

*** DRAFT - NOT YET FILED ***

4123-18-01

Provision of vocational rehabilitation services.

- (A) Pursuant to sections 4121.441 and 4121.61 of the Revised Code, the bureau shall adopt rules for the provision of vocational rehabilitation services to injured workers. Managed care organizations (MCOs) shall provide medical management, including the management of vocational rehabilitation to injured workers, and the bureau shall manage all other aspects of the claim.
- (B) The rules of this chapter shall be applicable to ~~all~~ the rehabilitation of injured workers ~~and employers~~, whether the rehabilitation services are administered by the bureau and managed by an MCO, or administered by a self-insuring employer participating in the rehabilitation surplus fund. Self-insuring employers not participating in the rehabilitation surplus fund shall also adhere to these rules to ensure that rehabilitation services provided to their injured workers are equal to or greater than the services defined in this chapter.
- (C) The bureau shall:
- (1) Develop policy to implement vocational rehabilitation services.
 - (2) Assure that injured workers receive appropriate remain at work and/or return to work vocational rehabilitation services.
 - (3) Audit the MCOs' vocational rehabilitation management practices and provision of services.
 - ~~(4) Prepare an annual report of vocational rehabilitation activities during the prior calendar year.~~

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Goals of vocational rehabilitation.

- (A) The bureau shall take measures and make expenditures as it deems necessary to aid injured workers who have sustained compensable injuries or contracted compensable occupational diseases to remain at work or to return to work.
- (B) The objectives of the surplus funded vocational rehabilitation program are to be addressed and considered in the following order:
- (1) To return the injured worker to the former employer in the original job, or, if this is not possible;
 - (2) To encourage the employer to modify the original job or to provide employment in a different job, or, if this is not possible;
 - (3) To assist the injured worker in finding employment in a related industry, and if not possible then in any industry.

The hierarchy of return to work objectives outlined above may require appropriate skill enhancement and/or remedial or short term training to aid injured workers in successfully returning to work at any of the steps.

- (C) The bureau shall ensure that injured workers who wish to become self-employed are informed of the opportunities available through the ~~state rehabilitation services commission~~ opportunities for Ohioans with disabilities agency, the federal small business administration office, the local Ohio small business development center, the Ohio department of development, or other resources.
- (D) The bureau will not make expenditures from the surplus fund established by section 4123.34 of the Revised Code for services solely directed toward the medical management of an industrial claim.

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Guidelines for referral to and acceptance into vocational rehabilitation.

(A) Scope of vocational rehabilitation.

- (1) Vocational rehabilitation is the process of restoring the vocational functioning of a worker who experiences an industrial injury or occupational disease and who voluntarily agrees to participate in vocational rehabilitation. Vocational rehabilitation services are focused on return to work and are not reimbursable from the surplus fund if solely directed toward the medical management of a claim.
- (2) The vocational rehabilitation rules of Chapter 4123-18 of the Administrative Code shall aid in the development of procedures for providing reimbursable vocational rehabilitation services.

(B) Referrals for vocational rehabilitation services.

- (1) Anyone can refer an injured worker for vocational rehabilitation services.
- (2) The bureau shall determine the eligibility of an injured worker referred for vocational rehabilitation services.
- (3) Once eligibility has been determined, the MCO shall contact the injured worker referred for vocational rehabilitation services within three working days.
- (4) After the MCO contacts the injured worker, the MCO, with bureau oversight, shall determine the feasibility of the injured worker referred for vocational rehabilitation services.
- (5) An injured worker shall not be able to participate in a vocational rehabilitation plan or receive vocational rehabilitation services until the injured worker has been determined to be both eligible and feasible for vocational rehabilitation services.
- (6) Referrals for vocational rehabilitation in inactive claims shall be processed in accordance with rule 4123-3-15 of the Administrative Code.

(C) Eligibility for vocational rehabilitation services.

