

GOVERNANCE COMMITTEE

Thursday, September 24, 2009, 8:00 a.m.

William Green Building

30 West Spring Street, 2nd Floor (Mezzanine)

Columbus, Ohio 43215

Members Present: Alison Falls, Chair
Larry Price, Vice Chair
William Lhota
James Hummel
Thomas Pitts

Members Absent: None

Other Directors Present: James Harris, David Caldwell, Kenneth Haffey,
Charles Bryan, Robert Smith (arrived 8:09), James
Matesich (arrived 8:05)

Counsel Present: John Williams, Assistant Attorney General

CALL TO ORDER

Ms. Falls called the meeting to order at 8:01 AM and the roll call was taken.

MINUTES OF AUGUST 27, 2009

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

REVIEW/APPROVE AGENDA

Ms. Falls reviewed the agenda and noted no changes.

The agenda was approved by unanimous roll call vote on a motion by Mr. Price, seconded by Mr. Hummel.

NEW BUSINESS / ACTION ITEMS

1. **Board Advisory Structure for Input on Medical Issues**

Per request of Ms. Falls, Legal Director James Barnes provided an overview of options available to the Board for consideration of policy development surrounding medical issues. House Bill 100 authorizes the creation of Board committees. However, O.R.C. §4121.12(F) states that overall administrative function rests with the Administrator in managing and discharging day to day operations. The Board's role is to set strategic goals for BWC, while management's function is to develop methods of accomplishing those goals and making recommendations to the Board. There may be a perception the Board is crossing or blurring the line. The Board must consult with experts within BWC, but not direct them on how to proceed with their functions.

Mr. Barnes noted there is also a potential conflict of interest in that participation may impact one's constituency, or give an appearance of undue influence. Even a perception of undue influence is a serious concern. The Ethics Commission has issued opinions in the past to provide guidance to the Board.

Mr. Harris asked how this issue differs with respect to a medical services committee as opposed to the other Board Committees. Mr. Barnes replied that no director has specific expertise with respect to medical issues. However, the concept of setting boundaries remains the same. For clarification, Ms. Falls asked if the boundaries for the Medical Committee would be similar to those for the Investment and Internal Audit Committees. Mr. Barnes replied in the affirmative. Mr. Barnes clarified that as legal counsel, he is cautioning the Board, but there is no prohibition against moving forward on this issue. Mr. Lhota commented this discussion is beneficial on a periodic basis.

Medical Director Robert Balchick commented that communication, transparency and presentation of diverse views make for better policy. Directors Smith, Pitts and Hummel each noted that they were more comfortable with the committee format than an individual medical liaison. This format provides greater transparency and less opportunity for individual influence. Administrator Marsha Ryan also noted her preference for a committee.

Ms. Falls summarized that the committee format has served the Board well and will assist in providing focus for this "mission critical" area of medical services.

A motion was made by Ms. Falls, seconded by Mr. Price, that the Governance Committee recommend that the BWC Board of Directors create a new standing committee of the Board, the Medical Services Committee. This motion is offered under the authority of Ohio Revised Code

4121.12(G)(2) which allows the Board of Directors to “create any committee . . . that the board determines are necessary to assist the board in performing its duties.” The motion was approved by unanimous roll call vote.

Ms. Falls then outlined a process for implementing the Medical Services Committee. Mr. Harris, Mr. Hummel and Mr. Pitts have expressed an interest in being members. The Governance Committee will accordingly be reduced to three (3) members, with Mr. Pitts and Mr. Hummel moving to Medical Services. Mr. Harris expressed a preference to discontinue Audit Committee membership because of the meeting schedule. Mr. Haffey will be added to the Investment Committee, leaving no director with more than two committee memberships. There were no forthcoming comments from the directors.

It will be a challenge to add to the meeting schedule. Investment and Audit Committees may be moved to a midday back-to-back time frame, in order to accommodate Mr. Haffey taking on another committee. When there is a public forum scheduled, so committee meetings may have to be scheduled simultaneously. Mr. Harris suggested that Governance Committee not be held simultaneously with other committees, as all directors like to attend that meeting. Robert Coury, Chief of Medical Services and Compliance, noted that Medical Services staff is frequently required to attend Audit Committee, as opposed to Actuarial or Investment.

The Medical Services Committee will have an initial meeting in October. Governance Committee will continue to review medical rules until the Medical Services Committee is fully organized with a charter. The Governance Committee will also review its ongoing schedule, as its rule review function should decrease over time.

A consensus was reached that Ms. Falls recommend to the Chairman, Mr. Lhota, that Mr. Harris, Mr. Hummel and Mr. Pitts form the Medical Services Committee and that Mr. Harris be the chair. Mr. Lhota opined a formal vote was not necessary. He thanked Ms. Falls, the new committee members and staff for their input of time and ideas into this process.

2. MOTIONS FOR BOARD CONSIDERATION

A. FOR SECOND READING

1. Workshops and Factories: Rules 4123:1-5

Don Bentley, Director of Technical Support, Division of Safety and Hygiene, presented 32 safety rules. All rules were subject to external and internal review, with stakeholder input provide by two representatives each of employers and employees. The goal was to create clear, specific rules

updated to current Occupational Safety and Health Administration (OSHA) standards.

In response to questions from last month's meeting, Mr. Bentley clarified that references in Rule 4123:1-5-99.1 to safety belts and harnesses being "securely fastened" to a "structure" are derived from the equivalent safety rule for construction, 4123:1-3-03. A structure is defined as a silo, hopper, tank or storage area. The exceptions have been reduced in Rule 4123:1-5-17 to provide for alternate safety devices. An example would be the difficulty of requiring a ladder cage for a chimney.

The use of skin designation regarding exposure to certain chemicals, if absorption will create an additional hazard, was also reviewed. Based on current OSHA standards, two chemicals were added and nine chemicals removed from Rule 4123:1-5-99.1. Exhaust ventilation illustrations contained in Rule 4123:1-5-99.2 were removed. These are only examples, which were being inappropriately cited as authority. Safety & Hygiene consultants continue to have this information in a manual. The stakeholder participants were in favor of this change.

Mr. Price noted that there was a great deal of stakeholder agreement to the proposals, and wondered if areas of disagreement remained. Mr. Bentley replied that if there was a disagreement, the parties looked to OSHA for a resolution and abided by those standards. There are no remaining issues.

A motion was made by Mr. Price, seconded by Mr. Lhota, that the Governance Committee recommend that the BWC Board of Directors approve the Administrator's recommendations on the five-year rule review of Chapter 4123:1-5 of the Administrative Code, the workshops and factories safety rules. The motion consents to the Administrator amending thirty-two rules of the workshops and factories safety rules as presented here today. The motion was approved by unanimous roll call vote.

RULES FOR FIRST READING

1. 2010 Inpatient Fee Schedule, Rule 4123-6-37.1

Freddie Johnson, Director, Managed Care Services, and Anne Casto, Medical Services Consultant, presented proposed rule changes to the inpatient fee schedule. While this is a small portion (.2%) of bills, it is a critical segment due to the seriousness of injuries and comprises 14% of annual expenses. The proposed increase in 2010 is 2.9%, which translates to \$2.4 million. This is scheduled for second reading next month and should take effect approximately February 1, 2010 after Board and JCARR approval.

To obtain the proper rate, Medicare information was reviewed using a base rate for each hospital, multiplied by the rate for a specific service, taking into account the resources used. This produces a base rate for the fee, which is then adjusted further for such factors as the patient base and the type of hospital, such as a teaching hospital. Per a question from Mr. Smith, Ms. Casto explained that base rates can be disparate, depending on these factors. Ms. Casto stated she has seen a base rate as high as \$8,000 and lower than the national average of \$5,100 for Ohio hospitals. The base rate calculation methodology was implemented by BWC in 2007.

The Medicare rule updates published August 27, 2009 were reviewed. There were no increases in coding and documentation adjustments, but there was a 1.6% increase in payments. The reason BWC is projecting a 2.9% increase is that BWC's top ten procedures/services differ from Medicare. While Medicare had decreased costs in six out of its top ten services, BWC had a decrease in only three of its top ten services. BWC also has more surgery and trauma encounters than Medicare.

Mr. Harris inquired if there is a difference in population covered by Medicare and BWC. Although the evaluation is similar, the differences have to do with level of severity. In response to a question from Mr. Bryan, BWC pays approximately 20% more than Medicare, to promote our focus on providing quality services. This payment percentage was last revised in 2008, and is comparable to private insurers based on what data BWC has been able to obtain. Mr. Johnson advised, per a question from Mr. Smith, that there has been no disagreement or complaint from stakeholders over lack of access to care. Mr. Pitts noted anecdotally that he does not see an issue from his constituency.

2. HPP Provider Rules 4123-6-19 to 4123-6-46

Before the presentation began, Don Berno, Board Liaison, explained that a more extensive chart reflecting the merger of Chapter 7 rules into Chapter 6 will be available to the Board next week.

Mr. Johnson and Nancy Leeper, Medical Policy Program Coordinator, presented proposed amendments to Rules 4123-6-19 through 4123-6-46 regarding Health Partnership Program (HPP) providers. These changes result from a joint effort between the Self- Insured and Medical Services Departments. The stakeholder feedback is included. Chapter 7 rules are being rescinded in their entirety and incorporated into Chapter 6, which are now applicable to both state fund and self-insuring employers per the newly created Rule 4123-6-01.1.

Mr. Johnson and Ms. Leeper reviewed the proposed amendments, noting specific changes to individual rules, rescission, additional language, and combining information into other rules. In particular, language was added to Rule 4123-6-06.2 limiting how providers may treat injuries to themselves or immediate family members. This was done to avoid conflicts of interest. Rule 4123-6-14 was revised to give more clarity on what is included in provider bill review. Rule 4123-6-16 clarifies what treatment guidelines will be used by managed care organizations in order to be consistent. Rule 4123-6-31 combines six (6) rules to consolidate payment criteria for services and supplies.

Mr. Pitts asked if Rule 4123-6-43(B) had any language changes. Mr. Johnson explained that it did not. Per a question from Mr. Hummel, Mr. Johnson stated there are no major content changes brought about by these amendments. This will be reflected on the updated crossover chart.

3. Policies and Procedures for Public Forums

Mr. Berno reviewed draft policies and procedures for public forums. Ms. Falls asked Mr. Lhota as Board Chair if item III(e), permitting directors to question speakers, would present a problem as a change in protocol. Mr. Lhota stated he did not see a problem so long as questions are directed through the Chair for approval. The Chair will also have discretion to control the discussion. Mr. Price expressed comfort with having the Chair control the proceedings. Mr. Pitts suggested the phrase “with permission of the Chair” be added to item III(e).

Per a question from Mr. Lhota, Mr. Barnes opined that a reference to Robert’s Rules of Order was not necessary because a public forum is not a Board or Committee meeting. Mr. Harris also noted a more extensive discussion could occur with constituents after the forum.

Per suggestion of Mr. Lhota, the language “with the approval of the Board” will be eliminated from the last sentence of the first paragraph. The Administrator will propose a schedule.

With respect to item IV, language will be changed to read “As appropriate, staff will inform Directors within two weeks of the forum of actions taken to address concerns raised by presenters.”

A motion was made by Ms. Falls, seconded by Mr. Pitts, that the Governance Committee recommend the BWC Board of Directors adopt the

policies and procedures for public forums, as amended, as approved here today. The motion was approved by unanimous roll call vote.

ADJOURNMENT

Due to time constraints, the remaining agenda items were deferred to the next meeting date.

Mr. Pitts moved to adjourn the meeting at 10:02 AM, seconded by Mr. Lhota and approved by unanimous roll call vote.

Prepared by Jill Whitworth, Staff Counsel
September 24, 2009

Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-37.1

Rule Review

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

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

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

What goal(s): The rule adopts a discounted hospital inpatient reimbursement methodology based on Medicare's "Medicare severity diagnosis related group" or "MS-DRG" methodology, 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 changes were presented to the Ohio Hospital Association on 9/1/09, with subsequent feedback being provided on 9/10/09. The proposed changes were also posted on BWC's website on 9/11/09, with comments being taken up to 9/24/09.

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 Hospital Inpatient Services
Payment Rule**

Introduction

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

Ohio Administrative Code 4123-6-37, initially adopted February 12, 1997 and amended March 1, 2004, provides general criteria for the payment of hospital services under the HPP. Ohio Administrative Code 4123-6-37.1 provides specific methodology for the payment of hospital inpatient services. It was initially adopted effective January 1, 2007, and has since been amended effective April 1, 2007, January 1, 2008, and February 1, 2009.

Background Law

R.C. 4123.66(A) provides that the BWC Administrator “shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper,” and that the Administrator “may adopt rules, with the advice and consent of the [BWC] board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefor.”

R.C. 4121.441(A)(8) provides that the BWC 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 rules regarding “[d]iscounted pricing for all in-patient . . . medical services.”

Pursuant 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 is required to adopt changes to its methodology for the payment of hospital inpatient services via the O.R.C. Chapter 119 rulemaking process.

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

Proposed Changes

Ohio Administrative Code 4123-6-37.1 currently incorporates by reference 42 Code of Federal Regulations (C.F.R.) Part 412 as published in the October 1, 2008 C.F.R., as well as Federal Register citations to the 2008 Medicare regulations under which the applicable MS-DRG reimbursement rate was determined during the last Medicare fiscal year. BWC is proposing to revise the Federal Register citations to the 2009 regulations, and the 42 CFR Part 412 citation to that published in the October 1, 2009 C.F.R.

BWC is proposing to keep the amount reimbursed to hospitals at one hundred twenty percent (120%) of the applicable MS-DRG, as under the current rule. BWC is also proposing to calculate the per diem rates for direct graduate medical education annually every February 1, to be consistent with the effective date of the rule. Outliers shall continue to be reimbursed at one hundred seventy-five percent (175%) of the applicable MS-DRG reimbursement rate for the hospital inpatient service.

MS-DRG exempt hospitals who submitted a 2008 cost report to the Ohio Department of Job and Family Services (ODJFS) shall continue to be reimbursed at seventy percent (70%) of billed charges; MS-DRG exempt hospitals who did not submit a 2008 cost report to ODJFS shall continue to be reimbursed at sixty-two percent (62%) of billed charges.

The proposed rule would also clarify that a QHP or self-insuring employer may reimburse hospital inpatient services at:

- the applicable rate under the or “MS-DRG” methodology; or
- seventy percent (70%) of billed charges for hospitals who submitted a 2008 cost report to ODJFS, and sixty-two percent (62%) of billed charges for hospitals who did not submit a 2008 cost report to ODJFS; or
- the rate negotiated between the hospital and the QHP or self-insuring employer in accordance with rule 4123-6-46 of the Administrative Code.

Finally, BWC proposes to make the new hospital inpatient reimbursement rule applicable to hospital inpatient services with a discharge date of February 1, 2010 or later.

Stakeholder Involvement

The proposed inpatient payment methodology was provided for review to the Ohio Hospital Association. The OHA has provided written comment. OHA has no opposition to BWC’s adoption of the revised updates for the payment of inpatient hospital bills with discharge dates of February 1, 2010 or later.

The proposed rule and changes were also posted on the BWC website, with a comment period open from 9/11/09 to 9/24/09.

BWC 2010 Proposed Inpatient Hospital Fees

Medical Service Enhancements

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

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

Inpatient Hospital Fee Schedule Methodology

Introduction

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

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

Methodology

BWC implemented Medicare's Inpatient Prospective Payment System (IPPS) that utilizes the diagnosis-related groups (DRGs) classification system in January 2007 but with customized outlier and medical education payments. In 2008, BWC revised its program to implement Medicare's new MS-DRG methodology. The BWC inpatient fee schedule

was last updated by the Board effective February 2009. In 2009, BWC adopted Medicare's 2009 MS-DRG outlier formula and updated the payment adjustment factors.

The adopted methodology in 2009 reflected a Medicare's pricing standard based on the annually updated Medicare Severity Diagnosis Related Groups (MS-DRG). BWC's methodology includes updating our rule annually to reference the new federal rule reflecting the most current Medicare model. In addition, as part of the annual process, BWC takes the opportunity to 1) review the adjustment factors it uses and 2) ensure that the methodology is meeting BWC's goals.

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

Prior to completing the recommendations as set forth below, BWC completed an analysis of the Medicare's Inpatient Prospective Payment System final rule. This analysis included completing a review of Medicare's modifications to the MS-DRG case rates. Based on the 2010 market basket of 2.1 percent and modest changes reflected in the rule, the projected impact to hospital of the Medicare rule in general is 1.6% increase in reimbursement.

2010 Proposed Inpatient Fee Schedule Recommendations

For BWC rate year 2010 (February 2010-January 2011), the Medical Services Division recommends the adoption of version 27.0 of the MS-DRGs and pricing factors as published in Medicare's Inpatient Prospective Payment System (IPPS) Final Rule.

BWC is further proposing to maintain the 2009 payment adjustment factors utilized in the current 2009 hospital inpatient methodology. BWC will continue to reimburse inliers at 120 percent of the IPPS rate which includes 120 percent of the direct graduate medical education per diem for those facilities that qualify. Encounters that are classified as outliers under IPPS will be reimbursed at 175 percent IPPS rate.

Using 2009 BWC hospital data and figures published in the IPPS final rule, it is projected that the hospital inpatient payments would increase by 2.9 percent for BWC rate year 2010. Although Medicare is projecting only a 1.6 percent increase, the 2.9 percent increase projected by BWC is the result of an increase in the MS-DRG case rates for the BWC mix of services.



Bureau of Workers' Compensation

Governor **Ted Strickland**
Administrator **Marsha P. Ryan**

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Stakeholder feedback and recommendations for changes to the BWC Hospital Inpatient Services Fee Schedule - O.A.C. 4123-6-37.1

Line #	Rule # / Subject Matter	Stakeholder	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
1	General Comment	CompManagement Health System	Stakeholder feels it is imperative that BWC address recent changes in Medicare and redefine an outlier payment with much greater detail and specifics that reflected in the rule.	Stakeholder believes that the outlier definition is vague as to what constitutes an outlier. That the current BWC payment methodology for outliers has not fully addressed the concerns with price markups on large dollar surgeries.	BWC has adopted the underlying Medicare methodology defining and governing outlier payments. This methodology was adopted in 2009 and has had a significant impact on reducing outlier payments. BWC continues to refine our reimbursement methodology to adopt Medicare's methodology adjustment to address providers price markup changes.	Maintain current proposal to adopt Medicare's MS-DRG methodology including outlier definition.
2	General Comment	Ohio Hospital Association	General comment to indicate they will not oppose the rule			
4	General Comment	Aetna Inc.	No rule change suggestions or recommendations			
5	General Comment	Hunter Consulting	We are fine with these changes			
6	General Comment	CareWorks Consultants	Requesting fee schedule be published 6 weeks in advance of effective date		This will be accommodated	

OHIO BWC 2010 HOSPITAL INPATIENT SERVICES FEE SCHEDULE PROPOSAL

Medical Services Division
Freddie Johnson, Director, Managed Care Services
Anne Casto, Casto Consulting
October 29, 2009

Introduction and Guiding Principles

- Legal Requirements For Fee Schedule Rule
- Proposed Time-line for Implementation
 - Stakeholder Feedback - September 9th – 23rd
 - Board Presentation - September/October
 - Proposed to JCARR - November
 - Effective Date – February 1, 2010
- Guiding Principle:

Ensure access to high-quality medical care and vocational rehabilitation services by establishing an appropriate Benefit plan and Terms of service with competitive fee schedule which, in turn, enhances medical/vocational provider network

Fee Schedule Methodology

- Evaluation of current inpatient services and experiences, considering the need for annual payment updates and/or other policy changes
- Evaluation of the Medicare Inpatient Prospective Payment System Updates
- Setting payment adjustment factor (payment rate) at the right level
- Develop payment adjustments that accurately reflect market, service, and patient cost differences

Recommendation

- Adopt the FFY 2010 IPPS system as published in CMS final rule
 - Exclude Hospital Acquired Conditions provision
 - Remains unchanged from 2009
- No modification to payment adjustment factors
 - 120% inliers
 - 120% direct graduate medical education (DGME)
 - 175% outliers
- No modification to exempt methodology
 - Cost-to-charge ratio (CCR) plus 12 percentage point, not to exceed 70% allowed billed charges
 - Average CCR will be calculated for 2008 CCRs is .62, which is the same as last year

Estimated Impact of Recommendations

- Model under 2010 IPPS
 - Estimated overall reimbursement increase estimated at 2.9%
 - Estimated Dollar Impact is \$2.4 million
- Maintain competitive fee schedule which ensures injured workers' access to quality care

Thank You

Appendix

Calculating Hospital Inpatient Fees

Not a listed fee, but a calculated fee per encounter based on the below formula

Hospital Specific Base Rate X MS-DRG Relative Weight =
Base Rate

(Base Rate X Adjustment Factor) + Other Adjustment =
BWC Rate

IPPS CMS Update

- IPPS Medicare Final rule released; published 8/27/2009 in FR
 - Market basket is 2.1% for 2010
 - CMS proposed but did not accept an increase in the Coding and Documentation Adjustment
 - Overall Impact as published in IPPS Final Rule
 - Overall 1.6%
 - Urban 1.6%
 - Rural 1.6%
 - Teaching 1.6%

MS-DRG Payment Changes for 2010

Top 10 Medicare MS-DRGs

MS-DRG	Short Description	2008 Volume	2008 RW*	2009 RW*	2010 RW*	% change 2008-2010
470	Joint Replace	422,043	1.9871	2.0077	2.0613	4%
871	Septicemia	275,846	1.7484	1.8222	1.8437	5%
392	Gastroenteritis	251,442	0.7121	0.6703	0.6921	-3%
291	Heart Failure with MCC	217,598	1.2585	1.4601	1.4609	16%
194	Pneumonia	217,319	1.0235	1.0056	0.9976	-3%
292	Heart Failure with CC	209,589	1.0134	1.0069	0.9740	-4%
313	Chest Pain	197,140	0.5489	0.5314	0.5404	-2%
690	Kidney & Urinary Infections	196,009	0.8000	0.7581	0.7708	-4%
641	Nutritional Disorders	188,260	0.7248	0.6820	0.6843	-6%
312	Syncope	170,386	0.7197	0.7097	0.7215	0%

* Relative Weight – assigned weight that reflects the relative resource consumption associated with a payment classification or group.

*Relative weight adjustments are made annually to reflect the changes in treatment patterns, technology and any other factors that may change the relative use of hospital resources.

MS-DRG Payment Changes for 2010

Top 10 BWC MS-DRGs

MS-DRG	Short Description	2008 Volume	2008 RW*	2009 RW*	2010 RW*	% change 2008-2010
460	Spinal Fusion	584	3.4870	3.5607	3.7097	6%
470	Joint Replace	366	1.9871	2.0077	2.0613	4%
473	Cervical Fusion	273	1.9446	1.9140	2.0033	3%
491	Back & Neck Proc	252	1.0066	0.9383	0.9522	-5%
494	Lower Ext Proc	217	1.2752	1.2353	1.2619	-1%
603	Cellulitis	120	0.8087	0.8027	0.8178	1%
552	Medical Back	117	0.7839	0.7657	0.7937	1%
885	Psychoses	100	0.7783	0.8477	0.8899	14%
906	Hand Procedures	91	0.9803	1.0086	0.9991	2%
482	Hip & Femur Proc	70	1.5644	1.4949	1.5071	-4%

* Relative Weight – assigned weight that reflects the relative resource consumption associated with a payment classification or group.

*Relative weight adjustments are made annually to reflect the changes in treatment patterns, technology and any other factors that may change the relative use of hospital resources.

2009 Hospital Inpatient Experience*

Bill Type	Volume	Percent of Total Volume	Allowed Billed Charges	Percent of Total Allowed Billed Charges	Payment	Percent of Total Payment
DRG	1,292	84%	48,804,691	75%	18,610,225	69%
Outlier	45	3%	7,063,170	11%	2,800,632	10%
Exempt	195	13%	9,237,780	14%	5,507,426	21%
Total	1,532		65,105,641		26,918,282	

*Four months of data

2008 Hospital Inpatient Experience

Bill Type	Volume	Percent of Total Volume	Allowed Billed Charges	Percent of Total Allowed Billed Charges	Payment	Percent of Total Payment
DRG	4,531	78%	147,809,133	64%	62,690,444	60%
Outlier	544	10%	52,691,661	23%	21,976,077	21%
Exempt	709	12%	31,069,184	13%	19,475,843	19%
Total	5,784		231,569,978		104,142,364	

2007 Hospital Inpatient Experience

Bill Type	Volume	Percent of Total Volume	Allowed Billed Charges	Percent of Total Allowed Billed Charges	Payment	Percent of Total Payment
DRG	4,130	77%	114,782,724	62%	49,856,672	58%
Outlier	677	13%	49,280,225	26%	22,743,249	26%
Exempt	545	10%	22,395,480	12%	14,129,503	16%
MCO Priced	2	0%	22,595	0%	7,293	0%
Total	5,354		186,481,024		86,736,717	

Average Charges, Costs and Payment Trends

	2007	2008	2009*
Average Allowed Charge	\$34,830	\$40,036	\$42,497
Average Cost	\$16,201	\$17,267	\$17,466
Average Payment	\$16,200	\$18,005	\$17,571
	2007	2008	2009
Median Allowed Charge	23,600	\$27,162	\$30,336
Median Cost	10,420	\$11,435	\$12,288
Median Payment	11,277	\$12,268	\$12,776

*Four months of data

Hospital Acquired Conditions (HAC) Provision

- CMS' Paying for Value provision mandated by the Deficit Reduction Act 2005
- CMS has established a list of diagnoses that could reasonably be prevented through the application of evidence-based guidelines
 - Catheter-associated urinary tract infections
 - Pressure ulcers
 - Air embolism
 - Blood incompatibility
 - Falls resulting in fracture, dislocation, intracranial injury, crushing injuries and burns
- When the conditions are acquired during the hospital stay the lower weighted MS-DRG is reimbursed rather than the higher weighted MS-DRG
- Implemented in fiscal year 2009
- First data set including this provision will be available in mid-2010

Detail Estimated Impacts

- Model under 2010 IPPS
 - Reimbursement for MS-DRG inliers increase 4.0%
 - Reimbursement for MS-DRG outliers increase 2.4%
 - Reimbursement for Exempt encounters decrease 0.62%
 - Overall increase estimated at 2.9%
 - Impact estimated at \$2.4 million
 - 2.2 million associated with inliers
 - \$200,000 associated with outliers
 - -\$34,000 associated with exempt cases

- Maintain competitive fee schedule which ensures injured workers' access to quality care

Common Sense Business Regulation (BWC Rules)

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

**Chapter 4123-6 Health Partnership Program
Provider Credentialing Rules (14 rules)**

Rule Review

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

Citation: R.C. 4121.44, R.C. 4121.441(A)(11) and (12)

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

What goal(s): The rules set forth criteria and guidance for the certification and/or decertification of medical providers to provide services and supplies to injured workers in the Ohio workers' compensation system.

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: BWC's proposed 5-year rule review changes to the HPP provider credentialing rules were e-mailed to the BWC Medical Division's list of stakeholders on April 23, 2009 for a two-week review period.

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
Self-Insuring Employer Provider Payment Rules
Chapter 4123-7

Introduction

Chapter 4123-7 of the Ohio Administrative Code contains BWC rules governing provider payment by self-insuring employers. BWC enacted the bulk of the Chapter 4123-7 self-insuring employer provider payment rules in January 1978. The rules have been periodically updated as needed, and last underwent five-year rule review in 2004.

As part of the current five-year rule review process, BWC is proposing that all 30 rules in Chapter 4123-7 be rescinded, and that the Chapter 4123-6 provider payment rules going forward will apply to both State Insurance Fund (SIF) and self-insuring employer claims, whether the self-insuring employer has a Qualified Health Plan (QHP) or not.

This change is not intended to be substantive. Self-insuring employers are already required to provide medical benefits equal to or greater than those provided in SIF claims, and the current Chapter 4123-7 rules are largely duplicative of existing Chapter 4123-6 rules.

Background Law

R.C. 4123.66(A) provides that the BWC Administrator "shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper," and that the Administrator "may adopt rules, with the advice and consent of the [BWC] board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefor."

R.C. 4123.35(B) provides that "Employers who will abide by the rules of the [BWC] administrator and who may be of sufficient financial ability to render certain . . . the furnishing of medical, surgical, nursing, and hospital attention and services and medicines, and funeral expenses, equal to or greater than is provided for in sections 4123.52, 4123.55 to 4123.62, and 4123.64 to 4123.67 of the Revised Code . . . [may be] granted status as a self-insuring employer."

Proposed Changes

As stated above, BWC is proposing that all 30 rules in Chapter 4123-7 be rescinded, and that the Chapter 4123-6 provider payment rules going forward will apply to both State Insurance Fund (SIF) and self-insuring employer claims, whether the self-insuring employer has a Qualified Health Plan (QHP) or not.

Where existing Chapter 4123-6 rules do not adequately cover an item covered by a Chapter 4123-7 rule, BWC is proposing to either add language to an existing Chapter 4123-6 rule or create a new Chapter 4123-6 rule. This is further explained in the Chapter 4123-7 "crosswalk" document and matrix included with these materials, and in the comments to the Chapter 4123-7 (and Chapter 4123-6) rules.

Stakeholder Involvement

BWC developed and distributed an announcement to stakeholders informing them of the five-year administrative code rule review process regarding the BWC medical rules. The announcement

informed stakeholders that BWC would be reviewing medical rules internally and would be periodically sending medical rules, in groups, to the external stakeholders for input. This announcement was distributed through a public e-mail box designed to facilitate distribution of the rules to interested parties and to stakeholder groups. Stakeholders were informed of the opportunity to provide input on the medical rules and the changes proposed by BWC, and the timeline to respond.

BWC's proposed five-year rule review changes to the self-insuring employer provider payment rules were e-mailed to the following lists of stakeholders on Monday, September 14, 2009 with comments due back on Friday, September 18, 2009:

- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
 - Council of Smaller Enterprises (COSE)
 - Ohio Manufacturer's Association (OMA)
 - National Federation of Independent Business (NFIB)
 - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third Party Administrator (TPA) distribution list

OAC Chapter 4123-6: Medical Services
Rules Amended Since First BWC Board Reading

CHAPTER 6 RULE #	CHAPTER 6 RULE TITLE	RULE CHANGES MADE SINCE FIRST READING
4123-6-03.10	Conflict of interest	Rule amended to further reduce conflicts of interest.
4123-6-03.2 (D)(3)	MCO participation in the HPP -- MCO application for certification or recertification	Business trusts are authorized by Ohio Revised Code Chapter 1746 to transact business in Ohio.
4123-6-03.3 (A)	MCO participation in the HPP - MCO participation based on MCO capacity	Adding back in concept that the MCO's request to be placed at capacity must be based on objective data.
4123-6-03.9	MCO participation in the HPP - MCO disclosure of relationship	New language changed from 1 st reading to state "as defined in" rather than "as provided by" OAC 4123-6-05.1.
4123-6-04.3 (F)	MCO scope of services - MCO medical management and claims management assistance	Other proposed revisions to this rule limiting MCOs to requesting that BWC schedule an ADR IME have been withdrawn. BWC may still schedule medical examinations under Ohio Revised Code 4123.53.
4123-6-07	Balance billing prohibited	Was "No Change" in 1 st reading; rule is being rescinded as duplicative-of language found in Ohio Revised Code 4121.44 (K).
4123-6-18 (A)	Data gathering and reporting	Paragraph (A) of the rule changed from the 1 st reading to state the "administrator" shall require, rather than "administrator or designee," as "designee" specification is unnecessary and is not part of the underlying statute.
4123-6-25 (C)(2)	Payment for medical supplies and services.	Amended to provide greater flexibility and to conform to standard bill coding conventions.
4123-6-30 (B)	Payment for physical medicine.	Amended to add additional provider types listed in Ohio Revised Code 4755.481(B) as having authority to prescribe physical therapy.
4123-6-44	Bureau fees for provider services rendered by in-state and out-of-state providers	Title of rule changed from 1 st reading to change both "provider" references to "practitioner" for consistency.

