

Chapter 9: MCO Policy and Reference Guide Updated and New Policies

Policy Name:	Miller Case Criteria
Policy #:	MP-13-01
Code/Rule Reference:	Ohio Administrative Code (OAC) 4123-6-16.2, and 4123-6-06.2; State, ex rel. Miller v. Indus. Comm., 71 Ohio St.3d 229 (1994)
Effective Date:	06/25/13
Approved:	Freddie Johnson, Chief of Medical Services (Signature on file)
Origin:	Medical Policy
Supersedes:	All policies and procedures, directives or memos regarding Miller case criteria that predate the effective date of this policy.
History:	New
Review date:	06/25/18

I. POLICY PURPOSE

The purpose of this policy is to ensure that the Bureau of Workers Compensation (BWC) complies with the criteria set forth in the case of *State, ex rel. Miller v. Indus. Comm.*, hereafter *Miller*, and uses the criteria to evaluate and make determinations for authorization and reimbursement of medical services and supplies.

II. APPLICABILITY

This policy applies to staff of the BWC and Managed Care Organizations (MCOs) who approve purchases of medical services and supplies.

III. DEFINITIONS

Miller criteria: mandatory evaluative three-prong test outlined by the Supreme Court of Ohio in the *Miller* case establishing that each prong must be met in order to allow reimbursement for any request for medical services/supplies. The three-part test was subsequently enacted as paragraphs (B)(1) through (B)(3) of 4123-6-16.2 of the Ohio Administrative Code.

IV. POLICY

- A. It is the policy of BWC to authorize and reimburse for the service or supply that meets all three of the criteria outlined in *Miller*. The three criteria are:
 1. Are the medical services reasonably related to the industrial injury (allowed conditions)?
 2. Are the services reasonably necessary for the treatment of the industrial injury

(allowed conditions)?

3. Is the cost of these services medically reasonable?
- B. In determining whether the cost of services is medically reasonable under the third prong of the *Miller* criteria, BWC may consider whether a lesser cost service or supply meets the injured worker's needs. In such instances, BWC may authorize reimbursement for the lesser cost service or supply. However, BWC may not interfere with an injured worker's free choice of provider on the grounds that a different provider type or specialty could meet the injured worker's needs at lesser cost.
- C. Miller clarifications/exceptions based on case law:
 1. Weight Loss Programs - BWC authorizes weight loss programs in claims in which obesity is not an allowed condition when it is documented that the weight loss will improve the allowed condition(s) in the claim.
 - a. This improvement must be curative (therapeutic/healing, tending to overcome disease and promote recovery); and
 - b. Not merely palliative (pain relieving).
 2. Treatment directed specifically to a body part or specific condition of a body part - Treatment shall be considered only after the additional specific body part or specific condition of a body part has been allowed in the claim.
 3. Psychiatric treatment - Treatment shall only be approved when psychiatric conditions are allowed in the claim, unless otherwise permissible under BWC law or policy, as in catastrophic claims and as part of a vocational rehabilitation plan.
 4. Contributing Non-allowed Condition - Treatment that is independently required for the allowed condition(s) in the claim may be approved even though a contributing non-allowed condition exists and/or may also be addressed in the course of the treatment.
- D. For Non-allowed generalized conditions or diseases (e.g., obesity, diabetes, hypertension, etc.)
 1. Reimbursement may be considered for non-allowed generalized conditions or diseases when the *Miller* test is met, and one of the following is likely to occur:
 - a. Treatment of the non-allowed generalized condition(s) has a positive impact on the treatment outcome of the allowed condition(s) in the claim; or
 - b. The non-allowed generalized condition(s) becomes uncontrolled or temporarily exacerbated and the uncontrolled or temporarily exacerbated state is likely to delay, impede, or prevent treatment of the allowed condition(s) in the claim.

In such instances, staff shall authorize medical services:

 - i. Until the symptoms or condition returns to baseline; or
 - ii. The temporary exacerbation has ended.
 2. If a pre-existing non-allowed generalized condition is not brought under control or never returns to baseline, consideration should be given to an additional allowance in the claim.

Below are case scenarios on how *Miller* case criteria should be applied to non-allowed generalized conditions.

A diabetic injured worker sustains a laceration to the hand. The claim is allowed for the hand laceration and appropriate medical treatment is provided for the allowed condition, but not the non-allowed generalized condition of diabetes. If, however, the hand becomes infected and the diabetes is out of control, it is reasonable under *Miller* to authorize payment for the treatment of the diabetes until it is stabilized. The rationale for this decision is that treatment of the diabetes may promote resolution of the infection in the

hand laceration, thereby improving the allowed condition. Note that the diabetes is not an additional allowance in the claim and should only be treated until the non-allowed generalized condition is stabilized.

An injured worker with controlled high blood pressure is undergoing an outpatient surgical procedure for their allowed condition. In the recovery room the injured worker experiences a hypertensive emergency, is given an IV antihypertensive medication, and then admitted to the hospital for observation. Authorization for this IV medication, hospitalization and services until the high blood pressure is under control are reasonable. However, once the blood pressure is controlled and the patient is released from the hospital, treatment for the high blood pressure is the responsibility of the injured worker and is not reimbursable by BWC. The rationale for this decision is that it was the treatment of the allowed condition that temporarily exacerbated the pre-existing non-allowed generalized condition.

Below is a case scenario on how *Miller* case criteria should be applied to contributing non-allowed conditions.

An injured worker sustains an industrial injury to the left knee. Two conditions have been formally allowed in the IW’s claim: "contusion, left knee" and "internal derangement/tear medial meniscus left knee." The IW’s physician requests approval for arthroscopic knee surgery on the grounds that the allowed conditions require the arthroscopy, advising that while early arthritic changes appear to be present in the IW’s knee, the IW was having enough trouble from the allowed conditions to require the arthroscopic procedure. The physician's preoperative and postoperative diagnoses include non-allowed "degenerative arthritis, left knee" as well as "contusion, left knee" and "internal derangement/tear medial meniscus, left knee". The arthroscopic knee surgery may be approved, even though the IW has a contributing non-allowed condition of “degenerative arthritis,” because the surgery was independently required for the allowed conditions.

Below is a case scenario on how medically reasonable cost should be considered in determining reimbursement for medical supplies and/or services.

It has been determined that an injured worker weighing 450 lbs. needs a bedside commode, and that the bedside commode is both reasonably related to and reasonably necessary for the treatment of the allowed conditions. In determining reimbursement for the bedside commode, two models are available, both of which would meet the IW’s needs and are comparable in all practical aspects (see comparison chart below). BWC and the MCO may determine that the cost of the Brand A bedside commode is the medically reasonable choice as compared with the cost of Brand B. Padded seating, armrests, and backrest are not medically necessary to serve the IW’s needs, and by adding these amenities, it increases the cost by \$278.77.

Brand	A	B
Weight capacity	1000 lbs	850 lbs
Construction	Heavy duty steel	Heavy duty steel
Arms	Drop arms	Drop arms

Seat width	23.5"	24"
Warranty	3 year warranty	Limited lifetime warranty
Height	Adjustable	Adjustable
Amenities	None	Padded seat, arm rests and backrest
Price	\$247.55	\$526.32

Policy Name:	FIFTEEN THOUSAND DOLLAR MEDICAL ONLY PROGRAM (\$15,000 MEDICAL ONLY PROGRAM)
Policy #:	CP-06-04
Code/Rule Reference:	R.C. 4123.29 (A) (6) O.A.C. 4123-17-59
Effective Date:	08/12/13
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance (Signature on file)
Origin:	Claims Policy (CP)
Supersedes:	08/24/12; All policies and procedures regarding the \$15,000 medical only program that predate the effective date of this policy.
History:	New 08/24/12; Rev. 08/12/13
Review date:	08/12/18

I. POLICY PURPOSE

The purpose of this policy is to ensure the BWC administers the fifteen thousand dollar medical only program in accordance with the laws and rules.

II. APPLICABILITY

This policy applies to BWC field operations, BWC employer program unit, and managed care organizations (MCO).

III. DEFINITIONS

Fifteen thousand dollar medical only program (\$15,000 Medical Only Program): An employer program which allows state fund employers the opportunity to pay up to the first \$15,000 in medical and pharmacy bills for medical only claims with a date of injury on or after September 10, 2007.

Five thousand dollar medical only program (\$5,000 Medical Only Program): An employer program which allows state fund employers the opportunity to pay up to the first \$5,000 in medical and pharmacy bills for medical only claims with a date of injury on June 30, 2006 to September 9, 2007.

Medical benefits: For purposes of this policy, medical benefits include treatment, services, supplies, and pharmacy benefits.

One thousand dollar medical only program (\$1,000 Medical Only Program): An employer program which allows state fund employers the opportunity to pay up to the first \$1,000 in medical and pharmacy bills for medical only claims with a date of injury on July 1, 1995 to June 29, 2006.

IV. POLICY

- A. It is the policy of BWC to ensure that state-fund employers may participate in the medical only program that allows the covered state fund employers to choose to pay the first \$15,000 of medical benefits of a medical only claim, including reimbursement for BWC file reviews/independent medical examinations (IME). The medical only program shall not apply to claims in which an employer with knowledge of a claimed compensable injury or occupational disease has paid salary continuation (wages in lieu of temporary total compensation).
- B. BWC shall follow the standard process for making a medical only claim determination when an employer is enrolled in the medical only program. BWC shall also ensure that medical benefits are not reimbursed while a particular claim is enrolled in the medical only program. Once the employer is enrolled, all medical only claims with a date of injury on or after the enrollment date will be automatically included in the appropriate medical only program. A claim that is changed to lost time is automatically removed from the medical only program.
- C. It is the policy of BWC that medical only claims that are enrolled in the medical only program shall not be medically managed by the managed care organizations (MCO).
- D. It is the policy of BWC that when a claim is removed from the medical only program for any reason, the MCO shall process the claim under standard protocols for claims management.
- E. It is the policy of BWC that the MCO shall not reconcile duplicative payments (i.e., employer paid bills and BWC paid bills), and that the MCO shall refer the employer to the provider for reconciliation of duplicate payments.
- F. An employer electing to participate in the medical only program must keep a record of the injury and shall keep a copy of all bills with proof and date of payment under the medical only program for six years from the last date a bill has been paid by the employer. This information must be made available to BWC, the injured worker and/or his/her representative upon request. BWC may request this information from the employer not more than twice a year. When an employer is enrolled in the medical only program payment of medical benefit bills in the claim extends the statute of limitations based on the last medical paid date by the employer.

BWC staff may refer to the corresponding procedure for this policy entitled "Procedure for \$15,000 Medical Only Program" for further guidance.

Procedure Name:	PROCEDURE FOR \$15,000 MEDICAL ONLY PROGRAM
Procedure #:	CP-06-04.PR1
Policy # Reference:	CP-06-04
Effective Date:	08/12/13
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance (Signature on file)
Supersedes:	08/24/12; All policies and procedures regarding the \$15,000 medical only program that predate the effective date of this procedure.
History:	New 08/24/12; Rev. 08/12/13
Review date:	08/12/18

I. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.

II. Enrollment or termination of the \$15,000 medical only program

- A. To determine if a claim is enrolled or if a claim terminated participation in the medical only program, field staff shall:
 - 1. Open a claim in the claims management system.
 - 2. Go to Maintenance – Employer window.
 - 3. If the claim is enrolled in the medical only program, the 15K Program area shall:
 - a. Display a date in the Start Date field, and
 - b. Display a check mark in the Enrolled field.
 - 4. If the claim is not enrolled (terminated participation) in the medical only program, the 15K Program area shall:
 - a. Display a date in the Start Date field, and
 - b. Display a date in the End Date field, and
 - c. Display no check mark in the Enrolled field, and
 - d. Display a termination reason.
 - 5. If the 15K Program area is blank, the claim was never enrolled in the medical only program.
- B. To determine if an employer is enrolled in the medical only program, field staff shall:
 - 1. In an open claim in the claims management system, shall:
 - a. Go to Maintenance – Employer window.
 - b. Click [Lookup...]
 - c. Click [View...]
 - d. Find the employer in the Employer Key Entry window then click [Detail...] to access the look-up Employer Information window.
 - e. If the employer is enrolled, the 15K start date field will display a date.
 - f. If the 15K end date displays, the employer was enrolled but has terminated participation in the program.

- g. If the employer is not enrolled in the program, no dates will display in the window.
- 2. In the claims management system with no open claim, field staff shall:
 - a. Go to Lookup – Employer.
 - b. Enter Risk/policy number or enter employer name
 - c. Click [View...]
 - d. Find the employer in the Employer Key Entry window then click [Detail...] to access the look-up Employer Information window.
 - e. If the employer is enrolled, the 15K start date field will display a date.
 - f. If the 15K end date displays, the employer was enrolled but has terminated participation in the program.
 - g. If the employer is not enrolled in the program, no dates will display in the window.
- C. When an employer is enrolled in the medical only program, the assigned field staff is able to enroll and/or terminate a particular claim from the program as long as the date of injury is after the policy enrollment date and medical benefits have not been paid.
 - 1. Field staff may enroll a particular claim in the medical only program as appropriate by updating the claims management system:
 - a. Update Maintenance – Employer window;
 - b. Enter the Begin date (date of injury);
 - c. Check the box next to Enrolled;
 - d. Select ok.
 - 2. When an employer elects to remove a particular claim from the medical only program and contacts the assigned field staff. Field staff shall update the claims management system by:
 - a. Access the specific claim;
 - b. Go to Maintenance – Employer window;
 - c. Enter the End Date specified by the employer;
 - i. If an employer no longer wishes to be responsible for the bills in a particular claim, the employer can choose the date the participation ends. Enter the date provided by the employer in the end date field.
 - ii. If the claim is to be removed entirely, enter the date of injury in the 15K End Date field.
 - d. The termination reason drop down box must also be updated. Select one of the following reasons:
 - i. Employer pays bills through the end date. This is selected when the employer has provided BWC with an end date because they no longer wish to be responsible for the bills in a specific claim.
 - ii. Employer withdraws effective DOI. This is selected when the employer does not wish to make any medical benefits payments in the claim at all and wants the claim excluded from date of injury.
 - iii. Reached Limit. This is selected when the employer has notified BWC that they have paid the medical only program maximum allowable.
 - 3. Enter a note in the claims management system with action taken.
- D. If field staff has questions in regards to claims in the medical only program, staff may send an email to the BWC Claims Policy Field Techs mailbox.
- E. If field staff has questions in regards to the employer in the medical only program, staff may send an email to the BWC Employer Programs Unit mailbox.

III. Benefit type or policy (risk) number changes or combining claims for claim(s) in the medical only program.

- A. Benefit type changes

1. Depending on how a claim is filed with BWC, the claims management system may not correctly reflect an employer's enrollment in the medical only program. For example, a claim is filed as a lost-time (LT) claim instead of a medical only (MO) claim, and upon correction, if the employer is enrolled in the medical only program, the field staff shall manually place the claim in the medical only program.
 2. If it is determined that a LT claim is appropriately a MO claim field staff shall:
 - a. Check to see if the employer is enrolled in the medical only program,
 - b. If the employer is not enrolled in the medical only program, field staff shall:
 - i. Change the claim type from LT to MO; and
 - ii. Enter a note in the claims management system with action taken and why.
 - c. If the employer is enrolled in the medical only program field staff shall:
 - i. Change the claim type from LT to MO
 - ii. If there have been no medical benefits paid in the claim, field staff shall
 - a) Enroll the claim in the medical only program, and
 - b) Enter a note with the action taken.
 - iii. If there have been medical benefits paid in the claim, field staff shall:
 - a) Refer to the medical only program workflow, and
 - b) Utilize the medical only program employer letter (found on claims on-line resource (COR)) to recover payments and remove charges from the employer's experience.
 - c) Enter a note with the action taken and why.
- B. Policy (risk) number changes
1. When field staff changes the policy number in a claim, the claim is not automatically (systematically) enrolled in the medical only program.
 2. When this occurs, the field staff shall follow section II. A. 2.
- C. Combined claims
1. If an employer is not properly enrolled in the medical only program when two or more claims are combined, the object claim (the one that remains after the combine) may need to be enrolled in the medical only program. In this instance, when the claims are combined, the claim is not automatically enrolled in the medical only program.
 2. Field staff shall investigate and make certain that the employer(s) is enrolled in the medical only program and if so, appropriately place the particular claim (s) in the program.
 3. Field staff shall follow section II. A. 2.

IV. Employer reimbursement to remove claim costs due to file reviews and independent medical examinations (IME) in medical only program claims

- A. All medical benefit bills should be sent to the employer for payment, except when BWC is processing the claim, or when a file review and/or independent medical examination (IME) is necessary.
- B. Payment for physician file reviews and/or IMEs shall be paid by BWC as claim costs and will be charged to the claim. This charge will appear as a charge to the employer's experience regardless that the claim is enrolled in the medical only program.
 1. Field staff shall remove these charges at the request of an employer.
 2. The employer is required to reimburse BWC for the claim costs;
 3. Upon receipt of monies from the employer, the charges shall be removed from the employer's experience.
- C. Field staff shall follow the Medical Only Program Workflow for File Reviews & IMEs and utilize the Medical Only Program Employer Letter for File Reviews & IMEs. (Located on COR)

V. Application for determination of Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability(C-92) in medical only program claims.

- A. C-92 applications may be filed in a claim that is enrolled in the medical only program.
- B. Field staff shall process the C-92 application in its normal manner. If the determination of the C-92 application results in:
 - 1. A 1% or greater award, changing the claim to LT to make the compensation payment will automatically (systematically) remove the claim from the medical only program.
 - 2. A 0% award, the claim shall remain in the medical only program.

VI. Treatment and claim reactivation requests in medical only program claims.

- A. When an MCO receives a Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9) and the claim is enrolled in the medical only program, the MCO staff shall:
 - 1. Dismiss the C-9 request;
 - 2. Do not include appeal language on dismissal; and
 - 3. Notify the employer and provider.
- B. When a claim is removed from the medical only program for any reason, the MCO shall be responsible for the:
 - 1. Medical management of the claim; and
 - 2. Processing of all bills, regardless of the date of service.
- C. When field staff receives a request for claim reactivation, staff shall verify whether the claim is enrolled in the medical only program.
 - 1. If the claim is enrolled in the medical only program, field staff shall:
 - a. Notify the MCO that
 - i. the claim is enrolled in the medical only program; and
 - ii. the claim reactivation request will not be processed.
 - b. Update notes in the claims management system with action taken and why.
 - 2. If the claim is not enrolled in the medical only program, field staff shall process the claim reactivation request.

VII. Statute of limitations in medical only program claims

- A. If there is a question as to whether the statute of limitations has expired in a claim, field staff shall request written documentation of the last medical benefit paid date from the employer. Once the employer submits the information, the field staff shall:
 - 1. Email the BWC V3 Customer Support Team mailbox and request the "Last Medical Paid Date" in the claims management system be updated;
 - 2. The BWC V3 Customer Support Team shall update the "Last Medical Paid Date" in the claims management system which will reset the statute of limitations date.
- B. If a conflict exists in determining the date last medical paid date or the employer fails to submit written documentation of the last medical paid date, field staff shall refer the issue to the Industrial Commission on a Notice of Referral.
- C. Refer to the Statutory Life of Claim – Continuing Jurisdiction for more information.

VIII. Incoming Complaints on \$15,000 medical only program

- A. BWC may receive complaints from an injured worker, his/her representative, and/or providers regarding non-payment of medical benefit bills by the employer.
- B. Field staff shall refer all complaints regarding the medical only program to the employer program unit, and document the complaints in notes in the claims management system.
- C. Field staff shall obtain the following information and document in an email to BWC Employer Program Unit mailbox:
 - 1. Injured worker name;

2. Claim number;
 3. Specific issue;
 4. Provider's name;
 5. Provider's contact phone number;
 6. Dates of service(s);
 7. Dollar amount billed to employer;
 8. Attempts made to receive payment from the employer.
- D. The employer program unit shall investigate the complaint with the employer and notify the assigned field staff of the outcome via email.
1. If the employer is to be removed entirely from the medical only program, employer program unit will remove the employer and notify the assigned field staff. When the employer is removed from the program, all claims for the employer are removed.
 2. If the claim is to be removed from the program, employer program unit shall notify the assigned field staff to remove the particular claim from the medical only program.
 3. If the claim is to remain in the medical only program, employer program unit shall notify the assigned field staff.
- E. The field staff shall enter a note in the claims management system with details on the outcome of the complaint.

