system. Upon implementation, a self-insuring employer may require pharmacy providers to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the established bill processing system as a condition of reimbursement, and may refuse submission by paper or by tape-to-tape. Self-insuring employers utilizing a point-of-service adjudication system may refuse to reimburse any third-party pharmacy biller that submits pharmacy bills on behalf of a pharmacy provider or that has purchased pharmacy bills from a pharmacy provider for subsequent submission to the self-insuring employer for payment.

(M) Self-insuring employers utilizing a point of service adjudication system may require prior authorization of drugs or therapeutic classes of drugs which appear on the bureau's published list of drugs or therapeutic classes of drugs for which prior authorization is required.

(N) Self-insuring employers utilizing a point-of-service adjudication system may apply the following dispensing limitations, adopted by the bureau, to medications approved and reimbursed by the self-insuring employer:

- (1) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.
- (2) Requests submitted that exceed either the days supply limit or maximum quantity limit shall be denied; provided, however, that the pharmacy provider may still fill the prescription up to the days supply limit or maximum quantity limit, as applicable. Denials may be overridden by the self-insured employer in cases where medical necessity and appropriateness have been determined.
- (3) Refills requested before seventy-five per cent of the days supply has been utilized will be denied, except in cases where the dosage of a drug has been changed and has a new prescription number. Denials may be overridden by the self-insured employer for the following documented reasons:
 - ~~(a) Previous supply was lost, stolen or destroyed;~~
 - ~~(b)(a) Pharmacist entered previous wrong day supply;~~
 - ~~(c)(b) Out of country vacation or travel;~~
 - ~~(d) Hospital or police kept the medication;~~
 - ~~(e)(c) Pharmacy will be closed for more than two days.~~
 - ~~(f)(d) An emergency or disaster, as defined in division (O) of section 4123.511 of the Revised Code, is declared by the governor of Ohio or the president of the United States.~~
- (O) Self-insuring employers utilizing a point-of-service adjudication system may apply the maximum allowable cost list of the point-of-service adjudication system vendor for multi-source medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations" in effect on the billed date(s) of service. For single source drugs, self-insuring employers utilizing a point-of-service adjudication system may utilize as a maximum allowable cost the drug's average wholesale price minus nine per cent.
- (P) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication for

which single source or multi-source medications exist that are pharmaceutically and therapeutically equivalent, as defined in paragraph (O) of this rule, shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price of the dispensed brand name drug minus nine per cent. However, the self-insuring employer or its vendor may approve reimbursement of the dispensed brand name drug at the average wholesale price of the drug minus nine per cent if the following circumstances are met:

- (1) The injured worker has a documented, systemic allergic reaction which is consistent with known symptoms or clinical findings of a medication allergy;
and
 - (2) The injured worker has been prescribed, and has tried, other A code drugs in the therapeutic class and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.
- (Q) A self-insuring employer has sufficient grounds to refuse to pay for the dispensing of drugs and other medications when a pharmacy provider fails to observe any state or federal law relating to his or her professional licensure or to the dispensing of drugs and other medication.

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Date

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4123-6-22

Stakeholders' health care quality assurance advisory committee.

The bureau of workers' compensation stakeholders' health care quality assurance advisory committee (HCQAAC) was created to advise the administrator, the chief of medical services, and the chief medical officer with regard to medical quality issues. A list of medical providers, each holding a professional license in good standing, who have agreed to serve on the HCQAAC, and who would add credibility and diversity to the mission and goals of the HCQAAC shall be developed and maintained by the chief medical officer. Providers may be nominated for inclusion on the list by provider associations and organizations including but not limited to: deans of Ohio's allopathic and osteopathic medical schools, deans of Ohio's colleges of pharmacy, deans of Ohio's dental schools, the dean of the Ohio college of podiatric medicine, the Ohio state medical association, the Ohio state osteopathic association, the Ohio state chiropractic association, specialty board associations of Ohio, the Ohio podiatric medical association, the Ohio psychological association, the Ohio dental association, the Ohio pharmacists association, the Ohio hospital association, the Ohio state medical board, the Ohio state chiropractic board, the Ohio state psychology board, the Ohio state pharmacy board, and the Ohio state dental board.

(A) The HCQAAC shall consist of the bureau's chief medical officer, the chief of medical services and not more than thirteen nor less than five voting members representing the diverse group of providers that provide medical care to the injured workers of Ohio as administrated through the bureau. The committee may create any subcommittees that the committee determines are necessary to assist the committee in performing its duties. Any subcommittee recommendations shall be submitted to the HCQAAC committee.

(B) HCQAAC members must meet the following requirements:

- (1) Providers must be familiar with issues relating to the treatment of injured workers in the Ohio workers' compensation system.
- (2) Providers must possess significant clinical or administrative experience in health care delivery, including but not limited to, medical quality assurance, disease management, and utilization review.
- (3) Providers must have experience with and an understanding of the concepts of evidence based medicine as well as contemporary best practices in their respective areas of practice.

(C) The appointing authority for members of the HCQAAC shall be the administrator or

the administrator's designee(s), who shall appoint members of the HCQAAC from the list of qualified providers developed and maintained by the chief medical officer. Terms of membership for individual members of the HCQAAC shall be for one year. Individuals may be reappointed to subsequent terms as determined by the administrator. Vacated terms shall be filled in a like manner as for the full term appointments and shall be for the remaining term of the vacated member.