OAC Chapter 4123-6: Medical Services
Rules Amended Since First BWC Board Reading

CHAPTER 6 RULE #	CHAPTER 6 RULE TITLE	RULE CHANGES MADE SINCE FIRST READING
4123-6-55	Employer participation in the QHP system - bureau's authority to decertify, refuse to certify or recertify a QHP.	References to notification of the "employee representative" have been restored.

**OAC Chapter 4123-6: Medical Services
Rules Amended Since First BWC Board Reading**

CHANGES BELOW ARE CLERICAL/GRAMMATICAL

CHAPTER 6 RULE #	CHAPTER 6 RULE TITLE	RULE CHANGES MADE SINCE FIRST READING
4123-6 Title	Chapter Title	Title of Chapter 4123-6 changed from 1 st reading to reflect applicability of revised chapter to state-fund, QHP and self-insuring employer claims.
4123-6-02.21 (A)	Provider access to the HPP - non-certified provider enrollment.	Rule references updated, as BWC is proposing to rescind the rules currently cited.
4123-6-02.21 (C)(8)	Provider access to the HPP - provider credentialing criteria	(added semicolons to separate the distinct requirements, and one comma to separate items in a series within a distinct requirement)
4213-6-02.2 (C)(20)	Provider access to the HPP - provider credentialing criteria	(made added provider type lower case in rule)
4123-6-02.6 (F)	Provider access to the HPP - selection by an MCO	Deletion made for clarification.
4123-6-05.1 (H)	Employer access to the HPP – MCO advertising and solicitation	Rewritten for clarification; “penalties and/or requirements” simplified to “penalties.”
4123-6-05.3 (B)	Employer access to the HPP; certain solicitation practices by MCOs prohibited	(A) Nonsubstantive technical corrections made to rule from 1 st reading; new language changed from 1 st reading to state “as defined in” (rather than “as provided by”) OAC 4123-6-05.1 (B) Expanded MCO ability to reimburse for education efforts from 1 st reading, as these benefit the entire workers’ compensation system.
4123-6-05.4	Employer access to the HPP; payment for referrals prohibited	Nonsubstantive technical correction made to rule from 1 st reading
4123-6-06	Employee access to medical services - generally	Title of rule changed from 1 st reading to reflect applicability of revised chapter to state-fund, QHP and self-insuring employer claims.

**OAC Chapter 4123-6: Medical Services
Rules Amended Since First BWC Board Reading**

CHAPTER 6 RULE #	CHAPTER 6 RULE TITLE	RULE CHANGES MADE SINCE FIRST READING
4123-6-06.1	Employee access to medical services - employee education by MCO and employer.	Title of rule changed from 1 st reading to reflect applicability of revised chapter to state-fund, QHP and self-insuring employer claims. New language changed from 1 st reading to state "for distribution" to each employee, rather than "for dissemination" to each employee,
4123-6-06.2	Employee access to medical services - employee choice of provider	Title of rule changed from 1 st reading to "Employee access to medical services" for consistency.
4123-6-10	Payment to providers.	Rule title changed from 1 st reading to delete reference to MCO, as rule now applies to state-fund, QHP, and self-insuring employer claims.

Chapter 4123-6 ~~Health Partnership Program~~
Medical Services

Comment [a1]: Title of Chapter 4123-6 changed from 1st reading to reflect applicability of revised chapter to state-fund, QHP and self-insuring employer claims.

Chapter 4123-6 Health Partnership Program Medical Services

4123-6-01 Definitions. (Amend)

As used in the rules of this chapter ~~and Chapter 4123-7~~ of the Administrative Code:

(A) "Health partnership program" or "HPP" means:

The bureau of workers' compensation's comprehensive managed care program under the direction of the chief of ~~injury management~~ medical services as provided in sections 4121.44 and 4121.441 of the Revised Code.

(B) "Qualified health plan" or "QHP" means:

A health care plan sponsored by an employer or a group of employers which meets the standards for qualification ~~developed by the health care quality advisory council~~ under section 4121.442 of the Revised Code and is certified as a qualified health care plan with the bureau.

(C) "Managed care organization" or "MCO" means:

A vendor as defined under section 4121.44 of the Revised Code who has contracted with the bureau to provide medical management and cost containment services ~~as part of the HPP~~ as provided in sections 4121.44 and 4121.441 of the Revised Code. As used in these rules, a managed care organization is not a health care provider.

(D) "Physician" means:

~~As defined in division (B) of section 4730.01 of the Revised Code, a~~ A doctor of medicine, doctor of osteopathic medicine or surgery, or doctor of podiatric medicine who holds a current, valid certificate of licensure to practice medicine or surgery, osteopathic medicine or surgery, or podiatry under Chapter 4731. of the Revised Code; ~~as provided in section 4734.09 of the Revised Code, a doctor of chiropractic who holds a current, valid certificate of licensure to practice chiropractic under Chapter 4734. of the Revised Code; as provided in section 4731.151 of the Revised Code, a doctor of mechanotherapy who holds a current, valid certificate of licensure to practice mechanotherapy under Chapter 4731. of the Revised Code and who was licensed prior to November 3, 1985; a psychologist who holds a current, valid certificate of licensure to practice psychology under Chapter 4732. of the Revised Code; or a dentist who holds a current, valid certificate of licensure to practice dentistry under Chapter 4715. of the Revised Code. A physician licensed pursuant to the equivalent law of another state shall qualify as a physician under this rule.~~

(E) "Physician of record" or "attending physician" means:

For the purposes of Chapters 4121. and 4123. of the Revised Code, the authorized physician chosen by the employee to direct treatment.

(F) "Practitioner" means:

A physician, or a physical therapist, occupational therapist, optometrist, or any other person currently licensed and duly authorized to practice within ~~their~~ his or her respective health care field.

Comment [a2]: BWC is proposing to rescind Chapter 4123-7 of the Administrative Code and make the requirements of Chapter 4123-6 directly applicable to self-insuring employers.

(G) "Health care provider" or "provider" means:

A physician or practitioner, or any person, firm, corporation, limited liability corporation, partnership, association, agency, institution, or other legal entity licensed, certified, or approved by a professional standard-setting body or by a regulatory agency under title XIII or XIX of the Social Security Act medicare or medicaid to provide ~~particular~~ medical services or supplies, including, but not limited to: a ~~hospital,~~ qualified rehabilitation provider, ~~pharmacist,~~ or durable medical equipment supplier.

(H) "Credentialing" or "recredentialing" means:

A process by which the bureau validates or reviews the application of a provider for ~~eligibility for participation in the HPP certification or recertification.~~

(I) "Certification" or "recertification" means:

A process by which the bureau approves a provider or MCO for participation in the HPP.

(J) "Provider application and agreement" means:

A bureau form which requests background information and documentation necessary for credentialing and which, if completed and signed by the provider and approved by the bureau, constitutes a written, contractual agreement between the bureau and ~~a~~ the provider. ~~The provider application and agreement may include a provider statement or affirmation that the statements made in the application and agreement are true.~~

Comment [a3]: This requirement is covered in OAC 4123-6-02.3, and therefore is unnecessary here.

(K) ~~recertification~~ "Recertification application and agreement" means:

~~A provider application and agreement bureau form sent by the bureau to bureau certified providers as part of the provider recredentialing and recertification process~~ which requests background information and documentation necessary for recredentialing and which, if completed and signed by the provider and approved by the bureau, constitutes a written, contractual agreement between the bureau and the provider.

Comment [a4]: Clarified to eliminate potential misinterpretation of certification and recertification application and agreement.

(L) "Bureau certified provider" means:

A credentialed provider who has completed and signed a provider application and agreement or recertification application and agreement with the bureau and is approved by the bureau for participation in the HPP.

(M) "Non-bureau certified provider" means:

A provider who has not completed and signed a provider application and agreement or recertification application and agreement with the bureau and is not approved by the bureau for participation in the HPP, or whose certification has lapsed and has not been reinstated pursuant to rule 4123-6-02.4 of the Administrative Code. ~~A non-bureau certified provider may participate in the HPP pursuant to rule 4123-6-027 of the Administrative Code.~~

Comment [a5]: This portion is deleted as redundant and conditions for enrollment of non-certified providers, when appropriate, are found in OAC 4123-6-02.21.

(N) "Employee" means:

As used in the rules of this chapter, the term "employee" includes the terms "injured worker" and "claimant" and all employees of employers covered under HPP.

(O) "Emergency" means:

Medical services that are required for the immediate diagnosis and treatment of a condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency, but is necessary to determine whether an emergency exists.

(P) "Medical management and cost containment services" means:

~~these~~ Those services provided by an MCO pursuant to its contract with the bureau, including return to work management services, that promote the rendering of high-quality, cost-effective medical care that focuses on minimizing the physical, emotional, and financial impact of a work-related injury or illness and promotes a safe return to work.

(Q) "Medically necessary" means:

Services which are reasonably necessary for the diagnosis or treatment of disease, illness, and injury, and meet accepted guidelines of medical practice. A medically necessary service must be reasonably related to the illness or injury for which it is performed regarding type, intensity, and duration of service and setting of treatment.

(R) "Authorization" or "prior authorization" means:

Notification by ~~an authorized representative of the MCO,~~ that a specific treatment, service, or equipment is medically necessary for the diagnosis and/or treatment of an allowed condition, except that the bureau reserves the authority to authorize or prior authorize the following services: caregiver services, home and van modifications, and return to work management services pursuant to paragraph (D) of rule 4123-6-04.6 of the Administrative Code.

(S) "Dispute resolution" means:

Procedures ~~developed by the MCO or the bureau to resolve~~ for the resolution of medical disputes prior to filing an appeal under section 4123.511 of the Revised Code.

(T) "Provider outcome measurement" means:

A medical management analysis tool used by the bureau or MCO which at a minimum, utilizes line item detail from a medical bill and employee specific information including, but not limited to, demographics, diagnosis allowances, ~~return to work~~ return to work and ~~remain at work~~ remain at work statistics, and other data regarding treatment; to evaluate a health care provider on the basis of cost, utilization and treatment outcomes efficiency and compliance with bureau requirements.

(U) "Utilization review" means:

The assessment of an employee's medical care by the MCO. This assessment typically considers medical necessity, the appropriateness of the place of care, level of care, and the duration, frequency or quality of services provided in relation to the allowed condition being treated.

(V) "Treatment guidelines" ~~mean~~ means:

Guidelines of medical practice developed through consensus of practitioner representatives; that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions.

(W) "Formulary" means:

A list of medications determined to be safe and effective by the food and drug administration which the bureau shall consider for reimbursement. The list shall be regularly reviewed and updated by the bureau to reflect current medical standards of drug therapy.

(X) "Medication" means:

The same as drug as defined by division (C) ~~(D)~~ of section ~~4729.02~~ 4729.01 of the Revised Code.

Comment [a6]: Recognizes renumbering of referenced ORC section.

(Y) "Injury" means:

For the purposes of the rules of this chapter ~~and Chapter 4123-7 of the Administrative Code only~~, an injury as defined in division (C) of section 4123.01 of the Revised Code or an occupational disease as defined in division (F) of section 4123.01 of the Revised Code.

Comment [a7]: BWC is proposing to rescind Chapter 4123-7 of the Administrative Code and make the requirements of Chapter 4123-6 directly applicable to self-insuring employers.

(Z) "Return to work services" means:

Services to support an injured worker in returning to employment where the injured worker is experiencing difficulty as a result of conditions related to an allowed lost time claim.

(AA) "Remain at work services" means:

Services to support an injured worker or employee in continued employment where the injured worker is experiencing difficulties performing a job as a result of conditions related to an allowed medical only claim.

(BB) "Transitional work" means:

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

(CC) "Hospital" means:

An institution that provides facilities for surgical and medical diagnosis and treatment of bed patients under the supervision of staff physicians and furnishes 24 hour-a-day care by registered nurses.

(1) For the purposes of the rules of this chapter of the Administrative Code relating to hospitals, "inpatient" means:

An injured worker is considered to be an inpatient when he or she has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. An injured worker is considered an inpatient if there is a formal order for admission from the physician. The

determination of an inpatient stay is not based upon the number of hours involved. If it later develops during the uninterrupted stay that the injured worker is discharged, transferred to another inpatient unit within the hospital, transferred to another hospital, transferred to another state psychiatric facility or expires and does not actually use a bed overnight, the order from the attending physician addressing the type of encounter will define the status of the stay.

(2) For the purposes of the rules of this chapter of the Administrative Code relating to hospitals, "outpatient" means:

The injured worker is not receiving inpatient care, as "inpatient" is defined in paragraph (CC)(1) of this rule, but receives outpatient services at a hospital. An outpatient encounter cannot exceed seventy-two hours of uninterrupted duration.

(DD) "Urgent care facility" means:

A facility where ambulatory care is provided outside a hospital emergency department and is available on a walk in, non-appointment basis.

Promulgated Under: 119.03
Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 2/16/96; 9/5/96; 1/1/99; 1/1/01; 3/29/02; 2/14/05

Comment [a8]: Adding hospital definitions in Rule to increase understanding of BWC application of terms when evaluating reimbursement pursuant to applicable fee reimbursement rules.

Comment [a9]: Adding urgent care facility definition in Rule to increase understanding of BWC application of terms when evaluating reimbursement pursuant to applicable fee reimbursement rules.

4123-6-01.1 Applicability of medical rules. (New)

Unless specifically stated otherwise, the rules of this chapter governing payment of medical services and supplies shall apply to payments to health care providers in all claims for industrial injuries and/or occupational diseases before the bureau, self-insuring employers, MCOs, QHPs, and the industrial commission.

However, nothing in these rules shall inhibit or diminish the commission's right to establish adjudicatory policy under Chapters 4121., 4123., 4127., and 4131. of the Revised Code, or otherwise prevent the full adjudication of claims properly before the commission or its hearing officers.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: _____

Comment [a10]: Clarification of application of Chapter 6 to all relevant entities given that a number of sections were separate under Chapter 7 are now combined within Chapter 6.

4123-6-02 Provider access to the HPP - generally. (Amend)

(A) The bureau is authorized to credential and certify a provider who wishes to participate in the HPP. The bureau is authorized to recredential and recertify a provider at least every two years. The bureau may, but is not required to, recredential and recertify providers on a staggered basis, in order of the provider's initial certification date.

(B) A provider shall be certified or recertified by the bureau to treat ~~employees under the HPP injured workers~~ if the provider ~~agrees to provide care to injured workers; participate in provider outcome measurement, peer review, quality assurance and utilization reviews; meet is a direct service provider~~; meets and maintain maintains basic credentialing criteria under rule 4123-6-02.2 of the Administrative Code; meets and maintains all other applicable criteria under the workers' compensation statutes and rules and as established by the bureau; and completes and signs a provider application and agreement or recertification application and agreement with the bureau.

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, 1/15/99, 1/1/01, 3/29/02

Comment [a11]: These items will be covered in the provider application and agreement and the recertification application and agreement rule OAC 4123-6-02.3(D)(8).

Comment [a12]: "Service coordinators" are not eligible for certification as providers.

4123-6-02.1 Provider access to the HPP - initial provider enrollment period established. (Rescind)

(A) The bureau shall establish an initial enrollment period to identify and contact providers for participation in the HPP upon inception of the HPP. The bureau shall contact all providers currently enrolled or providing services in the workers' compensation system, and may contact providers through state boards and provider associations.

(B) After the initial provider enrollment period at the inception of the HPP, the bureau shall continue to credential and certify providers and shall periodically, at least annually, update its list of bureau certified providers.

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

Comment [a13]: This rule is no longer necessary as it pertains to the program inception. The list of providers is covered in OAC 4123-6-02.6(A), and therefore is unnecessary here. Ongoing maintenance of credentials for certification in the HPP is found in OAC 4123-6-02.2.

4123-6-02.2 Provider access to the HPP - provider credentialing criteria. (Amend)

(A) The bureau shall establish minimum credentialing criteria for providers to qualify for participation in the HPP provider certification. Providers must meet all licensing, certification, or accreditation requirements necessary to provide services in Ohio. A provider licensed, certified or accredited pursuant to the equivalent law of another state shall qualify as a provider under this rule in that state.

(B) The minimum credentials for a provider, where applicable based upon the type of provider, are as follows. The provider shall:

(1) Be currently licensed to practice, as applicable, without disciplinary restrictions (including, but not limited to, disciplinary restrictions related to chemical dependency or substance abuse) that affect the provider's ability to treat patients, or that compromise patient care, ~~or that are related to chemical dependency or substance abuse.~~

(2) Meet other general certification requirements for the specific provider type, as provided in paragraph (C) of this rule.

(3) Possess a current and unrestricted drug enforcement agency registration, unless it is not required by the provider's discipline and scope of practice.

(4) Be currently eligible for participation in medicare, medicaid or the Ohio workers' compensation system.

(5) Not have a history of a felony conviction in any jurisdiction, a conviction under a federal controlled substance act, a conviction for an act involving dishonesty, fraud, or misrepresentation, a conviction for a misdemeanor committed in the course of practice or involving moral turpitude, or court supervised intervention or treatment in lieu of conviction pursuant to section 2951.041 of the Revised Code or the equivalent law of another state.

(6) Provide proof of and maintain adequate, current professional malpractice and liability insurance. The bureau shall establish the appropriate amount of such insurance coverage for each provider type. In establishing the appropriate amount of insurance coverage for out of state providers, the bureau may consider the regulations or the community standards of the provider's state of practice.

(7) Provide documentation of the provider's malpractice history for the previous five years.

(8) Not have any outstanding provider overpayment or other indebtedness to the bureau which has been certified to the attorney general for collection.

(9) Provide proof of and maintain workers' compensation coverage to the extent required under Ohio law or the equivalent law of another state, as applicable.

(10) Not have been excluded or removed from participation in other health plans for cause, or have lost hospital privileges for cause.

(C) The following minimum credentials apply to the providers listed below as provided in this rule.

(1) Ambulance, ambulette, or air ambulance service: license from Ohio medical transportation board if private; medicare participation if government/public.

(2) Ambulatory surgical center: license from Ohio department of health and medicare participation.

Comment [a14]: Rule paragraphs (C)(8) and (C)(20) changed from 1st reading as explained below.

Comment [a15]: This recommendation provides BWC flexibility to evaluate all provider problems utilizing the same criteria of patient treatment competency.

Comment [a16]: This standard is being added to be more consistent with the licensing boards.

- (3) Athletic trainer: license from Ohio occupational therapy, physical therapy, and athletic trainer board.
- (4) Audiologist: license from Ohio board of speech-language pathology and audiology.
- (5) Alcohol and drug counseling clinic: certified by Ohio department of alcohol and drug addiction services to administer outpatient counseling.
- (6) Dentist: license from Ohio state dental board.
- (7) Dialysis center: license from Ohio department of health and medicare participation.
- (8) Durable medical equipment supplier; ~~(excludes orthotics, prosthetics and pedorthics); state vendors license; and medicare participation, community health accreditation program (CHAP), or joint commission on accreditation of healthcare organization (JCAHO) accreditation; and Ohio respiratory care board home medical equipment license (non-CHAP or joint commission accredited suppliers) or certificate of registration (CHAP or joint commission accredited suppliers), as applicable.~~
- (9) Ergonomist: certification for certified professional ergonomist (CPE), certified human factors professional (CHFP), associate ergonomics professional (AEP), associate human factors professional (AHFP), certified ergonomics associate (CEA), certified safety professional (CSP) with "ergonomics specialist" designation, certified industrial ergonomist (CIE), certified industrial hygienist (CIH), assistive technology practitioner (ATP), or rehabilitation engineering technologist (RET).
- (10) Hearing aid dealer: license from Ohio hearing aid dealers and fitters licensing board.
- (11) Home health agency: medicare participation, joint commission ~~on accreditation of healthcare organization (JCAHO) accreditation, or community health accreditation program (CHAP) accreditation, or accreditation through an organization that has been granted deeming authority by the centers for medicare and medicaid services (CMS).~~
- (12) Hospital: approved by the centers for medicare and medicaid services (CMS) for medicare, ~~title XVIII of the Social Security Act; or obtained national accreditation (joint commission on accreditation of healthcare organization (JCAHO), or American osteopathic association healthcare facilities accreditation program (HFAP), or commission on accreditation of rehabilitation facilities (CARF) for rehabilitation hospitals).~~ The following facility types shall be credentialed and certified as hospitals: short-term general and specialty hospitals; long-term care hospitals; rehabilitation hospitals; psychiatric hospitals; hospital (provider) based urgent care facilities or clinics as designated on the hospital's medicare cost report.
- (13) Licensed social worker or licensed independent social worker (LSW) or (LISW): license from Ohio counselor and social worker board.
- (14) Laboratory: valid licensing from clinical laboratory improvement amendment (CLIA).
- (15) Massage therapist: certified by Ohio state medical board.
- (16) Non-physician acupuncturist: certificate of registration from Ohio state medical board.
- (17) Certified registered nurse anesthetist (CRNA): certified by national council on certification of nurse anesthetists or other certifying agency recognized by the Ohio board of nursing.

Comment [tam17]: Updating to reflect state vendors license is not independent credential for DME supplier. (from 1st reading, added semicolons to separate the distinct requirements, and one comma to separate items in a series within a distinct requirement).

Comment [a18]: Updated requirements to reflect new state agency regulating home durable medical equipment.

Comment [a19]: Language modified to include organizations granted authority to approve home health agencies to do business with CMS.

Comment [a20]: Reflects hospital types recognized and captured in the BWC database.

(18) Certified nurse practitioner: certified by American nurses credentialing center or other certifying agency recognized by the Ohio board of nursing.

(19) Clinical nurse specialist: certified by American nurses credentialing center or other certifying agency recognized by the Ohio board of nursing.

(20) Nursing home or residential care/assisted living facility: license from Ohio department of health or medicare participation.

(21) Occupational therapist: license from Ohio occupational therapy, physical therapy, and athletic trainer board.

(22) Optician: license from Ohio optical dispensers board.

(23) Optometrist: license from Ohio board of optometry.

(24) Orthotist, prosthetist or pedorthist: license from Ohio state board of orthotics, prosthetics and pedorthics.

(25) Physical therapist: license from Ohio occupational therapy, physical therapy, and athletic trainer board.

(26) Physician assistant: certified by national commission on certification of physician assistants and certified by Ohio state medical board.

(27) Physician (M.D. or D.O.): license from Ohio state medical board.

(28) Chiropractic physician (D.C.): license from Ohio state chiropractic board.

(29) Podiatric physician (D.P.M.): license from Ohio state medical board.

(30) Licensed professional clinical counselor (LPCC) or licensed professional counselor (LPC): license from Ohio counselor and social worker board.

(31) Psychologist: license from Ohio state board of psychology

(32) Radiology services (free-standing) state licensing, registration or accreditation: (mobile) state, county or city registration, or medicare participation or medicaid certification.

(33) Residential care/assisted living facility: license from Ohio department of health.

(34) Speech pathologist: license from Ohio board of speech pathology and audiology.

(35) Telemedicine: telemedicine certificate from Ohio state medical board.

(36) Traumatic brain injury (TBI) program: CARF accreditation for brain injury services (acute or post-acute).

(37) Urgent care facility (free standing): medicare participation.

Comment [tam21]: Provider type not before named but recognized by BWC (from 1st reading, changed added provider type to lower case).

Comment [a22]: Language modified to add medicare participation as is routinely inclusive with Ohio licensure.

Comment [a23]: This reflects a new provider licensure type and increases access to care.

Comment [a24]: This addition corrects the inadvertent deletion of urgent care facilities in the last revision of this rule.

~~(36)~~(38) Vocational rehabilitation case managers: certification for american board of vocational experts (ABVE), occupational health nursing (COHN), certified rehabilitation counselor (CRC), certified disability management specialist (CDMS), certified vocational evaluator (CVE), certified rehabilitation nurse (CRRN), or certified case manager (CCM).

Comment [a25]: BWC has identified this certification as also being qualified to provide vocational rehabilitation case management services for injured workers.

~~(37)~~(39) Vocational rehabilitation case management interns:

(a) Vocational rehabilitation case management may be provided by a bureau-certified intern. An intern is a non-credentialed individual who provides vocational case management services and is supervised by a credentialed vocational case manager, as identified in paragraph (C)~~(36)~~(38) of this rule.

(b) To become eligible for bureau certification and provide service as an intern, the intern must:

(i) Enroll with the bureau as an intern.

(ii) Qualify to take one of the examinations to become credentialed, as identified in paragraph (C)~~(36)~~(38) of this rule.

(c) Bureau certification of vocational rehabilitation case management interns shall be for a period of four years.

(d) Vocational rehabilitation case management interns may not be recertified for additional four-year periods.

~~(38)~~(40) Comprehensive pain management services program: (free standing) CARF accreditation; (hospital based) CARF or ~~JCAHO~~ joint commission accreditation.

~~(39)~~(41) Occupational rehabilitation programs (work hardening): CARF accreditation.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 2/16/96; 1/15/99; 3/29/02; 7/14/03; 9/12/04; 4/1/07

**4123-6-02.21 Provider access to the HPP - non-certified provider enrollment.
(Amend)**

(A) The bureau may enroll non-certified providers eligible under rule ~~4123-6-06.3~~ 4123-6-06.2 or ~~4123-6-12~~ 4123-6-10 of the Administrative Code or division (J) of section 4121.44 of the Revised Code to receive reimbursement for goods and services provided to injured workers, and for this purpose may require such non-certified providers to complete and sign an enrollment application and agreement as the bureau deems appropriate, provided such non-certified providers meet the minimum qualifications for their provider category as set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code.

Comment [a26]: Rule references updated, as BWC is proposing to rescind the rules currently cited.

(B) Persons or entities who do not fall within the provider categories set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code are not eligible for certification as providers in the HPP. The bureau may enroll such persons or entities to receive reimbursement for goods and services provided to injured workers, and for this purpose may require such persons or entities to complete and sign an enrollment application and agreement as the bureau deems appropriate.

(C) The certification of persons or entities certified as providers in the HPP prior to the effective date of this rule who do not fall within the provider categories set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code shall expire on a schedule determined by the bureau, and such persons or entities shall not be eligible for recertification as providers in the HPP.

(D) The enrollment of a non-certified provider, person, or entity pursuant to paragraphs (A) or (B) of this rule shall expire, on a schedule determined by the bureau, if the non-certified provider, person, or entity has had no billing activity with the bureau for a period of two years or longer.

Comment [a27]: This recommendation will facilitate effective maintenance of data in BWC's provider enrollment system.

(E) Expiration of provider certification or enrollment pursuant to paragraphs (C) or (D) of this rule does not constitute an adjudication order and is not subject to appeal pursuant to rule 4123-6-17 of the Administrative Code.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66
Effective: 4/1/07

**4123-6-02.3 Provider access to the HPP - provider application and credentialing.
(Amend)**

(A) Pursuant to rules 4123-6-02.1 and 4123-6-02.4 of the Administrative Code, ~~the~~ The bureau shall mail make available to each provider via the bureau's internet site a provider application and agreement or recertification application and agreement, as applicable, which shall require the provider to furnish credentialing documentation as provided in rule 4123-6-02.2 of the Administrative Code.

Comment [a28]: This change reflects current public access to the provider application and agreement.

(B) The provider application and agreement or recertification application and agreement may require the provider to make statements that the provider is without impairments that would interfere with the provider's ability to practice or that would jeopardize a patient's health, and a statement that the application is without misrepresentation, misstatement, or omission of a relevant fact or other acts involving dishonesty, fraud, or deceit. The provider shall provide to the bureau any additional documentation requested, and must shall permit the bureau, ~~upon reasonable notice,~~ to conduct a review of the provider's practice or facility. The provider shall notify the bureau within thirty days of any change in the provider's status regarding any of the credentialing criteria of paragraph (B) or (C) of rule 4123-6-02.2 of the Administrative Code.

Comment [a29]: This is being changed to reflect commonly accepted auditing and investigative protocols.

(C) The bureau shall review the application and agreement and all credentialing documentation submitted by the provider. The bureau may cross-check data with other governmental agencies or licensing bodies. The bureau may refer issues relating to malpractice history for review by the bureau's stakeholders health care quality assurance advisory committee as provided under rule 4123-6-22 of the Administrative Code.

(D) ~~The~~ By signing the provider application and agreement or recertification application and agreement, the shall include at a minimum the following provisions, as more fully detailed within the provider application and agreement or recertification application and agreement itself. The provider agrees to, and the bureau may refuse to certify or recertify or may decertify a provider for failure to:

(1) Provide health services that are applicable to a work-related injury, and not to substantially engage in the practice of experimental modalities of treatment.

(2) Acknowledge and treat injured workers in accordance with bureau recognized treatment guidelines.

Comment [a30]: Inserted to require that providers recognize BWCs treatment guidelines.

(3) Acknowledge and treat injured workers in accordance with the vocational rehabilitation hierarchy.

Comment [a31]: Inserted to require that providers understand the vocational rehabilitation hierarchy and practice accordingly.

(4) Provide adequate on-call coverage for patients.

~~(3)~~(5) Utilize bureau certified providers when making referrals to other providers.

~~(4)~~(6) Timely schedule and treat injured workers to facilitate a safe and prompt return to work.

~~(5)~~(7) Release information from the national practitioner data bank, healthcare integrity and protection data bank or the federation of state licensing boards. The bureau may submit a report to the appropriate state licensing board or data bank as required in the event that the provider's certification is terminated for reasons pertaining to the provider's professional conduct or competence.

Comment [a32]: The Healthcare Integrity and Protection Data Bank requires reporting of decertified providers.

~~(6)~~(8) Practice in a managed care environment and adhere to MCO and bureau administrative procedures, and procedures requirements concerning provider compliance, outcome measurement data, peer review, quality assurance, utilization review, billing procedures bill submission, and dispute resolution, subject to rule 4123-6-16 of the Administrative Code.

Comment [a33]: The rule citation is unnecessary.

~~(7) Pursuant to procedures developed by the bureau and the MCOs, report injuries of employees to employers and the bureau.~~

Comment [a34]: This rule citation is redundant, as provider injury reporting requirements are found in OAC 4123-6-02.8.

~~(9) Adhere to the bureau's confidentiality and sensitive data requirements, and use information obtained from the bureau by means of electronic account access for the sole purpose of facilitating treatment and no other purpose, including but not limited to engaging in advertising or solicitation directed to injured workers.~~

Comment [a35]: Added for provider clarity regarding new confidentiality/sensitive data requirements of BWC and use of electronic accounts.

~~(10) Comply with the workers' compensation statutes and rules and the terms of the provider application and agreement or recertification application and agreement.~~

Comment [a36]: Clarifies that the provider agrees to comply with BWC requirements that are encompassed within the statutes, rules, and application/agreement.

(E) Upon review and determination by the bureau that the provider has met bureau credentialing requirements, the bureau shall certify or recertify the provider as a bureau certified provider eligible to participate in the HPP.

~~(F) By signing the provider application and agreement or recertification application and agreement, the provider agrees to abide by all bureau HPP and medical rules, the provider billing and reimbursement manual, and the provider application and agreement or recertification application and agreement.~~

Comment [a37]: This provision has been incorporated into paragraph D above; therefore, it can be deleted here.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 2/16/96; 1/15/99; 3/29/02; 2/14/05

4123-6-02.4 Provider access to the HPP - provider recredentialing and recertification. (Amend)

(A) The bureau shall initiate the recredentialing process by sending certified providers notice and a recertification application and agreement, which must be completed, signed and ~~returned~~ submitted to the bureau if the provider wishes to be considered for recertification.

(B) Except as otherwise provided in paragraph ~~(C)~~ (E) of this rule, if the bureau receives a completed and signed recertification application and agreement from a provider, the provider's certification ~~to participate in the HPP~~ shall remain in effect until the bureau issues a final order approving or denying the provider's application for recertification.

(C) If the bureau does not receive a completed and signed recertification application and agreement from the provider within sixty days from the date of the notice sent in accordance with paragraph (A) of this rule, the bureau shall send a second notice to the provider stating that the provider has thirty days from the date of the second notice to complete, sign and submit the recertification application and agreement to the bureau if the provider wishes to be considered for recertification.

(D) If the bureau does not receive a completed and signed recertification application and agreement from the provider within thirty days from the date of the notice sent in accordance with paragraph (C) of this rule, the provider's certification ~~to participate in the HPP~~ shall lapse. Such lapse of certification is not an adjudication order and is not subject to appeal pursuant to rule 4123-6-17 of the Administrative Code.

