

**BWC Board of Directors
Audit Committee**

DRAFT

Thursday, July 24, 2008 4:00 P.M.
William Green Building
Neil Schultz Conference Center
30 W Spring St, 2nd Floor (Mezzanine)
Columbus, OH 43215

Members Present: Kenneth Haffey, Chair
Philip Fulton
William Lhota
James Harris (arrived at 4:27 PM)
James Matesich

Members Absent: None

Other Directors Present: Larry Price, James Hummel, Alison Falls and Robert Smith

CALL TO ORDER

Mr. Haffey called the meeting to order at 4:02 PM and the roll call was taken.

MINUTES OF JUNE 26, 2008

The minutes were approved without further changes by unanimous roll call vote on a motion by Mr. Matesich, seconded by Mr. Lhota.

NEW BUSINESS / ACTION ITEMS

1. Proposed Rule 4123-6-05: HPP MCO Open Enrollment

Tom Sico, Assistant General Counsel, and Robert Coury, Chief of Medical Services, presented proposed Rule 4123-6-05. This amendment eliminates a post-merger open enrollment period for a Managed Care Organization (MCO) which is purchased by a competing MCO. After inquiry by Mr. Matesich, Mr. Sico reviewed the common sense business regulation checklist, noting constituent participation in developing the rule.

Mr. Coury stated that the open enrollment was a barrier to MCO consolidation and devalued the acquired MCO. This was weighed versus protecting employer choice. The amended rule retains the language in subparagraph (E) that if BWC determines it is in the employer's best interest, the employer may select a new MCO.

Mr. Fulton questioned the lack of process explanation in subparagraph (E). Mr. Coury explained that the process is implicit and employers are familiar with this language. Pete Mihaly, BWC

Legal Counsel, also noted that affected employers receive letters from BWC and the acquiring MCO. Mr. Lhota echoed Mr. Fulton's concerns. Mr. Coury designated by name the various constituent parties which had reviewed and approved the proposed rule, including the MCO League, all participating MCO's, NFIB, Ohio Chamber of Commerce, COSE and the Ohio Manufacturing Association.

After further discussion, the matter was tabled to later in the agenda so that clarifying language could be drafted for approval.

2. Medical Fee Schedules

Robert Coury, Chief of Medical Services, and Judy Brabb, Medical Policy Manager, presented a PowerPoint on proposed 2008 provider fees schedules. The Ohio Hospital Association case mandated that these schedules are subject to the administrative rule process. They will be incorporated in an Appendix to OAC Rule 4123-6-08. The public comment period for these proposed schedules runs through August 15, 2008. A provider forum was held July 22, 2008. After review and comment, the schedules will be presented to the Audit Committee for approval at the August meeting. The guiding principle is to "ensure access to high-quality medical care by establishing an appropriate Benefit plan and Terms of service with competitive fee schedule which, in turn, enhances medical provider network."

Mr. Coury and Ms. Brabb explained the methodology and computation process based upon the Medicare model for paying Current Procedure Terminology (CPT) codes, which make up 85% of BWC spending in this area. BWC research and review, including benchmarking Ohio and other payers, produced a conversion factor (CF) of \$50, as opposed to Medicare's \$35 CF. This proposed figure is applicable to all service classes except surgery, which remains at \$79.10. This is comparable to many other state workers' compensation systems with a state fund, whether those systems are privatized or a monopoly. The overall impact of the fee schedule changes is a 5.1% cost increase, or approximately \$18.4M.

Mr. Fulton noted that payments with respect to physical medicine have decreased 5% since 2003, and encouraged adoption of a \$51 conversion factor. Mr. Coury stated that such input is welcomed, but to date there has been no evidence to suggest a change in the figure is necessary. Mileage reimbursement is being increased from \$.30 per mile to \$.51 per mile. Any additional input received before August 15, 2008, including an upcoming meeting with vocational rehabilitation providers, will be shared with the Committee members and Board in August. Administrator Ryan commended the Medical Services personnel for their work in producing this information and encouraged the Board members to provide input and questions. She emphasized that our figures are not outside the benchmarks, and substantially beyond what Medicare provides.

Mr. Hummel raised a question about private company benchmarking. Ms. Brabb explained that although information was requested from insurers, a valid comparison could not be made because the companies would not release all relevant information. We do know that such insurers also use the Medicare benchmarks.

Further discussion on this issue will occur at the August meeting.

3. BWC Fiscal Year 09 Financial Projections

Tracy Valentino, Chief of Fiscal and Planning, and Ray Mazzotta, Chief Operating Officer, provided further review of the financial projections for FY 09, from July 1, 2008 through June 30, 2009. It was noted BWC's track record for projecting the 2007-2008 budgets was not particularly accurate, so further review was conducted of other state agencies such as Tax and ODJFS, along with economic forecasts, payroll trends, investment information, and cash flow.

The projected statement of operations was also addressed. Payroll and premium projections are flat. BWC has taken a very conservative view of benefits and compensation, with no growth in net assets, and some decrease in cash which is not significant. Some one-time events from prior years, such as payouts based on the Santos and OHA rulings, will not occur or impact the 2009 figures.

Mr. Matesich and Ms. Falls raised issues with respect to moving away from targeted figures, whether targets were too aggressive, and is there an overall problem which must be addressed. Administrator Ryan clarified that page 14 of the Board materials addresses these issues, and that targets may require change. Mr. Matesich asked that future projections be displayed with trend lines.

DISCUSSION ITEMS

1. FY 2010/2011 Proposed Budget

Ms. Valentino explained the biennial budget process for submission to the General Assembly by September 15, 2008 for approval of an appropriation (spending cap). BWC spending has been well below the appropriated amount for FY 2008/2009. This budget is subject to Board approval. An executive summary and line-item breakdown will be reviewed at the August Audit Committee meeting. Ms. Valentino and her staff will also provide OBM and Legislative Services Commission budget analysis reports as available. Ms. Falls suggested that the Board undertake a strategic financial planning process for future budgets.

Mr. Hummel suggested the Directors make an effort to attend the budget hearings. Ms. Valentino advised these will be held approximately March 2009.

2. External Audit Update

Mr. Haffey reported on his meeting with the external auditors from Schneider Downs. The first portion of the audit process is concluding and a meeting with management is scheduled for July 31, 2008. The second part of the audit involves balance sheet testing. Mr. Haffey conveyed that no significant matters have arisen to date, management comments are minimal, and everything is proceeding according to expectations.

3. Further Discussion of Rule 4123-6-05

Mr. Sico presented the following clarifying language to subparagraph (E):

“At the bureau’s discretion or upon the employer’s request, the bureau may reassign an employer from the MCO if the bureau determines that the reassignment is in the best interest of both the employer and the MCO.”

Mr. Matesich moved to recommend approval of the proposed Rule 4123-6-05, as amended, to the Board of Directors, seconded by Mr. Fulton. The motion was approved by unanimous roll call vote.

3. Office of Budget and Management, Internal Audit Update

Joe Bell transitions to the OBM effective August 4, 2008, but will still attend Board and Committee meetings. A Request for Proposal for consultants to help establish the State Internal Audit office has been issued. Mr. Bell met with the State Audit Committee chair. The first committee meeting is tentatively set for September 2008.

4. Litigation Update

There was nothing to report for this agenda item.

Calendar Review

The Committee discussed and agreed to move the October Audit Committee meeting date to October 28, 2008 from 4 PM to 6 PM. Mr. Matesich will be unable to attend.

ADJOURNMENT

The next Audit Committee meeting is August 28, 2008 at 4:00 PM.

Mr. Lhota moved to adjourn the meeting at 6:05 PM, seconded by Mr. Fulton.

Prepared by Jill Whitworth, BWC Staff Counsel
July 25, 2008

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.

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.

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31

Rule Amplifies: 4121.121, 4123.05

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.

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.13, 4121.30, 4121.31

Rule Amplifies: 4121.11, 4121.121, 4123.05

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

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.12, 4121.30, 4121.31

Rule amplifies: RC 4121.11, 4121.121, 4123.05, 4123.28

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

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

Rule promulgated under: RC Chapter 119.

Rule amplifies: RC 4121.121, 4121.30, 4121.31 in conjunction with 4121.13 and 4123.05

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

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.13, 4121.30, 4121.31

Rule amplifies: RC 4121.121, 4123.05, 4123.59

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

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 3 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 claims, 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

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.30, 4121.31

Rule amplifies: RC 4121.121, 4123.032, 4123.05, 4123.28, 4123.511, 4123.68, 4123.84, 4123.85, 4123.89

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

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)(11) 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~~ After an appeal of the bureau's order, hearings before a district hearing officer with notices to the interested parties shall be scheduled at the earliest possible date but no later than forty-five days after the filing of the appeal.

(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.

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~~ bureau. 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 an 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 the 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 or her 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

Rule promulgated under: RC Chapter 119.

Rule authorized by: RC 4121.121

Rule amplifies: RC 4121.121, 4121.43, 4123.651

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.

(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.

Effective: 02/15/2008

R.C. 119.032 review dates: 11/30/2007 and 02/15/2013

Promulgated Under: 119.03

Statutory Authority: 4121.30, 4121.31, 4121.43

Rule Amplifies: 3121.0311, 4121.12, 4121.121, 4123.311

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

4123-3-11 Reports of payments by self-insuring employers. (to amend)

(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.~~ (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-payment 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 therefor 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

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.11, 4121.30

Rule amplifies: RC 4121.121, 4123.05, 4123.35

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

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

Rule promulgated under: RC 111.15

Rule authorized by: RC 4121.121, 4121.11, 4121.13, 4123.05

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

Rule promulgated under: RC 119.03

Rule amplifies: RC 4121.121, 4123.05, 4123.57

Rule authorized by: RC 4121.13, 4121.30

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

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

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.30, 4121.31, 4123.05

Rule amplifies: 4121.121, 4123.57, 4123.65

R.C. 119.032 review dates: 01/08/2003 and 03/01/2008

4123-3-16 Motions. (to amend)

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

(B) Motions 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 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 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 shall bear the signature of the ~~applicant~~ applicant or their his 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. Motions 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. Motions requesting the recognition of an additional condition of a psychiatric nature shall be accompanied by supporting medical evidence consisting of a report by a licensed psychiatric specialist, a clinical psychologist, licensed clinical counselors (LPCC), and licensed independent social workers (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 a medical 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) The request is within the jurisdiction of the bureau 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 request shall be referred to the commission for further consideration.~~

~~(5) If the claimant fails to comply with the bureau's request, the claim file shall be referred to the commission with recommendation to dismiss the motion.~~

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

Rule promulgated under: RC Chapter 119.

Rule amplifies: RC 4121.121, 4121.30, 4121.31 in conjunction with 4121.13, 4123.05

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

Rule promulgated under: RC 119.03

Rule amplifies: RC 4121.121, 4123.05

Rule authorized by: RC 4121.13, 4121.30, 4121.31

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

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

(A) Administrative appeals.

(1) The right of administrative appeal is limited to the claimant, the dependents of a deceased worker, the employer and the administrator; the administrator or his representative acting 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 ~~OIC 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 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~~ on the date the order is received by the employer 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 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 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.

Payment of medical benefits shall commence on the date the order is issued by the staff hearing officer or the date of the final administrative or judicial determination, whichever is earlier.

~~(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~~ fourteen day appeal period, provided that no appeal was filed.

(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
Rule promulgated under: RC Chapter 119.
Rule authorized by: RC 4121.121
Rule amplifies: RC 4121.121, 4121.13, 4121.30, 4121.31, 4123.05, 4123.516, 4123.519

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
Rule promulgated under: RC 119.03
Rule authorized by: RC 4121.121, 4121.30, 4121.31
Rule amplifies: RC 4121.121, 4123.05
R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

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
Rule promulgated under: RC 111.15
Rule authorized by: RC 4121.121, 4121.11, 4121.13, 4123.05

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.

(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 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 year prior to its use;
- (3) Members of the general assembly when in the course of their duties as such;
- (4) The governor, a select committee of the general assembly, a standing committee of the general assembly, the auditor of state, the attorney general, or the designee of any, in the pursuance of any duty imposed by Chapters 4121. and 4123. of the Revised Code.
- (5) Duly authorized employees of governmental agencies whose official duties require the information contained in the claim files;
- (6) Such other persons as are specifically authorized by a member of the commission or the administrator pursuant to the provisions of section 4123.88 of the Revised Code.

(E) A person entitled to inspect a claim file shall complete and file "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 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 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 is not receiving a fee for his 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
Rule promulgated under: RC 119.03
Rule authorized by: RC 4121.30, 4121.31
Rule amplifies: RC 4121.121, 4123.27, 4123.88
R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

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.

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008
Promulgated Under: 119.03
Statutory Authority: 4121.30, 4121.31
Rule Amplifies: 4121.121, 4123.66
Prior Effective Dates: 1/1/64, 1/9/67, 1/16/78

4123-3-24 Fee controversies. (no changes)

When a controversy exists between a party and his 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.

