

Executive Summary
Chapter 4123-3: Claims Procedures
Five-Year Rule Review

Introduction

Chapter 4123-3 of the Administrative Code contains BWC rules relating to claims procedures. Many of these rules are parallel to Industrial Commission rules in Chapter 4121-3 of the Administrative Code.

Five-Year Rule Review

Pursuant to R.C. 119.032, state agencies are required to review all agency rules every five years to determine whether to amend the rules, rescind the rules, or continue the rules without change. The statute requires the agency to assign a rule review date for each of its rules so that approximately one-fifth of the rules are scheduled for review during each calendar year. The rules of Chapter 4123-3 of the Administrative Code are scheduled for five year rule review on either November 1, 2013, or February 1, 2014. BWC last performed a five year rule review of these rules in 2008.

Background Law

The statutory authority for the rule provisions in Chapter 4123-3 are found in R.C. 4121.11, 4121.121, 4121.30, 4121.31, and 4123.05. Collectively, these statutes provide the general framework for the management of the BWC and the administration and processing of claims. Specifically, R.C. 4121.11 grants to BWC general rule making authority and provides that the “bureau of workers compensation may adopt its own rules of procedure and may change the same in its discretion.” However, where a Revised Code statute specifically addresses a claims issue, such as the time limit for a provider to file a medical fee bill, the BWC rule conforms to the statutory mandate.

Rule Changes

There are 26 rules in Chapter 4123-3 subject to the five-year rule review. BWC recommends retaining 8 rules without change, amending 16 rules, rescinding 2 rules, and adopting 1 new rule to replace an existing rule as summarized below and as indicated in more detail in the attached rules.

No Change Rules (8)

- 4123-3-01 Office locations; scope of rules.
- 4123-3-11 Reports of payments by self-insuring employers.
- 4123-3-17 Briefs.
- 4123-3-20 Additional awards by reason of violations of specific safety requirements.
- 4123-3-23 Limitations on the filing of fee bills.
- 4123-3-24 Fee controversies.
- 4123-3-31 Disabled workers' relief fund: claimant's payments.

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4123-3-37 Lump sum advancements.

Amended Rules (16)

4123-3-02 Forms.

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

4123-3-07 Applications for death benefits.

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

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

4123-3-10 Awards.

4123-3-15 Claim procedures subsequent to allowance.

4123-3-16 Motions.

4123-3-18 Appellate procedure.

4123-3-22 Inspection of claim files.

4123-3-25 Application for change of occupation allowance.

4123-3-29 Informing the claimant of the right to representation and status of the claim.

4123-3-32 Temporary total examinations.

4123-3-34 Settlement of state fund claims.

4123-3-35 Employer handicap reimbursement.

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

Rescinded Rules (2)

4123-3-14 Procedure in the original adjudication of noncomplying employers' claims.

4123-3-30 Procedures to inform claimant on request as to the status of his claim and of any action necessary to maintain the claim.

New Rules (1)

4123-3-14 Procedure in the original adjudication of noncomplying employers' claims.

4123-3-01 Office locations; scope of rules. (NO CHANGE)

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

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

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

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

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

Effective: 9/1/96

4123-3-02 Forms. (AMEND)

(A) Printed forms for all applications, reports, notices, proofs, etc., necessary for perfecting any claim before the bureau or commission will be furnished without charge by the bureau. Such forms may be obtained [online or](#) from any office of the bureau or commission.

(B) Each employer shall maintain a sufficient supply of forms as required by section 4123.07 of the Revised Code, and make the forms available to the employees who sustain industrial injuries or contract occupational diseases.

(C) ~~Such forms should be used in all claims and the information required thereon~~ [Any required form or equivalent](#) must be furnished ~~in~~ [with sufficient](#) detail to facilitate the prompt and accurate adjudication of the questions presented.

(D) Where reference is made to designated forms in these rules, such reference shall be to the form as it exists at the time of the adoption of these rules and as such form may be

revised, combined with other forms or deleted in the future.

(E) The bureau shall furnish to the public without charge printed forms for use in filing applications for benefits or compensation, or for submitting other necessary proof in any claim before the bureau and the industrial commission.

~~(F) Each office in charge of furnishing forms shall keep a record of requests to obtain forms to serve for statistical and control purposes.~~

Effective: 9/1/96

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

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

(B) Public employers and employers contributing to the private fund of the state insurance fund shall make such reports on the application for benefits ~~by completing the portion of the form designated for that purpose or on the appropriate form provided by the bureau of workers' compensation~~ or equivalent.

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

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

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

(F) Each employer shall give a copy of each report to the affected employee or the employee's surviving dependents as required by section 4123.28 of the Revised Code.

Effective: 10/4/04

4123-3-07 Applications for death benefits. (AMEND)

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

~~(A) The "First Report of Injury" form ("FROI-1") should be used for filing all applications for death benefits. This form should be used whether the employer is a public employer, a private employer contributing to the state insurance fund, an amenable but noncomplying employer, or a self-insuring employer~~

~~(B) In the event of disagreement between the applicant(s) and the self-insuring employer on the question of compensability of the death benefits, the procedure provided in rule 4121-3-13 of the Administrative Code shall be followed.~~

Effective: 10/4/04

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

(A) Preparation and execution of forms.

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

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

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

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

~~(5) If the employee is unable to sign the FROI-1 because the employee is in the armed services of the United States, the bureau shall process the claim in the regular manner under section 4123.511 of the Revised Code.~~

~~(6)~~(5) It shall be the duty of every employer to assist injured or disabled employees in the preparation and submission of reports for compensation and/or benefits. In the event that the employer refuses, neglects or unduly delays the completion of a report, the report may be filed without the part pertaining to the employer having been completed. The fact of refusal or neglect should be noted upon the report or with it by way of separate letter.

~~(7)~~(6) In cases where the death of the employee is not the result of injury or occupational disease, ~~the~~ an application for accrued compensation may be made as provided in sections 4123.57 and 4123.60 of the Revised Code.

~~(8)~~(7) Application for payment of the balance of percentage permanent partial disability compensation, awarded under division (A) of section 4123.57 of the Revised Code prior to the employee's death, shall be made by the injured employee's dependents. The application may be filed whether the death was related or unrelated to an industrial injury or occupational disease.

(B) Certification by the employer.

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

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

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

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

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

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

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

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

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

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

(2) In self-insuring employers' claims, the two-year time limitation is tolled if the

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

(a) A hospital bill;

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

(c) An orthopedic or prosthetic device.

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

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

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

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

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

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

the injurious exposure must be after October 12, 1945.

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

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

(f) The above provisions govern berylliosis and radiation claims except that payment of compensation is not restricted to temporary total, permanent total disability and/or death, and that exposure in this state is not required for radiation claims. In radiation claims, where disability began prior to November 2, 1959, the general occupational disease provisions apply.

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

(6) Death claims, alleging that death is the result of injury, must be filed within two years of death or be forever barred, except as provided in paragraphs (D)(8) and (D)(9) of this rule.

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

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

(9) Public works relief employees' claims must be filed within two years after the date when injured or the date of death, or be forever barred.

(10) Militia claims, special contract claims and apprentice claims are governed by the general time limits applicable to injury and occupational disease claims, as provided by

sections 4123.84 and 4123.85 of the Revised Code.

Effective: 11/5/09

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

(A) Numbering and recording.

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

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

(B) Initial review and processing of new claims.

Immediately after numbering and recording, all new claim applications, except applications of employees of self-insuring employers, shall be reviewed and processed by the ~~bureau's claims specialists on the question of compensability~~ [bureau](#).