(E) If the bureau receives a completed and signed recertification application and agreement from a provider after the provider's certification ~~to participate in the HPP~~ has lapsed pursuant to paragraph (D) of this rule, the provider's certification ~~to participate in the HPP~~ shall ~~be reinstated and shall remain in effect~~ remain lapsed until the bureau issues a final order approving or denying the provider's application for recertification.

(F) All recertification application and agreements are subject to credentialing review as provided in rule 4123-6-02.3 of the Administrative Code.

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: 3/29/02

Comment [a38]: This change reflects current processing requirements. The lapse in certification for a provider who failed to return the recertification application and agreement timely is effective until BWC makes a final determination to approve or deny recertification.

4123-6-02.5 Provider access to the HPP - provider not certified. (Amend)

(A) A provider not certified or recertified shall cure any defects in the provider application and agreement or recertification application and agreement within thirty days of notice by the bureau. ~~A provider not recertified shall cure any defects in the recertification application and agreement within thirty days of notice by the bureau.~~

Comment [a39]: This language is being simplified for better readability.

(B) The administrator of workers' compensation, pursuant to rule 4123-6-17 of the Administrative Code, may refuse to certify or recertify or may decertify a provider ~~from participation in the HPP where the provider has failed to comply with the workers' compensation statutes or rules governing providers or MCOs, the provider billing and reimbursement manual, or a provision the terms~~ of the provider application and agreement or recertification application and agreement.

Comment [a40]: This language is being simplified for better readability.

(C) Notwithstanding paragraph (B) of this rule, in any case where the administrator finds a serious danger to the public health and safety and sets forth specific reasons for such findings, or, in the case of an individual provider, the bureau receives notice from the appropriate state licensing board that the provider's professional license has been revoked or suspended, or the provider is convicted of or pleads guilty to a violation of sections 2913.48 or 2923.31 to 2923.36 of the Revised Code or any other criminal offense related to the delivery of or billing for health care benefits, the administrator may immediately revoke or suspend, ~~or provisionally revoke or suspend~~, the certification of a provider. The order shall be final unless the provider, within seven days of such order, requests a hearing before the administrator where the provider shall show cause why the order should not be final. The order of the administrator shall remain in force during the pendency of the show cause hearing.

Comment [a41]: This language is being added to conform to O.R.C. 4121.444(C)(1).

Comment [a42]: Changed to reflect current practice that certification requirements for eligibility must be met and maintained.

(D) The administrator may impose disciplinary sanctions upon a provider where the provider has failed to comply with the workers' compensation statutes or rules governing providers, ~~the provider billing and reimbursement manual, or a provision the terms~~ of the provider application and agreement or recertification application and agreement. The administrator may impose a disciplinary sanctions without an adjudication order under rule 4123-6-17 of the Administrative Code. In imposing a disciplinary sanction against a provider the administrator may consider, but is not limited to, suspending all reimbursements to a provider.

Comment [a43]: This will be covered in the provider application and agreement, and the recertification application and agreement.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 2/16/96; 1/15/99; 3/29/02; 2/14/05

4123-6-02.6 Provider access to the HPP -- selection by an MCO. (Amend)

(A) The bureau shall maintain a public list of bureau certified providers. The bureau shall make the list of bureau certified providers available to a requesting party at cost via the bureau's internet site.

(B) An MCO may, but is not required to, retain a panel of bureau certified providers. A bureau certified provider is eligible for selection by an MCO to participate on an MCO's provider panel. A bureau certified provider may participate in a single MCO panel or may participate in more than one MCO panel.

(C) A provider identified by an MCO for temporary privileges in its panel of providers that is not a bureau certified provider shall be assisted by the MCO in applying for bureau provider credentialing and certification.

(D) The bureau or MCO shall not discriminate against any category of health care provider when establishing categories of providers for participation in the HPP. However, neither the bureau nor an MCO is required to accept or retain any individual provider in the HPP.

(E) The MCO shall include in its panel or its arrangements with providers a substantial number of the medical, professional, and pharmacy providers currently being utilized by employees. An MCO may limit the number of providers on its MCO provider panel or with whom they enter into arrangements, but must do so based upon objective data approved by the bureau, such as reasonable patient access, community needs, the potential number of employees the MCO is applying to service, and other performance criteria, without discrimination by provider type.

(F) A bureau certified provider must submit to follow the medical management and return to work management approaches of the employee's employer's MCO medically managing an employee's claim, as provided in rule 4123-6-042 of the Administrative Code, whether or not the provider is, or is not, on the MCO's provider panel, or has an arrangement with the MCO.

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

Comment [a44]: Paragraph (F) changed from 1st reading as explained below.

Comment [a45]: This reflects that MCOs may have provider panels or arrangements.

Comment [tam46]: Deletion made for clarification.

Comment [a47]: This language is being simplified for better readability (and, from 1st reading, period at end of line 2 changed to comma).

4123-6-02.7 Provider access to the HPP - eligibility of non-bureau certified providers. (Rescind)

Non-bureau certified providers are eligible to treat injured workers subject to the payment restrictions recited in rule 4123-6-12 of the Administrative Code and the management restrictions recited in rule 4123-6-06.3 of the Administrative Code

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 2/16/96; 2/14/05

Comment [a48]: This information is redundant and conditions for enrollment of non-certified providers, when appropriate, are found in OAC 4123-6-02.21.

4123-6-02.8 Provider requirement to notify of injury. (Amend)

(A) HPP: Within one working day of initial treatment or initial visit of an injured worker, a provider must report the employee's injury or occupational disease in accordance with either paragraph (B) (A)(1) or (C) (A)(2) of this rule.

~~(B) (1) A provider may report an injury to the MCO responsible for medical management of the employee's treatment. When reporting the injury to the MCO, the provider shall do so in accordance with procedures established by the bureau MCO, pursuant to paragraph (E) of rule 4123-6-04.3 of the Administrative Code. The injury shall be reported to the MCO responsible for medical management of the employee's treatment.~~

~~(C) (2) A provider may report an injury to the bureau via the bureau's internet site pursuant to rule 4125-1-02 of the Administrative Code.~~

(B) QHP: Within one working day of initial treatment or initial visit of an injured worker, a provider must report the employee's injury or occupational disease to the QHP or employer.

(C) Self-insuring employer (non-QHP): Within one working day of initial treatment or initial visit of an injured worker, a provider must report the employee's injury or occupational disease to the self-insuring employer.

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

Comment [a49]: BWC establishes reporting requirements, not MCOs.

Comment [a50]: This requirement is moved from OAC 4123-6-71, so that all provider injury reporting requirements are in one rule.

Comment [a51]: This requirement is moved from OAC 4123-7-08, so that all provider injury reporting requirements are in one rule.

4123-6-02.9 Provider access to the HPP - provider marketing. (No Change)

(A) No bureau certified provider shall engage in any advertising or solicitation directed to injured workers which is false, fraudulent, deceptive, or misleading.

(B) No bureau certified provider shall hire, arrange for, or allow any other individual or entity to engage in any advertising or solicitation directed to injured workers on behalf of the provider which is false, fraudulent, deceptive, or misleading.

(C) No bureau certified provider shall pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker (including but not limited to free or discounted examinations, treatment, or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any goods or services for which payment may be made by the bureau, MCO, QHP, or self-insuring employer under Chapter 4121., 4123., 4127., or 4131. of the Revised Code.

(D) A bureau certified provider that violates this rule may be subject to decertification or disciplinary sanctions pursuant to the rules of this chapter of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 3/29/02; 4/1/07

4123-6-03 MCO participation in the HPP - generally. (Rescind)

A managed care organization that satisfies the certification requirements of this chapter shall be certified by the bureau as an MCO eligible to contract with the bureau to provide medical management and cost containment services in the HPP. The bureau shall continue to certify MCOs and shall periodically, at least annually, update its list of MCOs.

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: 2/19/96, 1/1/99

Comment [a52]: Rule is duplicative of language contained in OAC 4123-6-03.4.

4123-6-03.10 Conflict of interest. (Amend)

No individual who is an officer or employee of an MCO shall represent a claimant or employer in any matter before the industrial commission, the bureau of workers' compensation, or a court of competent jurisdiction ~~unless the claimant or employer is not assigned to the MCO and no fee is to be received from or charged against the claimant or employer.~~

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: 1/1/01

Comment [a53]: Rule amended from 1st reading to further reduce conflicts of interest.

4123-6-03.2 MCO participation in the HPP -- MCO application for certification or recertification. (New)

(A) Upon request by a managed care organization, the bureau shall send the managed care organization an MCO application for certification for the managed care organization to complete and submit to the bureau.

(B) The MCO application submitted to the bureau by the managed care organization shall include a list of bureau certified providers in its provider panel and/or bureau certified providers with which the managed care organization has arrangements.

(C) The MCO application submitted to the bureau by the managed care organization shall include the following, whether the managed care organization elects to retain a provider panel or enters into provider arrangements:

(1) A description of the managed care organization's health care provider panel or provider arrangements, which shall include a substantial number of the medical, health care professional and pharmacy providers currently being utilized by injured workers. The provider panel or provider arrangements shall cover the geographic area in which the managed care organization determines it shall compete, and may include out-of-state providers.

(2) A description of how the managed care organization's provider panel or provider arrangements shall provide timely, geographically convenient access to a full range of medical services and supplies for injured workers, including access to specialized services.

(3) A description of the managed care organization's process and methodology for credentialing providers in the managed care organization's provider panel, if applicable, and the managed care organization's process and methodology for assisting non-bureau certified providers in the managed care organization's provider panel or with which the managed care organization has provider arrangements in applying for bureau provider credentialing and certification.

(4) A description of the managed care organization's process and methodology for payment of providers in the managed care organization's provider panel or under a provider arrangement.

(5) A description of the managed care organization's policies and procedures for sanctioning and terminating providers in the managed care organization's panel, if applicable, and a description of the managed care organization's methodology to notify the bureau, employers and employees of any changes in the managed care organization's provider panel or provider arrangements.

(6) A description of the managed care organization's methodology for distributing provider panel and provider arrangement directories and directory updates to employers and employees.

(D) The MCO application for certification submitted to the bureau by the managed care organization shall include, at a minimum, the following information and provisions, as more fully detailed within the MCO application for certification itself:

Comment [a54]: Paragraph (D)(3) changed from 1st reading as explained below.

Comment [a55]: Existing language reorganized for clarity and language added to distinguish between an initial certification and a recertification.

(1) A statement that the application is without misrepresentation, misstatement, or omission of a relevant fact or other representations involving dishonesty, fraud, or deceit.

(2) A description of the geographic area of the state of Ohio for which the managed care organization wishes to be certified by the bureau. The minimum geographic area shall be a county. The bureau shall certify MCO participation on a county basis, subject to the provisions in rule 4123-6-03.3 of the Administrative Code. The managed care organization may apply for coverage in more than one county or statewide.

(3) A description of the managed care organization that includes, but is not limited to, a profile that includes a disclosure statement regarding the managed care organization's organizational structure, including subsidiary, parent and affiliate relationships, together with historical and current data. The managed care organization must identify its principals; provide the managed care organization's date of incorporation or formation of partnership, or limited liability company, or business trust; provide any trade names or fictitious names the managed care organization is, or has been, doing business under; provide the number of years the managed care organization has operated in Ohio; identify other states in which the managed care organization is doing business or has done business; provide a table of organization with the number of employees; and identify any banking relationships, including all account information with any financial institutions.

Comment [a56]: Business trusts are authorized by Ohio Revised Code Chapter 1746 to transact business in Ohio (addition from 1st reading).

Comment [a57]: Trade names and fictitious names may be registered with the Secretary of State per Ohio Revised Code 1329.01 to 1329.10.

(4) A description of the managed care organization's business continuation plan.

Comment [a58]: Added current MCO contract requirement to rule.

(5) A description of the bureau approved treatment guidelines used by the managed care organization, including a description of how the managed care organization shall implement the treatment guidelines.

(6) A description of the managed care organization's utilization review process.

(7) A description of the managed care organization's quality assurance/improvement standards program and process, including the use of satisfaction surveys.

(8) A description of the managed care organization's medical dispute resolution process that meets the requirements of rule 4123-6-16 of the Administrative Code.

(9) A description of the managed care organization's administrative and bill payment grievance processes.

(10) A description of the managed care organization's information system platforms, capabilities and capacities; a description of the managed care organization's system for reporting necessary data elements, including but not limited to those required for performance measurements; and the managed care organization's measures in place to ensure data security, including back-up systems.

Comment [a59]: Added current MCO contract requirement and contract requirement effective January 1, 2010.

(11) A description of the managed care organization's medical case management policies and procedures.

(12) A description of the managed care organization's policies and procedures regarding the protection of confidential and sensitive records.

(13) A description of the managed care organization's policies and procedures regarding retention of information.

(14) A description of the managed care organization's provider relations and education program.

(15) A description of the managed care organization's employer and employee relations and education program, including but not limited to a description of methodologies to be used to explain options available to injured workers, including treatment by non-network providers and the dispute resolution process.

(16) A description of the managed care organization's provider bill payment processes including, but not limited to, **clinical editing software** (including review criteria, process and methodology).

Comment [a60]: Added new requirement to match MCO contract and best billing practices.

(17) Proof of current general and professional liability insurance, the adequacy of which shall be determined by the bureau, and current workers' compensation coverage.

(18) A description of any and all individuals and entities the managed care organization is affiliated with (including, but not limited to, a subcontractor or subcontractee, vendor or vendee, joint venture or other arrangement), and a copy of the MCO's contract or agreement with each individual or entity. For purposes of this rule, "affiliated with the MCO" shall have the same meaning as defined in paragraph (E) of rule 4123-6-05.1 of the Administrative Code.

(19) Other descriptions and requirements as contained in divisions (C)(1) to (C)(10) of section 4121.44 of the Revised Code.

(E) For MCO recertification, prior to the expiration of an MCO's certification, the bureau shall send the certified MCO an application for recertification, which must be completed and returned to the bureau. The MCO must be able to provide proof of delivery of the completed application to the bureau upon request. **The MCO application for recertification may be amended from time to time at the bureau's discretion.**

Comment [a61]: Allows BWC flexibility in determining the information the MCOs are required to submit for recertification.

(F) The bureau shall review the application for certification or recertification submitted by the managed care organization. The bureau reserves the right to cross-check data with other governmental agencies or licensing or accrediting bodies.

(G) During the bureau's review of the application for certification or recertification, the managed care organization shall provide to the bureau any additional documentation requested and shall permit the bureau, upon request and with reasonable notice given, to conduct an onsite review of the managed care organization.

(H) **A managed care organization may cure any defects in its application for certification or recertification within thirty days of notice by the bureau of such defect in its application.**

Comment [a62]: Language moved from OAC 4123-6-03.4 (E) into this rule, as it relates to the application process.

(I) The bureau shall hold as confidential and proprietary information contained in a managed care organization's application for certification or recertification, and other information furnished to the bureau by a managed care organization for purposes of obtaining certification or to comply with performance and auditing requirements established by the administrator, in accordance with divisions (D)(1) and (D)(2) of section 4121.44 of the Revised Code.

(J) The bureau shall not accept or approve any MCO applications for certification or recertification in which the managed care organization proposes to subcontract or outsource **medical case management services**.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96; 1/1/99; 1/1/01; 2/14/05

Comment [a63]: Medical case management services are at the core of MCO responsibilities. As such, it should not be outsourced. Under this amendment, former grandfather allowances for such outsourcing would no longer be sanctioned.

4123-6-03.2 MCO participation in the HPP -- MCO application. (Rescind)

(A) Upon request by a managed care organization, the bureau shall mail a managed care organization an MCO application for certification.

(B) The MCO application for certification shall include a list of bureau certified providers.

(C) A provider identified by an MCO for inclusion in its panel of providers that is not a bureau certified provider may be assisted by the MCO in applying for bureau provider credentialing and certification.

(D) An MCO shall demonstrate arrangements and reimbursement agreements with a substantial number of medical, professional and pharmacy providers currently being used by injured employees.

(E) The MCO application for certification shall include, at a minimum, the following provisions, as more fully detailed within the MCO application for certification itself:

(1) A statement that the application is without misrepresentation, misstatement, or omission of a relevant fact or other acts involving dishonesty, fraud, or deceit. The managed care organization shall provide to the bureau any additional documentation requested and shall permit the bureau, upon reasonable notice, to conduct a review of the managed care organization.

(2) A description of the geographic area of the State of Ohio for which the managed care organization wishes to be certified by the bureau. The minimum geographic area shall be a county. The bureau shall certify MCO participation on a county basis, subject to the provisions in rule 4123-6-03.3 of the Administrative Code. The managed care organization may apply for coverage in more than one county or statewide.

(3) A description of the managed care organization that includes, but is not limited to a profile that includes a disclosure statement regarding the managed care organization's organizational structure, including subsidiary, parent and affiliate relationships. Historical and current data shall be provided. The managed care organization must identify its principals; provide the managed care organization's date of incorporation or formation of partnership or limited liability company, if applicable; provide any fictitious names the managed care organization is, or has been, doing business under; provide the number of years the managed care organization has operated in Ohio; provide a table of organization with the number of employees; identify other states in which the managed care organization is doing business or has done business in the last five years, and identify any banking relationships, including all account information with any financial institutions doing business in Ohio.

(4) An explanation of how the managed care organization will provide timely, geographically convenient access to medical care.

(5) A description of the managed care organization's treatment guidelines, including a description of the rationale underlying the development of the treatment guidelines.

(6) A description of the managed care organization's utilization review process.

(7) A description of the managed care organization's quality assurance/improvement standards program and process, including the use of satisfaction surveys.

(8) A description of the managed care organization's medical dispute resolution process that meets the requirements of rule 4123-6-16 of the Administrative Code.

(9) A description of the managed care organization's non-medical service grievance process.

(10) A description of the managed care organization's information system capabilities and capacities.

(11) A description of the managed care organization's medical case management policies and procedures.

(12) A description of the managed care organization's policies and procedures regarding the confidentiality and protection of records.

(13) A description of the managed care organization's policies and procedures regarding retention of information.

(14) A description of the managed care organization's provider relations and education program.

(15) A description of the managed care organization's employer and employee relations and education program; including but not limited to a description of methodologies to be used to explain options available to injured workers, including treatment by non-network providers and the dispute resolution process.

(16) A description of the managed care organization's system for reporting the necessary data elements required for bureau calculation of performance measurements.

(17) Other descriptions and requirements as contained in divisions (C)(1) to (C)(10) of section 4121.44 of the Revised Code.

(18) A description, with at least galley proofs or the equivalent, of the managed care organization's marketing materials to be used in marketing to employers.

(19) Proof of current public liability insurance, the adequacy of which shall be determined by the bureau.

(F) The MCO's application shall include the following, both where the MCO elects to retain a provider panel and where the MCO does not retain a provider panel but enters into arrangements with providers:

(1) A description of the structure of the health care provider panel or arrangements with providers to be offered by the managed care organization. The provider panel or arrangements with providers shall cover the geographic area in which the managed care organization determines it shall compete, and may include out-of-state providers.

(2) An explanation of how the managed care organization's provider panel or arrangements with providers shall provide a full range of medical services and supplies for injured workers and provide access for specialized services.

(3) A description of the process and methodology of credentialing of providers in the managed care organization's panel.

(4) A description of the managed care organization's payment process and methodology to providers in the managed care organization's provider panel or to providers with which the managed care organization has provider arrangements.

(5) A description of the managed care organization's policies and procedures for sanctioning and terminating providers in the managed care organization's panel; and a description of the managed care organization's methodology to notify the bureau, employers and employees of any changes in the provider panel or arrangements with providers.

(6) A description of the managed care organization's methodology for distributing provider panel directories or directories of arrangements with providers and updated provider panel directories or directories of arrangements with providers to employers and/or employees.

(G) The bureau shall review the application for certification submitted by the managed care organization. The bureau reserves the right to cross-check data with other governmental agencies or licensing or accrediting bodies.

(H) The bureau shall hold as confidential and proprietary the managed care organization's descriptions of process, methodology, policies, procedures and systems as required for the application for certification.

(I) The bureau shall not accept or approve any applications in which the managed care organization proposes to subcontract or outsource any of the following functions: first report of injury (FROI) intake, medical case management, or bill processing and payment. However, this paragraph does not prohibit the bureau from accepting or approving applications for recertification of managed care organizations who subcontract or outsource one or more of these functions if the managed care organization subcontracted or outsourced the function or functions immediately prior to the effective date of this paragraph.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96; 1/1/99; 1/1/01; 2/14/05

4123-6-03.3 MCO participation in the HPP - MCO conditional certification participation based on MCO capacity. (Amend)

(A) An MCO may establish its own capacity based on objective data, which must include at a minimum bureau data related to past claims history for the geographic area to be covered by the MCO, and accordingly may be conditionally certified by the bureau on a county basis request the bureau to limit employers from selecting the MCO or to limit the Bureau from employer assignment by providing the bureau with written notice that it is at capacity and that it is unable to accept further employer selections or assignments as of the date identified in the notice. The request shall fully detail any and all reasons for the capacity limitation request, based on objective data, and it shall identify the counties where capacity will be limited. However, if the aggregate number of MCOs within a county does not meet established bureau determined targets for sufficient capacity within that county to adequately meet the needs of all employees and of employers in that county, the bureau may deny the MCO's request and all MCOs certified or conditionally certified in that county may be required to expand their capacity to meet the needs of all employees and of employers in that county.

(B) The bureau may declare an MCO ineligible to solicit or accept selection of the MCO by an employer or assignment of an employer to the MCO by the bureau by placing the MCO at capacity. The bureau shall base such determination on the failure by the MCO to meet predetermined performance criteria set forth in the MCO agreement contract.

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, 1/1/99

Comment [a64]: Paragraph (A) changed from 1st reading as explained below.

Comment [a65]: Adding back in concept that the MCO's request to be placed at capacity must be based on objective data.

Comment [a66]: BWC no longer grants conditional certification, if it ever did. Other changes made to clarify the MCOs' option of placing themselves at capacity.

4123-6-03.4 MCO participation in the HPP - MCO certification. (Amend)

(A) Upon review by and satisfactory to the bureau that the managed care organization has met bureau certification standards, the bureau shall certify an MCO as eligible to participate in the HPP contract with the bureau to provide medical management and cost containment services for injured workers and employers.

Comment [a67]: Language added from OAC 4123-6-03, which is being rescinded.

(B) MCO certification by the bureau in the HPP shall be for a period of two years. Upon approval by the bureau, an MCO may expand its coverage area after the first year of participation in the HPP certification and every year thereafter.

(C) The bureau may certify any number of MCOs for each county or statewide.

(D) The bureau shall maintain a current list of all bureau certified MCOs. The list shall include the name and address of each MCO and the counties in which the MCO is certified for participation in the HPP.

(E) ~~A managed care organization not certified may cure any defects in the MCO application for certification within thirty days of notice by the bureau of such defect in its application.~~

Comment [a68]: This language was moved to the MCO application rule, OAC 4123-6-03.2.

(F) An MCO may apply to the bureau for recertification that wishes to continue in the HPP beyond the first two years of certification may be recertified by the bureau.

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, 1/1/99

4123-6-03.6 MCO participation in the HPP - administrator's authority to terminate MCO contracts. (Amend)

The administrator may terminate any MCO contract with the bureau if the administrator determines that it is in the best interest of the workers' compensation system to do so. The grounds for termination include, but are not limited to, the following:

(A) The MCO is insolvent.

(B) Any act of fraud or misrepresentation by an MCO of the amount or cost of services or supplies rendered or provided to any injured worker.

(C) Any act of fraud or misrepresentation by an MCO in reporting or submitting data to the bureau, including data that affects is used by the bureau to calculate bureau's calculation or determine determination of payment to the MCO.

(D) The MCO implements an unapproved change in its organizational structure or a material change in its operations.

(E) Decertification of the MCO.

(F) Failure of the MCO to comply with the workers' compensation statutes or rules governing MCOs.

Comment [a69]: These provisions have been added to reflect terms in the MCO contract.

(G) Substantial failure to perform on the part of the MCO in accordance with the terms and conditions of any contract or agreement between the MCO and the bureau.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96, 1/1/99, 2/14/05

**4123-6-03.7 MCO participation in the HPP - bureau's authority to ~~Decertify~~
decertify, to refuse to certify or recertify an MCO. (Amend)**

(A) Should the administrator determine that sufficient evidence exists that an MCO has failed to comply with applicable workers' compensation statutes, rules governing MCOs, or a provision of a contract between the bureau and the MCO or for any other reason as set forth in rule 4123-6-03.6 of the Administrative Code, the administrator has the authority to decertify, or refuse to certify or recertify an MCO.

(B) In any case where the administrator finds a serious danger to the public health and safety and sets forth specific reasons for such findings, the administrator may immediately decertify an MCO.

(C) Upon a final order of the administrator to decertify, or refuse to recertify an MCO, employees and employers shall not receive services from such MCO pursuant to the HPP.

(D) Upon a final order of the administrator to decertify or refuse to recertify an MCO, any obligation of a provider to provide services under the HPP pursuant to a contract or agreement with such MCO shall be null and void.

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: 2/16/95, 1/1/99

**4123-6-03.9 MCO participation in the HPP - MCO disclosure of relationship.
(Amend)**

If the managed care organization is ~~related to~~ **affiliated with** another corporation or entity, as defined in rule 4123-6-05.1 of the Administrative Code, that has had or contemplates activities of any nature with the Ohio workers' compensation system and such relationship creates or presents either the opportunity for a conflict of interest or the appearance of a conflict of interest for the managed care organization and/or the other corporation or entity, the managed care organization shall provide to the bureau a description of the resolution of such opportunity for or the appearance of a conflict of interest satisfactory to the bureau.

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, 10/26/00

Comment [a70]: New language changed from 1st reading to state "as defined in" rather than "as provided by" OAC 4123-6-05.1.

Comment [a71]: Language changed from "related to" to "affiliated with" to match proposed changes to OAC 4123-6-05.1.

4123-6-04 MCO scope of services -- generally. (Rescind)

By use of managed care and return to work management strategies, an MCO shall provide medical management and cost containment services that promote the rendering of high-quality, cost-effective medical care that focuses on minimizing the physical, emotional, and financial impact of a work-related injury or illness and promotes a safe return to work.

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

Comment [a72]: Language combined into OAC 4123-6-04.3.

4123-6-04.2 MCO scope of services -- management of medical treatment of provider selected by employee. (Rescind)

Comment [a73]: Language duplicative of OAC 4123-6-02.6 (F) and OAC 4123-6-06.2.

(A) An employee may select a bureau certified provider. If the MCO selected by or assigned to the employee's employer has elected to retain a provider panel, the employee may select an MCO panel provider. In either case, the MCO shall manage the medical treatment of all workers' compensation related injuries or diseases incurred by the employee for that employer.

(B) An employee may select a provider who is not a bureau certified provider. In such case, the MCO for the employee's employer shall manage only the initial or emergency care to the employee; further treatment shall not be authorized except as provided by rule 4123-6-12 of the Administrative Code.

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

4123-6-04.3 MCO scope of services - MCO medical management and claims management assistance. (Amend)

Comment [a74]: Paragraph (F) of the rule changed from 1st reading as explained below.

(A) ~~The bureau shall determine the compensability of all claims as provided in rule 4123-6-04.5 of the Administrative Code. Upon referral from an MCO, the bureau will determine both the causal relationship between the original injury and the current incident precipitating shall refer a medical treatment reimbursement request and the necessity and appropriateness of the requested treatment in a an inactive claim which has not had activity or a request for further action within a period of time in excess of thirteen months; as provided in rule 4123-3-15 of the Administrative Code, with the MCO's recommendation, to the bureau for a determination of both the causal relationship between the original injury and the current incident precipitating the treatment request and the necessity and appropriateness of the requested treatment.~~

Comment [a75]: Language changed to reflect the MCO's responsibility in this process.

(B) The MCO, in conjunction with the employer, employee, attending physician, and the bureau claims personnel assigned to the claim, shall ~~seek a course of medical or rehabilitative treatment that provide medical management and cost containment services that provide the injured worker high-quality, cost-effective medical care that focuses on minimizing the physical, emotional, and financial impact of a work-related injury or illness~~ and promotes a safe and timely return to work.

Comment [a76]: This language moved from OAC 4123-6-04, which is being rescinded.

(C) ~~After the claim has been filed, the bureau shall assign a claim number and shall notify the employee, employer and MCO of that claim number.~~

Comment [a77]: This language moved to OAC 4123-6-04.5 as it is a BWC function.

~~(D)~~ The MCO shall comply with bureau procedures for reporting injuries to the bureau and employers, and shall instruct the provider to forward to the MCO and the bureau, subject to the confidentiality provisions contained in rule 4123-6-15 of the Administrative Code, all necessary data to effectuate medical and claims management.

~~(E)~~ ~~(D)~~ MCO guidelines may not be more restrictive for a non-panel provider than for a an MCO panel provider. An MCO may not create a procedure that restricts an employee's option to change providers.

~~(D)~~ ~~(E)~~ Except as provided in paragraph (D) of rule 4123-6-04.6 of the Administrative Code, an MCO shall provide medical management and return to work management services for the life of a claim, as long as the employer remains ~~in contract with~~ assigned to the MCO. ~~An MCO shall manage all claims of the employer, regardless of the date of injury of the claim. In cases where an employee has multiple claims with different employers, each claim shall remain with the associated employer and shall be managed by that employer's current MCO.~~

Comment [a78]: Employers do not execute contracts with MCOs.

~~(E)~~ ~~(F)~~ Pursuant to divisions (A)(1), (A)(5), and (A)(9) of section 4121.441 of the Revised Code, an Either the MCO or the bureau may schedule an independent medical examination (IME) of the claimant to assist ~~the MCO~~ in the alternative dispute resolution (ADR) process under rule 4123-6-16 of the Administrative Code ~~or in the medical management of a claim with a date of injury prior to October 20, 1993.~~

Comment [a79]: This provision is no longer necessary, as these examinations are no longer performed.

(1) An MCO may obtain only one independent medical examination in a claim with a date of injury prior to October 20, 1993 for the purpose of medical management of the claim. An MCO independent medical examination ADR IME shall be limited to issues relating to the management of medical treatment and medical treatment disputes, and shall not include extent of disability issues. An ~~MCO independent~~

Other proposed revisions to this rule limiting MCOs to requesting that BWC schedule an ADR IME have been withdrawn. BWC may still schedule medical examinations under Ohio Revised Code 4123.53.

~~medical examination~~ ADR IME shall not be conducted at the request of an employer and does not substitute for an examination permitted under section 4123.65.1 of the Revised Code.

~~(2) If the MCO schedules a medical examination~~ an ADR IME is scheduled under this rule, the MCO shall promptly inform the bureau and the parties, and their representatives, if any, ~~shall be promptly notified~~ as to the time and place of the examination, and the questions and information provided to the doctor. ~~A~~ An ~~electronic~~ copy of the ~~examination~~ ADR IME report shall be submitted to the bureau, ~~the parties and their representatives upon the MCO's receipt of the report from the doctor claim file.~~ The claimant shall be reimbursed for the claimant's traveling and meal expenses, in a manner and at the rates as established by the bureau from time to time. ~~The MCO shall provide the claimant with a proper form to be completed by the claimant for reimbursement of such expenses.~~

~~(3) If the MCO schedules a medical examination~~ an ADR IME is scheduled under this rule to assist the MCO in resolving a medical dispute, the MCO shall ~~complete the independent medical examination and IME and dispute resolution within the ADR process shall be completed in accordance with the time limits established under requirements of rule 4123-6-16 of the Administrative Code.~~

~~(3) (4) If a claimant refuses to attend an independent medical examination scheduled by the MCO to assist the MCO in resolving a medical dispute in a claim, as part of the alternative dispute resolution process under rule 4123-6-16 of the Administrative Code, or in a claim with a date of injury prior to October 20, 1993, the MCO shall refer the issue to the bureau.~~

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, 1/1/99, 3/27/00, 1/1/01, 2/1/04

4123-6-04.4 MCO Scope of services - fee bill review and audit process. (Amend)

(A) The MCO shall review all bills submitted to it for payment by a provider for appropriateness consistent with the MCO's previous treatment reimbursement approval/denial of the service billed, the MCO's utilization standards, the criteria set forth in OAC 4123-6-25, applicable industry standards, and certification the requirements of the MCO contract.