- (D) The chief medical officer of the bureau shall be the chairperson of the HCQAAC and shall provide notice of meeting to the members and be responsible for the meeting agenda. In addition, the chief medical officer and chief of medical services may be self-designated as an ad hoc member of any subcommittees of the HCQAAC; ~~however,~~. However, the chief of medical services shall not be a voting member of the HCQAAC or any subcommittee, and the chief medical officer shall be a voting member of the HCQAAC and any subcommittees only in the case of tie votes. The bureau's medical director, the industrial commission's medical director, and one physician chosen by the MCOs may participate in discussions; however, they shall not be voting members.
- (E) The HCQAAC shall develop and establish bylaws for the organization and operations of the committee and subcommittees, subject to the requirements of this rule and approval by the administrator and the chief medical officer.
- (F) The HCQAAC shall be responsible to respond to requests for action on any medical quality assurance issue submitted by the bureau's administrator, chief of medical services, or chief medical officer including, but not limited to:
- (1) Review of medical treatment guidelines referred to the bureau;
 - (2) Review of any of the bureau's policies and procedures related to medical quality assurance issues;
 - (3) Review of any of the bureau's medical providers' professional performance and conduct, including bureau certification and malpractice issues. The HCQAAC shall perform peer review according to generally accepted standards of medical practice and may recommend sanctions as well as decertification of any provider determined to have consistently failed to meet those standards of care;
 - (4) Review of any of the bureau's managed care organizations' professional performance and conduct regarding the management of medical services for the bureau. This may include interfacing with any quality assurance committee of any of the individual managed care organizations.

The HCQAAC may make such recommendations as it deems necessary to address any medical quality assurance issue impacting the bureau.

- (G) The HCQAAC shall hold at least quarterly meetings. The HCQAAC and all subcommittees shall keep written records of the agenda and minutes of each meeting. The records of all committees shall remain in the custody of the chief medical officer.
- (H) The HCQAAC shall submit an annual report of its activities and recommendations to the administrator. In addition to inclusion in the annual report, all recommendations from the HCQAAC and subcommittees shall be submitted to the chief medical officer in a timely fashion upon completion and approval by the respective subcommittees and HCQAAC committee.
- (I) Each member of the HCQAAC and its respective subcommittees may be paid such fees as approved by the administrator or administrator's designee. The expenses incurred by the HCQAAC and its subcommittees and the fees of their members shall be paid in the same manner as other administrative costs of the bureau.

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4123-6-25

Payment for medical supplies and services.

- (A) Medical or other services to be approved for payment must be rendered as a direct result of an injury sustained or occupational disease contracted by a claimant in the course of and arising out of employment. The claim must be allowed by an order of either the bureau of workers' compensation or the industrial commission, or have been recognized by a self-insuring employer.

Medical supplies and services will be considered for payment when they are medically necessary for the diagnosis and treatment of conditions allowed in the claim, are causally related to the conditions allowed in the claim, and are rendered by a health care provider. Payment for services rendered to a claimant shall be paid to a health care provider only when the provider has either delivered, rendered or ~~directly~~ supervised the examination, treatment, evaluation or any other medically necessary and related services ~~provided to the claimant~~. Provider supervision of services shall comply with the requirements of the provider's regulatory board and the centers for medicare and medicaid services (CMS), if applicable, for supervision of the service, as in effect on the billed date of service, unless otherwise specified in the bureau's provider billing and reimbursement manual in effect on the billed date of service. By submitting any fee bill to the bureau, in either hardcopy or electronic format, the health care provider affirms that medical supplies and services have been provided to the claimant as required by this rule.

Providers billing for services rendered shall follow the procedures set forth in the bureau's provider billing and reimbursement manual in effect on the billed date of service.

- (B) Services rendered by health care providers are subject to review for coding requirements outlined in paragraph (C) of this rule. Payments to health care providers may be adjusted based upon these guidelines.

(C) Coding systems.

(1) Billing codes.

- (a) Practitioners are required to use the edition of the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) in effect on the billed date of service to indicate the procedure or service rendered to injured workers.

- (b) Inpatient and outpatient hospital services must be billed using the national uniform billing committee's revenue center codes in effect on the billed

date of service (date of discharge for inpatient services).

- (c) Outpatient medication services must be billed pursuant to the requirements described in the bureau's provider billing and reimbursement manual in effect on the billed date of service.
- (d) To insure accurate data collection, the bureau shall adopt a standardized coding structure which shall be adopted by any MCO, QHP, or self-insuring employer.

(2) Diagnosis codes.

Providers must use the appropriate "International Classification of Diseases, clinical modification" codes for the condition(s) treated to indicate diagnoses.

- (D) Prior to services being delivered, the provider must make reasonable effort to notify the claimant, bureau, MCO, QHP or self-insuring employer when the provider has knowledge that the services may not be related to the claimed or allowed condition(s) related to the industrial injury or illness, or that a service is non-covered. The provider may not knowingly bill or seek payment from the bureau, MCO, QHP or self-insured employer for services that are not related to the claimed or allowed condition(s) related to the industrial injury or illness. The provider may not knowingly mislead or direct providers of ancillary services to bill or seek payment for services that are not related to the claimed or allowed condition.

The provider may not bill or seek payment from the claimant for services determined as medically unnecessary through the use of bona fide peer review based on accepted treatment guidelines.