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008
Promulgated Under: 119.03
Statutory Authority: 4121.30, 4121.31
Rule Amplifies: 4121.121, 4123.06
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 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

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.13, 4121.30, 4121.31

Rule amplifies: RC 4121.121, 4123.05, 4123.57

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

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) The request is within the jurisdiction of the bureau 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 request shall be referred to the commission for further consideration.

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

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.13, 4121.30, 4121.31

Rule amplifies: RC 4121.121, 4123.05, 4123.57
R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

4123-3-29 Informing the claimant of the right to representation. (no changes)

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

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008
Promulgated Under: 119.03
Statutory Authority: 4121.30, 4121.31
Rule Amplifies: 4121.121
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
Rule promulgated under: RC 119.03
Rule authorized by: RC 4121.30, 4121.31
Rule amplifies: RC 4121.121
R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

4123-3-31 Disabled workers' relief fund: claimant's payments. (no changes)

(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 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 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.

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008
Promulgated Under: 119.03
Statutory Authority: 4121.121
Rule Amplifies: 4123.412, 4123.413, 4123.414
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

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.30

Rule amplifies: RC 4121.121, 4121.53, 4121.56

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

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.

Effective: 02/16/2007

R.C. 119.032 review dates: 11/02/2006 and 03/01/2011

Promulgated Under: 119.03

Statutory Authority: 4123.52, 4123.65

Rule Amplifies: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05

Prior Effective Dates: 7/12/99

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.

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

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

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.121, 4121.30, 4123.05

Rule amplifies: RC 4123.343, 4123.511

Rule Replaces: 4121-3-28

R.C. 119.032 review dates: 11/28/2003 and 03/01/2008

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	Opn 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	Opn wnd 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 fingr w thumb
942.12 1st deg burn chest wall
881.00 Open wound of forearm
879.2 Opn wnd anterior abdomen
881.02 Open wound of wrist
918.0 Superfic inj 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 Opn wnd 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

Rule promulgated under: RC Chapter 119.

Rule authorized by: RC 4121.12, 4121.30, 4121.31, 4123.05

Rule amplifies: RC 4123.511

119.032 review date: 12/17/06

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

Rule promulgated under: RC 119.03

Rule authorized by: RC 4121.12, 4121.121, 4121.30, 4123.05

Rule amplifies: RC 4123.64

R.C. 119.032 review dates: 03/01/2008

Common Sense Business Regulation (BWC Rules)

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

Rules Chapter 4123:1-21

Rule Review

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

Citation: Ohio Constitution Art. II, Sec. 35; 4121.12; 4121.13.

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

What goal(s): The five year rule review of these rules ensures that the fire fighter safety 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; Fire Alliance: Ohio Association of Professional Fire Fighters (OAPFF) representing full-time unionized firefighters; Ohio Fire Chiefs Association (OFCA) representing fire chiefs; and Ohio State Fire Fighters Association (OSFA) representing volunteer firefighters.

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
Fire Fighting rules: 4121:1-21
Personal and protective clothing and equipment for fire fighting

Introduction

Chapter 4123:1-21 of the Administrative Code contain safety rules. An employer's violation of a specific safety rule can lead to an additional award for the injured worker (VSSR award). The cost of the VSSR award is billed to the employer as a penalty.

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 safety rules of Chapter 4123:1-21 of the Administrative Code are scheduled for review this year. BWC last reviewed these rules in 2003.

Rule Changes

A Task Force consisting of members from Ohio fire organizations and labor groups worked with the BWC Division of Safety and Hygiene on revising and updating the rules of Chapter 4123:1-21 of the Administrative Code, Personal and protective clothing and equipment for fire fighting. The Alliance consisted of professional fire fighter association members and fire company representatives. There are seven rules in this Chapter:

4121:1-21-01. Scope and definitions

4121:1-21-02. Personal protective clothing and equipment for structural fire fighting

4121:1-21-03. Personal protective clothing and equipment for wildland fire fighting

4121:1-21-04. Automotive fire apparatus

4121:1-21-05. Ground ladders

4121:1-21-06. Fire hose, couplings, and nozzles

4121:1-21-07. Fire department occupational safety and health

Because of the technical nature of these rules, BWC will not attempt to summarize their content in this executive summary.

Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-08

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 fee schedule for workers' compensation medical 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 fee schedule was placed on www.ohiobwc.com on July 7, 2008 and stakeholders were given until August 15, 2008 to submit comments. In addition, a fee schedule forum was held in the BWC William Green Auditorium on July 22, 2008.

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.

BWC Board of Directors Executive Summary BWC Provider Fee Schedule Rule

Introduction

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including rules relating to the adoption of a provider fee schedule. BWC initially enacted the bulk of the Chapter 4123-6 HPP operational rules (Ohio Administrative Code 4123-6-01 to 4123-6-19), including OAC 4123-6-08, the provider fee schedule rule, in February 1996.

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 medical services.

Pursuant to 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 provider fee schedule itself 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 provider fee schedule via the O.R.C. Chapter 119 rulemaking process. BWC has undergone a systematic revision of its provider fee schedule, which has not been revised since 2004, and now proposes to adopt the newly revised provider fee schedule as an Appendix to OAC 4123-6-08.

Rule Changes

4123-6-08 Bureau fee schedule.

BWC is proposing to amend current OAC 4123-6-08 to include the provider fee schedule itself as an appendix to the rule. The proposed fee schedule would become effective January 1, 2009.

4123-6-08 Bureau fee schedule.

(A) Pursuant to division (A)(8) of section 4121.441 of the Revised Code, the bureau administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall develop, maintain, and publish a provider fee schedule for the various types of billing codes. The administrator hereby adopts the fee schedule shall be schedule indicated in the attached appendix A, developed with provider and employer input, effective January 1, 2009.

(B) Whether the MCO has elected to retain a provider panel or not, an MCO may contract with providers. Every provider contract shall describe the method of payment to the providers. The MCO shall provide an MCO fee schedule to each provider that contracts with the MCO. The MCO fee schedule may be at different rates than the bureau fee schedule. The MCO shall make the MCO fee schedule available to the bureau as part of its application for certification. The bureau shall maintain the MCO fee schedule as proprietary information.

Appendix A

BUREAU OF WORKERS' COMPENSATION

PROVIDER FEE SCHEDULE

EFFECTIVE JANUARY 1, 2009

Effective: 1/1/2009

R.C. 119.032 review dates: 3/1/2009

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96; 1/1/01

BWC 2008 Proposed Professional Provider Fee

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. It also ensures access to quality, cost-effective service. Access for injured workers means the availability of appropriate treatment, which facilitates faster recovery and a prompt, safe return to work. For employers, it also means the availability of appropriate, cost-effective treatment provided on the basis of medical necessity.

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.

Professional Provider 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. The Ohio Bureau of Workers Compensation reimburses approximately 70,000 providers for medical services rendered to Ohio's injured workers. An appropriate fee schedule is integral to maintaining an effective and comprehensive network of physicians, specialists, and support services and supplies. An equitable and competitive fee for the right medical service is essential to maintain a quality provider network across the wide range of necessary provider disciplines.

The BWC medical fee schedule has not been revised since 2004. As a result, BWC Medical Services undertook a comprehensive review of the benefit plan and corresponding medical fee schedule. The process for the comprehensive review included:

- A.** Reviewing the coverage status of specific goods and services in relation to indicators of medical necessity and appropriateness of care and revising accordingly.
- B.** Assessing the existing maximum number of service units for all codes in relation to expected patterns of service delivery and revising accordingly.

- C. Researching fees for medications, durable medical equipment and supplies in relation to current market basket values and adjusting accordingly.
- D. Analyzing conversion factors used in the calculation of professional fees.

In executing on the above process, the Medical Policy staff reviewed over 10,000 CPT®¹ codes, 3600 HCPCS² codes and 170 local codes.

Provider fees for each of the grouping of codes utilize a different calculation. Provider fees for the CPT® code grouping utilize a Relative Value Unit, a Geographical Practice Cost Index and a BWC Conversion Factor (or dollar amount). Provider fees for the HCPCS code grouping utilizes Medicare's published fee schedule which BWC increases by twenty percent (20%). Provider fees for the 170 Local codes groupings utilizes BWC's separately developed fee schedule.

Calculating Provider Fees Per the CPT codes

BWC currently utilizes the Resource-Based Relative Value Scale (RBRVS) developed in 1992, by the Federal Center for Medicare and Medicaid Services for professional reimbursements associated with the CPT® codes. The foundation of RBRVS is a strong, empirical research methodology. BWC has utilized the RBRVS, at least, since 1997.

Each year Medicare updates its CPT fees under the RBRVS approach. Medicare fees are composed of two component parts: the relative value unit (RVU) and a conversion factor (CF). The fee schedule includes services such as office visits, hospital care, procedures, etc.

An individual RVU is calculated for each procedure by looking at the associated relative work and costs of services. RVUs allow comparison of apples to oranges (i.e., surgery to primary care visits) and can relatively and appropriately set the allowable payment for any service in any specialty.³ Each specific CPT code for a medical service is assigned a RVU based on the degree of service intensity the procedure requires. Further, the RVUs reflect costs for overhead and malpractice. Finally, there is a regional cost adjustment. The regional cost adjustment is called the Geographical Practice Cost Index (GPCI). There is a separate GPCI for work expended, overhead, and malpractice.

The fee, or the amount of payment, for service, then, is a function of the multiplication of the service's designated RVU by the CF. The CF is the dollar amount selected for that category of service. While the BWC adopts Medicare's RVUs for relevant CPT Codes, it uses its own CF to set the final fee for service.

¹ Current Procedure Terminology - The manual published by the American Medical Association (AMA) which assigns numeric codes to describe procedures for professional services.

² Health Care Procedural Coding System as provided by Federal Center for Medicare and Medicaid Services (CMS)

³ Johnson and Newton, Resource-Based Relative Value Units: A Primer for Academic Family Physicians, Department of Family Medicine, University of North Carolina (2002)

The following table provides BWCs current CF.

Current Conversion Factors

Service Group CPT Codes for:	Current CF	Pct of Medicare
Radiology	\$55.00	148%
Phys Med	\$51.00	134%
Gen Med	\$44.27	117%
Surgery	\$79.10	200%
Anesthesia (*)	See Below	239%
Pathology (**)	See Below	125%

* Anesthesia is paid at \$42.50 time the number of base units plus \$42.50 per 15 minutes
 ** Pathology is paid at 125% of Medicare Fee Schedule
 Medicare has a single CF of \$38.0870

Ohio Bureau of Workers' Compensation

The following table demonstrates the payment calculation for two varied services – a simple laceration repair and total knee replacement:

Calculating Fee Schedule for a CPT code

Fee Schedule	12001 - simple laceration repair			27447 - total knee replacement		
	RVU	GPCI	Product	RVU	GPCI	Product
Work	1.7200	0.9920	1.7062	23.0400	0.9920	22.8557
Practice Expense	1.8600	0.9300	1.7298	13.5800	0.9300	12.6294
Malpractice	0.1500	1.0970	0.1646	3.8000	1.0970	4.1686
Sum of Products			3.60			39.65
Times Conversion Factor			\$79.10			\$79.10
Reimbursement Rate (Fee Schedule)			\$284.81			\$3,136.61

Ohio Bureau of Workers' Compensation

Calculating Provider Fees Utilizing HCPCS Codes

The 3600 HCPCS codes mentioned earlier includes services such as durable medical equipment, supplies, medications, vision services, prosthetics and others. Medicare annually evaluates all of the services and supplies listed under those codes and establish a fee for each of those services. The BWC has, at least since 1997, utilized the Medicare set fees with a twenty percent (20%) addition.

An example of a HCPCS calculation is as follows: calculation for a: Range of Motion Device (rental)

$$\begin{array}{r r r r r r r} \text{Medicare Fee} & + & 20\% & = & \text{Provider Fee} \\ \$22.00 & + & \$4.40 & = & \$26.00 \end{array}$$

Calculating Provider Fees Utilizing 170 Local Codes

The 170 Local codes include services such as vocational rehabilitation services, exercise equipment, supplies, mileage reimbursement, and others. Local codes have been devised to assign a coding scheme for services not included in the Medicare HCPCS manual. The BWC for the 2008 recommendation performed market pricing to establish the recommended fee schedule for professional services and products placed under these codes.

2008 Proposed Fee Schedule Recommendations

The BWC 2008 proposed revisions take into account industry best practices and inflation since the last update of the fee schedule in 2004. Further, the BWC took advantage of all of the empirical research the Federal Center for Medicare and Medicaid Services underwent when the Center updated the RBRVS.

Therefore, the BWC Medical Services recommends updating the fee schedule to reflect current Medicare 2008 RVUs for all relevant CPT codes. Additionally, Medical Services recommends that the proposed change to the fee schedule contain two CFs. The CF recommendation is **\$50.00** for all relevant services, with the exception of surgery. The surgical CF will remain at **\$79.10**.

The following table provides BWCs proposed conversion factors.