Policy Name:	Artificial Appliance Requests
Policy #:	MP-01-01
Code/Rule Reference:	R.C. 4123.57(B), (C); 4779.01(I); OAC 4123-6-39; 4123-6-25
Effective Date:	07/22/2013
Approved:	Freddie Johnson, Chief of Medical Services (signature on file)
Origin:	Medical Policy
Supersedes:	All policies and procedures regarding artificial appliance and self insured prosthesis requests that predate the effective date of this policy
History:	New
Review date:	07/22/2018

I. POLICY PURPOSE

The purpose of this policy is to ensure, in compliance with R.C. 4123.57 and OAC 4123-6-39, appropriate payment of artificial appliance and repair requests and appropriate processing of self insured artificial appliance and repair requests.

II. APPLICABILITY

This policy applies to all Managed Care Organizations (MCOs), field staff, BWC nurses and the Medical Billing and Adjustment Unit.

III. DEFINITIONS

Amputee Clinic: 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.

Artificial appliance: 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 R.C. 4123.57(B), and that The Ohio State University hospital amputee clinic, the Rehabilitation Services Commission, an amputee clinic approved by the administrator or the administrator's designee, or a 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, prosthetics, artificial eyes, wheelchairs, canes, crutches, walkers, braces, etc.

Multidisciplinary Evaluation (MDE): An independent examination that, depending on the needs of the injured worker, is conducted by a specialty physician, licensed physical or occupational therapist, and an independent prosthetist, who will consider and assess the injured worker's current condition regarding the amputation site and prosthetic needs. A prosthetist is considered to be independent if s/he has not provided services to the injured worker within the past two years.

Prosthesis: 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.

IV. POLICY

General Policy Statements

- A. It is the policy of BWC to pay for approved artificial appliance purchases or repairs:
 - 1. Out of the surplus fund;
 - 2. When the request for the artificial appliance purchase or repair meets the criteria established in *State, ex. Rel. Miller v. Industrial Commission, 71 Ohio St. 3d 229 (1994)*(See *Miller Policy*); and
 - 3. When the injured worker has received an award under R.C. 4123.57(B) and the injured worker's need for the artificial appliance arises out of that award.

- B. State Fund Claim Requests
 - 1. MCOs shall process state fund claim requests for artificial appliances.
 - 2. MCO-approved artificial appliance requests shall be paid from the surplus fund if the injured worker has received an award under R.C. 4123.57(B) and the injured worker's need for the artificial appliance arises out of that award.
 - 3. MCOs may utilize BWC's self insured policy and procedure in developing artificial appliance evaluation criteria.
 - 4. MCOs may staff the following artificial appliance issues with BWC:
 - a. Medical appropriateness of requested artificial appliance;
 - b. Medical examination scheduling;
 - c. Billing reimbursement codes.
 - 5. MCOs shall schedule medical examinations as set forth in paragraph IV.G.
 - 6. BWC shall pay travel expenses associated with an artificial appliance in accordance with the *Travel Reimbursement Policy*.

- C. Self-Insured Claim Requests
 - 1. BWC shall process eligible self-insured claim requests for artificial appliances if the injured worker has received an award under R.C. 4123.57(B) and the injured worker's need for the artificial appliance arises out of that award.
 - 2. BWC shall reimburse prior authorized travel expenses associated with an artificial appliance processed under IV.C.1 out of the surplus fund. See *Travel Reimbursement Policy*.
 - 3. Artificial appliance requests that BWC determines do not arise under the provisions of R.C. 4123.57(B) shall not be processed by BWC and shall be returned to the self-insured employer for processing.

- D. Self-insured employers requesting BWC processing of artificial appliance requests shall submit all of the following to BWC:
1. Written evidence of payment to the injured worker of a scheduled loss or facial disfigurement award under R.C. 4123.57(B) for the body part for which an artificial appliance is being requested.
 2. Sufficient medical and claim information for BWC to process a request for an artificial appliance.
- E. BWC shall ensure that the following information is available for processing an artificial appliance request and may contact the provider(s) and/or prosthetist to obtain the information if necessary:
1. Written evidence that an artificial appliance has been determined to be medically necessary for the injured worker from one of the following:
 - a. The Ohio State University hospital amputee clinic;
 - b. The Rehabilitation Services Commission;
 - c. An amputee clinic approved by the administrator or the administrator's designee;
 - d. A prescribing physician approved by the administrator or the administrator's designee.
 2. Dated and signed prescription of the item being requested including the manufacturer, brand name and model number;
 3. Recent physical examination that includes a functional assessment with current and expected ability, impact upon activities of daily living, assistive devices utilized and co-morbidities that impact the use of the prescribed artificial appliance;
 4. Clinical rationale for requested artificial appliance, replacement part(s) or repair(s) and a description of any labor involved;
 5. Coding description for the artificial appliance or repair utilizing the healthcare common procedure coding system (HCPCS). If a miscellaneous code is requested, all component items bundled in the miscellaneous code shall be listed along with a complete description and itemization of charges;
 6. Copy of the manufacturer's price list for items requested under a miscellaneous HCPCS code; and
 7. Copy of any warranties related to the requested artificial appliance.
- F. It is the prosthetist's responsibility to assure that any prosthetic device fits properly for three months from the date of dispensing. Any modifications, adjustments or replacements within the three months 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.

Medical Examinations

1. BWC (for self-insuring employer requests) shall, and the MCO (for state fund requests) may, schedule a multidisciplinary examination (MDE) for prosthetics or an independent medical examination (IME) for all other requests if:
 - a. A requested artificial appliance has not been available on the United States market for at least two years; or
 - b. In all cases that a physician review recommends an MDE or IME.
2. BWC (for self-insuring employer requests) shall, and the MCO (for state fund requests) may, schedule a MDE for the following prosthesis claim requests:
 - a. All initial multi-articulating hands or finger component prostheses;
 - b. All initial microprocessor knees and feet;

- c. Requests for replacement knees and feet microprocessor components when any of the following apply:
 - i. Microprocessor components are still under warranty;
 - ii. Documentation evidences non-use of the prosthesis by the injured worker;
 - iii. Documentation evidences that replacement is inappropriate due to a change in medical condition;
 - d. All initial custom silicone restorative passive devices;
 - e. Requests for replacement of custom silicone passive devices when either of the following apply:
 - i. Documentation evidences non-use of the prosthesis by the injured worker;
 - ii. Documentation establishes that replacement is inappropriate due to a change in medical condition;
 - f. Cases with a history of five or more repairs and/or modifications of the prosthesis within the past twelve months;
 - g. Cases involving requests for authorization for specialized surgical intervention relating to external/augmented prosthetic control (e.g., targeted muscle reinnervations), skeletal attachment (e.g., osteo-integration) or similar new or advanced technology.
3. BWC (for self-insuring employer requests) and the MCO (for state fund requests) may schedule an MDE or an IME for individuals requesting an artificial appliance or artificial appliance repair that are not subject to the provisions of IV.G.1. or IV.G.2., above.

BWC staff may refer to the corresponding procedure for this policy entitled “Procedure for Artificial Appliance Requests” for further guidance.

Procedure Name:	Procedures for Artificial Appliance Requests
Procedure #:	MP-16-01.PR1
Policy # Reference:	MP-01-01
Effective Date:	07/22/2013
Approved:	Freddie Johnson, Chief of Medical Services (signature on file)
Supersedes:	All policies and procedures regarding artificial appliance and self insured prosthesis requests that predate the effective date of this procedure
History:	New
Review date:	07/22/2018

- I. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.

II. State Fund Claim Requests

- A. Managed Care Organizations (MCOs) process state fund requests for artificial appliances, replacement part(s) or repair thereof if the injured worker has received an award under R.C. 4123.57(B) and the injured worker's need for the artificial appliance arises out of that award, and may request BWC staffing of the following issues relating to artificial appliance requests:
1. Medical appropriateness of requested artificial appliance;
 2. Medical examination scheduling;
 3. Billing reimbursement codes.
- B. MCOs shall direct staffing requests, noting the injured worker's (IW) name and claim number, to:
1. BWC staff assigned to the claim; or
 2. BWC catastrophic (CAT) nurse via email to: BWC.catnurse@bwc.state.oh.us.
- C. BWC staff shall respond to the staffing request or forward it to the appropriate CAT nurse for response.
- D. MCOs are responsible for processing payment requests for MCO-approved artificial appliances in accordance with Medical Billing and Adjustment Unit processing requirements.
- F. MCOs shall forward travel reimbursement requests to BWC for processing.

III. Self-Insured (SI) Claim Requests

- A. Field staff reviewing a request for an artificial appliance, replacement part or repair thereof, shall process the request if the injured worker has received an award under R.C. 4123.57(B) and the injured worker's need for the artificial appliance arises out of that award.
1. Field staff shall request additional documentation from the employer if insufficient documentation has been received to make a determination.
 2. Field staff may consult with their local BWC attorney for assistance if necessary in determining whether the injured worker's need arises out of the award under R.C. 4123.57(B).
 3. Field staff shall return the request to the self insured employer for processing if the requirements of this paragraph are not met and shall note in the claim file the decision rationale.
- B. Once a decision is made to process the request, field staff shall:
1. Send an email to the CAT nurse (BWC.catnurse@bwc.state.oh.us) with the IW's name and claim number. Field staff process the request and shall work with the CAT nurse as noted.
 2. Document that the following are met prior to approving the artificial appliance, replacement part or repair:
 - a. The necessity for the artificial appliance was identified in writing by one of the following:
 - i. The Ohio State University hospital amputee clinic;
 - ii. The Rehabilitation Services Commission;
 - iii. An amputee clinic approved by the administrator or the administrator's designee;
 - iv. A prescribing physician approved by the administrator or the administrator's designee.
 - b. The *Miller* criteria are satisfied. (Refer to the *Miller* Policy). The following information will assist in determining whether *Miller* criteria are satisfied:
 - i. From the physician of record:
 - a) A detailed written order that is signed and dated and includes:
 - i) The individual's name and claim number;
 - ii) Narrative condition/description;
 - iii) Dated prescription;
 - iv) Description of the item being requested including the manufacturer, brand name, model number;
 - b) Medical documentation supporting the necessity of the requested item reflecting:
 - i) Amputation history (if relevant), therapeutic intervention, clinical course and treatment plan;
 - ii) Recent physical examination that includes a functional assessment and impact upon activities of daily living (if relevant), assistive devices utilized and co-morbidities that impact the use of prescribed artificial appliance;
 - ii. From the prosthetist (if a prosthesis is requested):
 - a) Medical documentation supporting the necessity of the requested item;

- b) If relevant, dated and signed records documenting current and expected functional ability with an explanation of any difference. Lower limb prosthesis may utilize Medicare Functional Classification Levels (K-levels) to express functional ability;
 - c) Dated and signed medical records reflecting office visits and clinical rationale for the requested prosthesis, replacement part(s) or repair(s) and description of any labor involved;
 - iii. A coding description for the artificial appliance, replacement part(s) or repairs(s) utilizing the healthcare common procedure coding system (HCPCS). If a miscellaneous code or by report (BR) code is requested, all component items bundled in the miscellaneous or BR code listed along with a complete description and itemization of charges;
 - iv. Manufacturer's price list for items requested under a miscellaneous or BR code;
 - v. Warranties related to the requested artificial appliance.
 - 3. If information set forth in III.B.2. is not in the provided medical records, field staff shall contact the provider and/or prosthetist to obtain the necessary information.
- C. Artificial appliance requests meeting the criteria set forth in paragraph III.B. may be approved. Field staff shall complete the following when approving:
 - 1. Staff the billing reimbursement codes with the CAT nurse. If there are questions relating to requested codes or pricing, the CAT nurse or field staff shall contact the provider to discuss the requested codes or discrepancies between the usual and customary rate (UCR) and the amount billed.
 - 2. Update the claim management system with the approval, including a notation of the specific allowed codes and allowed miscellaneous or BR prices in the prior authorization screen with the allowed date range (window).
 - 3. Send an approval letter (C-47) to the parties noting all allowed codes and the UCR or the allowed pricing for the miscellaneous or BR codes.
 - a. Upon receipt of the C-19 Service Invoice from the provider, field staff shall:
 - i. Compare the allowed codes and allowed prices in the claim management system and the C-47 to the billed codes on the C-19 Service Invoice to ensure a match.
 - ii. If the allowed codes and pricing and the billed codes and pricing match, field staff shall approve the invoice.
 - iii. If there is a discrepancy between any of the allowed codes and pricing and the billed codes and pricing on the C-19, field staff shall additionally note in the "Remarks" block on the C-19, the following:
 - a) Any code(s) that were not authorized in the C-47 letter;
 - b) Any pricing discrepancies between the C-19 and the C-47.
 - b. Compare the date of service on the C-19 (date of delivery of the service) to the allowed date range in the claim management system. The service date must fall within the allowed date range. If within the date range, field staff shall change the date range in the claim management system to the date of service on the C-19. If the date of service is out of the allowed date range, field staff shall contact the CAT nurse.
 - c. Send the C-19 to Medical Billing and Adjustments (MBA) so the bill can be paid via the surplus fund.
- D. Field staff may consult with the CAT nurse for assistance in reviewing an artificial appliance request. Staffing will result in one of the following:

1. The request will be pended: field staff shall send an additional request for documentation.
2. The request will be denied: field staff shall update the claim management system and issue a denial letter (C-48) to all parties.
3. The request will be referred for physician file review or the injured worker will be scheduled for an independent medical examination (IME) or a multidisciplinary evaluation (MDE): field staff shall notify the injured worker in writing of the scheduling of an IME or MDE.
 - a. If the physician file review or multidisciplinary evaluation recommends denial of the request, field staff shall deny the request, update the claim management system, generate a C-48 and send it to all parties.
 - b. If the physician file review or multidisciplinary evaluation recommends approval of the request, field staff shall approve the request and follow the provisions set forth in paragraph III.C.

E. The CAT nurse may contact the physician and/or prosthetist to discuss recommended amendments to the requested artificial appliance and/or repair request. Recommended amendments may arise from the CAT nurse, physician review recommendations and/or IME or MDE recommendations.

1. If amendments are recommended, the CAT nurse shall request withdrawal of the original C-9 and request a revised C-9 reflecting the recommended amendments.
2. If a revised C-9 is submitted, the CAT nurse will review it to ensure that recommended amendments were incorporated and shall forward the request to field staff to complete the approval process as set forth in III.C.2. and III.C.3.
3. If agreement cannot be reached with the physician and/or prosthetist to withdraw and submit a revised C-9, field staff shall deny the C-9 request, update the claim management system and send a C-48 to all parties.

IV. BWC staff (for SI employer requests) shall schedule Multidisciplinary Evaluations and/or Independent Medical Examinations as follows:

A. The BWC CAT nurse shall schedule an:

1. MDE for prosthetics if:
 - a. A requested prosthetic has not been available on the United States market for at least two years;
 - b. A physician review recommends an MDE; or
 - c. One of the following is requested:
 - i. All initial multi-articulating hands or finger component prostheses;
 - ii. All initial microprocessor knees and feet;
 - iii. Requests for replacement knees and feet microprocessor components when any of the following apply:
 - a) Microprocessor components are still under warranty;
 - b) Documentation evidences non-use of the prosthesis by the injured worker;
 - c) Documentation evidences that replacement is inappropriate due to a change in medical condition;
 - iv. All initial custom silicone restorative passive devices;
 - v. Requests for replacement of custom silicone passive devices when either of the following apply:
 - a) Documentation evidences non-use of the prosthesis by the injured worker;
 - b) Documentation establishes that replacement is inappropriate due to a change in medical condition;

- vi. Cases with a history of five or more repairs and/or modifications of the prosthesis within the past twelve months;
 - vii. Cases involving requests for authorization for specialized surgical intervention relating to external/augmented prosthetic control (e.g., targeted muscle reinnervations), skeletal attachment (e.g., osteo-integration) or similar new or advanced technology.
2. IME for any artificial appliance if:
 - a. A requested artificial appliance has not been available on the United States market for at least two years; or
 - b. A physician review recommends an IME.
- B. The BWC CAT nurse may schedule an MDE or an IME for individuals requesting an artificial appliance or artificial appliance repair that are not subject to the provisions of IV.A.

V. The Multidisciplinary Evaluation

- A. MDEs shall be scheduled at an amputee clinic and, depending on the needs of the injured worker, shall be conducted by a specialty physician, licensed physical or occupational therapist, and an independent prosthetist, who will consider and assess the injured worker's current condition regarding the amputation site and prosthetic needs. A prosthetist is considered to be independent if he or she has not provided services to the injured worker within the past two years.
- B. The MDE shall include the following:
1. A physician report including:
 - a. Medical history;
 - b. History and physical;
 - c. Diagnostics that were reviewed;
 - d. Discussion of contributory medical conditions that could be a barrier to use of the requested prosthetic device;
 - e. Discussion of current condition of the amputation site and residual limb; and
 - f. Current functional status and expected potential.
 2. A physical or occupational therapist report including:
 - a. Current functional status; and
 - b. Expected functional outcome.
 3. A prosthetist report including:
 - a. Prior prosthetic use, if applicable;
 - b. Current functional status;
 - c. Expected functional outcome;
 - d. HCPCS coding of the recommended device or repair; and
 - e. Manufacturer list pricing of the recommended device.
- C. Staff shall provide relevant information available in the claim file to the clinic performing the MDE, shall inform the clinic of the information set forth in paragraph V.B. to be addressed through the MDE and provide any additional questions to be addressed relevant to the requested artificial appliance, replacement part(s) or repair(s).
- E. The provider(s) performing the MDE shall bill for services rendered in the MDE on a C-19 Service Invoice.

VI. Travel Reimbursement

- A. Field staff (or the CAT nurse when scheduling an MDE) shall process travel reimbursement requests as set forth in the *Travel Reimbursement* Policy.
- B. Field staff shall notify the IW of the location of the travel reimbursement form (Form C-60) on ohiobwc.com and mail a form to the IW if requested.

Policy/ Procedure Name:	Due Process
Policy #:	CP-04-06
Code/Rule Reference:	The Fifth Amendment to the U.S. Constitution; the Ohio Constitution, Article 1, Section 16.
Effective Date:	08/06/2013
Approved:	Dale Hamilton, Chief Operating Officer (signature on file)
Origin:	Claims Policy
Supersedes:	All policies and procedures, memos and directives regarding due process that predate the effective date of this policy.
History:	New
Review date:	08/06/2018

I. POLICY PURPOSE

The purpose of this policy is to provide general Workers' Compensation due process guidelines.

II. APPLICABILITY

This policy applies to Bureau of Workers' Compensation (BWC) staff and managed care organization (MCO) staff.

III. DEFINITIONS

Due Process: Legal principle that government may not deprive an individual of life, liberty or protected property rights without providing notice and an opportunity to be heard.

Notice: The timely provision of information, as needed, to the claim parties by phone, fax, letter or password-protected email regarding a particular claim issue.

Examples:

- Making a phone call to the employer to afford the employer the opportunity to be heard prior to BWC issuing a decision on an injured worker's request for temporary total compensation;
- Issuing an order providing notice to parties of the right to appeal a claim decision, the timeframe to file that appeal and in what forum the appeal will be heard.

Parties to the Claim: for purposes of this policy the injured worker and employer. BWC is also a party to the claim if the claim is appealed to the Industrial Commission or court.

IV. POLICY

- A. It is the policy of BWC to ensure that a party is afforded due process when required. The Supreme Court of Ohio mandated that BWC provide due process because an individual has a protected property interest in receiving medical benefits. See State ex rel. Haylett v. Ohio Bur. Of Workers' Comp., 87 Ohio St.3d 325.
- B. The type of due process afforded to a party depends on the impact to the party's protected rights. Due process may occur by:
 - 1. Giving notice of a requested action or service;
 - 2. Providing a copy of the decision;
 - 3. Providing an opportunity to be heard; and/or
 - 4. Giving notice of a right to appeal and the appropriate forum in which to appeal.
- C. BWC and MCO staff shall follow due process requirements mandated in specific subject matter policies and procedures impacting injured worker and employer rights.
- D. Miscellaneous issues related to due process:
 - 1. If the last day for response to a notice falls on a weekend, a legal holiday, a day in which BWC is closed or a day in which BWC closes before its usual closing time, the last day for response shall be extended to the next business day.
 - 2. Staff shall not provide due process to employers that are out of business or no longer doing business in Ohio, unless the employer specifically requests continued notice or has retained an authorized representative to oversee the employer's claims.