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4123-6-26

Claimant reimbursement.

~~When the claimant or any other person making payment on behalf of the claimant, including a volunteer, pays for medical services or supplies directly to a health care provider and the claim or condition is subsequently allowed, the payor shall be reimbursed upon submission of evidence of the receipt and payment for that service or supply. The payor will receive no more than the amount that would have been paid to the health care provider as provided by the rules of this chapter of the Administrative Code. However, in cases where the payor is the claimant's health insurer, if the claimant seeks reimbursement for an out-of-pocket copayment and the claimant's health insurer has already been reimbursed or later seeks reimbursement, the claimant may be reimbursed for the copayment and the claimant's health insurer may be reimbursed up to the amount that would have been paid to the health care provider as provided by the rules of this chapter of the Administrative Code. When payment has been made to the health care provider, the payor shall be informed to seek reimbursement from the provider.~~

~~The bureau shall inform a claimant or payor whether a health care provider participates in the HPP or QHP.~~

(A)When the claimant or any other person making payment on behalf of the claimant, including a volunteer, pays for medical services or supplies directly to a health care provider and the claim or condition is subsequently allowed, the payor shall be reimbursed upon submission of evidence of the receipt and payment for that service or supply. Except as otherwise provided in paragraphs (A)(1) and (A)(2) of this rule, the payor will receive no more than the amount that would have been paid to the health care provider as provided by the rules of this chapter of the Administrative Code.

(1)In cases where the payor is the claimant's health insurer, if the claimant seeks reimbursement for an out-of-pocket copayment, the claimant may be reimbursed for the copayment and the claimant's health insurer may be reimbursed up to the amount that would have been paid to the health care provider as provided by the rules of this chapter of the Administrative Code.

(2)In cases where the claimant pays a pharmacy out of pocket for an outpatient medication because the medication is not payable under division (I) of section 4123.511 of the Revised Code on the date of service, if the medication later becomes payable, the claimant may be reimbursed the full amount of the claimant's out-of-pocket payment.

(B)When the bureau has already made payment to the health care provider, the payor shall be informed to seek reimbursement from the provider. The bureau shall inform a claimant or payor whether a health care provider participates in the HPP or QHP.

(C)Requests for reimbursement pursuant to this rule shall be subject to the timeframes set forth in division (B) of section 4123.52 of the Revised Code and in rule 4123-3-23 of the Administrative Code.

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4123-6-30

Payment for physical medicine.

- (A) "Physical medicine" is the evaluation and treatment of a claimant by physical measures and the use of rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating any work related disability. Physical medicine includes the establishment and modification of physical rehabilitation programs, treatment planning, instruction, and consultative services. "Physical measures" include massage, heat, cold, air, light, water, electricity, sound, manipulation, and the performance of tests of neuromuscular function as an aid to such treatment. Physical medicine does not include the diagnosis of a patient's disability, the use of roentgen rays or radium for diagnostic or therapeutic purposes, or the use of electricity for cauterization or other surgical purposes. Physical medicine includes, but not limited to, chiropractic treatments, physiotherapy, and physical therapy.
- (B) Physical medicine must be prescribed by the physician of record or other approved treating provider licensed to practice medicine, osteopathy, chiropractic, mechanotherapy, dentistry, podiatry, or nursing ~~as a certified registered nurse anesthetist~~, clinical nurse specialist, certified nurse midwife, or certified nurse practitioner, or holding a certificate to practice as a physician assistant. Physical medicine may be provided in the physician's office or referred to another licensed provider.
- (C) To be eligible for reimbursement, physical medicine services must be provided by a physician, chiropractic physician, physical therapist, occupational therapist, massage therapist, athletic trainer or other qualified non-physician provider practicing within the scope of his or her license, certification, or registration.
- (D) Fees for up to twelve physical ~~therapy~~ medicine treatments within sixty days following the date of injury may be reimbursed without prior authorization, provided the treatments are for allowed soft tissue and musculoskeletal conditions in allowed claims and the criteria set forth in paragraphs (B)(1) to (B)(3) of rule 4123-6-16.2 of the Administrative Code are met. Otherwise, physical ~~therapy~~ medicine treatment must be prior authorized.
- (E) Payment for physical medicine used for treatment of the allowed conditions shall be made in accordance with rule 4123-6-10 of the Administrative Code.
- ~~(F) Physical medicine treatments must be provided in conjunction with:~~
- ~~(1) In cases of temporary total disability, interim medical reports and medical documentation meeting the requirements specified in paragraph (B) of rule~~

~~4123-6-20 of the Administrative Code.~~

~~(2) A current, written treatment plan meeting the requirements specified in paragraph (C) of rule 4123-6-20 of the Administrative Code.~~

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4123-6-31

Payment for miscellaneous medical services and supplies.

(A) Acupuncture.

- (1) Acupuncture is a recognized method of treatment in Ohio and must be administered by a licensed doctor of medicine, doctor of osteopathic medicine and surgery, or doctor of podiatric medicine who has completed a course of study in acupuncture under the administration of an approved college of medicine, college of osteopathic medicine and surgery, or college of podiatric medicine, doctor of chiropractic who holds a certificate to practice acupuncture from the Ohio state chiropractic board or a registered non-physician acupuncturist. Such treatment must be prior authorized.
- (2) Services provided by a non-physician acupuncturist must be prescribed by persons licensed under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery or podiatry or Chapter 4743. of the Revised Code to practice chiropractic. A registered non-physician acupuncturist shall perform acupuncture under the general supervision of the injured worker's prescribing physician or chiropractic physician. General supervision does not require that the acupuncturist and the prescribing physician or chiropractic physician practice in the same office.