To be eligible for rehabilitation services the injured worker must meet the following criteria:

- (1) Referred claim that is:
 - (a) A claim allowed by an order of the bureau of workers' compensation or the industrial commission or of its hearing officers with eight or more days of lost time due to a work related injury; or
 - (b) A claim certified by a state university or state agency; or
 - (c) A claim certified by a self-insuring employer.
- (2) The injured worker must have a significant impediment to employment or the maintenance of employment as a direct result of the allowed conditions in the referred claim.
- (3) The injured worker must have at least one of the following present in the referred claim:
 - (a) The injured worker is receiving or has been awarded temporary total, non-working wage loss, or permanent total compensation for a period of time that must include the date of referral. For purposes of this section, payments made in lieu of temporary total compensation (e.g. salary continuation) shall be treated the same as temporary total compensation; or
 - (b) Granted a scheduled loss award under division (B) of section 4123.57 of the Revised Code; or
 - (c) Received or awarded a permanent partial award under division (A) of section 4123.57 of the Revised Code and has job restrictions as a result of that award documented by the physician of record and dated not more than one hundred eighty days prior to the date of referral; or
 - (d) Determined to have reached maximum medical improvement in the claim (with eight or more days of lost time due to a work related injury) by an order of the bureau or the industrial commission, or the injured worker's physician of record has documented in writing that the injured worker has reached maximum medical improvement in the claim, and the injured worker is not currently receiving compensation and has job

restrictions in the claim documented by the physician of record and dated not more than one hundred eighty days prior to the date of referral; or.

- (e) Is receiving job retention services to maintain employment or satisfies the criteria set forth in paragraph (E) of this rule on the date of referral; or
 - (f) Sustained a catastrophic injury claim and a vocational goal can be established; or
 - (g) Was receiving living maintenance wage loss not more than ninety days prior to the date of referral, has continuing job restrictions documented by the physician of record as a result of the allowed conditions in the claim, and has lost his or her job through no fault of his or her own.
- (4) The injured worker must not be working on the date of referral, with the exception of referral for job retention services.
- (D) Eligibility for rehabilitation services for an employee of a state agency or state university employer.

Notwithstanding that an employee of a state agency or state university may not meet the eligibility criteria of paragraph (C)(3) of this rule, the employee shall be eligible for rehabilitation services where the employee meets the eligibility criteria of paragraph (C)(1)(b) of this rule and the employee and employer agree upon a program of rehabilitation services.

(E) Job retention services.

- (1) Job retention may be furnished when an injured worker is working and experiences a significant work related problem as a direct result of the allowed conditions in the claim.
- (2) Job retention services may be provided if:
 - (a) The injured worker has received temporary total compensation or salary continuation from an allowed claim with eight or more days of lost time due to a work related injury; and
 - (b) The physician of record provides a written statement in office notes or correspondence indicating that the injured worker has work limitations related to the allowed conditions in the claim that negatively impact the

injured workers' ability to maintain the injured worker's employment;
and

- (c) The injured worker's employer describes the specific job task problems the injured worker is experiencing to the MCO and the MCO documents these problems in the claim. The MCO shall include a statement describing why the injured worker needs job retention services to maintain employment.

(F) Non-eligibility for vocational rehabilitation services.

The injured worker is not eligible for vocational rehabilitation services and such services shall be terminated:

- (1) After the effective date of a lump sum settlement (medical and/or indemnity); or
- (2) If the claim is subsequently disallowed by an order of the industrial commission, its district or staff hearing officers, or by an order of the court.

(G) Diagnostic evaluations.

Prior to comprehensive rehabilitation plan implementation, diagnostic evaluations may be used in determining feasibility for vocational rehabilitation services. Payment for such examination(s) and the vocational rehabilitation case management occurring during this period may be charged to the surplus fund.

(H) Determination of feasibility for vocational rehabilitation services.

- (1) Feasibility for vocational rehabilitation services means there is a reasonable probability that the injured worker will benefit from services at this time and return to work as a result of the services. Feasibility is initially determined at the time of referral and is assessed throughout the rehabilitation process.
 - (a) An injured worker is feasible for vocational rehabilitation services when a review of all available information demonstrates that it is likely the provision of such services will result in the injured worker returning to work.
 - (b) An injured worker is not feasible for vocational rehabilitation services when a review of all available information demonstrates that, in spite of the provision of such services, it is likely the injured worker will not return to work.

(c) "All available information" means records, documents, written and oral statements, and any and all medical, psychological, vocational, social, and historical data, of any kind whatsoever, developed in the claim through which vocational rehabilitation is sought or otherwise, that is relevant to the determination of an injured worker's feasibility for vocational rehabilitation services.

(2) A determination of feasibility shall be written and shall enumerate all available information utilized in making the determination.

(I) Appeal process for vocational rehabilitation eligibility and feasibility determinations.

(1) Facts supporting a decision concerning either the acceptance or denial of an injured worker into vocational rehabilitation due to eligibility shall be documented in the bureau's decision. Appeals of eligibility determinations shall be filed with the bureau within fourteen days of receipt of the bureau's determination.