Proposed CPT Revisions Conversion Factors				
Service Grouping	Current		Proposed	
	CF	Pct of Medicare	CF	Pct of Medicare
Radiology	\$55.00	148%	\$50.00	132%
Physical Medicine	\$51.00	134%	\$50.00	132%
General Medicine	\$44.27	117%	\$50.00	132%
Surgery (*)	\$79.10	200%	No Change	200%
Pathology (**)	See Below	125%	No Change	125%
Anesthesia (***)	\$42.50	239%	See Below	239%

* Injections paid at \$50.00 CF
 **Pathology is paid at 125% of Medicare Fee Schedule
 *** Anesthesia is paid at \$25.00 time the number of base units plus \$25.00 per 10 minutes
 Medicare has a single CF of \$38.0870

Ohio Bureau of Workers' Compensation 9

The proposed CF recommendations are based on research comparing various states' approaches to provider payments. Based on research of the various states, the proposed fee schedule places Ohio well within the range of other payers, which is appropriate considering factors such as Ohio cost of living, access to care, etc.

The proposal also takes into account provider access to care issues and provides our Physicians of Record with a necessary increase. Our Physicians of Record (POR) were historically paid at a lower rate than other specialties. When considering the RBRVS payment methodology, the level of reimbursement for POR services is relatively low.

Medical Services further recommends that the 2008 fee schedule be updated to reflect Medicare's 2008 HCPCS fees with a twenty percent (20%) addition.

Medical Services further recommends that the 2008 fee schedule be updated to adjust the Local codes to current market basket values.

Projected Impacts and Outcomes

The financial impact to the state fund is estimated at \$18.4 million or an increase of about 5.1% over the 2007 related medical payments. It should be noted, that the detail projections did reflect that approximately 85% of the 2007 services and product experience would potentially experience an increase, while 15% would experience a decrease with the recommended fee schedule changes.

Additionally, BWC will experience other medical services enhancements such as an improved better benefit plan, more competitive reimbursement rates, consistency of reimbursement across providers, and improved access to care.

Additional Consideration

It is essential that BWC obtain provider insight on the benefit plan and corresponding fee schedule. Therefore, BWC has proactively engaged all impacted stakeholders. In early July, notification letters were mailed to over 28000 BWC providers. In addition, all stakeholders groups, including employer associations and provider associations were sent email notifications. The notifications indicated that the recommended fee schedule was posted on the BWC website and comments were being accepted from July 8 through August 15th. Over 175 comments have been received to-date.

A provider forum was held on July 22, 2008 with representatives from twelve (12) medical associations in attendance. Also, BWC has conducted small group provider association meetings, with more planned.

The Medical Services staff has been actively working on evaluating and responding to the points made by those submitting comments and letters. Some of the points raised have resulted in the Medical Services staff revisiting some individual service fees. This effort will continue through August 15th.

OHIO BWC 2008 PROFESSIONAL FEE SCHEDULE PROPOSAL

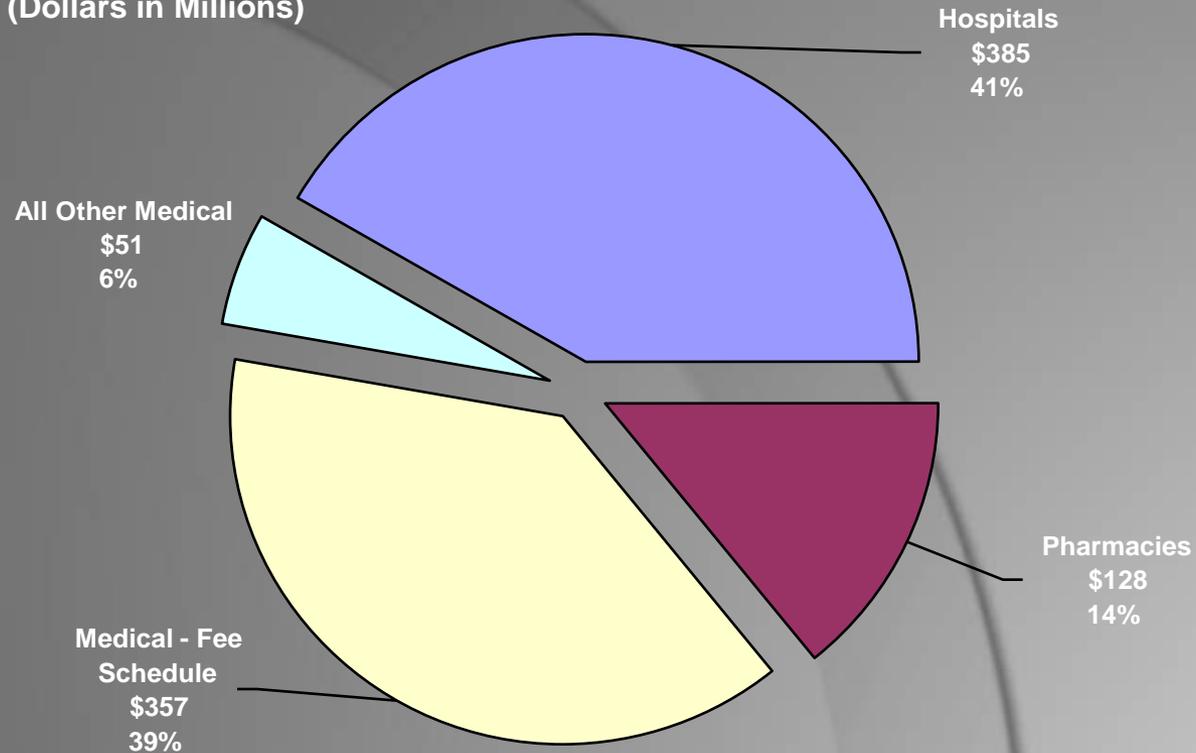
Medical Services Division
Bob Coury, Chief, Med. Serv. & Compliance
Judy Brabb, Medical Policy Manager
August 28, 2008

Introduction and Guiding Principles

- Legal Requirement for Fee Schedule Rule
- Proposed Time-line for implementation
- Guiding Principle:
 - Ensure access to high-quality medical care by establishing an appropriate Benefit plan and Terms of service with competitive fee schedule which, in turn, enhances medical provider network
- Financial Impact of Revision

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

Fee Schedule Revision Methodology

- Coverage status determined
- The maximum number of units reimbursable for all codes
- Fees for medical services, medications, durable medical equipment and supplies were researched and assigned
- Researched and benchmarked Ohio against other payers

Project Scope

- Over 10,000 CPT® codes
 - Current Procedure Terminology
 - Services include surgery, anesthesia, etc.

- Over 3,600 HCPCS codes
 - Healthcare Common Procedure Coding System
 - Services include durable medical equipment, supplies, medications, vision services, prosthetics, etc.

- 170 Local Codes
 - Local version of HCPCS
 - Services include vocational rehabilitation, mileage, exercise equipment, etc.

Calculating CPT Fees

- The RVU for each CPT code includes three components:
 - Work - level of difficulty to provide the service
 - Practice Expense - overhead such as staff, rent, utilities
 - Malpractice – level of risk associated with the service
- Geographical Practice Cost Index (GPCI)
 - Modifier reflecting cost-of-living differences
 - Is different for each State, and in some cases Regions
- Conversion Factor (CF)
 - BWC's assigned price for each category of service

Proposed CPT Revisions

Relative Value Units (RVU)

- RVUs updated per 2008 Medicare Fee Schedule
- Some RVUs will increase while others decrease
 - Approximately 85% increased

Proposed CPT Revisions

Conversion Factors

Service Grouping	Current		Proposed	
	CF	Pct of Medicare	CF	Pct of Medicare
Radiology	\$55.00	148%	\$50.00	132%
Physical Medicine	\$51.00	134%	\$50.00	132%
General Medicine	\$44.27	117%	\$50.00	132%
Surgery (*)	\$79.10	200%	No Change	200%
Pathology (**)	See Below	125%	No Change	125%
Anesthesia (***)	\$42.50	239%	\$40.00	235%

* Injections proposed to be paid at \$50.00 CF

**Pathology is currently paid at 125% of Medicare Fee Schedule

*** Anesthesia is currently paid at \$42.50 time the number of base units plus \$42.50 per 15 minutes

Medicare has a single CF of \$38.0870 Medicare's Anesthesia is base rate is \$17.00

Conversion Factor Comparison for 2008 Proposed Fee Schedule Recommendation

	Surgery	Radiology	Physical Medicine	General Medicine
<i>Medicare (3)</i>	<i>38.09</i>	<i>38.09</i>	<i>38.09</i>	<i>38.09</i>
Mountain State Blue Cross/Blue Shield	66.71	78.47	47.69	47.69
Minnesota WC	77.56	N/A	61.55	77.56
Utah WC	37.00	53.00	44.00	44.50
West Virginia WC	46.53	42.30	42.30	42.30
Washington State WC	61.53	61.53	61.53	61.53
Arizona WC (1)	142.24	***	***	***
Maryland WC	53.77	40.70	40.70	40.70
Tennessee WC	95.22	76.17	49.51	60.94
Illinois WC (2)	***	***	***	***
Texas WC	59.58	52.83	52.83	52.83
Michigan WC	50.20	50.20	50.20	50.20
North Dakota WC	60.00	60.00	60.00	60.00
Nevada WC (1)	175.99	31.88	***	***
Group Mean CF	77.19	54.71	51.03	53.83
Group Median CF	60.76	52.91	49.86	51.51
BWC Proposed CF	79.10	50.00	50.00	50.00

- (1) Reimbursement Fees of less than \$20 were identified as outliers and excluded from the group average calculations.
- (2) Illinois pays a flat 76% of the providers billed amount.
- (3) Medicare used as a standalone baseline comparison, it was not included in the group average calculations.

Provider Feedback and Comments

- Provider comment period open from July 7 – August 15
- As of August 15th 253 inquiries/comments were received via the Medical Policy email address
 - Comments categorized in 5 primary specialties
 - Anesthesia
 - Chiropractic Manipulations
 - Radiology
 - Orthotics
 - Vocational Rehabilitation
 - 34 Provider specialties were represented
- Meetings were conducted at BWC with these associations
 - Anesthesiologists
 - Ohio Association of Rehabilitation Facilities
 - International Association of Rehabilitation Professionals

Impacts and Outcomes

■ Medical Costs Impact

- An estimated 5.0% increase over provider reimbursement made between April 2007 – March 2008
- Estimated dollar figure is \$18 million

■ Medical Service Enhancements

- Established better benefit plan
- More competitive reimbursement rates
- Improve consistency of reimbursement across providers
- Improve access to care

Proposal Impact – by Service Type

(Dollars in Millions)

Service Type	Current	Proposed	Change
Anesthesia	\$ 10.4	\$ 9.8	\$ (0.6)
Surgery	\$ 55.6	\$ 56.3	\$ 0.7
Therapeutic Injections	\$ 6.9	\$ 6.4	\$ (0.5)
Radiology	\$ 22.3	\$ 20.5	\$ (1.8)
Pathology	\$ 0.9	\$ 0.9	\$ (0.0)
Gen. Medicine	\$ 21.7	\$ 23.4	\$ 1.7
Phys. Medicine	\$ 102.8	\$ 100.1	\$ (2.7)
Eval & Mgmt	\$ 61.8	\$ 77.6	\$ 15.8
Other (HCPCS & Local)	\$ 74.7	\$ 79.9	\$ 5.2
TOTALS	\$ 357.1	\$ 374.9	\$ 17.8

Dollar amounts are based on actual services paid for between April 1, 2007 and March 31, 2008.

Thank You

Fiscal Year 2010 - 2011 Biennial Budget
Executive Summary

Attached is information regarding BWC's proposed Fiscal Years 2010 and 2011 biennial administrative budget. The information reflects proposed funding levels for the Administrative Cost Fund and the Safety & Hygiene Fund. In addition, the information reflects proposed funding levels associated with the Disabled Workers' Relief Fund, the Marine Industry Fund and the Coal Workers' Pneumoconiosis Fund.

The current biennium has brought major changes to BWC. The accomplishments and milestones of the recent past have provided a strong foundation. We are now moving forward to comprehensively improve service for our customers and make fundamental changes to workers' compensation in Ohio. By providing effective, customer-focused services, BWC will enhance the quality of life of Ohio's work force, promote economic success for Ohio's employers, and strengthen the state's economic vitality.

BWC is proposing a total budget of \$328 million for each fiscal year of the biennium. The increased request from the Fiscal Year 2009 annual budget is a result of BWC's need to be flexible in addressing future budget needs. As BWC moves into the next biennium, there are major program reforms and capital projects anticipated. Until these projects have been completely analyzed and planned, it is difficult to establish the total related costs. As such, BWC is requesting a funding level that will enable the agency to adapt to future needs.

While requesting a funding level consistent with prior year biennial budget requests, BWC will continue to perform a detailed, annual budget methodology. This may result in an actual annual budget below the established biennial budget requested.