(B) ~~Braces, shoes, and other orthotic~~ Orthotic devices.

- (1) Payment is made only for those orthotic devices prescribed in writing by the physician of record for treatment of an allowed injury or occupational disease. The use of the orthotic device must be directly related to the allowed industrial injury or occupational disease.
- (2) Orthotic devices shall be custom fitted or custom fabricated and delivered to the satisfaction of the prescribing physician and the administrative agencies. Repairs, modifications, and adjustments to secure satisfactory application of the orthotic appliance shall be made within sixty days of fitting and application without additional charge by the supplier of the orthotic device.
- (3) No charge shall be made for measurement, transportation, or other expenses incurred by the supplier-orthotist, except when the supplier-orthotist is required to travel beyond the limits of the metropolitan community in which he maintains his place of business by reason of the physical incapacity of the claimant or by reason of direct prescription by the attending physician. The supplier-orthotist shall be paid for traveling expenses on a round-trip basis.

Additional charges must be separately specified on the supplier-orthotist's billing, including the points of travel and the name of the physician prescribing the travel. Payment will be made for a maximum of three round-trip calls.

(4) Once payment for the orthotic device has been made, replacement requests may be denied in instances of malicious damage, neglect, culpable irresponsibility or wrongful disposition.

(C) Dental care.

(1) Payment for dental care shall be made in the following cases:

(a) ~~Where an industrial injury or occupational disease either has caused damage or has adversely affected the claimant's natural teeth. Where an injury or industrial accident not only causes an injury, but also results in the damage or loss of the claimant's artificial teeth or other denture. Once the artificial teeth or other denture(s) have been repaired, replaced, or adjusted, no further replacement will be approved.~~ Where an injury or industrial accident not only causes an injury, but also results in the damage or loss of the claimant's artificial teeth or other denture. Once the artificial teeth or other denture(s) have been repaired, replaced, or adjusted, no further replacement will be approved.

(b) ~~For industrial injuries or occupational diseases sustained prior to January 1, 1979, artificial teeth or other denture must be in place in the worker's mouth at the time of damage or loss. Where an industrial injury or occupational disease either has caused damage or has adversely affected the claimant's natural teeth. Once payment for the artificial teeth or other denture(s) has been made, replacement requests may be denied in instances of malicious damage, neglect, culpable irresponsibility or wrongful disposition.~~ Where an industrial injury or occupational disease either has caused damage or has adversely affected the claimant's natural teeth. Once payment for the artificial teeth or other denture(s) has been made, replacement requests may be denied in instances of malicious damage, neglect, culpable irresponsibility or wrongful disposition.

(c) ~~For industrial injuries or occupational diseases sustained on or after January 1, 1979, the requirements of paragraph (C)(1)(b) of this rule do not apply.~~

(2) Responsibility for injuries or occupational diseases affecting the claimant's natural teeth is limited to the repair or replacement of those teeth actually injured at the time of the accident, or directly affected by the injury or disease. This responsibility does not include the replacement of teeth which are extracted or repaired for purposes unrelated to the industrial injury or occupational disease.

~~(3) Replacement of artificial teeth when the injury or occupational disease has resulted in a deformity of the jaw to the extent that artificial teeth cannot be used, is subject to the limitations of paragraphs (C)(1)(b) and (C)(1)(c) of this rule.~~

~~(4)~~(3) Responsibility for the repair of both natural and artificial teeth is limited to the damage done at the time of the accident, or to the damage directly caused by an allowed injury or occupational disease.

(D) Eyeglasses and contact lenses.

(1) ~~Payment~~ Payment for eyeglasses or contact lenses shall be made in the following cases:

~~(a) is approved to replace eyeglasses or contact lenses when~~ Where an industrial injury or an industrial accident not only causes an injury, but also results in the damage or loss of the claimant's eyeglasses or contact lenses. Once the eyeglasses or contact lenses have been repaired, replaced, or adjusted, no further replacement will be approved.

~~(a) In the event of injury prior to January 1, 1979, the eyeglasses must be in place on the claimant's face or the contact lenses shall be in place in the claimant's eye(s) at the time of injury.~~

~~(b) In the event of injury on or after January 1, 1979, the requirements of paragraph (D)(1)(a) of this rule do not apply.~~

~~(2)(b) Contact lenses or glasses are reimbursed when~~ Where loss of vision is the direct result of an allowed injury or occupational disease. Once payment for the eyeglasses or contact lenses has been made, replacement requests can be denied in instances of malicious damage, neglect, culpable irresponsibility or wrongful disposition.

~~(3)~~(2) Refractions will be approved in situations described in paragraph ~~(D)~~(2) (D)(1)(b) of this rule.

~~(4)~~(3) Replacement of glasses with contact lenses is approved when medical evidence indicates a direct need due to an allowed injury or occupational disease.

~~(5)~~(4) Glasses or contact lenses will be approved for treatment purposes, when necessary, as a direct result of the allowed injury or occupational disease. Any subsequent adjustment, maintenance supplies or change in a claimant's glasses or contact lenses, if required for treatment of the allowed injury or occupational disease, will also be approved when supported by evidence of a direct causal relationship.