(2) Facts supporting a decision concerning either the acceptance or denial of an injured worker into vocational rehabilitation due to feasibility shall be documented in the MCO's decision. Appeals of feasibility determinations shall be governed by the alternative dispute resolution process provided for in rule 4123-6-16 of the Administrative Code.

(J) Injured worker's right to compensation or benefits.

Denial of rehabilitation services will not affect an injured worker's right to compensation or benefits under Chapters 4123., 4127., and 4131. of the Revised Code for which the injured worker otherwise qualifies.

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Living maintenance allowance.

The bureau shall order living maintenance to be paid from the surplus fund, established by section 4123.34 of the Revised Code, to each injured worker in accordance with the guidelines listed below. Living maintenance payments are compensation under Chapters 4121. and 4123. of the Revised Code.

An injured worker is eligible for living maintenance payments in accordance with the guidelines of this rule.

- (A) Living maintenance payments shall begin on the date that the injured worker actually begins to participate in an approved vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan as defined in rule 4123-18-05 of the Administrative Code. Living maintenance is not payable on the date of referral for vocational rehabilitation services, nor the date the injured worker signed the rehabilitation agreement. Activities performed prior to the injured worker's active participation in the approved vocational rehabilitation assessment plan and/or comprehensive vocational rehabilitation plan are considered pre-plan activities for which living maintenance is not paid.

If salary continuation is offered by the employer of record, an injured worker maintains the right to choose to receive either salary continuation or living maintenance during vocational rehabilitation. However, if temporary total or living maintenance has been paid in the claim, the injured worker shall be paid living maintenance when participating in an approved vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan. Whenever salary continuation is paid by the employer, it must be paid at the injured worker's regular (full) salary level.

- (B) The bureau shall order suspension of living maintenance payments at such time as it becomes evident that the injured worker will not be able to participate actively in their vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan for a period of thirty days or more due to the medical instability of the injured worker. The suspension of living maintenance shall not affect an injured worker's right to compensation or benefits under the Revised Code for which the injured worker otherwise qualifies.

- (1) The bureau shall assist the injured worker in obtaining the payment of other workers' compensation benefits to which the injured worker would normally be entitled absent involvement in a vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan upon the cessation of living maintenance payments.

(2) Medical hold and eligibility.

Upon request from the MCO, the bureau shall determine whether, based on adequate medical documentation, the injured worker's vocational rehabilitation plan should be closed with a medical hold.

(a) A medical hold will retain the injured worker's eligibility for vocational rehabilitation services for up to a maximum of two years from the date of vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan file closure. The bureau and the MCO shall thereafter monitor the injured worker's medical status with the attending physician.

(b) When the bureau becomes aware of the re-stabilization of the injured worker's medical condition, the injured worker's vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan shall be reactivated and, absent any extenuating circumstances, appropriate rehabilitation services shall begin as soon as possible.

(C) The bureau shall order termination of living maintenance payments upon the earlier of:

- (1) The injured worker's return to work other than as part of a gradual return to work plan; or
- (2) Closure of the injured worker's vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan pursuant to paragraph (E) of rule 4123-18-05 of the Administrative Code.

The termination of living maintenance shall not affect an injured worker's right to compensation or benefits under the Revised Code for which the injured worker otherwise qualifies.

(D) The bureau may order deduction from any living maintenance payment an amount equal to:

- (1) One-seventh of the weekly payment to which an injured worker is entitled for each full day during which the injured worker fails, without good cause, to participate in their approved vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan.

- (2) Any wages or other remuneration received by the injured worker while participating in an approved vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan and receiving living maintenance must either be endorsed over to the bureau, or will be deducted from the injured worker's living maintenance payments or from future awards of compensation.

- (E) Living maintenance payments shall not be ordered by the bureau for a period or periods exceeding six months in the aggregate, unless the bureau determines that the injured worker will benefit from an extension of vocational rehabilitation services.

- (F) Appeals regarding determination of an injured worker's eligibility for living maintenance payments shall be filed with the bureau within fourteen days of receipt of the bureau's determination.

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4123-18-05

Individualized written vocational rehabilitation plan.