(B) The MCO shall have in place and operating a grievance hearing procedure allowing a provider, employer, or employee to grieve a disputed bill payment.

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

Comment [TAA80]: Changes made to clarify factors considered in MCO determination of "appropriateness."

4123-6-04.5 MCO scope of services - bureau claims management. (Amend)

(A) Upon receipt of notification of a workers' compensation claim, the bureau shall assign a claim number and shall notify the employee, employer and MCO of that claim number. ~~The bureau shall will determine the compensability of the claim and the allowed conditions of the claim pursuant to the provisions of section 4123.511 of the Revised Code. The bureau will notify all parties and the MCO of the allowed conditions in the claim.~~

Comment [a81]: Language moved from OAC 4123-6-04.3 as this is a BWC function.

(B) ~~The employer or employee or representative may appeal the bureau's order to the industrial commission pursuant to section 4123.511 of the Revised Code.~~ Upon referral from an MCO of a medical treatment reimbursement request in an inactive claim as provided in rule 4123-3-15 of the Administrative Code, the bureau will determine, after considering the MCO's recommendation, both the causal relationship between the original injury and the current incident precipitating a medical treatment reimbursement request and the necessity and appropriateness of the requested treatment ~~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 provided in rule 4123-3-15 of the Administrative Code.~~ The bureau will notify all parties and the MCO of its determination.

Comment [a82]: Language changed to reflect BWC's responsibility in this process.

The employer or employee or representative may appeal the bureau's order to the industrial commission pursuant to section 4123.511 of the Revised Code.

(C) The bureau shall not make medical payments in a disallowed claim or for conditions not allowed in a claim until permitted to do so under the provisions of section 4123.511 of the Revised Code or except as provided by the rehabilitation rules of Chapter 4123-18 of the Administrative Code. The bureau shall notify all parties and the MCO when a claim or conditions are allowed or disallowed and indicate whether treatment rendered therefore may or may not be paid.

Comment [a83]: Language moved from OAC 4123-6-09, which is being rescinded.

(D) During the adjudication process, the provider may continue to render or the MCO may continue to manage medical services on behalf of the employee, but the bureau ~~will shall~~ not pay ~~the MCO~~ for medical services in a disallowed claim or for disallowed conditions. If the claim or condition is disputed, the MCO shall ~~notify the claimant that continued treatment may be at the claimant's expense~~ inform the employee and the provider that the services provided may not be covered by workers' compensation and may be the responsibility of the employee.

Comment [a84]: Language moved from OAC 4123-6-09, which is being rescinded.

(E) ~~The bureau will provide ongoing indemnity and disability claims management on allowed claims.~~

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; 11/01/04

4123-6-04.6 Thirty-day return to work assessment. (No Change)

(A) The bureau may perform a return-to-work assessment of an injured worker who has a lost time claim as defined in section 4123.52 of the Revised Code and who has not returned to work within an acceptable timeframe as determined by the bureau.

(B) The assessment may include, but is not limited to, the case management goals, identification of barriers, return to work plan, medical stability and vocational status of the claim.

(C) All findings and conclusions of the assessment and all recommendations for addressing deficiencies shall be documented in writing to the MCO assigned to the claim. The assigned MCO shall have five business days from receipt of the bureau's findings to initiate or complete the recommended action steps identified by the bureau or propose alternative action steps acceptable to the bureau.

(D) If the assigned MCO does not carry out the recommended action steps or if the MCO fails to propose an acceptable alternative course of action to resolve the return-to-work barriers, the bureau may assume the vocational rehabilitation management of the claim.

(E) For any claim assumed pursuant to paragraph (D) of this rule, the bureau may charge the assigned MCO a financial penalty, to include hourly case management fees, in accordance with rule 4123-6-13 of the Administrative Code and the terms of the MCO contract.

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: 1/1/01

4123-6-05.1 Employer access to the HPP – MCO advertising and solicitation.
(New)

(A) No MCO, or individual or entity affiliated with the MCO or acting on behalf of the MCO, shall directly solicit an employer outside of an open enrollment period as provided in rule 4123-6-05.2 of the Administrative Code.

(B) No MCO, or individual or entity affiliated with the MCO or acting on behalf of the MCO, shall engage in any advertising or solicitation directed to employers which is false, fraudulent, deceptive, or misleading.

(C) No MCO, or individual or entity affiliated with the MCO or acting on behalf of the MCO, shall engage in any advertising or solicitation in violation of the MCO “firewall” rule, rule 4123-6-03.9 of the Administrative Code.

(D) No MCO, or individual or entity affiliated with the MCO or acting on behalf of the MCO, shall engage in any advertising or solicitation in violation of the MCO “anti-kickback” rule, rule 4123-6-05.3 of the Administrative Code.

(E) For purposes of this rule, an individual or entity is “affiliated with an MCO” when it:

(1) Owns, is owned by, or is under common ownership with an MCO, directly or indirectly through one or more intermediaries;

(2) Controls, is controlled by, or is under common control with an MCO, directly or indirectly through one or more intermediaries;

(3) Has a contractual or other business arrangement with an MCO;

(4) Has one or more owners, shareholders, partners, members, officers, directors or other persons who exercise operational or managerial control in common with the MCO.

(F) For purposes of this rule, “directly solicit” or “direct solicitation” means phone calls, on-site visits or any media materials (print, radio, website, television, etc.) distributed to an employer that encourage the employer to select a new MCO, or that contain comparisons of any MCO to another MCO or that indicate the MCO is “best”, “#1”, etc.

“Directly solicit” or “direct solicitation” does not include phone calls, on-site visits or any media materials (print, radio, website, television, etc.) distributed to an employer that encourage the employer to select a new MCO, or that contain comparisons of any MCO to another MCO or that indicate the MCO is “best”, “#1”, etc. generated in response to a request by the employer.

Direct solicitation materials that contain comparisons of any MCO to another MCO or that indicate the MCO is “best”, “#1”, etc. must include a legible, audible, or viewable footnote that identifies all of the information used as the basis for the comparison including the source of the data, the timeframe or measurement period covered, and a reasonable description or definition of the terms used.

Comment [a85]: Paragraph (H) of the rule changed from 1st reading as explained below.

Comment [a86]: Rule changed to reflect changes made to the MCO marketing policy in the April 2008 release of Appendix A of the MCO contract.

(G) Notwithstanding any other provision of this rule, solicitation of an employer on behalf of an MCO by a third party administrator, whether affiliated with the MCO or not, is limited to the third party administrator's educating, recommending, and advising its existing client employers regarding MCO selection, and only during an open enrollment period as provided in rule 4123-6-05.2 of the Administrative Code, unless requested by the employer. A third party administrator shall not engage in any of the above educational or advisory activities directed to employers which are false, fraudulent, deceptive, or misleading, and shall not receive any form of remuneration or "kickback" from the MCO.

(H) An MCO that violates this rule, or on whose behalf any third party administrator or individual or entity affiliated with the MCO has violated this rule, shall be subject to one or more of the following penalties, in the bureau's discretion:

Comment [a87]: Rewritten for clarification; "penalties and/or requirements" simplified to "penalties."

- (1) The MCO may be placed at capacity,
- (2) The MCO may be required to issue a retraction,
- (3) Any employer selection(s) resulting from the violation may be removed from the MCO,
- (4) The MCO may be subject to any penalties specified in the MCO contract, and/or
- (5) The MCO may be subject to decertification and/or termination of its contract pursuant to the rules of this chapter of the Administrative Code.

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, 1/1/99, 4/5/99, 7/17/00, 1/1/03

4123-6-05.1 Employer access to the HPP - employer enrollment period established. (Rescind)

(A) Except where the bureau has placed an MCO at capacity pursuant to rule 4123-6-03.3 of the Administrative Code, an employer may be solicited by and may select for its employees' coverage under the HPP any MCO that has contracted with the bureau. An MCO, or any entity or individual on behalf of the MCO, may directly solicit an employer only during periods of open enrollment as provided in this rule and rule 4123-6-05.2 of the Administrative Code. During such open enrollment direct solicitation, the MCO shall comply with the provisions of rules 4123-6-03.9 and 4123-6-05.3 of the Administrative Code, and with the MCO contract. Each employer may select an MCO, subject to paragraph (B) of rule 4123-6-05.2 of the Administrative Code.

(B) The bureau shall determine an open enrollment period during which time an employer may change its selection of an MCO; however, beginning January 1, 1999, the bureau shall establish an open enrollment period at least once every two years but no more than once in a year.

(C) During employer open enrollment periods, the bureau shall distribute to employers the list of all MCOs contracting with the bureau pursuant to rule 4123-6-03.4 of the Administrative Code.

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, 1/1/99, 4/5/99, 7/17/00, 1/1/03

4123-6-05.2 Employer access to the HPP-employer enrollment and selection of MCO. (Amend)

(A) An employer may select any bureau certified MCO that has contracted with the bureau, and has not been placed at capacity pursuant to rule 4123-6-03.3 of the Administrative Code, during an open enrollment period as provided in this rule. The bureau shall develop a process for verifying an employer's MCO selection.

(B) The bureau shall select an MCO for a state fund employer that fails to select an MCO, as necessary.

(C) If an MCO merges into or is acquired by another MCO, the bureau shall assign the employers formerly assigned to that MCO to the surviving MCO.

(D) If the administrator decertifies an MCO or terminates any agreement or contract between the bureau and an MCO, the bureau shall randomly assign the employers formerly assigned to the decertified or terminated MCO to all remaining, eligible MCOs.

(E) Selection of an MCO by an employer or selection by the bureau shall be until the next open enrollment period. 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.

(F) Once the MCO has been selected by either the employer or the bureau, the employer shall notify all employees of the selection.

(G) The bureau shall establish an open enrollment period during which time an employer may change its selection of an MCO at least once every two years, but no more than once in a year. During an open enrollment period, an employer may:

(1) Select a new MCO; or

(2) Continue with the employer's current MCO. In such case, the employer is not required to notify the bureau during the open enrollment period.

(H) The bureau shall maintain and make available to employers ~~via the bureau's internet site~~ electronically the list of all MCOs contracting with the bureau, and shall provide adequate notice to employers in writing of the deadline for new MCO selection.

(I) An MCO may not refuse to accept an employer that has selected it or has been assigned to it by the bureau, unless the MCO has placed itself at capacity pursuant to rule 4123-6-03.3 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.44, 4121.441, 4123.66

Prior Effective Dates: 4/19/96, 1/20/98, 1/1/99, 4/5/99, 7/17/00, 10/16/08

4123-6-05.3 Employer access to the HPP; certain solicitation practices by MCOs prohibited. (Amend)

(A) In soliciting employers as provided under rule ~~4123-6-05~~ 4123-6-05.1 of the Administrative Code, an MCO, or any ~~parent, subsidiary, affiliated, or related~~ individual or entity affiliated with the MCO as defined in rule 4123-6-05.1 of the Administrative Code, or any ~~agent or person~~ other individual or entity acting on behalf of an MCO or for the benefit of an MCO, shall not:

(1) Pay, allow, or give, or offer to pay, allow, or give, to any prospective employer or to any other person, firm, or corporation not an employee or agent of the MCO, either directly or indirectly, as an inducement to or in return for an employer's selection of the MCO ~~for its employees' coverage under the HPP~~, any rebate, premium, or kickback, or any special favor or advantage, or any other valuable consideration or inducement not provided for under Chapter 4123-6 of the Administrative Code.

(2) Pay, allow, or give, or offer to pay, allow, or give any commission, consideration, money, or other thing of value to any person, firm, or corporation not an employee or agent of the MCO for soliciting, negotiating, procuring, placing, writing, renewing, forwarding, or transmitting to the bureau an employer's selection of the MCO ~~for its employees' coverage under the HPP~~.

(3) Pay, allow, or give, or offer to pay, allow, or give a lead fees fee to any person, firm, or corporation other than an employee or agent of the MCO. For purposes of this rule, "lead fees fee" are is defined as payments by an MCO to any person, firm, or corporation other than an employee or agent of the MCO for referrals of prospective employers where such payments are:

(a) Conditioned on the prospective employer selecting the MCO ~~for its employees' coverage under the HPP~~; and/or

(b) Not reasonably related to actual expense reimbursement by the MCO to the person, firm or corporation referring the prospective employer.

(B) Notwithstanding paragraph (A) of this rule, ~~once an employer has selected an MCO under the HPP~~, the MCO may reimburse to a trade or business association certain expenses in accordance with the following requirements as provided in this paragraph of this rule:

(1) The trade or business association shall meet the requirements for being a sponsoring organization for group rating under section 4123.29 of the Revised Code and rules 4123-17-61 to 4123-17-68 of the Administrative Code.

(2) The MCO may reimburse to the trade or business association only ~~the its~~ actual and reasonable expenses incurred ~~by the trade or business association in marketing to or educating its member employers on the HPP and the MCO selection process bureau and MCO medical management and cost containment services and related rules, policies, and processes~~.

(3) The MCO may reimburse to the trade or business association only its actual and reasonable expenses incurred in marketing the MCO to its member employers, subject to the limits set forth in paragraph (B)(4) of this rule, so long as such marketing is in compliance with rule 4123-6-05.1 of the Administrative Code.

Comment [a88]: Nonsubstantive technical corrections made to rule from 1st reading; new language changed from 1st reading to state "as defined in" (rather than "as provided by") OAC 4123-6-05.1.

Comment [a89]: Language changed to match proposed changes to OAC 4123-6-05.1.

Comment [a90]: Expanded MCO ability to reimburse for education efforts from 1st reading, as these benefit the entire workers' compensation system.

Comment [a91]: Language added to match proposed changes to OAC 4123-6-05.1.

(4) The reimbursement of a trade or business association's actual and reasonable expenses incurred in marketing the MCO to its member employers during a calendar year shall not exceed sixteen one-hundredths of one per cent (.16%) of the premium of those employers which that are members of the trade or business association and which that have selected the MCO. The premium used in calculating allowable reimbursement under this rule shall be the premium used by the bureau to calculate payments to the MCO under the payment provisions of the MCO contract.

(4) (5) The MCO and the trade or business association shall keep accurate records of all marketing and education services provided to its member employers for a period of two four years from the date of performance of any such service. The MCO and the trade or business association shall provide the bureau with access to such records within a reasonable time after a request for audit of such records by the bureau.

(C) Except as provided in paragraph (B) of this rule, no person, firm, or corporation not an employee or agent of the MCO shall knowingly receive any payment, commission, lead fee, rebate, premium or kickback, or any other valuable consideration or thing of value prohibited under paragraph (A) of this rule.

(D) For purposes of this rule, "affiliated with an MCO" shall have the same meaning as in paragraph (E) of rule 4123-6-05.1 of the Administrative Code.

(E) For purposes of this rule, "agent" of the MCO means:

(1) An insurance agent or broker contracted by the MCO and licensed by the Ohio department of insurance pursuant to Title XXXIX of the Revised Code;

(2) An entity contracted by the MCO to conduct non-telephonic marketing that has not had and does not contemplate having activities of any nature with the Ohio workers' compensation system so as to create a conflict of interest or the appearance of a conflict of interest under rule 4123-6-03.9 of the Administrative Code;

(3) A telemarketer or telemarketing firm contracted by the MCO who has obtained a certificate of registration from the Ohio attorney general in accordance with Chapter 4719. of the Revised Code.

"Agent" of the MCO does not include the following: a third party administrator, group rating sponsor, business or trade association, or an individual or entity affiliated with the MCO that has had or contemplates having activities with the Ohio workers' compensation system so as to create a conflict of interest or the appearance of a conflict of interest under rule 4123-6-03.9 of the Administrative Code.

(D)(E) An MCO that violates this rule may shall be subject to decertification or termination of its contract pursuant to the rules of this chapter of the Administrative Code the penalties specified in paragraph (H) of rule 4123-6-05.1 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/30/98 (Emer.), 4/29/98, 1/1/99, 10/26/00, 1/1/01, 2/14/05

Comment [a92]: Definition added for clarity and to match language added to the MCO Marketing policy in the April 2008 release of Appendix A of the MCO contract.

4123-6-05.4 Employer access to the HPP; payment for group-rating referrals prohibited. (Amend)

(A) An MCO shall not solicit, receive, or accept any payment, commission, consideration, money, or other thing of value, including, but not limited to any rebate, premium, or kickback, as an inducement to or in return for the MCO's referral of employers ~~who have selected or been assigned to it~~ to any sponsoring organization or group for the purpose of participating in a group experience rating program authorized under section 4123.29 of the Revised Code and rules 4123-17-61 to 4123-17-68 of the Administrative Code.

(B) An MCO shall not solicit, receive, or accept any payment, commission, consideration, money, or other thing of value, including, but not limited to any rebate, premium, or kickback, as an inducement to or in return for the MCO's referral of employers to any individual or entity for the provision of any goods or services.

(C) An MCO shall not solicit, receive, or accept any payment, commission, consideration, money, or other thing of value, including, but not limited to any rebate, premium, or kickback, as an inducement to or in return for the MCO's referral of injured workers to any provider for the provision of any goods or services.

(D) An MCO that violates this rule may be subject to decertification or and/or termination of its contract pursuant to the rules of this chapter of the Administrative Code.

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: 1/30/98 (Emer.), 4/29/98, 1/1/99, 1/1/01

Comment [a93]: Nonsubstantive technical correction made to rule from 1st reading

Comment [a94]: Rule changed to prohibit kickbacks for other than group rating referrals.

Comment [a95]: Prohibition against the MCO receiving a "kickback" for referrals of injured workers and/or employers to any provider, individual, or entity, affiliated with the MCO or not.

4123-6-06 Employee access to the HPP -- generally. (Rescind)

Comment [a96]: Language is duplicative of OAC 4123-6-06.2.

As more fully set forth in rule 4123-6-06.2 of the Administrative Code, an employee may select a physician of record who is: a bureau certified provider; a bureau certified provider who is a member of a panel of a bureau certified MCO selected by the employee's employer; or a non-bureau certified provider.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96, 1/1/01, 2/14/05

4123-6-06.1 Employee access to ~~the HPP~~ medical services -- employee education by MCO and employer. (Amend)

An MCO selected by an employer and the employer shall educate employees regarding access to and use of services offered by the MCO for injuries resulting from an industrial accident, including, ~~if the MCO has elected to retain a provider panel,~~ information regarding MCO panel providers or providers with whom the MCO has arrangements. Education of the employee shall stress, among other things, the need for the employee to report any accident immediately to the employer, the employee's treating provider, and the bureau, and shall inform the employee how to seek care through the MCO. ~~An MCO card~~ identification cards shall be provided to the employer for distribution to each employee.

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

Comment [a97]: Title of rule changed from 1st reading for consistency with title of new OAC 4123-6-062.

New language changed from 1st reading to state "for distribution" to each employee, rather than "for dissemination" to each employee.

Comment [a98]: Providers are required to submit the First Report of Injury (FROI) and must be aware of possible workers' compensation implications.

**4123-6-06.2 Employee access to medical services -- employee choice of provider.
(New)**

Comment [a99]: Title of rule changed from 1st reading to "Employee access to medical services" for consistency.

(A) HPP.

(1) Except as provided in paragraph (A)(2) of this rule, an injured employee may seek medical care for an industrial injury from:

(a) A bureau certified provider; or

(b) A non-bureau certified provider, subject to an employee's payment responsibilities as delineated below.

(2) Except in cases of emergency, an injured employee may not seek medical care for an industrial injury from himself, herself, or an immediate family member. An injured employee may not select as physician of record, himself, herself, or an immediate family member. The MCO, bureau, employer, and industrial commission shall not reimburse treatment to an injured employee delivered, rendered or directly supervised by the injured employee or an immediate family member. "Immediate family member" shall have the same meaning as in paragraph (A)(3)(b) of rule 4123-6-02.51 of the Administrative Code.

Comment [TAA100]: Added to eliminate potential conflicts of interest when the provider is treating himself/herself or immediate family members.

(3) At the time of an injury, the employee may seek medical care directly from a provider or may seek assistance from the MCO in selecting a provider. If the employee has not already sought medical care or selected a provider, the MCO may refer the employee to a provider or list of providers. The employee may, but is not required to, seek medical care from the referred provider or providers. The MCO shall not discriminate against any category of health care provider when referring the employee to a provider.

(4) If the employee seeks medical assistance from a provider, the employee shall inform the provider of the employee's MCO. The provider shall then report the industrial injury in accordance with OAC 4123-6-02.8.

(a) If the provider is a non-bureau certified provider, the MCO shall inform the provider that the care for the first visit will be compensated by the MCO if the claim and the treated conditions are subsequently allowed and that, unless otherwise permitted by paragraphs (A)(5)(a) or (A)(5)(b) of this rule, no further treatment will be authorized.

(b) If the provider is a non-bureau certified provider, the provider shall inform the employee upon the initial or emergency treatment that the provider is not a participant in the HPP and that payment will not be made by the bureau, MCO, or employer for the cost of further treatment after the initial or emergency treatment.

Comment [a101]: Language moved from OAC 4123-6-12, which is being rescinded.

(5) An injured employee may continue treatment with a non-bureau certified provider under two circumstances:

(a) The MCO has determined that the treatment to be provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider and has authorized the non-bureau certified provider to continue to provide the treatment, or

Comment [TAA102]: Language moved from OAC 4123-6-12, which is being rescinded.

(b) The employee may continue to treat with the non-bureau certified provider, but at the employee's own expense without recourse against the bureau, MCO, or employer.

(6) Notwithstanding any other provision of this rule, if the employee's date of injury is prior to October 20, 1993 and the employee's physician of record is a non-bureau certified provider, the employee may continue treatment with that non-bureau certified provider. The employer's MCO shall manage the medical care and treatment and return to work services in the claim and shall manage medical payment for the provider. However, if the employee changes the physician of record for any reason, the employee shall select a bureau certified provider as a physician of record. If the employee selects a physician of record who is a non-bureau certified provider, payment for the provider shall be governed by the provisions of this rule applicable to non-bureau certified providers.

Comment [a103]: Language moved from OAC 4123-6-06.3, which is being rescinded. The 10/20/93 "grandfather" date corresponds to the effective date of HB 107.

(B) QHP.

Comment [a104]: Language moved from OAC 4123-6-56 and OAC 4123-6-57, which are being rescinded.

(1) An employee of an employer that participates in a QHP has freedom of choice of providers within the QHP network of providers established by the employer's QHP. If the employee's date of injury is prior to the establishment of the employer's QHP, and the employee's physician of record is not a provider on a panel of the QHP when established, the employee may continue treatment with that physician of record. The physician of record shall be subject to and participate in the dispute resolution process as provided in rule 4123-6-69 of the Administrative Code. After the establishment of the QHP, the employer's QHP shall manage the medical care and treatment in the claim. If an injured worker changes from the physician of record who is not in the QHP for any reason, the employee shall select a QHP panel provider as the physician of record.

(2) An employee of an employer that participates in a QHP, who is dissatisfied with the health care services of a provider in the QHP, after written notice to the QHP, may request a change of providers and may select another provider within the QHP, or any bureau certified provider. An employee's request for change of provider does not require notification to the bureau, but shall contain the reasons for the request. The QHP shall approve written requests for a change of provider within the QHP, or to any bureau certified provider, within seven days of receipt.

(3) Notwithstanding the provisions contained in paragraph (B)(2) of this rule, an employee who incurs a new medical condition, injury or claim requiring medical treatment, not related to a prior medical condition, injury or claim, shall first seek treatment from a provider on the panel of the injured worker's employer's QHP.

(4) Medical management of all injured workers' claims, whether medical services are provided within or without the QHP network of providers, shall be provided by the employer's QHP.

(5) A provider certified to participate in the HPP shall be eligible to participate in and to treat injured workers under the QHP system.

(C) Self-insuring employer (non-QHP).

Comment [a105]: Language moved from OAC 4123-7-10, which is being rescinded.

(1) In claims with a date of injury on or after November 2, 1959, employees of self-insuring employers have free choice to select licensed physicians for treatment, as well as other medical services, including but not limited to, hospital and nursing services. In claims with a date of injury prior to November 2, 1959, medical services furnished by the self-insuring employer must be utilized.

Comment [a106]: "Grandfather" date prior to which employees of self-insuring employers did not have free choice of providers under Ohio law.

(2) Emergency treatment shall not constitute an exercise of free choice of physician.

(3) Once an employee of a self-insuring employer goes to a physician for treatment other than on an emergency basis, the employee is deemed to have made a choice of physician and the employee shall notify the employer of a change of physician.

(a) Change of physician requests shall be made to the self-insuring employer in writing, and shall include the name and address of the new physician and the proposed treatment.

(b) Self-insuring employers shall approve written requests for a change of physician within seven days of receipt.

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

**4123-6-06.2 Employee access to the HPP -- employee choice of provider.
(Rescind)**

(A) An injured employee may seek medical care for an industrial injury from

(1) A bureau certified provider

(2) An MCO panel provider; or

(3) A non-bureau certified provider, subject to an employee's payment responsibilities as delineated in rule 4123-6-12 of the Administrative Code.

(B) At the time of an injury, the employee may seek medical care directly from a provider or may seek assistance from the MCO. If the employee has not already sought medical care or selected a provider, the MCO may refer the employee to a provider. The MCO shall ask if the employee has any preference as to specialty of provider and shall make any referrals accordingly. The MCO shall not discriminate against any category of health care provider when referring the employee to a provider. The employee may, but is not required to, seek medical care from the referred provider.

(C) If the employee seeks medical assistance from a provider, the employee shall inform the provider of the employee's MCO. The provider shall then notify the MCO of the contact by the employee. If the provider is a bureau certified provider, the provider must agree to provide treatment pursuant to the MCO's guidelines. If the provider is a non-bureau certified provider, the provider will be informed by the MCO that the care for the first visit will be compensated by the MCO if the claim and the treated conditions are subsequently allowed. The MCO will inform the non-bureau certified provider that no further treatment will be authorized.

(D) An injured employee may continue treatment with a non-bureau certified provider under two circumstances:

(1) The provider may apply to the MCO for emergency credentialing as necessary for care and services which are unavailable through like MCO panel providers, or

(2) The employee may continue to treat with a non-bureau certified provider, but at the employee's own expense without recourse against the MCO, employer, or bureau.

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

**4123-6-06.3 Employee access to the HPP -- application of rules to claims.
(Rescind)**

Comment [a107]: Language combined into new OAC 4123-6-06.2.

(A) The rules of this chapter of the Administrative Code shall apply to all claims with the date of injury on or after October 20, 1993. The employee's medical care and treatment and return to work services in such claims shall be managed under the HPP by the employer's MCO as provided in the rules of this chapter.

(B) Notwithstanding rule 4123-6-06.2 of the Administrative Code, if the employee's date of injury is prior to October 20, 1993 and the employee's physician of record is a non-bureau certified provider, the employee may continue treatment with that non-bureau certified provider. The employer's MCO shall manage the medical care and treatment and return to work services in the claim and shall manage medical payment for the provider.

(C) In all claims with a date of injury prior to October 20, 1993, and notwithstanding paragraph (B) of this rule, if the employee changes the physician of record for any reason, the employee shall select a bureau certified provider as a physician of record and the claim is thereafter governed by all of the HPP rules of this chapter. If the employee selects a physician of record who is a non-bureau certified provider, payment for the provider shall be governed by rule 4123-6-12 of the Administrative Code.

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

4123-6-07 Balance billing prohibited. (Rescind)

No health care provider, whether certified or not, shall charge, assess, or otherwise attempt to collect from an employee, employer, a managed care organization, or the bureau any amount for covered services or supplies that is in excess of the allowed amount paid by a managed care organization, the bureau or a qualified health plan.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96; 2/14/05

Comment [a108]: Was "No Change" in 1st reading; rule is being rescinded as duplicative-of language found in Ohio Revised Code 4121.44 (K).

4123-6-09 Payment during adjudication of claim. (Rescind)

Comment [a109]: Language is duplicative of OAC 4123-6-04.5.

(A) The bureau shall not make medical payments in a disallowed claim or for conditions not allowed in a claim until permitted to do so under the provisions of section 4123.511 of the Revised Code or except as provided by the rehabilitation rules of Chapter 4123-18 of the Administrative Code. If during the adjudication of the claim before either the bureau or the industrial commission the claim or conditions therein are either allowed or disallowed, the bureau shall notify all parties and the MCO that the claim or conditions are allowed or disallowed, and if disallowed, that treatment rendered therefore may not be paid by the bureau.

(B) During the adjudication process, the provider may continue to render or the MCO may continue to manage medical services on behalf of the employee, but the bureau shall not pay the MCO for services in a disallowed claim or for disallowed conditions. The MCO shall inform the employee that the services provided may not be covered by workers' compensation and may be the responsibility of the employee.

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

4123-6-10 MCO Payment to providers. (New)

(A) HPP.

(1) The MCO shall accumulate medical records and bills for services rendered to employees for provider services and submit the bills electronically to the bureau for payment in a bureau approved format, utilizing billing policies defined by the bureau. The MCO shall submit a bill to the bureau within seven business days of its receipt of a valid, complete bill from the provider.

(2) For a provider in the MCO's panel or with whom the MCO has entered into an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider either the lesser of the bureau fee schedule, the MCO contracted fee, or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

(3) For a bureau-certified provider who is not in the MCO's panel or with whom the MCO does not have an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider either the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

(4) For a non-bureau certified provider who is not in the MCO's panel or with whom the MCO does not have an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider for initial or emergency treatment either the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

(5) For a non-bureau certified provider who is not in the MCO's panel or with whom the MCO does not have an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider for subsequent treatment after the initial or emergency treatment either the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee, only under the following circumstances:

(a) Where the treatment provided by the non-bureau certified provider is not reasonably available through a like bureau-certified provider and the MCO has authorized the treatment pursuant to rule OAC 4123-6-06.2, or

(b) Where the treatment provided by the non-bureau certified provider is reasonably available through a like bureau-certified provider, the non-bureau certified provider may only be reimbursed for the treatment if the provider becomes bureau-certified. If the provider refuses or fails to become bureau-certified, the treatment shall not be reimbursed.

(6) For hospital services, the bureau shall electronically transfer to the MCO for payment to the hospital either the lesser of the applicable amount pursuant to rules 4123-6-37.1 (inpatient) or 4123-6-37.2 (outpatient) of the Administrative Code or the MCO contracted fee, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

Comment [a110]: Rule title changed from 1st reading to delete reference to MCO, as rule now applies to state-fund, QHP, and self-insuring employer claims.

Comment [a111]: Hospitals are excluded, as they are reimbursed under different payment methodologies pursuant to OAC 4123-6-37.1 and OAC 4123-6-37.2.

Comment [TAA112]: Language added as companion to language in new OAC 4123-6-06.2(A)(5)(a) to delineate how these services will be reimbursed.

(7) The MCO shall have authority to negotiate fees with providers, either by contract or on a case-by-case basis, in the following circumstances:

(a) As permitted under rule 4123-6-08 of the Administrative Code (including the appendix to the rule);

(b) As permitted under rules 4123-6-37.1, 4123-6-37.2 or 4123-6-37.3 of the Administrative Code;

(c) As permitted under rule 4123-18-09 of the Administrative Code;

(d) With non-bureau certified providers outside the state, where the treatment provided by the non-bureau certified provider is not reasonably available through a like bureau-certified provider;

(e) With bureau certified providers and non-bureau certified providers within the state, where unusual circumstances justify payment above BWC's maximum allowable rate for the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) Level II and Level III coded services/supplies, and such circumstances are documented and approved by the bureau.

(8) The bureau shall not pay for missed appointments or procedures. Bills must only contain descriptions of services that have been actually delivered, rendered, or directly supervised by the provider for the actual conditions treated. A provider shall not transmit to the MCO or bureau any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

(B) QHP.

(1) Within each QHP, all payments shall be in accordance with consistent billing and payment policies and practices established by the QHP and consistent with the provisions contained in paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.

(2) With the exception that no financial arrangement between an employer or QHP and a provider shall incentivize a reduction in the quality of medical care received by an injured worker, an employer or QHP may pay a QHP panel provider a rate that is the same, is above or, if negotiated with the provider in accordance with rule 4123-6-46 of the Administrative Code, is below the rates set forth in the applicable provider fee schedule rules developed by the bureau. Nothing in the rules pertaining to the QHP system shall be construed to inhibit employers or QHPs and providers in their efforts to privately negotiate a payment rate.