"Processing on the question of compensability" means making a determination on the validity of the industrial claim.

(1) ~~Noneontested~~ [Uncontested](#) or undisputed claims.

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

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

(b) In the processing of initial applications in state fund claims, requesting payment of compensation in addition to medical benefits, the claims specialist may approve temporary total disability compensation over a period not to exceed four weeks, without medical proof in the record, provided that the application has been properly completed and signed, certified by the employer and was otherwise noncontroversial. If medical

proof was submitted with the initial application, the above limitation shall not apply. Upon approval of the claim the claimant shall be notified in writing that his or her attending physician's report will be necessary for consideration of any additional payment of compensation and an appropriate form shall be enclosed, with the necessary instructions, for the claimant's convenience.

~~(e) Immediately after the initial processing and execution of orders, claims shall be referred to the proper location for housing, as provided in division (B)(11) of section 4121.121 of the Revised Code.~~

(2) Contested or disputed claims.

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

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

(3) Applications for death benefits.

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

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

(C) Proof.

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

"Probative" means having a tendency to prove or establish.

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

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

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

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

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

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

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

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

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

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

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

(a) Such an examination, if requested, shall be in lieu of any rights under paragraph (C)(5)(b) of this rule and in no event will the claimant be examined on the same issue by a physician of the employer's choice more than one time. The exercise of this examination right shall not be allowed to delay the timely payment of benefits or scheduled hearings. Requests for further examinations will be made to the bureau or commission following the provisions of paragraph (C)(5)(b) of this rule. The cost of any examination initiated by the employer shall be paid by the employer including any fee

required by the doctor, and the payment of all of the claimant's traveling and meal expenses, in a manner and at the rates as established by the bureau from time to time. If employed, the claimant will also be compensated for any loss of wages arising from the scheduling of an examination.

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

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

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

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

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

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

If, upon a review of the claim file the bureau is of the opinion that the request should be denied for the reason that the claimant has been recently examined by a doctor of the employer's choice, or for any other reason indicating that further examination would not be pertinent to the defense of the claim, based on the facts and circumstances of each particular case, the matter shall be referred, forthwith, to the appropriate district hearing officer for further consideration. In cases of temporary total disability, a medical

examination performed within the past thirty days shall be regarded as "recent." If the question involves additional allowance of claim for an additional condition allegedly causally related to the allowed injury or occupational disease, a medical examination performed within the past sixty to ninety days may be regarded as "recent," depending on the nature and type of the condition and/or disability.

(e) All reasonable expenses incurred by the claimant in submitting to such examination, including any travel expense that the claimant may properly incur, shall be paid by the employer immediately upon receipt of the billing.

Payment for traveling expenses shall not require an order of the bureau or commission, unless there is a dispute. The employer shall provide the claimant with a proper form to be completed by the claimant for reimbursement for traveling expenses. In addition, if the request for such examination is filed on or after January 1, 1979, and the claimant sustains lost wages as a result of such examination, the employer shall reimburse the claimant for such lost wages within three weeks from the date of examination. Expenses incurred by the claimant and wages lost by reason of attending such examination are not to be paid in the claim.

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

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

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

(D) Hearings and orders ~~issued pursuant thereto~~.

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

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

~~(3) Upon the request of the industrial commission, the bureau shall assist the district hearing officers in administrative matters preliminary to formal (public) hearings, such as: the setting and publication of dockets, preparation and mailing notices of hearing, assistance in handling requests for continuance of hearing, etc. In addition, the bureau shall make available to each district hearing officer the facilities and assistance of bureau employees, as needed. In all such matters the bureau shall follow the procedural rules of the industrial commission.~~

~~(4) If prior to or after a formal hearing it is apparent that additional information is necessary for proper adjudication of a claim, the bureau shall be responsible for securing the necessary information.~~

~~(5) The administrator of the bureau of workers' compensation, or his or her designee, shall be given a reasonable advance notice of all formal hearings affecting the state insurance fund and/or the surplus fund. Such notice shall be in writing, sent by inter-office mail. In emergency hearings such notice may be by telephone in addition to inter-office mail. Time limits applicable to advance notification of other parties under the rules of the commission shall apply herein.~~

~~(6)~~⁽³⁾ The administrator or his or her designee may appear at such hearings to represent the interest of the state insurance fund and/or the surplus fund.

~~(7)~~⁽⁴⁾ The bureau shall make payment on orders of the commission, and district or staff hearing officers in accordance with law and rules of the bureau and the industrial commission.

~~(8)~~⁽⁵⁾ If the administrator or his or her designee is of the opinion that an emergency exists which requires an immediate hearing of a claim, he or she may request an emergency hearing. "Emergency," as used herein, means a sudden, generally unexpected occurrence or set of circumstances demanding immediate action.

Such request shall be made in accordance with the rule of the industrial commission on emergency hearings ~~(,as defined in~~ rule 4121-3-30 of the Administrative Code~~).~~

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

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

pending before the bureau.

~~(1) If the bureau or the parties believe that clarification of issues will facilitate the processing of the claim, the claimant, employer, and/or their duly authorized representatives (see rule 4123-3-22 of the Administrative Code) shall be given an opportunity to be heard by the bureau (service office director, section director or their designee) on questions pertaining to the claim pending before the bureau.~~

~~(2) The parties may appear before the bureau together, at the same time, or separately, at different times, as circumstances may require; they may choose to be or not to be represented; a duly authorized representative may appear on behalf of a party, without the party being present.~~

~~(3) Evidence may be submitted in writing or offered orally. Oral statements shall be reduced to writing by the bureau's authorized personnel.~~

~~(4) The new evidence shall be made a part of the claim file to be considered by the bureau when the determination is made on the issue pending before the bureau.~~

Effective: 11/5/09

4123-3-10 Awards. (AMEND)

(A) Compensation check issuance, delivery and endorsement.

(1) Definition of claimant.

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

(2) Time limit for issuance.

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

(b) The initial payment of the bureau in payment of compensation under an order shall be issued within the time limits set forth in division (H) of section 4123.511 of the Revised Code. The payment will include compensation accrued and due the claimant at that time. Further payment of compensation due under that order shall be made by the bureau in

biweekly installments. In self-insuring employers' claims payment will be made in accordance with ~~the law~~ [applicable laws](#) and ~~the rules of the bureau~~.

(3) To whom paid.

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

~~(b) In cases of lump sum advancements, claimant's creditors may be co-payees.~~

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

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

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

~~(4) Information to accompany payment.~~

~~All payments for compensation shall be accompanied by information which clearly indicates the source of payment, type of payment, method of computation, inclusive days of payment, the reason for any changes in payment and the telephone number or address for inquiries concerning the payment that was made.~~

~~(5)~~(4) Delivery of the bureau's payment to claimant and exceptions.

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

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

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

order approving such advancements.

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

~~(6)~~(5) Personal pick-up of the bureau's checks by a claimant and/or by parties other than a claimant.

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

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

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

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

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

~~(7)~~(6) Endorsement of checks and procedure in the event of claimant's death.

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

(b) When a claimant dies prior to endorsing a compensation check or accessing an electronic benefit payment, no one has the right to endorse and cash such check or access the electronic benefit funds. In order to ensure that the bureau or commission effectively obtains notice of death of a claimant, each check payable to a claimant shall bear on the reverse side, immediately above the point specified for endorsement, a printed certification to the effect that the signer or endorser certifies that he or she is the person to whom the check is payable and that the signature is his or her signature.