**BUREAU OF WORKERS' COMPENSATION
 PROPOSED BUDGET SUMMARY
 FISCAL YEARS 2010 AND 2011
 In Millions**

Expense Type	Fiscal Year 2008 Estimated Spending	Fiscal Year 2009 Approved Budget	Fiscal Year 2010 Proposed Budget	Fiscal Year 2011 Proposed Budget
Payroll	\$195.2	\$195.0	\$202.3	\$209.3
William Green Building Bond	20.2	20.7	19.9	19.1
Other Rent	12.5	10.5	11.5	11.5
Personnel Services	19.0	15.2	15.8	16.1
Maintenance	19.6	20.6	20.1	20.5
Supplies and Printing	2.6	3.0	3.1	3.1
Utilities	1.7	1.9	1.9	2.0
Travel	0.6	0.7	0.8	0.8
Communications	6.8	7.0	7.1	7.2
Training	1.6	1.0	1.3	1.4
Equipment	0.4	2.0	2.0	2.0
Inter Agency Payments (example: AG and DAS)	7.6	9.1	8.8	9.0
Subtotal	\$287.8	\$286.7	\$294.6	\$302.0
Safety Grants	3.8	4.0	4.0	4.0
Long Term Care Loans	0.0	2.0	2.0	2.0
Legislative Requirements			3.0	3.0
Strategic Projects	18.0	12.2	21.6	14.7
Examples:				
Rating Reform Initiatives				
Deloitte Recommendations				
Employer Management Systems				
Provider File Enhancements				
IT Equipment Replacement				
Capital Improvements		3.9	2.8	2.3
Examples:				
Replace Boilers				
Carpet Replacement				
Chiller Replacement				
Grand Total	\$309.6	\$308.8	\$328.0	\$328.0

**BWC Board of Directors
Audit Committee**

FY 08 4th Quarter Executive Summary Report

August 28, 2008

Caren Murdock, Chief of Internal Audit
Rich Ridewood, IT Audit Director
Keith Elliott, Senior Manager



To: Audit Committee Members
From: Caren Murdock, Chief of Internal Audit
Date: August 28, 2008

Fiscal Year 08 4th Quarter Executive Summary report

Following you will find the Fiscal Year 2008 4th Quarter Executive Summary report containing:

1. Audit comment status
 - 1a. Comments issued 4th quarter
 - 1b. Comments outstanding as of June 30, 2008
2. Audit follow-up procedures
3. Audit comment rating criteria
4. Fiscal Year 09 Audit Plan

**BWC INTERNAL AUDIT DIVISION
COMMENTS ISSUED – 4TH QUARTER ACTIVITY**

Subrogation Audit – February 2008

Business area: **Legal**

The focus of the Subrogation Audit was to assist management in evaluating the subrogation process by reviewing key compliance and internal control related components of processing and administering subrogation claims. The audit scope consisted of a review of subrogated claims processed between April 9, 2003 through December 31, 2007, and Santos case claims from 1993 through 2003.

Activity Reviewed:

- Evaluated if current internal controls were adequately designed for processing and administering subrogation claims;
- Determined the adequacy of controls for the recovery process;
- Assessed the adequacy of quality assurance procedures;
- Determined if subrogated claims were processed in accordance with BWC policy/procedures and statutory requirements; and
- Evaluated whether the subrogation process is efficiently and effectively administered.

	Recommendation	Disposition
1	Collaborate with all units involved to document an agency-wide workflow of the subrogation process. Significance Rating: Material Weakness	The Subrogation Unit will work with the applicable business units to document an agency-wide subrogation process. Responsible Chief: Chief Legal Officer Target Resolution Date: December 2008
2	Reevaluate and appropriately reassign responsibilities to ensure a proper crosscheck of duties. Significance Rating: Material Weakness	An employee now verifies postings performed by the Customer Service Assistant and the process will be re-evaluated to ensure a proper crosscheck of duties. Responsible Chief: Chief Legal Officer Target Resolution Date: December 2008
3	Reconcile the monies received for accuracy and completeness, and verify the accuracy of the outstanding balance. Significance Rating: Material Weakness	The Subrogation Unit’s management will collaborate with all units involved to define responsibilities, develop, and implement a reconciliation process. Responsible Chief: Chief Legal Officer Target Resolution Date: September 2008

	Recommendation	Disposition
4	Provide refresher-training modules and implement monitoring procedures and quality assurance reviews to identify missed subrogation referrals. Significance Rating: Material Weakness	A workgroup will be formed to address missed and incomplete subrogation referrals encompassing all items included in discussion components. Responsible Chief: Chief of Customer Services Target Resolution Date: September 2008
5	Establish proactive controls to monitor invoicing and collection, update policies and procedures, automate the billing process, and create management reports. Significance Rating: Significant Weakness	The Subrogation Unit will work with Infrastructure & Technology to develop an automated billing system and create internal controls to verify the billing process is accurate and complete. Responsible Chief: Chief Legal Officer Target Resolution Date: June 2009
6	Consider assigning unit responsibilities based on job skills and dollar thresholds, prioritize cases and evaluate if a portion of the caseload can be outsourced to external parties, and develop monitoring and quality assurance reviews to ensure timely and efficient processing. Significance Rating: Significant Weakness	Management will re-evaluate staffing needs and recommend the appropriate changes. Responsible Chief: Chief Legal Officer Target Resolution Date: November 2008
7	Define responsibilities, provide additional training, improve communication between the two departments, and utilize the Service Offices' subrogation coordinators to research incomplete referrals. Significance Rating: Significant Weakness	A workgroup will define responsibilities and implement a plan to ensure a quality subrogation referral. Responsible Chief: Chief of Customer Services Target Resolution Date: September 2008
8	Establish proactive controls and monitoring processes to ensure eligible class members receive repayment notices within the court decreed timelines. Significance Rating: Significant Weakness	The 14-day address update was fixed when Infrastructure & Technology developed tracking for address updates in Rates and Payments. Responsible Chief: Chief Legal Officer Target Resolution Date: August 2008
9	Develop ongoing reporting and conduct detailed trending and analysis of data to assist in monitoring the subrogation processes. Significance Rating: Significant Weakness	A staff member will be assigned to manage the Attorney General Office's portfolio and the Unit will meet with Infrastructure & Technology to request enhancements to the current system. Responsible Chief: Chief Legal Officer Target Resolution Date: September 2008 (Meet with IT); December 2009 (potential target date for IT)

	Recommendation	Disposition
10	Consider collaborating with Infrastructure & Technology (IT) to explore potential system enhancements to better support the subrogation process. Significance Rating: Significant Weakness	The Subrogation Unit will work with IT to develop a system that is integrated with other BWC systems. Responsible Chief: Chief Legal Officer Target Resolution Date: September 2008 (Meet with IT); December 2009 (potential target date for IT)
11	Consider establishing a settlement process similar to the Service Offices and implement quality assurance procedures to verify compliance with policies. Significance Rating: Significant Weakness	The Subrogation Unit will update the policies and procedures to include key items required to be in the Subrogation file and implement a quality assurance process. Responsible Chief: Chief Legal Officer Target Resolution Date: September 2008
12	Establish a list of required subrogation documents, store files in a centralized repository, and implement quality assurance procedures to verify compliance with policies. Significance Rating: Significant Weakness	The Subrogation Unit will update the Subrogation Training Manual to define required documents and implement a quality assurance process to verify compliance with policy. Responsible Chief: Chief Legal Officer Target Resolution Date: September 2008

Auditor Opinion:

Management should take immediate action to address segregation of duties weaknesses and the lack of key internal controls within the subrogation recovery process. In general, a lack of communication and collaboration exists among the units involved in the subrogation process. There are no agency-wide documented policies and procedures. In addition, the process for identifying potential subrogation claims and referrals should be made more effective and efficient, and quality assurance procedures do not adequately verify compliance with policy and procedures. Lastly, the communication and reporting of Santos case claim information is inadequate.

Forthwith/ Miscellaneous Special Payments Audit – July 2008

Business area: Fiscal and Planning

The BWC Internal Audit Division conducted an audit of forthwith (including payment-on-demand or POD) and miscellaneous special payments to assist management in evaluating controls over the forthwith and miscellaneous special payments process. The audit scope consisted of payment transactions completed between January 1, 2007 and December 31, 2007.

Activity Reviewed:

- The level of compliance with BWC policies and procedures;
- The adequacy of design and operating effectiveness of current internal controls; and
- The adequacy of quality assurance procedures in place over the process.

	Recommendation	Disposition
1	Revise payment processing procedures for payments requested via the C-31RE forms to require the submission of proof of appropriate higher level authorizations. Significance Rating: Significant Weakness	The Fiscal and Planning Division has modified the authorization procedures for manual day work and special payments. Responsible Chief: Chief of Fiscal & Planning Current Resolution Status: Implemented
2	Revise written policies and procedures for payment processing to specify the group of authorized approvers (and their alternates) for Payment on Demand request forms and require signatures of Senior Staff for larger forthwith payments. Significance Rating: Significant Weakness	Subsequent to the identification of this issue, the Fiscal and Planning Division revised the signature requirements on payments. Responsible Chief: Chief of Fiscal & Planning Current Resolution Status: Implemented
3	Recover the \$100,000 overpayment from the Attorney General Office (AGO). Significance Rating: Significant Weakness	The Accounts Receivable Department recovered the overpayment to the AGO. Responsible Chief: Chief of Fiscal & Planning Current Resolution Status: Implemented
4	Revise forthwith/payment on demand procedures to ensure that such payments are not issued without proper authorization. Significance Rating: Significant Weakness	While management feels that existing policies are clear regarding electronic benefit transfer load authorization requirements, and management review procedures resulted in the identification of the identified items, the Accounting Department will review the processes to determine additional cost-effective methods of improving controls. Responsible Chief: Chief of Fiscal & Planning Target Resolution Date: July 2008
5	Update the records in Data Warehouse for the affected warrants to reflect their current warrant status. Management should evaluate controls in place to ensure proper warrant status information in Data Warehouse (DW). Significance Rating: Significant Weakness	The outstanding warrants in the DW were a result of an implementation issue associated with sending all payments to the DW and the impacted records were corrected. Responsible Chief: Chief Information Officer Current Resolution Status: Implemented
6	Modify the Rates & Payments system to include basic information on all warrants initiated within it. Significance Rating: Significant Weakness	Phase 1 of the Electronic Funds Transfer Mandate program is to be implemented in November 2008. Responsible Chief: Chief Information Officer Target Resolution Date: November 2008
7	Explore options of incorporating data on forthwith/payment on demand and miscellaneous special payments into V3. If this is not feasible, management should consider alternatives to strengthen controls	Developing the interface between V3 and Rates & Payments is extremely complex and probably will not occur due to resource limitations. Customer Services will work with Fiscal and Planning to properly identify

	Recommendation	Disposition
	to provide additional protections against duplicate payments. Significance Rating: Significant Weakness	miscellaneous special payments in data warehouse and develop a continuous monitoring report. Responsible Chief: Chief of Customer Services Target Resolution Date: December 2008

Auditor Opinion:

Overall, the audit identified various areas in which controls over the forthwith and miscellaneous special payments process were working effectively. However, the audit identified a number of processes controls which could be improved. The primary improvements included:

- Revision of payment processing procedures for payments requested via the C-31RE forms to require the submission of proof of appropriate higher level authorizations; and
- Revision of written policies and procedures for payment processing to specify the group of authorized approvers (and their alternates) for payment on demand request forms and require signatures of Senior Staff for larger forthwith payments.

Management is generally in agreement with the audit findings and recommendations and in some instances has already implemented corrective action. The audit also identified five minor recommendations for management’s consideration.

Managed Care Organization (MCO) Audit #4 – July 2008

The BWC Internal Audit Division conducted an audit of MCO # 4. The audit focused primarily on the evaluation of internal controls and compliance with contractually required policies and procedures established by BWC. The audit scope consisted of a review of activity occurring between January 2007 and March 2008.

Activity Reviewed:

- Evaluated internal control design and whether controls were placed in operation;
- Assessed compliance with contract requirements and policy established by BWC;
- Areas of focus included:
 - Case management;
 - Provider account controls and accuracy;
 - Bill processing;
 - Resolution of prior audit recommendations (BWC issues, SAS 70 audit findings, external auditor issues); and
 - Review of key outsourced operations at vendor locations.