(3) An employer or QHP shall pay a bureau certified non-QHP panel provider other than a hospital the lessor of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.

(4) An employer or QHP shall pay a bureau certified non-QHP panel hospital the applicable amount under rules 4123-6-37.1 (inpatient) or 4123-6-37.2 (outpatient) of the Administrative Code, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.

Comment [TAA113]: Based on language from OAC 4123-63, OAC 4123-6-66, and OAC 4123-6-67, which are being rescinded.

(5) Employers' financial arrangements with company-based providers remain intact, and services provided by company-based providers need not be billed separately through QHP arrangements.

(6) An employer in the QHP system shall authorize and pay for initial or emergency medical treatment for an injury or occupational disease that is an allowed claim or condition provided by a non-bureau certified provider as follows:

(a) The employer shall pay a non-bureau certified provider only for initial or emergency treatment of an employee for a workers' compensation injury, unless the QHP specifically authorizes further treatment. A non-bureau certified provider shall inform the employee that the provider is not a participant in the QHP and that the employee may be responsible for the cost of further treatment after the initial or emergency treatment, unless payment for further treatment is specifically authorized by the QHP. The employee may continue to obtain treatment from the non-bureau certified provider, but the payment for the treatment shall be the employee's sole responsibility, except as provided above.

(c) An employer or QHP shall pay a non-bureau certified provider that provides initial or emergency medical treatment or further medical treatment that has been specifically authorized by the QHP, other than a hospital, the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.

(7) An employer or QHP shall pay a non-bureau certified hospital that provides initial or emergency medical treatment or further medical treatment that has been specifically authorized by the QHP the applicable amount under rules 4123-6-37.1 (inpatient) or 4123-6-37.2 (outpatient) of the Administrative Code, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.

(8) The employer or QHP shall not pay for missed appointments or procedures. Bills must only contain descriptions of services that have been actually delivered, rendered, or directly supervised by the provider for the actual conditions treated. A provider shall not transmit to the employer or QHP any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

(C) Self-insuring employer (non-QHP).

(1) Payment for medical services and supplies by self-insuring employers shall be equal to or greater than the fee schedule established by the bureau in state fund claims, unless otherwise negotiated with the provider in accordance with rule 4123-6-46 of the Administrative Code. All payments by the self-insuring employer shall be consistent with the provisions contained in paragraph (L)(5) of rule 4123-19-03 of the Administrative Code.

Comment [TAA114]: Includes language moved from OAC 4123-7-07, which is being rescinded.

(2) The self-insuring employer shall not pay for missed appointments or procedures. Bills must only contain descriptions of services that have been actually delivered, rendered, or directly supervised by the provider for the actual conditions treated. A provider shall not transmit to the self-insuring employer any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

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: _____

4123-6-10 MCO Payment to providers. (Rescind)

Comment [a115]: Language combined into OAC 4123-6-14.

The MCO shall pay to providers at least the amount paid by the bureau to the MCO for provider services.

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

4123-6-11 Payment to bureau certified provider. (Rescind)

Comment [a116]: Language combined into new OAC 4123-6-10.

(A) All payments by the bureau for the allowed services of a bureau certified provider shall be through the MCO managing the care of the claim, whether for an MCO panel provider or a bureau certified provider who is not a panel provider of that MCO.

(B) The MCO shall accumulate the various medical records and bills for services rendered to employees for allowed conditions by its MCO panel providers and submit the bills electronically to the bureau for payment in a bureau approved format utilizing billing policies defined by the bureau. The MCO shall submit a bill to the bureau within seven business days of its receipt of the bill from the provider.

(C) The MCO shall accumulate the various bills for services rendered to employees for allowed conditions by bureau-certified providers who are not MCO panel providers for that MCO, but whose care is managed by the MCO, and submit the bills electronically to the bureau for payment in a bureau approved format utilizing billing policies defined by the bureau. The MCO shall submit a bill to the bureau within seven business days of its receipt of the bill from the provider.

(D) For an MCO panel provider, the bureau shall reimburse the MCO the least of the bureau fee schedule, the MCO panel provider fee schedule, or the billed charges by the provider for the services rendered.

(E) For a bureau certified provider who is not an MCO panel provider for that MCO but whose care is managed by that MCO, the bureau will reimburse the MCO the lesser of the bureau fee schedule or the billed charges by the provider for the services rendered.

(F) The bureau does not pay for failed or missed appointments or procedures. Bills must only contain descriptions of services that have been actually rendered for the actual conditions treated. A provider shall not transmit to the MCO or bureau any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

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, 1/15/99, 1/1/01

4123-6-12 Payment to non-bureau certified provider. (Rescind)

Comment [a117]: Language combined into new OAC 4123-6-06.2 and new OAC 4123-6-10.

(A) The bureau shall pay a non-bureau certified provider only for initial or emergency treatment of an employee for a workers' compensation injury under the HPP. If the non-bureau certified provider does not obtain further authorization of treatment from the employer's MCO as provided in paragraph (B) of this rule, the employee may continue to obtain treatment from the non-bureau certified provider, but the payment for the treatment shall be the employee's sole responsibility. The non-bureau certified provider shall inform the employee upon the initial or emergency treatment that the provider is not a participant in the HPP and that the employee will not be reimbursed by the bureau, MCO, or employer for the cost of further treatment after the initial or emergency treatment.

(B) The bureau shall pay a non-bureau certified provider for subsequent treatment after the initial or emergency treatment in the following circumstances:

(1) Where the services provided by the non-bureau certified provider are unavailable through a like provider in the MCO provider panel, the MCO may allow special authorization for the provider to continue treatment where medically necessary for the employee's care. The MCO shall notify the bureau accordingly.

(2) Where the services provided by the non-bureau certified provider are available through a like provider in the MCO provider panel, the MCO may authorize the treatment by a non-bureau certified provider only if the provider becomes a bureau-certified provider. In such case, the MCO shall assist the provider in completing the bureau provider application and bureau provider agreement prior to authorization of or payment for additional treatment. Upon application by the non-bureau certified provider and certification by the bureau, the provider shall be paid for service rendered pursuant to rule 4123-6-11 of the Administrative Code.

(3) All payments by the bureau for the allowed services of a non-bureau certified provider shall be through the employer's MCO.

(C) The MCO shall accumulate the various bills and medical records for services rendered to employees for allowed conditions from non-bureau certified providers who are not MCO panel providers for that MCO, but whose care is managed by the MCO, and shall submit the bills electronically to the bureau for payment in a bureau approved format utilizing billing policies defined by the bureau. The MCO shall submit a bill to the bureau within seven business days of its receipt of the bill from the provider.

(D) For a non-bureau certified provider whose care is managed by the MCO for an initial or emergency visit, the bureau shall pay the MCO the lesser of the bureau fee schedule or the billed charges by the provider for the services rendered.

(E) The bureau does not pay for failed or missed appointments or procedures. Bills must only contain descriptions of services that have been actually rendered for the actual conditions treated. A provider shall not transmit to the MCO or bureau any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

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, 1/15/99

4123-6-13 Payment to MCOs. (Amend)

(A) The bureau shall determine fee payments to an MCO ~~which is selected by or assigned to employers with zero payroll, noncomplying employers, employers who are no longer in business, new employers, and other employer situations in which the employer's premium does not adequately account for an MCO's~~ providing medical management and cost containment services and administrative services.

Comment [a118]: Changed to allow for non-premium based payment methodologies such as percentage of activity.

(B) ~~The bureau shall pay an MCO an administrative fee for its medical management and administrative services in a manner determined by the administrator. The administrative MCO fee payments may be subject to a disincentive penalty~~ penalties based upon the failure of the MCO to meet predetermined performance criteria set forth in the MCO contract. The bureau may pay an MCO a performance payment and may pay an incentive payment.

Comment [a119]: Relevant language moved to paragraph A of the rule.

(C) In establishing performance measures, the bureau shall ~~shall~~ may evaluate an MCO's performance based upon criteria including, but not limited to:

(1) ~~Quality performance measures that may include~~ including, but not limited to, return to work rates and ~~re-injury~~ re-injury rates.

(2) Process performance measures including, but not limited to, first report of injury (FROI) timing, FROI accuracy, and bill timing.

(3) ~~Total cost measures that may include~~ including, but not limited to, average total paid cost, average incurred cost, and lost-time claims to total claims ratio.

~~(3)~~(4) ~~Change in cost measures that may include~~ including, but not limited to, change in average total paid cost, change in average incurred cost, and change in lost-time to total claims ratio.

~~(4)~~(5) ~~Customer satisfaction that may include in-network utilization rate and~~ measures including, but not limited to, MCO network utilization rates and employee, employer, and provider satisfaction surveys.

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, 1/1/99, 1/1/01

4123-6-14 MCO bill submission to bureau. (Amend)

(A) The MCO shall submit bills electronically to the bureau. The bureau shall review all bills for allowed conditions and allowed claims, and payment eligibility. The bureau's review may include, but not be limited to, verification of the following:

(1) the services were delivered, rendered, or directly supervised by providers who meet bureau credentialing and licensing criteria.

(2) the bills conform to standard clinical editing criteria in effect on the billed date(s) of service, including but not limited to: the bureau's billing and reimbursement manual, the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS), and the national correct coding initiative (NCCI) guidelines.

The bureau shall pay electronically transfer funds to the MCO for allowed payments after receipt of a proper invoice and after a final adjudication permitting payment for the claim bill. Upon receipt of payment funds from the bureau, the MCO shall pay the billing provider within seven days or less, if otherwise agreed by contract between the MCO and the provider. The MCO shall pay to providers at least the amount electronically transferred by the bureau to the MCO for reimbursement of provider services.

(B) A provider that bills an MCO for services in expectation of payment from the MCO is responsible for the accuracy of all billing data and information the provider transmits to the MCO. The MCO is responsible for the accuracy of translating billing data received from the provider and the accuracy of transmitting billing data to the bureau that results in payment to the MCO or to the provider.

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, 1/15/99

Comment [TAA120]: Language added to reflect that BWC's review of medical bills includes more than just verification of claim and condition allowances.

Comment [a121]: Language moved from former OAC 4123-6-10.

4123-6-15 Confidentiality of records. (New)

Comment [a122]: Language was updated to reflect current MCO contract requirements.

(A) Subject to sections 2317.02, 4123.27, and 4123.88, of the Revised Code, certain employer premium, payroll and claim file information is confidential and exempt from the general open records laws of Ohio, as set forth in section 149.43 of the Revised Code.

(B) In the course of medical management in the HPP, some confidential information may be provided by the bureau to the MCO, and/or exchanged among the bureau, the MCO, the employer and its representative, the employee and his or her representative, and the provider. All parties receiving and/or exchanging confidential information for use in the HPP shall ensure transmission of confidential information via secured methods, including but not limited to encryption, password protection, transmission over telephone lines (fax to fax), and other secure methods.

(C) All parties receiving and/or exchanging confidential information for use in the HPP shall not use such confidential information for any use other than to perform duties required by the HPP, and shall prevent such information from further disclosure or use by unauthorized persons. MCOs shall not release any confidential information, other than in accordance with rule 4123-3-22 of the Administrative Code, to any third parties (including, but not limited to, parent, subsidiary, or affiliate companies, or subcontractors of the MCO) without the express prior written authorization of the bureau.

(D) MCOs shall comply with, and shall assist the bureau in complying with, all disclosure, notification or other requirements contained in sections 1347.12, 1349.19, 1349.191, and 1349.192 of the Revised Code, as may be applicable, in the event computerized data that includes personal information, obtained by the MCO for use in the HPP, is or reasonably is believed to have been accessed and acquired by an unauthorized person and the access and acquisition by the unauthorized person causes, or reasonably is believed will cause a material risk of identity theft or other fraud.

(E) MCOs shall comply with all electronic data security measures as may be required by Ohio law, Ohio department of administrative services or other state agency directive, executive order of the governor of Ohio, and/or the MCO contract.

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

4123-6-15 Confidentiality of records. (Rescind)

(A) Subject to sections 2317.02, 4123.27, and 4123.88, of the Revised Code, certain employer premium, payroll and claim file information is confidential and exempt from the general open records laws of this state, as set forth in section 149.43 of the Revised Code.

(B) In the course of medical management in the HPP, some confidential information may be provided by the bureau to the MCO, the employer and its representative, the employee and his or her representative, and the provider. All parties requiring such confidential information for use in the HPP shall not use such confidential information for any use other than to perform duties required by the HPP, and shall prevent such information from further disclosure or use by unauthorized persons.

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

4123-6-16.1 HPP medical treatment guidelines. (New)

In reviewing medical treatment reimbursement requests pursuant to rule 4123-6-16.2 of the Administrative Code and conducting independent reviews of medical disputes pursuant to rule 4123-6-16 of the Administrative Code, the MCO and the bureau shall refer to treatment guidelines adopted by the bureau. In the event of a conflict between these guidelines and any provision of Chapter 4123-6 of the Administrative Code, the provisions contained in the Administrative Code shall control.

Rule promulgated under: RC 119.03

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

Rule amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 4/29/98; 9/12/04

Comment [PW123]: Added to this rule to ensure treatment guidelines are utilized at the time of the initial decision.

Comment [PW124]: Specific vendor names have been removed to allow BWC more flexibility to select treatment guidelines.

4123-6-16.1 Bureau review of HPP medical disputes. (Rescind)

In conducting an independent review of a medical dispute referred to the bureau by an MCO pursuant to rule 4123-6-16 of the Administrative Code, the bureau shall refer to the most recent editions of the work loss data institute's official disability guidelines: treatment in workers' compensation, the Milliman and Robertson, Inc. healthcare management guidelines, the American accreditation healthcare commission/URAC national workers' compensation utilization management standards, the American college of occupational and environmental medicine's treatment occupational medicine practice guidelines, the McKesson Health Solutions LLC's InterQual workers' compensation and disability management guidelines, the agency for health care policy and research's low back pain guidelines, the guidelines for chiropractic quality assurance and practice parameters, and the mercy center consensus conference's synopsis of the guidelines for chiropractic quality assurance and practice parameters. In the event of a conflict between these standards or guidelines and any provision of Chapter 4123-6 of the Administrative Code, the provisions contained in the Administrative Code shall control.

Rule promulgated under: RC 119.03
Rule authorized by: RC 4121.12, 4121.30, 4121.31, 4123.05
Rule amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 4/29/98; 9/12/04

4123-6-17 Bureau refusal to certify or recertify, action to decertify a provider or MCO - standards and procedures for adjudication hearings. (Amend)

(A) The administrator of workers' compensation may refuse to certify or recertify or may decertify a provider or MCO from participation in the HPP where the provider or MCO has failed to comply with the workers' compensation statutes or rules governing providers or MCOs as provided in paragraph (B) of rule 4123-6-02.5 of the Administrative Code and paragraph (A) of rule 4123-6-03.7 of the Administrative Code.

Comment [a125]: This language is being changed to reference other rules that discuss BWC's authority to decertify providers and MCOs, rather than repeat the discussion here.

(B) The bureau shall monitor and may investigate a provider or MCO, and may participate with other state or federal agencies or law enforcement authorities in gathering evidence for such matters. When the bureau medical services division determines there is sufficient evidence ~~that a provider or MCO has failed to comply with the workers' compensation statutes or rules governing providers or MCOs to refuse to certify or recertify or to decertify a provider or MCO,~~ the bureau medical service services division shall present this evidence to the administrator with a recommendation for an adjudication order.

Comment [a126]: This change is to clarify and simplify the intent of the paragraph.

(C) Prior to the administrator issuing an adjudication order on the matter, the administrator shall afford the provider or MCO an opportunity for a hearing in accordance with the provisions of Chapter 119 of the Revised Code and ~~as provided in this rule.~~

(D) Prior to the administrator entering an adjudication order, the administrator bureau shall send written notice to the provider or MCO by certified mail containing the following information:

(1) A statement of the reasons and a summary of the evidence relied upon for the proposed administrative action concerning the provider or MCO;

(2) A citation of statutes or rules forming the basis for the administrative action;

(3) A statement indicating that the provider or MCO is entitled to a hearing, if requested within thirty days of the time of the mailing of the notice;

(4) A notice statement indicating that the provider or MCO may appear at the hearing in person, and may be represented by an attorney, or may present its position, arguments or contentions in writing;

(5) A statement that at the hearing the provider or MCO may present evidence and examine witnesses appearing for and against the provider or MCO, and that the provider or MCO may request that the bureau issue subpoenas to compel the attendance of witnesses;

(6) A statement informing the provider or MCO that in the event a hearing is not requested and the request received by the bureau within thirty days of the time of mailing of the written notice, the administrator may proceed with an adjudication order concerning the provider or MCO.

(E) If no timely request for a public hearing is made by the provider or MCO, the administrator may issue an adjudication order concerning the provider or MCO ~~for a period of time as determined by the administrator.~~ Such order shall be sent by certified mail to the provider or MCO.

Comment [a127]: Deleted as adjudication order is not time dated.

(F) If the provider or MCO files a timely request for a hearing, the bureau shall immediately set the date, time, and place for such hearing, not less than seven nor more than fifteen days from the bureau's receipt of the request for hearing. The bureau shall notify the provider or MCO and any representatives of the hearing. The bureau may continue the date of the hearing upon the application of any party or upon its own motion. The hearing shall be held at the bureau central office in Columbus, but if requested by the

provider or MCO, the bureau may hold the hearing in the district office closest to the place of business of the provider or MCO.

(G) The administrator may conduct the hearing personally or may delegate the hearing to a referee, who shall be an attorney at law. The referee may be from the bureau ~~law section~~ legal division or an attorney employed by the administrator especially for such purpose. The burden of proof shall be on the bureau to establish cause for taking action against the provider or MCO, and shall be by a preponderance of the evidence. The bureau shall be represented by the attorney general at the adjudication hearing. A stenographic record of the hearing shall be made. Should the hearing be conducted by a referee, the referee shall issue a report and recommendation, a copy of which shall be mailed ~~sent~~ to all parties and representatives by certified mail, and which may be objected to in writing within ten days of receipt of the report and recommendation. The administrator may approve, disapprove, or modify the report and recommendation of the referee, but shall not take such action until ~~the~~ after the expiration of the period for objection to the referee's report. The administrator may order additional testimony. The administrator shall ~~issue a decision in writing, sent a written order and shall send,~~ by certified mail, a certified copy of the order and a statement of the time and method by which an appeal may be perfected to the provider or MCO. ~~The administrator shall also mail a copy of the order to and any representative informing the parties of the administrator's decision in the matter of the provider or MCO.~~

Comment [a128]: The rule is being modified to clarify the processing making it easier for the intended user (MCO or provider).

(H) Should the provider or MCO prevail in the adjudicating hearing, the provider or MCO may be entitled to attorney fees. The procedure for determining attorney fees shall be in accordance with section 119.092 of the Revised Code.

(I) Should the provider or MCO be adversely affected by the order of the administrator, the provider or MCO may file an a notice of appeal of the decision to the court of common pleas of Franklin county as provided in section 119.12 of the Revised Code. The provider or MCO shall file notice of said appeal with the administrator, setting forth the order appealed from and the grounds of the provider's or MCO's appeal. The provider or MCO shall also file a copy of the notice of appeal with the court of common pleas of Franklin county. Notices of appeal shall be filed within fifteen days after the mailing of the order of the administrator. Within thirty days after receipt of the notice of appeal from an order in any case in which a hearing was required, the bureau shall prepare and certify to the court a complete record of the proceedings in the case.

Comment [a129]: This rule is being modified to clarify the processing making it easier for the intended user (MCO or provider).

(J) Any adjudicating order of the administrator to decertify, or to refuse to recertify a provider or MCO ~~from participation in the HPP~~ shall include a clear indication of the beginning date of such action and the specific medical services or dates of medical services or supplies that shall be excluded from payment.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 2/16/96; 1/1/99; 2/14/05

4123-6-18 Data gathering and reporting. (Amend)

(A) Pursuant to division (F) ~~(H)~~ of section 4121.44 of the Revised Code and division (A)(6) of section 4121.441 of the Revised Code, the ~~chief of injury management services~~ administrator shall require employees, employers, and medical providers, medical vendors (MCOs), and plans that participate in the workers' compensation system to report data to be used by the administrator to:

(1) Measure and perform comparison analyses of costs, quality, appropriateness of medical care, and effectiveness of medical care delivered by all components of the workers' compensation system.

(2) Compile data to support activities of the MCOs and to measure the outcomes and savings of the HPP.

(3) Publish and report compiled data to the governor, the speaker of the house of representatives, and the president of the senate ~~every six months on the first day of each January and July~~ to gauge the measures of outcomes and savings of the HPP.

(B) The ~~chief of injury management services~~ administrator shall compile at least and ~~distribute~~ annually and make available electronically to each employer ~~in the HPP~~ a report that summarizes the performance of each ~~employer's~~ MCO pursuant to the performance criteria described in rule 4123-6-13 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.121, 4121.44, 4121.441, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96, 1/1/99, 2/14/05

Comment [a130]: Paragraph (A) of the rule changed from the 1st reading to state the "administrator" shall require, rather than "administrator or designee," as "designee" specification is unnecessary and is not part of the underlying statute.

Comment [a131]: Changed to reflect the language in O.R.C. 4121.44 (H)(3).

4123-6-20 Obligation for submitting medical documentation and reports. (Amend)

(A) ~~As provided in rules 4123-6-02.8 and 4123-6-71 of the Administrative Code, a provider who undertakes treatment in an industrial case assumes the obligation to notify the bureau, MCO, QHP, or self-insuring employer of the injury within twenty-four hours of the initial treatment or initial visit. A provider is responsible for the accuracy of all reports, information, and/or documentation submitted by the provider, the provider's employees, or the provider's agents to the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer in connection with a workers' compensation claim. The provider, the provider's employees, and the provider's agents shall not submit or cause or allow to be submitted to the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer any report, information, and/or documentation containing false, fraudulent, deceptive, or misleading information.~~

Comment [a132]: Language added to paragraphs (A) and (E) regarding the provider's responsibility for the accuracy of information provided in workers' compensation claims and in performing independent medical examinations (IMEs).

Comment [tam133]: Language removed as duplicative of OAC 4123-6-02.8.

(B) Interim medical reports and medical documentation.

Compensation for temporary total disability is payable upon submission of current supporting medical documentation. ~~Interim reports must be filed, on forms provided by the bureau, at least every thirty days while~~ While the claimant remains on temporary total disability, interim reports must be filed in accordance with paragraph (D) of rule 4123-5-18 of the Administrative Code. Interim reports must include at least:

Comment [a134]: Language changed to be consistent with OAC 4123-5-18(D).

- (1) The date of the report;
 - (2) The date of the last examination;
 - (3) ~~The current~~ "International Classification of Disease" diagnosis code(s) recognized in the claim for all conditions and all parts of the body being treated that are affecting the length of disability, including a primary diagnosis code, with a narrative description identifying the ~~condition~~ condition(s) and specific ~~areas~~ area(s) of the body being treated;
 - (4) Any reason(s) why recovery has been delayed;
 - (5) The date temporary total disability began;
 - (6) The current physical capabilities of the claimant;
 - (7) An estimated or actual return to work date;
 - (8) An indication of need for vocational rehabilitation;
 - (9) Objective findings; and
 - (10) Clinical findings supporting the above information.
- (C) Treatment plan.

Comment [a135]: Language added from OAC 4123-6-28, which is being rescinded.

(1) Upon allowance of a claim by the bureau, industrial commission, or self-insuring employer, the physician of record and other providers treating the claimant shall provide and continue to update a treatment plan to the MCO, QHP, or self-insuring employer according to the format or information requirements designated by the bureau. A treatment plan should include at least the following:

(a) Details of the frequency, duration, and expected outcomes of medical interventions, treatments, and procedures;

(b) The projected or anticipated return to work date; and

(c) Factors that are unrelated to the work related condition, but are impacting recovery.

(2) Modifications should be made to the initial treatment plan as treatment is extended, changed, completed, added, deleted or canceled. The modification should describe the current prognosis for the injured worker, progress to date, and expected treatment outcomes.

(3) Treatment plans should be updated when significant changes occur in the claim which impact claims management. Changes include:

(a) Additional allowance;

(b) Re-activation;

(c) Authorization of expenditures from the surplus fund;

(d) Return to modified or alternative work;

(e) Maximum medical improvement;

(f) Rehabilitation;

(g) A new injury while receiving treatment in the claim.

(4) Supplemental reports from the attending physician and other providers may be requested by the bureau, industrial commission, employer, MCO, QHP, or by the claimant or representative. These reports shall be used to determine the appropriateness of a benefit or bill payment.

(D) In accepting a workers' compensation case, a medical provider assumes the obligation to provide to the bureau, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer, upon written request or facsimile thereof and within five business days, all medical, psychological, or psychiatric documentation relating causally or historically to physical or mental injuries relevant to the claim required by the bureau, MCO, QHP, or self-insuring employer, and necessary for the claimant to obtain medical services, benefits or compensation.

(E) Independent medical examinations.

(1) A provider performing an independent medical examination of a claimant shall create, maintain, and retain sufficient records, papers, books, and documents in such form to fully substantiate the accuracy of the resulting report submitted to the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer in connection with a workers' compensation claim. The provider, the provider's employees, and the provider's agents shall keep such records in accordance with rule 4123-6-45.1 of the Administrative Code, and such records shall be subject to audit pursuant to rule 4123-6-45 of the Administrative Code.

(2) A provider performing an independent medical examination of a claimant shall keep confidential all information obtained in the performance of the independent medical examination, including but not limited

to knowledge of the contents of confidential records of the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer. The provider, the provider's employees, and the provider's agents shall maintain the confidentiality of such records in accordance with all applicable state and federal statutes and rules, including but not limited to rules 4123-6-15 and 4123-6-72 of the Administrative Code.

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: 1/27.97, 1/15/99, 1/1/01, 1/1/03

4123-6-20.1 Charges for copies of medical reports. (Amend)

(A) The purpose of this rule is to provide parties to a workers' compensation claim reasonable access to and reasonable charges for medical records necessary for the administration of the claim.

(B) Except as provided in this rule, a medical provider may not assess a fee or charge the claimant, employer, or their representatives for the costs of completing any bureau form or documentation required under rule 4123-6-20 of the Administrative Code which is required by the bureau, MCO, QHP, or self-insuring employer and is necessary for the claimant to obtain medical services, benefits, or compensation.

(C) A medical provider shall provide copies of medical records to the bureau, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer as provided in paragraph (D) of rule 4123-6-20 of the Administrative Code. A medical provider may not assess a fee or charge the bureau, industrial commission, MCO, QHP, or self-insuring employer for the costs of providing medical records or completing any bureau form or documentation which is required by the bureau, MCO, QHP, or self-insuring employer and is necessary for the claimant to obtain medical services, benefits, or compensation.

(1) The bureau shall provide authorized parties to the claim access to all filed medical records without charge through secure electronic access.

(2) Where the bureau has provided access to medical records electronically and a party requests copies of such medical records, the bureau may charge a fee for the copies in accordance with the Ohio public records laws.

(3) Where a provider has filed copies of medical records with the bureau or MCO and the bureau has provided access to such medical records electronically or the provider has filed copies of medical records with the self-insuring employer, if a party requests such medical records of the provider, the provider may charge a fee for the copies. ~~Where a provider has filed copies of medical records with the self-insuring employer, if a party requests such medical records of the provider, the provider may charge a fee for the copies. The provider's fee shall be based upon the actual cost of furnishing such copies, not to exceed twenty-five cents per page.~~

Comment [tam136]: Language deleted as redundant.

(D) As provided in division (B) of section 4123.651 of the Revised Code, a claimant shall promptly provide a current signed release of medical information, records, and reports relative to the issues necessary for the administration of the claim when requested by the employer. The employer shall immediately provide copies of all medical information, records, and reports to the bureau and to the claimant or the claimant's representative upon request.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.30
Rule Amplifies: 149.43, 3701.741, 4113.23, 4121.121, 4121.44, 4121.441, 4123.651
Prior Effective Dates: 1/1/03

4123-6-21 Payment for outpatient medication. (No Change)

(A) Medication must be for the treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer. The bureau may deny a therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of the allowed conditions in a claim.

(B) Medication must be prescribed by the physician of record in the industrial claim or by the treating physician, or by such other treating provider as may be authorized by law to prescribe such medication.

(C) Drugs covered are limited to those that are approved for use in the United States by the Food and Drug Administration and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) The bureau may require prior authorization of certain drugs or therapeutic classes of drugs, and shall publish a list of all such drugs or therapeutic classes of drugs for which prior authorization is required.

(E) Drugs which fall into one of the following categories may be approved and reimbursed by an MCO as part of a comprehensive treatment plan submitted by the physician of record or treating physician:

(1) Drugs for the treatment of obesity;

(2) Drugs for the treatment of infertility;

(3) Drug Efficacy Study Implementation (DESI) drugs or drugs that may have been determined to be identical, similar, or related;

(4) Extemporaneous or simple compounded prescriptions;

(5) Injectable drugs not intended for self-administration;

(6) Drugs used to aid in smoking cessation;

(7) Drugs dispensed to a claimant while the claimant is admitted to a hospital during an approved inpatient admission or during the course of an outpatient visit in a hospital. Drugs approved by the MCO under this rule shall not be reimbursed through the bureau's pharmacy benefits management vendor.

(F) Payment for medications to pharmacy providers shall include a product cost component and a dispensing fee component.

(1) The product cost component shall be the lesser of the following: maximum allowable cost, if applicable, or the average wholesale price of the commonly stocked package size plus or minus a percentage. The percentage amount added or subtracted from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.

(2) The dispensing fee component shall be a flat rate fee, which shall be subject to annual review.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN) per rolling twenty-five days. Exceptions to the single dispensing fee are:

(i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;

(ii) Cases where the physician has changed the dosage;

(iii) Cases where the medication did not last for the intended days supply;

(iv) Cases where the medication has been lost, stolen or destroyed;

(v) Controlled substances (which are limited to two dispensing fees per twenty-five days).

(G) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined by the bureau. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(H) The bureau may establish a maximum allowable cost for medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations." The methodology used to determine a maximum allowable cost for a qualified drug product shall be determined by the medical policy department and shall be subject to annual review. The bureau may choose to utilize the maximum allowable cost list of a vendor or develop its own maximum allowable cost list.

(I) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug.

(J) The following dispensing limitations may be adopted by the bureau:

(1) The bureau may publish a list of drugs identifying those drugs that are considered "chronic" medications. Drugs not identified as "chronic" medications shall be considered "acute" medications.

(2) The bureau may publish supply limitations for acute and chronic drugs which represent the maximum number of days supply that may be dispensed at any one time for a single prescription.

(3) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription

(4) Requests submitted that exceed any published days supply limit or maximum quantity limit shall be denied. Denials may be overridden by the bureau in cases where medical necessity and appropriateness have been determined.

(5) Refills requested before seventy-five per cent of any published days supply limit has been utilized will be denied, except in cases where the dosage of a noncontrolled drug has been increased and has a new prescription number. Denials may be overridden by the bureau for the following documented reasons:

- (a) Previous supply was lost, stolen or destroyed;
- (b) Pharmacist entered previous wrong day supply;
- (c) Out of country vacation or travel;
- (d) Hospital or police kept the medication.

(K) Through internal development or through vendor contracts, an on-line point-of-service adjudication system may be implemented. Upon implementation, pharmacy providers may be required to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the established bill processing system as a condition of provider enrollment or reimbursement. Submission by paper or by tape-to-tape may be refused upon implementation of an on-line point-of-service system.

(L) Claimant reimbursement for medications shall not exceed the bureau's established rate for the medication regardless of the price paid by the claimant. Upon implementation of a point-of-service system, claimant reimbursement may be limited to the following situations:

- (1) Claimants whose claims are not allowed on the date of service;
- (2) Emergency situations where an enrolled pharmacy provider with point-of-service capabilities is not available;
- (3) Claimants who reside out of the country.

(M) The bureau may formulate medication utilization protocols for select conditions or diseases consistent with one or more of the following

(1) Compendia consistent of the following:

- (a) "United States Pharmacopoeia – Drug Information";
- (b) "American Medical Association Drug Evaluations";
- (c) "Drug Facts and Comparisons"; or,

(2) Peer reviewed medical literature. Compliance with the established protocols shall be monitored through the on-line, point-of-service adjudication system. Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's refusal to reimburse for such medications.