(c) Checks that cannot be endorsed because the claimant is deceased must be returned to the bureau's benefits payable section, ~~PO box 15429, Columbus, Ohio 43215-0429~~ [at the address designated by the administrator](#), by the party handling the claimant's affairs, notifying the bureau of the date of death, if known. Upon receipt of information of claimant's death, payment of compensation shall be terminated and proper entry made in the records of the bureau.

~~(8)(7)~~ Procedure for a lump sum payment and attorney fees where the claimant is an obligor for child support payments.

(a) If a claimant is entitled to a lump sum payment of one hundred and fifty dollars or greater and the claimant is an obligor for child support payments, prior to issuing the lump sum payment, the bureau shall notify the claimant and the claimant's attorney in writing that the claimant is subject to a support order. The bureau shall hold the lump sum payment for thirty days, pending application by the attorney for attorney fees as provided in paragraph ~~(A)(8)(b)~~ [\(A\)\(7\)\(b\)](#) of this rule.

(b) The bureau shall instruct the claimant's attorney in writing to file a copy of the fee agreement signed by the claimant, along with an affidavit signed by the attorney setting forth the amount of the attorney's fee with respect to that lump sum payment award to the claimant and the amount of all necessary expenses, along with documentation of those expenses, incurred by the attorney with respect to obtaining that lump sum award. The attorney shall file the fee agreement and affidavit with the bureau within thirty days after the date the bureau sends the notice under paragraph ~~(A)(8)(a)~~ [\(A\)\(7\)\(a\)](#) of this rule.

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

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

(iii) The attorney fee shall be limited to the fee for obtaining the specific lump sum payment that is the subject of the bureau notice provided in paragraph ~~(A)(8)(a)~~ [\(A\)\(7\)\(a\)](#)

of this rule. The attorney fee shall be limited to the written fee agreement of the initial lump sum payment of the award. The bureau will reject a fee application that includes fees from awards other than the subject lump sum payment or that request a fee from future payments of the award after the lump sum payment.

(iv) If the attorney claims reimbursement for expenses in the affidavit, the expenses shall be limited to the expenses for obtaining the specific lump sum payment that is the subject of the bureau notice provided in paragraph ~~(A)(8)(a)~~ [\(A\)\(7\)\(a\)](#) of this rule. The attorney shall provide itemized expenses and documentation to support the expenses. If the attorney fails to provide the required information on expenses, the bureau may reject that portion of the fee application, but shall process the attorney fee portion of the application.

(v) Where the bureau has paid the attorney fee under paragraph ~~(A)(8)(e)~~ [\(A\)\(7\)\(c\)](#) of this rule, the bureau will not honor ~~a power of attorney~~ [an authorization to receive workers' compensation payment or equivalent](#) for that award under paragraph ~~(A)(6)~~ [\(A\)\(5\)](#) of this rule, except in cases of court settlement of the workers' compensation claim.

(vi) Before rejecting an attorney fee affidavit or fee agreement due to noncompliance with any part of this rule, the bureau shall notify the attorney of the noncompliance and provide the attorney an opportunity to submit additional information during the thirty day hold period provided in paragraph ~~(A)(8)(a)~~ [\(A\)\(7\)\(a\)](#) of this rule.

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

(d) After deducting any attorney's fee and necessary expenses, if the lump sum payment is one hundred fifty dollars or more, the bureau shall hold the balance of the lump sum award in accordance with division ~~(A)(10)~~ [\(A\)\(11\)](#) of section 3121.037 of the Revised Code.

(B) Medical awards.

Medical awards shall be paid by the bureau within the time limits set forth in rule ~~4123-6-12~~ [4123-6-42](#) of the Administrative Code.

(C) Rules for self-insuring employers.

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

(1) It is the duty of the employer to pay, in accordance with the act, the amount of

compensation due a claimant whose injury or occupational disease has resulted in more than seven days lost time. Payment to be made in the manner provided by law and the rules of the bureau.

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

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

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

(5) Self-insuring employers shall follow the procedures in paragraph ~~(A)(8)~~ (A)(7) of this rule relating to a lump sum payment and attorney fees where the claimant is an obligor for child support payments.

(D) Electronic payment of compensation and benefits.

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

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

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

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

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

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

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

issue to the payee an electronic benefits card.

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

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

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

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

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

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

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

Effective: 2/15/08

4123-3-11 Reports of payments by self-insuring employers. (NO CHANGE)

(A) During the continuance of temporary total disability, temporary partial disability, or wage loss compensation caused by an injury or occupational disease, the employer shall, at the request of the bureau of workers' compensation or the industrial commission at any time or at the request of the claimant or claimant's representative where the issue of

compensation is pending in a workers' compensation hearing or adjudication matter, file a report of compensation payments with the bureau showing the amount and type of compensation paid to such employee during the preceding period. The report shall indicate the date when the first installment of the type of compensation reported was paid.

(B) In the event an injury or occupational disease results in a disability compensable under division (A) or (B) of section 4123.57 of the Revised Code, and an agreement has been entered into between the employee and the employer as to the compensation to be paid for such permanent partial disability, the agreement shall state when the first installment of such compensation is to be paid. Such agreement shall be signed by the employee and employer and shall be filed with the bureau as soon as it has been completed. Such agreement shall be accompanied by a report from the attending physician which shall indicate the extent of the permanent partial disability sustained.

(C) In cases of compensable death claims, where the employer and the dependents or legal representatives of a deceased employee agree that the death is compensable, and there being no question of apportionment of death benefits, they enter into an agreement in writing as to the benefits which are to be paid; such agreement shall be reported by the employer. It shall indicate the date of the first installment of payment, the weekly rate of death benefits, the period of time over which such benefits will be paid (lifetime or specific dates) and the total amount of benefits in cases where it is known. Such agreement shall be signed by the employer and the dependent, dependents, or legal representatives and shall be filed with the bureau within one month of the date of execution of the agreement. Such agreement shall include provision for the payment of appropriate funeral, medical, hospital and other expenses. Subsequent reports of the payment of death benefits shall be filed with the bureau at the request of the bureau or the commission at any time or at the request of the claimant or claimant's representative where the issue of compensation is pending in a workers' compensation hearing or adjudication matter. Should there be a change in death benefits as a result of changes in the dependency status of the recipients, employer's reports shall reflect same.

In cases of compensable death claims, where the employer and the dependents or legal representatives of a deceased employee agree that the death is compensable but where there is a question of apportionment, the self-insuring employer may choose to pay death benefits before a hearing at the industrial commission. The first such payment should indicate to the beneficiaries that because there is a question of apportionment among the surviving spouse, dependent children, or other dependents, the commission must issue an order apportioning the payment; therefore, payments until such order issues are subject to an adjustment in accordance with the apportionment ordered by the commission among the beneficiaries at such time as the apportionment order issues.→

In other death claims approved for payment by the industrial commission or its hearing officers, the employer shall report payments in the same general manner as indicated above.

(D) In all claims, the self-insuring employer shall, upon completion of the payment of

compensation and benefits, report that fact to the bureau at the request of the bureau or the commission at any time or at the request of the claimant or claimant's representative where the issue of compensation is pending in a workers' compensation hearing or adjudication matter indicating the dates of the payment of the first and last installments of compensation, and the total amount of each type paid, together with the total amounts expended for benefits other than compensation according to type of benefit.

(1) Such report shall be signed by the employer and the employee or his or her dependents or their legal representatives as the circumstances may require.

(2) Upon receipt of such report by the bureau, it shall be examined to determine whether or not the payments made have been in conformity with the provisions of the workers' compensation law. If it is found that the reported payments do conform to the provisions of the workers' compensation law, the same shall be approved by the bureau and the employer shall be advised thereof. If it is found that the reported payments do not conform, the bureau shall notify the employer of that fact indicating the further payments that are to be made. The employer shall make such payments and file a revised report with the bureau.