	Recommendation	Disposition
1	Modify the MCO system backup procedures to ensure that backup devices are encrypted.	Management is in the process of revising backup procedures to include encryption of

	Recommendation	Disposition
	Significance Rating: Significant Weakness	backup devices. This should be completed by 12/31/2008. Target Resolution Date: December 2008
2	Log all incoming checks upon arrival and reconcile bank deposits/statements to the log. Significance Rating: Significant Weakness	Management revised the procedures to include the logging of incoming checks and reconciliation of daily deposit information to the log. Current Resolution Status: Implemented
3	Revise procedures to ensure that the mailroom date stamps all mail (including bills) upon receipt. Posted procedures should match the MCO's policy and procedure manual. Significance Rating: Significant Weakness	Management has updated the policies and procedures to ensure posted procedures match the policies and procedures manual. Management disagrees with the recommendation to date stamp items immediately upon receipt and feels existing processes ensure accurate receipt information. Target Resolution Date: May 2008 (policy updates)
4	Work with BWC adjustment personnel to attempt to resolve provider account reconciling items in a timely manner. Significance Rating: Significant Weakness	Management is reviewing internal processes and reconciliation communications and will develop an escalation plan to ensure reconciling items are resolved in a timely manner. Target Resolution Date: August 2008
5	Work with the MCO vendor to ensure the MCO's mail is date stamped with the MCO's stamp immediately upon receipt. Significance Rating: Significant Weakness	Management is working with the vendor to modify the date stamp to include the MCO's name and MCO number. Management disagrees with the recommendation to require the vendor to date stamp items immediately upon receipt and feels existing processes ensure accurate receipt information. Target Resolution Date: August 2008 (Establishment of date for new vendor stamp)
6	The MCO's documents at vendor locations should be maintained in a secure area. Significance Rating: Significant Weakness	The vendor has modified their procedures to ensure that all the MCO's documents are maintained in the secured area. Current Resolution Status: Implemented

Auditor Opinion:

Overall, internal controls for the MCO were generally well designed and functioning effectively. Case management plans appeared to be prepared in a timely manner and response requirements for alternative dispute resolution cases were generally met. Resolution of voided checks and segregation of duties for the provider account were also reasonable.

The audit did note several areas in which controls could be improved, which included:

- Modify the MCO system backup procedures to ensure that backup devices are encrypted;
- Date-stamp and log all incoming checks upon arrival; and
- Revise procedures to ensure that the mailroom date stamps all mail, including bills, upon receipt.

Employer Compliance Department Draft Policies and Procedures Manual – July 2008
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Business area: **Customer Services**

The BWC Internal Audit Division reviewed a draft of the Employer Compliance Department's (ECD) policies and procedures manual in an effort to provide proactive guidance for designing effective and efficient internal controls. The project scope consisted of a review of the manual's scope, content, presentation and format. Five minor recommendations were identified for management's consideration.

**BWC INTERNAL AUDIT DIVISION
OUTSTANDING COMMENTS AS OF JUNE 30, 2008**

Non-Complying Employer Audit – August 2004

	Recommendation	Disposition
1	BWC currently does not lapse employers that do not pay all premium amounts owed within a designated time period. While the remaining balances are certified to the Attorney General for collection, the employer continues to have active coverage. This is contrary to industry standard practice.	Weekly reports identify policies with open balances for the current payroll reporting period that are greater than \$100 and the underpayment represents 35% or more of the total premium for the policy period. Policies on this report are reviewed and lapsed where appropriate. Responsible Chief: Chief of Fiscal and Planning Target Resolution Date: December 2007 December 2008 (IT related) Current Resolution Status: Implemented

MDL and Capital Coin Fund Control Review – June 2005

	Recommendation	Disposition
1	Establish processes to monitor activities of investment managers to ensure compliance with agreements.	Integration of the new Mellon Analytical System monitoring, compliance and performance measurement features are a current focus of the Investment Division and are being implemented with assistance from both the investment consultant and the vendor. Responsible Chief: Chief Investment Officer Target Resolution Date: June 2008 Current Resolution Status: In-process
2	Establish controls ensuring that the Board of Directors is informed of and approves significant changes in investment strategy by approved managers or funds.	The Investment Committee and Board discussed and approved at the respective January 2008 meeting revisions to the Investment Policy Statement (IPS) that requires the Chief Investment Officer to inform and receive approval by the Board of any significant change in investment strategy of approved outside investment managers. Procedures are being developed to provide out-of-compliance notification to the interested internal parties via the Mellon Analytical System. The Chief Investment Officer is required under the IPS to notify the Board of compliance matters on a

	Recommendation	Disposition
		monthly basis. Responsible Chief: Chief Investment Officer Target Resolution Dates: March 2008(IPS); June 2008 (MAS); September 2008 (MAS) Current Resolution Status: In-process

Bankrupt Self-Insured Claims – March 2006

	Recommendation	Disposition
1	Consider a legislative change to permit BWC to offset Permanent Total Disability compensation for an injured worker receiving Social Security Retirement benefits, potentially saving \$60 million annually; “grandfather-in” current PTD recipients receiving both benefits to avoid financial hardship to those individuals.	The Deloitte Study is evaluating rates, reserves, surplus and a wide spectrum of injured worker compensation issues. Management has tabled this issue until conclusion of the Deloitte Study in December 2008. Responsible Chief: Chief of Customer Services Target Resolution Date: December 2008 Current Resolution Status: In-process

Medical Billing and Adjustments (MB&A) – May 2006

	Recommendation	Disposition
1	There is a general lack of controls over the identification and processing of medical bill adjustments which result in the need to adjust the employers’ claims experience data. Significance Rating: Significant Weakness	The MIRA II team will not be ready to implement the electronic adjustment file until later in the year. However, they may be ready to implement with the third quarter file in Oct/Nov 2008 using the quarter ending claim cost files to identify the adjustments. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: September 2008 December 2008 (IT related) Current Resolution Status: In-process

	Recommendation	Disposition
2	To ensure the current interest payment methodology operates in accordance with statutory requirements, obtain clarification regarding the correct interest payment calculation and ensure MIIS and Cambridge Systems calculations are consistent. Significance Rating: Significant Weakness	Further analysis showed a new resolution was required. Therefore, a preliminary meeting is planned to discuss requirements for implementing the interest calculation. This project is being added in Clarity using the EPMO model for project management. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: September 2008 December 2008 (IT related) Current Resolution Status: In-process
3	There are currently two active systems in place for processing medical payments with limited Infrastructure & Technology and Health Partnership Program technical support. Maintenance of the two systems is inefficient and results in increased systems maintenance costs. Significance Rating: Significant Weakness	Request for proposal responses are due 06/17/08. This information will be used to develop a timeline for shutting down MIIS, which is dependent upon the PEACH II implementation. The RFP responses will meet the June 2008 target date; however, total shutdown of the MIIS system cannot yet be determined. The RFP evaluation committee continues to meet to evaluate the RFP responses received. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: June 2008 (IT related) Current Resolution Status: In-process

Risk/ Employer Operational Review – June 2006

	Recommendation	Disposition
1	Policy and procedures were not written for most functions and activities. Significance Rating: Significant Weakness	The four remaining core procedures are on schedule to be completed. Responsible Chief: Chief of Customer Services Target Resolution Date: July 2008 Current Resolution Status: In-process
2	BWC does not ensure all employers under jurisdiction of Ohio workers' compensation laws have obtained workers' compensation coverage. Systematic cross checks should exist with other state agencies. Significance Rating: Material Weakness	The Employer Compliance project team completed its recommendations and issued its report on May 1, 2008. Management accepted the team's recommendations on May 12, 2008 and laid out a 3 phase implementation plan. Management, in conjunction with OCSEA labor union leadership, instituted a voluntary canvassing of existing BWC employees to fill the new unit. On July 10, 2008, 6 staff

	Recommendation	Disposition
		<p>members were chosen for phase I rollout. Staff was trained the week of July 21, 2008 and the compliance team officially began August 3, 2008. Phase II will begin in the fall of 2008 and the final phase (Phase III) will complete statewide rollout in first quarter on 2009.</p> <p>Responsible Chief: Chief of Customer Services Target Resolution Date: April 2008 August 2008 Current Resolution Status: In-process</p>
3	<p>Minimum premiums may not be adequate. The recently revised Ohio Administrative Code Section 4123-17-26, (administrative charge rule) has been increased to cover the administrative expense of maintaining the policies that report no payroll. However, there is still inherent risk with the policies that have greater exposure due to industry type.</p> <p>Significance Rating: Material Weakness</p>	<p>The Deloitte Study will evaluate this issue and will be completed by December 2008.</p> <p>Designated Chief: Chief Actuarial Officer Target Resolution Date: December 2007 (RFP issuance); December 2008 (consultant report) Current Resolution Status: In-process</p>
4	<p>Current process controls do not adequately identify duplicate employer policies. Employers can avoid higher premiums by acquiring a new policy, while having an existing policy for the same business.</p> <p>Significance Rating: Significant Weakness</p>	<p>System change requests are being reevaluated.</p> <p>Responsible Chief: Chief of Customer Services Target Resolution Date: April 2008 September 2008 (IT related) Current Resolution Status: In-process</p>
5	<p>When payroll reports are received there is no review to determine if estimated Premium Security Deposits are correct. The lack of review could result in lost revenue due to under reported estimates for premium security deposits.</p> <p>Significance Rating: Significant Weakness</p>	<p>This project is being prioritized by the Employers Services change management team, but is not yet scheduled. The Deloitte Study will also evaluate this issue and is due to be completed by December 2008.</p> <p>Responsible Chief: Chief of Customer Services Target Resolution Date: June 2008 December 2008 (IT related) Current Resolution Status: In-process</p>

Time Reporting and Leave Usage – August 2006

	Recommendation	Disposition
1	<p>Management should conduct research to determine the reason for modifications to ending leave balances. Policies and</p>	<p>Payroll staff have identified errors and made corrections. Documentation for one of the corrections has been provided to Internal</p>

	<p>procedures for these modifications should be reviewed to ensure that only properly authorized and valid adjustment entries are posted.</p> <p>Significance Rating: Significant Weakness</p>	<p>Audit. Payroll staff is gathering the remaining documentation.</p> <p>Responsible Chief: Chief of Fiscal and Planning</p> <p>Target Resolution Date: June 2008 July 2008</p> <p>Current Resolution Status: Implemented</p>
2	<p>Develop controls to validate that payroll report information is entered accurately and completely into the database system and that the amounts in the payroll disbursement journals agree with the information on the payroll reports.</p> <p>Significance Rating: Significant Weakness</p>	<p>The implementation of OAKs and the electronic entry and approval of employee time has improved controls to help ensure accuracy of payroll information. Fiscal and Planning staff have been working with OAKs personnel to develop a report of payroll adjustments to provide assurance that only properly approved adjustments to payroll information are performed. The OAKs system at this time does not accommodate this type of report and additional time has been required to develop it.</p> <p>Responsible Chief: Chief of Fiscal and Planning</p> <p>Target Resolution Date: October 2007 May 2008 September 2008</p> <p>Current Resolution Status: In-process</p>

Medical Bill Payment Controls – September 2006

	Recommendation	Disposition
1	<p>System edit checks exist yet inappropriate or fraudulent provider billings still occur within the system. Consider the feasibility of implementing clinical editing software and an Explanation of Benefits (EOB) process as added controls in guarding against inappropriate or fraudulent provider billing.</p> <p>Significance Rating: Significant Weakness</p>	<p>The clinical editing software was implemented on 06/30/08. Two edits which will identify inappropriate and/or fraudulent provider bills were set to post and will be set to deny on 10/7/08. HPP Systems Support has initiated edits which are set to deny for unusually high provider billed amounts. MCOs are submitting override EOBs indicating that they have reviewed the bills. Compliance & Performance Monitoring has initiated the 10k bill data accuracy reviews.</p> <p>Responsible Chief: Chief of Medical Services and Compliance</p> <p>Target Resolution Date: January 2007 (MCO contract); April 2008 May 2008 June 2008 (clinical editing)</p> <p>Current Resolution Status: Implemented</p>

Claims Operational Review – September 2006

	Recommendation	Disposition
1	<p>Systematically assign new injury claims filed with no return to work date and an ICD-9 code to the lost time service offices. Significance Rating: Significant Weakness</p>	<p>The triage system change has been evaluated as a Tier 2 enterprise initiative. Following planning and implementation of all strategic initiatives, Tier 2 initiatives will be scheduled based upon available resources. Responsible Chief: Chief of Customer Services Target Resolution Date: June 2008 December 2008 (IT related) Current Resolution Status: In-process</p>
2	<p>Enhance current V3 system to link an injured worker with multiple claims to the same case manager or team. Significance Rating: Significant Weakness</p>	<p>The service delivery and response allocation study is complete and we are addressing staffing priorities as resources become available. For example, we are reviewing reallocating death and Permanent Total Disability claims to specialized regional teams as a result of the study. We will establish new processes to address other inefficiencies highlighted in the study. Responsible Chief: Chief of Customer Services Target Resolution Date: June 2008 June 2009 Current Resolution Status: In-process</p>
3	<p>Research, benchmark, and devote the resources necessary to create, train, and implement the use of pertinent, financially focused performance and outcome measurements to support the staffing process. Significance Rating: Significant Weakness</p>	<p>The study is complete and we are addressing staffing priorities as resources become available. For example, we are reviewing reallocating death and Permanent Total Disability claims to specialized regional teams as a result of the study. We will establish new processes to address other inefficiencies highlighted in the study. Responsible Chief: Chief of Customer Services Target Resolution Date: June 2008 June 2009 Current Resolution Status: In-process</p>

Manual Override – October 2006

	Recommendation	Disposition
1	<p>Resolve the current rating inequity between group rated and non-group rated employers. Management should also adopt standard controls to prevent rate manipulation by</p>	<p>Actuarial Division staff have been working with our actuarial consultants to develop a comprehensive plan to address issues related to the group rating program. This plan was</p>