- (A) When surplus funds are used, the MCO shall oversee that a vocational rehabilitation case management provider contacts the injured worker and prepares an individualized written comprehensive vocational rehabilitation plan for the injured worker's acknowledgment and approval. The vocational rehabilitation case management provider shall, where practical, consult with the injured worker's employer, the physician of record, and others considered appropriate. A vocational rehabilitation assessment plan may be prepared prior to the individualized written comprehensive vocational rehabilitation plan. The assessment plan may be up to four weeks in length, during which time the injured worker will be actively engaged in career exploration and assessment activities.
- (B) Each written vocational rehabilitation assessment plan shall include, at a minimum, the following information:
- (1) The evaluation questions to be answered by the assessment;
 - (2) The types of services required to complete the assessment, including:
 - (a) The estimated costs for the services;
 - (b) The estimated length of time required to complete the services;
 - (c) The provider for the services;
 - (3) The estimated length of time required to complete the assessment.
- (C) Each written comprehensive vocational rehabilitation plan shall include, at a minimum, the following information:
- (1) Identification of the injured worker's return to work goals and barriers to employment;
 - (2) The types of services required;
 - (3) The estimated costs;
 - (4) The estimated length of time required to attain the goals of the plan;

- (5) An explanation of the specific strategies that will be employed to assist the injured worker in returning to work. The MCO must document that the return to work goal is addressed in the following order:
- (a) The injured worker's original job; or
 - (b) Another job with the same employer; or
 - (c) A job in a related industry or business; or
 - (d) A job in another industry or business;
 - (e) The hierarchy of return to work objectives, as outlined above may require appropriate skill enhancement and/or remedial or short term training to aid injured workers in successfully returning to work at any of the steps;
- (6) The method of evaluating services.

(D) Each written job retention plan shall include the following information:

- (1) The problems to be addressed by the plan;
- (2) The specific services necessary for the injured worker to maintain current employment;
- (3) The estimated costs for the services;
- (4) The estimated length of time required to complete the services;
- (5) The provider for the services.

~~(D)~~(E) The MCO shall administer the development of the vocational rehabilitation assessment plan and/or comprehensive vocational rehabilitation plan, monitor the injured worker's progress and where circumstances warrant, direct the amendment or modification of the plan. Once a comprehensive vocational rehabilitation plan is initiated, the MCO shall approve a change in the assigned vocational rehabilitation case manager only for extraordinary circumstances.

~~(E)~~(F) The bureau shall determine if living maintenance payments are appropriate and shall monitor all other surplus fund expenditures.

~~(F)~~(G) The MCO, in conjunction with the bureau, shall close an injured worker's vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan for the following objectively determined or identified reasons:

- (1) The injured worker has completed a vocational rehabilitation assessment plan and it is determined further vocational rehabilitation services are not needed;
- (2) The injured worker has failed to fulfill the responsibilities outlined in the vocational rehabilitation assessment plan, ~~or~~ comprehensive vocational rehabilitation plan, or job retention plan;
- (3) The injured worker is unable to attain the goals of the vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan;
- (4) The injured worker has refused, without good cause, to accept an offer of employment within the vocational goal of the comprehensive vocational rehabilitation plan;
- (5) The injured worker is no longer living;
- (6) The injured worker does not agree with the MCO's or bureau's decision to approve or deny specific vocational rehabilitation assessment plan or comprehensive vocational rehabilitation plan, or job retention plan services; or
- (7) The claim is subsequently disallowed by an order of the industrial commission, its district or staff hearing officers, or by an order of the court;
- (8) The claim is settled (medical and/or indemnity);
- (9) The injured worker has completed a comprehensive vocational rehabilitation plan;
- (10) The injured worker has completed a job retention plan;
- ~~(10)~~(11) The injured worker is determined to be no longer feasible for vocational rehabilitation services as defined in rule 4123-18-03 of the Administrative Code.

~~(G)~~(H) Appeals regarding vocational rehabilitation plan closure shall be governed by the alternative dispute resolution process provided for in rule 4123-6-16 of the

Administrative Code.

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4123-18-08

Payment for rehabilitation services and related expenses from the surplus fund.

(A) General principles.

