

BWC Board of Directors

Audit Committee

Thursday, September 25, 2008, 4:00 p.m.

William Green Building

Neil Schultz Conference Center
30 West Spring Street, 2nd Floor (Mezzanine)
Columbus, Ohio 43215

Members Present: Kenneth Haffey, Chairman
Robert Smith, Vice Chair
James Harris
William Lhota

Members Absent: Jim Matesich

Other Directors Present: Charles Bryan, David Caldwell, Alison Falls, James Hummel,
Thomas Pitts, and Larry Price

CALL TO ORDER

Mr. Haffey called the meeting to order at 4 p.m. and the roll call was taken.

MINUTES OF AUGUST 28, 2008

Mr. Smith moved that the minutes of August 28, 2008, be approved. Mr. Lhota seconded and the minutes were approved by a unanimous voice vote.

EXECUTIVE SESSION

Mr. Haffey moved that the Audit Committee enter executive session pursuant to Ohio Revised Code §121.22(D)(2) for the purpose of conducting an audit conference with Mr. Joe Patrick of Schneider Downs & Co. Inc. He discussed the status of the audit which was due to the Auditor of State by September 30, 2008. Mr. Lhota seconded and the motion was approved by unanimous roll call vote.

ADJOURNMENT FROM EXECUTIVE SESSION

Mr. Lhota moved that the Audit Committee adjourn from executive session. Mr. Smith seconded and the motion was approved by unanimous roll call vote.

FOLLOW-UP ITEMS FROM AUGUST MEETING

Joe Bell, Office of Budget and Management, Chief Audit Executive, and Caren Murdock, Chief of Internal Audit, reported on the internal audit executive summary for the fourth quarter of fiscal year 2008. Four new audits have been completed: the subrogation program, the process for forthwith and miscellaneous special payments, a Managed Care Organization (MCO), and draft policies and procedures manual for the Employer Compliance Department.

Ms. Murdock reported that Internal Audit identified four material weaknesses and eight significant weaknesses in the subrogation program. Four of these were corrected immediately.

Mr. Haffey asked when the last internal audit of the subrogation program was conducted. Ms. Murdock replied that this was the first audit. Mr. Bell added that the audit was conducted after observing growth of collections and focus of the program.

Ms. Murdock next reported that Internal Audit had identified seven significant weaknesses in the forthwith and miscellaneous special payments process. Five of the weaknesses have been resolved through implementation and validation. Mr. Haffey noted that the audit was completed in July 2008 and resolutions have been implemented and validated.

Ms. Murdock also reported on an audit of an MCO. Internal Audit identified six significant weaknesses, of which two were implemented and validated. Additional weaknesses are targeted for completion in December 2008.

Ms. Murdock reported that Internal Audit reviewed a draft of the Employer Compliance Department policies and procedures manual to provide proactive guidance for designing internal controls. Five minor recommendations were identified for management consideration.

Ms. Murdock further reported on outstanding audit comments as of June 30, 2008. In addition, proposed audit changes to the audit plan were discussed – delaying the Safety and Hygiene audit to the third quarter while moving the Fleet and Self Insured Bankrupt Securitization Process audit to the second quarter. The department has seven of nineteen staff positions which need filling, including, especially, an investments auditor.

NEW BUSINESS/ACTION ITEMS

RULES FOR FIRST READING: INPATIENT HOSPITAL PAYMENT, OHIO ADMINISTRATIVE CODE RULE 4123-6-37.1

Robert Coury, Chief Medical Services & Compliance, recommended amendment of Ohio Administrative Code Rule 4123-6-37.1 to adopt a new inpatient hospital fees schedule. This is a first reading of the rule. The new schedule was presented to the Ohio Hospital Association in July and August. After approval, the rule will go through the process of the Joint Committee on Agency Rule Review (JCARR) for enactment in February 2009. BWC is adopting the methodology of the Medicare Severity Diagnosis-Related Groups. Ann Casto, Casto and Associates, explained the Medicare reimbursement system and how BWC is adopting it for the fee schedule. Special attention will be paid to outlier cases, where the patient is admitted at the time of injury for an extended stay.

Mr. Harris asked if the proposal had been presented to stakeholders. Mr. Coury replied that it was presented to them on August 2008 and BWC had received preliminary support. Mr. Harris asked if BWC had researched the Federal Register for comments on Medicare rules. Ms. Casto replied that she has read all comments in the Federal Register and that a majority of comments are not directed to these changes.

Mr. Pitts asked about the exclusion by BWC of the Medicare provisions on hospital-acquired conditions. Ms. Casto replied that it is very controversial because Medicare reduces payments for thirteen types of conditions which could be present at admission.

RULES FOR CONSIDERATION AND POSSIBLE VOTE: PROFESSIONAL PROVIDER FEE SCHEDULE, OHIO ADMINISTRATIVE CODE RULE 4123-6-08

Mr. Haffey recused himself from discussions and vote on this rule because of his prior relationship with a provider. Mr. Smith assumed the chair of the Audit Committee for this issue.

Mr. Coury and Jean Graff, Medical Policy Analyst, recommended approval of amendments to Ohio Administrative Code Rule 4123-6-08 on the professional provider fee schedule. Mr. Coury reviewed the time-line for adoption. The rules were posted to the BWC web-site in July and two hundred comments have been collected. BWC plans to implement the rules in January after approval by the JCARR process.

Mr. Harris asked if BWC has comparisons of utilization with other states. Mr. Coury answered that BWC did not have enough data to measure provider performance. The goal is to have that data by the third quarter of 2009. Ms. Graff reported that the data so far shows some states limit the number of treatments of specific therapies.

Mr. Price asked for an interpretation of the mean average conversion factor comparisons. Ms. Graff replied that Ohio falls in the middle of all states that BWC has been using as a comparison.

Mr. Lhota asked when BWC would come to the Workers' Compensation Board again for new provider rates. Mr. Coury replied that BWC will return in 2009, beginning the process in October 2008. In March 2009, new rules will be brought before the Workers' Compensation Board, to go into effect in July 2009. Mr. Lhota stated that he supported the methodology presented to the Audit Committee at the August meeting and would support an alternative since BWC will be returning to the Workers' Compensation Board in early 2009.

Mr. Pitts asked if the Miller criteria should control until the 2009 fee changes. Mr. Coury agreed. Mr. Smith asked if, aside from the Miller criteria, BWC should compare itself with other states. Mr. Coury replied that Ohio should make comparisons and that is the reason for the need for utilization review.

Mr. Lhota requested a recommendation from BWC on whether to raise total provider fees by a total of 5% or 6%. Mr. Coury replied that BWC had no change from its recommendation in August to raise fees by 5% because BWC would be back to the Workers' Compensation Board in six months with more data and another recommendation.

Mr. Lhota moved that the Audit Committee recommend the Bureau of Workers' Compensation Board of Directors approve the Administrator's recommendation to amend Rule 4123-6-08 of the Administrative Code Rule, "Bureau Fee Schedule," to adopt the provider fee schedule effective January 1, 2009. The motion consents the Administrator amending Rule 4123-6-08 and enacting Appendix A to the Rule as presented here today.

Mr. Smith stated that this was the same motion approved at the August meeting of the Audit Committee. Mr. Price noted that the recommendation was withdrawn at the meeting of the Workers' Compensation Board. James Barnes, Chief Counsel, pointed out that the vote of the Audit Committee was not rescinded. Mr. Price stated that it would be better to amend the recommendation and the motion to amend must come from one of those who voted for the original motion. Mr. Smith stated he would rather take back the August motion to the Workers' Compensation Board at its September 26 meeting.

Of those present today and voting for the motion at the August meeting, neither Mr. Smith nor Mr. Lhota moved to amend the August motion.

The motion of Mr. Lhota for the September meeting died for want of a second.

RULES FOR CONSIDERATION AND POSSIBLE VOTE: FIRE FIGHTING RULES, OHIO ADMINISTRATIVE CODE RULE/CHAPTER 4123:1-21

Mr. Haffey resumed his position as chair of the committee.

Tom Sico, Assistant General Counsel, recommended adoption of amendments to the fire fighting safety rules. The amendments were distributed to stakeholders by CD-ROM.

Mr. Lhota asked why BWC did not adopt NFPA safety rules in total. Mike Ely of the Division of Safety and Hygiene replied that these rules are in a multivolume work. Also, many Ohio local and volunteer departments lack resources to adopt all rules.

Mr. Smith moved that the Audit Committee recommend that the Bureau of workers' compensation Board of Directors approve the Administrator's recommendations on the five-year rule review of seven fire fighting safety rules of chapter 4123:1-21 of the Administrative Code. The motion consents to the Administrator amending the seven fire fighting rules of chapter 4123:1-21 as presented here today. Mr. Lhota seconded and the motion was approved by a unanimous roll call vote.

ADJOURNMENT

Mr. Lhota moved to adjourn, Mr. Smith seconded and the meeting was adjourned.