Recommendation	Disposition
<p>employer groups. Possible corrective actions could include restoring credibility factors assigned to employer groups to levels consistent with sound actuarial standards and prohibiting groups from utilizing claims experience as an eligibility criterion for group participation. Significance Rating: Material Weakness</p>	<p>presented to and adopted by the Board of Directors. Staff are now working to implement the plan. Responsible Chief: Chief Actuarial Officer Target Resolution Date: December 2006 (actuarial study); July 2009 (implementation plan) Current Resolution Status: In-process</p>

Indemnity Claims Overpayment Audit – October 2006

Recommendation	Disposition
<p>1 In order to ensure the required employer experience adjustments are performed, develop a process to ensure all claims that meet the criteria requiring a referral to the Employer Rate Adjustment (ERA) Unit are identified and forwarded to the ERA Unit. Significance Rating: Significant Weakness</p>	<p>Customer Services is working with Actuarial to create a referral document. This process was put on hold due to the changes in MIRA and the impact those changes will have on this criteria. Responsible Chief: Chief of Customer Services Target Resolution Date: February 2008 August 2008 Current Resolution Status: In-process</p>
<p>2 Implement procedures requiring supervisory review and approval of requests for the removal or adjustment of overpayment amounts. Significance Rating: Significant Weakness</p>	<p>Overpayment policy currently under review as part of yearly review; Injury Management Supervisor review process will be verified and policy updated accordingly. Responsible Chief: Chief of Customer Services Target Resolution Date: February 2008 May 2008 September 2008 (policy) Current Resolution Status: In-process</p>
<p>3 To effectively collect injured worker overpayments, determine best practices for injured worker overpayment collection and request legislative changes allowing the BWC to adopt the best practices identified. Significance Rating: Significant Weakness</p>	<p>Overpayments are recouped to the extent allowed by existing legislation. Project has been delayed by other business priorities and staffing issues. Responsible Chief: Chief of Fiscal and Planning Target Resolution Date: January 2008 December 2008 Current Resolution Status: In-process</p>

Information Technology General and Application Controls Risk Assessment – January 2007

NOTE: The Internal Audit Division worked together with the IT Division to voluntarily contract with an external auditing firm to perform a baseline review of the internal general and applications controls of BWC's IT Division.

	Recommendation	Disposition
1	<p>Security violation and monitoring is not in effect for all computer environments or applications. Therefore, trending or advanced analysis for security violations is not performed.</p> <p>Significance Rating: Material Weakness</p>	<p>The monitoring/logging software has been installed on 60% of the servers. The rollout to the remaining servers is expected to be completed by 08/31/2008.</p> <p>Responsible Chief: Chief Information Officer</p> <p>Target Resolution Date: March 2008 June 2008 August 2008</p> <p>Current Resolution Status: In-process</p>
2	<p>There is no periodic process to evaluate changes in architecture and security impacts to the asset base.</p> <p>In addition, there is no consistent process in place to aid in mitigating vulnerabilities.</p> <p>Significance Rating: Material Weakness</p>	<p>The vulnerability assessment process has been defined and ongoing scans and subsequent meetings have been established to evaluate the results. In addition, external parties conduct periodic penetration tests to measure the effectiveness of BWC's security architecture.</p> <p>Responsible Chief: Chief Information Officer</p> <p>Target Resolution Date: March 2008 April 2008</p> <p>Current Resolution Status: Implemented</p>
3	<p>Powerful IDs are neither logged nor monitored. Therefore, activities performed using a powerful ID (e.g., default database, system, or network administrator account) or powerful utility are neither captured nor reviewed.</p> <p>Significance Rating: Material Weakness</p>	<p>The monitoring/logging software has been installed on 60% of the servers. The rollout to the remaining servers is expected to be completed by 08/31/2008.</p> <p>Responsible Chief: Chief Information Officer</p> <p>Target Resolution Date: March 2008 June 2008 August 2008</p> <p>Current Resolution Status: In-process</p>
4	<p>There is an inconsistency in approval of hardware modifications. Formal processes do not exist to determine if system software needs to be modified (e.g. patches/upgrades), including required documentation and approvals required. Asset management is not used pervasively across Infrastructure & Technology (IT) to track critical elements of all relevant IT assets.</p> <p>Significance Rating: Material Weakness</p>	<p>The updated change management policies, standards, & procedures review process was communicated at the 5/13/08 IT Division all hands meeting. While no central repository of all IT assets is maintained, a number of databases and processes are in place to mitigate this issue. In addition, ongoing processes exist to verify BWC's asset base with vendors such as IBM hardware, Microsoft software and BMC software.</p>

	Recommendation	Disposition
		Responsible Chief: Chief Information Officer Target Resolution Date: March 2008 May 2008 Current Resolution Status: Implemented
5	<p>There is no business continuity in the disaster recovery plan (DRP). The DRP has been tested for legacy applications and databases; however, exposure exists for some client/server systems. The current DRP is not sufficient to ensure effective Infrastructure & Technology (IT) support in the event of a significant system outage. IT governance is weak regarding established Key Performance Indicators (KPI)/Metrics. While some formal reporting exists, there is little KPI metric-based reporting or accountability. There is no internal process to continually monitor the adequacy and effectiveness of the IT controls environment. No formal procedures have been established or documented to classify application and underlying data from a privacy perspective, the process is informal and goes unmonitored. Processes and procedures have not been established to ensure adherence to federal, state, and local regulations.</p> <p>Significance Rating: Material Weakness</p>	<p>Encryption has been installed on all mobile devices as of 06/30/2008. In addition, all data that is considered sensitive has been identified and documented in the Sensitive Data Transmission Policy. The location of sensitive data in databases will be documented by August 29, 2008.</p> <p>Responsible Chief: Chief Information Officer Target Resolution Date: June 2008 August 2008 Current Resolution Status: In-process</p>
6	<p>The disaster recovery plan (DRP) is not updated as part of the overall change management process. There are pockets of asset management, but there is no universal or consistent asset management tool or process currently being utilized.</p> <p>Significance Rating: Significant Weakness</p>	<p>Documenting the impact of changes on disaster recovery plans was included in the updated change management process. This was communicated during the 5/13/08 Infrastructure & Technology Division all hands meeting. While no central repository of all IT assets is maintained, a number of databases and processes are in place to mitigate this issue. In addition, ongoing processes exist to verify BWC's asset base with vendors such as IBM hardware, Microsoft software and BMC software.</p> <p>Responsible Chief: Chief Information Officer Target Resolution Date: June 2008 Current Resolution Status: Implemented</p>

Compensation Audit Review – March 2007

	Recommendation	Disposition
1	<p>Implement controls on Compensation Audits completed by the Injury Management Supervisors (IMS)/Service Office Managers to provide reasonable assurance that audits are completed accurately and consistently. Also, take appropriate steps to ensure IMS are properly utilizing the Compensation Audit Tool and apply a consistent audit methodology to each question.</p> <p>Significance Rating: Significant Weakness</p>	<p>Recommended changes and enhancements to the Claim Audit Tool have been submitted to Infrastructure & Technology for updates. Due to Office '07 conversion issues the changes to the Access Database have not been completed.</p> <p>Responsible Chief: Chief of Customer Services</p> <p>Target Resolution Date: Field Operations – April 2007; Field Operations (QA Related) – February 2008 June 2008</p> <p>Current Resolution Status: In-process</p>

Salary Continuation Program – March 2007

General Comment Regarding Resolution of Salary Continuation Audit Observations:

Since December 2007, management has taken several steps to mitigate the more critical data integrity and injured worker benefit accountability risks identified in the Salary Continuation audit. Most program changes took effect July 1, 2008. However, Deloitte has recently released their analysis of several BWC premium discount programs, including salary continuation. Based on their analysis, BWC management is now evaluating the effectiveness of those discount programs and their impact on employer premium rates. To that end, management is postponing any additional changes to the salary continuation program until December 2008, at which time product recommendations are targeted for delivery to the BWC Board of Directors.

	Recommendation	Disposition
1	<p>Develop management reporting to ensure initial contacts and all ongoing contacts are being made in Salary Continuation (SC) claims. Enforce existing policy and implement the necessary incentives and penalties as a control to ensure that participating employers are meeting all reporting requirements. Conduct a data and status cleanup project on the SC claims in an “unknown” status. Amend the SC policy to clarify expectations, roles, and responsibilities of BWC as well as MCO staff.</p> <p>Significance Rating: Significant Weakness</p>	<p>Updated policy is being trained during June with an effective date of July 1. Based on new policy, failure to comply with the reporting requirements will result in Temporary Total (TT) compensation being ordered. Employers have 60 days to become compliant for claims where SC is currently being paid and must be compliant for all new claims beginning July 1. Field Operations created a Salary Continuation report which identifies claims that have newly created SC plans built to ensure the current policy has been followed. For lost time claims, the clean-up is completed. Management is also awaiting results of the Deloitte Study.</p> <p>Responsible Chief: Chief of Customer Services</p> <p>Target Resolution Date: December 2007;</p>

		<p>April 2008 (“unknown claim” project clean up) May 2008 July 2008 Current Resolution Status: Implemented</p>
2	<p>Establish controls for monitoring and reporting wage submissions. Significance Rating: Significant Weakness</p>	<p>Based on the updated policy which is effective July 1, Temporary Total compensation will be ordered in claims where the employer fails to submit wage information. After the new policy is effective, Field Operations will ensure compliance. Responsible Chief: Chief of Customer Services Target Resolution Date: December 2007 May 2008 July 2008 Current Resolution Status: Implemented</p>
3	<p>Enforce existing policy and implement the necessary incentives and penalties as a control to ensure that participating employers are meeting all reporting requirements. Significance Rating: Material Weakness</p>	<p>Salary continuation program changes were implemented July 2008 that require employers to submit documentation for each period of salary continuation paid and to comply with salary continuation guidelines. Employers who fail to comply with guidelines will be given opportunity to correct non-compliance or claim will be denied salary continuation and Temporary Total compensation will be ordered. Additional program changes (including promulgation of a rule) are being postponed pending outcome of the Deloitte Study, which will be presented to the Board of Directors in December, 2008. Responsible Chief: Chief of Customer Services Target Resolution Date: December 2007 May 2008 July 2008 Current Resolution Status: Implemented</p>
4	<p>Ensure that injured workers receive sufficient information to make informed decisions concerning salary continuation. Significance Rating: Significant Weakness</p>	<p>Based on the new policy the letter to the injured worker (IW) has been eliminated. A new letter, addressed to the employer and copied to all parties in the claim outlines the requirements for salary continuation payment. The BWC order which allows salary continuation will also include an insert which sets wages and informs the IW the Temporary Total rate that would be payable in the claim. Responsible Chief: Chief of Customer Services Target Resolution Date: April 2008 July 2008</p>

		Current Resolution Status: Implemented
5	<p>Regarding lost time changeovers, BWC should ensure return to work dates, salary continuation, and lost time changeovers are re-assigned to the proper service offices. Reserve these claims properly and apply the corrected dollar impacts to the premiums and to the state fund. Develop management reporting to keep future claims from being overlooked, and to eliminate adverse impacts to the state fund.</p> <p>Significance Rating: Material Weakness</p>	<p>The clean-up project has been completed.</p> <p>Responsible Chief: Chief of Customer Services</p> <p>Target Resolution Date: Staffing - February 2007; Procedure Updates - September 2007; Quality Control- Implemented - December 2007; Claim project clean up - April 2008</p> <p>Current Resolution Status: Implemented</p>
6	<p>Revise the existing policy to contain clear and concise language for utilization of Independent Medical Exams (IME) and other claims management tools to avoid confusion and multiple interpretations. Ensure all IMEs are completed correctly and timely in accordance with BWC Policy.</p> <p>Significance Rating: Significant Weakness</p>	<p>All offices are being trained during June for the policy which goes into effect on July 1. The portion of the policy regarding Independent Medical Exams is included in this training.</p> <p>Responsible Chief: Chief of Customer Services</p> <p>Target Resolution Date: December 2007 July 2008</p> <p>Current Resolution Status: Implemented</p>
7	<p>Develop a standard referral system to identify, contact, educate, and track all employers who are not in compliance with the Salary Continuation Policy. Communicate to all of Field Operations that the Policy Department role is defining the policy, not enforcing the policy. Promulgate a formal rule to support program enforcement.</p> <p>Significance Rating: Material Weakness</p>	<p>Salary continuation program changes were implemented July 2008 that require employers to submit documentation for each period of salary continuation paid and to comply with salary continuation guidelines. Employers who fail to comply with guidelines will be given opportunity to correct non-compliance or claim will be denied salary continuation and Temporary Total compensation will be ordered. Additional program changes (including promulgation of a rule) are being postponed pending outcome of the Deloitte Study, which will be presented to the Board of Directors in December, 2008.</p> <p>Responsible Chief: Chief of Customer Services</p> <p>Target Resolution Date: December 2007 May 2008 December 2008</p> <p>Current Resolution Status: In-process</p>