Policy Name:	Travel Reimbursement
Policy #:	CP-20-01
Code/Rule Reference:	O.A.C 4123-6-40
Effective Date:	05/09/2014
Approved:	Rick Percy, Chief of Operational Policy, Analytics & Compliance (Signature on file)
Origin:	Claims Policy
Supersedes:	Policy CP-20-01, effective 01/01/2014
History:	Rev.01/01/2014, 08/01/2013, 07/08/2013; New 11/21/2012
Review date:	05/09/2019

I. POLICY PURPOSE

The purpose of this policy is to ensure consistent and efficient reimbursement to the injured worker (IW) for allowable travel expenses.

II. APPLICABILITY

This policy applies to managed care organization (MCO) staff and BWC Field Operations staff.

III. DEFINITIONS

None

IV. POLICY

- A. BWC shall reimburse an IW for reasonable and necessary travel expenses, upon the filing of a proper request, (excepting sections IV.B and C) when:
 1. The IW has been ordered or authorized by BWC or the IC to undergo a medical examination outside the community where he or she lives and the travel distance exceeds the mileage distance determined by BWC in the *Injured Worker Reimbursement Rates for Travel Expense (C-60A)*.
 2. When specialized medical treatment, including a service contained in an approved vocational rehabilitation plan, is necessary for the allowed condition, cannot be obtained within the IW's community, the treatment has been pre-authorized and approved by the MCO, and the travel distance exceeds the mileage distance determined by BWC in the C-60A.
 3. The IW's physical condition requires the use of taxi or other special transportation for treatment or examination for the allowed injury or disease.

- B. The employer is responsible for the reimbursement of travel expenses when the travel is related to a request for a medical examination by a physician of the employer's choice. Reimbursement of travel expenses under this provision shall not require an order of BWC or the IC, unless there is a dispute. Reimbursement by the employer under this provision is not subject to the minimum mileage requirement applicable to BWC reimbursed travel.
- C. The self-insuring employer is responsible for reimbursement of travel expenses if related to a self-insured claim, unless the travel is for:
 - 1. an exam prior to a determination for percentage permanent partial disability; or
 - 2. the provision of a prosthetic device pursuant to the *Artificial Appliance Requests* policy.
- D. To obtain reimbursement, the IW must, as soon as possible, complete and submit an *Injured Worker Statement for Reimbursement of Travel Expense* (C-60), or an equivalent documented travel reimbursement request to the responsible party reflected in sections IV.A-C.
- E. BWC will deny travel expenses submitted more than two years after the IW's date of travel.
- F. It is the policy of BWC that the following types of travel expenses must be pre-authorized by BWC to be reimbursable:
 - 1. Lodging;
 - 2. Travel in excess of 400 miles round trip;
 - 3. Companion travel;
 - 4. Travel by taxicabs, bus, train, air, or other special transportation; and
 - 5. Any other expenses identified on the C-60A as requiring pre-authorization.
- G. Rates of Reimbursement:
 - 1. BWC shall maintain C-60A, that details the amounts used to compute reimbursement of travel expenses.
 - 2. Travel by automobile shall be reimbursed on a per mile basis, portal to portal, using the most direct and practical route.
 - 3. Meals shall be reimbursed based on the distance traveled, at reasonable cost, up to the maximum amount reflected on the C-60A.
 - 4. Travel by airplane, railroad, bus, taxi, or other special transportation shall be reimbursed at the actual and necessary cost of such fare; receipts are required.
 - 5. Lodging shall be reimbursed at reasonable actual cost, up to the maximum amount reflected on the C-60A; receipts are required.
 - 6. Miscellaneous expenses, such as tolls and parking, shall be reimbursed at actual and necessary cost; receipts are required.
- H. BWC Pre-Pay Travel Program
 - 1. BWC may, in its sole discretion, assist an IW by pre-paying allowable lodging and/or transportation expenses, such as airplane or railroad fares. Such assistance is not mandated by statute or rule.
 - 2. Travel by automobile or taxi, meals, or other miscellaneous travel expenses are not eligible for pre-payment.
 - 3. An IW seeking to have travel expenses pre-paid shall submit the request to field staff as soon as possible prior to travel. Field staff shall advise the IW on the requirements and process for approval and arrangements.

Procedure Name:	Procedures for Travel Reimbursement
Procedure #:	CP-20-01.PR1
Policy # Reference:	CP-20-01
Effective Date:	05/09/2014
Approved:	Rick Percy, Chief of Operational Policy, Analytics & Compliance (Signature on file)
Supersedes:	Procedure CP-20-01.PR1, effective 01/01/2014
History:	Rev.01/01/2014, 08/01/2013, 07/08/2013; New 11/21/2012
Review date:	05/09/2019

IX. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.

II. General Provisions and Pre-Authorization

- A. Field staff may reimburse travel expenses when one of the following occur:
1. When the Injured worker (IW) is ordered or authorized to appear for a medical examination occurring forty-five (45) miles or more, round trip from the IW's residence, by:
 - a. BWC;
 - b. The Industrial Commission (IC);
 - c. The managed care organization (MCO);
 2. When the MCO has determined that specialized medical treatment, including a service contained in an approved vocational rehabilitation plan, is required and cannot be obtained within 45 miles round trip from the IW's residence;
 3. When the IW's physical condition requires the use of taxi or other special transportation for treatment or examination for the allowed injury or disease.
- B. The following travel expenses must be pre-authorized by field staff prior to travel required pursuant to section II.A:
1. Lodging;
 2. Travel in excess of 400 miles round trip;
 3. Companion travel;
 4. Travel by taxicabs, bus, train, air, or other special transportation; and
 5. Any other expenses identified on the *Injured Worker Reimbursement Rates for Travel Expenses* (C-60A) as requiring pre-authorization.
- C. In cases arising under section II.A.2, the MCO shall identify the closest provider of the service, utilizing the hierarchy of distance (i.e., a provider in the following order of preference: within the local community, regional community, statewide community, or contiguous states where services can be obtained).

1. The MCO shall staff its provider recommendations and the need for any pre-authorizations with field staff before authorizing treatment.
2. The MCO and field staff shall document the rationale for the choice of provider(s) in the claim notes and what travel expenses are pre-authorized, if any.
3. The MCO shall advise the IW to contact BWC for more information regarding requirements and procedures for obtaining reimbursement of travel expenses.

III. Submission of a Travel Reimbursement Request

- A. The IW must submit a request for travel reimbursement on a current *Injured Worker Statement for Reimbursement of Travel Expense* (C-60) form or an equivalent document (e.g., email, letter, or outdated C-60).
- B. If field staff receives a travel reimbursement request and the reason for travel was for a medical examination scheduled by the IW's employer, field staff shall return the request to the IW, advising him or her that the request must be submitted to his or her employer for reimbursement.
- C. If field staff receives a travel reimbursement request and the IW is employed by a self-insuring employer, field staff shall return the request to the IW, advising him or her that the request must be submitted to his or her employer for reimbursement unless the travel is for:
 1. an exam prior to a determination for percentage permanent partial disability; or
 2. the provision of a prosthetic device pursuant to the *Artificial Appliance Requests* policy.
- D. If field staff receives a travel reimbursement request and the reason for the travel was for a medical examination scheduled by the IC, field staff shall forward the request to the IC office that scheduled the exam or fax the request to the IC at 614-466-1661.

IV. Review and Approval of Travel Expenses

- A. Field staff shall review the C-60 or other equivalent documented travel reimbursement request by the IW, and verify that the expenses submitted meet the criteria for reimbursement, including necessary pre-authorizations. Field staff shall contact the IW to obtain any necessary clarification and/or missing documentation (e.g., receipts).
- B. If the travel reimbursement request is for treatment that was not approved by the MCO, field staff shall deny the request. If the treatment is subsequently approved by the MCO, the travel reimbursement request will be approved, consistent with the requirements of this policy.
- C. If field staff identifies that the need for treatment was approved, but the need for travel was not staffed or documented in notes, field staff shall approve the travel reimbursement request to the extent it is in compliance with the *Travel Reimbursement* policy.

V. Calculating Reimbursement

- A. After field staff determines that all reimbursable costs are reasonable and necessary, field staff shall calculate reimbursement for travel expenses in the following manner:

1. Reimbursement for travel by a personal vehicle shall be at the rate indicated on the C-60A, per mile, for the date(s) of travel.
 - a. The total reimbursement is determined by multiplying the number of miles traveled by the per mile rate;
 - b. Internet resources may be used as a tool to help determine reasonable and necessary mileage.
 2. When travel equals or exceeds 100 miles one way, staff shall reimburse for meals (gratuities included) up to the maximum amounts indicated on the C-60A.
 3. Pre-authorized lodging for the IW shall be reimbursed at reasonable actual cost (receipts required), up to the maximum amount indicated on the C-60A, plus applicable taxes.
 4. Travel by taxi, train, airplane, bus or other special transportation shall be reimbursed at reasonable actual cost (receipts required).
 5. Miscellaneous travel expenses, such as tolls and parking, shall be reimbursed at the actual amount (receipts required).
 6. Approved travel expenses related to pre-authorized companions shall be reimbursed at the same rates permitted for the IW, except: companions shall share the IW's room when lodging is required, unless special circumstances require a separate room. Mileage is only reimbursable to the IW.
- B. To process and document the C-60 form, field staff shall:
1. Enter the calculations in the appropriate section of the "Official Use Only" section of the form;
 2. Indicate the appropriate procedure code(s) to be charged;
 3. Check the "Surplus Fund" box if the travel expenses are related to:
 - a. a percentage permanent partial exam;
 - b. services in an approved rehabilitation plan;
 - c. a prosthetic provided to the IW pursuant to the *Artificial Appliances Requests* policy; or
 - d. a medical exam for a denied statutory occupational disease. (See the *Occupational Disease Claims* policy for further information).
 4. Sign, date, enter his or her phone number and "A" number where indicated, image a copy of the C-60 into the claim and send a copy to the IW with a copy of the C-60A;
 5. Fax a copy of the completed C-60 to Benefits Payable at 1-614-621-1140. Benefits Payable will notify field staff if a C-60 is not completed properly. Field staff shall be responsible for correcting the C-60 and resubmitting.
- C. If the request for travel reimbursement has not been submitted on a C-60, field staff shall process and document the request noting on the request or any attached document:
1. Calculations of reimbursable travel expenses;
 2. The related procedure codes, as designated on the C-60; and
 3. Whether any charges are to be made to the Surplus Fund.
- D. If any of the IW's travel reimbursement request appears unreasonable or unnecessary, or is otherwise questionable, field staff shall contact the IW in an attempt to resolve.
 Example: Mileage submitted by IW is thirty miles more than an online resource indicates the trip would be using the most direct route. Contact with the IW reveals that there was an accident causing a detour, resulting in the additional miles.

VI. Denial of Travel Reimbursement

- A. If, after reviewing the C-60 or other submitted documentation, field staff determines that all or some of the submitted travel expenses do not meet the criteria for reimbursement per the *Travel Reimbursement* policy and procedures, field staff shall publish a miscellaneous order which states:
 1. “ After a thorough review of your request for travel reimbursement filed on [date] BWC has determined that [a portion of] your request does not meet the criteria listed below:”
 2. The appropriate travel denial reason; and
 3. Any additional explanation needed to explain the basis for the denial and the statement: Therefore, we have denied [a portion of] your request for travel reimbursement.

- B. In addition to a miscellaneous order, if only a portion of a travel reimbursement request is denied, field staff shall:
 1. Strike out the denied expenses on the C-60;
 2. Calculate the totals for the allowed expenses and indicate the amount of reimbursement;
 3. Image a copy of the C-60 into the claim and send a copy to the IW with a copy of the C-60A; and
 4. Fax the amended C-60A to Benefits Payable.

VII. IW Pre-pay Travel Program (Restricted Use)

- A. If an IW requests assistance from BWC to prepay allowable and authorized lodging and or transportation expenses (e.g., hotel, airfare, bus fare) field staff shall advise the IW to submit the request to BWC management (i.e., team leader, supervisor or service office manager) as soon as possible prior to travel. The Pre-Pay Travel (PPT) unit shall be available for consultation via the “ BWC Pre-Pay Travel” email box. Field staff shall also advise the IW that approval must be granted before any travel arrangements are made.

- B. Field staff and BWC management shall staff the request.
 1. If approved by BWC management, field staff, in consultation with the IW shall complete the *Injured Worker Travel Card Authorization Log* (A-53) and submit it to the PPT unit for final approval or disapproval. The following information shall be submitted to the PPT:
 - a. Date(s) of travel;
 - b. Preferred travel time;
 - c. Travel destination (city and state);
 - d. Mode of travel (automobile travel excluded);
 - e. Appointment date and time;
 - f. Name, address and phone number of facility or physician;
 - g. Companion expenses, if any;
 - h. Hotel accommodations, including any special needs (e.g., handicap accessible, non-smoking/smoking, double beds). Incidental room expenses, such as room service, will not be pre-paid, though they may be reimbursable via a C-60, if appropriate;
 2. Within two business days of receipt of the A-53 the PPT unit will approve or disapprove the request and notify field staff by email.
 - a. If approved, the PPT unit will proceed with making travel arrangements.
 - b. If disapproved, the A-53 will be cancelled and returned to field staff.
 - c. Field staff shall document the approval or disapproval in the claim notes.

- C. To process the approved A-53:
1. The PPT unit will:
 - a. Document the travel arrangements on the A-53 with the confirmed vendor, dates of travel, the total cost of travel and the confirmation numbers;
 - b. Attach any itineraries received from the appropriate vendors and fax this information along with the approved A-53 to field staff;
 - c. Maintain the completed and confirmed copy of the A-53 and fax a copy to Benefits Payable to be processed.
 2. Field staff shall image the A-53 and document the travel approval in the claim notes.
- D. Once the A-53 is received by field staff:
1. Field staff shall prepare a letter of confirmation to send to the IW, which includes the arrangements made by the PPT unit, any itineraries, and a C-60 for any expenses incurred by the IW that are not prepaid but approved, or otherwise meet the requirements of the *Travel Reimbursement* policy and procedures.
 2. Field staff shall set a diary for the next business day after the expected return date of the IW's travel;
 3. Field staff shall verify the IW traveled and kept the appointment per the arrangements confirmed on the A-53 and document the verification in claim notes;
 4. Field staff shall assure that any travel reimbursement request submitted by the IW does not include the pre-paid travel arrangements.
 5. If field staff determines that the prearranged travel was not utilized, the IW shall be contacted to determine if there are justifiable reasons or circumstances that prevented the travel. This information shall be documented in the claim notes.
- E. If, for any reason, the IW cancels the arrangements and does not make alternative arrangements, field staff shall notify the PPT unit immediately via the BWC Pre-Pay Travel email box. The PPT unit will contact the vendors and cancel the arrangements to avoid fees or penalties.
1. Upon receipt of the cancellation notice, the PPT unit shall send a copy of the A-53 with the required cancellation notations, including any fee or penalties to Benefits Payable;
 2. Field staff shall document the travel cancellation in the claim notes;
 3. If new travel arrangements are made, a new A-53 shall be prepared and processed consistent with the Travel Reimbursement policy and procedures.

VIII. Overpayment of Travel Expenses

If there is an overpayment of travel expenses, field staff shall issue an order indicating the overpayment and that the overpayment will be collected at 100% from any future approved travel expense reimbursement to the IW. The IW may also repay the overpayment amount at any time.

Policy and Procedure Name:	Drug Testing
Policy #:	MP-21-01
Code/Rule Reference:	R.C. 4121.441, 4123.66; O.A.C. 4123-6-08, 4123-6-16.2, 4123-6-25
Effective Date:	09/23/16
Approved:	Freddie L. Johnson, Chief of Medical Services (signature on file)
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding urine drug testing that predate the effective date of this policy.
History:	Rev. 08/11/15, 05/09/14 and 12/11/13
Review date:	09/23/21

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for the utilization of drug testing (DT) for injured workers (IW), especially those who are receiving or being considered for chronic opioid therapy in the management of chronic non-cancer pain.

II. APPLICABILITY

This policy applies to MCOs and providers of drug tests.

III. DEFINITIONS

Alternative drug testing (ADT): a chemical analysis of bodily specimens, with the exception of urine, that are obtained to identify presence or absence of parent drugs or their metabolites. For the purpose of this policy, it is inclusive of both the immunoassay and a confirmation test such as gas chromatography, mass spectrometry or high-performance liquid chromatography.

Chronic opioid therapy: the consistent use of opioids for more than ninety (90) days.

Chronic pain: discomfort (i.e., pain) that extends beyond the expected period of healing.

Point-of-care testing: done at or near the site of patient care using commercial devices (e.g., in-office urine drug testing).

Urine drug testing (UDT): a chemical analysis of the urine to identify presence or absence of parent drugs or their metabolites. For the purpose of this policy, it is inclusive of both the immunoassay and a confirmation test such as gas chromatography, mass spectrometry or high-performance liquid chromatography.

IV. POLICY

A. It is the policy of BWC to:

1. Ensure appropriate use of opioids in the treatment of chronic pain management by allowing DTs;
2. Require provider submission of the IW's level of risk to the MCO prior to determining the appropriate number of DTs to authorize for the IW;
3. Allow up to four DTs yearly as determined by the injured worker's (IW) individual risk assessment, which shall be submitted no less than once a year; and
4. Allow up to two additional DTs yearly when a provider documents the demonstration of aberrant behavior by an IW.

B. Drug testing methods:

1. It is the policy of BWC that UDTs are the preferred method of drug testing.
2. It is the policy of BWC to allow Alternative Drug Testing (ADT) (e.g., blood, saliva and hair follicle):
 - a. **Only** when a urine specimen is unobtainable due to medically documented reasons; and
 - b. **Only** when testing facilities/labs use FDA approved test kits/devices to obtain ADTs.

C. It is the policy of BWC to reimburse for:

1. DT performed in a laboratory that is CLIA (Clinical Laboratory Improvement Amendments) certified;
2. DTs performed following the process outlined in the procedure section of this document;
3. DT billed under codes reflected in this link ([DT codes](#)).
4. Quantitative testing for an individual drug that the IW is prescribed which is not included in the standard drug panel listed in C.5;
5. A standard drug panel immunoassay test that includes the following drugs:
 - a. Amphetamines;
 - b. Opiates;
 - c. Cocaine;
 - d. Benzodiazepines;
 - e. Barbiturates;
 - f. Oxycodone;
 - g. Methadone;
 - h. Fentanyl;
 - i. Marijuana; and
 - j. Hydrocodone.
6. DT that includes the standard drug panel listed above in Section IV.C.5. a-j, when the IW is taking a prescription drug that is not paid for by BWC.
7. Additional tests for drugs not included in the standard drug panel listed above in Section IV.C.5. a-j when:
 - a. The IW is prescribed the drug; and/or
 - b. The physician deems the testing medically necessary.
8. Point-of-care DTs when medical documentation identifies an immediate need.
9. Drug confirmation by gas chromatography, mass spectrometry or high-performance liquid chromatography solely for the drug in question when the immunoassay results are positive or when:
 - a. An unexpected drug or its metabolites are identified;
 - b. The prescribed drug or its metabolites are not identified in the DT.
10. DTs immediately prior to the initiation of opioid therapy for chronic non-cancer pain or for the extension of opioid therapy beyond the acute phase (e.g., a patient has been on opioids for the treatment of an acute injury for six weeks or more and the practitioner is considering opioids for chronic pain).
11. DTs while a patient is on opioid therapy for chronic non-cancer pain to:
 - a. Verify compliance with the treatment regimen; and/or
 - b. Identify undisclosed drug use and/or abuse.