(N) A "pharmacy provider" designation and provider number can be obtained by a provider who meets all the following criteria:

- (1) Has a valid "terminal distributor of dangerous drugs" as defined in section [4729.02](#) of the Revised Code if located within Ohio; or an equivalent state license if located outside of Ohio; and,

(2) Has a valid drug enforcement agency (DEA) number; and,

(3) Has a licensed registered pharmacist in full and actual charge of a pharmacy. ; and,

(4) Has the ability and agrees to submit bills at the point of service. All state and federal laws relating to the practice of pharmacy and the dispensing of medication by a duly licensed pharmacist must be observed.

(O) The bureau may contract with a vendor to perform drug utilization review and on-line bill processing, maintain a pharmacy provider network and prior authorization program for medications, and provide management reports. The bureau or its vendor may also contract rebate agreements with drug manufacturers, and be responsible for maintaining a drug formulary. The bureau may utilize other services or established procedures of the vendor which may enable the bureau to control costs and utilization and detect fraud.

(P) The bureau may identify circumstances under which it may consider reimbursement for pharmacist professional services (also known as cognitive services) when payment for such services results in a measurable, positive outcome. The bureau shall be responsible for developing the criteria which will be used to assess the compensability of billed pharmacist professional services. The bureau shall be responsible for developing the structure of the reporting of the measurable outcomes used to justify the payment of pharmacist professional services. The amount that could be reimbursed for pharmacist professional services shall be determined by the bureau's medical policy department.

(Q) The bureau shall secure the services of a pharmacist to assist the bureau in the review of drug bills. The bureau may employ a staff pharmacist on a full or part-time basis or may contract for such services. The pharmacist may assist the bureau in determining the appropriateness, eligibility, and reasonableness of compensation payments for drug services. The bureau may consult with a pharmacy and therapeutics committee, which shall be a subcommittee of the stakeholders' health care quality assurance advisory committee established by rule 4123-6-22 of the Administrative Code, on the development and ongoing annual review of a drug formulary and other issues regarding medications.

(R) The bureau will publish line by line billing instructions in a health care provider billing and reimbursement manual. At least thirty days written notice will be given prior to required changes in billing procedures.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/27/97, 1/1/03, 10/1/05

4123-6-21.1 Payment for outpatient medication by self-insuring employer. (New)

Comment [a137]: New self-insuring employer pharmacy rule created, identical to former OAC 4123-7-23, which is being rescinded.

(A) Medication must be for treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer.

(B) Medication must be prescribed by the physician of record in the industrial claim or by the treating physician, or by such other treating provider as may be authorized by law to prescribe such medication.

(C) Drugs covered are limited to those that are approved for use in the United States by the Food and Drug Administration and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) A self-insuring employer may approve and reimburse for various drugs as a part of a comprehensive treatment plan submitted by the physician of record or a treating physician when reasonably related to and medically necessary for treatment of the allowed conditions in the claim, provided that such approval and reimbursement shall not constitute the recognition of any additional conditions in the claim even if such drugs are used to treat conditions that have not been allowed in the claim.

(E) Payment for medications to pharmacy providers shall include a product cost component and a dispensing fee component.

(1) The product cost component shall be the lesser of the following: maximum allowable cost established under paragraph (O) of this rule, if applicable, or the average wholesale price of the commonly stocked package size plus or minus a percentage. The percentage amount added or subtracted from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.

(2) The dispensing fee component shall be a flat rate fee determined by the bureau and subject to annual review, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider pursuant to rule 4123-7-39 of the Administrative Code.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN), or other proprietary code that serves to group together pharmaceutically equivalent products (defined as products that contain the same active ingredients in the same strengths, dosage forms, and routes of administration), per rolling twenty-five days. Exceptions to the single dispensing fee are:

(i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;

(ii) Cases where the physician has changed the dosage;

(iii) Cases where the medication did not last for the intended days supply;

(iv) Cases where the medication has been lost, stolen or destroyed;

(v) Controlled substances (which are limited to two dispensing fees per twenty-five days).

(vi) Cases where the self-insuring employer determines the limitations of this paragraph to be unnecessary under the specific circumstances.

(F) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined in paragraph (E) of this rule, unless the self-insuring employer has negotiated a payment rate with the provider pursuant to rule 4123-7-39 of the Administrative Code. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(G) The pharmacy provider is required to follow all applicable line by line billing instructions as published in the bureau's health care provider billing and reimbursement manual. At least thirty days written notice will be given prior to required changes in billing procedures.

(H) Claimant reimbursement for medications shall at least be equal to the bureau's established rate for the medication, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider utilized by the claimant pursuant to rule 4123-7-39 of the Administrative Code, in which case the claimant reimbursement shall be at least the rate negotiated with the provider. Requests for reimbursement must be paid within 30 days of receipt of the request.

(I) Self-insuring employers must obtain a drug utilization review from a physician before terminating payment for current medications, as follows:

(1) Before terminating payment for current medications, the self-insuring employer shall notify all parties to the claim (including authorized representatives) and the prescribing physician, in writing, that a physician drug review is being performed, or has been performed, regarding the necessity and appropriateness of the continued use of current medications (by therapeutic drug class).

(2) The written notice shall inform all parties to the claim (including authorized representatives) and the prescribing physician that they have 21 days from receipt of the notice to provide additional information and/or medical documentation to justify the need for continued use of the medications (by therapeutic drug class).

(3) The self-insuring employer shall provide all medically related information regarding the medications to an independent physician reviewer for review and opinion as to the necessity or appropriateness of the medications. If the self-insuring employer has obtained an independent physician reviewer's report prior to sending the notice required by paragraph (I)(1) of this rule and subsequently receives additional information and/or medical documentation pursuant to paragraph (I)(2) of this rule, the self-insuring employer shall provide the additional information and/or medical documentation to the independent physician reviewer and obtain an addendum. The independent physician reviewer's report (and addendum, if applicable) shall address the medical rationale, necessity and appropriateness of the drug treatment in the control of symptoms associated with the allowed conditions in the claim.

(4) When the independent physician reviewer's report (and addendum, if applicable) indicates the drug treatment is not medically necessary or appropriate for treatment or in the control of symptoms associated with the allowed conditions in the claim, the self-insuring employer may terminate reimbursement for the medications (by therapeutic drug class) effective as of the date of receipt of the independent physician reviewer's report, or addendum if one is obtained, or in the case that a drug is in a therapeutic class that requires a "weaning-off" period, such other date as agreed to by the prescribing physician and self-insuring employer.

(5) In the event the self-insuring employer terminates reimbursement for the medications as set forth in paragraph (I)(4) of this rule, the self-insuring employer or its authorized representative shall provide all parties to the claim (including authorized representatives) and the prescribing physician with a copy of the independent physician reviewer's report (and addendum, if applicable) and the self-insuring employer shall notify the employee and the employee's representative in writing of its decision to terminate. The employer's notification to the employee and employee's representative shall indicate that the employee has the right to request a hearing before the Industrial Commission.

(6) In the event there is a dispute as to whether the drug treatment is medically necessary or appropriate for treatment of the symptoms associated with the allowed conditions in the claim, the disputed matter shall be adjudicated in accordance with Rule 4123-19-03(K)(5) of the Administrative Code.

(J) Self-insuring employers may deny initial requests for a therapeutic class of drugs as not being reasonably related to or medically necessary for the treatment of the allowed conditions in a claim.

(K) Self-insuring employers may utilize medication utilization protocols formulated by the bureau for select conditions or diseases consistent with one or more of the following:

(1) Compendia consistent of the following:

(a) "United States Pharmacopoeia – Drug Information";

(b) "American Medical Association Drug Evaluations";

(c) "Drug Facts and Comparisons"; or,

(2) Peer reviewed medical literature.

Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's or self-insured employer's refusal to reimburse for such medications.

(L) Through internal development or through vendor contracts, self-insuring employers may implement a point-of-service adjudication system. Upon implementation, a self-insuring employer may require pharmacy providers to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the established bill processing system as a condition of reimbursement, and may refuse submission by paper or by tape-to-tape.

(M) Self-insuring employers utilizing a point of service adjudication system may require prior authorization of drugs or therapeutic classes of drugs which appear on BWC's published list of drugs or therapeutic classes of drugs for which prior authorization is required.

(N) Self-insuring employers utilizing a point of service adjudication system may apply the following dispensing limitations, adopted by the bureau, to medications approved and reimbursed by the self-insuring employer:

(1) The bureau may publish a list of drugs identifying those drugs that are considered "chronic" medications. Drugs not identified as chronic medications shall be considered "acute" medications.

(a) Acute medications may be limited by the self-insuring employer to a thirty-four day supply.

(b) Chronic maintenance medications may be limited by the self-insuring employer to a one-hundred-two day supply.

(2) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

(3) Requests submitted that exceed either the days supply limit or maximum quantity limit shall be denied; provided, however, that the pharmacy provider may still fill the prescription up to the days supply limit or maximum quantity limit, as applicable. Denials may be overridden by the self-insured employer in cases where medical necessity and appropriateness have been determined.

(4) Refills requested before seventy-five per cent of the days supply has been utilized will be denied, except in cases where the dosage of a noncontrolled drug has been increased and has a new prescription number. Denials may be overridden by the self-insured employer for the following documented reasons:

(a) Previous supply was lost, stolen or destroyed;

(b) Pharmacist entered previous wrong day supply;

(c) Out of country vacation or travel;

(d) Hospital or police kept the medication.

(O) Self-insuring employers utilizing a point of service adjudication system may apply the maximum allowable cost list of the point of service adjudication system vendor to medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations." Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug.

(P) A self-insuring employer has sufficient grounds to refuse to pay for the dispensing of drugs and other medications when a pharmacy provider fails to observe any state or federal law relating to his or her professional licensure or to the dispensing of drugs and other medication.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30

Rule Amplifies: 4121.44, 4123.66

Prior Effective Dates: _____

4123-6-22 Stakeholders health care quality assurance advisory committee. (No Change)

The bureau of workers' compensation stakeholders' health care quality assurance advisory committee is hereby created to advise the administrator and the chief of injury management services of the bureau of workers' compensation with regard to medical issues.

(A) A list of physicians who have agreed to serve on the committee shall be developed by approval recommendations from the deans of Ohio's medical and osteopathic schools, presidents of the Ohio state medical association, the Ohio state osteopathic association, the Ohio state chiropractic association, Ohio board specialty associations, the Ohio podiatry association, the Ohio psychology association, the Ohio hospital association, the Ohio pharmacists association, the Ohio dental association, the Ohio state medical board, the Ohio state chiropractic board, the Ohio state psychology board, the Ohio state pharmacy board, the Ohio state dental board, and the industrial commission of Ohio. This list shall be maintained by the bureau's chief of injury management services and additional names may be added as needed or desired.

(B) The appointing authority for members of this advisory committee shall be the administrator or his designees, and shall appoint members of the committee from the lists of approved physicians.

(C) The bureau's chief of injury management services shall be the chairman of the advisory committee, and may be self-designated an ad hoc member of any other subcommittees formed by the advisory committee. The chief of injury management services may delegate these duties to a chairperson elected by the voting members. The chief of injury management services shall be a voting member of the advisory and subcommittees only in case of tie votes.

(D) In addition to the bureau's chief of injury management services, the advisory committee shall consist of at least one M.D., one D.O., one D.C., one clinical psychologist and one pharmacist, each holding a license in good standing in the state of Ohio, and one person representing the Ohio hospital association. The bureau's medical director, the industrial commission's medical director, and one physician chosen by the MCOs may participate in discussions; however, they shall not be voting members.

(E) Terms of membership for individual members of the advisory committee shall be for twelve months, subject to review by the administrator. Vacated terms shall be filled in like manner as for the full term appointments.

(F) The advisory committee shall develop and establish bylaws for the organization and operations of the committee and subcommittees, subject to the requirements of this rule and approval by the administrator and the bureau's chief of injury management services.

(G) The advisory committee may initiate assessment of any medical quality assurance issue impacting the bureau and shall be responsible to respond to requests for assessment of any medical quality assurance issue submitted by the bureau's chief of injury management services, including:

- (1) Reviewing managed care data reporting;
- (2) Recommending system-wide non-coverage policies or determinations that MCOs would be required to follow;
- (3) Interfacing with MCO quality assurance committees;

(4) Reviewing performance measures;

(5) Addressing problems with MCO treatment guidelines;

(6) Providing ongoing peer review of the bureau's MCO and provider certification processes, including making recommendations to the bureau for imposing sanctions or granting or denying certification or recertification of a provider based upon a review of the provider's malpractice history;

(7) Advising the bureau regarding the decertification of providers and MCOs, including making recommendations to the bureau for imposing sanctions or decertification of a provider based upon a review of the provider's malpractice history; and

(8) Review of medical disputes referred to the bureau pursuant to rule 4123-6-16 of the Administrative Code.

(H) The advisory committee shall hold at least quarterly meetings. The advisory committee and all subcommittees shall keep written records of the agenda and minutes of each meeting. The records of all committees shall remain in the custody of the bureau's chief of injury management services.

(I) The advisory committee shall submit an annual report of their activities and recommendations to the administrator. In addition to inclusion in the annual report, all recommendations from the advisory committee and subcommittees shall be submitted to the bureau's chief of injury management services in a timely fashion upon completion and approval by the respective committees.

(J) Each member of the advisory committee and its respective subcommittees may be paid such fees as may be approved by the administrator. The expenses incurred by the advisory committee and its subcommittees and the fees of their members shall be paid in the same manner as other administrative costs of the bureau.

(K) The administrator may request that the advisory committee appoint peer review subcommittees to review and provide recommendations to the administrator on disputes arising over quality assurance issues, determinations that a service provided to a claimant is not covered or is medically unnecessary, or billing adjustments arising from bureau audits or reviews of records involving individual health care providers. For these disputes the appointed panel shall consist of providers licensed pursuant to the same section of the Revised Code and system specialty as the individual health care provider for whom review has been requested. The panel may conduct an informal hearing, and shall advise the administrator, whose decision shall be final.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/27/97, 1/15/99, 6/1/05

4123-6-23 Jurisdictional principles applicable to payment of bills for medical services rendered by health care providers (Amend)

Jurisdictional requirements for payment for medical services rendered by a health care provider are as follows:

(A) Bills must be filed within the time provided in rule 4123-3-23 of the Administrative Code.

(B) In claims where the date of injury is on or after December 11, 1967, and prior to ~~October 11, 2006~~ August 25, 2006, there is no jurisdiction to consider payment for medical services, if six years or more have elapsed since the date of the last payment of a medical bill and no compensation has been paid, except as provided in the following cases:

Comment [tam138]: Date changes in this rule are a result of *Thornton v. Montville Plastics & Rubber, Inc.*, 121 Ohio St.3d 124, 2009-Ohio-360.

(1) A bill filed within the six-year period for services rendered within the period can be paid after the six-year period when, except for the time passage, it would have been paid.

(2) When an application requesting the payment of medical bills and/or compensation is filed within the six-year period, there is justification to act on the application after the period.

(a) Bills for services rendered within the six-year period can be ordered paid and can be paid after the period. However, these bills must be filed no later than two years after the date that services were rendered.

(b) Compensation can be ordered paid provided that evidence in the claim supports an award. If compensation is paid, the claim is opened for an additional ten years for the payment of compensation and bills. When there has been a payment of compensation under section 4123.56, 4123.57, or 4123.58 of the Revised Code, the claim is active for ten years from either the date of the last payment of compensation, or ten years from the last payment of a medical bill, whichever is later.

(3) Payment for medical services can be made when the claimant has received wages paid by the employer, instead of compensation for total disability. Medical services may be reimbursed when wages have been paid within six years of the date of injury with the employer's knowledge that an allowed claim exists.

(4) When a request for authorization of treatment beyond the six-year period is filed within the six-year period, the authorization for treatment after that period cannot be granted, unless the claim has been opened by the payment of compensation.

(5) There is no jurisdiction to consider the merits of any application filed after the six-year period, even though supporting evidence for the application was on file within the period.

(6) A bill filed within the six-year period that requires reactivation of the claim cannot be paid when an application for reactivation is not filed within the period. This rule also applies to bills filed after the expiration of the six-year period for treatment rendered within that period.

(C) In claims where the date of injury is prior to December 11, 1967, there is no jurisdiction to consider payment for medical services if ten years or more have elapsed since the payment of compensation or benefits, or, when no compensation has been awarded, ten years have elapsed since the date of injury.

(D) In claims where the date of injury is on or after ~~October 11, 2006~~ August 25, 2006, there is no jurisdiction to consider payment for medical services if five years or more have elapsed since the payment

Comment [tam139]: Date changes in this rule are a result of *Thornton v. Montville Plastics & Rubber, Inc.*, 121 Ohio St.3d 124, 2009-Ohio-360.

of compensation or benefits. The provisions of paragraph (B) of this rule shall apply to the payment of medical bills in claims where the date of injury is on or after ~~October 11, 2006~~ August 25, 2006, except that where those provisions reference six year and ten year time limits, the time limits shall be five years.

Promulgated Under: 119.03

Statutory Authority: 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.12, 4121.121, 4121.44, 4121.441, 4123.52, 4123.66

Prior Effective Dates: 2/12/97; 04/01/07

Comment [tam140]: Date changes in this rule are a result of *Thornton v. Montville Plastics & Rubber, Inc.*, 121 Ohio St.3d 124, 2009-Ohio-360.

4123-6-24 Treatment necessary due to an industrial injury or occupational disease. (Rescind)

Medical or other services to be approved for payment must be rendered as a direct result of an injury sustained or occupational disease contracted by a claimant in the course of and arising out of employment. The claim must be allowed by an order of either the bureau of workers' compensation or the industrial commission, or have been recognized by a self-insuring employer.

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: 2/12/97

Comment [a141]: Language added to OAC 4123-6-25.

4123-6-25 Payment for medical supplies and services. (Amend)

(A) Medical or other services to be approved for payment must be rendered as a direct result of an injury sustained or occupational disease contracted by a claimant in the course of and arising out of employment. The claim must be allowed by an order of either the bureau of workers' compensation or the industrial commission, or have been recognized by a self-insuring employer.

Comment [a142]: Language moved from OAC 4123-6-24, which is being rescinded.

Medical supplies and services will be considered for payment when they are medically necessary for the diagnosis and treatment of conditions allowed in the claim, are causally related to the conditions allowed in the claim, and are rendered by a health care provider. Payment for services rendered to a claimant shall be paid to a health care provider only when the provider has delivered, rendered or directly supervised the examination, treatment, evaluation or any other medically necessary and related services provided to the claimant. By submitting any fee bill to the bureau, in either hardcopy or electronic format, the health care provider affirms that medical supplies and services have been provided to the claimant as required by this rule.

Providers billing for services rendered shall follow the procedures set forth in the bureau's provider billing and reimbursement manual in effect on the billed date of service.

Comment [a143]: Language moved from OAC 4123-7-17, which is being rescinded, and is applicable to all claims, not only self-insuring employer claims.

(B) Services rendered by health care providers are subject to review for coding requirements outlined in paragraph (C) of this rule. Payments to health care providers may be adjusted based upon these guidelines.

(C) Coding systems.

(1) Billing codes.

(a) Practitioners are required to use the ~~most current~~ edition of the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) in effect on the billed date of service to indicate the procedure or service rendered to injured workers.

(b) Inpatient and outpatient hospital services must be billed using the national uniform billing committee's revenue center codes.

(c) Outpatient medication services must be billed pursuant to the requirements described in the bureau's provider billing and reimbursement manual.

(d) To insure accurate data collection, the bureau shall adopt a standardized coding structure which shall be adopted by any MCO, QHP, or self-insuring employer.

(2) ICD-9 Diagnosis codes.

Providers must use the ~~most current edition of the~~ appropriate "International Classification of Diseases, clinical modification" codes for the condition(s) treated to indicate diagnoses.

Comment [a144]: Amended to provide greater flexibility and to conform to standard bill coding conventions.

(D) Prior to services being delivered, the provider must make reasonable effort to notify the claimant, bureau, MCO, QHP or self-insuring employer when the provider has knowledge that the services may not be related to the claimed or allowed condition(s) related to the industrial injury or illness, or that a service is non-covered. The provider may not knowingly bill or seek payment from the bureau, MCO, QHP or self-insured employer for services that are not related to the claimed or allowed condition(s) related to the

industrial injury or illness. The provider may not knowingly mislead or direct providers of ancillary services to bill or seek payment for services that are not related to the claimed or allowed condition.

The provider may not bill or seek payment from the claimant for services determined as medically unnecessary through the use of bona fide peer review based on accepted treatment guidelines.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97, 4/1/07

4123-6-26 Claimant reimbursement. (No Change)

When the claimant or any other person making payment on behalf of the claimant, including a volunteer, pays for medical services or supplies directly to a health care provider not participating in the HPP or QHP and the claim or condition is subsequently allowed, the payor shall be reimbursed upon submission of evidence of the receipt and payment for that service or supply. The payor will receive the amount that would have been paid to the health care provider as provided by the rules of this chapter of the Administrative Code. When payment has been made to the health care provider, the payor shall be informed to seek reimbursement from the provider.

The bureau shall inform a claimant or payor whether a health care provider participates in the HPP or QHP.

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: 2/12/97

4123-6-27 Treatment by more than one physician. (No Change)

Medical fees shall not be approved for treatment by more than one physician for the same condition over the same period of time, except where a consultant, anesthetist, or assistant is required, or where the necessity for treatment by a specialist is clearly shown and approved in advance of treatment. This rule does not apply in cases of emergency, or where the physician of record's approved treatment plan indicates the necessity for multidisciplinary services.

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: 2/12/97

4123-6-28 Treatment of more than one condition or to more than one part of the body. (Rescind)

In claims involving treatment of more than one condition or more than one part of the body, the attending physician must report all conditions and all parts of the body being treated that are affecting the length of disability. The conditions submitted shall include a primary international classification of disease diagnosis code and a description of the condition being treated. This information may be used in the determination of the extent of disability resulting from the industrial injury or occupational disease.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2-12-97; 2-14-05

Comment [a145]: Language moved to rule OAC 4123-6-20(B).

4123-6-29 Request for information by the treating provider. (Amend)

A provider treating an injured worker may, at any time, make a request in writing, ~~facsimile facsimile,~~ or e-mail, or ~~by telephone~~ in accordance with the bureau's confidentiality and sensitive data requirements, for relevant information concerning conditions, treatment or history for the claim. The request for information shall be accompanied by an appropriate patient release of medical information. A prompt response will be given to this request.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97; 2/14/05

Comment [a146]: Nonsubstantive change (misspelling corrected) from 1st reading.

Comment [tam147]: Language modified to provide heightened data security.

4123-6-30 Payment for physical medicine. (Amend)

(A) "Physical medicine is the evaluation and treatment of a claimant by physical measures and the use of rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating any work related disability. Physical medicine includes the establishment and modification of physical rehabilitation programs, treatment planning, instruction, and consultative services. "Physical measures" include massage, heat, cold, air, light, water, electricity, sound, manipulation, and the performance of tests of neuromuscular function as an aid to such treatment. Physical medicine does not include the diagnosis of a patient's disability, the use of roentgen rays or radium for diagnostic or therapeutic purposes, or the use of electricity for cauterization or other surgical purposes. Physical medicine includes, but is not limited to, chiropractic treatments, physiotherapy, and physical therapy.

(B) Physical medicine must be prescribed by the physician of record or other approved treating ~~physician, who is provider~~ licensed to practice medicine, osteopathy, chiropractic, mechanotherapy, dentistry, ~~or~~ podiatry, ~~or nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.~~ Physical medicine may be provided in the physician's office or referred to another licensed provider.

(C) To be eligible for reimbursement, physical medicine services must be provided by a physician, chiropractic physician, physical therapist, occupational therapist, massage therapist, athletic trainer or other qualified non-physician provider practicing within the scope of his or her license, certification, or registration.

(D) Fees for up to twelve physical therapy treatments within sixty days following the date of injury may be reimbursed without prior authorization, provided the treatments are for allowed soft tissue and musculoskeletal conditions in allowed claims and the criteria set forth in paragraphs (B)(1) to (B)(3) of rule 4123-6-16.2 of the Administrative Code are met. Otherwise, physical therapy treatment must be prior authorized.

~~(C)~~(E) Payment for physical medicine used for treatment of the allowed conditions shall be made pursuant to in accordance with rule ~~4123-6-25~~ 4123-6-10 of the Administrative Code.

~~(D)~~(F) Physical medicine treatments must be provided in conjunction with:

(1) In cases of temporary total disability, interim medical reports and medical documentation meeting the requirements specified in paragraph (B) of rule 4123-6-20 of the Administrative Code.

(2) A current, written treatment plan meeting the requirements specified in paragraph (C) of rule 4123-6-20 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97

Comment [a148]: Amended to add additional provider types listed in Ohio Revised Code 4755.481(B) as having authority to prescribe physical therapy.

Comment [nj149]: Standardization of services between state fund and self-insured employers. This reduces the administrative burden for the physician and supports the objective of early and safe return to work for the injured worker.

4123-6-31 Payment for miscellaneous medical services and supplies. (New)

Comment [nj1150]: Six rules were rescinded and combined into new rule for ease of reading and consolidation of payment criteria for these services/supplies.

(A) Acupuncture.

(1) Acupuncture is a recognized method of treatment in Ohio and must be administered by a licensed doctor of medicine, doctor of osteopathic medicine and surgery, or doctor of podiatric medicine who has completed a course of study in acupuncture under the administration of an approved college of medicine, college of osteopathic medicine and surgery, or college of podiatric medicine, doctor of chiropractic who holds a certificate to practice acupuncture from the Ohio state chiropractic board or a registered non-physician acupuncturist. Such treatment must be prior authorized.

(2) Services provided by a non-physician acupuncturist must be prescribed by persons licensed under Chapter 4731, of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery or podiatry or Chapter 4743, of the Revised Code to practice chiropractic. A registered non-physician acupuncturist shall perform acupuncture under the general supervision of the injured worker's prescribing physician or chiropractic physician. General supervision does not require that the acupuncturist and the prescribing physician or chiropractic physician practice in the same office.

(B) Braces, shoes, and other orthotic devices.

(1) Payment is made only for those orthotic devices prescribed in writing by the physician of record for treatment of an allowed injury or occupational disease. The use of the orthotic device must be directly related to the allowed industrial injury or occupational disease.

(2) Orthotic devices shall be custom fitted or custom fabricated and delivered to the satisfaction of the prescribing physician and the administrative agencies. Repairs, modifications, and adjustments to secure satisfactory application of the orthotic appliance shall be made within sixty days of fitting and application without additional charge by the supplier of the orthotic device.

(3) No charge shall be made for measurement, transportation, or other expenses incurred by the supplier-orthotist, except when the supplier-orthotist is required to travel beyond the limits of the metropolitan community in which he maintains his place of business by reason of the physical incapacity of the claimant or by reason of direct prescription by the attending physician. The supplier-orthotist shall be paid for traveling expenses on a round-trip basis. Additional charges must be separately specified on the supplier-orthotist's billing, including the points of travel and the name of the physician prescribing the travel. Payment will be made for a maximum of three round-trip calls.

(C) Dental care.

(1) Payment for dental care shall be made in the following cases:

(a) Where an industrial injury or occupational disease either has caused damage or has adversely affected the claimant's natural teeth.

(b) For industrial injuries or occupational diseases sustained prior to January 1, 1979, artificial teeth or other denture must be in place in the worker's mouth at the time of damage or loss.

(c) For industrial injuries or occupational diseases sustained on or after January 1, 1979, the requirements of division (C)(1)(b) of this rule do not apply.

(2) Responsibility for injuries or occupational diseases affecting the claimant's natural teeth is limited to the repair or replacement of those teeth actually injured at the time of the accident, or directly affected by the injury or disease. This responsibility does not include the replacement of teeth which are extracted or repaired for purposes unrelated to the industrial injury or occupational disease.

(3) Replacement of artificial teeth when the injury or occupational disease has resulted in a deformity of the jaw to the extent that artificial teeth cannot be used, is subject to the limitations of paragraphs (C)(1)(b) and (C)(1)(c) of this rule.

(4) Responsibility for the repair of both natural and artificial teeth is limited to the damage done at the time of the accident, or to the damage directly caused by an allowed injury or occupational disease.

(D) Eyeglasses and contact lenses.

(1) Payment is approved to replace eyeglasses or contact lenses when an industrial injury or an industrial accident not only causes an injury, but also results in the damage or loss of the claimant's eyeglasses or contact lenses.

(a) In the event of injury prior to January 1, 1979, the eyeglasses must be in place on the claimant's face or the contact lenses shall be in place in the claimant's eye(s) at the time of injury.

(b) In the event of injury on or after January 1, 1979, the requirements of paragraph (D)(1)(a) of this rule do not apply.

(2) Contact lenses or glasses are reimbursed when loss of vision is the direct result of an allowed injury or occupational disease.

(3) Refractions will be approved in situations described in paragraph (D)(2) of this rule.

(4) Replacement of glasses with contact lenses is approved when medical evidence indicates a direct need due to an allowed injury or occupational disease.

(5) Glasses or contact lenses will be approved for treatment purposes, when necessary, as a direct result of the allowed injury or occupational disease. Any subsequent adjustment, maintenance supplies or change in a claimant's glasses or contact lenses, if required for treatment of the allowed injury or occupational disease, will also be approved when supported by evidence of a direct causal relationship.

When eyeglasses and/or contact lenses were damaged or broken in an industrial accident in which an injury was sustained by the claimant and have been replaced, no further replacement will be approved due to subsequent breakage or for any other reason, except as provided in this paragraph of this rule.

(E) Hearing aids.

(1) When an industrial injury or an industrial accident which causes an injury also damages the claimant's hearing aid(s), payment to replace the hearing aid(s) is approved as follows:

(a) For injuries or accidents sustained prior to January 1, 1979, the hearing aid(s) must be in place in the claimant's ear(s) at the time of the injury or accident.

(b) For injuries or accidents sustained on or after January 1, 1979, the requirements of paragraph (E)(1)(a) of this rule do not apply.

(c) Once hearing aid(s) have been replaced, no further replacement will be approved.

(2) When a partial loss of hearing is the direct result of an allowed industrial injury or occupational disease, payment for a hearing aid(s) is justified in order to improve the claimant's ability to hear.

(F) X-rays.

Payment for x-ray examinations (including CT, MRI, and discogram) shall be made when medical evidence shows that the examination is medically necessary either for the treatment of an allowed injury or occupational disease, or for diagnostic purposes to pursue more specific diagnoses in an allowed claim. Providers shall follow all prior authorization requirements in effect at the time when requesting authorization and payment for such studies.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.44, 4121.441, 4123.66

Prior Effective Dates: _____

4123-6-31 Payment for acupuncture. (Rescind)

Comment [a151]: Language combined into new OAC 4123-6-31.

(A) Acupuncture is a recognized method of treatment in Ohio and must be administered by a licensed doctor of medicine, doctor of osteopathic medicine and surgery, or doctor of podiatric medicine who has completed a course of study in acupuncture under the administration of an approved college of medicine, college of osteopathic medicine and surgery, or college of podiatric medicine, doctor of chiropractic who holds a certificate to practice acupuncture from the Ohio state chiropractic board or a registered non-physician acupuncturist.

(B) Services provided by a non-physician acupuncturist must be prescribed by persons licensed under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery or podiatry or Chapter 4743. of the Revised Code to practice chiropractic. A registered non-physician acupuncturist shall perform acupuncture under the general supervision of the injured worker's prescribing physician or chiropractic physician. General supervision does not require that the acupuncturist and the prescribing physician or chiropractic physician practice in the same office.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.44, 4121.441, 4123.66

Prior Effective Dates: 9/22/08

4123-6-32 Payment for x-rays. (Rescind)

Payment for x-ray examinations (including CT, MRI, and discogram) shall be made when medical evidence shows that the examination is medically necessary either for the treatment of an allowed injury or occupational disease, or for diagnostic purposes to pursue more specific diagnoses in an allowed claim. Providers shall follow all bureau prior authorization policies in effect at the time when requesting authorization and payment for such studies.

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: 2/12/97, 10/14/02

Comment [a152]: Language combined into new OAC 4123-6-31.