Pharmacy Benefit Manager Audit – May 2007

	Recommendation	Disposition
1	<p>Develop payment structure that does not reimburse for drugs not dispensed. Significance Rating: Significant Weakness</p>	<p>BWC has authorized the Pharmacy Benefit Management vendor to modify the existing code to address this issue. The code is currently being developed and will be tested by BWC. The system change is scheduled to be implemented in July 2008. Letters, faxes and emails were sent to all pharmacies notifying them of the change. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: July 2008 Current Resolution Status: In-process</p>
2	<p>Require vendor to resume imaging of bills and increase oversight. Significance Rating: Significant Weakness</p>	<p>The vendor has resumed imaging of bills. Compliance & Performance Monitoring was unable to validate the imaging of bills during the April 2008 on-site review. CPM is planning to validate at the Pharmacy Benefit Management vendor's Henderson, SC office during 4th quarter 2008. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: April 2008 December 2008 Current Resolution Status: In-process</p>
3	<p>Develop retrospective Drug Utilization Review (DUR) criteria to enhance utilization of the services of the vendor. Significance Rating: Significant Weakness</p>	<p>BWC authorized a letter to be sent to prescribers who's Injured Workers receive medications that are contraindicated. This letter is scheduled to be mailed in August 2008. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: July 2008 August 2008 Current Resolution Status: In-process</p>
4	<p>Evaluate program resources, review contract, and require the vendor to submit an attestation letter stating that rebates and discounts have not been received. Significance Rating: Significant Weakness</p>	<p>The pharmacy consultant report was received on 6/27/2008. BWC is analyzing the report to determine the best use of the information and which recommendations to implement. Those recommendations requiring a contract change will be incorporated into the Request for Proposals process and new contract implementation. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: October 2008</p>

	Recommendation	Disposition
		(PBM contract RFP issued); December 2008 (RFP responses received and vendor selected); January 2009 (execute contract with new vendor); July 2009 (new contract effective date); October 2009 (complete compliance testing) Current Resolution Status: In-process
5	Consider utilizing vendor's technology. Significance Rating: Significant Weakness	Changes to the preferred drug list were implemented in January 2008. The revised target date for additional therapeutic drug classes is September 2008. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: March 2008 June 2008 September 2008 Current Resolution Status: In-process
6	Develop action plan to strengthen oversight and improve management of the program. Significance Rating: Significant Weakness	Target dates for implementation were added to the plan and were based on existing staffing levels. Responsible Chief: Chief of Medical Services and Compliance Current Resolution Status: Implemented
7	Periodically test transactions to ensure discounts are passed-through to BWC. Significance Rating: Significant Weakness	The pharmacy consultant report was received on 6/27/2008. BWC is analyzing the report to determine the best use of the information and which recommendations to implement. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: April 2008 August 2008 (complete analysis on pharmacy consultant report); October 2008 (PBM contract RFP issued); December 2008 (RFP responses received and vendor selected); January 2009 (execute contract with new vendor); July 2009 (new contract effective date); October 2009 (complete compliance testing)
8	Conduct sufficient review and analysis to identify opportunities. Significance Rating: Significant Weakness	The pharmacy consultant report was received on 6/27/2008. BWC is analyzing the report to determine the best use of the information and which recommendations to implement. Any program improvement opportunities requiring a contract language change would be implemented with the new contract period beginning 7/1/09. Responsible Chief: Chief of Medical Services and Compliance

	Recommendation	Disposition
		<p>Target Resolution Date: April 2008 August 2008 (complete analysis on pharmacy consultant report); October 2008 (PBM contract RFP issued); December 2008 (RFP responses received and vendor selected); January 2009 (execute contract with new vendor); July 2009 (new contract effective date); October 2009 (complete compliance testing)</p> <p>Current Resolution Status: In-process</p>

Retrospective Rating Program Audit – June 2007

	Recommendation	Disposition
1	<p>Evaluate additional alternatives to augment, compliment, or replace financial statement audit requirements.</p> <p>Significance Rating: Significant Weakness</p>	<p>The Deloitte Study includes the Retro Program (December 2008) and BWC management is expecting comments regarding the audited financial requirement which will be considered at that time.</p> <p>Responsible Chief: Chief of Customer Services</p> <p>Target Resolution Date: December 2007 (Recommendations to senior staff) December 2008 (Deloitte Study); July 2008 (implementation for private employers) and January 2009 (public entities)</p> <p>Current Resolution Status: In-process</p>
2	<p>Enforce provisions set forth in Ohio Administrative Code Section 4123-17-42 by establishing and implementing an effective procedure for the management review process.</p> <p>Significance Rating: Material Weakness</p>	<p>Beginning July 2007, the revised Management Review Process was used for the private employers (PA) applying to the program for 7/1/07 – 6/30/08 program period. Employer Services and Self Insured followed the new steps to review any applications where the underwriters indicated a clear approval or denial was unachievable. In December 2007, the Employer Management Policy Department drafted a formal policy on the Retro Management review process. Due to resource and prioritization issues, finalization of the policy has been delayed; however, the revised Management Review process was employed in July 2007 and will be employed for the 7/1/08 PA Retro applications. The process is in place awaiting final policy approval,</p>

	Recommendation	Disposition
		<p>expected by the end of 9/08. Responsible Chief: Chief of Customer Services Target Resolution Date: December 2007 June 2008 September 2008 Current Resolution Status: In-process</p>
3	<p>Evaluate requirements and objectives of the program to ensure support exists for all goals and outcomes. Consider eliminating the allowance of any employer who is financially unstable, including employers who are in a part pay status from the program. Significance Rating: Material Weakness</p>	<p>After review, the ability for employers in part pay plans that meet the stated financial requirements to participate in the Retrospective Rating Program has been determined to be appropriate and in support of program financial objectives and safety goals. Results of the Deloitte Study of employer programs being conducted in 2008 could cause this to be reconsidered at a later date. Responsible Chief: Chief of Customer Services Target Resolution Date: December 2008 (Deloitte Study) Current Resolution Status: In-process</p>
4	<p>Develop ongoing reporting and conduct detailed trending and analysis of pertinent program management data. Significance Rating: Significant Weakness</p>	<p>A bankruptcy measurement to gauge effectiveness has been implemented. The Deloitte Study will review the cost effectiveness of the Retro Program and results from that study are expected to identify additional reporting measurements. Responsible Chief: Chief of Customer Services Target Resolution Date: April 2008 December 2008 (Deloitte Study) Current Resolution Status: In-process</p>

Medical Bill Payment Controls Memorandum – June 2007

	Recommendation	Disposition
1	<p>The BWC Medical Services Division should implement preventive and detective controls to include caps or limits on the amounts reimbursable for hospital bill charges. Preventive controls, coupled with monitoring by management, will help guard against intentional or unintentional keying errors of billed amounts by either the hospitals or Managed Care Organizations (MCO). Significance Rating: Significant Weakness</p>	<p>The clinical editing software was implemented on 06/30/08. Two edits which will identify inappropriate and/or fraudulent provider bills have been set to post. It is anticipated that these edits will be set to deny by 10/7/08. Health Partnership Program Systems Support has initiated edits which are set to deny for unusually high provider billed amounts. MCOs are submitting override explanations of benefits indicating that they</p>

	Recommendation	Disposition
		<p>have reviewed the bills. Compliance & Performance Monitoring has initiated the 10k bill data accuracy reviews.</p> <p>Responsible Chief: Chief of Medical Services and Compliance</p> <p>Target Resolution Date: August 2007 (Cambridge solutions, RFP results, budget decision); April 2008 May 2008 June 2008 (implement and train on clinical editing software)</p> <p>Current Resolution Status: Implemented</p>

Personal Trading Policy Consulting Project – October 2007

	Recommendation	Disposition
1	<p>Establish a Personal Trading Compliance Committee to develop a personal trading policy and ongoing monitoring procedures for BWC.</p> <p>Significance Rating: Significant Weakness</p>	<p>Personal Trading Policy Committee met 2-06-08 and received legal advice from the Legal Division. Copies of internal trading policies from other entities were obtained. The Chief Ethics Officer and the Legal Division have met and Legal has developed a preliminary draft of the policy. After consultation with the Chief Investment Officer, the Chief Ethics Office will revise the draft policy by September 2008. The committee will review and comment on the draft by September 2008.</p> <p>Responsible Chief: Chief Ethics Officer (consultation by Chief Investment Officer)</p> <p>Target Resolution Date: Committee formation – Implemented; Policy implementation – To be determined by committee October 2008</p> <p>Current Resolution Status – In-process</p>

Investment Reconciliation Consulting Project – October 2007

	Recommendation	Disposition
1	<p>Enhance month-end reporting standards placed on external investment managers and require them to report detailed holdings data. Reconcile returns calculated by the BWC’s performance provider to those calculated by the external investment managers on a monthly basis.</p> <p>Significance Rating: Significant Weakness</p>	<p>Procedures have been formalized for the review of holdings reconciliations between BWC’s book of record and the external investment managers. Procedures still need to be formalized for the review of the performance reconciliations.</p> <p>Responsible Chief: Chief of Fiscal and Planning</p> <p>Target Resolution Date: April 2008 June 2008-August 2008</p> <p>Current Resolution Status – In-process</p>

Vocational Rehabilitation Audit– October 2007

	Recommendation	Disposition
1	<p>Implement processes to review the actual vocational rehabilitation costs billed in claims for reasonableness and appropriateness.</p> <p>Significance Rating: Material Weakness</p>	<p>Members of Vocational Rehabilitation Policy and Compliance & Performance Monitoring have met to discuss reports that can be generated routinely to monitor the outliers.</p> <p>Responsible Chief: Chief of Medical Services and Compliance</p> <p>Target Resolution Date: April 2008 June 2008</p> <p>Current Resolution Status: In-process</p>
2	<p>Take steps to eliminate the potential conflict of interest created by Managed Care Organizations (MCOs) that refer vocational rehabilitation cases to their related companies.</p> <p>Significance Rating: Material Weakness</p>	<p>Labor/Management/Government Workgroup has concluded and the final report is in development. BWC Redesign Project Team has begun work with representation from field operations and central office. Steering Committee of senior and mid-level management has been identified.</p> <p>Responsible Chief: Chief of Medical Services and Compliance</p> <p>Target Resolution Date: October 2008</p> <p>Current Resolution Status: In-process</p>

	Recommendation	Disposition
3	<p>Formalize policy regarding the authority of the Disability Management Coordinators (DMCs) to challenge MCO feasibility determinations.</p> <p>Significance Rating: Material Weakness</p>	<p>Management is implementing a process requiring written authorization by the DMC of the feasibility and service provider recommendations. When the rehab redesign project is fully adopted this rule and policy will be written and formalized.</p> <p>Responsible Chief: Chief of Medical Services and Compliance</p> <p>Target Resolution Date: October 2008</p> <p>Current Resolution Status: In-process</p>
4	<p>Implement controls over the coordination agreement with the Rehabilitation Services Commission (RSC) to ensure costs expended under that program are only incurred for eligible injured workers and are reasonable and appropriate.</p> <p>Significance Rating: Material Weakness</p>	<p>After meetings with RSC a new process for securing eligibility has been agreed upon but due to IT restraints at RSC the rollout of the eligibility request process has been pushed to August 15, 2008. A draft of the enhanced detailed data reporting by RSC has been received and implementation is in process. Target date moved to October 2008.</p> <p>Responsible Chief: Chief of Medical Services and Compliance</p> <p>Target Resolution Date: June 2008 October 2008</p> <p>Current Resolution Status: In-process</p>
5	<p>Establish effective quality assurance review procedures to ensure various controls and activities performed by Disability Management Coordinators (DMCs) are proper, timely, and in accordance with policies and statutes.</p> <p>Significance Rating: Significant Weakness</p>	<p>DMCs are evaluating individual performance measures that will actually reflect the highest level of professional service they offered in a day's time. These ideas are being discussed by a Rehab Redesign workgroup.</p> <p>Responsible Chief: Chief of Medical Services and Compliance</p> <p>Target Resolution Date: June 2008 August 2008</p> <p>Current Resolution Status: In-process</p>
6	<p>Implement written procedures for establishing reimbursement rates for vocational rehabilitation services and for periodically reviewing and updating such rates.</p> <p>Significance Rating: Significant Weakness</p>	<p>The procedure has been written and is under review.</p> <p>Responsible Chief: Chief of Medical Services and Compliance</p> <p>Target Resolution Date: March 2008</p> <p>Current Resolution Status: In-process</p>

	Recommendation	Disposition
7	Review credentialing and position requirements for Disability Management Coordinator (DMC) positions and ensure individuals possess the qualifications to manage the vocational rehabilitation process. Establish a process to monitor DMC certifications to ensure the required credentials are maintained. Significance Rating: Significant Weakness	Revised position minimum qualifications have been presented to Human Resources and are under review. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: March 2008 October 2008 Current Resolution Status: In-process