V. PROCEDURE FOR UDT AND ADT COLLECTION

A. UDT

1. Providers of urine drug tests shall ensure a collection protocol that protects the security and integrity of the urine collection by:
 - a. Testing the IW as soon as possible after the physician order is given;
 - b. Verifying the IW's identification via a photo identification or other confirming ID;
 - c. Collecting only one specimen at a time;
 - d. Having the IW remove any garments which might conceal substances or items to adulterate the urine specimen;
 - e. Instructing the IW to wash and dry his/her hands prior to urination;
 - f. Securing all water sources;
 - g. Ensuring the water in the toilet tank and bowl are blue;
 - h. Inspecting the testing site to ensure no unauthorized substances are present;
 - i. Removing all soaps, disinfectants, cleaning agents or other possible adulterants from the testing area;
 - j. Providing individual privacy for the IW during specimen collection;
 - k. Measuring the specimen temperature within four (4) minutes of its collection to ensure the temperature is between 90-100 Fahrenheit;
 - l. Visually inspecting the urine for color and contaminants;
 - m. Sealing and labeling the specimen with seals containing the date and specimen number in the presence of the IW;
 - n. Having the IW initial the seals, certifying that it is his/her specimen.
 2. A chain of custody form (appendix A) or equivalent form containing a minimum of the following elements shall be used in the collection and processing of the urine specimen:
 - a. IW's name, address, date of birth, signature, date of signature and claim number;
 - b. Collection site's name, address, phone and fax number;
 - c. Reason for the test;
 - d. Drugs to test for;
 - e. Specimen temperature within four (4) minutes of collection;
 - f. Additional comments;
 - g. Collection time, date and printed name and signature of collector;
 - h. Date and name of courier to whom the specimen was released;
 - i. Printed name and signature of lab employee receiving the specimen and the date of specimen receipt;
 - j. Documentation that the specimen bottle seals were intact upon the labs receipt of the specimen;
 - k. Results and result date.
- B. ADT shall be collected pursuant to the FDA approved drug kit.
- C. Specimens failing to meet the above listed criteria shall be rejected for testing.

Chain of Custody Form
Appendix A

Injured worker (donor) demographics		
Name:	Contact number:	Claim number:
Address, City, State and Zip Code:		Date of birth:
I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.		
Injured worker's signature:		Date (mm/dd/yy):
Collection site demographics		
Name:		Address, City, State and Zip Code:
Phone number:	Fax number:	
To be completed by the collector		
Reason for testing: <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/cause <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify) _____		
Drug test to be performed: <input type="checkbox"/> Amphetamines <input type="checkbox"/> Opiates <input type="checkbox"/> Cocaine <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Barbiturates <input type="checkbox"/> Oxycodone <input type="checkbox"/> Methadone <input type="checkbox"/> Fentanyl <input type="checkbox"/> Marijuana metabolite <input type="checkbox"/> Hydrocodone <input type="checkbox"/> Other (specify) _____		
Temperature within 90 and 100 F within 4 minutes of collection: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Specimen collection: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None provided (explain) _____		
Additional observations:		
Time of collection:	Date of collection (mm/dd/yy):	
<i>I certify that the specimen given to me by the donor was collected, labeled, sealed and released to the courier service noted in accordance with applicable Federal requirements.</i>		
Collector's name (please print):	Signature of collector:	
Time of specimen release:	Date of specimen release (mm/dd/yy):	
Name of courier the specimen bottles were released to: _____		
To be completed by the lab upon receipt of the specimen		
Accessioner's name (please print):	Signature of accessioner:	
Specimen receipt date:	Specimen bottle seal intact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of person specimen bottles released to:		
<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Dilute <input type="checkbox"/> Test cancelled <input type="checkbox"/> Refusal to test <input type="checkbox"/> Adulterated <input type="checkbox"/> Substituted Remarks: _____		
Positive for: <input type="checkbox"/> Amphetamines <input type="checkbox"/> Opiates <input type="checkbox"/> Cocaine <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Barbiturates <input type="checkbox"/> Oxycodone <input type="checkbox"/> Methadone <input type="checkbox"/> Fentanyl <input type="checkbox"/> Marijuana metabolite <input type="checkbox"/> Hydrocodone		
Other (list):		
Remarks:		
Lab technician's name (please print):	Signature of Lab technician:	Date (mm/dd/yy):

Policy and Procedure Name:	Return to Work Data
Policy #:	CP-18-01
Code/Rule Reference:	None
Effective Date:	12/23/2013
Approved:	Rick Percy, Chief of Operational Policy, Analytics & Compliance (Signature on File)
Origin:	Claims Policy
Supersedes:	All policies and procedures, directives or memos regarding return to work data that predate the effective date of this policy and procedure.
History:	New
Review date:	12/23/2018

I. POLICY PURPOSE

The purpose of this policy is to ensure that MCO and BWC staff appropriately verify, update and/or maintain return to work (RTW) data in the claims management system.

II. APPLICABILITY

This policy applies to MCO and Field Operations staff.

III. DEFINITIONS

Actual Return to Work: The confirmed date the injured worker (IW) returns to employment, with or without work restriction(s). This may include an IW that has returned to the workplace with restrictions, but is participating in a vocational rehabilitation plan service or program such as:

- Employer Incentive;
- On-the Job Training;
- Transitional Work; or
- Gradual Return to Work.

Estimated Return to Work: The anticipated future date the IW may be able to return to employment.

Last Date Worked: The last date the IW reported to work prior to taking time off due to the work-related injury or illness, regardless of the length of time the IW worked on that date.

Return to Work Data: Data that includes any combination of the dates related to return to work: last date worked, estimated return to work, released to return to work or actual return to work.

Released to Return to Work: The date the physician of record releases the IW to return to employment (with or without restrictions). This may include an IW that is released to return to work with restrictions and is participating in a vocational rehabilitation service or program such as:

- Job Search/Job Seeking Skills Training;
- Job Retraining; or
- Work Trial.

Wage Replacement Compensation: Compensation intended to replace an IW's earnings. This includes temporary total, living maintenance, living maintenance wage loss, wage loss (working and non-working), permanent total disability and salary continuation.

IV. POLICY

- A. It is the policy of BWC to rely primarily on the managed care organizations (MCO) to provide accurate return to work data.
- B. It is the policy of BWC to ensure that return to work data is identified, verified, properly updated and maintained in the claims management system.

V. PROCEDURE

- A. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.
- B. The MCO shall provide RTW data on medical only claims, which will systematically update in the claim management system.
- C. For lost time claims, Field Operations staff shall presume the reliability of RTW data provided by the MCO when accompanied by a detailed MCO note which contains the following information:
 - 1. The estimated or release to RTW date, and the verified actual (i.e., employee physically reports to work) return to work date;
 - 2. The name of the person who provided the RTW information;
 - 3. The date the MCO spoke to the person who provided the RTW information;
 - 4. Clarifying details, including when "other" is noted as a reason the IW has not returned to work, if needed; and
 - 5. Any other information relevant to the RTW data.
- D. If the MCO has not entered a note containing the above-listed information, or if for any other reason further verification is needed, Field Operations staff shall first contact the MCO, and then, only if necessary, the employer or employer representative, IW or IW representative, medical provider, rehabilitation provider or other reliable resource. Staff may also use documentation for verification, as appropriate.
- E. An estimated RTW date or an actual RTW date must be entered into the claims management system (even if there is a "Release to RTW" date, or a "No RTW" reason pursuant to V.H) in order to:
 - 1. Pay any form of compensation; and/or

2. Measure a period of disability.
- F. Field Operations staff shall enter an estimated RTW date when:
1. A future date is received on a MEDCO-14 or other medical documentation;
 2. When wage continuation information is received from the employer and there is no estimated date provided on the MEDCO-14 or other medical documentation;
 3. A RTW date is entered to adjust a permanent total disability plan as a result of the IW's death.
- G. Field Operations staff shall enter an actual RTW date when:
1. MCO staff has verified the IW has actually returned to employment;
 2. BWC staff has verified the IW has actually returned to employment; or
 3. The IW is receiving non-working wage loss, in which case the actual RTW date is entered as the first day non-working wage loss is paid.
- H. When entering actual RTW data, Field Operations staff shall ensure the following are documented in the case management system:
1. Whether the RTW was:
 - a. Light/modified duty (i.e., with restrictions); or
 - b. Full duty (i.e., with no restrictions); and
 2. The RTW job being returned to was:
 - a. Same job, same employer;
 - b. Different job, same employer;
 - c. Same job, different employer; or
 - d. Different job, different employer.
- I. No RTW Information Provided
1. Once the IW is no longer receiving any type of wage replacement compensation and Field Operations staff obtains a specific reason why the IW will not be returning to work, Field Operations staff shall update the claims management system to reflect one or more of the following reasons:
 - a. Termination;
 - b. Resignation;
 - c. Layoff;
 - d. Social Security retirement;
 - e. Voluntary workforce abandonment;
 - f. Incarceration;
 - g. School enrollment;
 - h. Retirement;
 - i. Social Security disability;
 - j. Other.
 2. Field Operations staff shall use the "Other" option as a reason for IW not returning to work only when no other listed reason is accurate for the situation.
 3. Field Operations staff shall not delete the estimated RTW date even when one of the reasons listed in H.1 above, apply.
- J. Released to Return to Work
- Field Operations staff shall enter the released to return to work date when provided. A release to return to work does not necessarily indicate that the IW will be returning to work, and Field Operations staff shall not delete the estimated RTW date. The estimated RTW date shall be consistent with the documentation in the claim.

- K. Field Operations staff shall ensure that all periods of lost time related to the allowed condition(s) are reflected in the claims management system with appropriately identified last date(s) worked and return to work date(s), including periods of lost time when the IW does not receive compensation. Field Operations staff shall ensure that compensation is not paid over periods of ineligibility. Field Operations staff shall not delete periods of lost time from the claims management system unless the periods are incorrect.
1. Example 1: The IC has issued an order which states that temporary total disability (TT) is denied because the IW violated a written work rule and was fired, and thus the IW voluntarily abandoned the job. In this case, the period of lost time would remain because the IC did not state that the period of disability is not related to the claim, only that it is not payable.
 2. Example 2: The IC has issued an order which states that TT is not payable because the IW lost time from work because of some reason other than the allowed conditions in the claim. In this case, the period of lost time would be removed because it is not related to the allowed conditions.
 3. Example 3: The MCO approves surgery for an allowed condition, but the IW does not request compensation for that period of lost time. Field Operations staff shall still enter all appropriate RTW data.
- L. Permanent Total Disability (PTD)
- If an IW is receiving PTD compensation, Field Operations staff shall remove any actual or estimated RTW dates which are after the most recent last date worked (the last date worked remains in the claim). Entering an actual RTW date into the claim will prevent a PTD plan from being built and stop any current PTD compensation.

Policy Name:	Transitional Work Developer; Transitional Work Grant & Transitional Work Bonus
Policy #:	MP- 20-1
Code/Rule Reference:	OAC 4123-17-55, 4123-6-01, 4123-6-02.2. Employer Policies EP-20-01 (<i>Transitional Work Grants</i>) and EP-20-02 (<i>Transitional Work Performance Bonus</i>)
Effective Date:	06/01/15
Approved:	John Annarino, Chief Medical and Health Officer (Signature on file)
Origin:	Medical Policy
Supersedes:	All Medical policies, directives or memos regarding Transitional Work Grant & Bonus Program that predate the effective date of this policy.
History:	Rev 06/01/15; New 05/30/14
Review date:	06/01/20

I. POLICY PURPOSE

The purpose of this policy is to ensure appropriate evaluation and approval of transitional work plans, ensure appropriate reimbursement for services provided by transitional work developers, and monitor participating employer utilization of transitional work plans for bonus payment calculation.

This policy complements the Transitional Work Grants Policy and the Transitional Work Performance Bonus Policy developed by BWC Employer Services.

II. APPLICABILITY

This policy applies to BWC staff, Transitional Work Developers, Managed Care Organizations (MCOs) and Employers taking part in the Transitional Work Grant Program or the Transitional Work Performance Bonus Program.

III. DEFINITIONS

Eligible Employer – an employer that has met the BWC Employer Management eligibility criteria for participation in the Grant Program or Bonus Program.

Implementation Funds – funds remaining in the employer’s Grant Program account after initial reimbursement for transitional work plan development. Implementation funds may be used to assist utilizing the transitional work plan with the first claim under the plan, provide transitional work plan program improvements, update a job analysis or add additional job analyses, or provide employer training relating to the transitional work plan.

Transitional Work (TW) – a work-site program that provides an individualized interim step in the recovery of an injured worker with job restrictions resulting from the allowed conditions in a claim. Developed in conjunction with the employer and the injured worker, or with others as needed, including, but not limited to the collective bargaining agent (where applicable), the physician of record, rehabilitation professionals, and the managed care organization, a transitional work program assists the injured worker in progressively performing the duties of a targeted job. OAC 4123-17-55(A)(5)

Transitional Work Developer (Developer) – the provider who develops the employer’s transitional work grant plan. OAC 4123-17-55(A)(5)

Transitional Work Plan (TW Plan) – a plan with the following components: corporate analysis, employer-employee relations, policies and procedures, job analysis and program evaluation.

Transitional Work Bonus Program (Bonus Program) – Employers with a transitional work plan may receive a back-end discount for using their TW plan to return injured workers back to work. A BWC incentive is provided to qualified employers who return an injured worker to work quickly and safely after an injury through utilization of the employer’s transitional work plan.

Transitional Work Grant Program (Grant Program) – BWC funds provided to qualified employers used to reimburse a percentage of the cost of development of a customized transitional work plan in the workplace.

IV. POLICY

D. Grant Program

1. It is the policy of BWC that:
 - a. Once BWC has approved an employer to participate in the Grant Program, the employer has 2 years from the date of application to complete development of a TW Plan and to complete reimbursement. Refer to the Employer Services *Transitional Work Grant Policy*, Policy # EP-20-01, for details.
 - b. Only developers meeting BWC eligibility requirements set forth in this policy shall develop TW Plans for the Grant Program. Employers may request assistance locating a developer by checking the appropriate box on the Transitional Work Grant (TWG-1) application.
 - c. BWC’s TW Unit shall review TW Plans submitted by employers and shall notify employers of Grant Program approval or denial following review of the TW Plan.
 - i. Per the Employer Services Policy, BWC may approve an associated policy number for grant monies based on corporate organization if the associated policy number submits an application and meets all Grant Program eligibility requirements under its own policy number.
 - ii. If multiple policy numbers are involved, BWC will work with the employer and developer to develop a TW Plan at the corporate level.
 - d. BWC will reimburse employers for TW Plan development costs based on reimbursement guidelines set forth in this policy.
 - e. Grievances:
 - i. An employer may file a grievance with the TW Unit if:
 - a) The TW Unit denied the Grant Program application based on the TW Plan submitted; or
 - b) The employer disputes the TW Unit reimbursement for TW Plan development costs.
 - ii. The TW Unit grievance decision shall be final.
 - f. Employer requests, documentation and grievances shall be submitted via:
 - i. Email to TWSupport@bwc.state.oh.us (the preferred method of submission);
 - ii. Facsimile to: 614-621-5758; or
 - iii. Mailed to: Transition Work Unit, BWC, 30 West Spring Street, L-21, Columbus, Ohio 43215.
2. BWC may assist employers in developing and/or updating a TW Plan if requested. Employers are not eligible for reimbursement relating to BWC assistance to the employer.
 - a. BWC may assist in the following circumstances:
 - i. Employer is eligible to participate in the Bonus Program and does not have a TW Plan or needs assistance updating an existing TW Plan;

- ii. Employer has multiple policy numbers approved to participate in the Grant Program and needs assistance developing a corporate level TW Plan;
 - iii. Employer was denied participation in the Grant Program because the employer reported fewer than 11 employees on its last payroll report to BWC; or
 - iv. Employer previously received a grant from BWC for development of a TW Plan and needs assistance updating the TW Plan.
 - b. BWC assistance in developing and/or updating a TW Plan may include but is not limited to:
 - i. Providing templates for the TW Plan development;
 - ii. Conducting workshops to train employers;
 - iii. Phone and/or on-site consultation at BWC's discretion;
 - iv. Generic job analysis; and/or
 - v. Assistance implementing existing grant plans or programs.
3. Transitional Work Developer Eligibility. Eligible developers shall be added to the Transitional Work Developer list on bwc.ohio.gov. The list includes the transitional work developer's name, service areas, business address, email and phone number.
- a. Developers shall meet all of the following requirements to be eligible:
 - i. Be certified to participate in the Health Partnership Program as a vocational rehabilitation case manager, a licensed occupational therapist or a licensed physical therapist.
 - ii. Complete a Transitional Work Developer Application (TWD-115 Form), available on bwc.ohio.gov, and meet the criteria set forth in the application. Applicants unable to meet the experience criteria set forth in the application may still be eligible to participate if they:
 - a) Provide evidence of verified experience in developing transitional work programs or verified mentoring experience with a developer of transitional work services; or
 - b) Request via email to TWSupport@bwc.state.oh.us that the Transitional Work Unit (TW Unit) provide names of developers that may be willing to provide guidance and/or mentoring. The TW Unit does not guarantee that the developer will provide mentoring experience.
 - iii. Complete a BWC sponsored transitional work training program prior to delivering a TW Plan (if accredited between 2001 and 2006, the developer shall take a BWC sponsored refresher course for the current Grant and Bonus Program).
 - b. Failure to complete the training shall result in denial of the TW plan submitted by the employer.
 - c. Developers that BWC determines do not meet requirements, except the provider certification requirement that shall be addressed by the Provider Credentialing Unit, may file a grievance with the TW Unit. The TW Unit shall investigate and its decision shall be final.
 - d. Developer applications and grievances shall be submitted via:
 - i. Email to: TWSupport@bwc.state.oh.us (the preferred method of submission);
 - ii. Facsimile to: 614-621-5758; or
 - iii. Mailed to: Transition Work Unit, BWC, 30 West Spring Street, L-21, Columbus, Ohio 43215.
4. Transitional Work Plan Review. TW Plans shall be reviewed based on criteria set forth in Appendix A to this policy. Review criteria include corporate description, management and employee relations, policies and procedures, job analysis and evaluation and auditing process.
5. Employer Reimbursement.
- a. Reimbursement is a 3:1 match up to the amount of the grant award. Grant Program caps are based on the number of employees reported on the employer's last payroll report to BWC. If the employer did not report a number on the last payroll report, the number may be updated in the BWC web when completing the online application. Grant Caps are:
 - i. 11-49 employees – up to \$2900;
 - ii. 50-199 employees - \$5200;
 - iii. 200+ employees - \$6300.

- b. BWC will reimburse employers seventy-five percent (75%) of the final, total out-of-pocket cost the employer paid to the developer for covered services, after any discounts, rebates, or other cost or price adjustments offered by the developer are applied, subject to the following limitations:
 - i. The maximum rate per service is:
 - a) \$200 per hour for TW developer labor;
 - b) \$200 per job analysis;
 - ii. Developer hours or number of job analyses per employer are not limited;
 - iii. Ineligible or unnecessary costs are not reimbursable and include but are not limited to:
 - a) Costs associated with a developer's preparing and submitting a proposal to an employer;
 - b) Travel and lodging expenses;
 - c) Costs associated with development of a TW Plan by a non-BWC approved developer;
 - iv. Reimbursement shall not exceed the amount of the employer's grant award.
- c. Employers may obtain reimbursement for TW Plan development costs after all of the following occur:
 - i. The employer submits the developer's TW Plan to BWC;
 - ii. BWC approves the TW Plan;
 - iii. The employer pays the developer; and
 - iv. The employer submits the following forms (available at bwc.ohio.gov) and documentation to BWC:
 - a) Transitional Work Grant Reimbursement Request Form (Form TWG-2);
 - b) BWC Service Invoice;
 - c) BWC Transitional Work Agreement (Form TWG-3);
 - d) Developer invoice to employer; and
 - e) Employer proof of payment to the developer. Acceptable proof of payment includes:
 - i) Cancelled check that has been redacted of all confidential employer information;
 - ii) Credit card statement that has been redacted of all confidential employer information; or
 - iii) PayPal verification.
- d. Implementation fund reimbursement is subject to the 3-to-1 match until the balance remaining is \$200. At \$200, the remaining balance may be paid for services. To obtain implementation fund reimbursement (if available), an employer shall submit to BWC the following documentation:
 - i. Description of the service provided;
 - ii. Invoice from the developer for services provided; and
 - iii. Verification of payment for service provided.
- e. BWC shall cancel checks disbursed and not cashed within 90 days or checks returned undelivered.