Prepared by: Larry Rhodebeck, Staff Counsel
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October 1, 2008

11/4/2008 9:25 AM

Appointment of Caren R. Murdock as Chief of Internal Audit for the Ohio Bureau of Worker's Compensation

Ohio Revised Code 4121.125(J) states:

The administrator, with the advice and consent of the board, shall employ an internal auditor who shall report findings directly to the board, workers' compensation audit committee, and administrator, except that the internal auditor shall not report findings directly to the administrator when those findings involve malfeasance, misfeasance, or nonfeasance on the part of the administrator. The board and the workers' compensation audit committee may request and review internal audits conducted by the internal auditor.

Administrator Ryan requests that the Committee recommend to the Board that Caren R. Murdock be appointed as the Chief of Internal Audit for the Ohio Bureau of Worker's Compensation.

Caren's resume follows.

11/4/2008 9:25 AM

Caren R. Murdock, CPA, CIA, CISA

SUMMARY OF QUALIFICATIONS

Experienced and detail-oriented professional, with a proven ability to perform a broad range of functions quickly and accurately in a fast-paced environment. Strong leadership traits with a 12-year proven record of providing measurable value to the organization through audit/financial related work. Adept in client relations with the ability to handle and resolve issues. Personable, self-motivated, results-oriented, dependable, analytical, and an effective listener. Recognized for dedication, work ethic, and going the extra mile to get the job done. Additional areas of expertise include:

- Strategic planning, developing goals and policies and procedures.
- Team building and leadership.
- Proven ability to multitask, driven by self-motivation and high ethical standards.
- Highly motivated to meet new challenges by capitalizing on experience and skills.
- Process design, technology utilization and effective monitoring techniques.
- Sensitive to confidentiality of financial data and business records.
- Self-motivated employee who performs diligently to accomplish business goals.
- Proven ability to plan and supervise work of others to achieve departmental goals.
- Goal-oriented individual with a history of proven results.

PROFESSIONAL EXPERIENCE

Internal Audit Director - January 2008 to August 2008 **Bureau of Workers' Compensation, State of Ohio – Columbus, Ohio**

Provide independent appraisal and consultation to management with objective evaluations, appraisals, and recommendations concerning the risk management, control and governance activities.

- Oversee audit activities to ensure significant risk is identified and evaluated.
- Ensure internal audit reports provide full and accurate account of internal operations being audited and the recommendations contribute to the improvement of risk management and systems of internal control.
- Evaluate corrective action taken by management for satisfactory disposition of audit comments.

Assistant Deputy Director of Fiscal Services - April 2007 to January 2008 **Job and Family Services, State of Ohio – Columbus, Ohio**

Managed the Bureau of Accounting and the Bureau of Cost and Cash Management. Responsible for overseeing the department's 16.7 billion dollar budget. Key player in streamlining processes to ensure efficient use of resources.

- In-depth knowledge of generally accepted accounting principles as well as federal and state regulations.
- Recommended and implemented internal controls to ensure compliance with state and federal requirements.
- Skilled decision maker, problem solver and team leader.
- Solid customer relationship skills with ability to build on credibility and gain clients' respect and trust.
- Key employee for special projects and assignments requested by the Director and Assistant Director.
- Proven ability to facilitate change and revitalize departmental performance.

Internal Audit Manager and Audit Director - April 2003 to April 2007 **Attorney General's Office, State of Ohio – Columbus, Ohio**

Reported to the Attorney General's Audit Committee and Board of Managers; conformed to *International Standards for the Professional Practice of Internal Auditing*. Developed annual financial and operational audit plans. Used risk assessment to align internal audit activities with risk priorities. Maintained an annual operating budget of \$300K and internal audit plan of over 3,500 annual audit hours.

- Developed process efficiencies which streamlined and improved many complex systems.
- Completed 87% of planned significant process reviews; maintained 7-day response time on special requests.
- Objective, reliable, and value-added consultant.
- Reputation for building working relationship with audit clients and providing top-notch audit service. Equally outstanding relationship with colleagues, supervisors and management.

Special Projects Manager - April 2002 to April 2003

Ohio Department of Alcohol and Drug Addiction Services, State of Ohio – Columbus, Ohio

Developed an internal audit program to ensure compliance with federal subrecipient requirements. Eliminated the organizations reportable conditions and material weaknesses noted in the State of Ohio single audit report.

- Developed and implemented the Department's audit guidelines and policies.
- Directed the Department's subrecipient monitoring system.
- Auditor of preference for tense, hostile and problem audits.
- Planned, managed, evaluated and monitored the activities of the community capital projects.
- Supervised the Department's Federal Medicaid funds payment and payment reconciliation process.

Senior Internal Auditor - April 2000 to April 2002

Internal Auditor – October 1998 to April 2000

Ohio Department of Development, State of Ohio – Columbus, Ohio

Performed financial, compliance and performance audits of sub-grantees to ensure compliance with state and federal laws and regulations.

- Auditor-In-Charge of financial, compliance & performance audits.
- Provided financial and technical assistance to the Department's grantees during the audit fieldwork.
- Prepared audit workpapers documenting audit tests, results and conclusions.
- Analyzed the audit work to document citations and internal control weaknesses.
- Prepared the audit report for the grantees and the Departmental staff.
- Conducted internal control risk assessments for various program offices.

Staff Accountant - May 1997 to October 1998

Auditor of State's Office, State of Ohio – Columbus, Ohio

Performed financial, operational, performance, and special investigation audits for state agencies in accordance with *Generally Accepted Accounting Principles* and *Government Auditing Standards*.

- Obtained and documented an understanding of the internal control structure of clients in a variety of audit environments.
- GAAP Support Specialist – Office of Budget and Management/State Accounting and the Department of Human Services.
- Developed audit findings and prepared drafts for audit reports and other communications.

LEADERSHIP RESPONSIBILITIES / EDUCATION / CERTIFICATIONS

LEADERSHIP RESPONSIBILITIES:

- Association of Government Accountants President-Elect 2007 to current
- Association of Government Accountants Board Chairperson 2005 to 2007
- Attorney General's Employee of the Month Fiduciary Counsel 2005-2006

EDUCATION/CERTIFICATIONS:

- Bachelor of Science in Business Administration, Accounting, Ohio State University, Columbus, Ohio
- Certified Public Accountant designation
- Certified Internal Auditor designation
- Certified Information Systems Auditor designation
- Member in the following professional associations: Institute of Internal Auditors, Ohio Internal Audit Committee, American Institute of Certified Public Accountants, Ohio Society of Certified Public Accountants, and Association of Government Accountants.

References Available Upon Request

11/4/2008 9:27 AM

Common Sense Business Regulation (BWC Rules)

(Note: The below criteria apply to existing and newly developed rules)

Rules Chapter 4123-3

Rule Review

1. The rule is needed to implement an underlying statute.

Citation: R.C. 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, et seq.

2. The rule achieves an Ohio specific public policy goal.

What goal(s): The five year rule review of these rules ensures that the claims procedure rules of the bureau are current.

3. Existing federal regulation alone does not adequately regulate the subject matter.

4. The rule is effective, consistent and efficient.

5. The rule is not duplicative of rules already in existence.

6. The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.

7. The rule has been reviewed for unintended negative consequences.

8. Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: Internal BWC review of rules; Ohio Association of Justice; OSBA

9. The rule was reviewed for clarity and for easy comprehension.

10. The rule promotes transparency and predictability of regulatory activity.

11. The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.

12. The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? _____

13. The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

Executive Summary

Chapter 4123-3

Claims Procedure

Introduction

Chapter 4123-3 of the Administrative Code contains the claim procedure rules. The rules describe the processes and procedures for the adjudication of claims before BWC.

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 legislation 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 claims procedure rules of Chapter 4123-3 of the Administrative Code are scheduled for review this year. BWC last reviewed these rules in 2003.

Rule Changes

BWC reviewed 29 rules in Chapter 4123-3.

No change rules: BWC is proposing no changes to 12 rules. The rules are listed with their prior effective dates:

- 4123-3-01 Office locations scope of rules. (9/1/96)
- 4123-3-02 Forms. (9/1/96)
- 4123-3-03 Employers' reports of injuries and occupational diseases. (10/4/04)
- 4123-3-07 Applications for death benefits. (9/1/96)
- 4123-3-10 Awards. (2/15/08; next review date: 2/15/13)
- 4123-3-11 Reports of payments by self-insuring employers. (10/4/04)
- 4123-3-14 Procedure in the original adjudication of noncomplying employers' claims. (10/4/04)
- 4123-3-20 Additional awards by reason of violations of specific safety requirements. (10/4/04)
- 4123-3-23 Limitations on the filing of fee bills..(1/16/78)
- 4123-3-31 Disabled workers' relief fund: claimant's payments. (11/8/86)
- 4123-3-34 Settlement of state fund claims. (2/16/07; next review date: 3/1/11)
- 4123-3-37 Lump sum advancements (12/1/04)

Rules to be rescinded: BWC is proposing to rescind three rules:

- 4123-3-05 Applications for the payment of medical expenses only. (to rescind)
- 4123-3-12 Suspension of the processing of claims.
- 4123-3-21 Change of address.

Executive Summary: Chapter 3 rules

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Amended rules: BWC is proposing amendments to 14 rules. Changes include updating the rules for current BWC procedures, changes in terminology, and statutory and rule references. Other amendments too numerous to highlight are contained in the rules.