(3) If, for any reason, it is impossible for the employer to promptly file a report of payments or an agreement as to compensation paid or to be paid, the employer shall immediately report that fact and the reason to the bureau. Failure to do so shall be sufficient reason for the administrator to take such action as may be indicated.

(E) Where compensation has been ordered paid or where the employee and employer have agreed upon the compensation to be paid, request to the bureau may be made by either the employer the employee, other employee's dependents for authorization to pay all or part of the unpaid balance of the award in one or more lump sum payments.

(F) Whenever a self-insured employer that is a professional sports franchise domiciled in Ohio makes payment pursuant to the terms of a contract of hire or a collective bargaining agreement during a period of disability resulting from the injury or occupational disease, the self-insurer shall report such payments on the same basis as required in paragraph (A) of this rule. The total amount of such payments, the period of disability for which those payments were made, and the amount such payments exceed the compensation that was due for that period shall be reported. The amount such payments exceed the compensation payable or, in the event no compensation was payable, the total amounts of such payments, shall be considered advanced payments and shall be applied to offset future payments of compensation for disability under sections 4123.56 to 4123.58 of the Revised Code. The self-insurer shall report these offsets on the same basis as required in paragraph (A) of this rule. Offsets shall be made only in cases where the employee's application for compensation is pending on or after August 22, 1986.

Effective: 10/4/04

4123-3-14 Procedure in the original adjudication of noncomplying employers' claims. (RESCIND)

~~(A) Immediately after the claim has been numbered and recorded by the bureau, the bureau shall prepare and, by certified mail, file for record in the office of the county recorder in the counties where the employer's property is located, if known, or in the county (or counties) where the employer's business is located, an affidavit showing the date on which the application for compensation and/or benefits was filed, the name and address of the employer against whom it was filed, and the fact that said employer has not complied with section 4123.35 of the Revised Code. A copy of the application for compensation and/or benefits shall be filed with the affidavit. The affidavit shall constitute a lien on employer's real property and tangible personal property within the county where it was filed.~~

~~(B) The bureau shall notify the employer, within the shortest time possible, of the filing of the application, which notice shall be mailed by certified mail. Such notice shall be accompanied by a copy of the application and a copy of the bureau's affidavit, as described in paragraph (A) of this rule, and shall advise the employer that unless the employer files an answer to the application within fourteen days after the receipt of the notice, except if otherwise required by the rules of the bureau, the claim shall be adjudicated upon the application that has been filed.~~

~~(C) The answer of the employer shall be verified by the employer, or the employer's agent or attorney. Upon the filing of such answer the bureau shall immediately mail a copy of the answer to the employee. If the employee is represented, a copy shall be mailed to the representative.~~

~~(D) Except as herein provided, the adjudication of such applications shall be in conformity to rule 4123-3-09 of the Administrative Code.~~

~~(E) The lien on employer's property, as described in paragraph (A) of this rule, shall be cancelled under the following circumstances:~~

~~(1) The employer has paid the amount of all awards made by the bureau and/or the industrial commission.~~

~~(2) There was a final order of disallowance of claim or claims.~~

~~(3) The bureau, industrial commission, or a court has determined that the employer subject to the lien is not the employer of record in the claim.~~

~~(4) The employer has filed a bond in such amount and with such surety as the bureau approves, conditioned on the employer's payment of all awards made by the bureau and/or the industrial commission. The bureau may, in discretion, grant a partial release of the lien, should this be necessary to facilitate the conduct of the employer's business, provided a sufficient security remains to pay any award that may be made in the claim or~~

~~claims.~~

~~(F) In all cases of employer's failure to pay the awards granted, payment of such awards from the surplus fund and the recovery of the monies so paid by the bureau shall be in accordance with section 4123.75 of the Revised Code.~~

Effective: 10/4/04

4123-3-14 Procedure in the original adjudication of non-complying employers' claims. (NEW)

Where the bureau originally adjudicates a claim and determines that the employer is a non-complying employer, the bureau shall note the employer's non-complying employer status in the claim and the bureau order. The bureau shall notify the employer of the filing of the application and the employer's noncompliance, and shall proceed to secure the employer's obligation to reimburse the bureau for any cost of the claim as provided in rule 4123-14-04 of the Administrative Code.

4123-3-15 Claim procedures subsequent to allowance. (AMEND)

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

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

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

(b) Where the employee seeks to have the bureau or commission grant a new award of compensation or to settle the claim; or

(c) Where the claimant seeks to secure the allowance of a disability or condition not previously considered; or

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

(e) Except for a medical issue relating to a prosthetic device or durable medical equipment as designated by the administrator, the bureau, in consultation with the MCO assigned to the claim, shall issue an order on a medical treatment reimbursement request

in a claim which has not had activity or a request for further action within a period of time in excess of twenty-four months as follows:

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

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

(2) Requests which require proof shall conform to the standards required by paragraph (C) of rule 4123-3-09 of the Administrative Code and rules [4123-5-18](#) and [4123-6-20](#) ~~and [4123-7-08](#)~~ of the Administrative Code.

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

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

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

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

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

(6) Such requests shall be determined with or without formal (public) hearing as the circumstances presented require. If the request is within the jurisdiction of the bureau and

the matter is not contested or disputed, the bureau shall adjudicate the request in the usual manner. In all other cases, the request shall be acted upon by the industrial commission's hearing officer or as otherwise required by the rules of the commission, depending on the subject matter.

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

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

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

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

(3) Each applicant for a determination of the percentage of permanent partial disability shall be scheduled for an examination by a physician designated by the bureau, and the examining physician shall file a report of such examination, together with an evaluation of the degree of impairment as a part of the claim file. The bureau shall send a copy of the report of the medical examination to the employee, the employer, and their representatives.

(4) Upon receipt of the examining physician's report, the bureau shall review the medical

evidence in the employee's claim file and shall make a tentative order as the evidence at the time of the making of the order warrants. If the bureau determines that there is a conflict of evidence, the application, along with the claimant's file, shall be forwarded to the industrial commission to set the application for hearing before a district hearing officer.

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

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

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

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

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

tentative order shall go into effect. In no event shall there be a reconsideration of a tentative order issued under this division. If an objection is timely made, the matter shall be referred to a district hearing officer who shall set the application for a hearing in accordance with the rules of the industrial commission. The employer may obtain a medical examination of the employee and submit a defense medical report at any stage of the proceedings up to a hearing before a district officer.

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

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

(1) The bureau or self-insuring employer will determine the payment of ~~permanent partial disability pursuant to division (B) of section 4123.57 of the Revised Code~~ [scheduled loss](#) for a loss by amputation or for a loss of use ~~upon information in the claim file, such as on the first report of injury, or~~ upon the motion of a party for such award. To determine the payment of the award, the bureau or self-insuring employer may review the medical evidence in the file, may request additional medical information from the parties, or may refer the injured worker for an examination by a physician designated by the bureau or self-insuring employer.

(2) The bureau shall enter an order on or the self-insuring employer shall make a decision on the payment of ~~permanent partial disability pursuant to division (B) of section 4123.57 of the Revised Code~~ [scheduled loss](#) for a loss by amputation or for a loss of use and shall notify the employee, the employer, and their representatives, in writing, of the order or decision. The parties have a right to appeal the order or contest the decision pursuant to section 4123.511 of the Revised Code.