~~When eyeglasses and/or contact lenses were damaged or broken in an~~

~~industrial accident in which an injury was sustained by the claimant and have been replaced, no further replacement will be approved due to subsequent breakage or for any other reason, except as provided in this paragraph of this rule.~~

(E) Hearing aids.

(1) ~~When~~ Payment for hearing aid(s) should be made where an industrial injury or an industrial accident which not only causes an injury, but also damages results in the damage or loss of the claimant's hearing aid(s), payment to replace the hearing aid(s) is approved as follows: Once the hearing aid(s) have been repaired, replaced, or adjusted, no further replacement will be approved.

~~(a) For injuries or accidents sustained prior to January 1, 1979, the hearing aid(s) must be in place in the claimant's ear(s) at the time of the injury or accident.~~

~~(b) For injuries or accidents sustained on or after January 1, 1979, the requirements of paragraph (E)(1)(a) of this rule do not apply.~~

~~(c) Once hearing aid(s) have been replaced, no further replacement will be approved.~~

(2) When a partial loss of hearing is the direct result of an allowed industrial injury or occupational disease, payment for a hearing aid(s) is justified in order to improve the claimant's ability to hear.

(F) X-rays.

Payment for x-ray examinations (including CT, MRI, and discogram) shall be made when medical evidence shows that the examination is medically necessary either for the treatment of an allowed injury or occupational disease, or for diagnostic purposes to pursue more specific diagnoses in an allowed claim. Providers shall follow all prior authorization requirements in effect at the time when requesting authorization and payment for such studies.

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4123-6-38

Payment for home health nursing services.

(A) Employment of nursing service.

- (1) The need for nursing services must be the direct result of an allowed injury or occupational disease.
- (2) Except as described in rule 4123-6-38.1 of the Administrative Code, home health nursing services shall be provided by registered nurses and licensed practical nurses employed by a home health agency meeting the qualifications specified in paragraph (C) of rule 4123-6-02.2 of the Administrative Code.

(B) Fees for home health agency nursing services.

Fees for home health agency nursing services will determined by the bureau. Payment will be made for home health nursing services in accordance with rule 4123-6-10 of the Administrative Code.

(C) Authorization for home health nursing services.

- (1) Authorization for home health nursing services shall be considered only in cases where the claimant, as the direct result of an allowed injury or occupational disease, is bedfast or otherwise confined to the home, is mentally incapable of self-care or requires home care services ordered for hospital discharge follow-up.
- (2) The request for authorization from the physician of record or treating physician must identify the reason for home health nursing services, the period of time the services will be required, the specific services and the number of hours per day that are required.
- (3) In addition to skilled nursing services provided by a registered nurse or licensed practical nurse, the claimant may be approved for home health aide services. If he/she is unable to independently perform activities of daily living, including, but not limited to, feeding, bathing, dressing, providing personal hygiene, and transferring from bed to chair. Household, personal or other duties such as related to maintaining a household, including but not limited to care or upkeep to the inside or outside of the residence, washing clothes, preparing meals, or running errands are not considered nursing services and will not be reimbursed, except to the extent such services are incidental to care of the claimant.

- (4) Authorization must be obtained prior to rendering home health nursing services, except in cases of emergency or where the claimant's allowed condition could be endangered by the delay of services.
- (D) All covered home health services must be rendered on a part-time or intermittent care basis, in accordance with the written treatment plan and the bureau standard of care. Part-time or intermittent care means that services are generally rendered for no more than eight hours per day. Home health services rendered on a full time or continuous care basis are not covered. More appropriate alternative settings will be considered for claimants requiring more than eight hours per day of care, where medical necessity is documented. Exceptional cases may be reviewed by the bureau.
- (E) A review of the claim or assessment of the injured worker will be conducted at least annually to ensure that nursing services are necessary as a direct result of the allowed injury or occupational disease.
- (F) Documentation requirements for home health agencies.

Home health agency providers must maintain records which fully document the extent of services provided to each claimant. All records must be maintained in accordance with the conditions of participation required for medicare certification, joint commission accreditation, or community health accreditation program (CHAP) accreditation, or accreditation through an organization that has been granted deeming authority by the centers for medicare and medicaid services (CMS). The provider may be required to furnish detailed hourly descriptions of care delivered to a claimant to review care needs and medical necessity.

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4123-6-38.1

Payment for nursing and caregiver services provided by persons other than home health agency employees.

(A) Nursing services provided prior to December 14, 1992.

- (1) Registered nurses and licensed practical nurses who are not employed by a medicare certified, joint commission accredited, or community health accreditation program (CHAP) accredited home health agency may continue to provide authorized services to a claimant if the services began prior to December 14, 1992.
- (2) The need for nursing services must be the direct result of an allowed injury or occupational disease.
- (3) In the event the registered nurse or licensed practical nurse is no longer able to provide approved services or if services are stopped and later restarted, nursing services shall be provided only by an employee of a medicare certified, joint commission accredited, or community health accreditation program (CHAP) accredited home health agency.

(B) Non-licensed caregiver services.