- 4123-3-08 Preparation and filing of applications for compensation and/or benefits.
- 4123-3-09 Procedures in the processing of applications for benefits.
- 4123-3-15 Claim procedures subsequent to allowance.
- 4123-3-16 Motions.
- 4123-3-17 Briefs.
- 4123-3-18 Appellate procedure.
- 4123-3-22 Inspection of claim files.
- 4123-3-24 Fee controversies.
- 4123-3-25 Application for change of occupation allowance. (rescind and replace)
- 4123-3-29 Informing the claimant of the right to representation.
- 4123-3-30 Procedures to inform claimant on request as to the status of his [or her] claim
and of any action necessary to maintain the claim.
- 4123-3-32 Temporary total examinations.
- 4123-3-35 Employer handicap reimbursement.
- 4123-3-36 Immediate allowance and payment of medical bills in claims.

Chapter 4123-3 Claims Procedure

4123-3-01 Office locations scope of rules. (no changes)

(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.

Prior Effective Dates: 10/17/68, 1/16/78, 9/1/96

4123-3-02 Forms. (no changes)

(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 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 must be furnished in 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.

Prior Effective Dates: 1/1/64, 9/1/96

4123-3-03 Employers' reports of injuries and occupational diseases. (no changes)

(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 or 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.

(C) Self-insuring employers shall use the appropriate form 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.

(D) Self-insuring employers shall make a similar report on the appropriate form 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 (C) of section 4123.57 of the Revised Code and effective August 22, 1986, division (B) of section 4123.57 of the Revised Code. In such cases involving occupational disease, the report shall be on the appropriate form.

(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 employee it concerns or his or her surviving dependents as required by section 4123.28 of the Revised Code.

HISTORY: Eff 1-1-64; 1-16-78; 1-10-87; 8-22-86 (Emer.); 11-17-86 (Emer.); 1-10-87; 9-1-96; 10-4-04

4123-3-05 Applications for the payment of medical expenses only. (to rescind)

(A) Injury claims involving seven days or less of lost time.

(1) State insurance fund.

An employee of an employer contributing to the private fund shall make application for the payment of such incurred medical expenses on form C-3. A public employee shall make such application on form C-72.

(2) Self-insuring employers.

An employee of a self-insuring employer, filing an application for medical expenses with the bureau shall file such application on form C-50. Disagreements as to compensability of the claim shall be resolved in the same manner as in contested state fund claims. Whenever the employee elects to receive medical attention other than that furnished by the employer, he shall advise the employer of that fact. No specific form is prescribed. Disagreements between the employer and employee relative to such services shall be resolved in the manner provided in paragraph (E) of rule 4123-7-11 of the Administrative Code.

(3) Amenable but noncomplying employers.

An employee of an employer who was amenable to the workers' compensation law at the time of the injury and who had not complied therewith by the payment of premium into the state insurance fund may file an application for a hearing and the determination of his rights to benefits, as provided in section 4123.75 of the Revised Code, with the bureau. Such application shall be on form C-67.

(B) Occupational disease claims involving seven days or less of lost time.

(1) State insurance fund.

A public employee or an employee of an employer contributing to the private fund shall make application for the payment of medical expenses only on form OD-3.

(2) Self-insuring employers.

An employee of a self-insuring employer, filing an application for medical expenses with the bureau shall file such application on form OD 1-22. Disagreements as to compensability of the claim shall be resolved in the same manner as in contested state fund claims. Whenever the employee elects to receive medical attention other than that furnished by the employer, he shall advise the employer of that fact. No specific form is prescribed. Disagreements between the employer and the employee relative to such services shall be resolved in the manner provided in paragraph (E) of rule 4123-7-11 of the Administrative Code.

(3) Amenable but noncomplying employers.

An employee of such noncomplying employer may file an application for a hearing and the determination of benefits, as provided in section 4123.75 of the Revised Code, with the bureau. Such application shall be made on form C-67.

HISTORY: Eff (Amended) 10-17-68; 1-16-78

4123-3-06 Applications for the payment of compensation and medical expenses. [Rescinded]

Rescinded eff 10-4-04

4123-3-07 Applications for death benefits. (no changes)

Where 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 .

HISTORY: Eff 10-17-68; 1-16-78; 10-4-04

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

(A) Preparation and execution of forms.

(1) The "First Report of Injury" form (FROI-1) for applying for payment from the state insurance fund due to an injury, occupational disease, or death shall be completed by ~~both~~ the employee. 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) 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.

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

(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 ~~shall~~ may sign the report at the designated point and return the requested information to the bureau, or the bureau may ~~also~~ 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 4123-3-08 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 ~~for a period amounting in all to at least three years~~. 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 ~~the minimum three-year injurious exposure in the state is not required that exposure in this state is not required for radiation claims~~. In radiation claim where the 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 began, 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) ~~Civil defense 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.

HISTORY: Eff 1-16-68; 8-22-86 (Emer.); 11-8-86; 1-27-97; 10-4-04

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

(A) Numbering and recording.

(1) Upon receipt, each initial application for benefits shall be assigned by the bureau a claim number and shall be recorded. The claim number shall be furnished 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 for death benefits and~~ applications of employees of self-insuring employers, shall be reviewed and processed by the bureau's claims ~~examiners~~ specialists on the question of compensability. "Processing on the question of compensability" means the making of a determination on the validity of the claim as an industrial claim.

(1) Noncontested or undisputed claims.

A "contested or disputed claim," as used herein, is one the validity of which, as an industrial claim, is questioned by the employer or by the bureau of workers' compensation. 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 ~~examiner~~ specialist shall have authority to approve such claim for payment of medical bills and temporary total disability compensation. ~~Should the claimant be entitled to compensation for partial disability under division (B) of section 4123.57 of the Revised Code, or to an award for the change of occupation under division (D) or (E) of section 4123.57 of the Revised Code, such awards must be referred to a district hearing officer for approval.~~ 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. ~~Orders approved for payment shall be forwarded to the proper department of the bureau in charge of execution of orders no later than the next working day following the approval of the claim.~~

(b) In the processing of initial applications in state fund claims, requesting payment of compensation in addition to medical benefits, the claims ~~examiner~~ 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. ~~Immediately upon~~ 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.

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

(2) Contested or disputed claims.

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. ~~Formal hearings~~ After an appeal of the bureau's order, the bureau shall refer the contested issue for a hearing before a district hearing officer with notices to the interested parties ~~shall be scheduled at the earliest possible date.~~

(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 district hearing officers~~ the bureau.

(4) Contested (disputed) applications for workers' compensation benefits filed by employees of self-insuring employers shall be ~~processed in accordance with rule 4123-3-13 of the Administrative Code and the general rules applicable to the processing of contested claims referred to the industrial commission for a~~ hearing.

~~In cases where there is no dispute, the claims shall be examined to determine whether the payments approved by the self-insuring employers are in conformity to the law and the rules of the industrial commission. If it is found that the approved payments do not conform, the bureau shall immediately notify the employer of that fact, indicating what payments are to be made. If there is a disagreement, such claims shall be set for a formal (public) hearing before an appropriate district hearing officer with notices to all interested parties.~~

(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 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 degree of probability. A mere possibility is conjectural, speculative and does not meet the required standard.

(4) The bureau, ~~board~~ 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 exam 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 ~~commission~~ 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 ~~or the regional board of review~~ and the question sought to be clarified by such examination is not within the jurisdiction of the bureau (for example: ~~original allowance of a disputed claim, permanent partial or permanent total disability, settlement negotiations~~), the request shall be referred, forthwith, to the industrial commission, or to the appropriate hearing officer ~~or to the board of review~~, 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.

(i) 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.

~~(ii) In all other cases, the bureau shall issue a tentative order, as outlined below, approving the requested examination:~~

~~"The administrator grants, pursuant to paragraph (C)(5) of rule 4123-3-09 of the Administrative Code, employer's request to have claimant examined by a doctor of employer's choice; claimant is directed to submit to such examination; employer is directed to have such examination held promptly at its expense and to file a copy of the doctor's report with the bureau; action on claim is deferred pending filing of such report."~~

~~A copy of the order shall be mailed immediately to the claimant, his employer and to their respective representatives of record. An objection to the order, in writing, may be raised by the claimant within fourteen days from the date of the receipt of the order, in which case the order shall be voided and the matter referred, forthwith, to the district hearing officer for further consideration.~~

(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, ~~board~~ 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 the taking of such 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) ~~Uncertified claims and disputed~~ Disputed or contested claims shall be set for a formal (public) hearing on the question of ~~original~~ allowance before the district hearing officers. A "disputed or contested claim," as used herein, means a claim the validity of which as an industrial claim is questioned by the employer, the bureau or by the industrial commission. No claim shall be regarded by the bureau 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).

(3) ~~The~~ 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's~~ 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 investigators of the district offices of the~~ bureau shall be responsible for securing the necessary information.

(5) The administrator of the bureau of workers' compensation, as representative of the state insurance fund and of the surplus fund, 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) 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, as the case may be.