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

(4) Where ~~an award under division (B) of section 4123.57 of the Revised Code~~ [a scheduled loss award](#) has been ordered but not paid prior to the death of an employee, upon application, the award is payable to the surviving spouse, or if there is no surviving spouse, to the dependent children of the employee, and if there are no such children surviving, then to such other dependents as the bureau may determine.

Effective: 7/11/13

4123-3-16 Motions. (AMEND)

- (A) Form C-86 motion shall be used to request action from the bureau or commission.
- (B) A motion may be submitted by the employee or the employer to seek a determination by the bureau or the commission on any matter not otherwise provided for in this chapter. It is appropriate to file a motion in order to secure allowance of a disability or condition not previously considered in a claim. A motion shall not be used as a substitute for an untimely appeal.
- (C) A motion shall fully set forth the question presented together with a succinct statement of the action or relief sought.
- (D) A motion shall be accompanied by substantial competent proof conforming to the standards established in paragraph (C) of rule 4123-3-09 of the Administrative Code.
- (E) Where required, a motion shall contain citations to the legal authorities relied upon.
- (F) Except in matters not affecting the rights of the opposite party, the applicant filing a motion shall mail a copy of the motion to the opposite party and the copy of the motion filed with the bureau board or the commission shall indicate that a copy has been so mailed. When in doubt, the applicant shall mail a copy of the motion to the opposite party.
- (G) A motion shall bear the signature of the applicant or the applicant's authorized representative.
- (H) Failure to comply with the provisions of this rule shall be sufficient reason for the dismissal of the motion.
- (I) Motions shall be adjudicated in the same manner as provided in paragraph (A)(7) of rule 4123-3-15 of the Administrative Code, except motions for allowance of a psychiatric disability (paragraph (J) of this rule).
- (J) Procedure governing motions for allowance of a psychiatric disability:
- (1) A motion requesting that a claim be additionally recognized for a psychiatric condition shall include a typed or printed statement, personally signed and dated by the claimant, setting forth the following declaration: "I am aware that this motion is being filed to request that the bureau or commission recognize my emotional problem, nervous condition, or psychiatric disability as being a result of the injury for which this claim is allowed."
 - (2) A motion requesting the recognition of an additional condition of a psychiatric nature

shall be accompanied by supporting evidence consisting of a report by a licensed psychiatric specialist, a clinical psychologist, a licensed [professional](#) clinical counselor (LPCC), or a licensed independent social worker (LISW).

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

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

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

Effective Date: 2/10/09

4123-3-17 Briefs. (NO CHANGE)

(A) Parties may, of their own volition, file briefs with the bureau or commission on legal questions presented in claims.

(B) The bureau or commission may require parties to file briefs on legal questions presented in claims. A time certain shall be fixed for the filing of such briefs allowing a reasonable time for preparation.

(C) In either instance, the submitted briefs shall be legibly typewritten on paper not exceeding eight and one-half inches by eleven inches in size and filed without a protective cover. The party filing a brief shall furnish a copy to the opposite party at the time that the brief is filed with the bureau or the commission. If the brief is directed to a matter before the bureau, the brief shall be filed with the bureau. If the brief is directed to the attention of the commission, the brief shall be filed with the commission unless otherwise directed by the commission.

Effective: 2/10/09

4123-3-18 Appellate procedure. (AMEND)

(A) Administrative appeals.

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

surplus fund.

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

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

(4) ~~Appeal (also called "Notice of Appeal") should be made on form IC-12 formerly I-12, or as provided by rules of the industrial commission. "Notice of Appeal" shall state the names of the claimant and the employer, the number of the claim, the date of the decision appealed from and the fact that the appellant appeals therefrom~~ Appeals shall be filed in accordance with rule 4121-3-18 of the Administrative Code.

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

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

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

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

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

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

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

employers' claims, payment shall be made in accordance with ~~rules of the industrial commission~~ applicable laws and rules.

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

(B) Appeals to court.

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

(2) "Notice of Appeal" stating the names of the claimant and the employer, the number of the claim, the date of the decision appealed from and the fact that the appellant appeals from such order must be filed with the industrial commission and with the court of common pleas within sixty days after the date of the receipt of the decision appealed from or the date of receipt of the order of the commission refusing to permit ~~an~~ further appeal ~~from a regional board of review~~.

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

Effective: 2/10/09

4123-3-20 Additional awards by reason of violations of specific safety requirements. (NO CHANGE)

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

Effective: 10/4/04

4123-3-22 Inspection of claim files. (AMEND)

(A) Authorizations for representation shall be in writing and signed by the authorizing party. When the authorization is on behalf of the employee, it shall be filed on an "Authorization of Representation of Injured Worker" form or equivalent. There shall be a separate authorization filed with the bureau for each claim to which the authorization is to extend. ~~The authorization card shall remain with the application for benefits until a claim file is established, at which time the authorization shall be made a part of the claim file.~~ When the authorization is on behalf of the employer, a blanket authorization may be filed with the ~~claims section in Columbus and with the local district and/or branch office~~ bureau.

~~(B) Authorizations on behalf of the employee shall not be accepted for filing when they do not bear the claim number unless the following identifying information is furnished:~~

~~(1) A specific year of injury;~~

~~(2) Name and address of employer at time of injury;~~

~~(3) date of birth;~~

~~(4) City or community where accident occurred;~~

~~(5) Nature of disability.~~

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

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

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

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

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

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

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

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

~~(E) A person entitled to inspect a claim file shall complete and file a "Request to Inspect Claim File" form at the time of each inspection. Such request shall bear the signature of the person inspecting the claim file and shall be incorporated in the claim file when the inspection is completed.~~

~~(F) When a party desires to inspect a claim at a point other than that where the claim is located, the claim file will be forwarded to that point. If such request is made by an authorized representative, the representative shall be required to pay the amount of the postal charges involved. Claims which are forwarded to another point for inspection shall be held at that point for seven days following notification of the party or the party's representative that the claim is available for inspection.~~

~~(G) Requests for inspection shall not be honored when an inspection would constitute a material interference with the processing of the claim, such as the necessity to cancel a scheduled medical examination of the claimant, a scheduled public hearing, etc.~~

~~(H) Request for inspection shall not be honored where the request is made by a person representing a claimant unless such person is an attorney at law, authorized to practice in the state of Ohio, or unless such person certifies on the authorization that he or she is not receiving a fee for his or her participation in the claim.~~

~~(I) Representatives of the parties may have copies of any material in the claim file, provided that copying costs are paid.~~

Effective: 2/10/09

4123-3-23 Limitations on the filing of fee bills. (NO CHANGE)

(A) Except as otherwise provided in this rule, fee bills for medical or vocational rehabilitation services rendered in a claim shall be submitted to the bureau or commission

for payment within one year of the date on which the service was rendered or one year after the date the services became payable under division (I) of section 4123.511 of the Revised Code, whichever is later, or shall be forever barred.

(B) A self-insuring employer may, but is not required to, negotiate with a provider to accept fee bills from the provider for a time period other than as set forth in paragraph (A) of this rule.

(C) Paragraph (A) of this rule shall not apply to the following; however, division (A) of section 4123.52 of the Revised Code shall still apply:

(1) Requests made by the centers for medicare and medicaid services in the United States department of health and human services for reimbursement of conditional payments made pursuant to section 1395y(b)(2) of title 42, United States Code (commonly known as the "Medicare Secondary Payer Act");

(2) Fee bills submitted outside the timeframe set forth in paragraph (A) of this rule due to administrative error by the MCO or the bureau;

(3) Fee bills submitted outside the timeframe set forth in paragraph (A) of this rule because the fee bills were initially submitted to a patient, different third-party payer, or state or federal program that reimburses for medical or vocational rehabilitation services and that patient, payer, or program has determined that it is not responsible for the cost of the services.