- (1) Vocational rehabilitation services and living maintenance when appropriate, shall be paid from the surplus fund, established by section 4123.34 of the Revised Code, so long as such costs are incurred in a lost time claim pursuant to an approved vocational rehabilitation assessment plan, comprehensive vocational rehabilitation plan, or job retention plan.
- (2) Vocational rehabilitation services, as mentioned in paragraph (A)(1) of this rule, can include but must not be solely directed toward medical management and allied medical treatment of the injured worker in an approved vocational rehabilitation assessment plan, comprehensive vocational rehabilitation plan, or job retention plan.
- (3) Notwithstanding paragraph (A)(1) of this rule, any period of treatment relating to the allowed condition(s) of the claim which has been prescribed and provided prior to the approval of the vocational rehabilitation plan by the ~~attending~~ physician of record in the claim, by a specialist to whom the injured worker has been referred by the ~~attending~~ physician of record, the injured worker's employer, the MCO, or the bureau of workers' compensation, and which extends into the calendar period of the injured worker's approved vocational rehabilitation assessment plan, comprehensive vocational rehabilitation plan, or job retention plan shall continue to be charged to the risk of the employer.
- (4) Vocational rehabilitation case management costs incurred in the development and preparation of an approved vocational rehabilitation comprehensive vocational rehabilitation plan, or job retention plan, including costs for necessary medical, psychological, and vocational evaluations, are vocational rehabilitation services and are paid from the surplus fund. On-going vocational rehabilitation case management professional services and travel are also paid from the surplus fund while the approved vocational rehabilitation assessment plan, comprehensive vocational rehabilitation plan, or job retention plan ~~case~~ is open.
- ~~(5) Preacceptance or vocational rehabilitation plan development costs for medical, psychological, and vocational evaluations may be charged to the surplus fund.~~

(B) Nonallowed conditions.

- (1) The MCO and bureau shall authorize payment for treatment of a condition which is unrelated to the injury or occupational disease as long as it is clearly evident that the unrelated condition is aggravating the industrial injury or occupational disease, preventing healing, impeding vocational rehabilitation, or is a barrier to returning to work. The payment for these conditions shall not exceed two thousand dollars for each claim.
- (2) The MCO shall fully document the rationale for these expenditures in both the approved vocational rehabilitation assessment plan, comprehensive vocational rehabilitation plan, or job retention plan and the MCO's rehabilitation case file.
- (3) Payment for such treatment shall not constitute a recognition of the unrelated condition as a part of the disability in the claim.
- (4) As soon as the unrelated condition is no longer affecting the industrial injury or occupational disease, the responsibility for its treatment ceases and payment for any subsequent treatment that may be given will be injured worker's own responsibility.

(C) Expenses incurred by injured workers.

Travel expenses shall be paid in an approved vocational rehabilitation plan in accordance with rule 4123-6-40 of the Administrative Code, except as additionally provided under the following circumstances:

- (1) The bureau may authorize ~~advancements for planned and preauthorized~~ and prepay approved travel expenses.
- (2) All bureau approved expenses under this rule shall be paid from the surplus fund established by section 4123.34 of the Revised Code.
- (3) Relocation expenses may be paid from the surplus fund. The MCO shall determine the reasonable and necessary costs. These payments may be authorized up to two thousand dollars per injured worker. These costs may be approved when all of the following criteria are met:
 - (a) Job opportunities for which the injured worker is qualified do not exist within a reasonable commute on a daily basis.
 - (b) The injured worker has secured a job at the new location as determined by

the MCO.

- (c) When the criteria under paragraphs (C)(3)(a) and (C)(3)(b) of this rule are satisfied, the bureau may ~~order the payment of~~ pay relocation expenses with temporary lodging for up to sixty days to find a new residence if the injured worker must sell the injured worker's last place of residence. The relocation expenses may include temporary lodging for up to sixty days.

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4123-18-11

Incentive payments to employers who hire or retain injured workers who have completed a rehabilitation ~~plan~~ program.

The bureau, as a means of encouraging employers to retain, rehire, or hire injured workers who have successfully completed a prescribed rehabilitation ~~plan~~ program, may make payments to employers from the surplus fund established by section 4123.34 of the Revised Code.