E. Bonus Program

1. Per the Employer Services *Transitional Work Performance Bonus* policy, EP-20-02, in addition to meeting Employer Services eligibility criteria, employers are required to submit documentation evidencing a developed and implemented TW Plan.
 - a. Bonus Program employer applicants not utilizing the current Grant Program shall submit written documentation to the TW Unit that includes but is not limited to:
 - i. Executive summary describing the TW Plan signed by a corporate officer;
 - ii. Copy of the employer's TW Plan.
 - b. An employer approved to participate in the Bonus Program is not required to submit TW Plan documentation with subsequent bonus period applications if there has been no lapse

- in Bonus Program participation, and the employer continues to meet Employer Services eligibility criteria.
2. Documentation shall be submitted prior to the bonus period cutoff date set forth in Employer Services *Transitional Work Performance Bonus* policy, EP-20-02, for inclusion in the current bonus period.
 - a. Employers failing to timely submit documentation shall be denied and not be considered for the current bonus payment period.
 - b. Documentation shall be submitted via:
 - i. Email to: TWSupport@bwc.state.oh.us (the preferred method of submission);
 - ii. Facsimile to: 614-621-5758; or
 - iii. Mail to: Transition Work Unit, BWC, 30 West Spring Street, L-21, Columbus, Ohio 43215.
 - c. BWC shall review submitted documentation and may contact the employer by phone or email to offer assistance, including, but not limited to:
 - iv. Recommendations for improving or enhancing the TW Plan;
 - v. Strategies and suggestions for implementing transitional work and light duty successfully;
 - vi. Informational assistance including:
 - a) BWC job templates;
 - b) BWC services to support transitional work such as job modifications, job analyses and vocational rehabilitation; and/or
 - c) Process for submitting Transitional Work Offer and Acceptance Forms (TWB-2).
 - d. An employer that has its application for the transitional work bonus denied, or that disagrees with BWC's performance bonus determination, may file an appeal to BWC's Adjudicating Committee pursuant to Ohio Revised Code 4123.291 and OAC 4123-14-06. Employer appeals filed due to transitional work plan issues (e.g., employer believes it did not get appropriate credit for a return to work) will be addressed by the TW Unit.

F. MCO Responsibilities for the Bonus Program

1. Gathering and transmitting return to work information;
2. Reviewing and updating return to work information; and
3. Assisting employers in the collection of required forms.

Appendix A- Transitional Work Grant & Transitional Work Bonus Policy

Review of transitional work plans shall be based on the following criteria:

1. **Corporate Description Criteria:** In reviewing the corporate description developed by the developer, BWC shall consider whether the developer reviewed/addressed the following areas:
 - a. Corporate description with analysis of the following:
 - i. Current organizational status;
 - ii. Corporate demographic information relating to:
 - a) Number of employees;
 - b) Industry type;
 - c) Job classifications;
 - d) Union positions, if applicable;
 - e) Multiple business locations, if any;
 - f) Related companies and associated policy numbers, if any;
 - g) Managed Care Organization (MCO);
 - h) Third Party Administrator (TPA), if applicable;
 - iii. On-site interviews with employer-owners, supervisors, team leaders, union representatives, if applicable, and employees;
 - b. Review of current corporate policies with recommendations for improvement in the following areas:
 - i. Accident reporting;
 - ii. Modified duty program;
 - iii. Dispute procedures;
 - iv. Return to work policies;
 - v. Americans with Disabilities Act policies;
 - vi. Training policies;
 - vii. Safety policies;
 - c. Transitional work grant plan objectives;
 - d. Barriers to transitional work plan implementation.
2. **Management and Employee Relations Criteria:** Formation of a Transitional Work/Safety Committee with participation by:
 - a. Management;
 - b. Union, if applicable; and
 - c. Labor.
3. **Policies and Procedures Criteria:** A developer may use BWC's policy and procedure templates or customize them to meet the needs of the employer but is not permitted to charge for the use of BWC templates or forms. BWC shall consider whether the developer identified:
 - a. A company transitional work coordinator;
 - b. Employer mission statement;
 - c. Eligibility, entry, extension and exit guidelines;
 - d. Timeframes for implementation;
 - e. Dispute resolution policy;
 - f. Americans with Disabilities Act compliance and accommodation at alternate work sites, if applicable;
 - g. Multilingual and multicultural needs;
 - h. Interpreter Services offered or required;
 - i. Training plan including training for the company transitional work coordinator, management, supervisors and employees. At a minimum, the following educational requirements must be met:
 - i. Written policies that are discussed with employees prior to program initiation;

- ii. Written course materials relating to the program provided to employees with the opportunity to review and comment or ask questions regarding the program and policies;
 - iii. A method to document employee knowledge and understanding of the program;
 - iv. Provision for employee education within six (6) weeks of employment; and
 - v. Provision for refresher courses with educational materials on a yearly basis to all employees. The refresher course may be incorporated with annual safety training.
- j. Community resources and contact list provided by the developer including formal agreements with preferred community providers to provide services to the employees, a community resource list with contact names, phone and fax numbers. A different community resource directory shall be developed for different locations and for workers in remote locations, if applicable. Community resources include:
- i. Physicians and physician groups in the area;
 - ii. Urgent care centers and emergency departments;
 - iii. Occupational medicine and physical medicine specialists;
 - iv. Rehabilitation providers on-site and at clinics;
 - v. Case managers and vocational rehabilitation managers.
- k. Roles and responsibilities of the following:
- i. Managed care organization and third party administrator, if applicable;
 - ii. Physician;
 - iii. On-site providers;
 - iv. Injured worker;
 - v. BWC;
 - vi. Employer-transitional work coordinator; and
 - vii. Vocational rehabilitation professionals.
4. **Job Analysis Criteria:** A job analysis examining different jobs and collecting measurements while the job is being performed. A job analysis may utilize the BWC's job analysis templates but the job analysis must be customized to meet the needs of the employer. In reviewing the job analysis developed by the developer, BWC shall consider if the following criteria are met:
- a. A job analysis may only be performed by a BWC certified:
 - i. Occupational Therapist;
 - ii. Physical Therapist;
 - iii. Certified Professional Ergonomist (CPE);
 - iv. Certified Human Factors Professional (CHFP);
 - v. Associate Ergonomics Professional (AEP);
 - vi. Associate Human Factors Professional (AHFP);
 - vii. Certified Ergonomics Associate (CEA);
 - viii. Certified Safety professional (CSP) with "Ergonomics Specialist" designation;
 - ix. Certified Industrial Ergonomist (CIE);
 - x. Assistive Technology Practitioner (ATP); or
 - xi. Rehabilitation Engineering Technologist (RET).
 - b. At a minimum, the job analysis shall include the following:
 - i. The job title and summary description;
 - ii. Essential functions of the job divided into work tasks with a description of the physical demands of required tasks analyzed at the job site with the worker's input including frequency, duration, and postures and the use of devices to measure force;
 - iii. Equipment or tools used in the job performance of each work task;
 - iv. Working environment and conditions of the job including knowledge, skill and experience generally required to perform the job.
 - c. Repeat job analysis are prohibited unless a component of the job analysis is customized for a particular part of the job.
 - d. All job analysis must be signed and dated by the actual servicing provider and must specify his/her credentials.

- e. All job analysis shall be submitted to BWC for use by claims and rehabilitation staff.
5. **Evaluation and Auditing Process Criteria:** Evaluation and auditing measures the effectiveness of the Grant Program and/or Bonus Program from both the employer and employee perspective. Any of the following outcome-measures may be addressed:
- a. Bonus Program calculations indicating successful utilization of the TW plan in returning injured workers to work;
 - b. Workers' Compensation savings analysis supplied by BWC Employer Services;
 - c. Reports supplied to the company by the MCO or TPA;
 - d. Productivity measurements;
 - e. Worker and management satisfaction.

Procedure Name:	Procedure for Transitional Work Developer; Transitional Work Grant & Transitional Work Bonus
Procedure #:	MP- 20-01.PR1
Policy # Reference:	MP-20-01
Effective Date:	06/01/15
Approved:	John Annarino, Chief Medical and Health Officer (Signature on file)
Supersedes:	All Medical procedures, directives or memos regarding Transitional Work Grant & Bonus Program that predate the effective date of this procedure.
History:	Rev 06/01/15; New 05/30/14
Review date:	06/01/20

II. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.

III. Transitional Work Developer Review

- A. The Transitional Work Unit (TW Unit) shall review Transitional Work Developer (Developer) applications (Form TWD-115). Upon receipt of Form TWD-115, the TW Unit shall determine if the applicant:
1. Is certified in the Health Partnership Program (HPP) as one of the following provider types designated in O.A.C. 4123-6-02.2:
 - a. Vocational rehabilitation case manager;
 - b. Occupational therapist;
 - c. Physical therapist.
 2. Has sufficient experience in transitional work development.
- B. TW Unit staff shall notify applicants meeting developer requirements of required training via email.
- C. TW Unit staff shall add the developer's name, service areas, business address, email and phone number to the BWC Certified Transitional Work Developer list on bwc.ohio.gov following completion of a BWC-sponsored training program noted in II.B.
- D. TW Unit staff shall refer, via email, applicants not currently enrolled in HPP to the Provider Enrollment and Certification (Medco-13) form on bwc.ohio.gov.
- E. TW Unit staff shall consult with the TW Unit manager if a determination is made that the applicant does not meet the experience criteria. If after consultation, the decision is to deny the applicant, staff shall send an email to the applicant with a list of developers that the applicant may contact to request mentoring to develop transitional work plans.
- F. If an applicant files a grievance for the denial, the TW Unit shall investigate and respond to the grievance.
1. The TW Unit shall:
 - a. Send a written response via email within 10 business days of receipt of the grievance.

- b. If additional time is required to investigate the grievance, the TW Unit shall notify the grievant via email of the date by which it will issue a decision.
 2. The TW Unit grievance decision shall be final.

IV. Grant and Bonus Program Evaluation Tools; TW Unit and Disability Management Coordinator (DMC) Roles and Responsibilities

- A. Employers submit Transitional Work Grant Program (Grant Program) and Transitional Work Bonus Program (Bonus Program) applications online, via fax or by mail. The TW Unit is responsible for ensuring the paper applications are entered online into bwc.ohio.gov.
- B. If Employer Services (ES) underwriting criteria are met, the system automatically creates a “TW Plan Look-Up” shell on BWCWeb. See Appendix A for detailed Plan Look-Up categories.
 1. The created TW Plan Look-Up notes the following:
 - a. Type of application: Grant Program or Bonus Program;
 - b. Application Date;
 - c. Application status:
 - i. If the application is for the Grant Program, the application status is “Approved” (because the application passed ES underwriting criteria).
 - ii. If the application is for the Bonus Program, the application status is “Received” (the application cannot be “Approved” until the DMC completes verification and ES runs a final eligibility screening for the assigned bonus period).
 - d. TW Plan Status. Plan Status will note “Expected.” Expected means:
 - i. BWC is expecting a TW plan from the Grant Program applicant; or
 - ii. BWC is expecting documentation confirming a TW plan from the Bonus Program applicant.
 2. The system automatically assigns applications on a rotating basis to a DMC from the service office to which the employer’s policy number is assigned.
 - a. Injury Management Supervisors in each service office are authorized to re-assign an application based on workload/vacation schedules.
 - b. TW Unit staff are authorized to re-assign applications.
 - c. Employers with multiple policy numbers have a separate TW Plan Look-Up shell for each policy number.
 - i. The TW Unit shall assign employers with multiple TW Plan Look-Up shells to one DMC.
 - ii. DMCs shall notify the TW Unit via email if the DMC finds an employer with multiple TW Plan Look-up shells assigned to different DMCs.
- C. TW Unit and DMC staff:
 1. Work together to:
 - a. Review and approve Grant Program TW plans;
 - b. Verify Bonus Program TW plan documentation.
 2. Utilize the following programs during the review process:
 - a. BWCWeb – location of TW Plan Look-Up for the Grant Program and Bonus Program.
 - b. SharePoint – location of Grant Program transitional work checklist created by TW Unit.
 - c. Universal Document System (UDS) –depository for TW plan documents, emails and correspondence received and sent out by TW Unit and DMC.
 - d. Claims Management System – links approved (Grant Program) or verified (Bonus Program) TW plan to employer claims. The TW Unit utilizes this system to monitor Bonus Program employers.

V. Grant Program TW Plan Review

- A. The TW Unit shall:

1. Process all TW plan documentation received via email, fax or mail and send out all correspondence relating to TW plan review and reimbursement decisions.
2. Review the TWSupport@bwc.state.oh.us email box at least twice daily.
3. Verify that submitted TW plans were developed by an approved transitional developer listed on bwc.ohio.gov.
4. Scan documents received and sent out to UDS indexed by employer risk/policy number with a document type selected. Following are available document types:
 - a. "TWSupplInfo"- Bonus Program documents;
 - b. "TWGrant"- existing and new Grant Program documents; developer reimbursement documents;
 - c. "TWB-1"- Bonus Program applications;
 - d. "TWG-1" – Grant Program applications;
 - e. "Correspond"- letters and correspondence to employers.
5. Make sure a "TWG Checklist" (Checklist) exists in SharePoint for the employer risk/policy number noted on the submitted document(s). If no Checklist exists, TW Unit staff shall create the Checklist so that the DMC will have a "shell" in which to input their TW plan reviews.
6. Access BWCWeb TW Plan Look-up Grant Program to:
 - a. Insert the TW plan receipt date;
 - b. Update the TW Plan Status from "Expected" to "In Process." Changing the plan status to "In Process" gives notice to the DMC to begin TW plan review.
7. Email notice to the assigned DMC that documentation has been received.
8. Monitor BWCWeb to ensure:
 - a. DMC processing of submitted documentation:
 - i. If, within five business days of the TW Work Unit updating BWCWeb Plan Status to "In Process" there is no change in the plan status, the TW Unit shall send an email to the assigned DMC noting that paperwork was scanned into UDS and no action has been taken with respect to the plan status.
 - ii. If BWCWeb Plan Status remains in "Pended" status for 30 days following the DMC updating the plan status to "Pended," the TW Unit shall send an email to the assigned DMC noting the plan status remains pended (a plan status is pended if the DMC needs additional information).
 - b. Transfer of Checklist information into the Transitional WorkGRANTS Reimbursement database. An "Approved" plan status alerts the TW Unit staff to transfer Checklist information into the database used to determine employer reimbursement.
 - c. Timely mailing of Grant Program correspondence following DMC TW plan review. The TW Unit shall email an approval or denial letter (as appropriate) to the employer within five business days of the DMC updating BWCWeb Plan Status to "Approved" or "Denied." Approval letters shall inform employers of required reimbursement documentation.
9. Investigate and respond to grievances relating to TW plan decisions.
 - a. A written response shall be sent via email within 10 business days of receipt of grievance.
 - b. If the grievance relates to actions taken by ES, the TW Unit shall forward the grievance to ES and notify the grievant via email letter of such action.
 - c. If additional time is required to investigate the grievance, the TW Unit shall notify the grievant via email of the date by which a decision will be made.
 - d. The TW Unit's grievance decision shall be final.
10. Upload the policy numbers of employers approved/denied for the Grant Program to the appropriate MCO Portal along with denial rationale.

B. DMCs shall:

1. Review the BWCWeb database daily to determine assigned workload and status of assigned employer TW plans.
2. Within five business days following notice by the TW Unit of document receipt:

- a. Review TW plan documentation (located in the UDS system) utilizing the Checklist to determine if review criteria are met; and
 - b. Update BWCWeb Grant Program Plan Status.
- If unable to timely complete a review and update Plan Status, the DMC shall email the TW Unit to notify of delay so that the TW Unit may reassign the application.
3. If the DMC determines that the TW plan meets review criteria, the DMC shall:
 - a. Update BWCWeb Grant Program Plan Status to "Approved." (TW Plan approval automatically updates the claims management system to reflect the presence of an approved TW program for that employer's claims).
 - b. The DMC shall then review BWCWeb to determine if the employer submitted a Bonus Program application.
 - i. If a Bonus Program application has not been received for the present bonus period, the DMC shall:
 - a) Contact the employer's TW coordinator via email or telephone and request submission of an online Bonus Program application;
 - b) Monitor BWCWeb for the submission of a Bonus Program application by the employer; and
 - c) If/when the BWCWeb notes a BWC ES approved Bonus Program application; the DMC shall update the Bonus Program Plan Status to "Approved."
 - ii. If a Bonus Program application has been received for the present bonus period, the DMC shall update the BWCWeb Bonus Program Plan Status to "Approved" in addition to updating the BWCWeb Grant Program Plan Status.
 4. If TW plan information is missing or incomplete or does not meet required plan criteria, the DMC shall:
 - a. Update BWCWeb Grant Program Plan Status to "Pended" and take the following actions:
 - i. Determine what is needed;
 - ii. Prepare questions (using SharePoint template) addressed to the employer's TW coordinator;
 - iii. Call employer's TW coordinator to discuss what is needed;
 - iv. Email the questions to employer's TW coordinator confirming the conversation (if applicable) or requesting information (if unable to contact TW coordinator). The email shall include the following information:
 - a) Timeframe for receipt of information if the DMC is confirming information provided by employer's TW coordinator over the phone;
 - b) Timeframe for response to DMC's request if no conversation with employer's TW coordinator occurred.
 - v. Save the email to UDS.
 - vi. If there is no response from the employer following the first phone call or no response to the email within three business days of sending, the DMC shall:
 - a) Place another call to employer's TW coordinator;
 - b) Send a second email letter, save the email to UDS; and
 - c) Place written notes in comments section of Checklist reflecting DMC's attempts to contact employer.
 - b. Staff with TW Unit Manager if, after following the steps set forth in IV.B.4.a., TW plan information continues to be missing or incomplete or the TW plan does not meet required plan criteria. The TW Unit shall contact the developer to assist in obtaining information.
 - c. If the decision is to deny the TW plan, the DMC shall note the denial reason in the Checklist and update the BWCWeb Grant Program Plan Status to "Denied." The TW Unit shall then send an email "denial" letter to the employer's TW coordinator and save the letter to UDS.

VI. Grant Program TW Plan Reimbursement/Implementation Funds

- A. Employers submit reimbursement requests to the TW Unit for Grant Program TW plan development costs and implementation funds.
- B. Upon receipt of documentation, the TW Unit shall:
 - 1. Scan the documents into UDS. If an employer submits a check or credit card statement that does not have confidential information redacted, TW Unit staff shall redact confidential employer information prior to scanning the document.
 - 2. Utilize the Transitional WorkGRANTS Reimbursement database checklist to ensure all required documentation was received and input invoice information.
 - 3. Review submitted documentation and take one of the following actions:
 - a. If all required documentation is submitted and payment is for allowed expenses, the TW Unit shall process the payment;
 - b. If all required documentation is not submitted, pend payment authorization and contact employer via email noting additional documentation required for processing; or
 - c. If request is for a non-allowed expense(s), deny the non-allowed reimbursement request and contact employer via email noting the non-allowed expense(s).
- C. TW Unit staff shall utilize the Rates & Payments TW Grant Reimbursement System (R&P Program) for payment processing as follows:
 - 1. Two individuals shall be responsible for processing reimbursement requests (a “Creator” and a payment “Approver”). The creator and approver cannot be the same person. See Appendix B for specific payment processing steps.
 - 2. The creator shall:
 - a. Create an invoice in the R&P Program for employer; and
 - b. Enter invoice information into the system.
 - 3. The approver shall:
 - a. Review payment request input by creator for accuracy and appropriateness of payment; and
 - b. Approve payment of invoice. Approval authorizes BWC Benefits Payable to create a check and reimburse the employer. The approver shall staff all payment concerns with creator.
 - 4. Following approval, the TW Unit shall send a payment letter to the employer noting amount to be reimbursed and amount of funds remaining in grant award.
 - a. Checks disbursed but not cashed after 90 days shall be cancelled by commission. If contacted by the employer, the TW Unit and BWC Benefits Payable staff shall work together to issue a replacement check.
 - b. Checks returned undelivered shall be cancelled by BWC Benefits Payable. The TW Unit and BWC Benefits Payable shall work together to determine the appropriate address so that a replacement check can be issued.
- D. The TW Unit shall monitor for employers eligible for reimbursement that have not submitted a reimbursement request. If a reimbursement request has not been submitted, the TW Unit may send an email reminder to the employer.
- E. The TW Unit shall investigate and respond to employer-submitted grievances relating to TW plan development and implementation cost reimbursement.
 - 1. A written response shall be sent via email within 10 business days of receipt of a grievance.
 - 2. If additional time is required to investigate a grievance, the TW Unit shall notify grievant via email of the date by which a decision will be made.
 - 3. The TW Unit’s grievance decision shall be final.