4123-6-33 Payment for dental care. (Rescind)

Comment [a153]: Language combined into new OAC 4123-6-31.

(A) Payment for dental care shall be made in the following cases:

(1) Where an industrial injury or occupational disease either has caused damage or has adversely affected the claimant's natural teeth.

(2) For industrial injuries or occupational diseases sustained prior to January 1, 1979, artificial teeth or other denture must be in place in the worker's mouth at the time of damage or loss.

(3) For industrial injuries or occupational diseases sustained on or after January 1, 1979, the requirements of division (A)(2) of this rule do not apply.

(B) Responsibility for injuries or occupational diseases affecting the claimant's natural teeth is limited to the repair or replacement of those teeth actually injured at the time of the accident, or directly affected by the injury or disease. This responsibility does not include the replacement of teeth which are extracted or repaired for purposes unrelated to the industrial injury or occupational disease.

(C) Replacement of artificial teeth when the injury or occupational disease has resulted in a deformity of the jaw to the extent that artificial teeth cannot be used, is subject to the limitations of paragraphs (A)(2) and (A)(3) of this rule.

(D) Responsibility for the repair of both natural and artificial teeth is limited to the damage done at the time of the accident, or to the damage directly caused by an allowed injury or occupational disease.

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: 2/12/97

4123-6-34 Payment for eyeglasses and contact lenses. (Rescind)

Comment [a154]: Language combined into new OAC 4123-6-31.

(A) Payment is approved to replace eyeglasses or contact lenses when an industrial injury or an industrial accident not only causes an injury, but also results in the damage or loss of the claimant's eyeglasses or contact lenses.

(1) In the event of injury prior to January 1, 1979, the eyeglasses must be in place on the claimant's face or the contact lenses shall be in place in the claimant's eye(s) at the time of injury.

(2) In the event of injury on or after January 1, 1979, the requirements of paragraph (A)(1) of this rule do not apply.

(B) Contact lenses or glasses are reimbursed when loss of vision is the direct result of an allowed injury or occupational disease.

(C) Refractions will be approved in situations described in paragraph (B) of this rule.

(D) Replacement of glasses with contact lenses is approved when medical evidence indicates a direct need due to an allowed injury or occupational disease.

(E) Glasses or contact lenses will be approved for treatment purposes, when necessary, as a direct result of the allowed injury or occupational disease. Any subsequent adjustment, maintenance supplies or change in a claimant's glasses or contact lenses, if required for treatment of the allowed injury or occupational disease, will also be approved when supported by evidence of a direct causal relationship.

When eyeglasses and/or contact lenses were damaged or broken in an industrial accident in which an injury was sustained by the claimant and have been replaced, no further replacement will be approved due to subsequent breakage or for any other reason, except as provided in this paragraph of this rule.

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: 2/12/97

4123-6-35 Payment for hearing aids. (Rescind)

Comment [a155]: Language combined into new OAC 4123-6-31.

(A) When an industrial injury or an industrial accident which causes an injury also damages the claimant's hearing aid(s), payment to replace the hearing aid(s) is approved as follows:

(1) For injuries or accidents sustained prior to January 1, 1979, the hearing aid(s) must be in place in the claimant's ear(s) at the time of the injury or accident.

(2) For injuries or accidents sustained on or after January 1, 1979, the requirements of paragraph (A)(1) of this rule do not apply.

(3) Once hearing aid(s) have been replaced, no further replacement will be approved.

(B) When a partial loss of hearing is the direct result of an allowed industrial injury or occupational disease, payment for a hearing aid(s) is justified in order to improve the claimant's ability to hear.

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: 2/12/97

4123-6-36 Payment for braces, shoes, and other orthotic devices. (Rescind)

Comment [a156]: Language combined into new OAC 4123-6-31.

Payment is made only for those orthotic devices prescribed in writing by the physician of record for treatment of an allowed injury or occupational disease. The use of the orthotic device must be directly related to the allowed industrial injury or occupational disease.

(A) Orthotic devices shall be custom fitted or custom fabricated and delivered to the satisfaction of the prescribing physician and the administrative agencies. Repairs, modifications, and adjustments to secure satisfactory application of the orthotic appliance shall be made within sixty days of fitting and application without additional charge by the supplier of the orthotic device.

(B) No charge shall be made for measurement, transportation, or other expenses incurred by the supplier-orthotist, except when the supplier-orthotist is required to travel beyond the limits of the metropolitan community in which he maintains his place of business by reason of the physical incapacity of the claimant or by reason of direct prescription by the attending physician. The supplier-orthotist shall be paid for traveling expenses on a round-trip basis. Additional charges must be separately specified on the supplier-orthotist's billing, including the points of travel and the name of the physician prescribing the travel. Payment will be made for a maximum of three round-trip calls.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97; 2/14/05

4123-6-37 Payment of hospital bills. (Amend)

(A) Direct reimbursement will not be made to members of a hospital resident staff.

(B) Payment for personal comfort items, which include, but are not limited to, telephones, television, and private rooms provided at the patient's request, are not compensable.

(C) Bureau fees for hospital inpatient services.

(1) Bureau fees for hospital inpatient services will be based on usual and customary methods of payment, such as prospective payment systems, including diagnosis related groups (DRG), per diem rates, rates based on hospital cost to charge ratios or percent of allowed charges.

(2) Except in cases of emergency as defined in this chapter, prior authorization must be obtained in advance of all hospitalizations. ~~The hospital must notify the bureau, and/or the injured worker's MCO, QHP, or self-insuring employer of emergency inpatient admissions within one business day of the admission. Failure to comply with this rule shall be sufficient ground for denial of room and board charges by the bureau, or MCO, QHP, or self-insuring employer from the date of admission up to the actual date of notification. Room and board charges denied pursuant to this rule may not be billed to the injured worker.~~

Comment [nj1157]: Language deleted as unnecessary, since definitions are reflected in OAC 4123-6-01.

(D) Bureau fees for hospital outpatient services.

(1) Bureau fees for hospital outpatient services, including emergency services, will be reimbursed in accordance with usual and customary methods of payment which may include prospectively determined rates, allowable fee maximums, ambulatory payment categories (APC), hospital cost to charge ratios, or a percent of allowed charges, as determined by the bureau.

(2) Treatment in the emergency room of a hospital must be of an immediate nature to constitute an emergency as defined in this chapter. Prior authorization of such treatment is not required. However, in situations where the emergency room is being utilized to deliver non-emergency care, notification will be provided to the injured worker, the hospital, and the provider of record that continued use of the emergency room for non-emergent services will not be reimbursed.

(E) The bureau may establish the same or different fees for in-state and out-of-state hospitals based on the above reimbursement methodologies

~~(F) Payment will be made for hospital services based on rules 4123-6-11 and 4123-6-12 in accordance with rule 4123-6-10 of the Administrative Code.~~

Comment [nj1158]: OAC 4123-6-11 and OAC 4123-6-12 are being combined into OAC 4123-6-10.

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: 2/12/97, 3/1/04

4123-6-38 Payment for home health nursing services. (Amend)

(A) Employment of nursing service.

(1) The need for nursing services must be the direct result of an allowed injury or occupational disease.

(2) Except as described in rule 4123-6-38.1 of the Administrative Code, home health nursing services shall be provided by registered nurses and licensed practical nurses employed by a ~~medicare-certified, joint-committee on accreditation of healthcare organizations (JCAHO)-accredited, or community health accreditation (CHAP)-accredited~~ home health agency meeting the qualifications specified in paragraph (C)(11) of rule 4123-6-02.2 of the Administrative Code.

Comment [nj1159]: Language updated to clarify criteria required for home health agencies to be eligible for reimbursement.

(B) Fees for home health agency nursing services.

Fees for home health agency nursing services will be determined by the bureau. Payment will be made for home health nursing services ~~based on rules 4123-6-11 and 4123-6-12 in accordance with rule 4123-6-10 of the Administrative Code.~~

Comment [nj1160]: OAC 4123-6-11 and OAC 4123-6-12 being combined into OAC 4123-6-10.

(C) Authorization for home health nursing services.

(1) Authorization for home health nursing services shall be considered only in cases where the claimant, as the direct result of an allowed injury or occupational disease, is bedfast or otherwise confined to the home, is mentally incapable of self-care or requires home care services ordered for hospital discharge follow-up.

(2) The request for authorization from the physician of record or treating physician must identify the reason for home health nursing services, the period of time the services will be required, the specific services and the number of hours per day that are required.

(3) In addition to skilled nursing services provided by a registered nurse or licensed practical nurse, the claimant may be approved for home health aide ~~or attendant~~ services. If he/she is unable to independently perform activities of daily living, including, but not limited to, feeding, bathing, dressing, providing personal hygiene, and transferring from bed to chair. Household, personal or other duties such as maintaining a household, washing clothes, preparing meals or running errands are not considered nursing services and will not be reimbursed.

Comment [nj1161]: Attendant services are not reimbursable under the BWC fee schedule.

(4) Authorization must be obtained ~~from the MCO~~ prior to rendering home health nursing services, except in cases of emergency or where the claimant's allowed condition could be endangered by the delay of services.

Comment [nj1162]: Language modified to apply to self-insured and QHP as well as State Insurance Fund claims.

(D) All covered home health services must be rendered on a part-time or intermittent care basis, in accordance with the written treatment plan and the bureau standard of care. Part-time or intermittent care means that services are generally rendered for no more than eight hours per day. Home health services rendered on a full time or continuous care basis are not covered. More appropriate alternative settings will be considered for claimants requiring more than eight hours per day of care, where medical necessity is documented. Exceptional cases may be reviewed by the bureau.

(E) A review of the claim or assessment of the injured worker will be conducted at ~~least~~ least annually to ensure that nursing services are necessary as a direct result of the allowed injury or occupational disease.

(F) Documentation requirements for home health agencies.

Home health agency providers must maintain records which fully document the extent of services provided to each claimant. All records must be maintained in accordance with the conditions of participation required for medicare certification, joint ~~committee on~~ commission accreditation of healthcare organizations (JCAHO) accreditation, or community health accreditation program (CHAP) accreditation. The provider may be required to furnish detailed hourly descriptions of care delivered to a claimant to review care needs and medical necessity.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97; 2/14/05

4123-6-38.1 Payment for nursing and caregiver services provided by persons other than home health agency employees. (Amend)

(A) Nursing services provided prior to December 14, 1992.

(1) Registered nurses and licensed practical nurses who are not employed by a medicare certified, joint commission ~~on accreditation of healthcare organizations (JCAHO)~~ accredited, or community health accreditation program (CHAP) accredited home health agency may continue to provide authorized services to a claimant if the services began prior to December 14, 1992.

(2) The need for nursing services must be the direct result of an allowed injury or occupational disease.

(3) In the event the registered nurse or licensed practical nurse is no longer able to provide approved services or if services are stopped and later restarted, nursing services shall be provided only by an employee of a medicare certified, joint commission ~~on accreditation of healthcare organizations (JCAHO)~~ accredited, or community health accreditation program (CHAP) accredited home health agency.

(B) Non-licensed caregiver services.

(1) Requests for extension of caregiver services initially provided prior to December 14, 1992.

(a) Prior to December 14, 1992, caregiver services provided by a non-licensed person including claimant's spouse, friend or family member were considered for reimbursement in cases where the claimant, as a direct result of an allowed injury or occupational disease, was bedfast, confined to a wheelchair, had a disability of two or more extremities which prevented the claimant from caring for his/her own body needs or was otherwise unable to take care of his/her own bodily functions. Services include, but are not limited to, feeding, bathing, dressing, providing personal hygiene, and transferring from bed to chair. Household, personal or other duties such as maintaining a household, washing clothes, preparing meals, or running errands, are not considered nursing services, and will not be reimbursed.

(b) Requests for an extension of caregiver services approved ~~by the bureau~~ prior to December 14, 1992, delivered by a non-licensed person, other than an attendant, aide, or claimant's spouse, but including other family members or friends, will be approved only if:

(i) The claimant does not have a spouse because the claimant is not married, or the claimant's spouse is deceased, or the claimant's spouse is physically or mentally incapable of caring for the claimant; and,

(ii) The approved home health agency is greater than thirty-five miles from the claimant's location and the home health agency refuses to provide services to the claimant.

(c) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a medicare certified, joint commission ~~on accreditation of healthcare organizations (JCAHO)~~ accredited, or community health accreditation program (CHAP) accredited home health agency.

(2) Requests for extension of caregiver services initially provided on or after December 14, 1992 and prior to January 9, 1995.

(a) Requests for approval of caregiver services delivered by a non-licensed person, other than an attendant, aide, or claimant's spouse were considered for reimbursement only if the claimant did not have a spouse or the spouse was physically or mentally incapable of caring for the claimant, or an approved

Comment [tam163]: "Grandfather" date arising from 1992 amendments to predecessor rule OAC 4123-7-25.

Comment [tam164]: "Grandfather" date arising from 1995 amendments to predecessor rule OAC 4123-7-25.

home health agency was greater than thirty-five miles from the claimant's location and the home health agency refused to provide services to the claimant.

(b) Criteria for approval of caregiver services were as indicated in paragraph (B)(1)(a) of this rule.

(c) After January 9, 1995, persons who are not home health agency home health aides or attendants, but who are currently approved to provide caregiver services to a claimant, may continue to do so until services are no longer medically necessary or unless services are not authorized. After January 9, 1995, approval of caregiver services shall only be considered when services are rendered by a home health agency home health aide or attendant.

(d) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a medicare certified, joint commission ~~on accreditation of healthcare organizations (JCAHO)~~ accredited, or community health accreditation program (CHAP) accredited home health agency.

(C) All covered home health services must be rendered on a part-time or intermittent care basis, in accordance with the written treatment plan and the bureau standard of care. Part-time or intermittent care means that services are generally rendered for no more than eight hours per day. Home health services rendered on a full time or continuous care basis are not covered. More appropriate alternative settings will be considered for claimants requiring more than eight hours per day of care, where medical necessity is documented. Exceptional cases may be reviewed by the bureau.

(D) A review of the claim or assessment of the injured worker will be conducted at least ~~least~~ annually to ensure that nursing services are necessary as a direct result of the allowed injury or occupational disease.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97; 2/14/05

4123-6-38.2 Payment of nursing home and residential care/assisted living services. (Amend)

(A) Payment to a nursing home or residential care/assisted living facility for the care of a claimant who sustained an injury or contracted an occupational disease in the course of and arising out of employment shall be made only when the need for such care is the direct result of the allowed conditions in the claim.

(B) Payment will be made only for care provided in ~~state licensed, medicaid certified~~ nursing homes and residential care/assisted living facilities meeting the qualifications specified in paragraph (C)(20) of rule 4123-6-02.2 of the Administrative Code.

(C) ~~In claims managed by an MCO,~~ Nursing home or residential care/assisted living facility care must be pre-authorized, except when a nursing home or residential care/assisted living facility is used immediately following an approved or emergency hospitalization.

(1) The allowed per diem rate for a claimant shall be no greater than the bureau's fee schedule or the rate negotiated between the nursing home or residential care/assisted living facility and the bureau, MCO, QHP, or self-insuring employer.

(2) Nursing home care shall be provided on a semiprivate ~~or ward~~ bed basis, unless a situation exists when the use of a private room is medically necessary due to the allowed industrial condition. In these cases, the use of such a private room must be pre-authorized, except in cases of emergency, as defined in rule 4123-6-01 of the Administrative Code, or where the claimant's condition would be endangered by delay.

(3) Fee bills for prescription medication provided to claimants in nursing homes and residential care/assisted living facilities for the treatment of the allowed industrial injury or occupational disease shall be submitted by the providing pharmacy in compliance with ~~rule 4123-6-24~~ the rules of this chapter of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 02/14/2005

4123-6-39 Payment for prosthetic device or other artificial appliances used by disabled claimants following a loss of member award. (Amend)

(A) In all cases arising under division (B) of section 4123.57 of the Revised Code, if a claimant requires the purchase or repair of an artificial appliance, as determined by any one of the following: (1) the amputee clinic at the Ohio state university medical center; (2) the rehabilitation services commission; (3) a multidisciplinary amputee clinic or prescribing physician approved by the administrator or the administrator's designee, the bureau shall pay the cost of purchasing or repairing the artificial appliance out of the surplus fund. The purchase or repair is made regardless of whether the appliance is part of the claimant's vocational rehabilitation, or if the claimant has, or will ever be able, to return to work.

Comment [a165]: Language added to conform to Ohio Revised Code 4123.57(C), to ensure evaluation is completed by an appropriate provider who will provide a comprehensive assessment specific to the claimant's prosthetic needs.

(B) The bureau is responsible for processing requests for prosthetics and travel expenses associated with the prosthetic in all self-insured claims. When a prosthetic device is needed in a self-insured claim, the provider will send a request for the prosthetic and/or request for repair, as well as the subsequent bills, to the bureau.

Comment [nj1166]: Language added from rule OAC 4123-7-28, which is being rescinded

Promulgated Under: 119.03
Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4121.61, 4123.57, 4123.66
Prior Effective Dates: 2/12/97; 2/14/05

4123-6-40 Payment of claimant travel expenses. (No Change)

(A) A claimant's travel expenses shall be paid, upon the filing of a proper request, under the following circumstances:

(1) When the claimant has been ordered or authorized to undergo a medical examination outside of the city or community limits where he resides. The claimant shall be reimbursed for travel only if the travel distance exceeds a mileage distance as periodically determined by the bureau. The minimum mileage distance for reimbursement shall be published periodically by the bureau.

(2) When specialized treatment necessary for the allowed industrial condition cannot be obtained within the city or community where the claimant resides, and the treatment has been pre-authorized and approved. The claimant shall be reimbursed for travel only if the travel distance exceeds a mileage distance as periodically determined by the bureau. The minimum mileage distance for reimbursement shall be published periodically by the bureau.

(3) When the claimant has been requested to undergo a medical examination by a physician of the employer's choice, travel expenses incurred as a result of the examination are to be paid by the employer immediately upon the receipt of the bill. Payment of the bill shall not require an order of the bureau or commission, unless there is a dispute. The employer shall provide the claimant with a proper form to be completed by the claimant for reimbursement of traveling expenses. The minimum mileage provision of paragraphs (A)(1) and (A)(2) of this rule shall not apply for reimbursement of examinations under this paragraph of the rule.

(4) In situations described in paragraphs (A)(1) and (A)(2) of this rule, the following provisions apply:

(a) If the claimant is traveling by automobile, the claimant shall be entitled to a reasonable payment, as established and periodically published by the bureau, on a per mile basis if the mileage exceeds the distance established as provided under paragraph (A) of this rule, portal to portal, using the most direct and practical route.

(b) If the claimant is traveling by airplane, railroad or bus, the claimant shall be entitled to the actual and necessary airplane, railroad or bus fare.

(c) The reasonable cost of necessary meals, based on distance traveled, will be refunded to the claimant. It shall be paid in accordance with a schedule adopted by the bureau and periodically revised.

(d) Necessary hotel bills will be paid at reasonable actual cost. Hotel accommodation must be pre-authorized.

(5) Taxicab fares will be refunded only when the claimant's physical condition requires such transportation for treatment or examination on account of an allowed injury or occupational disease. Taxicabs or other special transportation shall be pre-authorized.

(6) The payment rates for meals, lodging and travel shall be published periodically by the bureau.

(B) Actual payment or refund shall be made in accordance with requirements outlined in this rule.

(C) This rule applies to all claims for industrial injuries and/or occupational diseases, regardless of whether the employer is part of the state fund, is self-insuring, is non-complying, etc.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97, 10/14/02, 6/1/05

4123-6-41 No legal relationship between the industrial commission or bureau and a health care provider. (Amend)

(A) Direct payment to a health care provider or other person by the industrial commission, self-insuring employer, bureau of workers' compensation, or their agent, for medical care rendered to a claimant does not imply or create a legal relationship between the provider or person and the commission, self-insuring employer, bureau, or their agent.

Comment [nj1167]: Language added from OAC 4123-7-30, which is being rescinded.

Comment [nj1168]: Language added from OAC 4123-7-30, which is being rescinded.

(B) The services rendered to the claimant are the legal obligation of the claimant. The direct payment to the health care provider is a discretionary method by which the award made to the claimant for medical expenses may be discharged.

(C) Except as prohibited by division (K) of section 4121.44 of the Revised Code and rule 4123-6-07 of the Administrative Code, ~~whether when~~ payment is made to the claimant, ~~or the claimant's obligation is discharged by a direct payment to the health care provider through payment to the MCO or QHP,~~ the sole legal recourse of the health care provider is against the claimant.

Comment [tam169]: Language modified for clarification.

Promulgated Under: 119.03
Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 2/12/97; 1/1/99; 2/14/05

4123-6-42 Payment Interest on late payments for equipment, materials, goods, supplies or services and interest incurred in state insurance fund, public work relief employees' compensation fund, coal workers' pneumoconiosis fund, and marine industry fund claims. (Amend)

(A) Payment is made for equipment, materials, goods, supplies, or services incurred by the claimant in connection with claims against ~~the state insurance fund, public work relief employees' compensation fund, coal workers' pneumoconiosis fund, or marine industry fund based on~~ in accordance with section 126.30 of the Revised Code. For the purpose of this rule, the required payment date is the date on which payment is due under the terms of a written agreement between the bureau, or its agent, and the provider. Payment will be made either thirty days after the bureau, or its agent, receives a proper invoice for the amount of the payment due, or thirty days after the final adjudication allowing payment of an award to the claimant, whichever is later.

Comment [a170]: Language added to clarify which funds are responsible for paying interest on late provider payments.

(1) A "proper invoice" includes but is not limited to the claimant's name, claim number, date of injury or occupational disease, employer's name, provider's name and address and assigned payee number, a description of the service provided, the procedure code for the service provided, the date provided, and the amount of the charge. If more than one item has been included in the invoice, each item is to be considered separately to determine if it is a proper invoice.

(2) If the bureau or its agent determines that an invoice is improper, the bureau or its agent shall send notification to the provider through the MCO or QHP at least fifteen days prior to what would be the required payment date if the invoice did not contain an error. The notice shall describe the error and the additional information needed to correct the error. The required payment date shall be redetermined upon receipt of a proper invoice.

(3) If an invoice is for payment of either a condition not allowed in a claim, or for a claim that is not allowed, the payment date is thirty days after final adjudication of allowance of the condition or claim. As defined in section 126.30 of the Revised Code, "final adjudication" is the date that the decision of the bureau, industrial commission, or court becomes final, with no further right of appeal. If any section of the Revised Code contains a faster timetable for payments, however, such provisions shall not be superseded by this rule.

(B) Interest shall be paid based on division (E) of section 126.30 of the Revised Code. Any interest charges payable under section 126.30 of the Revised Code are to be paid by the bureau of workers' compensation.

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

4123-6-43 Payment for transcutaneous electrical nerve stimulators and neuromuscular electrical stimulators. (Amend)

(A) Payment will be approved for a transcutaneous electric nerve stimulator (TENS) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in this rule and in the bureau's provider billing and reimbursement manual.

(1) ~~Prior authorization may be is required to have a prescribed transcutaneous electrical nerve stimulator for (TENS) unit units and supplies furnished to the claimant. Each claimant who requires a TENS unit will Claimants shall be provided only one TENS unit at a time. For each TENS unit request approved, the unit may shall be rented for a thirty day trial period lasting a minimum of one month but no more than four months before purchase of the TENS unit. This trial period is to evaluate the medical necessity and effectiveness of the TENS treatment. TENS treatment will be discontinued at the end of the thirty day trial period month where the treatment has not proven to be medically necessary or effective. Reimbursement of rental costs will be considered only for the trial period that the TENS unit was actually used before treatment was discontinued. For each TENS unit provided, payment shall be limited to necessary disposable or rechargeable batteries, but not both.~~

Comment [nj1171]: Language incorporated from OAC 4123-7-34, which is being rescinded.

(2) ~~If the rental of the TENS unit is required prior to purchase, all BWC shall apply all rental payments previously made will be applied to the purchase price of the TENS unit. A TENS unit purchased and furnished to the claimant, is not the personal property of the claimant, but remains the property of the bureau, or self-insuring employer, or their agent. At its discretion, the The bureau, or self-insuring employer, or their agent, reserves the right to reclaim and recover the TENS unit from the claimant at the completion of the course of TENS treatment. Once a TENS unit is purchased, of the bureau, or self-insuring employer, or their agent, will reimburse for repair or replacement of the unit, at its discretion, upon submission of a request from the physician of record. The request must include or treating provider that includes medical documentation substantiating the continued medical necessity and effectiveness of the unit.~~

(B) ~~Claimants who have TENS units must complete and submit to the TENS provider a monthly written request for specific supplies needed in the following month. The written request must be initiated and signed by the claimant, and must be received by the TENS provider prior to the delivery of supplies and/or equipment. The TENS provider shall then deliver the supplies and bill the bureau, MCO, QHP, or self-insuring employer after the claimant's written request is received. The provider shall retain the original written request for supplies in accordance with the time frames set forth in rule 4123-6-45.1 of the Administrative Code. The bill must indicate the actual date of service, reflecting the date that services or supplies were provided. The bureau, MCO, QHP, or self-insuring employer may adjust bills upon audit if the audit discloses the provider's failure to comply with this rule.~~

Comment [nj1172]: Language incorporated from OAC 4123-7-34, which is being rescinded, and language added to provide clarification on requirements for providers as to the provision and billing for supplies necessary for TENS units

(C) The TENS provider shall maintain the following records and make them available for audit upon request:

- (1) The injured worker's monthly written requests;
- (2) Records of the provider's wholesale purchase of TENS supplies or equipment; and,
- (3) Records of delivery of supplies to injured workers and of the delivery or return of TENS units.

Upon request, the provider shall supply copies of the record information to the requester at no cost. Failure to provide the requested records ~~will~~ may result in denial or adjustment of bills related to these records.

~~(C)~~(D) Payment will be approved for a neuromuscular electrical stimulator (NMNSNMES) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in the bureau's provider billing and reimbursement manual.

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: 2/12/97

4123-6-44 Bureau fees for practitioner provider services rendered by in-state and out-of-state practitioners providers (Amend)

Bureau fees for in-state or out-of-state practitioners providers will be established by the administrator of workers' compensation with the assistance of the bureau's medical management and cost containment division. The bureau may establish different fees for in-state and out-of-state practitioners providers. The methods of payment may include rates based on resource based relative value scale (RBRVS), percent of allowed charges, or usual, customary and reasonable fee maximas, as determined by the bureau's medical management and cost containment division. Rates will be reviewed at least annually by the bureau to determine the need for appropriate adjustment.

Payment for practitioner provider services will be made based on rules 4123-6-11 and 4123-6-12 in accordance with rule 4123-6-10 of the Administrative Code.

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

Comment [a173]: Title of rule changed from 1st reading to change both "provider" references to "practitioner" for consistency.

Comment [a174]: Language was modified to include entities other than licensed individuals- example would be ambulance providers.

Comment [a175]: Rules OAC 4123-6-11 and OAC 4123-6-12 are being combined into OAC 4123-6-10.

4123-6-45 Audit of providers' patient and billing related records. (No Change)

(A) Providers' patient and billing related records, including but not limited to those records described in rule 4123-6-451 of the Administrative Code, may be reviewed by the bureau or the MCO to ensure workers are receiving proper and necessary medical care, and to ensure compliance with the bureau's statutes, rules, policies, and procedures.

(1) Based on division (B)(16)(c) of section 4121.121 of the Revised Code, provider records may be reviewed before, during, or after the delivery of services. Reviews may be random, with no unreasonable infringement of provider rights, or may be for cause. Reviews may include the utilization of statistical sampling methodologies and projections based upon sample findings. Records reviews may be conducted at or away from the provider's place of business.

(2) Based on division (B)(17) of section 4121.121 of the Revised Code, legible copies of providers' records may be requested. Providers shall furnish copies of the requested records within thirty calendar days of receipt of the request. The bureau shall establish a schedule for payment of reasonable costs for copying records, which shall be published in the health care provider billing and reimbursement manual.

(3) Original records shall not be removed from the provider's premises, except upon court order or subpoena issued by the bureau pursuant to section 4121.15 or 4123.08 of the Revised Code.

(B) Upon any finding of improper or unnecessary medical care, the administrator shall, if requested by the provider, appoint a subcommittee of the stakeholders' health care quality assurance advisory committee to review and advise the administrator as provided in paragraph (K) of rule 4123-6-22 of the Administrative Code. The administrator may sanction, suspend, or exclude a health care provider from participation in the workers' compensation system based on rule 4123-6-17 of the Administrative Code.

(C) The bureau or the MCO may deny payment for services or declare as overpaid previous payments to providers who fail to provide records or access to records to either the bureau or the MCO. The bureau may decertify a health care provider that fails to provide records requested pursuant to Chapters 2913., 4121., and 4123. of the Revised Code.

Promulgated Under: 119.03
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 2/12/97, 1/15/99

4123-6-45.1 Records to be retained by provider. (No Change)

(A) A health care provider shall create, maintain, and retain sufficient records, papers, books, and documents in such form to fully substantiate the delivery, value, necessity, and appropriateness of goods and services provided to injured workers under the HPP or of significant business transactions. The provider shall retain such records for a minimum period of three years from the date of payment for said goods or services, or three years from the date of referral to a certified or non-certified provider, or until any initiated audit or investigation is completed, whichever is longer. The provider shall create and maintain the records at the time the goods or services are delivered or within seven days from the date the service was rendered.

(B) The provider shall retain records documenting the following minimum information concerning the goods or services provided to injured workers:

- (1) Date the service was provided;
 - (2) Description of service, treatment or product provided;
 - (3) Record of patient appointments, if appropriate;
 - (4) Dates where injured worker canceled or failed to appear for a scheduled examination, treatment, or procedure;
 - (5) Treatment plans;
 - (6) Subjective and objective complaints, if the provider is the practitioner or physician of record;
 - (7) Injured worker's progress, if the provider is the practitioner or physician of record;
 - (8) Wholesale purchase records, if goods, products, or prescriptions are delivered;
 - (9) Delivery records, if goods, products, or prescriptions are delivered by way of a third party;
 - (10) The identity and qualifications of any individual involved in the delivery of health care or billing for services to injured workers on behalf of the provider billing for the services.
- (C) A provider's failure to create, maintain, and retain such records shall be sufficient cause for the bureau to deny payment for goods or services, to declare overpaid previous payments made to the provider, or to decertify the provider.

Promulgated Under: 119.03
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 1/15/99

**4123-6-46 Standardized or negotiated payment rates for services or supplies.
(Amend)**

(A) The bureau or self-insuring employer may negotiate payment rates with health care providers for services and supplies provided in the treatment of workers' compensation claims.

(B) ~~Volume-based contracts~~ The bureau or self-insuring employer may be made enter into volume-based contracts with medical providers for services including, but not limited to, the purchase or rental of durable medical equipment and supplies.

(C) ~~Injured workers~~ The bureau or self-insuring employer may be informed inform injured workers of the availability of services, supplies, or equipment from particular health care providers with whom a contract for services or supplies, a negotiated a payment rate for services or supplies, or a contract for cost-effective payment levels or rates has been ~~made entered into, so long as. In each case,~~ access to quality and convenient medical services or supplies must be for injured workers is maintained for claimants.

Promulgated Under: 119.03
Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.651, 4123.66
Prior Effective Dates: 2/12/97; 2/14/05

Comment [a176]: Language rewritten to active voice for clarification and references to self-insuring employer added, as rule OAC 4123-7-39 is being rescinded.

4123-6-50 Self-insured employer participation in the QHP system; reporting requirements for non-participating employers. (Rescind)

All self-insured employers that do not participate in the QHP system shall comply with the reporting requirements for participating self-insured employers set forth in rule 4123-6-70 of the Administrative Code. Data collected and stored by the bureau in furtherance of the provisions of this rule and rule 4123-6-70 of the Administrative Code shall be in accordance with section 4123.27 of the Revised Code, paragraph (A) of rule 4121-15-03 of the Administrative Code, and paragraph (A) of rule 4123-15-03 of the Administrative Code for the purpose of ensuring confidentiality and avoiding the appearance of impropriety.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a177]: SI employer reporting of the type discussed by this rule is no longer required per statutory amendments enacted by Senate Bill 7 (SB7).