~~(7) It shall be the function of the bureau, unless otherwise ordered by the industrial commission, to publish orders of the district hearing officers, the boards of review, staff hearing officers and of the industrial commission, except orders on percentage of permanent partial disability compensation. Copies of the orders shall be mailed, at the earliest possible moment, to the parties and to the authorized representatives of record of each party. In cases affecting the state insurance fund or the surplus fund a copy of the order shall also be mailed to the administrator or his designee.~~

~~(8) The bureau shall make payment on orders of the commission, the regional boards of review and district or staff hearing officers in accordance with law and rules of the bureau and the industrial commission.~~

(9) 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 (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.

(1) A claimant, an 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 (district service office director, section director or their designee) on any question pertaining to matters pending before the bureau in a respective claim, if the bureau or the parties feel that this shall facilitate the processing of the claim by clarification of issues involved.

(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, ~~and certified under oath (or affirmation) by the person making the~~ statement.

(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.

HISTORY: Eff 10-9-76; 1-16-78; 12-21-79; 8-22-86 (Emer.); 11-17-86 (Emer.); 1-10-87

4123-3-10 Awards. (no changes)

(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 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.

(c) 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) 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) 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) 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, 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) 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. On all types of compensation, other than percentage of permanent partial compensation, the authorization must be filed prior to or at the 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. 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.

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

(a) A power of attorney, 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 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) 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) 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) 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) 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) 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)(c) of this rule, the bureau will not honor a power of attorney for that award under paragraph (A)(6) 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) 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) 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 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.

Projected Impacts and Outcomes

The goal is for the aggregate payments to be similar to 2008, but for the distribution of payment to be more equitable. Additionally, Medicare builds into the inpatient prospective payment system a modest increase that reflects the price inflation providers will experience during the next fiscal year. Medicare refers to this increase as the market basket forecast. Therefore, BWC payments will experience this modest increase as well. The proposed change to the outlier methodology will reduce the percent of total payments for outliers from 20% to 9%. The table below depicts BWC inpatient hospital payments for bills with discharge dates between January 1 and June 30, 2008 and models the proposed changes using the 2009 methodology.

2008 Q1 and Q2 BWC Hospital Inpatient Experience						
Bill Type	Bill Volume	% of Total Bill Volume	Charges	Percent of Total Charges	Payment	Percent of Total Payment
DRG	1835	81%	59,403,278	68%	24,950,640	65%
Outlier	185	8%	18,550,840	21%	7,673,540	20%
Exempt	234	11%	9,212,127	11%	5,918,306	15%
Totals	2254		87,166,245		38,542,487	
2008 Q1 and Q2 Data Modeled Under 2009 Rule						
Bill Type	Bill Volume	% of Total Bill Volume	Charges	Percent of Total Charges	Payment	Percent of Total Payment
DRG	1983	88%	68,908,492	79%	28,417,197	75%
Outlier	37	2%	9,045,626	10%	3,471,827	9%
Exempt	234	10%	9,212,127	11%	5,918,306	16%
Totals	2254		87,166,245		37,807,330	
Overall Impact					-735,157	-2%

Medicare delayed the release of the final pricing factors for their inpatient reimbursement system due to the Medicare Improvements for Patients and Providers Act of 2008. The pricing factors were published October 3, 2008 in the Federal Register. Additionally, Medicare published a regulatory impact analysis. Medicare indicates that there will be an increase of 5.0 percent in operating payments and an increase of 0.7 percent in capital payments. The expected increase from Medicare combined with the decrease associated with the outlier methodology change will result in 2009 aggregate payment increase of approximately 3 to 4 percent. This is in alignment with the market basket forecast of 3.6 percent that is provided for 2009.

(5) Self-insuring employers shall follow the procedures in paragraph (A)(8) 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.

Prior Effective Dates: 1/1/64, 1/16/78, 10/4/04, 4/1/07, 02/15/08

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, or the 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.

HISTORY: Eff 3-25-73; 1-16-78; 8-22-86 (Emer.); 11-8-86; 9-15-91; 10-4-04

4123-3-12 Suspension of the processing of claims. (to rescind)

(A) When the Bureau, Board or the Commission orders an injured or disabled employee to submit to medical examination and such employee refuses to be examined or in any way obstructs the examination, the employee's claim for compensation shall be suspended during the period of his refusal or obstruction.

(B) In the event an employee fails to supply required facts, complete the required forms, submit to medical examinations ordered by the Commission, Board or Bureau or submit other proof which may be requested or in any way unduly delays the expeditious processing of his claim, the Bureau, Board or Commission may withhold action on the claim and may withhold future actuarial reserve while such situation obtains. In such cases further consideration shall be given to the claim when the employee remedies the condition which invoked suspension of action on the claim.

HISTORY: (former IC/WC-21-12); Eff 1-1-64

4123-3-14 Procedure in the original adjudication of noncomplying employers' claims. (no changes)

(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 its 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.

HISTORY: Eff 10-17-68; 1-16-78; 10-4-04

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

~~(A) The procedure specified in this rule shall be applicable to the several classifications of claims.~~

~~(B)~~ 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 thirteen 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 thirteen 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 thirteen 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 thirteen 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 4123-6-20 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 (B)(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.

~~(C)~~(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 attorney 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 of the application and any accompanying proof to the employer and the employer's representative. 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; ~~provided that, if the employer requests an examination of the claimant by a physician of its choosing, the application shall not be referred for review nor the applicant examined by the bureau sooner than ninety days from the mailing of the application.~~ 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 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 commission may determine.

HISTORY: Eff 10-9-76; 1-16-78; 8-22-86 (Emer.); 11-8-86; 7-16-90; 11-1-2004

4123-3-16 Motions. (to hend)

(A) Form C-86 motion shall be used to ~~present motions to~~ request action from the bureau or commission.

(B) ~~Motions~~ 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 these rules. It is appropriate to file a motion in order to secure allowance of a disability

or condition not previously considered in a claim. ~~In no event should a~~ A motion shall not be used as a substitute for an untimely appeal, ~~an application to reactivate a claim, an application for the determination of the percentage of permanent partial disability, or an application to increase an award of percentage of permanent partial~~ disability.

(C) A motion shall fully set forth the question presented together with a succinct statement of the action or relief sought.

(D) ~~Motions~~ 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 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) ~~Motions~~ A motion shall bear the signature of the applicant or ~~his~~ the applicant's authorized representative ~~on behalf of such party.~~

(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 ~~(B)~~ (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) Upon the receipt of such motion, properly completed, the bureau shall mail to the claimant a questionnaire, in form of an affidavit, with instructions for completion of same, and showing bureau's procedure in case of failure to comply. If a claimant is represented, a copy shall be mailed to the representative. 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) The claimant shall have fourteen days from the date of receipt of the bureau's request for return of the completed affidavit. 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 clinical counselor (LPCC), or a licensed independent social worker (LISW).~~

~~(3) If the affidavit, properly completed by the claimant, is returned to the bureau, the following action shall be taken: The bureau may have the claimant scheduled for an examination by an independent specialist.~~

~~(a) A copy of the affidavit shall be mailed to the opposite party and his representative;~~

~~(b) The claim file shall be referred to the industrial commission's medical section to have claimant scheduled for a medical examination by a disinterested specialist;~~

~~(c) When the claim file is returned from the medical section with the specialist's opinion, the matter shall be referred to a district hearing officer for further consideration.~~

(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.

HISTORY: Eff (Amended) 10-17-68; 1-16-78

4123-3-17 Briefs. (to amend)

(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 ~~or board~~ unless otherwise directed by the commission.

HISTORY: Eff 1-1-64; 1-16-78; 10-4-04

4123-3-18 Appellate procedure. (to amend)

(A) Administrative appeals.

(1) The right of an administrative appeal is limited to the claimant, the dependents of a deceased worker, the employer, and the administrator, where the administrator or ~~his~~ the administrator's representative acting 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, ~~regional board of review~~ or staff hearing officers.

(3) Decisions of district hearing officers are appealable to the ~~regional boards of review~~. staff hearing officers. Decisions of the ~~regional boards of review and of the staff hearing officers~~ are appealable to the industrial commission.

(4) Appeal (also called "Notice of Appeal") should be made on form ~~OTC 3000~~ 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.

(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, ~~boards of review~~ or of the industrial commission.

~~(7) Appeal from orders of a district hearing officer to a regional board of review shall be filed within twenty days of receipt of the order from which the appeal is taken.~~

~~(8)~~(7) The same time limits apply to appeals filed from the decision of the ~~regional boards of review~~ or staff hearing officers to the industrial commission.

~~(9)~~(8) Appellate review and determination of claims being within the exclusive jurisdiction of the ~~boards of review and of the industrial commission~~, the conduct of hearings and other incidental matters are governed by the rules of the industrial commission.

~~(10)~~(9) The bureau's ~~law section~~ 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 shall be entitled to proper notice of any action taken by the appellate body on appeals filed by the bureau.

~~(11)~~(10) Payment The bureau shall make payment of an award of compensation and/or benefits made in a claim ~~pursuant to a decision of a district hearing officer~~ shall commence ~~twenty days after the date of the decision~~ 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 ~~appeal~~ reconsideration allows such compensation.