VII. Bonus Program TW Plan Verification

- A. The TW Unit shall:
1. Review the TWSupport@bwc.state.oh.us email box at least twice daily.
 2. Process all TW Plan documentation received via email, fax or mail.
 3. Scan to UDS all emails and documents received and sent out by the TW Unit.
 4. Access BWCWeb TW Plan Look-Up Bonus Program to:
 - a. Insert plan documentation receipt date;
 - b. Update Plan Status from “Expected” to “In Process.” Changing plan status to “In Process” gives notice to the DMC to verify plan documents.
 5. Monitor BWCWeb to ensure DMC processing of submitted documentation. If, within five business days of TW Work Unit updating Plan Status to “In Process,” there is no change in Plan Status, the TW Unit shall send an email to assigned DMC noting that paperwork was scanned into UDS and no action has been taken with respect to Plan Status.
 6. Upload the following TW plan reports to the appropriate MCO Portal for use by MCOs:
 - a. At the close of the bonus application period (as set forth in the ES policy), a report noting policy numbers of employers approved to participate in the Bonus Program;
 - b. A weekly Transitional Work Bonus Claims Participation report with an update of all claims for employers approved to participate in the Bonus Program.
 7. Investigate and respond to appeals to BWC’s Adjudicating Committee pursuant to Ohio Revised Code 4123.291 and OAC 4123-14-06 relating to transitional work plan documentation timeliness, DMC review decisions and employer appeals relating to return to work credit.
- B. DMCs shall:
1. Monitor BWCWeb daily to determine assigned workload and status of assigned employer TW plans.
 2. Review and verify TW plan documentation (located in the UDS system) within five business days following notice by the TW Unit of document receipt. TW plan verification may be demonstrated through submission of:
 - a. Executive summary describing the TW Plan signed by a corporate officer;
 - b. Copy of the employer’s TW Plan.
 3. Following review and verification, update the BWCWeb Bonus Program TW Plan Status to “Approved.” If the employer risk/policy number has an “Approved” Grant Program application and a Grant Program Plan_Status that is not in “Approved” status, the DMC shall update the Bonus Program TW Plan Status to “Remeditin” [sic].
 - a. Updating the Bonus Program grant status to “Remeditin” [sic] causes the system to change the Grant Program TW Plan Status to “Remeditin” [sic] which the system recognizes as “Expected.”
 - b. The DMC may contact the employer to determine if the employer wants to continue with the Grant Program application.
 - c. The system recognizes a Bonus Program TW plan in “Remeditin” [sic] status as “Approved” when Employer Services runs a final eligibility screening for the assigned bonus period.
 4. Monitor BWCWeb Bonus Program application status for assigned employer policy/risk numbers.
 - a. If an assigned employer’s Bonus application is in “Received” status and the DMC has not been notified by the TW Unit that documentation has been received, the DMC shall contact the employer and request documentation submission prior to the Employer Service cutoff date for inclusion in the current the bonus period (See Employer Services policy EP-20-02).
 - b. If the employer does not timely submit documentation, the DMC shall update BWCWeb Bonus Program TW Plan Status to “Denied.” (The Bonus application will be denied at the time Employer Services runs a final eligibility screening for the assigned bonus period and the employer will be notified of the denial by Employer Services).

- C. DMCs may contact the employer by email letter and/or phone following review of submitted documentation to offer BWC consultation services including but not limited to:
 - 1. Recommendations for improving or enhancing the TW plan;
 - 2. Strategies and suggestions for implementing transitional work and light duty successfully;
 - 3. Informational assistance including:
 - a. BWC job templates;
 - b. BWC services to support transitional work such as job modifications, job analyses and vocational rehabilitation; and/or
 - c. Process for submitting Transitional Work Offer and Acceptance forms (TWB-2).

VIII. Managed Care Organization (MCO) Responsibilities

- A. MCOs shall:
 - 1. Follow the *Return to Work Data Policy*;
 - 2. Work with employers participating in the Bonus Program to obtain a completed BWC Offer and Acceptance Form (TWB-2) if not received;
 - 3. Update the “Released Type” on bwc.ohio.gov no sooner than the day after sending the return to work (RTW) date; and
 - 4. Verify data entry accuracy of RTW dates and released type information on the Transitional Work Bonus Claims Participation weekly report posted on the MCO portal by the TW Unit.
- B. MCOs may:
 - 1. Update “Actual Job” indicators on bwc.ohio.gov;
 - 2. Identify the job type of actual return to work including “same job, same employer” (SJSE), “different job, same employer” (DJSE), “same job, different employer” (SJDE), or “different job, different employer” (DJDE).

Appendix A

BWC Web TW Plan Look-up contains the following categories:

- Policy Number – employer’s risk/policy number
- Plan Status – status of transitional work plan. Plan status categories include:
 - Expected – BWC is expecting a transitional work plan;
 - In Process – a plan has been received and DMC should begin reviewing the plan;
 - Pended – DMC has reviewed transitional work plan, items are missing, and the plan is on hold awaiting additional information;
 - Approved – DMC has approved transitional work plan;
 - Denied – transitional work plan has been denied;
 - Not Needed – Employer notified BWC that Grant or Bonus application no longer being requested or Employer Services denied Grant application because of an Attorney General balance;
 - Remedintin [sic] – “placeholder” category created because Grant and Bonus shells are “linked.” Utilized when an employer submits both a Grant Program and Bonus Program application that pass Employer Service initial screening criteria and the Grant Program TW plan review has not yet been completed.
- Plan Status Effective Date – date transitional work plan was approved by DMC;
- Plan Receipt Date – date transitional work plan was received by BWC;
- Program Type - Grant or Bonus;
- Application Status – status of Bonus or Grant Application from Employer Services perspective.
- Application Date – receipt date of Bonus or Grant application from employer;
- Program Year Begin Date – only applies to Bonus applications. Notes what year to begin calculation for Bonus Program;
- DMC Assigned;
- Action – tool to input actions into BWCWeb.

Appendix B

1. The creator opens the Rates and Payments program and chooses Payment Menu on TW Grant Reimbursement screen. The Employer Reimbursement menu will open. Choose “Special Payments” on the menu bar and on the drop-down menu, select “Employer Payment” then select “Employer Reimbursement” from the subsequent drop down menu.
2. An “Employer Reimbursement – Window” will open. Enter employer’s policy number in appropriate box. If employer policy number is not noted on documentation, choose “Lookup” in top right corner of screen to find employer’s risk/policy number.
 - a. If employer’s TW Grant application and TW Grant plan are in “Approved” status, the “Employer Reimbursement” window will be displayed.
 - b. If employer’s TW Grant Plan Status is not in “Approved” status, a message will be displayed stating that the employer does not have an approved plan. No further action may be taken until TW Plan Look-up Grant Program plan status is in “Approved” Plan Status. Staff shall review why the plan is not in “Approved” status.
3. At the “Employer Reimbursement” screen, the creator will click on the “create” button to create the invoice in the system on the “Payment Entry” screen. (The “Payment Entry” screen provides information relating to the maximum grant allowable amount, the total grant amount paid and the remaining eligible amount). On the “Payment Entry” screen, the creator shall:
 - a. Enter “Invoice From” and “Invoice To” information;
 - b. Enter Invoice Amount. The allowed amount will be calculated by the system.
 - c. Click the “ok” button on the screen.
4. Once the “ok” button is clicked, the approver is able to open the “Employer Reimbursement” screen. The approver shall:
 - a. Review payment request for accuracy and appropriateness of payment;,
 - b. Highlight invoice information noted; and
 - c. Click the “Details” button on the screen.
 - d. The “Payment Entry” screen will appear and the approver clicks the “Approve Invoice” button on the screen. At this point, the payment is authorized and will go through Benefits Payable batching to be paid that evening.

Policy and Procedure Name:	Durable Medical Equipment (DME)
Policy #:	MP-4-01
Code/Rule Reference:	R.C. 4123.66; O.A.C. 4123-6-02.2, 4123-3-15, 4123-6-07, 4123-6-16.2, and 4123-6-25
Effective Date:	06/06/14
Approved:	Freddie Johnson, Esq., Chief of Medical Services
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives or memos regarding durable medical equipment that predate the effective date of this policy.
History:	Rev. 07/16/13; New 09/21/12
Review date:	06/06/19

I. POLICY PURPOSE

The purpose of this policy is to ensure that the Bureau of Workers Compensation (BWC) reimburses for equipment meeting the criteria of Durable Medical Equipment (DME) when the equipment is reasonably related to and medically necessary for the treatment of an authorized condition(s) in a claim.

II. APPLICABILITY

This policy applies to all BWC and Managed Care Organization (MCO) staff having the responsibility of authorizing DME rental/purchase.

III. DEFINITIONS

Durable Medical Equipment: Equipment which is suitable for use outside of a medical facility and that:

- can withstand repeated use;
- can primarily and customarily serve a medical purpose;
- generally is not useful to a person in the absence of illness or injury;
- is appropriate for use in the home; and
- does not include disposable items.

Examples of DME include walkers, canes, crutches, hospital beds, bedside commodes, breathing machines, wheelchairs, power operated vehicles, etc.

IV. POLICY

- A. It is the policy of BWC to reimburse providers for:
 - 1. DME purchases or rentals up to the purchase price, when deemed necessary and reasonable using the criteria outlined in *State, ex rel. Miller v. Indus. Comm.*, 71 Ohio St.3d 229 (1994,);
 - 2. DME purchased through a BWC certified supplier or in the absence of a certified provider, a supplier meeting the minimum credentialing standards for DME suppliers set forth in OAC 4123-6-02.2; and
 - 3. A single DME item of specified use, unless medical documentation substantiates the need for multiple items of the same use. This shall be evaluated on a case-by-case basis.

- B. It is the policy of BWC to require that:
 - 1. MCOs ensure, in accordance with the Provider Reimbursement Manual, that providers have obtained prior authorization for the purchase of DME costing \$250 or more.
 - 2. MCOs obtain prior authorization from BWC for the rental of DME when the total cost of the rental is anticipated, or has the probability, to exceed eighty percent (80%) of the purchase price of the DME.

- C. Special considerations for specific equipment
 - 1. Manual Wheelchairs
 - a. A wheelchair is covered when the injured worker's (IW) condition is such that without a wheelchair she/he would be bed or chair bound.
 - b. Upgrades beneficial solely in allowing the IW to perform leisure or recreational activities are generally not covered.
 - c. Specially sized wheelchairs are reimbursable when documentation supports the need, such as for IW's with slender or obese builds, or narrow doorways.
 - d. Information submitted by the DME supplier must be corroborated by documentation in the IW's medical records and available upon request.
 - 2. Power Operated Vehicles (POV)/Motorized Wheelchairs
 - a. Medical Requirements:
 - i. Requests must be from a physician in one of the following specialties:
 - a) Physical Medicine;
 - b) Orthopedic Surgery;
 - c) Neurology; or
 - d) Rheumatology.
 - ii. If an above listed specialist is more than one day's round trip from the IW's home, the physician of record may make the request.
 - iii. Requests with insufficient medical evidence to support the need for a POV requires a Justification of Medical Necessity for Seating/Wheeled Mobility form / C-190 or equivalent from a physician listed above, or an Occupational Therapist (O.T) or Physical Therapist.
 - iv. Require an occupational therapy (O.T) evaluation by a BWC certified Occupational Therapist not employed by the DME vendor documenting type of POV/wheelchair needed, medical indications, necessary options/accessories, and appropriate vehicle size to accommodate mobility throughout IW's living quarters.
 - b. Physical/mobility requirements:
 - i. The IW's movement throughout the home must not be possible without the POV

- ii. The IW must have adequate trunk stability to ride in a POV and safely transfer in and out of a POV.
- iii. The IW must be unable to operate a manual wheelchair, but be capable of safely operating the controls of a POV.

V. PROCEDURE

A. Requirements for the purchase or rental of DME

1. The MCO shall process DME that is reimbursable via the fee schedule in accordance with:
 - a. The *C-9 Processing* policy and procedure; or
 - b. The *Claim Reactivation* policy and procedure.
2. If the MCO cannot process the DME pursuant to procedure A. 1. a-b, then they shall process DME provided by a BWC-certified provider according to the *Override Process* policy and procedure.

B. Procedural requirements for a POV

3. Prior to authorizing the purchase of a POV, the MCO shall discuss with the BWC catastrophic nurse if home modifications will be necessary to accommodate the POV/motorized wheelchair.
4. The MCO shall ensure that it receives a signed itemized quote from the DME vendor including all features, accessories and the inclusion of a rental at no charge for repairs occurring during the warranty period of the POV/wheelchair is required.
5. The MCO shall call the IW after the delivery of the POV/wheelchair to ensure the POV/wheelchair comfortably accommodates the IW, fits inside the home and has the options medically necessary for the IW to perform activities of daily living. If there are issues, the MCO may schedule a post delivery O.T. follow-up evaluation.

Policy and Procedure Name:	Pricing Override Process
Policy #:	MP-16-01
Code/Rule Reference:	N/A
Effective Date:	06/06/2014
Approved:	Freddie Johnson, Esq., Chief of Medical Services (Signature on File)
Origin:	Medical Policy
Supersedes:	All policies, procedures, directives and memos (specifically the memo issued 03/01/2012) regarding pricing overrides that predate the effective date of this policy.
History:	New
Review date:	06/06/2019

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides the necessary information to MCOs for completion of documentation and provision of appropriate EOB codes for a pricing override process.

II. APPLICABILITY

This policy applies to MCOs.

III. DEFINITIONS

None

IV. POLICY

- F. For pricing overrides, it is the policy of BWC:
 1. To have BWC process MCO requests for payment above fee schedule from the following provider types:
 - a. Certified in-state providers;
 - b. Certified out-of-state providers;
 - c. Non-certified in-state providers;
 2. To have BWC verify requests via a retrospective audit and not require MCOs to obtain front-end approval from BWC for:
 - a. Non-certified out of state providers for payment over fee schedule;
 - b. Requests for pricing codes designated as By Report/Not Routinely Covered.

- G. It is the policy of BWC to require MCOs to document/include, at a minimum, the following in all claims for which a pricing override is being requested:
 - 1. How *Miller* criteria is met;
 - 2. Supporting documentation;
 - 3. Research that confirms the correct code was billed;
 - 4. Cost analysis information;
 - 5. Negotiation attempts; and
 - 6. Clinical rationale for authorization.
- H. The MCO is responsible for maintaining all supporting documentation for pricing override requests.

V. Procedure

- A. MCOs shall maintain supporting documentation for all pricing override requests.
- B. For pricing override requests requiring BWC front-end approval, the MCO shall submit the completed Pricing Override template to the MedPol email box.
- C. For pricing override requests not requiring BWC front-end approval, the MCOs shall:
 - 1. Create a note entitled "MCO code and fee approval" with the following information, at a minimum:
 - a. Date of service;
 - b. Description of service with code;
 - c. Description of how *Miller* criteria is met;
 - d. MCO approved amount per code;
 - e. Provider name; and,
 - f. Bill type (e.g., professional, ASC, outpatient, inpatient).
 - 2. For the following:
 - a. Codes designated as By Report/Not Routinely Covered that exceed \$10,000 (ten thousand); or,
 - b. By Report vocational rehabilitation codes;
 - c. Submit the following:
 - i. An explanation detailing why the MCO is approving payment;
 - ii. Supporting documentation;
 - iii. Bill containing EOB 752 and all applicable EOBs from the following list, indicating the services and circumstances related to the authorization:
 - a) 787 – Prosthetics
 - b) 788 – J3490 Unclassified drugs
 - c) 789 – Unlisted CPT codes
 - d) 790 – Unlisted HCPCS codes
 - e) 791 – Other coded services/procedure requiring EOB 752 override
 - f) 792 – Out-of-state non-certified provider payment above fee schedule (used in addition to EOB 860 for BR/NC/NRC codes); and,
 - iv. Bill containing EOB 717 with:
 - a) An email to MB&A with EOB 717 listed in the subject line;
 - b) Detailed instructions, including manual pricing instructions, in a secured document emailed to the MBASUPV email box.
 - c) Both MB&A and the MCO, for auditing purposes, shall maintain supporting documentation for bills processed using EOB 717.

Policy Name:	Medical Evidence for Diagnosis Determinations (MEDD)
Policy #:	CP-13-02
Code/Rule Reference:	RC 4123.53; O.A.C. 4123-3-09
Effective Date:	05/26/2015
Approved:	Rick Percy, Chief of Operational Policy, Analytics & Compliance (signature on file)
Origin:	Operational Claims Policy
Supersedes:	All Injury Management policies, directives and memos regarding MEDD that predate the effective date of this policy.
History:	New
Review date:	05/26/2020

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC considers and makes determinations based on the sufficiency of medical evidence required to support allowances in the claim, and that staff use the Disability Determination Guidelines (DDG) to improve the quality of referrals to the Medical Service Specialist or the physician reviewer/examiner.

II. APPLICABILITY

This policy applies to field staff and Managed Care Organizations (MCO).

III. DEFINITIONS

Causal relationship: For purposes of this policy and related procedure, 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.

Contrary medical evidence: For purposes of this policy and related procedure, medical evidence that does not support the allowance of a claim or condition, and may derive from the medical opinion of a BWC physician review/exam or from medical documentation that conflicts with the medical documentation submitted to support the allowance of the condition.

Disability Determination Guidelines (DDG): Tool used by BWC to identify the appropriate medical information needed to support field staff's processing a requested condition in the claim without needing to seek additional medical input; also used to improve the quality of referrals to the Medical Service Specialist and the physician reviewer/examiner.

Medical Evidence: Relevant information that may prove or disprove whether a requested condition is medically supported in a claim; one criterion that BWC must consider when determining compensability of a claim or allowance of a condition.

Minor Injury: Injury type, as specifically identified by BWC, that requires no medical evidence for staff to

allow the condition in the claim and permits staff to make a claim allowance or condition allowance decision based on the description of the accident.

Preponderance of the evidence: A standard of proof which is met when a party's evidence on a fact indicates that it is "more likely than not" that the fact is as the party alleges it to be.

IV. POLICY

- C. It is the policy of BWC to:
 - 1. Use the DDG as a tool to assess the sufficiency of medical evidence;
 - 2. Weigh the medical evidence as one criterion with other required legal factors such as jurisdiction, coverage, compensability and causality;
 - 3. Make claim and condition determinations based on the totality of the evidence.

- D. BWC shall not use the DDG as the exclusive criteria to either allow or deny a claim or new condition.

- E. BWC staff will consider the causal relationship between the requested condition and the mode or method of injury.
 - 1. Causality shall be established in one of the following ways:
 - a. Direct causation (i.e., proximately caused);
 - b. Substantial aggravation/exacerbation of a pre-existing condition (i.e., a worsening);
 - c. Acceleration (i.e., hastened progression); or,
 - d. Flow-through (i.e., new condition that develops as a result of an allowed condition).
 - 2. MCOs must make and document at least two efforts to contact the provider. The MCO must try to obtain causality information. The MCOs must submit causality indicators, as indicated below, to BWC and identify the documentation the MCO is relying upon to support the indicator. The MCOs must submit one of three values:
 - a. "Y" – indicates yes; the provider indicates the injury is causally related to the IW's employment;
 - b. "N" – indicates no; the provider does not indicate that the injury is causally related to the IW's employment;
 - c. "U" – indicates that the causality is undetermined and that BWC must seek additional information. Examples include:
 - i. Provider failed to respond to whether a causal connection existed.
 - ii. The injured worker did not seek medical treatment and the injury is not a minor injury.

- F. Medical documentation, except as noted in Section IV.E, below, is required and must establish that the condition probably occurred as a result of the injury or as a flow-through to already allowed conditions.