- (A) The payments shall be negotiated with the employer and based upon a written agreement signed by the employer; and the injured worker, and approved by the bureau. The basis for negotiation shall be:
- (1) The nature of the disability of the injured worker as determined by the bureau;
 - (2) The relationship of the disability to the job requirements; and
 - (3) The individual merits of the case.
- (B) The period(s) of such payment shall not exceed six months in the aggregate, unless the bureau determines that the injured worker would benefit from an extension of payments.
- (C) Payments under this rule shall be made directly to the employer on a monthly basis, pursuant to an administrative order of the bureau, provided the employer is a complying employer in the states in which it is subject to workers' compensation coverage requirements or has been accepted by the administrator of workers' compensation as a self-insuring employer under section 4123.35 of the Revised Code. Payments may be made to out-of-state employers who are not subject to the workers' compensation laws of Ohio if a reasonable but unsuccessful effort has been made to secure employment for the injured worker within Ohio. Such payments shall be in amounts stated in the written agreement and shall be charged to the surplus fund established by section 4123.34 of the Revised Code.
- (D) The bureau may make incentive payments from the surplus fund to an employer where the employer offers ~~its employee~~ the injured worker paid transitional work activities at the employer's worksite and the employee has completed required medical rehabilitation services and has successfully satisfied vocational rehabilitation readiness requirements. An employee meets vocational rehabilitation readiness requirements when the employee has been officially referred for vocational rehabilitation, is medically stable, and has a significant impediment to a return to full employment.

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Bureau authorized to employ and secure cooperation of others required to meet its goals.

- (A) The bureau may sponsor, cooperate with, or employ the services and resources of any public entity or private person, business or association in fulfilling its responsibilities to provide vocational rehabilitation services for eligible injured workers.

- (B) The rehabilitation services commission, the department of job and family services, and any other public officer, employee or agency of the state shall, pursuant to this rule and section 4121.69 of the Revised Code, give to the bureau full cooperation and shall, at the request of the administrator of the bureau of workers' compensation, enter into a written agreement stating the procedures and criteria for referring, accepting, and providing services to injured workers in approved vocational rehabilitation plans.

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4123-18-13

Referral to rehabilitation services commission permitted.

- (A) In appropriate cases, the bureau may refer an injured worker to the rehabilitation services commission to participate in a plan offered by the rehabilitation services commission (the bureau of vocational rehabilitation and the bureau of services for the visually impaired).
- (B) The administrator of the bureau of workers' compensation will order payment from the surplus fund established by section 4123.34 of the Revised Code to compensate the rehabilitation services commission for the nonfederal portion of its services.

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Injured workers suffering compensable injuries, occupational diseases or death while in an approved vocational rehabilitation plan.

- (A) Claims for injury, occupational disease or death incurred in the course of and arising out of participation in an approved vocational rehabilitation plan may be filed for compensation and benefits as if the injured worker's employer were the bureau of workers' compensation.
- (B) The full or average weekly wage for the rehabilitation injury, occupational disease, or death claim shall be calculated using the full or average weekly wage information in the original claim pursuant to which the injured worker undertook participation in the prescribed rehabilitation program; provided, that if the statewide average weekly wage in the year of the rehabilitation injury, occupational disease or death is different from that applicable to the original claim, the injured worker's full or average weekly wage shall be calculated using the original wage information but subject to the maximum compensation rate in such subsequent year.
- (C) All compensation and benefit awards arising out of such a claim shall be charged to the surplus fund account established by section 4123.34 of the Revised Code, and not charged through the state insurance fund to the employer against which the claim was allowed so long as the employer pays assessments into the surplus fund account for the payment of such compensation and benefits.

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Self-insuring employer's obligation to provide vocational rehabilitation services.

- (A) Employers who provide compensation and benefits pursuant to section 4123.35 of the Revised Code shall furnish all eligible and feasible injured workers with vocational rehabilitation services equal to or greater in quality and content than the services administered by the bureau and managed by the MCOs.
- (B) Upon referral, a self-insuring employer shall determine whether the injured worker is eligible and feasible for vocational rehabilitation services using the criteria set forth in rule 4123-18-03 of the Administrative Code. If it is determined that the injured worker is eligible and feasible for vocational rehabilitation services, the self-insuring employer shall provide vocational rehabilitation case management services equal to or greater in quality and content than the services administered by the bureau and managed by the MCOs, utilizing the services of a provider who meets the minimum credentialing criteria set forth in rule 4123-6-02.2 of the Administrative Code. The self-insuring employer shall submit a copy of the approved vocational rehabilitation plan to the injured worker and the injured worker's representative.
- (C) The bureau shall inspect and review the quality and content of all authorized self-insuring employers' vocational rehabilitation services in order to determine whether or not such services are equal to or greater in quality and content than the services administered by the bureau and managed by the MCOs. Such inspections and reviews shall be conducted upon receipt of evidence indicating that a self-insuring employer's vocational rehabilitation services are of a lesser quality than the services administered by the bureau and managed by the MCOs.
- (D) The bureau may direct complaints of sub-standard vocational rehabilitation programs to the bureau's self-insured department for review.
- (E) The self-insuring employer shall promptly pay living maintenance, wages in lieu of compensation, or salary continuation directly to the injured worker. Payments shall be made in accordance with paragraph (A) of rule 4123-18-04 of the Administrative Code.