~~(12)~~(11) In all other cases, if the decision of the ~~district~~ district hearing officer is appealed by the employer or the administrator, the bureau shall withhold ~~compensation and medical~~ benefits during the course of appeal to the ~~regional board of review staff hearing officer~~, but where the ~~regional board of review staff hearing officer~~ rules in favor of the claimant, ~~compensation and 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~~.

~~(13)~~(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 ~~after expiration of the twenty-day appeal period, provided that no appeal was filed upon the bureau's receipt of the order~~.

(B) Appeals to court.

~~(1) The claimant or the employer may appeal a decision of the industrial commission in any injury case other than a decision as to the extent of disability to the court of common pleas in the county in which the injury was sustained or in which the contract of employment was made, if the injury occurred without this state, or in which the contract of employment was made if the exposure occurred outside the state. In the event that a claimant or employer is unable to properly vest jurisdiction in a court for the purposes of an appeal by the use of the jurisdictional requirements described in this paragraph, the appellant then may resort to the venue provisions in the "Rules of Civil Procedure" to vest jurisdiction in a court. Such a party may also appeal a decision of the regional board of review from which the industrial commission has refused to permit an appeal to the commission. The claimant or the employer may appeal an order of the industrial commission made 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 for 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 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.

HISTORY: Eff 10-17-68; 1-16-78; 8-22-86 (Emer.); 11-8-86

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

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.

HISTORY: Eff 10-17-68; 1-16-78; 10-4-04

4123-3-21 Change of address. (to rescind)

(A) To effect a change of address, an employee shall file a signed request for such change, which request shall indicate the former address as well as the new address. If an employee has more than one claim pending, he shall file a separate request for each claim. When the change of address has been effected, the request for change shall be incorporated in the applicable claim file.

(B) To effect a change of address, an employer shall file a signed request for such change, which request shall indicate the former address as well as the new address. A separate request shall be filed in each claim pending against the employer's risk and shall be incorporated in the applicable claim file. When the Claims Section receives a request for a change of address from an employer, that Section shall notify the Accounts, Actuarial, and Underwriting-Field Auditing Sections, which sections shall effect the change of address upon their records.

HISTORY: (former IC/WC-21-21); Eff 1-1-64

4123-3-22 Inspection of claim files. (to 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. 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.

(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) ~~Employee's social security number and age~~ date of birth;
- ~~(4)~~ (3) City or community where accident occurred;
- ~~(5)~~ (4) Nature of disability.²

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

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

(1) The parties and/or their duly authorized representatives as outlined in paragraphs (A), (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 ~~sixty days~~ one month 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 "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, ~~he~~ 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 ~~his~~ 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.

HISTORY: Eff. 1-1-64; 1-16-78; 10-4-04

4123-3-23 Limitations on the filing of fee bills. (no changes)

Fee bills requesting payment for medical or other services rendered in a claim shall be filed with the bureau or commission within two years of the date on which the service was rendered or shall be forever barred. In cases where the claim was disallowed and by later action is allowed, such fee bills shall be filed within six months from the date of the mailing of the final order allowing the claim or be forever barred. Thus, a fee bill to be timely filed, must be filed either within two years from the date services were rendered or

within six months from the date of the mailing of the final order of allowance of claim, whichever period of time is longer, or be forever barred.

Prior Effective Dates: 1/1/64, 1/9/67, 1/16/78

4123-3-24 Fee controversies. (to end)

When a controversy exists between a party and ~~his~~ 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.

Prior Effective Dates: 1/1/64, 1/16/78

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

(A) A request for a change of occupation allowance shall be made by motion. Such motion shall be properly completed and signed in accordance with instructions set forth thereon and the rules of the bureau.

(B) The adjudication of change of occupation benefits is within the jurisdiction of the bureau. The bureau shall issue an order indicating ~~its~~ its decision on the request for change of occupation. A wage statement must also be filed to support the fact that the occupation has been changed. The award is based on the actual change of occupation.

HISTORY: Eff 1-1-64; 1-16-78; 10-1-04

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

(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 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 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 rule 4123-3-16 (A) 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.

HISTORY: Eff 1-1-64; 1-16-78; 10-1-04

4123-3-29 Informing the claimant of the right to representation. (to amend)

(A) Whether a claimant is or is not represented in an industrial claim is a matter of his 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 of the Revised Code.

Prior Effective Dates: 1/16/78

4123-3-30 Procedures to inform claimant on request as to the status of his [or her] claim and of any action necessary to maintain the claim. (to amend)

(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-file 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. ~~Letters concerning status of claims located in general files of the central office shall be referred by the file room supervisor, together with the claim file, to the correspondence unit for reply.~~

(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 ~~file~~, or to have said office immediately notify the claimant in writing of the status of the claim.

HISTORY: Eff 1-16-78; 10-1-04

4123-3-31 Disabled workers' relief fund: claimant's payments. (to amend)

(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 ~~(three hundred forty-two dollars per month adjusted annually)~~ 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 ~~he~~ 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 ~~he~~ 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.

Prior Effective Dates: 8/22/86 (Emer.), 11/8/86

4123-3-32 Temporary total examinations. (to 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 ~~not~~ 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.

(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.

HISTORY: Eff 9-15-91; 10-4-04

4123-3-34 Settlement of state fund claims. (no changes)

(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) 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.

(F) 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) 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) 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) 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) and (G) of this rule, the agreed settlement shall be final and cannot be appealed to the industrial commission or to court.

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

(L) 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.

Prior Effective Dates: 7/12/99, 2/16/07

4123-3-35 Employer handicap reimbursement. (to 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)(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~~ degenerative disc disease, spondylosis, spondylolysis, and spondylolisthesis do not constitute evidence of arthritis for purposes of satisfying the statute.

(2) 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.~~ (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 30 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 31 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 self-insuring employer that has elected to continue to participate in the handicap reimbursement program, the application shall be filed as provided in paragraph (G) of this rule. 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 as 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 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, signed, 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 ~~the coverage was lapsed or canceled on the date of the application or hearing, the employer is entitled to a determination of handicap relief under section 4123.343 of the Revised Code~~ 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.

(1) 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.

HISTORY: Eff 1-10-78; 12-11-78; 2-16-87; 7-12-99; 10-4-04

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

~~(A) Pursuant to section three of Sub. H.B. 75 of the 124th General Assembly, the administrator, with the advice and consent of the workers' compensation oversight commission, hereby adopts this rule to identify specified medical conditions for which the administrator may grant immediate allowance and immediate payment in accordance with this rule.~~

~~(B) The administrator shall establish a pilot program to determine the effectiveness of the immediate allowance of medical conditions under this rule. The pilot program and this rule shall be effective through April 10, 2004, at which time the bureau shall terminate the pilot program and the rule shall cease to be effective.~~

~~(C) The administrator shall identify specific medical conditions that have a historical record of being allowed whenever included in a claim.~~

(A) In accordance with R.C. 4123.511(A) 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 ~~may identify~~ has identified these medical conditions by ICD code ~~or other method of designation~~ and narrative description.

(2) The administrator ~~may use~~ used historical statistical criteria to determine the appropriate specific medical conditions to include in the ~~pilot program under this rule~~. The criteria ~~may include, but are not limited to,~~ 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) The medical conditions that the administrator ~~determines are~~ determined to be included ~~in the pilot program under this rule~~ are attached as Appendix A.

(D) 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 of 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.

(E) 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.

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

HISTORY: Eff 12-17-01

4123-3-37 Lump sum advancements. (no changes)

(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) Except for advancements of awards of compensation made pursuant to division (B) of section 4123.57 of the Revised Code, 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.

HISTORY: Eff. 12-1-04

Common Sense Business Regulation (BWC Rules)

(Note: The below criteria apply to existing and newly developed rules)

Rule 4123-6-37.1

Rule Review

1. The rule is needed to implement an underlying statute.

Citation: O.R.C. 4121.441(A)(8); O.R.C. 4123.66

2. The rule achieves an Ohio specific public policy goal.

What goal(s): The rule adopts a discounted pricing methodology for hospital inpatient services in accordance with O.R.C. 4121.441(A)(8) and *Ohio Hosp. Assn. v. Ohio Bur. of Workers' Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499.

3. Existing federal regulation alone does not adequately regulate the subject matter.

4. The rule is effective, consistent and efficient.

5. The rule is not duplicative of rules already in existence.

6. The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.

7. The rule has been reviewed for unintended negative consequences.

8. Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.

Explain: The proposed rule changes were presented for review and comment to the Ohio Hospital Association (OHA), and to various employer stakeholder groups.