(D) Requests for additional payment on fee bills that were initially timely submitted under this rule shall be submitted within one year and seven days of the adjudication of the initial fee bill by the bureau or shall be forever barred.

(E) Paragraphs (A) to (C) of this rule shall apply to bills with dates of service on or after July 29, 2011. Paragraph (D) of this rule shall apply to bills with dates of service on or after September 12, 2011.

Effective: 9/12/11

4123-3-24 Fee controversies. (NO CHANGE)

When a controversy exists between a party and the party's representative concerning fees for services rendered in industrial claims, either the party or the representative may make a written request to the commission to resolve the dispute. Such request must be completed and filed in accordance with the rules of the industrial commission, the matter being within the exclusive jurisdiction of the industrial commission. Any such request, if filed with the bureau, shall be referred, forthwith, to the industrial commission for further consideration.

Effective: 2/10/09

4123-3-25 Application for change of occupation allowance. (AMEND)

(A) Eligibility for a change of occupation allowance:

(1) Where it is found that a change of occupation is medically advisable for an employee suffering from silicosis, coal miners' pneumoconiosis, or asbestosis contracted in the course of employment, but the employee is not totally disabled therefrom, and any other diseases which may be specified by law for which the statutory allowance for change of occupation may be granted, or

(2) Where it is found that a change of occupation is medically advisable for a fire fighter or police officer suffering from a cardiovascular and pulmonary disease contracted in the course of employment, but the employee is not totally disabled therefrom,

(3) Pursuant to the provisions of section 4123.57 of the Revised Code, such employee shall file a motion in accordance with paragraph (A) of rule 4123-3-16 of the Administrative Code requesting the approval of the statutory allowance for such change of occupation, in order to decrease substantially further injurious exposure.

(B) This rule is applicable to public employees, employees of employers contributing to the private fund, employees of self-insuring employers, and employees of amenable but non-complying employers.

(C) If there is no conflict in the medical or the matter is not contested or disputed, the bureau shall adjudicate the request. If a conflict in the medical exists or the request is contested or disputed, the bureau shall refer the request to the commission for further consideration.

(D) To qualify for an award, the employee must establish by appropriate evidence that the employee has discontinued employment or has changed his or her occupation to one in which the exposure is substantially decreased. The fact that the employee continues employment with the same employer will not preclude the granting of the award so long as the employment subsequent to the change is such that the exposure is substantially decreased and the change of occupation is certified by the claimant as permanent.

(E) An award for change of occupation in excess of the initial thirty weeks must be supported by evidence of ~~reasonable attempts to secure employment. Reasonable attempts means such action taken to accomplish the purpose as may be customary, appropriate, rational, and suitable to the circumstances and which would carry the purpose into effect but for the intervention of factors independent of the will of the party~~ employment in an occupation in which the exposure is substantially decreased or evidence of reasonable attempts to secure employment in an occupation in which the

[exposure is substantially decreased.](#)

Effective Date: 2/10/09

4123-3-29 Informing the claimant of the right to representation and status of the claim. (AMEND)

(A) Whether a claimant is or is not represented in an industrial claim is a matter of the claimant's free choice. No employee of the bureau or of a self-insuring employer shall directly or indirectly convey any information in derogation of this right.

(B) Upon receipt of a claim the bureau shall notify the claimant and the employer of the number assigned to the claim. Also, the claimant shall be informed of his or her right to representation or to elect no representation in the processing of the claim. It shall be the responsibility of the bureau to aid and assist a claimant in the filing of a claim as provided in division (A) of section ~~4123.512~~ [4123.511](#) of the Revised Code.

[\(C\) Upon request, the bureau shall inform the claimant of the status of the claim and of any action necessary to maintain the claim.](#)

Effective: 2/10/09

~~4123-3-30 Procedures to inform claimant on request as to the status of his claim and of any action necessary to maintain the claim.~~ (RESCIND)

~~(A) Request made by letter.~~

~~When a claimant by letter requests information as to the status of his or her claim, it shall be the responsibility of the section or service office manager, where the claim is located at the time of receipt of letter, to have such inquiry answered within five working days from the date of its receipt in the section or office. The reply letter shall advise the claimant of the status of the claim and of any action necessary to maintain the claim. Should filing of a supplemental application, statement or affidavit be indicated, appropriate forms will accompany the reply. In case the claim was transferred to another location prior to the actual receipt of claimant's letter in the section or office to which it was mailed by the claimant or to which it was forwarded, the reply letter shall notify the claimant within five working days of the current location of the claim and of the fact that the claimant's inquiry was referred to such location for reply. It shall be the duty of the section or service office manager to which the claimant's letter was referred for reply to answer it within five working days from the receipt and to furnish a copy of the reply letter to the forwarding office to facilitate the follow-up.~~

~~(B) Request made by telephone.~~

~~The public inquiries employee of the section or office receiving a telephone call from a claimant regarding the status of the claim shall inform the claimant of the location of the claim file. The claimant shall have an option either to appear in the office where the claim is located for a review of the claim, or to have said office immediately notify the claimant in writing of the status of the claim.~~

~~Effective: _____ 2/10/09~~

**4123-3-31 Disabled workers' relief fund: claimant's payments.
(NO CHANGE)**

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

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

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

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

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

Effective: 2/10/09

4123-3-32 Temporary total examinations. (AMEND)

(A) Pursuant to the provisions of section 4123.53 of the Revised Code, the bureau of workers' compensation shall schedule an examination to determine the employee's continued entitlement to temporary total disability compensation, the employee's rehabilitation potential, and the appropriateness of the employee's medical treatment. The examination shall be conducted not later than thirty days following the end of the initial ninety-day period of temporary total disability compensation.

(B) An employer of an employee scheduled for an examination by the bureau under section 4123.53 of the Revised Code may waive the bureau's scheduling of any such examination. The waiver shall be submitted in writing to the bureau. The employer shall indicate whether the waiver is temporary or permanent, the reason for the waiver, and, if applicable, a recommended subsequent date upon which the employee should be reevaluated for scheduling the examination if the employee is receiving temporary total disability compensation. The waiver shall be dated and shall indicate the name and title of the person waiving the examination for the employer. Upon reviewing a claim file where a waiver has not been received, the bureau may recommend to the employer that the examination be waived, and shall contact the employer by telephone or in writing to confirm the waiver of the examination, except where the bureau has determined the employer is out of business. The bureau may waive the examination even if the employer indicates that the examination should proceed where the bureau determines that an examination is not necessary. The bureau shall mail a copy of all waivers, whether received directly from the employer or initiated by the bureau, to the employee, employer, and their authorized representatives, except where the bureau has determined the employer is out of business.

(C) The bureau shall conduct ninety day examinations for employees of self-insuring employers upon the request of the self-insuring employer. A self-insuring employer may determine that a ninety day examination is not necessary, and in that instance may decide not to request such examination be conducted by the bureau. At the appropriate time thereafter, the self-insuring employer may request that the ninety day examination be conducted. The self-insuring employer shall pay for the ninety day examination, as well as all reasonable expenses associated with the ninety day examination.

(D) Medical examinations scheduled under this rule shall not operate to limit medical examinations provided for in other provisions of Chapter 4121. or Chapter 4123. of the Revised Code.