- (1) Requests for extension of caregiver services initially provided prior to December 14, 1992.
 - (a) Prior to December 14, 1992, caregiver services provided by a non-licensed person including claimant's spouse, friend or family member were considered for reimbursement in cases where the claimant, as a direct result of an allowed injury or occupational disease, was bedfast, confined to a wheelchair, had a disability of two or more extremities which prevented the claimant from caring for his/her own body needs or was otherwise unable to take care of his/her own bodily functions. Services include, but are not limited to, feeding, bathing, dressing, providing personal hygiene, and transferring from bed to chair. Household, personal or other duties ~~such as~~ related to maintaining a household, including but not limited to care or upkeep to the inside or outside of the residence, washing clothes, preparing meals, or running errands, are not considered nursing services, and will not be reimbursed, except to the extent such services are incidental to care of the claimant.

- (b) Requests for an extension of caregiver services approved prior to December 14, 1992, delivered by a non-licensed person, other than an attendant, aide, or claimant's spouse, but including other family members or friends, will be approved only if:
 - (i) The claimant does not have a spouse because the claimant is not married, or the claimant's spouse is deceased, or the claimant's spouse is physically or mentally incapable of caring for the claimant; and,
 - (ii) The approved home health agency is greater than thirty-five miles from the claimant's location and the home health agency refuses to provide services to the claimant.
 - (c) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a medicare certified, joint commission accredited, or community health accreditation program (CHAP) accredited home health agency, or a home health agency accredited through an organization that has been granted deeming authority by the centers for medicare and medicaid services (CMS).
- (2) Requests for extension of caregiver services initially provided on or after December 14, 1992 and prior to January 9, 1995.
- (a) Requests for approval of caregiver services delivered by a non-licensed person, other than an attendant, aide, or claimant's spouse were considered for reimbursement only if the claimant did not have a spouse or the spouse was physically or mentally incapable of caring for the claimant, or an approved home health agency was greater than thirty-five miles from the claimant's location and the home health agency refused to provide services to the claimant.
 - (b) Criteria for approval of caregiver services were as indicated in paragraph (B)(1)(a) of this rule.
 - (c) After January 9, 1995, persons who are not home health agency home health aides or attendants, but who are currently approved to provide caregiver services to a claimant, may continue to do so until services are no longer medically necessary or unless services are not authorized. After January 9, 1995, approval of caregiver services shall only be considered when services are rendered by a home health agency home

health aide or attendant.

- (d) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a medicare certified, joint commission accredited, or community health accreditation program (CHAP) accredited home health agency, or a home health agency accredited through an organization that has been granted deeming authority by the centers for medicare and medicaid services (CMS).
- (C) All covered home health services must be rendered on a part-time or intermittent care basis, in accordance with the written treatment plan and the bureau standard of care. Part-time or intermittent care means that services are generally rendered for no more than eight hours per day. Home health services rendered on a full time or continuous care basis are not covered. More appropriate alternative settings will be considered for claimants requiring more than eight hours per day of care, where medical necessity is documented. Exceptional cases may be reviewed by the bureau.
- (D) A review of the claim or assessment of the injured worker will be conducted at least annually to ensure that nursing services are necessary as a direct result of the allowed injury or occupational disease.

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4123-6-39

Payment for prosthetic device or other artificial appliances.

(A) ~~In~~ For purposes of this rule:

- (1) "Amputee clinic" means an interdisciplinary group of professional providers led by a physician with a specialty in physical medicine and rehabilitation, orthopedic surgery or vascular surgery knowledgeable in the field of prosthetics and physical disabilities, comprised of members that may include a podiatrist, physical therapist, occupational therapist, kinesiotherapist, prosthetist and other medical specialists that serves individuals requiring prosthetic devices.
- (2) "Artificial appliance" means any item that replaces a body part or function of a body part of an injured worker who has received a scheduled loss or facial disfigurement award for that body part under division (B) of section 4123.57 of the Revised Code, and that the amputee clinic at the Ohio state university medical center, the opportunities for Ohioans with disabilities agency, or a multidisciplinary amputee clinic or prescribing physician approved by the administrator or the administrator's designee determines is needed by the injured worker. Examples of artificial appliances include, but are not limited to, prosthetic devices, artificial eyes, wheelchairs, canes, crutches, walkers, braces, etc.
- (3) "Prosthetic device" means a custom fabricated or fitted medical device that is a type of artificial appliance used to replace a missing appendage or other external body part. It includes an artificial limb, hand, or foot, but does not include devices implanted into the body by a physician, artificial eyes, intraocular lenses, dental appliances, ostomy products, cosmetic devices such as breast prostheses, eyelashes, wigs, or other devices that do not have a significant impact on the musculoskeletal functions of the body.

(B) In all cases arising under division (B) of section 4123.57 of the Revised Code, if a claimant requires the purchase or repair of an artificial appliance, as determined by any one of the following: (1) the amputee clinic at the Ohio state university medical center; (2) the ~~rehabilitation services commission~~ opportunities for Ohioans with disabilities agency; (3) a multidisciplinary amputee clinic or prescribing physician approved by the administrator or the administrator's designee, the bureau shall pay the cost of purchasing or repairing the artificial appliance out of the surplus fund. The purchase or repair is made regardless of whether the artificial appliance is part of the claimant's vocational rehabilitation, or if the claimant has, or will ever be able, to return to work.

~~(B)~~(C) The bureau is responsible for processing requests for ~~prosthetics~~ artificial appliance and travel expenses associated with the ~~prosthetic~~ artificial appliance in

all self-insured claims. When a prosthetic artificial appliance device is needed in a self-insured claim, the provider will send a request for the prosthetic artificial appliance and/or request for repair, as well as the subsequent bills, to the bureau.