9. The rule was reviewed for clarity and for easy comprehension.

10. The rule promotes transparency and predictability of regulatory activity.

11. The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.

12. The rule is not unnecessarily burdensome or costly to those affected by rule.

If so, how does the need for the rule outweigh burden and cost? _____

13. The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

Hospital Inpatient Reimbursement Rule 2009 Annual update Calendar

April	CMS (Medicare) releases proposed rule for hospital inpatient prospective payment system
April – May	BWC reviews rule and analyzes prior years experience
June	BWC drafts rule update
August	CMS releases final rule for hospital inpatient prospective payment system
August	BWC obtains stakeholder comment; finalizes rule update
September - October	Medical Services Division presents to the Board
November	Proposed rule submitted to JCARR
February 2010	Updated rule becomes effective

Professional Fee Schedule Reimbursement Rule 2009 Annual update Calendar

October	Begin work on 2009 recommendations for 2010 fee schedule. Setting goals, developing guiding principles, scheduling strategy meetings with stakeholder group, began evaluation of benefit coverage, began research, provider penetration determination, etc.
November	CMS (Medicare) releases final revisions via The Federal Register for professional fee schedule, including changes in the conversion factor and relative value units (RVU).
November - December	BWC reviews Medicare proposed additional CPT and HCPCS codes to determine BWC coverage eligibility
December-January	BWC reviews BWC's current CPT, HCPCS and local codes against Medicare proposed codes for changes in RVUs, conversion factors and pricing; compiling and posting 2009 recommended fee schedule.
February	BWC obtains, evaluates and incorporate stakeholder input and comment into final recommendation
February-March	Medical Services Division presents to the Board
April 14	Proposed rule submitted to JCARR
July 1	Updated rule becomes effective

BWC Board of Directors
Executive Summary
BWC Hospital Inpatient Services
Payment Rule

Introduction

The Health Partnership Program (HPP) rules were first promulgated in 1996, prior to the implementation of the HPP in 1997. Subsequently, HPP rules establishing criteria for the payment of various specific medical services were adopted in February 1997.

Ohio Administrative Code 4123-6-37 provides general criteria for the payment of hospital services under the HPP. Ohio Administrative Code 4123-6-37.1 provides specific methodology for the payment of inpatient hospital services. It was initially adopted effective January 1, 2007, and was later amended effective April 1, 2007 and January 1, 2008.

Background Law

R.C. 4121.441(A)(8) provides that the Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to injured workers, including but not limited to discounted pricing for all inpatient medical services.

In accordance with this statute, BWC adopted OAC 4123-6-08. Since its promulgation in February 1996, OAC 4123-6-08 has provided that “. . . the bureau shall develop, maintain, and publish a provider fee schedule for the various types of billing codes. The fee schedules shall be developed with provider and employer input.”

However, prior to the 10th District Court of Appeals decision in *Ohio Hosp. Assn. v. Ohio Bur. of Workers' Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499, BWC adopted the specific methodology for the payment of hospital inpatient services in the manner provided for in O.R.C. 4121.32(D), which grants BWC authority to “establish, adopt, and implement policy guidelines and bases for decisions involving reimbursement issues including, but not limited to . . . reimbursement fees . . . set forth in a reimbursement manual and provider bulletins.”

Pursuant to the Court of Appeals’ decision in the *OHA* case, BWC is now required to adopt changes to its methodology for the payment of hospital inpatient services via the O.R.C. Chapter 119 rulemaking process.

BWC’s hospital inpatient reimbursement methodology is based on Medicare’s “diagnosis related group” or “DRG” (changing this year to “Medicare severity diagnosis related group” or “MS-DRG”) methodology, which is updated annually. Therefore, BWC must also annually update OAC 4123-6-37.1, to keep in sync with Medicare.

Rule Changes

4123-6-37.1 Payment of hospital inpatient services.

Ohio Administrative Code 4123-6-37.1 currently incorporates by reference 42 C.F.R. Part 412 as published in the October 1, 2007 Code of Federal Regulations (C.F.R.), as well as Federal Register citations to the 2007 Medicare regulations under which the applicable DRG reimbursement rate was determined during the last Medicare fiscal year. BWC is proposing to revise the rule citations the Federal Register citations to the 2008 regulations, and 42 CFR Part 412 as published in the October 1, 2008 C.F.R.

The updated Medicare regulations move from the DRG methodology referenced in the current rule to a “Medicare severity diagnosis related group” or “MS-DRG” methodology, so BWC is proposing to amend its rule to reflect this change.

BWC is proposing to increase the amount reimbursed to hospitals to one hundred twenty percent (120%) of the applicable MS-DRG, rather than the one hundred fifteen percent (115%) of the applicable DRG under the current rule. Hospital specific per diem rates for direct graduate medical education shall be calculated annually by the bureau effective January 1 of each year, rather than October 1, to sync up with the effective date of the rule.

In addition, BWC is proposing that references in the current rule to hospitals’ “2006 total inpatient cost-to-charge ratios as reported to Ohio Medicaid” be defined with greater specificity and updated to the 2007 state fiscal year cost reports. MS-DRG exempt hospitals who submitted a 2007 cost report to ODJFS shall be reimbursed at seventy percent (70%) of billed charges; MS-DRG exempt hospitals who did not submit a 2007 cost report to ODJFS shall be reimbursed at sixty-two percent (62%) of billed charges.

BWC is proposing a new methodology for the payment of outliers. Under the proposed rule change, outliers will be reimbursed at one hundred seventy-five percent (175%) of the applicable MS-DRG reimbursement rate for the hospital inpatient service. Finally, language is added to the rule to clarify that the new reimbursement rate will apply to hospital inpatient services with a discharge date of January 1, 2009 or later.

4123-6-37.1 Payment of hospital inpatient services.

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-08 of the Administrative Code, reimbursement for hospital inpatient services with a discharge date of January 1, 2009 or after shall be as follows:

(A) Reimbursement for hospital inpatient services, other than outliers as defined in paragraph (C) of this rule or services provided by hospitals subject to reimbursement under paragraph (D) of this rule, shall be equal to one hundred ~~fifteen~~ twenty percent of the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare program inpatient prospective payment system.

(B) In addition to the payment specified by paragraph (A) of this rule, hospitals operating approved graduate medical education programs and receiving additional reimbursement from medicare for costs associated with these programs shall receive an additional per diem amount for direct graduate medical education costs associated with hospital inpatient services reimbursed by the bureau. Hospital specific per diem rates for direct graduate medical education shall be calculated annually by the bureau effective ~~October~~ January 1 of each year, using the most current cost report data available from the ~~Centers for Medicare and Medicaid Services~~ centers for medicare and medicaid services, according to the following formula:

~~1.15~~ $1.20 \times [(\text{total approved amount for resident cost} + \text{total approved amount for allied health cost}) / \text{total inpatient days}] = \text{direct graduate medical education per diem}$.

Direct graduate medical education per diems shall not be applied to outliers as defined in paragraph (C) of this rule or services provided by hospitals subject to reimbursement under paragraph (D) of this rule.

(C) Reimbursement for outliers as determined by medicare's inpatient prospective payment system outlier methodology shall be determined as follows: equal to one hundred seventy-five percent of the applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate for the hospital inpatient service under the medicare inpatient prospective payment system.

~~(1) For hospitals with a 2006 total inpatient cost-to-charge ratio as reported to Ohio medicaid, outliers shall be defined as hospital inpatient stays in which the hospital's allowable billed charges multiplied by the hospital's 2006 total inpatient cost-to-charge ratio as reported to Ohio medicaid is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to the hospital's allowable billed charges multiplied by the hospital's 2006 total inpatient cost-to-charge ratio as reported to Ohio medicaid, not to exceed sixty percent of the hospital's allowable billed charges;~~

~~(2) For hospitals without a 2006 total inpatient cost-to-charge ratio as reported to Ohio medicaid and out-of-state hospitals, outliers shall be defined as hospital inpatient stays in which sixty percent of the hospital's allowable billed charges is more than two standard deviations above the applicable medicare DRG value, and reimbursement for outliers shall be equal to sixty percent of the hospital's allowable billed charges.~~

(D) Reimbursement for inpatient services provided by hospitals and distinct-part units of hospitals designated by the medicare program as exempt from the medicare inpatient prospective payment system DRG-based reimbursement shall be determined as follows:

(1) For Ohio hospitals ~~with a 2006 total inpatient cost to charge ratio as reported to Ohio Medicaid~~ who submitted a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2007 state fiscal year, reimbursement shall be equal to the hospital's allowable billed charges multiplied by the hospital's reported total facility inpatient cost-to-charge ratio (from schedule B, line 101 of the hospital cost report) plus twelve percentage points, not to exceed seventy percent of the hospital's allowed billed charges.

(2) For Ohio hospitals ~~without a 2006 total inpatient cost to charge ratio as reported to Ohio Medicaid~~ who did not submit a hospital cost report (JFS 02930) to the Ohio department of job and family services for the 2007 state fiscal year and for out-of-state hospitals, reimbursement shall be equal to ~~sixty-six~~ sixty-two percent of the hospital's allowed billed charges.