Effective: 2/10/09

4123-3-34 Settlement of state fund claims. (AMEND)

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

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

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

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

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

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

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

(C) Each settlement application shall:

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

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

~~(D) Settlement applications filed for lost time claims shall be filed in the service office responsible for processing the claim. Settlement applications for medical only claims shall be filed with the medical claims department.~~

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

~~(E)~~(E) The administrator shall utilize whatever methods the administrator determines to be appropriate, consistent with general insurance principles, to evaluate a claim for settlement. When a settlement agreement has been approved by the administrator, a

notice of approval shall be sent to the claimant, the employer, and their representatives, informing them of their rights to withdraw consent to the settlement agreement within thirty days. If written notice of the withdrawal of consent is not filed within the thirty day period, the settlement agreement is final.

An injured worker's refusal to endorse a settlement check issued as a result of an agreement reached pursuant to these procedures does not alter the finality of the settlement. The administrator may reopen a settled claim for purposes of conducting a fraud investigation.

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

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

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

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

~~(K)~~(J) The representative's signature for either the claimant or the employer satisfies the requirements for paragraphs (B) and (C) of this rule.

~~(L)~~(K) A settled claim may be used as a defense to a claim for the same or similar

conditions. A self-insuring employer shall not settle disabled workers' relief fund liability in state fund claims without the administrator's approval.

Effective: 2/16/07

4123-3-35 Employer handicap reimbursement. (AMEND)

(A) For the purposes of handicap reimbursement under section 4123.343 of the Revised Code, a "handicapped employee" means an employee who is defined as having one or more of the conditions listed in division (A) of section 4123.343 of the Revised Code.

(1) With respect to the handicap condition defined in division (A)(4) of section 4123.343 of the Revised Code, degenerative disc disease, spondylosis, spondylolysis, and spondylolistheses do not constitute evidence of arthritis for purposes of satisfying the statute.

(2) With respect to the handicap condition defined in division (A)(14) of section 4123.343 of the Revised Code, the employee must have in-patient treatment and admission for the psycho-neurotic disability in a recognized medical or mental institution. Out-patient treatment does not satisfy the statutory definition.

(3) With respect to the handicap condition defined in division (A)(25) of section 4123.343 of the Revised Code, an employer is not eligible for handicap reimbursement in the same claim in which the employee participated in a rehabilitation program. The employee must suffer a subsequent compensable injury or occupational disease claim, and any reimbursement rights would be in the subsequent claim.

(B) Under division (B) of section 4123.343 of the Revised Code, the administrator specifies the following grounds upon which the administrator may charge claims costs to the statutory surplus fund.

(1) The administrator will consider handicap reimbursement relief under section 4123.343 of the Revised Code only in claims satisfying all of the following prerequisites:

(a) The claimant is a handicapped employee as defined in division (A) of section 4123.343 of the Revised Code and paragraph (A) of this rule.

(b) The employer has filed an application for handicapped reimbursement while the claim is within the employer's claim experience period, as referred to in division (B) of section 4123.34 of the Revised Code.

(i) For a claim involving a private state fund employer, the application shall be filed by June thirtieth of the year no more than six years from the year of the date of the injury or occupational disease.

(ii) For a claim involving a public employer taxing district employer, the application shall be filed by December thirty-first of the year no more than five years from the year of the date of the injury or occupational disease.

(iii) For a claim involving a private state fund employer or a public employer taxing district employer participating in a retrospective rating plan, the application shall be filed within the time provided in paragraph (B)(1)(b)(i) or (B)(1)(b)(ii) of this rule, as applicable.

(iv) For a claim involving a self-insuring employer that has elected to continue to participate in the handicap reimbursement program, the application shall be filed within the time provided in paragraph (G)(1) of this rule.

(c) The bureau has awarded compensation to the claimant for temporary total disability, disabilities described under division (B) of section 4123.57 of the Revised Code, permanent total disability, or death benefits, or the claimant has received wages from the employer in lieu of compensation.

(2) For an employer granted relief, all or such portion as the administrator determines of the amount that otherwise would be charged to the employer's experience will be deducted from each claim arising from injury or occupational disease to a handicapped employee for the purpose of premium or assessment adjustment, in accordance with the following principles and paragraphs (E), (F), and (G) of this rule:

(a) All amounts deducted from the experience of the employer will be charged to the statutory surplus fund.

(b) The bureau will calculate the amount of the cost of the claim to remain in the employer's experience by applying the complement of the handicap percentage to the reducible costs contained within the claim cost as limited by the maximum value of a claim chargeable to the employer's experience, as determined by the employer's credibility group under rule ~~4123-17-05~~ [4123-17-05.1](#) of the Administrative Code.

(c) The bureau will apply the handicap reimbursement in a claim to only the following claims awards and reserves:

(i) Temporary total disability;

(ii) Disabilities described under division (B) of section 4123.57 of the Revised Code;

(iii) Permanent total disability;

(iv) Death benefits;

(v) Medical payments; and

(vi) Claims reserves.

(d) If the actual cost of a claim exceeds the maximum value of the claim chargeable to a particular employer's experience, the ratio of the nonreducible costs of the claim to the total cost of the claim shall be maintained in the maximum value chargeable to the particular employer's experience, so that when the handicap percentage is applied, it will be applied only to that portion of the maximum value that is reducible in accordance with division (B) of section 4123.343 of the Revised Code.

(e) Any agreement between an employer and the claimant as to the merits of a claim or the amount of the charge to the statutory surplus fund shall forfeit any rights of the employer to any handicap reimbursement under this rule. This provision does not apply to the employer's certification of the claim.

(C) The administrator of workers' compensation may delegate the authority granted to the administrator under Chapters 4121. and 4123. of the Revised Code for determining the amount an employer may be reimbursed from the statutory surplus fund in connection with the employer's handicapped employees under this rule. The decision of the administrator's designee shall be the decision of the administrator.

(1) An employer which seeks a handicap reimbursement award must file a complete and timely application and attach copies of all relevant medical evidence which the employer believes the administrator should consider when determining the appropriate award.

(a) The administrator may dismiss without prejudice an incomplete application. The administrator may dismiss without prejudice an application at the employer's request. Within the time limits and provisions of this rule the employer may refile an application that was dismissed without prejudice.

(b) The administrator may deny an application not file within the employer's experience as provided in division (B) of section 4123.34 of the Revised Code and paragraph (B)(1)(b) of this rule.

(c) The administrator may dismiss an application which fails to meet the jurisdictional requirements of paragraphs (A) and (B) of this rule.

(d) The administrator may dismiss an application if the initial allowance of the claim is being contested before the bureau, industrial commission, or a court of competent jurisdiction at the time the application is filed. Upon a final administrative or judicial determination allowing the claim, the employer may refile an application dismissed under this provision.

(2) The administrator may issue a handicap reimbursement order based on a review of the application and any information contained in any relevant claim file or any other relevant bureau or industrial commission records.

(3) The administrator shall afford an employer the opportunity for an informal conference if the application meets the jurisdictional requirements of this rule.

(a) If the administrator conducts an informal conference, the administrator shall mail a notice of conference to the employer and its representative by regular mail, setting forth the date, time, and place of the conference.

(b) The administrator shall notify the employer by mail not less than fourteen days before the date of such conference, unless the employer waives this requirement.

(c) At the request of the employer or another party, the administrator may conduct an expedited or an informal telephone conference.

(4) The administrator's decision shall be reduced to writing and mailed to all interested parties. The order shall state the evidence upon which the administrator based the decision.

(5) The administrator shall keep a record of handicap applications received, conferences scheduled, orders issued with publication dates and any waiver of appeals, and appeals to the industrial commission.