- G. It is the policy of BWC to permit field staff to allow, without the submission of medical evidence, a claim or condition classified as a minor injury.
 - 1. Minor injuries include only the following:
 - a. First degree burns to less than 10% of the body
 - b. Superficial lacerations (e.g., cut, open wound)
 - c. Superficial contusions (e.g., bruise, hematoma)
 - d. Insect stings
 - e. Minor animal or human bites
 - f. Superficial foreign body in the eye
 - g. Corneal abrasions
 - h. Conjunctivitis (also known as pink eye)
 - i. Dermatitis

- j. Blisters
 - k. Superficial injury/abrasion
 - 2. Staff shall not delay the investigation and processing of a minor-injury claim because BWC has not received medical evidence
 - 3. Field staff shall consider whether a causal relationship between the minor injury and the mode or mechanism of injury is established by a preponderance of the evidence (i.e., more likely than not).
 - 4. Field staff will consider the description of the accident to determine if the circumstances of the accident could produce the injury the IW is requesting.
 - 5. Staff may identify and code the diagnosis consistent with the mechanism of injury for these types of injuries if there is no medical evidence on file.
- H. For non-minor injuries, if field staff obtain the appropriate medical evidence in accordance with the DDG and determine that all other legal factors are met:
 - 1. Field staff will either:
 - a. Code the condition using the ICD code provided by the treating physician; or,
 - b. Code the diagnosis using the narrative diagnosis the treating physician has provided, whether or not the treating physician has provided an ICD code; or,
 - c. If the physician has provided both an ICD code and a narrative diagnosis and the two do not match, field staff will seek clarification from the BWC ICD Modification Unit.
 - 2. Field staff will verify the site/location of injury:
 - a. If field staff cannot verify the site or location:
 - i. Field staff will select a site/location.
 - ii. If it is discovered, even after expiration of the appeal period, that the site/location is different, BWC will consider such a clerical error and will issue a corrected order.
 - b. Field staff shall refer to the *ICD Modification* policy and procedure, if needed.
- I. If field staff cannot obtain appropriate or sufficient medical evidence in accordance with the DDG for initial allowance of the claim, staff may make a referral to the local nurse and/or request a physician review for an opinion.
 - 1. Field staff may allow the claim or condition for the diagnosis(es) the physician reviewer provides.
 - 2. If a physician reviewer recommends allowance of a diagnosis different than what the IW requested, BWC will notify the parties via an order that the requested condition will be considered when the IW submits supporting medical evidence for that particular condition.
 - 3. Example:
 - a. Treating physician diagnoses rotator cuff syndrome but no MRI was performed.
 - b. Per the DDG, staff cannot allow the condition without a physician review.
 - c. The physician reviewer recommends allowance of sprain/strain of the shoulder based on the medical evidence in the file.
 - d. Staff will issue an order allowing the sprain/strain of the shoulder and noting that the rotator cuff syndrome will be considered when the IW submits supporting medical evidence.
- J. For subsequent allowance requests, if field staff cannot obtain:
 - 1. Any medical evidence, the subsequent allowance request will be dismissed;
 - 2. Appropriate or sufficient medical evidence in accordance with the DDG, field staff shall seek a physician review and refer the issue to the IC.
- K. Signatures
 - 1. It is the policy of BWC to accept original or stamped signatures on physician reports.
 - 2. It is the policy of BWC to accept electronic data interface (EDI) transmissions of medical evidence to make medical determinations. However, if a claim is contested, BWC must obtain the hard copy medical report with a provider's signature from the MCO.

3. It is the policy of BWC to accept a healthcare provider's authorized representative's signature on medical reports. The physician of record (POR) or treating physician's authorized representative/designee will sign for the POR or treating physician and initial.
4. It is the policy of BWC to accept the signature of a nurse practitioner or a physician assistant to diagnose conditions for claim allowance decisions, additional conditions, and medical treatment decisions within the scope of their practice.
5. Please refer to the "Physician Signature on Medical Evidence" Chart, located on COR for BWC staff.

BWC staff may refer to the corresponding procedure for this policy entitled "Medical Evidence for Diagnosis Determinations (MEDD)" for further guidance.

Procedure Name:	MEDICAL EVIDENCE FOR DIAGNOSIS DETERMINATIONS (MEDD)
Procedure #:	CP-13-02.PR1
Policy # Reference:	CP-13-02
Effective Date:	05/26/15
Approved:	Rick Percy, Chief of Operational Policy, Analytics & Compliance (Signature on file)
Supersedes:	All Injury Management procedures, directives and memos regarding MEDD that predate the effective date of this procedure.
History:	New
Review date:	05/26/2020

IX. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements, and BWC staff and Managed Care Organization (MCO) staff shall follow any other specific instructions included in this procedure.

X. Staff shall ensure a claim is compensable for initial determination

- A. Staff shall refer to the following policies and procedures to evaluate a claim, in addition to using the Disability Determination Guidelines (DDG) detailed in this procedure and corresponding policy:
1. *Interstate Jurisdiction*
 2. *Jurisdiction*
 3. *Compensability and Coverage*.

B. Causality

1. BWC shall consider the relationship between the requested condition and the mode or method of injury to determine the specific theory of causation, which is one of the following:
 - a. Direct causation (i.e., the injury or employment proximately caused the condition);
 - b. Substantial aggravation/exacerbation of a pre-existing condition (i.e., the injury or employment worsened a condition the injured worker [IW] already had);
 - c. Acceleration (i.e., the injury or employment hastened the progression of a condition);
 - d. Flow-through (i.e., a new condition that develops as a result of an allowed condition);
 - e. A non-work related injury or illness.
2. Staff shall rely on medical documentation, except as noted in Section IV, below, to establish the condition probably resulted from the injury or employment.

C. The MCO is primarily responsible for gathering the documentation that establishes causality and shall submit the causality indicators to BWC via the Electronic Data Interchange (EDI) 148 for initial determinations (for subsequent decision requests, the MCO shall include this information in a detailed note).

1. The MCOs shall choose one of the following indicator values:
 - a. "Y" – Yes, the provider has indicated that the injury is causally related to the IW's injury or employment;
 - b. "N" – No, the provider has indicated that the injury is not causally related to the IW's injury or employment;
 - c. "U" – Undetermined. Reasons the MCO submits a "U" causality factor include, but are not limited to, the following reasons:

- i) The provider would not provide an opinion as to whether or not the injury was causally related to the IW's employment. The MCO shall enter a note indicating the provider declined to establish a causal connection.
 - ii) The provider did not provide an opinion as to whether or not the injury was causally related to the IW's employment and the MCO has documented at least two attempts to obtain the information.
 - iii) The injured worker did not seek medical treatment.
 - 2. The MCO shall identify the documentation that supports the causality indicator.
 - 3. The MCOs shall not submit the initial EDI 148 until the MCO has:
 - a. Obtained and provided the causality indicator; or,
 - b. Documented a failure to obtain the information after at least two attempts to contact the provider and secure the causality information.
- D. Field staff shall determine if the medical evidence the MCO gathered, including consideration of the causality factor, supports the subjective/objective exam findings for the diagnosis(es) being requested.

XI. Staff Shall Use the DDG

- A. Field staff shall refer to the DDG to ensure that the appropriate medical evidence required for the requested diagnosis(es) is submitted, and if all required evidence is in the claim, field staff may issue a decision without sending the claim for Medical Service Specialist (MSS) or physician review.
- B. If supporting evidence is submitted and field staff determines the requested condition(s) is related to the employment/injury, field staff shall follow the process in the *ICD Modification* policy and procedure.
- C. If the supporting evidence is submitted but field staff is not sure the diagnosis is related to the employment/injury, field staff shall:
 - 1. Refer the claim to the MSS to clarify and verify the medical documentation and assist in determining if the information in the submitted medical evidence meets the requirements of the DDG.
 - 2. Then, the MSS may request a physician review to opine on a diagnosis.
- D. If the IW's request for a condition is not supported by the medical evidence, field staff shall send for a physician review, and:
 - 1. If the decision is an initial determination and the physician reviewer recommends allowance of a diagnosis different from the requested condition(s), field staff shall allow the claim for the physician reviewer's recommended allowed conditions and include in the order the following statement: "The specific condition requested will be considered upon submission of appropriate medical evidence."
 - 2. If the decision is subsequent to the initial determination period, field staff shall:
 - a. Seek clarification of the request;
 - b. Ask the IW to modify the request;
 - i) If the IW agrees to modify, process the request; or
 - ii) If the IW will not agree to modify, refer the claim to the Industrial Commission (IC).
- E. If the supporting evidence is not submitted after attempts to secure it have been made (except for a minor injury, covered in Section IV below), field staff shall:
 - 1. Check to verify if a diagnostic test is planned, and if field staff does not yet have results, field staff may set a task in the claim to follow-up with the MCO to obtain the test results prior to sending the claim for physician review.
 - a. For an initial determination:

- i. If the evidence is not obtained before the determination date arrives and the IW is requesting only one condition, field staff shall deny the claim;
 - ii. If the IW is requesting more than one condition and evidence is obtained on some but not all of the conditions, field staff shall indicate that the condition for which no evidence was obtained is neither allowed nor disallowed.
- b. For a subsequent determination, if the evidence is not obtained before the determination date arrives, field staff shall process the claim with the evidence on file.
- 2. If no diagnostics are received or planned, send the issue to the Virtual Medical group so that an MSS may request a physician review to opine on the appropriate diagnosis, if any, for the claim allowance; and,
- 3. Code and process the claim based on the physician reviewer's diagnosis, if one is supplied.

XII. Minor Injuries

- A. Field staff shall rely on the description of the accident to determine if the mode or mechanism of injury could produce the requested condition.
- B. Staff shall not require medical evidence to determine the compensability of minor injuries. Minor injuries only include:
 - 1. First degree burns to less than 10% of the body
 - 2. Superficial lacerations (e.g., cut, open wound)
 - 3. Superficial contusions (e.g., bruise, hematoma)
 - 4. Insect stings
 - 5. Minor animal or human bites
 - 6. Superficial foreign body in the eye
 - 7. Corneal abrasions
 - 8. Conjunctivitis (also known as pink eye)
 - 9. Dermatitis
 - 10. Blisters
 - 11. Superficial injury/abrasion.
- C. Field staff shall, if determining the claim is compensable, identify a diagnosis code consistent with the mode/mechanism of injury.
- D. Field staff shall not allow a minor injury if there is contrary evidence on file, but shall:
 - 1. If it is an initial determination, issue an order based on the evidence; or,
 - 2. If it is a subsequent decision, refer the claim to the IC for hearing. Field staff may refer to the *Notice of Referral* policy and procedure.

XIII. How to Gather Medical Evidence or Additional Medical Evidence

- A. Field Staff shall work and coordinate with the MCO, who is primarily responsible, to gather medical evidence, as needed.
- B. Field staff shall follow up with the MCO if the MCO does not send medical evidence within three (3) days of BWC's receipt of the initial EDI 148. If the MCO does not submit the medical evidence within four (4) days of the BWC's receipt of the initial EDI 148, field staff shall coordinate efforts with the MCO and may contact the treating physician directly for information.
- C. Lost-time field staff shall call the MCO or provider to obtain information, and if that is unsuccessful, may send the "Request for Additional Information" letter to the treating provider, as needed, to obtain additional or sufficient medical evidence.
- D. Medical Claims staff may call the MCO or provider to obtain information, and shall send the "Request for Additional Information" letter to the treating provider, as needed, to obtain additional

or sufficient medical evidence.

XIV. Physician Signature

- A. Field staff shall ensure that physician reports are signed.
- B. Staff may accept electronic data interface (EDI) transmissions as medical evidence in making claim determinations. However, if a claim is contested, BWC must obtain the hard copy medical report with a provider's signature from the MCO.
- C. Staff shall ensure that the person signing the report has authority to do so. Staff shall refer to chart entitled "Physician Signature on Medical Evidence" for details on signatory authorization.
- D. Staff shall accept a healthcare provider's authorized representative's signature, pursuant to IC Resolution R97-1-06. The POR or treating physician's authorized representative (designee) will sign for the POR or treating physician and initial.
- E. Staff shall accept the signature of a nurse practitioner and/or physician assistant as valid medical evidence for claim allowance decisions and medical treatment decisions with the scope of practice, but not for disability certification.

Policy Name:	ICD MODIFICATION
Policy #:	CP-09-02
Code/Rule Reference:	R.C. 4121.32, 4121.39
Effective Date:	01/07/2016
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance (Signature on File)
Origin:	Claims Policy
Supersedes:	All Injury Management policies, directives or memos regarding ICD Modification that predate the effective date of this policy.
History:	New 08/11/2015
Review date:	01/07/2021

I. POLICY PURPOSE

The purpose of this policy is to ensure that claims are assigned the correct numeric ICD code(s) and/or injury description (narrative condition) based on the supporting medical evidence, and that the code is accurately reflected in the claims management system.

II. APPLICABILITY

This policy applies to BWC Field Operations staff, Medical Services staff and managed care organizations (MCOs).

III. DEFINITIONS

Encoder: web-based software that converts a narrative medical description into a numeric ICD description, or vice versa.

ICD: International Classification of Diseases. ICDs are standardized classifications of diseases, injuries, and causes of death, by etiology and anatomic localization and codified into a multi-digit number, which allows clinicians, statisticians, health planners and others to speak a common language, both in the US and internationally.

IV. POLICY

- A. It is the policy of BWC to assign the most accurate and specific ICD code and narrative description for each condition allowed and/or disallowed in a claim to ensure that the correct allowed conditions are captured in the claims management system and that all future correspondence, including requests for independent medical exams (IMEs), will contain the correct allowed conditions.
- B. It is the policy of BWC to update or modify condition(s) that have been coded incorrectly when:

1. The description does not exactly match the condition allowed by order in the claim; or
 2. ICD codes and descriptions in the claims management system encoder are not an exact match with the conditions that need to be allowed or which have been allowed in the claim; or
 3. ICD codes have expired or been revised due to changes in the diagnosis code set.
- C. It is the policy of BWC that the narrative condition/description requested on a First Report of Injury (FROI), *Request for Authorization and/or Recommendation of Additional Conditions (C-9)*, a *Motion (C-86)*, or allowed by BWC or Industrial Commission (IC) Order takes precedence over the actual numeric International Classification of Diseases (ICD) code(s).
- D. It is the policy of BWC that a BWC or IC Order is required for conditions to be recognized as allowed or denied.
- E. BWC shall provide notice of correction, modification, or deletion to the parties in the claim via BWC order or letter unless:
1. The ICD code is being changed but the narrative description remains the same; or
 2. The narrative description is being modified to reflect an earlier BWC or IC order.

BWC staff may refer to the corresponding procedure for this policy entitled "Procedure for ICD Modification" for further guidance

Procedure Name:	PROCEDURES FOR ICD MODIFICATION
Procedure #:	CP-09-02.PR1
Policy # Reference:	CP-09-02
Effective Date:	01/07/2016
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance
Supersedes:	All Injury Management procedures, directives and memos regarding ICD Modification that predate the effective date of this procedure.
History:	New 08/11/2015
Review date:	01/07/2021

- I. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.

II. General Guidelines for ICD Modifications

- A. Field staff shall obtain allowed conditions from the order which originally granted the condition(s). Field staff shall not obtain the conditions from the "previously allowed" section of an Industrial Commission (IC) order.
- B. Field staff shall not delete or modify narrative descriptions for conditions allowed outside BWC's jurisdiction and shall staff all requests for modifications to conditions allowed by the IC with a BWC Field Attorney.

- C. Field staff shall update the claims management system with all conditions allowed by BWC or IC Order.
- D. Field staff shall use the encoder, the ICD coding manual, *Medical Evidence for Diagnosis Determination* (MEDD) policy and procedure and/or the correct coding tool found on Claims On-Line Resources (COR) to:
 - 1. Ensure conditions are assigned the correct ICD code;
 - 2. Ensure any requested condition has not already been addressed by another ICD code; and
 - 3. Map an ICD-9 to an ICD-10.
- E. Field staff shall:
 - 1. Ensure all ICD-9 codes in claims with a Health Insurance Claim Number (HICN) have been converted to ICD-10 codes.
 - 2. Convert all ICD-9 codes to ICD-10 codes when in a claim for any reason.
 - 3. Convert all ICD-9 to ICD-10 codes when Alternative Dispute Resolution (ADR) issues are being processed.
- F. Field staff shall identify the correct site and location of all conditions when required.
- G. Field staff shall utilize the site drop-down box on the diagnosis/injury status maintenance window to clarify a condition, when necessary. For example, a First Report of Injury (FROI) is submitted with the condition "lumbar strain" and the accompanying ICD code S39.012A. The code S39.012A comes up "Strain of muscle, fascia and tendon of lower back." Field staff shall choose "lumbar" from the site drop-down box.
- H. Field staff shall seek agreement from all parties in the claim when a need for an ICD code modification is identified on a condition previously allowed by BWC order.
 - 1. When all parties are in agreement:
 - a. Field staff shall vacate the original BWC order and issue a new corrected order with the corrected narrative/condition when modifying or adding a new condition;
 - b. Field staff may staff modifications that require vacating an order and issuing a new order with a supervisor or BWC attorney.
 - 2. When all parties are not in agreement, or where the condition was previously allowed by IC order, field staff shall staff with a BWC attorney to consider referral to the IC for continuing jurisdiction.
- I. Field staff shall request a description be modified prior to issuing a BWC order or referring to the Industrial Commission (IC) via the "Notice of Referral" (NOR) if a description cannot be accurately coded.
- J. Field staff may correct or modify ICD codes without notice to the parties in the claim when the narrative description does not change.
- K. Field staff shall complete the electronic referral form located on the "BWC ICD Modification Request" SharePoint site when modifications, clarification or ICD coding assistance is needed, following the requirements below.
- L. General guidelines for requesting ICD modifications from the "BWC ICD Modification Request" SharePoint site:
 - 1. Staff shall follow these procedures for all claims requiring modification, including Self Insured (SI) claims.
 - 2. Field staff shall send requests for clarifications/modifications to the "BWC ICD Modification

- Request” SharePoint site:
- a. Whenever staff cannot, using the available tools, assign a code with the correct description for an allowed condition in the claim,
 - b. As a resource for coding assistance and clarification, or
 - c. For assistance in validating a code the staff selected or requesting the appropriate code that best reflects the diagnosis description.
3. Field staff shall review all medical documentation in the claim prior to sending the request to the ICD modification SharePoint site to ensure the requested modifications are appropriate. When appropriate, the requests for clarification/modification shall be sent through the SharePoint site:
 - a. Before a BWC order is issued;
 - b. Before a NOR to the IC is sent; or,
 - c. When an allowance made by IC Order is unclear.
 4. Field staff shall:
 - a. Have the following information available in order to complete the electronic referral form on the “BWC ICD Modification Request” SharePoint site:
 - i. IW’s name and claim number;
 - ii. The reason for the request, which will systematically assign the priority:
 - a) Additional Allowance (C86);
 - b) Additional Allowance (C9);
 - c) Death;
 - d) FROI;
 - e) IC Order;
 - f) MCO Request;
 - g) Modification;
 - h) New Claim (0-7 day);
 - i) New Claim (28 day);
 - j) New Claim (Surgery Pending);
 - k) New Claim (CAT Claim);
 - l) Question;
 - m) Sprain/Strain; or
 - n) Surgery pending (after claim determination).
 - iii. Whether the claim is Self Insured (SI), and if the condition/ICD code was allowed by the SI employer, the date of the correspondence and/or claims management note documenting this information;
 - iv. Whether the request is for a BWC order or IC order, and if it is for an IC order, the date of the order and the exact description of the condition as stated in the IC Order;
 - v. Dates of medical documentation, applications or orders (e.g., MRI report dated, *C-86 Motion* (C-86), IC Order, etc.) that impact or support the request;
 - vi. If supporting medical documentation was not provided, the date and type of documentation that was requested;
 - b. Any request that fails to provide the required elements listed above shall be returned specifying the missing elements that need to be included.
 5. Field staff shall receive a confirmation via the SharePoint site “BWC ICD Modification Request” SharePoint site coordinator. The returned SharePoint electronic referral form shall contain the correct ICD code to use or indicate that the ICD description has been corrected in the claims management system.
 6. The BWC ICD Modification Request SharePoint site coordinator shall return urgent or rush requests made by field staff the same day when requests are made prior to 1 p.m. Requests made by field staff after 1 p.m. will be returned the next business day.
 7. Field staff shall enter notes in the claims management system explaining the need for any diagnosis modification and shall identify the documentation used to support the decision.
 8. If the field and the “BWC ICD Modification Request” SharePoint site coordinator disagree with

the recommended modifications, the issue shall be staffed with the BWC Nursing Director or designee for determination.

9. Field staff shall send any questions regarding manual conversions (mapping ICD-9 to ICD-10) for existing claims to the ICD-9 to ICD-10 Conversion Referrals SharePoint site.
10. Field staff shall use the BWC ICD-10 Project Inquiry mailbox to:
 - a. Send questions regarding system-mapped ICD codes;
 - b. Request specific training topics (with 'training topic' or 'training request' in the subject line); and
 - c. Ask general ICD-10 project-related questions.