(E) For purposes of this rule, the "applicable medicare severity diagnosis related group (MS-DRG) reimbursement rate" or "value" shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 as amended, excluding 42 U.S.C. 1395ww(d)(4)(D), as implemented by the following materials, which are incorporated by reference:

(1) 42 CFR C.F.R. Part 412 as published in the October 1, 2007 2008 Code of Federal Regulations;

(2) Department of Health and Human Services, Centers for Medicare and Medicaid Services' "42 CFR Parts 411, 412, 413, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule." Federal Register, Volume 72, Number 162, Pages 47129-48175, August 22, 2007, as updated in CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 1374, November 7, 2007 of health and human services, centers for medicare and medicaid services' "42 C.F.R. Parts 411, 412, 413, 422, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Payments for Graduate Medical Education in Certain Emergency Situations; Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Updates to the Long-Term Care Prospective Payment System; Updates to Certain IPPS-Excluded Hospitals; and Collection of Information Regarding Financial Relationships Between Hospitals; Final Rule," 73 Fed. Reg. 48434-01 (2008).

Effective: 01/01/2009

Prior Effective Dates: 1/1/07, 4/1/07; 1/1/08

BWC 2009 Proposed Inpatient Hospital Fees

Medical Service Enhancements

Prompt, effective medical care makes a big difference for those injured on the job. It is often the key to a quicker recovery and timely return-to-work and quality of life for injured workers. Thus, maintaining a network of dependable medical and vocational rehabilitation service providers ensures injured workers get the prompt care they need. Maintaining a network of hospitals to provide appropriate care is an important element to ensure the best possible recoveries from workplace injuries. It also ensures access to quality, cost-effective service. Access for injured workers, and employers, means the availability of quality, cost-effective treatment provided on the basis of medical necessity. It facilitates faster recovery and a prompt, safe return to work.

The Medical Services Division has focused on improving its core medical services functions. Our goals are as follows: enhance our medical provider network, establish a better benefits plan, institute an updated and competitive provider fee schedule, improve our managed care processes, and establish excellent medical bill payment services.

Inpatient Hospital Fee Schedule

Introduction and Methodology

As stated, implementing a sound and effective provider fee schedule is a critical component of the Medical Services Division's goals. Inpatient bills represent a small number of the bills BWC processes annually, however, they are a critical segment as they represent the treatment given to our most seriously injured workers. Inpatient hospitalization may be the first treatment following an injury; it may also be part of later treatment intended to return the injured worker to employment.

In financial terms, these bills represent 14.2% of BWC's overall medical expenses, even though they are 0.20% of bills received by BWC. An appropriate inpatient fee schedule is integral to assuring that injured workers are receiving quality care so that they may achieve the best possible recovery from their injuries. For the period reviewed (January 2008-June 2008), BWC paid the following medical expenses: Inpatient Hospital - \$63 million, Outpatient Hospital - \$ 102 million, Pharmacy - \$ 66 million, and Professional and Other - \$ 209 million.

The BWC inpatient fee schedule was last updated by the Board effective January 2008. It is based on a standard Medicare pricing methodology, Medicare Severity Diagnosis Related Groups (MS-DRG) that is updated annually. BWC must update the rule annually to reference the new federal rule in order to be consistent with the Medicare model. In addition, as part of the annual process, BWC takes the opportunity to 1) review the adjustment factors it uses and 2) ensure that the methodology is meeting BWC's goals.

The methodology calculates a fixed price for groupings of procedures and diagnoses. Medicare adjusts pricing for each hospital using hospital-specific factors that include the hospital's average costs, its typical patient population, and prevailing wages in the hospital's geographic area within the state. In addition, the calculation provides additional reimbursement for complicated cases to ensure that hospital expenses are covered more equitably. Medicare also supports medical education programs by making additional payments to teaching hospitals.

BWC implemented Medicare's diagnosis-related groups (DRGs) in January 2007 but with customized outlier and medical education payments. In 2008, BWC revised its program to implement Medicare's new MS-DRG methodology. In the revision before you, we propose to implement Medicare's 2009 MS-DRG calculations and to make changes to our customized outlier calculation.

2009 Proposed Inpatient Fee Schedule Recommendations

For calendar year 2009, the Medical Services Division is recommending the following changes:

1. Revised outlier methodology
2. Revised payment adjustment factors
3. Update of cost-to-charge ratios for exempt providers
4. Change in the effective date for direct graduate medical education per diem rates
5. Exclusion of Medicare's hospital-acquired conditions provision

Overall, 2009 aggregate payments will be similar to those of 2008, but payments will be distributed more equitably among inpatient bill types.

1. Proposed Outlier Methodology

Currently, BWC has a customized calculation to identify outliers. Generally, an outlier is a case where costs are significantly higher than average for the type of service billed. When a bill is identified as an outlier, it is paid at a hospital-specific percentage of charges, not to exceed 60% of total charges. For 2008, this methodology has resulted in 20% of BWC's inpatient hospital payments reimbursed as outliers. However, Medicare requires that outlier payments constitute between 5 and 6 percent of total payments. Many commercial payers design reimbursement systems so that 6 to 8 percent of total payments are allocated for outlier cases. Four other workers' compensation jurisdictions (Texas, California, North Dakota and South Carolina) have adopted Medicare's MS-DRGs. All four of these jurisdictions utilize Medicare's methodology to identify outliers. Therefore, BWC analyzed 2008 first and second quarter data to determine if the Medicare outlier methodology would be appropriate for our hospital inpatient experience.

A review of BWC bills paid as outliers under the current approach demonstrated that several bills paid as outliers would not be outliers under the Medicare methodology.

Rather, these bills would be more appropriately reimbursed at the standard MS-DRG rate. This is supported by cost and length of stay data presented in the tables below.

Average Cost per Case 1Q and 2Q Hospital Inpatient Data				
	Volume 2008 Methodology	2008 Methodology	Volume 2009 Methodology	2009 Methodology
All Bills	2254	\$16,410	2254	\$16,410
DRG (non-outlier)	1835	\$12,729	1983	\$13,918
Outlier	185	\$42,307	37	\$96,926
Exempt	234	\$24,801	234	\$24,801

Average Length of Stay 1Q and 2Q Hospital Inpatient Data				
	Volume 2008 Methodology	2008 Methodology	Volume 2009 Methodology	2009 Methodology
All Bills	2254	4.2 days	2254	4.2 days
DRG (non-outlier)	1835	3.3 days	1983	3.4 days
Outlier	185	7.4 days	37	19.7 days
Exempt	234	8.9 days	234	8.9 days

During first and second quarter 2008, 185 bills were categorized as outliers under the current BWC outlier methodology. Using the Medicare methodology, 37 (20%) of those bills are categorized as Medicare outliers. The remaining 148 (80%) of the bills are then considered Medicare non-outliers. The data shows that this group of Medicare non-outliers significantly lower the average cost per case and average length of stay in the outlier category. Once these bills are removed from the outlier category the average cost per case increases from \$42,307 to \$96,926. Likewise, the average length of stay increases from 7.4 days to 19.7 days. When the Medicare non-outlier cases (148 bills) are moved to the DRG category the cost and length of stay data more in alignment with what one would expect. With this methodology, BWC is projecting that 9 percent of total payments would be provided for outlier bills. Therefore, utilizing the Medicare outlier methodology for outlier determination will provide the case distribution and BWC reimbursement allocation desired by BWC.

For 2009, we are proposing a payment methodology that will use Medicare's methodology to identify outliers, but use a distinct adjustment factor to ensure that hospitals are fairly reimbursed for these services and that reimbursement actually covers the hospitals' costs.

2. Proposed Adjustment Factors

We are proposing a two-tiered adjustment method, with MS-DRGs to be reimbursed at 120% of the Medicare rate and MS-DRG outliers to be reimbursed at 175% of Medicare.

Four other workers' compensation jurisdictions (Texas, California, North Dakota and South Carolina) were reviewed in developing this proposal. All of them have a single adjustment factor ranging between 120% (California) and 143% (Texas). North Dakota excludes a provision that adjusts payments when the injured worker is transferred to a non-acute hospital. Texas also allows providers to select a lower adjustment factor with an add-on payment for specific medical devices.

A detailed review of BWC's bill history led to the conclusion that a single adjustment factor would not adequately reimburse more serious cases as it would result in reimbursement of between 69% and 77% of the hospitals' costs on average. The proposed adjustment factors allow BWC to reimburse hospitals at slightly above cost for both MS-DRG and MS-DRG outlier payments.

3. Updated Cost-to-Charge Ratios for Exempt Providers

Hospitals that are not eligible to be reimbursed using the MS-DRG methodology (e.g. rehabilitation, psychiatric) are reimbursed at 12% above cost-to-charge ratios (CCRs) reported to Ohio Medicaid. We are proposing no change to the 12% adjustment factor, but propose updating to the latest CCRs (state fiscal year 2007). In addition, for hospitals who do not report CCRs to Ohio Medicaid (primarily out-of-state facilities), we propose an update to the statewide average used in determining their reimbursement rate. The current exempt rate for these providers is 66% of charges and is based on Ohio's 2004 statewide average. We propose a rate of 62% of charges, which is based on the 2007 statewide average.