(D) The burden of proof is upon the employer to establish entitlement to the relief under section 4123.343 of the Revised Code by appropriate medical evidence or other evidence as may be indicated

(1) With respect to any credit under division (D)(1) of section 4123.343 of the Revised Code, the administrator shall grant full handicap credit if the employer establishes that the injury or occupational disease would not have occurred but for the employee's pre-existing handicap condition.

(2) With respect to any credit under division (D)(2) of section 4123.343 of the Revised Code, the administrator shall determine the degree of relief to be granted based upon the following:

(a) The degree to which medical evidence or other evidence indicates the pre-existing handicap has affected the cost of the claim.

(b) The employer shall establish the relationship between the pre-existing condition and subsequent injury by way of aggravation or delayed recovery by proof on file but the condition need not be recognized by an order of allowance for such condition or aggravation of the condition.

(c) In determining the appropriate per cent of relief in the claim, the administrator shall consider the effect of the handicap condition on the past claims costs and shall also account for the effect of the handicap condition on the anticipated future costs of the claim.

(E) A non-complying employer shall not be entitled to relief under section 4123.343 of the Revised Code. If the employer had active coverage on the date of the injury but was a non-complying employer on the date of the application for handicap reimbursement relief, the administrator may dismiss the application.

(F) No employer shall in any rating year receive credit under section 4123.343 of the Revised Code in an amount greater than the premium it paid if a state fund employer or greater than its handicap assessment if a self-insuring employer.

(G) The administrator shall reimburse a self-insuring employer in the same manner as a state fund employer, except that reimbursement shall be made by direct payment to the selfinsurer from the statutory surplus fund.

(1) The self-insuring employer shall file an application for handicap reimbursement within five years from the date of injury or within five years from the beginning of disability in an occupational disease claim.

(2) A self-insuring employer may, for all claims filed after January 1, 1987, elect to pay compensation and benefits directly under this rule and shall receive no money or credit from the surplus fund for the payments under this rule, nor shall the employer be required to pay any amounts into the surplus fund that otherwise would be assessed for handicap reimbursement for claims filed after January 1, 1987. A self-insuring employer which makes such election also shall assume responsibility for compensation and benefits paid directly under this rule for all claims filed prior to January 1, 1987, and shall not be required to pay any amounts into the surplus fund by reason of this rule and may not receive any money or credit from that fund on account of this rule.

(3) A self-insured employer that has elected to remain in the handicap reimbursement program and has been granted handicap relief shall submit a request for direct reimbursement to the bureau's self-insured department on the form designated for reimbursement.

(H) An order issued by the administrator is appealable under section 4123.511 of the Revised Code.

(1) If the administrator holds an informal conference, the employer and the administrator may agree upon the amount of the handicap reimbursement in a claim, and the employer may waive its right to appeal.

(2) Upon waiver of the employer's right to an appeal or the expiration of the appeal period, the administrator's order is final, and the bureau will immediately process the award.

(3) If no agreement is reached at the informal conference and the employer files a written appeal within fourteen days of the employer's receipt of the administrator's decision, the

administrator shall forward the claim file to the industrial commission within seven days of the administrator's receipt of the notice of appeal for a hearing before a district hearing officer.

(4) The employer and the administrator are parties at any hearing conducted by the industrial commission or its hearing officers.

(5) Upon a final industrial commission order which grants handicap relief, the bureau will immediately process the award.

(I) Since pursuant to paragraph (D)(2)(c) of this rule the administrator shall consider the effect of the handicap condition on the past and future costs of the claim in determining the handicap relief, the employer is not entitled to consideration of a subsequent application for handicap relief for a condition in a claim in which the administrator has made a previous determination on the condition, regardless of whether there has been a change in circumstances such as allowance of the condition or payment of compensation. A subsequent application shall not substitute for an appeal of the administrator's order. The administrator shall dismiss or deny any subsequent application for an increase in handicap relief in a previously determined claim.

Effective: 2/15/09

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

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

~~(1) The administrator has identified these medical conditions by ICD code and narrative description.~~

~~(2)~~ (1) The administrator used historical statistical criteria to determine the appropriate specific medical conditions to include in the program. The criteria included but was not limited to the following:

- (a) Number of claims for the medical condition;
- (b) Per cent of claims for the medical condition disputed;
- (c) Per cent of claims for the medical condition appealed;
- (d) Per cent of claims for the medical condition disallowed; and

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

~~(3)~~ (2) The medical conditions that the administrator determined to be included [are](#) attached as appendix A to this rule.

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

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

Effective Date: 2/10/09

Appendix to rule 4123-3-36 (NO CHANGE)

Appendix A

ICD Code	ICD Description
692.79	Solar dermatitis nec
872.02	Open wound auditory canal
872.69	Open wound of ear nec
873.21	Open wound nasal septum
873.22	Open wound nasal cavity
873.65	Open wound of palate
878.0	Open wound of penis
878.4	Open wound of vulva
878.8	Open wound genital nec
879.4	Open wound lateral abdomen
879.6	Open wound of trunk nec
880.01	Open wound of scapula
880.02	Open wound of axilla
922.33	Contusion of interscapular region
930.2	FB in lacrimal punctum
940.3	acid burn cornea/conjunc
941.13	1st deg burn lip
941.14	1st deg burn chin
941.16	1st deg burn scalp

942.10 1st deg burn trunk nos
942.19 1st deg burn trunk nec
943.14 1st deg burn axilla
943.15 1st deg burn shoulder
943.19 1st deg burn arm-mult
945.11 1st deg burn toe
945.19 1st deg burn leg-mult
877.0 Open wound of buttock
940.1 Burn periocular area nec
941.12 1st deg burn eye
872.01 Open wound of auricle
943.12 1st deg burn elbow
941.11 1st deg burn ear
883.0 Open wound of finger
944.14 1 deg burn finger w thumb
942.12 1st deg burn chest wall
881.00 Open wound of forearm
879.2 Open wound anterior abdomen
881.02 Open wound of wrist
918.0 Superficial injury eyelids
944.15 1st deg burn palm
882.0 Open wound of hand
914.6 Foreign body hand
873.44 Open wound of jaw
921.3 Contusion of eyeball
913.6 Foreign body forearm
873.64 Open wound tongue/mouth flr
930.0 Corneal foreign body
930.1 FB in conjunctival sac
890.0 Open wound of hip/thigh

4123-3-37 Lump sum advancements. (NO CHANGE)

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

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

(2) The administrator may grant a lump sum payment to a surviving spouse from awards of compensation made pursuant to sections 4123.59 of the Revised Code. However, the advancement shall not exceed the amount of death benefits payable to the surviving

spouse over a two-year period.

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

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

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

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

(3) If the administrator determines that the lump sum application is advisable, the administrator shall determine the amount of the biweekly rate reduction and the terms of such reduction. The administrator shall fix a specific time for the reduction of the biweekly rate of compensation to repay the lump sum advancement. The administrator may include interest in the repayment schedule.

(4) The administrator shall issue an order approving or disapproving the application. If the application is approved, the order shall advise the injured worker of the amount of reduction of compensation and the terms of the lump sum advancement.

(C) Maximum rate reduction in compensation.

(1) No lump sum advancement shall be approved that will result in a rate reduction of more than one-third of the biweekly rate of compensation, except where the payment is for attorney's fees in accordance with section 4123.06 of the Revised Code.

(2) The administrator may approve more than one lump sum advancement in a claim, but shall not permit more than two concurrent lump sum advancements.

(3) Upon the repayment of the lump sum advancement in accordance with the terms of the order and agreement, the administrator shall remove the rate reduction due to the lump sum advancement and reinstate the injured worker's rate of compensation.

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

Effective: 7/11/13