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Certification

Date

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*** DRAFT - NOT YET FILED ***

4123-18-18

Labor-management - government advisory council.

- (A) As provided in section 4121.70 of the Revised Code, a statewide labor-management-government advisory council shall be created consisting of ~~twelve~~ fifteen members having special knowledge on matters concerning various aspects of the rehabilitation of workers who are disabled due to an injury or occupational disease.
- (B) Vacancies on the council shall be filled in the same manner as the original appointment as provided in section 4121.70 of the Revised Code. The council shall appoint a chairperson and vice-chairperson.
- (C) The administrator or the administrator's designee shall serve as secretary of the council without vote.
- (D) The council shall meet at the call of the chairperson or a majority of the members, and meetings may be requested by the administrator or the administrator's designee. The council shall meet not less than quarterly. Meetings may be held at any location in the state.
- (E) Council members shall serve without compensation, except that they shall be reimbursed for the actual and necessary costs of attending meetings upon approval of the bureau of workers' compensation. Payment shall be made in the same manner as other administrative costs of the bureau.
- (F) The administrator or the administrator's designee shall prepare the agendas and provide secretarial services to the council to record minutes, prepare reports, and perform other related support services.
- (G) The council shall serve in an advisory capacity to the bureau. Those voting affirmatively and negatively on recommendations of the council shall be identified in the council's official minutes. All recommendations of the council shall be reviewed and considered by ~~both~~ the bureau, and the administrator or the administrator's designee shall inform each council member of the disposition of each recommendation.
- (H) The functions of the council shall include the following:
 - (1) Provide timely advice and counsel relative to the rendering of rehabilitation services to injured workers and the quality and effectiveness of such services;

- (2) Provide active support of the rehabilitation function and program of the bureau and verbalize that support to peers, legislators, and the community at large;
 - (3) Offer advice on current and future planning within the bureau concerning rehabilitation services;
 - (4) Offer recommendations for changes of laws, rules, policies, and procedures relative to rehabilitation services;
 - (5) Offer encouragement to employees with work related injuries or occupational diseases relative to utilization of the specialized rehabilitation services.
- (I) The administrator or the administrator's designee shall keep all members informed of the internal affairs of the bureau as applicable to their service on the labor-management government advisory council.

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*** DRAFT - NOT YET FILED ***

4123-18-21

Wage loss payments to injured workers who complete rehabilitation ~~programs~~ plans.

(A) For purposes of this rule:

(1) "Successful return to work" as a result of an approved vocational rehabilitation plan means that the injured worker has obtained employment within sixty days of closure of the injured worker's approved comprehensive vocational rehabilitation plan or job retention plan and the employment:

(a) Is within the physical and/or psychiatric limitations caused by the impairments resulting from the allowed conditions in the claim in which the injured worker completed the comprehensive vocational rehabilitation plan or job retention plan, as documented by the injured worker's physician of record; and

(b) Is reasonable in comparison with the return to work goals of the comprehensive vocational rehabilitation plan or job retention plan completed by the injured worker.

(2) "Suitable employment" and "comparably paying work" shall have the same meaning as in rule 4125-1-01 of the Administrative Code.

~~(A)~~(B) In claims with a date of injury on or after August 22, 1986, the bureau shall make living maintenance wage loss payments to injured workers who complete an approved comprehensive vocational rehabilitation plan or job retention plan, successfully return to work, and experience a wage loss while employed.

(1) The wage loss must be as a consequence of the physical and/or psychiatric limitations caused by the impairments resulting from the allowed conditions in the claim as documented by the injured worker's physician of record on form MEDCO-14 or equivalent.

(2) Injured workers requesting living maintenance wage loss payments shall be required to submit an application for living maintenance wage loss (on form RH-18 or equivalent) and medical documentation of the physical and/or psychiatric limitations as referenced in paragraph (A)(1) of this rule.

(a) An injured worker must have successfully returned to work as defined in paragraph (E)(1) of this rule to submit an initial application for living maintenance wage loss payments.

(b) Subsequent applications for living maintenance wage loss payments must

be submitted by the injured worker before the specified end date of the restrictions provided by the injured worker's physician of record or every six months, whichever occurs first.