4. Change in Effective Date of Direct Graduate Medical Education Provision

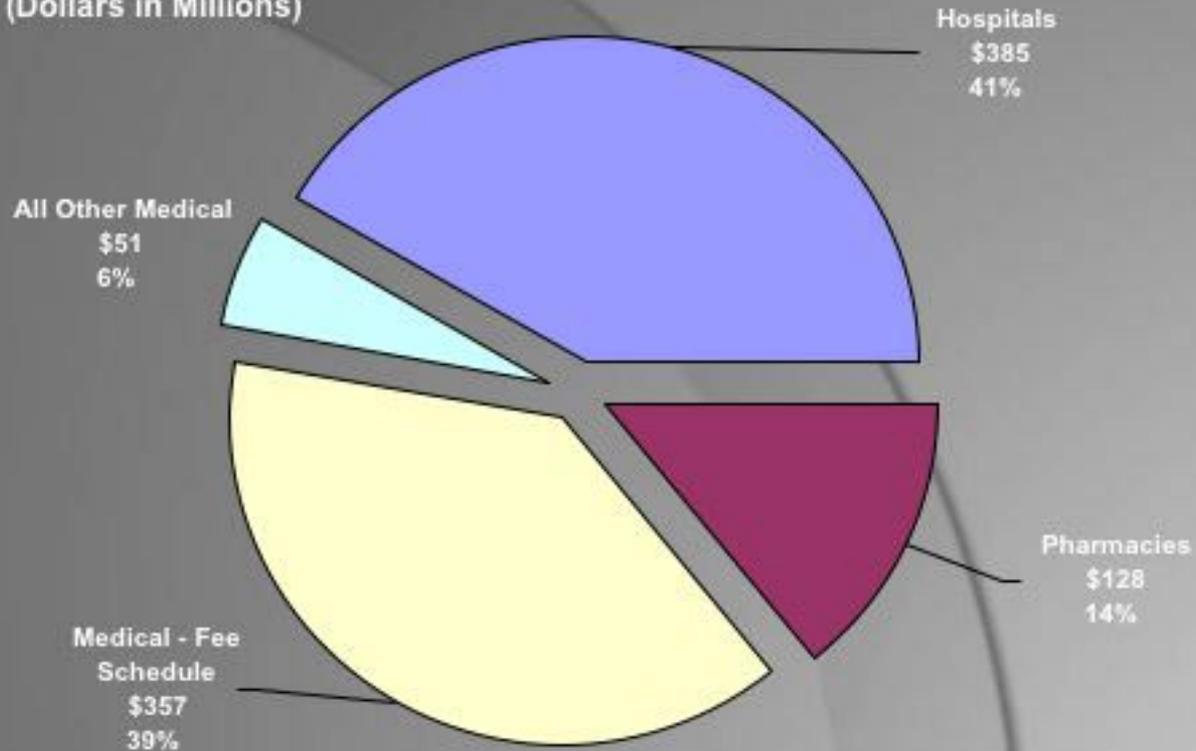
Like Medicare, under BWC's current methodology an additional per diem is paid to hospitals that support medical education programs. We are not proposing a change to this provision, but propose to make it effective on the same date as the hospital inpatient fee schedule. It is currently effective October 1 of each year, and coincides with the federal fiscal year, but not with any of BWC's pricing effective dates.

5. Exclusion of Medicare's hospital-acquired conditions provision

BWC is excluding Medicare's provision that reduces payment in cases where specific conditions are acquired during a hospital stay. This provision is new in 2008 and has generated a great deal of controversy as it is difficult to prove that the conditions were actually acquired in the hospital. (It is possible the conditions were not detected upon admission.) BWC prefers to exclude this aspect of payment at this time. This will allow time for Medicare to work out any issues with this aspect of the payment and will also allow BWC to validate that it receives accurate data for this payment. We do not currently capture the required data to execute this provision, but anticipate being able to capture it in early 2009.

Financial Overview

TOTAL MEDICAL PAYMENTS = \$799
April 2007 to March 2008
(Dollars in Millions)



All Other Medical include payments such as:

- Payments to Ambulatory Surgical Centers
- Payments (thru MIIS) for W-codes -- most notably file reviews and IMEs

OBWC Board of Directors

Audit and Finance Committee Charter

Purpose

The Audit and Finance Committee has been established to assist the Board of Directors of the Ohio Bureau of Workers' Compensation in fulfilling its fiduciary oversight responsibilities through:

- providing oversight of the integrity of financial reporting process;
- ensuring compliance with legal and regulatory requirements;
- monitoring the design and effectiveness of the system of internal control;
- confirming external auditor's qualifications and independence; and
- reviewing performance of the internal audit function and independent auditors.

Membership

The Committee shall be composed of a minimum of three (3) members. One member shall be the appointed certified public accountant member of the board. The Board, by majority vote, shall appoint two additional members to serve on the Audit Committee and may appoint additional members, who are not Board members, as the Board determines necessary. Members of the Audit Committee serve at the pleasure of the board and the board, by majority vote, may remove any member except the member of the committee who is the certified public accountant member of the board.

Each committee member will be independent from management. The Chair and Vice Chair is designated by the Board, based on the recommendation of the Board Chair. The Board Chair if not a member is an ex-officio member, shall not vote if his/her vote will create a tie vote when serving as ex-officio.

The Committee Chair will be responsible for scheduling all meetings of the Committee and providing the Committee with a written agenda for each meeting. The Committee will have a staff liaison designated to assist it in carrying out its duties.

Meetings

The Audit Committee shall meet at least nine (9) times annually, or as frequently as needed and will provide activity reports to the Board of Directors. The Committee will invite members of management, external auditors, internal auditors and/or others to attend meetings and provide pertinent information, as necessary. Subject to open meeting laws, the Committee will hold executive sessions with external auditors, when deemed appropriate in the performance of their duties. A quorum shall consist of a majority of the Committee members. Committee meetings will be conducted according to Robert's Rules of Order. The Committee will have a staff liaison designated to help it carry out its duties.

Duties and responsibilities

The Audit Committee shall have responsibility for the following:

1. Oversight of the integrity of the financial information reporting process:
 - a. Review with management and the external auditor significant financial reporting issues and judgments made in connection with the preparation of the financial statements.
 - b. Review with management and the external auditor the results of the audit.
2. Review all internal audit reports on regular basis.
3. Review results of each annual audit and management review; if problems exist, assess appropriate course of action to correct, and develop action plan. Monitor implementation of any action plans created to correct problems noted in annual audit.
4. Serve as the primary liaison for Bureau of Workers' Compensation Board of Directors and providing a forum for handling all matters related to audits, examinations, investigations or inquiries of the Auditor of State and other appropriate State or Federal agencies
5. Develop an oversight process to assess the adequacy and effectiveness of internal controls and provide the mechanisms for periodic assessment of system of internal controls on an ongoing basis.
6. Oversee the assessment of internal administrative and accounting controls by both the external independent financial statement auditor and internal auditor.
7. Consult on the appointment and/or removal of the Chief of Internal Audit and have oversight on the work of the Internal Audit Division.
8. Ensure the independence of the external auditor and approve all auditing, other attestations services and pre-approve non-audit services performed by the external auditor.
9. Review the internal financial statements on a monthly basis.
10. Review management's appropriation requests and recommend approval to the Board.
11. Receive and review reports from management regarding the status of appropriations bills.
12. Review and recommend to the Board the proposed annual fiscal year Administrative Cost budget prepared by management. Also, advise the Board of any adjustments made to the proposed budget.
13. At least once every 10 years, have an independent auditor conduct a fiduciary performance audit of BWC's investment program, policies and procedures. Provide a copy of audit to the Auditor of State. (ORC 4121.125(D), effective 2007)
14. After every meeting, report to the Board of Directors of the Bureau of Workers' Compensation on all activities, findings and recommendations of the Committee.
15. Establish policies and procedures to function effectively.
16. Recommend to the Board an accounting firm to perform the annual audit required under R.C. 4123.47. Recommend an auditing firm for the Board to use when conducting audits under R.C. 4121.125.
17. Retain and oversee consultants, experts, independent counsel, and accountants to advise the Committee on any of its responsibilities or assist in the conduct of an investigation.
18. Seek any information it requires from employees—all of whom are directed to cooperate with the Committee's requests, or the requests of internal or external parties working for

- the Committee. These parties include, but are not limited to internal auditors, all external auditors, consultants, investigators and any other specialists working for the Committee.
19. All Committee actions must be ratified or adopted by the Board of Directors of the Bureau of Workers' Compensation to be effective.
 20. Coordinate with the other Board Committees on items of common interest.
 21. At least annually, this charter must be reviewed by the Audit Committee and any proposed changes submitted to the Governance Committee and to the Board for approval.
 22. At least annually, meet with General Counsel and Chief of Internal Audit to review BWC Code of Ethics to ensure that it is adequate and up-to-date. Report on review and recommended changes, if necessary, to the Board.
 23. The Committee by majority vote may create a subcommittee consisting of one or more Directors on the Committee. In consultation with the chair, other board members may be appointed to the subcommittee as appropriate. The subcommittee shall have a specific purpose. Each subcommittee shall keep minutes of its meetings. The subcommittee shall report to the Board of Directors through the Committee. The Committee by majority vote may dissolve the subcommittee at any time.

Audit Committee Charter.doc
Draft 092607
Review & Approved 112107, Ken Haffey, Chair
Revised 012408
Revised 012508
Revised 092408
Annual Review and Revision 112108