Managed Care Organization (MCO) Audit #2 – January 2008

	Recommendation	Disposition
1	Take steps to improve the MCO's financial condition to ensure quality service is not interrupted to injured workers, employers, providers and BWC. Significance Rating: Material Weakness	MCO management has taken steps to resolve the financial difficulties experienced. Target Resolution Date: June 2008 Current Resolution Status: In-process
2	Establish processes to facilitate an annual review and testing of the entire disaster recovery plan and perform any necessary updates each year. Significance Rating: Significant Weakness	MCO management updated the disaster recovery plan and will work with their IT consultant to develop a process to periodically test the plan. Target Resolution Date: June 2008 Current Resolution Status: In-process
3	Establish processes and controls to help ensure audit findings are resolved within the contract timeframes. Take steps to refund the provider overpayments to BWC. Significance Rating: Significant Weakness	Management is in the process of recovering the provider overpayments and performing the required adjustments. Target Resolution Date: July 2008 Current Resolution Status: In-process

Permanent Total Disability Claims Audit – January 2008

	Recommendation	Disposition
1	Formalize policies, procedures, and training materials to ensure consistent, efficient, and effective processing of Permanent Total Disability claims. Additionally, create systematic processing procedures and/or training materials for Disabled Workers' Relief Fund (DWRF) claim functions. Significance Rating: Significant Weakness	The policy and training material have been reviewed and are in agreement. Regarding DWRF procedures, we have started the process and contemplate completing it September 2008. Responsible Chief: Chief of Customer Services Target Resolution Date: May 2008 September 2008 Current Resolution Status: In-process

	Recommendation	Disposition
2	Meet with IT management and evaluate the cost benefit of updating the Version 3 (V3) system to better assist in the process of Permanent Total Disability and Disabled Workers' Relief Fund or develop compensating controls. Significance Rating: Significant Weakness	Management is working with Infrastructure & Technology to evaluate and prioritize the system changes. Responsible Chief: Chief of Customer Services Target Resolution Date: December 2008 Current Resolution Status: In-process
3	Review other alternatives for processing Permanent Total Disability (PTD) claims to provide more effective and efficient claim maintenance. Significance Rating: Significant Weakness	Management is reviewing and prioritizing recommendations for regionalizing the handling of PTD and Death claims in specialized offices. Responsible Chief: Chief of Customer Services Target Resolution Date: June 2008 Current Resolution Status: In-process
4	Conduct the cross match each month and monitor reports to ensure appropriate actions have been taken based on the diary type. Significance Rating: Significant Weakness	The importance of this system change has been emphasized and the system change will be scheduled this summer. Depending on available resources, the target date may need to be extended by a quarter. Responsible Chief: Chief of Customer Services Target Resolution Date: June 2008 December 2008 Current Resolution Status: In-process
5	Implement controls to ensure that Disabled Workers' Relief Fund overpayments are processed and recouped in accordance with statute and BWC policy. Significance Rating: Significant Weakness	Updated overpayment policy is in development. Responsible Chief: Chief of Customer Services Target Resolution Date: October 2008 Current Resolution Status: In-process
6	Establish the essential resources needed to complete the previous clean up project by identifying and reviewing claims that have never been reviewed and correcting those claims with outstanding errors. Significance Rating: Significant Weakness	Phase III of the PTD clean-up project is almost complete with a final report due to management by June 30, 2008. Responsible Chief: Chief of Customer Services Target Resolution Date: June 2008 Current Resolution Status: In-process

	Recommendation	Disposition
7	<p>Create proactive controls and monitoring processes to ensure benefit payments due to injured workers are not inappropriately interrupted.</p> <p>Significance Rating: Significant Weakness</p>	<p>Management has requested a system change control to create diaries for suspended Permanent Total Disability claims and for non-suspended plans due to a date of death (DOD) not entered. Resources and timeframes have not been identified at this time. Data warehouse queries will be developed as an interim control measure.</p> <p>Responsible Chief: Chief of Customer Services</p> <p>Target Resolution Date: December 2008</p> <p>Current Resolution Status: In-process</p>
8	<p>Implement processes and/or controls to monitor claims in which the injured worker has clearly retired (or is eligible for retirement) are calculated and paid appropriately.</p> <p>Significance Rating: Significant Weakness</p>	<p>Management has requested a system change control so the diary will post to the assigned and Disabled Workers' Relief Fund Claims Service Specialist when an injured worker reaches the age 62 and there is no retirement date in V3. Resources and timeframes have not been identified at this time.</p> <p>Responsible Chief: Chief of Customer Services</p> <p>Target Resolution Date: December 2008</p> <p>Current Resolution Status: In-process</p>
9	<p>Determine the overall impact and best course of action regarding the incorrect overpayments to ensure the accounts receivable balance and BWC financial statements are accurate, and identify and correct the erroneous Disabled Workers' Relief Fund (DWRF) overpayments.</p> <p>Significance Rating: Significant Weakness</p>	<p>Management will work with Finance and Customer Service Divisions to determine the best solution for incorrect DWRF payments and inappropriate Permanent Total Disability offsets. A system change control was submitted to prevent incorrect DWRF overpayments. Resources and timeframes have not been identified at this time.</p> <p>Responsible Chief: Chief of Customer Services</p> <p>Target Resolution Date: April 2008 (overpayment correction); February 2009 (clean-up project); February 2008 (QA; IT related)</p> <p>Current Resolution Status: In-process</p>

Medical Bill Payment Process Audit – March 2008

	Recommendation	Disposition
1	<p>Determine the actual administrative costs associated with bill processing and develop strategies for continuous monitoring and reduction of these costs. Significance Rating: Material Weakness</p>	<p>The report is currently being developed using the May 2008 budget reports. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: July 2008 Current Resolution Status: In-process</p>
2	<p>Update or develop internal policies and procedures to enhance compliance with applicable laws and regulations and promote effective and efficient operations. Significance Rating: Significant Weakness</p>	<p>Management will update the Recovery and Overpayment policy and develop the Management Reporting and Distribution policy and procedures. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: July 2008 Current Resolution Status: In-process</p>
3	<p>Evaluate a change to the current Ohio Administrative Code to shorten the statute of limitations for medical bill payments to model other state workers' compensation systems. Significance Rating: Significant Weakness</p>	<p>Management will investigate shortening the statute of limitations for medical bill payments in conjunction with the strategic objective for benefit plan design and coverage. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: December 2008 Current Resolution Status: In-process</p>
4	<p>Complete a review to determine the feasibility of eliminating levels of appeals in the Alternative Dispute Resolution process. Significance Rating: Significant Weakness</p>	<p>A SMART objective workgroup is researching this option and developing a recommendation for the Chief of Medical Services approval. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: December 2008 Current Resolution Status: In-process</p>
5	<p>Finalize and approve the draft overpayment policy and make the final determination on the outstanding MCO and provider overpayments. Significance Rating: Significant Weakness</p>	<p>Medical Services Division will finalize the Recovery and Overpayment policy by July 2008, review the remaining 40 overpayment disputes, and make a final determination by October 2008. Responsible Chief: Chief of Medical Services and Compliance Target Resolution Date: October 2008 Current Resolution Status: In-process</p>

	Recommendation	Disposition
6	<p>Monitor and track the certification application process to verify all providers are routinely reapplying for certification and providing the Bureau with credentialing information.</p> <p>Significance Rating: Significant Weakness</p>	<p>Medical Services Division requested an interpretation of the Ohio Elections Law and its impact on the provider enrollment and certification processes and will comply with the Ohio Elections Commission opinion.</p> <p>Responsible Chief: Chief of Medical Services and Compliance</p> <p>Target Resolution Date: December 2008</p> <p>Current Resolution Status: In-process</p>
7	<p>Implement a comprehensive bill tracking and reporting process to include MCO timelines to monitor compliance with BWC policies; and consider reimbursing providers directly from BWC.</p> <p>Significance Rating: Significant Weakness</p>	<p>Management will perform a bill payment review of MCOs during the summer/fall of 2008.</p> <p>Responsible Chief: Chief of Medical Services and Compliance</p> <p>Target Resolution Date: December 2008</p> <p>Current Resolution Status: In-process</p>

Note: Comments designated as “Implemented” are based on managements’ assertions and have not yet been validated by Internal Audit.

BWC Internal Audit Division Audit Report Follow-up Procedures

The *International Standards for the Professional Practice of Internal Auditing* specifically addresses follow-up in Standard 2500. One of our primary responsibilities as professional auditors is determining that the audit customer takes corrective action on recommendations. This applies in all cases except where “senior management has accepted the risk of not taking action.” When senior management accepts the risk of not taking action the comment will be forwarded to the Administrator for review, the Chief of Internal Audit will report the comment with management’s response to the Audit Committee for consideration.

Being an integral part of the internal audit process, follow-up should be scheduled along with the other steps necessary to perform the audit. However, specific follow-up activity depends on the results of the audit and can be carried out at the time the report draft is reviewed with management personnel or after the issuance of the report. Typically, audit follow up should occur within 90 days of the issuance of the final report.

Follow-up activities may generally be broken down into three areas:

- Casual - This is the most basic form of follow-up and may be satisfied by review of the audit customer’s procedures or an informal phone call. Memo correspondence may also be used. This is usually applicable to the less critical findings.
- Limited - Limited follow-up typically involves more audit customer interaction. This may include actually verifying procedures or transactions and, in most cases, is not accomplished through memos or phone calls with the audit customer.
- Detailed - Detailed follow-up is usually more time-consuming and can include substantial audit customer involvement. Verifying procedures and audit trails, as well as substantiating account balances and computerized records, are examples. The more critical audit findings usually require detailed follow-up.

Follow-up scheduling can begin when corrective action is confirmed by acceptance of an audit recommendation or when management elects to accept the risk of not implementing the recommendation. Based on the risk and exposure involved, as well as the degree of difficulty in achieving the recommended action, follow-up activity should be scheduled to monitor the situation or confirm completion of the changes that were planned. These same factors establish whether a simple phone call would suffice or whether further audit procedures would be required.

At the end of each quarter, a summary follow-up report is prepared. This report reflects all current period findings with appropriate comments to reflect end-of-quarter status.

Additionally, this report highlights all outstanding findings from prior periods and their status. The intent of this summary report is to track all findings so that they are appropriately resolved.

**BWC Internal Audit Division
Audit Comment Rating Criteria**

Comment Rating	Description of Factors	Reporting Level
Material Weakness	<ul style="list-style-type: none"> • Overall control environment does not provide reasonable assurance regarding the safeguarding of assets, reliability of financial records, and compliance with Bureau policies and/or laws and regulations. A significant business risk or exposure to the Bureau that requires immediate attention and remediation efforts. • A significant deficiency, or combination of significant deficiencies, that results in <u>more than a remote likelihood</u> that a material misstatement of the annual or interim financial statements will not be prevented or detected by employees in the normal course of their work, or that a major operational or compliance objective would not be achieved. 	Audit Committee, Senior Management, Department Management
Significant Weakness	<ul style="list-style-type: none"> • Issue represents a control weakness, which could have or is having some adverse affect on the ability to achieve process objectives. The controls in place need improvement and if not improved could lead to an overall unsatisfactory or unacceptable state of control. Requires near-term management attention. • A control deficiency, or combination of control deficiencies, that results in a <u>remote</u> likelihood that a misstatement of the Bureau’s annual or interim financial statements is more than inconsequential will not be prevented or detected by employees in the normal course of their work, or that a major operational or compliance objective would not be achieved. 	Senior Management, Department Management, Audit Committee (optional)
Minor Weakness	<ul style="list-style-type: none"> • Issue represents a process improvement opportunity or a minor control weakness with minimal impact. Observations with this rating should be addressed by line level management. • A control deficiency that would result in <u>less than a remote</u> likelihood that the deficiency could reasonably result in a material misstatement of the financial statements or materially affect the ability to achieve key operational or compliance objectives. 	Department Management, Senior Management (optional)

NOTE: When management’s action plans for Significant Weakness comments are materially delayed from the intended implementation date the comment will elevate to a Material Weakness (pending circumstances).

**Internal Audit Division
FY 09 Annual Audit Plan**

Focus Area	1st Qtr.			2nd Qtr.			3rd Qtr.			4th Qtr.			Audit Effort
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	
Employer Compliance (Consulting)													1
Coal Mine Safety Program (Consulting)													2
Permanent Partial Benefits													4
Settlements Process													5
External Audit Assistance													5
Mainframe Security													5
Physical and Environmental Security													3
Employer Policy Application Process													4
Auto Adjudication													4
Safety and Hygiene													5
Investment Certification Control Testing													5
Self Insured Bankrupt Securitization Process													4
Backup Procedures													3
Accounts Payable													3
Ethics Review													1
Adjudicating Committee													4
Human Resources													4
Change Management Process													5
Purchasing													3
Coal Mine Safety Program													2
Employer Compliance and Premium Audit													5
FY 2010 Audit Plan													3
Fleet Management													3
Audit Validation Testing													5
MCO Audits													5

Audit Effort Explanations

Number	Level of Audit Effort	Hours
1	Extra Small	< 100 hours
2	Small	100 – 300 hours
3	Medium	301 – 500 hours
4	Large	501 – 800 hours
5	Extra Large	801 – 1200 hours