(D) It is the prosthetist's responsibility to ensure that any prosthetic device fits properly for three months from the date of dispensing. Any modifications, adjustments, or replacements within three months from the date of dispensing are the responsibility of the prosthetist who supplied the item and BWC will not reimburse for those services. The provision of these services by another provider will not be separately reimbursed.

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4123-6-40

Payment of claimant travel expenses.

(A) A claimant's travel expenses shall be paid, upon the filing of a proper request, under the following circumstances:

(1) When the claimant has been ordered or authorized to undergo a medical examination outside of the city or community limits where he resides. The claimant shall be reimbursed for travel only if the travel distance exceeds a mileage distance as periodically determined by the bureau. The minimum mileage distance for reimbursement shall be published periodically by the bureau.

(2) When ~~specialized~~ treatment necessary for the allowed industrial condition cannot be obtained within the city or community where the claimant resides, and the treatment has been pre-authorized and approved. The claimant shall be reimbursed for travel only if the travel distance exceeds a mileage distance as periodically determined by the bureau. The minimum mileage distance for reimbursement shall be published periodically by the bureau.

~~(3) When the claimant has been requested to undergo a medical examination by a physician of the employer's choice, travel expenses incurred as a result of the examination are to be paid by the employer immediately upon the receipt of the bill. Payment of the bill shall not require an order of the bureau or commission, unless there is a dispute. The employer shall provide the claimant with a proper form to be completed by the claimant for reimbursement of traveling expenses. The minimum mileage provision of paragraphs (A)(1) and (A)(2) of this rule shall not apply for reimbursement of examinations under this paragraph of the rule. When the claimant's allowed conditions require taxicab or other special transportation for treatment or examination on account of an allowed injury or occupational disease. Taxicab or other special transportation must be pre-authorized.~~

~~(4)~~(B) In situations described in paragraphs (A)(1) and (A)(2) of this rule, the following provisions apply:

~~(a)~~(1) If the claimant is traveling by automobile, the claimant shall be entitled to a reasonable payment, as established and periodically published by the bureau, on a per mile basis if the mileage exceeds the distance established as provided under paragraph (A) of this rule, portal to portal, using the most direct and practical route.

- ~~(b)~~(2) If the claimant is traveling by airplane, railroad or bus, the claimant shall be entitled to the actual and necessary airplane, railroad or bus fare.
- ~~(e)~~(3) The reasonable cost of necessary meals, based on distance traveled, will be refunded to the claimant. It shall be paid in accordance with a schedule adopted by the bureau and periodically revised.
- ~~(d)~~(4) Necessary ~~hotel~~ lodging bills will be paid at reasonable actual cost. ~~Hotel accommodation~~ Lodging must be pre-authorized.
- ~~(5)~~ Taxicab fares will be refunded only when the claimant's physical condition requires such transportation for treatment or examination on account of an allowed injury or occupational disease. Taxicabs or other special transportation shall be pre-authorized.
- ~~(6)~~ The payment rates for meals, lodging and travel shall be published periodically by the bureau.
- (C) When the claimant has been requested to undergo a medical examination by a physician of the employer's choice, travel expenses incurred as a result of the examination are to be paid by the employer immediately upon the receipt of the bill. Payment of the bill shall not require an order of the bureau or commission, unless there is a dispute. The employer shall provide the claimant with a proper form to be completed by the claimant for reimbursement of traveling expenses. The minimum mileage provision of paragraphs (A)(1) and (A)(2) of this rule shall not apply for reimbursement of examinations under this paragraph (C) of this rule.
- ~~(B)~~(D) Actual payment or refund shall be made in accordance with requirements outlined in this rule. The payment rates for meals, lodging, and travel shall be published periodically by the bureau.
- ~~(C)~~(E) This rule applies to all claims for industrial injuries and/or occupational diseases, regardless of whether the employer is part of the state fund, is self-insuring, is non-complying, etc.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/12/97, 10/14/02, 6/1/05

*** DRAFT - NOT YET FILED ***

4123-6-41

No legal relationship between the industrial commission or bureau and a health care provider.

- (A) Direct payment to a health care provider or other person by the industrial commission, self-insuring employer, bureau of workers' compensation, or their agent, for medical care rendered to a claimant does not imply or create a legal relationship between the provider or person and the commission, self-insuring employer, bureau, or their agent.
- (B) The services rendered to the claimant are the legal obligation of the claimant. The direct payment to the health care provider is a discretionary method by which the award made to the claimant for medical expenses may be discharged.
- (C) Except as prohibited by division ~~(K)~~(O) of section 4121.44 of the Revised Code, when payment is made to the claimant, the sole legal recourse of the health care provider is against the claimant.

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4123-6-43

Payment for transcutaneous electrical nerve stimulators and neuromuscular electrical stimulators.

(A) Payment will be approved for a transcutaneous electric nerve stimulator (TENS) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in this rule.

(1) Prior authorization is required for TENS units and supplies. A claimant shall be provided only one TENS unit at a time. For each TENS unit request approved, the unit shall be rented for a thirty day trial period before purchase of the TENS unit. This trial period is to evaluate the medical necessity and effectiveness of the TENS treatment. TENS treatment will be discontinued at the end of the thirty day trial period month where the treatment has not proven to be medically necessary or effective. Reimbursement of rental costs will be considered only for the trial period that the TENS unit was actually used before treatment was discontinued. For each TENS unit provided, payment shall be limited to necessary disposable or rechargeable batteries, but not both.