- (3) Injured workers requesting living maintenance wage loss payments shall not voluntarily limit their income by choosing to work fewer hours or at wages below reasonable expectations, if more appropriate jobs are reasonably available within their labor market. If the injured worker voluntarily limits his or her income by choosing to work fewer hours or by accepting a job which does not constitute suitable employment which is comparably paying work, the injured worker's living maintenance wage loss benefits shall be calculated as sixty-six and two-thirds per cent of the difference between the greater of the injured worker's full weekly wage or average weekly wage on the claim for which the injured worker underwent a rehabilitation plan and the weekly wage the injured worker would have earned had the injured worker not voluntarily limited his or her income.
 - (a) In determining whether an injured worker has voluntarily limited his or her income, the bureau may review all relevant factors set forth in rule 4125-1-01 of the Administrative Code in determining whether the injured worker has returned to suitable employment which is comparably paying work.
 - (b) An injured worker who wishes to change jobs after the initial receipt of living maintenance wage loss payments must notify the bureau. The bureau shall review the criteria set forth in paragraph (A)(3)(a) of this rule to ensure that the job the injured worker wishes to change to constitutes suitable employment which is comparably paying work.
- (4) In the event the injured worker accepts employment that is below the reasonable expectations of the return to work goals of the vocational rehabilitation plan, or if the injured worker can reasonably be expected to obtain different employment for which earnings are more comparable to those prior to the injury, the injured worker may be required to make a good faith effort to search for suitable employment which is comparably paying work. In determining whether a good faith effort to search for suitable employment is required, the bureau shall consider factors such as the goals of the vocational rehabilitation plan, the labor market, the skills and work history of the injured worker, and any other factors that would assist in determining whether a good faith job search should be required.
- (5) To receive living maintenance wage loss payments under this rule after approval of these benefits by the bureau, an injured worker must provide proof of earnings at least every four weeks, or on a quarterly basis if the

injured worker has a substantial variation in income, in the form of pay stubs, payroll reports from the injured worker's current employer, or a wage statement on form ~~C-94(A)~~ RH-94(A) or equivalent. ~~If the injured worker submits a C-94(A) completed by the injured worker, the form must be notarized. If the C-94(A) is signed by the employer, the form does not need to be notarized.~~

(6) Living maintenance wage loss payments shall be charged to the surplus fund established by section 4123.34 of the Revised Code.

~~(B)~~(C) The bureau shall be responsible for calculating living maintenance wage loss payment amounts based upon the information submitted by the injured worker pursuant to paragraph ~~(A)(4)~~ (B)(4) of this rule. Payments shall be sixty-six and two-thirds per cent of the difference between the greater of the injured worker's full weekly wage or average weekly wage on the claim for which the injured worker underwent a rehabilitation plan and the weekly wage received while employed up to a maximum per week equal to the statewide average weekly wage.

~~(C) Living maintenance wage loss payments shall be issued on a biweekly basis, or on a quarterly basis if the injured worker is self-employed or has a substantial variation in income and reports income to the bureau on a quarterly basis. Living maintenance wage loss payments shall be charged to the surplus fund established by section 4123.34 of the Revised Code.~~

(D) Payments may continue for up to a maximum of two hundred weeks but shall be reduced by the corresponding number of weeks in which an injured worker receives payments pursuant to division (B) of section 4123.56 of the Revised Code.

(E) ~~The following definitions shall apply to the adjudication of applications for living maintenance wage loss payments:~~ Facts supporting a decision concerning the eligibility or non-eligibility of an injured worker for living maintenance wage loss shall be documented in the bureau's decision. Appeals of living maintenance wage loss eligibility determinations shall be filed with the bureau within fourteen days of receipt of the bureau's determination.

(1) ~~"Successful return to work" as a result of an approved vocational rehabilitation plan means that the injured worker has obtained employment within sixty days of closure of the injured worker's approved vocational rehabilitation plan and the employment:~~

(a) ~~Is within the physical and/or psychiatric limitations caused by the impairments resulting from the allowed conditions in the claim in which the injured worker completed the vocational rehabilitation plan, as documented by the injured worker's physician of record; and~~

~~(b) Is reasonable in comparison with the return to work goals of the vocational rehabilitation plan completed by the injured worker.~~

~~(2) "Suitable employment" and comparably paying work shall have the same meaning as in rule 4125-1-01 of the Administrative Code.~~

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