III. Correcting/Modifying ICD Code/Description Before Issuing a BWC Decision

- A. Field staff shall ensure ICD codes and narrative descriptions correspond and are valid workers' compensation conditions on all requests/recommendations for allowances [i.e., *First Report of Injury (FROI)*, C-86 and C-9 *Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupation Disease (C-9)*], as well as ensure conditions identified on the documentation, are correct and valid workers' compensation conditions.
- B. Reviewing and Investigating the Request
 1. Field staff shall issue the BWC order or NOR to the IC, as appropriate, when the description provided can be accurately coded or the ICD and supporting documentation match exactly.
 2. Field staff shall review the FROI and/or medical documentation to obtain the correct location and/or site when that information is not identified on the request. For example: the FROI gives the condition "crushing injury of hand"; field staff shall review the available documentation to determine if the injury was to the right or left hand.
 3. Field staff shall not review medical documentation and diagnose a condition; all conditions other than minor injuries must be diagnosed by a physician. For example: If an MRI report is submitted but the POR has not formally accepted the findings, field staff cannot use those findings to support adding a condition to a claim.
 4. Field staff shall request the narrative description be modified/corrected if the requested/recommended description is correct based on the medical documentation in file but that description cannot be accurately coded in the claims management system. Field staff shall only do this when:
 - a. Issuing an initial order; or
 - b. Allowing a subsequent condition; or
 - c. Referring to the IC with a NOR (if a subsequent condition should be denied). Field staff shall clearly state BWC's position on the request and outline the supporting evidence following the *Notice of Referral* policy.
 5. Field staff shall contact the requesting party, MCO or physician of record/treating physician to clarify the code and/or condition description when:
 - a. The ICD code is provided without description;
 - b. The condition does not match a valid ICD code;
 - c. ICD code is correct but spinal levels are required but not documented.
 6. Field staff shall request medical documentation if clarification is not given and the documentation on file is insufficient to determine the appropriate ICD code/condition. Prior to sending to medical review, field staff shall request medical documentation from:
 - a. The MCO;
 - b. The physician of record/treating physician, when the MCO is unable to obtain the documentation.
 7. Field staff shall send the request to physician review if the condition has not been clarified to request what, if any, condition is supported by the medical evidence.
 8. Based on the result of the physician review, field staff shall adhere to the following policies to address the requested condition(s):
 - a. *Additional Allowance*; and/or

- b. *Order, Waivers, Appeals and Hearings; and/or*
- c. *Notice of Referral.*

9. Field staff shall use the ICD code A00.00 on claims for which there was no injury.
10. If requests or recommendations are made for symptoms and/or generic conditions, field staff shall:
- a. Determine if the symptom requested is addressed by a condition already allowed in the claim.
 - b. If the request is addressed by a condition already allowed in the claim, telephone the requesting party and ask the filing party to withdraw the request/recommendation.
 - c. If the request is not addressed by a condition already allowed in the claim, telephone the requesting party and/or physician of record/treating physician to clarify the request (i.e., determine what condition is causing this symptom).
 - d. Send the request to physician review asking what, if any, condition does the medical documentation support.
 - e. Based on the result of the physician review, follow the:
 - i. *Additional Allowance; and/or*
 - ii. *Orders, Waivers, Appeals and Hearings; and/or*
 - iii. *Notice of Referral.*

IV. Correcting/Modifying ICD Descriptions after Allowance

- A. Field staff shall not address ICD codes/conditions in claims that fall outside an employer's experience or were allowed more than five years ago for employers who are experience-rated, except in the following circumstances:
 - 1. The condition in question is one that is currently driving the claim cost (indemnity and/or medical).
 - 2. Anticipated future medical or indemnity costs may be incurred due to the condition in question (i.e., request for treatment or compensation may be filed).
- B. Field staff shall review retro-rated or Public Employer State Agency (PES) employer claims for modifications at any time when there are potential medical and/or indemnity impacts identified that adversely affect the claim cost.
- C. The field may staff with an Employer Service Specialist (ESS) or the BWC attorney to determine if the incorrect diagnosis is one that impacts claim costs.

V. Correcting/Modifying ICD Codes Never Formally Allowed by BWC or IC Order

- A. Field staff shall not address conditions which were never formally allowed by BWC or IC Order that fall outside an employer's experience or have been allowed more than five years ago unless potential medical and/or indemnity impacts are identified that adversely affect the claim cost.
- B. When the claims management system has an ICD code(s)/description listed that was never formally allowed by BWC or IC Order, field staff shall determine if the condition should be allowed, denied, or deleted, and staff shall follow the procedures in Section V. E-G below.
- C. Field staff shall include medical bill review in the investigation to determine if the condition(s) is supported by medical evidence and a causal relationship can be established, but a BWC or IC order recognizing the condition is still required.
- D. The condition(s) remains in an allowed status in the claims management system until the determination process is complete.

- E. Field staff shall follow the *Additional Allowance* policy to allow the condition or to refer the condition to the IC.
- F. If the condition was not previously allowed by BWC or IC Order and should be denied, the issue of denial of the condition cannot be sent to the IC unless there is a C-86 currently on file requesting the condition.
 - a. If the condition should be denied, and there is a C-86 on file, the C-86 is referred to the IC for hearing via a NOR.
 - b. If there is no C-86 on file, field staff shall follow the procedures to delete the condition.
- G. If field staff determines a condition should be deleted from the claim:
 - 1. Field staff shall review all conditions not formally addressed by a BWC or IC Order when there is no supporting medical evidence to allow the condition, or the condition does not appear to be related to the claim.
 - 2. Field staff shall address the conditions by issuing the “BWC ICD Deletion” letter found in COR. The ICD code shall not be deleted in the claims management system without issuing a “BWC ICD Deletion” letter to notify the parties in the claim.
 - 3. If there are multiple ICD codes on the claims management system that were never formally addressed by BWC or IC Order:
 - a. Field staff shall include all the conditions to be deleted in the “BWC ICD Deletion” letter.
 - b. Field staff shall issue both a BWC order and the “BWC ICD Deletion” letter when some conditions can be allowed through the *Additional Allowance* policy, and some conditions have no supporting medical evidence and should be removed.
 - 4. Field staff shall not remove the ICD codes addressed by the “BWC ICD Deletion” letter from the claims management system until 14 days after the “BWC ICD Deletion” letter has been sent, allowing parties the time to request/recommend allowance of the conditions by filing a C-86 or C-9 with supporting evidence.
 - a. Field staff shall delete the condition(s) after 14 days if no C-86 or C-9 is filed.
 - b. Field staff shall follow the *Additional Allowance* policy if a C-86 or C-9 is filed.
 - c. Field staff shall not delete the ICD Code(s) until the additional allowance process is complete.

VI. Correcting/Modifying ICD Description Allowed by Industrial Commission (IC) Order

- A. If field staff discovers a condition allowed by IC Order is not available through the encoder in the claims management system, field staff shall follow the general guidelines in Section II of this procedure to obtain the correct ICD code.
- B. Field staff shall request modification if the ICD code is correct but the condition description is not available through the claims management system encoder.
- C. Field staff shall manually generate the “Notice of Injury Claim Status” letter through the claims management system to notify the parties/provider of the corrected description once the correction is made.
- D. Field staff shall update the claims management system notes explaining that the ICD description has been modified to reflect the diagnosis description stated in the IC Order.

VII. Correcting/Modifying Miscoded ICD description

- A. When conditions were formally allowed by BWC or IC Order, but were miscoded in the claims management system:
 - 1. Field staff shall follow the general guidelines in Section II of this procedure to obtain the correct ICD code.
 - 2. Field staff shall determine if the ICD description needs to be modified to match the allowance in the order.

3. Field staff shall request modification if the ICD code is correct, but the ICD description is not available through the claims management system.
 4. Field staff shall update notes in the claims management system explaining that the ICD code and/or description has been modified to reflect the diagnosis description stated in the BWC or IC Order.
 5. Field staff shall manually generate the “Notice of Injury Claim Status” letter in the claims management system to notify the parties/provider of the corrected code and/or description once the correction is made.
- B. When conditions were formally allowed by BWC or IC Order, but modification was never requested, field staff shall:
1. Follow the general guidelines in Section II of this procedure to obtain the correct ICD code;
 2. Request the description be modified when the ICD code is correct, but the ICD description does not reflect the narrative description in the IC/BWC Order.
 - a. **Example:** BWC Order was issued using the description modification functionality in the claims management system and the ICD description on the diagnosis/injury screen was never updated to reflect the narrative description published on the BWC Order.
 - b. **Example:** Field staff discovers discrepancy between the ICD narrative description that was allowed by IC Order and the ICD narrative description that is contained in the claims management system. The ICD modification was never requested.

VIII. Adding Specific Levels for Back Injury Claims

- A. When the IC has allowed a back condition (e.g., degenerative disc disease) without indicating a specific level:
1. Field staff shall staff with the BWC field attorney to determine if the claim should be returned to the IC for clarification if the IC Order is still within the appeal period.
 2. Field staff shall not update the condition to add specific levels without a formal order.
- B. If treatment is requested in a claim where the level is not indicated and the MCO contacts field staff to clarify the allowed condition, field staff shall:
1. Review the medical documentation supporting the allowance that is referenced in the “based on” section of the IC Order;
 2. Determine what level(s) was supported by the medical documentation if indicated;
 3. Staff with the MCO to determine what level the requested treatment addresses.
 - a. If the requested treatment is for the level that is found in the medical evidence, document this in notes in the claims management system for future reference and share the information with the MCO. No updates shall be made to the allowed conditions;
 - b. If the requested treatment is for levels that appear to be unrelated to the level as indicated in the medical documentation cited in the IC Order; or, the level is supported by medical documentation received after the IC Order, field staff shall staff with the BWC attorney to consider filing a C-86 for continuing jurisdiction to clarify the allowance in the claim.

IX. How to Replace Expired ICD Codes

- A. Field staff shall request modification through the “BWC ICD Modification Request” SharePoint site when expired codes are identified.
- B. Field staff shall add current codes when expired codes are identified by the ICD Modification SharePoint site coordinator.
- C. BWC ICD Modification Request SharePoint site coordinator will modify the narrative to reflect the previously allowed condition(s).
- D. Field staff shall delete the expired code from the claims management system.

Policy Name:	Certification of Periods of Disability by Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants
Policy #:	MP-03-03
Code/Rule Reference:	R.C. 4723.43, 4730.08, 4730.09, O.A.C 4123-5-18, 4123-6-20
Effective Date:	02/26/16
Approved:	Freddie L. Johnson, Chief of Medical Services (Signature on file)
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding the Certification of Periods of Disability by Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants.
History:	New
Review date:	02/26/21

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction to medical providers, BWC staff and Managed Care Organizations (MCOs) on what provider types can certify periods of disability.

II. APPLICABILITY

This policy applies to BWC staff, MCOs and medical providers.

III. DEFINITIONS

Certified nurse practitioner (CNP): A registered nurse holding a certificate of authority to practice as a CNP from the Ohio Board of Nursing or equivalent, authorized to practice in collaboration with one or more physicians. A CNP may provide preventative and primary care services, provide services for acute illnesses, and evaluate and promote patient wellness within the nurse's nursing specialty, consistent with the nurse's education and certification, and in accordance with rules adopted by the nursing board. A CNP who holds a certificate to prescribe may, in collaboration with one or more physicians, prescribe drugs and therapeutic devices.

Clinical nurse specialist (CNS): A registered nurse holding a certificate of authority to practice as a CNS from the Ohio Board of Nursing or equivalent, authorized to practice in collaboration with one or more physicians. A CNS may provide and manage the care of individuals and groups with complex health problems and provide health care services that promote, improve, and manage health care within the nurse's nursing specialty, consistent with the nurse's education and in accordance with rules adopted by the nursing board. A CNS who holds a certificate to prescribe may, in collaboration with one or more physicians, prescribe drugs and therapeutic devices.

Physician assistant (PA): A skilled person holding a license to practice as a PA from the State Medical Board of Ohio or equivalent, qualified by academic and clinical training to provide services to patients

under the supervision, control and direction of one or more physicians with whom the physician assistant has entered into a supervision agreement approved by the state medical board and who are responsible for the PA's performance.

Physician extender (PE): For purposes of this policy, a physician extender is a certified nurse practitioner, clinical nurse specialist or physician assistant.

IV. POLICY

- A. It is BWC's policy to recognize, for purposes of this policy, the following as authorized to take action as outlined in section B., below:
 - 1. Physicians, or
 - 2. PEs, only if a physician co-signs for the PE.

- B. The authorized individuals as noted in section A., above, may do any of the following:
 - 1. Examine the injured worker (IW);
 - 2. Submit medical evidence to BWC supporting the IW's disability due to an allowed work-related injury or disease;
 - 3. Complete and submit a MEDCO-14 form, including certification of periods of disability; and
 - 4. Submit a detailed treatment and RTW plan.

- C. BWC does not authorize PEs to:
 - 1. Make medical determinations regarding other types of compensation;
 - 2. Work outside the scope of their collaborative or supervisory agreement;
 - 3. Be granted Physician of Record (POR) status; or
 - 4. Be granted the status of a Disability Evaluators Panel (DEP) physician.

Policy/Procedure Name:	On-site Case Management
Policy #:	MP-15-01
Code/Rule Reference:	N/A
Effective Date:	03/07/16
Approved:	Freddie L. Johnson, Chief of Medical Services (Signature on file)
Origin:	Medical Policy
Supersedes:	All medical policies, procedures, directives and memos regarding on-site case management claims that predate the effective date of this policy/procedure.
History:	New
Review date:	03/07/21

I. POLICY PURPOSE

The purpose of this policy is to ensure that the Bureau of Workers' Compensation (BWC) provides direction to the managed care organizations (MCO) for completing an on-site case management visit(s) and for developing and/or managing an individualized care plan for the injured worker (IW).

II. APPLICABILITY

This policy applies to BWC catastrophic nurse advocates (CNAs) and MCO staff.

III. DEFINITIONS

Case Management Plan: Compilation of all information that the medical case manager has gathered from the IW, the physician and the employer as well as any other pertinent sources that impact the progress and successful outcome of the claim resolution; action- oriented, time-bound and specific to the intervention(s) and resources to be used to assist the injured worker in achieving the specified goals specified within each phase of the plan; ensures that accountabilities are established so that all participants are aware of respective responsibilities in meeting the goals.

Catastrophic Claim: A claim in which there is a serious injury or occupational disease resulting in limited mobility and/or cognition related to the allowed conditions in the claim that severely limits the ability of the IW to perform activities of daily living and has a high probability of resulting in permanent disability.

Medical Case Management: Collaboration to assess, plan, implement, coordinate, monitor and evaluate options and services to meet an IW's health needs using communication and available resources to promote quality cost-effective outcomes; within the Ohio workers' compensation program, includes identifying and minimizing potential barriers to recovery, identifying and assessing future treatment needs, evaluating appropriateness and necessity of medical services, authorizing reimbursement for medical services, resolving medical disputes and facilitating successful return to

work or claim resolution for injured workers; can be telephonic and/or on-site depending on the need of the IW.

Non-catastrophic Claim: A claim that does not involve a catastrophic injury or occupational disease, but requires an on-site visit to remove barriers that undermine a case manager's effective management of the claim.

On-site Case Management: Oversight of a claim that requires a case manager to travel to various settings (e.g., hospital, home, rehabilitation center) when assessing, planning, implementing, coordinating, monitoring and evaluating the options and services required to meet the IW's health and human service needs; characterized by face-to-face advocacy, communication and resource management that promotes quality and cost-effective interventions and outcomes.

Task-based Visit: A one-time case management activity with a specific purpose or objective.

IV. POLICY

- A. It is the policy of BWC that on-site case management visit(s) may be conducted for catastrophic and non-catastrophic injuries for injured workers who reside in Ohio. Examples of claim issues or conditions that may require an on-site case management visit(s) include, but are not limited to, the following:
1. For catastrophic injuries or occupational diseases:
 - a. Brain injuries, moderate to severe;
 - b. All major extremity amputations, multiple complex fractures, crush injuries, loss of use of one or more limbs;
 - c. Spinal cord injuries such as paraplegia, quadriplegia, hemiplegia or diplegia;
 - d. Total occupational blindness (blindness that occurs as a result of work or occupational activity);
 - e. Severe burns, such as second or third degree burns on more than 25 percent of the body;
 - f. Anticipated hospitalization in excess of four weeks, i.e., ventilators, ICU, psychiatric hospitalization;
 - g. Severe occupational diseases (not end stage); bloodborne pathogens; and toxic exposure with long term complications; and
 - h. Any other medical diagnosis identified by the MCO and CNA.
 2. For non-catastrophic injuries or occupational diseases where the case manager has clearly documented the barriers in the claim:
 - a. Inability to obtain medical records precipitating the need for on-site record review and/or retrieval;
 - b. Documented unsuccessful telephonic case management;
 - c. The transfer of an injured worker from the hospital to another facility for rehabilitation or other care;
 - d. An extended hospital stay, recurrent admissions and failed or repeated surgeries;
 - e. Non-compliance with physician and/or rehabilitation appointments;
 - f. Delayed healing process;
 - g. Lack of an acceptable support system for the IW;
 - h. Delayed return to work;
 - i. Request by an employer, physician, injured worker, and/or the injured worker's family and/or representative request on-site case management;

- j. BWC recommendation for an on-site case management visit; and/or
 - k. BWC and /or the MCO's medical director determine that on-site case management would remove barriers that may impede the injured worker's return to work.
- B. It is the policy of BWC that on-site case management visit(s) shall be executed as follows:
- 1. For catastrophic claims:
 - a. A minimum of one, unless waived by BWC's CNA; and
 - b. More than one visit at the discretion of the MCO.
 - 2. For non-catastrophic claims:
 - a. No minimum number of visit(s) required; and
 - b. One or more visit(s) as determined by the MCO.
- C. It is the policy of BWC that on-site visit(s) shall be integrated into an individualized case management plan for cases that are in active case management in accordance with chapter three of the MPRG. The case management plan shall clearly outline how such visit(s) can support or address care of the IW.
- D. It is the policy of BWC that cases not in active case management but requiring the case manager to execute a task-based visit shall be documented in the claims management notes or integrated into a case management plan.
- E. It is the policy of BWC that only one task-based on-site visit shall be permitted on claims that are not in active case management and it shall be documented in claims management notes. If more than one on-site visit is necessary to address the IW's care or to remove barriers, a case management plan shall be developed or reactivated to reflect the current condition of the IW.
- F. MCO responsibilities:
- 1. The MCO shall ensure that on-site case management visit(s) are executed for catastrophic and non-catastrophic claims, as appropriate.
 - 2. The case manager develops an individualized case management plan for catastrophic claims that:
 - a. Incorporates any planned on-site case management visit(s), clearly outlining how such visit(s) will support or address care of the IW; and
 - b. Identifies and evaluates options and services needed to meet the IW's needs.
 - 3. The case manager shall develop the case management plan and share it with appropriate individuals, as needed, when on-site case management is deemed appropriate.
 - 4. The MCO shall ensure that a summary of the on-site case management visit(s) is documented in the claims management system using a standard note title "MCO On-site Case Management Visit."
 - 5. The on-site case management note shall include, but is not limited to, the following components:
 - a. The date of visit;
 - b. The care setting/location;
 - c. The name of participants and their roles;
 - d. The clinical justification or purpose for visit;
 - e. The summary of the visit including accomplishments and objectives met during visit; and
 - f. The follow-up steps from visit.
 - 6. The MCO shall send a request for waiver of an on-site case management visit to the BWC CNA mailbox at bwc.catnurse@bwc.state.oh.us with the subject line "Request for a Waiver." The email shall include the following information:
 - a. Claim number;
 - b. Name of the injured worker;
 - c. Date of injury; and
 - d. Explanation for waiver.
 - 7. The BWC CNA shall ensure that any case management visit(s) that he or she waives is documented in notes.

8. The CNA may waive on-site case management visit(s) for catastrophic claims when:
 - a. The CNA makes a clinical determination that an on-site case management visit is not indicated; or
 - b. The claim is managed by Paradigm.
9. When waiving an on-site case management visit, the CNA shall:
 - a. Conduct a careful assessment of the catastrophic claim to determine if it is appropriate to waive the on-site case management visit; and
 - b. Document the rationale in notes.