(2) The bureau shall apply all rental payments previously made to the purchase price of the TENS unit. A TENS unit purchased and furnished to the claimant is not the personal property of the claimant, but remains the property of the bureau or self-insuring employer. The bureau or self-insuring employer reserves the right to reclaim and recover the TENS unit from the claimant at the completion of the course of TENS treatment. Once a TENS unit is purchased, the bureau or self-insuring employer will reimburse for repair or replacement of the unit upon submission of a request from the physician of record or treating provider that includes medical documentation substantiating the continued medical necessity and effectiveness of the unit.

(3) To be eligible for reimbursement under this rule, the TENS unit must be prescribed by a physician and furnished by a provider holding a current, valid, license or certificate of registration from the Ohio respiratory care board to sell or rent home medical equipment.

(B) Claimants who have TENS units must complete and submit to the TENS provider a monthly written request for specific supplies needed in the following month. The written request must be initiated and signed by the claimant, and must be received by the TENS provider prior to the delivery of supplies and/or equipment. The TENS provider shall then deliver the supplies and bill the bureau, MCO, QHP, or self-insuring employer after the claimant's written request is received. The provider shall retain the original written request for supplies in accordance with the time frames set forth in rule 4123-6-45.1 of the Administrative Code. The bill must

indicate the actual date of service, reflecting the date that services or supplies were provided. The bureau, MCO, QHP, or self-insuring employer may adjust bills upon audit if the audit discloses the provider's failure to comply with this rule.

(C) The TENS provider shall maintain the following records and make them available for audit upon request:

- (1) The injured worker's monthly written requests;
- (2) Records of the provider's wholesale purchase of TENS supplies or equipment;
~~and~~;
- (3) Records of delivery of supplies to injured workers and of the delivery or return of TENS units; ~~and~~

Upon request, the provider shall supply copies of the record information to the requester at no cost. Failure to provide the requested records may result in denial or adjustment of bills related to these records.

(4) The TENS provider's current, valid, license or certificate of registration from the Ohio respiratory care board to sell or rent home medical equipment.

(D) ~~Payment~~ The bureau shall not pay for the rental or sale of devices that are labeled by the food and drug administration (FDA) for over-the-counter use and are identified with the FDA product code "NUH.OTC.TENS."

(E) Payment will be approved for a neuromuscular electrical stimulator (NMES) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in the bureau's provider billing and reimbursement manual in effect on the billed date of service.

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*** DRAFT - NOT YET FILED ***

4123-6-45

Audit of providers' patient and billing related records.

- (A) Providers' patient and billing related records, including but not limited to those records described in rule ~~4123-6-451~~ 4123-6-45.1 of the Administrative Code, may be reviewed by the bureau or the MCO to ensure workers are receiving proper and necessary medical care, and to ensure compliance with the bureau's statutes, rules, policies, and procedures.
- (1) Based on division (B)(16)(c) of section 4121.121 of the Revised Code, provider records may be reviewed before, during, or after the delivery of services. Reviews may be random, with no unreasonable infringement of provider rights, or may be for cause. Reviews may include the utilization of statistical sampling methodologies and projections based upon sample findings. Records reviews may be conducted at or away from the provider's place of business.
- (2) Based on division ~~(B)(17)~~ (B)(16)(c) of section 4121.121 of the Revised Code, legible copies of providers' records may be requested. Providers shall furnish copies of the requested records within thirty calendar days of receipt of the request. The bureau shall establish a schedule for payment of reasonable costs for copying records, which shall be published in the health care provider billing and reimbursement manual.
- (3) Original records shall not be removed from the provider's premises, except upon court order or subpoena issued by the bureau pursuant to section 4121.15 or 4123.08 of the Revised Code.
- (B) Upon any finding of improper or unnecessary medical care, the administrator shall, if requested by the provider, appoint a subcommittee of the stakeholders' health care quality assurance advisory committee to review and advise the administrator as provided in paragraph ~~(K)~~ (F) of rule 4123-6-22 of the Administrative Code. The administrator may sanction, suspend, or exclude a health care provider from participation in the workers' compensation system based on rule 4123-6-17 of the Administrative Code.
- (C) The bureau or the MCO may deny payment for services or declare as overpaid previous payments to providers who fail to provide records or access to records to either the bureau or the MCO. The bureau may decertify a health care provider that fails to provide records requested pursuant to Chapters 2913., 4121., and 4123. of the Revised Code.

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*** DRAFT - NOT YET FILED ***

4123-6-46

Standardized or negotiated payment rates for services or supplies.

- (A) The bureau or self-insuring employer may negotiate payment rates with health care providers for services and supplies provided in the treatment of workers' compensation claims.
- (B) The bureau or self-insuring employer may enter into volume-based or optional-use contracts with medical providers for services including, but not limited to, the purchase or rental of durable medical equipment and supplies and catastrophic claim services.
- (C) The bureau or self-insuring employer may inform injured workers of the availability of services, supplies, or equipment from particular health care providers with whom a contract for services or supplies, a negotiated payment rate for services or supplies, or a contract for cost-effective payment levels or rates has been entered into, so long as access to quality and convenient medical services or supplies for injured workers is maintained.

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