4123-6-51 Employer participation in the QHP system - bureau certification of QHPs. (Amend)

(A) A health plan that satisfies the QHP certification requirements of this chapter shall be certified by the bureau as a QHP to manage medical treatment, direct care or provide services or supplies to or on behalf of an employee for an injury or occupational disease that is compensable under Chapter 4121., 4123., or 4131. of the Revised Code.

(B) An employer may establish a bureau certified QHP, that shall comply with the thirteen standards set forth in divisions ~~(D)(1) to (D)(13)~~ (A)(1) to (A)(13) of section 4121.442 of the Revised Code, ~~Division~~ division (K) of section 4121.44 of the Revised Code, and rules 4123-6-53 and 4123-6-54 of the Administrative Code.

(C) QHP certification by the bureau shall be for a period of three years.

(D) The bureau, at least annually, shall develop and make available information that describes employer and employee rights under QHP.

(E) The bureau shall continue to certify health plans and shall periodically, at least annually, update its list of certified QHPS.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66
Prior Effective Dates: 9/5/96

Comment [a178]: Amended to update Revised Code citation.

Comment [a179]: This language was moved from OAC 4123-6-52, which is being rescinded.

Comment [a180]: This language was moved from OAC 4123-6-73, which is being rescinded.

Comment [a181]: This language was moved from OAC 4123-6-52(B), as OAC 4123-6-52 is being rescinded.

4123-6-52 Employer participation in the QHP system - initial QHP certification enrollment period established; length of certification period. (Rescind)

(A) The bureau shall establish an initial QHP certification enrollment period upon inception of the QHP system to allow health plans to seek certification for participation in the QHP system.

(B) After the initial QHP certification enrollment period upon inception of the QHP system, the bureau shall continue to certify health plans and shall periodically, at least annually, update its list of certified QHPS.

(C) QHP certification by the bureau shall be for a period of three years.

Comment [a182]: This language is no longer necessary, as the initial enrollment period for QHPs has long since passed.

Comment [a183]: This language was moved to OAC 4123-6-51.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66
Prior Effective Dates: 9/5/96

4123-6-53 Employer participation in the QHP system - QHP quality assurance program required. (No Change)

(A) Each QHP shall have a quality assurance program that monitors the operation and measures the effectiveness of peer review, utilization review, and dispute resolution within the QHP. Data collected from the quality assurance program shall be used to assist an employer in determining the quality, efficiency and effectiveness of the employer's QHP and the QHP system in accordance with division (D) of section 4121.442 of the Revised Code.

(B) Each quality assurance program shall include a mechanism for monitoring and the methodology for measuring and improving the QHP's compliance with each of the following eleven elements:

- (1) Peer review and evaluation of clinical performance;
- (2) Credentialing and recredentialing and use of provider profiling;
- (3) Utilization management to determine the appropriateness of care;
- (4) Evaluation of employee and provider dispute resolution procedures and outcomes;
- (5) Evaluation of outcomes of care based on clinical data;
- (6) Procedures for remedial action for inappropriate or substandard services;
- (7) Evaluation of employee satisfaction with the plan;
- (8) Evaluation of provider satisfaction with the plan;
- (9) Evaluation of employer satisfaction with the plan;
- (10) Periodic evaluation of medical records and office procedures; and
- (11) Practice patterns compared to accepted medical criteria.

(C) The quality assurance program shall include a quality assurance committee or other mechanism adequate to evaluate the outcomes of each of the eleven elements listed in paragraph (B) of this rule.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66
Prior Effective Dates: 9/5/96

4123-6-54 Employer participation in the QHP system - QHP certification application. (No Change)

(A) Upon request by an employer or health plan seeking certification, the bureau shall mail the employer or health plan seeking certification a QHP application for certification.

(B) The QHP application for certification shall include a list of bureau certified providers.

(C) The QHP application for certification shall include, at a minimum, the following provisions, as more fully detailed within the QHP certification application itself:

(1) A statement that the application is without misrepresentation, misstatement, or omission of a relevant fact or other acts involving dishonesty, fraud, or deceit;

(2) Proof that a self-insured employer has been granted status as a self-insured employer in accordance with section 4123.35 of the Revised Code;

(3) A description of the geographic or regional area of the state of Ohio to be serviced by the QHP, taking into account the unique circumstances of the individual employer, such as multiple locations, and/or the need for a statewide network;

(4) A description of the role of each vendor that will be a component of the QHP including, but not limited to, the following: if an employer uses or anticipates using company-based providers, a description of the role of company-based providers as distinguished from QHP network providers; if an employer uses or anticipates using a third party administrator, a description of the role of the third party administrator;

(5) If an employer contemplates contracting with a vendor that has been certified by the bureau under Chapter 4123-6 of the Administrative Code to provide services under the employer's QHP, proof that certification has been granted by the bureau and that such certification is current;

(6) A description of the structure of the medical management component and the health care provider network to be offered by the QHP;

(7) A description of the QHP's plan and methodology for providing, at least annually, QHP network provider information, by provider type, and updated QHP network provider directories to employees;

(8) A description of the QHP's quality assurance program, including but not limited to, the proposed structure and operation and a description of the mechanism for monitoring and the methodology for measuring and improving the QHP's compliance with the elements listed in paragraph (B) of rule 4123-6-53 of the Administrative Code;

(9) A description of the QHP's employee education program. The description shall include but shall not be limited to: a description of the process to be used to educate employees regarding their rights and responsibilities in the QHP system; a description of the process to be used to explain the time, place and manner of services to be delivered under the QHP; and a description of the process to be used to explain options available to injured workers, including the process for changing providers within the QHP and referral and transfer to the HPP; and

(10) A description of the plan satisfactory to the bureau to be implemented by the QHP in the event a final order to revoke certification, or to refuse to recertify a QHP is issued by the administrator, pursuant to rule 4123-6-55 of the Administrative Code, that includes, but is not limited to, a plan that describes continuation and continuity of care of injured workers; a plan that describes payment of providers for medical services rendered prior to revocation of certification or refusal to certify. The injured worker may continue receiving medical services from the same provider or may choose a provider in a new approved plan for delivery of medical services, both of whom shall accept medical management of the medical services through the employer's new approved plan.

(D) The bureau shall review the application for certification submitted by the health plan seeking certification. The bureau reserves the right to cross-check data with other governmental agencies or licensing or accrediting bodies.

(E) The bureau shall hold as confidential and proprietary the vendor's descriptions of process, methodology, policies, procedures and systems as required for the application for certification.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

4123-6-55 Employer participation in the QHP system - bureau's authority to ~~revoke certification~~ decertify, to refuse to certify or recertify a QHP. (Amend)

(A) The bureau is authorized to ~~revoke certification~~ decertify, to refuse to certify or recertify a QHP from participation in the QHP system.

(B) Should the bureau determine that sufficient evidence exists that an employer or QHP has failed to comply with applicable workers' compensation statutes or rules governing QHPs, the bureau, shall take one of two courses of action:

(1) The bureau shall notify the employer, employee representative and QHP in writing by certified mail of the facts and issues relating to the bureau's determination that the employer or QHP has failed to comply with applicable workers' compensation statutes or rules governing QHPs. Such notice shall and has set forth a period of time for the employer or QHP to resolve or correct the problem. Failure of the employer or QHP to resolve or correct the problem within the time period shall result in notification from the bureau to the employer and QHP in writing by certified mail of administrative action that might result in a bureau determination to revoke certification, refusal to certify or recertify, and the employer's and QHP's right to a hearing within thirty days of the notice, if requested by the employer or QHP, pursuant to rule 4123-6-17 of the Administrative Code.

(2) Notify the employer, employee representative and QHP in writing by certified mail of administrative action that might result in a bureau determination to revoke certification, refusal to certify or recertify, and the employer's and QHP's right to a hearing within thirty days of the notice, if requested by the employer or QHP, pursuant to rule 4123-6-17 of the Administrative Code.

(3) For the purpose of this rule, "employee representative" does not include the employee's attorney.

(C) Notwithstanding paragraph (B) of this rule, in any case where the Administrator finds a serious danger to the public health and safety and sets forth specific reasons for such findings, the administrator may immediately revoke or suspend, ~~or provisionally revoke or suspend~~, the certification of a QHP. The order shall be final unless the employer or QHP, within seven days of such order, requests a hearing before the administrator where the employer or QHP shall show cause why the order should not be final. The order of the administrator shall remain in force during the pendency of the show cause hearing.

(D) Upon a final order of the administrator to ~~revoke certification of~~ decertify, refuse to recertify, or revoke or suspend the certification of a QHP, employees and employers shall not receive services from such QHP pursuant to the QHP system.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66
Prior Effective Dates: 9/5/96

Comment [a184]: References to notification of the "employee representative" have been restored from 1st reading.

Comment [a185]: BWC does not provisionally revoke or suspend certification of QHPs.

**4123-6-56 Employee access to the QHP system- choice and change of provider.
(Rescind)**

Comment [a186]: This language will be combined into choice of provider rule OAC 4123-6-06.2.

(A) An employee of an employer that participates in a QHP has freedom of choice of providers within the QHP network of providers established by the employer's QHP. In all claims that precede the establishment of the employer's QHP, and where the employee's physician of record is not a provider on a panel of the QHP when established, the employee may continue treatment with that physician of record. The physician of record shall be subject to and participate in the dispute resolution process as provided in rule 4123-6-69 of the Administrative Code. After the establishment of the QHP, the employer's QHP shall manage the medical care and treatment in the claim. If an injured worker changes from the physician of record who is not in the QHP for any reason, the employee shall select a QHP panel provider as the physician of record.

(B) An employee of an employer that participates in a QHP, who is dissatisfied with the health care services of a provider in the QHP, after written notice to the QHP, may change providers and select another provider of the employee's choice within the QHP. An employee's notice for change of provider within a QHP does not require notification to the bureau. To provide the employer's QHP with data necessary for QHP tracking of employee choice of provider and to provide the bureau with data necessary for recertification of providers, an employee's notice for a change of provider within a QHP shall be in a writing that contains the reasons therefore.

(C) An employee who first has chosen and received health care services from a provider in the employer's QHP, but is dissatisfied with the health care services provided by the employer's QHP, may request and shall be granted a change of provider to a bureau certified provider. An employee's notice for a change of provider to a bureau certified provider in the HPP shall be in a writing to both the employer's QHP and to the administrator of the bureau.

(1) The bureau shall provide all QHPs with a list of bureau certified providers in the employees' area. The QHP shall provide an employee with a list of bureau certified providers upon request. The bureau shall provide an employee, upon request to the bureau, with a list of bureau certified providers within the employee's area.

(2) An employee who first has chosen and received health care services from a provider in the employer's QHP, and who has requested and has been granted a change of provider to a bureau certified provider in the HPP, shall submit a written request to the QHP medically managing the treatment and shall be granted approval to change providers within the HPP. An employee's request for change of provider within the HPP does not require notification to the bureau of the request. An employee who has requested and has been granted a change of provider from an employer's QHP to a bureau certified provider in the HPP shall be permitted to return to the employer's QHP at any time for health care services.

(3) Notwithstanding the provisions contained in paragraph (C)(2) of this rule, an employee who incurs a new medical condition, injury or claim requiring medical treatment, not related to a prior medical condition, injury or claim, shall first seek treatment from a provider on the panel of the injured worker's employer's QHP.

(4) To provide the employer's QHP with data necessary for QHP tracking of employee choice of provider and to provide the bureau with data necessary for recertification of providers, an employee's request for a change of provider from a QHP to a bureau certified provider in the HPP, or a change of provider within the HPP, shall state a reason for the request.

(D) Medical management of all injured workers' claims, whether medical services are provided within or without the QHP network of providers, shall be provided by the employer's QHP.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

4123-6-57 Provider access to the QHP system - generally. (Rescind)

(A) A provider who participates in the QHP system shall be certified by the bureau, pursuant to rules 4123-6-02 to 4123-6-025 of the Administrative Code, and credentialed by the QHP.

(B) Notwithstanding rule 4123-6-02 of the Administrative Code, a provider who is an employee or an independent contractor of an employer that participates in the QHP shall have the provider's credentials reviewed and the bureau shall verify that the provider's credentials meet bureau standards. Such provider may sign a provider agreement set forth in rule 4123-6-02 of the Administrative Code.

(C) A provider who meets the certification requirements as set forth in the administrative code relating to the certification of providers under the HPP, and is certified as a provider eligible to participate in the HPP, shall be eligible to participate in and to treat injured workers under the QHP system.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a187]: This rule is unnecessary. The requirement that BWC certified providers participate in the QHP will be governed by choice of provider rule OAC 4123-6-06.2.

4123-6-58 Provider access to the QHP system - provider participation in QHP system and other related health care program not linked. (Amend)

A QHP or vendor that provides medical management and cost containment services shall not require a provider to participate in a workers' compensation network of providers in order to maintain membership in a related health care program. If the QHP utilizes a leased provider network, the QHP shall not apply the discounted payment rates of the leased network to services rendered by the provider in the QHP unless the signed, written consent of the provider has been obtained.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a188]: This mirrors a similar requirement in the MCO contract for provider networks leased by the MCOs.

4123-6-59 Provider access to the QHP system - QHP provider selection. (Amend)

~~(A)~~ The bureau shall maintain a public list of bureau certified providers. The bureau shall make the list of bureau certified providers available to a requesting party at cost.

Comment [a189]: This language is duplicative of language in OAC 4123-6-02.6(A).

~~(B)~~ An employer that develops a QHP, a vendor within the QHP system, or a QHP shall develop and implement standards of credentialing of providers in the QHP network that meet but may exceed the bureau credentialing requirements in the HPP.

~~(C)~~ ~~(B)~~ An employer that develops a QHP may selectively contract with providers or contract with a vendor that selectively contracts with providers.

~~(D)~~ ~~(C)~~ Only a bureau certified provider is eligible for selection by an employer that develops a QHP, by a QHP as a QHP panel provider or by a vendor as a panel provider to participate in the QHP system. A provider identified by a QHP for inclusion in its panel of providers that is not a bureau certified provider may be assisted by the QHP in applying for bureau provider credentialing and certification.

~~(E)~~ ~~(D)~~ The bureau, an employer, a QHP or a vendor shall not discriminate against any category of health care provider when establishing categories of providers for participation in the QHP system. However, an employer, a QHP or a vendor is not required to accept or retain any individual provider in the QHP system.

~~(F)~~ ~~(E)~~ The bureau, an employer, a QHP and a vendor shall comply with state and federal laws prohibiting discrimination based on, but not limited to, race, national origin, or color, and shall not discriminate against any health care provider when establishing categories of providers for participation in the QHP system on the basis of race, religion, national origin, color, gender, sexual orientation or age.

~~(G)~~ ~~(F)~~ A QHP shall include in its panel a substantial number of the medical, professional, and pharmacy providers currently being utilized by employees. A QHP may limit the number of providers on its provider panel, but shall do so based upon objective data that demonstrates that the fundamental needs of the employer and employees are met based on reasonable standards such as historical claims data or other geographic information approved by the bureau. In addition, a QHP shall include in its application for QHP certification information including reasonable patient access, the potential number of employees the QHP is applying to service, and other performance criteria, without discrimination by provider type. Subject to the provisions of rules 4123-6-67 and 4123-6-68 of the Administrative Code, a QHP seeking QHP certification may select out-of-state providers as members of the QHP panel.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

4123-6-60 Provider access to the QHP system - medical record keeping. (Rescind)

(A) Providers who treat injured workers who originate in the QHP system shall develop and/or maintain a system that accomplishes efficient transfer of copies of injured workers' medical records among providers when the following occurs:

- (1) An employee changes provider within or without the employer's QHP network;
- (2) An employer terminates a QHP, or
- (3) An employer transfers to another QHP or the HPP.

(B) Release or transfer of injured workers' medical records shall be in accordance with section 4123.651 of the Revised Code and rule 4121-17-30 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a190]: This rule is unnecessary. Providers' requirements for providing medical records in the workers' compensation system are governed by rules OAC 4123-6-20 and OAC 4123-6-21.

**4123-6-61 Payment in the QHP system - employer responsibility - generally.
(Rescind)**

An employer utilizing a QHP is responsible for payment of all goods and services that are medically necessary and appropriate for allowed condition(s) in claims for injured workers under a QHP. Within each QHP, all payments shall be in accordance with consistent billing and payment policies and practices established by the QHP and consistent with the provisions contained in paragraph (L)(5) of rule 4123-19-03 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a191]: This rule is unnecessary. Billing and payment procedures for SI employers, with or without a QHP, are governed by OAC 4123-19-03(K)(5).

4123-6-62 Payment in the QHP system - balance billing prohibited. (Rescind)

(A) No health care provider shall charge, assess, or otherwise attempt to collect from an employee any amount for covered services or supplies that is in excess of the amount reimbursed by the employer, a vendor, or a QHP.

(B) An employer or QHP shall hold an employee harmless for all balanced billing from providers who are members of the employer's QHP panel or who have signed a provider agreement with a QHP and/or employer.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a192]: This rule is unnecessary. Rule OAC 4123-6-07 already prohibits providers from balance billing for services paid by a QHP.

4123-6-63 Payment in the QHP system - application of bureau fee schedule in the QHP system. (Rescind)

(A) With the exception of the restrictions recited in rule 4123-6-65 of the Administrative Code, and with the exception that no financial arrangement between an employer or QHP and a provider shall reduce the quality of medical care received by an injured worker, an employer or QHP may pay a provider a rate that is the same, is above or is below the rates set forth in the provider fee schedule developed by the bureau pursuant to division (A)(8) of section 4121.441 of the Revised Code, and nothing in the rules pertaining to the QHP system shall be construed to inhibit employers or QHPs and providers in their efforts to privately negotiate a payment rate.

(B) An employee, dissatisfied with the medical services provided by the employer's QHP, may request and shall be granted a change of provider as provided in rule 4123-6-56 of the Administrative Code. The employee's health care shall be managed by the QHP. In such event, the provider shall be reimbursed by the employer or QHP the lessor of the bureau fee schedule or the billed charges by the provider for services rendered, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider.

(C) Employers' financial arrangements with company-based providers remain intact, and services provided by company-based providers need not be billed separately through QHP arrangements.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66
Prior Effective Dates: 9/5/96

Comment [a193]: This language will be combined into provider payment rule OAC 4123-6-10.

4123-6-64 Payment in the QHP system - vendor payment to providers. (Rescind)

A vendor retained by an employer shall not benefit financially from the difference between the fee schedule negotiated with the provider and the rate paid to the provider by the employer.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a194]: This rule is duplicative in intent to rule OAC 4123-6-65, and is being rescinded.

4123-6-65 Payment in the QHP system - employer payment to vendor that provides medical management and cost containment services and/or QHPs. (No Change)

The bureau shall not interfere with nor impose restrictions upon an arrangement for payment negotiated between an employer and a vendor that provides medical management and cost containment services and/or a QHP under the QHP system, except that no financial arrangement between an employer and a vendor that provides medical management and cost containment services and/or a QHP shall incentivize a reduction in the quality of medical care received by an injured worker.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

4123-6-66 Payment in the QHP system - authorization and payment for initial emergency medical treatment. (Rescind)

(A) An employer in the QHP system shall authorize and pay for initial emergency medical treatment for an injury or occupational disease that is an allowed claim or condition provided by a health care provider who is not part of the employer's QHP in accordance with the provisions and limitations contained in this rule.

(B) The employer shall pay a health care provider who is not part of the employer's QHP only for initial-emergency treatment of an employee for a workers compensation injury. The health care provider who is not part of the employer's QHP shall inform the employee upon the initial emergency treatment that the provider is not a participant in the QHP and that the provider will not be paid nor will the employee be reimbursed by the QHP or employer for the cost of further treatment after the initial emergency treatment, unless authorized otherwise by the employer or QHP.

(C) Subsequent emergency medical treatment by a provider who is not part of the employer's QHP for the same injury or occupational disease shall be reviewed by the QHP unless payment is otherwise authorized by the QHP. The employee may continue to obtain treatment from the health care provider who is not part of the employer's QHP, but the payment for the treatment shall be the employee's sole responsibility, except as provided above.

(D) A provider that provides initial emergency medical treatment or subsequent emergency medical treatment for the same injury or occupational disease authorized by the QHP shall be paid in accordance with the rates established in Ohio workers' compensation fee schedule or the provider's billed charges, whichever is less unless an alternate payment arrangement is negotiated between an employer or QHP and a provider.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66
Prior Effective Dates: 9/5/96

Comment [a195]: This language will be combined into provider payment rule OAC 4123-6-10.

4123-6-67 Payment in the QHP system - payment to providers in states that border Ohio. (Rescind)

(A) Out-of-state providers that are certified by the bureau in states that border Ohio shall accept and be paid as payment in full in accordance with the Ohio workers' compensation state fee schedule or the amount billed, whichever is less, unless an alternate provider agreement exists between provider, and employer and/or the QHP. No health care provider shall charge, assess, or otherwise attempt to collect from an employee, employer, a vendor, or a QHP, any amount for covered services or supplies that is in excess of the amount reimbursed by the employer, a vendor, or a QHP.

(B) An employer or QHP shall hold an employee harmless for all balanced billing from out-of-state providers in states that border Ohio and who are a member of a QHP panel or who have signed a provider agreement with a QHP and/or employer.

(C) Payment to out-of-state providers in states that border Ohio who are not certified by the bureau, in the absence of a provider agreement with an employer and/or QHP, shall be the sole responsibility of the employee unless otherwise authorized by the employer or QHP.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66
Prior Effective Dates: 9/5/96

Comment [a196]: Payment to providers both in state and out-of-state will be governed by provider payment rule OAC 4123-6-10.

4123-6-68 Providers in states that do not border Ohio - QHP freedom to negotiate; restriction on provider charges to employee. (Rescind)

(A) A QHP may negotiate all issues with providers in states that do not border Ohio.

(B) Paragraph (A) of this rule notwithstanding, no provider in a state that does not border Ohio shall charge, assess, or otherwise attempt to collect from an employee with an Ohio claim who works in Ohio but who resides in another state any amount for covered services or supplies that is in excess of the amount reimbursed by the employer, a vendor, or a QHP.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a197]: Payment to providers both in state and out-of-state will be governed by provider payment rule OAC 4123-6-10.

Comment [a198]: This language is unnecessary. Rule OAC 4123-6-07 already prohibits providers from balance billing for services paid by a QHP.

4123-6-69 QHP dispute resolution process. (No Change)

(A) This rule shall provide time frames and procedures for review of requests for the delivery of medical services and for the resolution of disputes that may arise between an employee and an employer, an employee and a provider, or an employer and a provider. This rule applies to, but is not limited to, reviews of records, medical disputes arising over issues such as, but not limited to, quality assurance, utilization review, a determination that a service provided to an employee is not covered, is covered or is medically unnecessary; or disputes involving individual health care providers.

(B) Initial review and decision upon requests for the delivery of medical services that include, but are not limited to, medical treatment, major diagnostic testing, hospitalization, surgery and physical therapy, shall be completed by the QHP. The employee, employer and provider shall be notified verbally of the outcome of the initial review within forty-eight hours of the request. Within seven working days of the verbal notification, the verbal notification shall be committed to writing and mailed to the employee, employer and provider.

(C) A QHP shall have a dispute resolution process beyond initial review that includes a minimum of two levels of peer review of a medical diagnosis or treatment issue if an individual health care provider is involved in the dispute, or a minimum of two levels of dispute resolution if an individual health care provider is not involved in the dispute.

(D) A QHP dispute resolution process shall be completed and the QHP shall notify the parties to the dispute and their initial written notice of a dispute, unless an extension of time is otherwise agreed to by the parties. Any party appealing a decision to a higher level within a QHP's dispute resolution process shall provide notice of such appeal to all the parties to the dispute within seven working days of notice of decision.

(E) The dispute resolution process shall begin upon written notice of the dispute by the party maintaining the dispute to the parties of the dispute. If an individual health care provider is involved in the dispute, there shall be available at least two levels of peer review if appealed, with at least one level conducted by an individual or individuals licensed pursuant to the same section of the revised code as the health care provider who is a party to the dispute. The other level of peer review shall include, at the discretion of the QHP medical director, one or more of the following: a review conducted by a multi-disciplinary medical panel or board; an independent or agreed upon medical examination; or the use of other resources beneficial to the resolution of the dispute.

(F) A dispute unresolved by a QHP dispute resolution process may be appealed to the industrial commission pursuant to section 4123.511 of the Revised Code. Parties to a dispute shall exhaust the dispute resolution procedures of this rule prior to filing an appeal under section 4123.511 of the Revised Code.

(G) Notwithstanding the requirements set forth in paragraph (F) of this rule, a dispute unresolved by a QHP providing medical management and cost containment services for a state fund employer shall be referred by the QHP to the bureau within seven working days of the final decision rendered within the QHP dispute resolution process. Within fourteen days of receipt of an unresolved medical dispute, the

bureau shall conduct an independent review of the unresolved medical dispute received from the QHP and enter a final bureau order pursuant to section 4123.511 of the Revised Code. This order shall be mailed to all parties and may be appealed to the industrial commission pursuant to section 4123.511 of the Revised Code. Parties to a dispute shall exhaust the dispute resolution procedures of this rule prior to filing an appeal under section 4123.511 of the Revised Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

4123-6-70 Evaluation of the QHP system by the bureau; reporting requirements by employers and QHPs. (Amend)

(A) To enhance the quality of the QHP system, and pursuant to division (G) of section 4121.44 of the Revised Code, divisions (D)(9) and (G) (A)(9) of section 4121.442 of the Revised Code, and division (D)(2)(d) of section 4121.125 of the Revised Code, the deputy administrator for the division of medical management and cost containment shall require employers and QHPs that participate in the workers' compensation QHP system to report data to be used by the administrator to:

Comment [a199]: Amended to remove and update outdated Revised Code citations.

(1) Measure measure and perform comparison analyses of costs, quality, appropriateness of medical care, and effectiveness of medical care delivered by all components of the workers compensation system; and

(2) Publish and report compiled data to the governor, the speaker of the house of representatives, and the president of the senate every six months to gauge the measures of outcomes and savings of the QHP system.

Comment [a200]: These reports are no longer required per statutory amendments enacted by Senate Bill 7 (SB7).

(B) The bureau shall evaluate the effectiveness of the QHP system based on standardized data and reporting requirements developed by the bureau.

(C) The bureau shall receive, define and publish data elements and data collection techniques that meet the thirteen standards set forth in divisions (D)(1) to (D)(13) (A)(1) to (A)(13) of section 4121.442 of the Revised Code and are necessary to evaluate the effectiveness of the QHP system. Performance indicators used by the bureau to evaluate the effectiveness of the QHP system may include, but shall not be limited to, the following: customer satisfaction; system cost drivers; improvements in quality, and cost reductions.

(D) QHPs shall submit to the bureau no more than twice per year, on standardized forms developed by the bureau, data that provide the bureau with information enabling the bureau to determine the effectiveness of the QHP system.

Comment [a201]: BWC no longer requires these reports per statutory amendments enacted by Senate Bill 7 (SB7).

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

4123-6-71 Initial report of an injury and reporting requirements by providers and employees in the QHP system. (Rescind)

(A) A provider who initially becomes aware of an employee's injury or occupational disease, at a minimum, shall notify the QHP or employer of the injury or occupational disease in a standard format no later than one working day after the date the provider becomes aware of the injury or occupational disease.

(B) Providers shall abide by current standard state workers' compensation reporting requirements for treatment of injured workers, pursuant to rule 4123-7-08 of the Administrative Code.

(C) The injured worker, when the injured worker's medical condition does not prohibit him from doing so, shall notify the QHP or employer of the injury or occupational disease as soon as possible after the date the injured worker becomes aware of the injury or occupational disease.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a202]: BWC is proposing to move the relevant language to OAC 4123-6-02.8.

4123-6-72 Confidentiality. (No Change)

Subject to the requirements and protections contained in Ohio law pertaining to release of confidential and/or privileged information, in the course of medical management in the QHP system, confidential information may be exchanged among the bureau, the QHPs, an employer and its representative, an employee and his or her representative, and the provider. All parties providing or requiring such confidential information for use in the QHP system shall not provide or use such confidential information for any purpose other than to perform duties required under the QHP system, and shall prevent such information from further disclosure or use by unauthorized persons.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

4123-6-73 Bureau requirement to develop information describing rights under the QHP system. (Rescind)

The bureau, at least annually, shall develop and make available information that describes employer and employee rights under the QHP system.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a203]: BWC is proposing to move this language to OAC 4123-6-51.

Common Sense Business Regulation (BWC Rules)

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

Chapter 4123-7 Payments to Health Care Providers

Rescission of Rules (30 rules)

Rule Review

1. The rule is needed to implement an underlying statute.
Citation: O.R.C. 4123.66(A); O.R.C. 4123.35(B)

2. The rule achieves an Ohio specific public policy goal.
What goal(s): All thirty rules in Chapter 4123-7 are being rescinded as duplicative of Chapter 4123-6 rules (as amended concurrent with this rule rescission), as the Chapter 4123-6 provider payment rules will also apply to self-insuring employers going forward.

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. The Chapter 4123-7 rules are duplicative of Chapter 4123-6 as amended; this proposed rescission will eliminate the duplication consistent with Executive Order 2008-04S and O.R.C. 119.032.

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: BWC's proposed changes to the Chapter 4123-7 provider payment rules were e-mailed to the BWC Medical Division's list of stakeholders for review on Monday, September 14, 2009 with comments due back on Friday, September 18, 2009.

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
Self-Insuring Employer Provider Payment Rules
Chapter 4123-7

Introduction

Chapter 4123-7 of the Ohio Administrative Code contains BWC rules governing provider payment by self-insuring employers. BWC enacted the bulk of the Chapter 4123-7 self-insuring employer provider payment rules in January 1978. The rules have been periodically updated as needed, and last underwent five-year rule review in 2004.

As part of the current five-year rule review process, BWC is proposing that all 30 rules in Chapter 4123-7 be rescinded, and that the Chapter 4123-6 provider payment rules going forward will apply to both State Insurance Fund (SIF) and self-insuring employer claims, whether the self-insuring employer has a Qualified Health Plan (QHP) or not.

This change is not intended to be substantive. Self-insuring employers are already required to provide medical benefits equal to or greater than those provided in SIF claims, and the current Chapter 4123-7 rules are largely duplicative of existing Chapter 4123-6 rules.

Background Law

R.C. 4123.66(A) provides that the BWC Administrator “shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper,” and that the Administrator “may adopt rules, with the advice and consent of the [BWC] board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefor.”

R.C. 4123.35(B) provides that “Employers who will abide by the rules of the [BWC] administrator and who may be of sufficient financial ability to render certain . . . the furnishing of medical, surgical, nursing, and hospital attention and services and medicines, and funeral expenses, equal to or greater than is provided for in sections 4123.52, 4123.55 to 4123.62, and 4123.64 to 4123.67 of the Revised Code . . . [may be] granted status as a self-insuring employer.”

Proposed Changes

As stated above, BWC is proposing that all 30 rules in Chapter 4123-7 be rescinded, and that the Chapter 4123-6 provider payment rules going forward will apply to both State Insurance Fund (SIF) and self-insuring employer claims, whether the self-insuring employer has a Qualified Health Plan (QHP) or not.

Where existing Chapter 4123-6 rules do not adequately cover an item covered by a Chapter 4123-7 rule, BWC is proposing to either add language to an existing Chapter 4123-6 rule or create a new Chapter 4123-6 rule. This is further explained in the Chapter 4123-7 “crosswalk” document and matrix included with these materials, and in the comments to the Chapter 4123-7 (and Chapter 4123-6) rules.

Stakeholder Involvement

BWC developed and distributed an announcement to stakeholders informing them of the five-year administrative code rule review process regarding the BWC medical rules. The announcement

informed stakeholders that BWC would be reviewing medical rules internally and would be periodically sending medical rules, in groups, to the external stakeholders for input. This announcement was distributed through a public e-mail box designed to facilitate distribution of the rules to interested parties and to stakeholder groups. Stakeholders were informed of the opportunity to provide input on the medical rules and the changes proposed by BWC, and the timeline to respond.

BWC's proposed five-year rule review changes to the self-insuring employer provider payment rules were e-mailed to the following lists of stakeholders on Monday, September 14, 2009 with comments due back on Friday, September 18, 2009:

- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
 - Council of Smaller Enterprises (COSE)
 - Ohio Manufacturer's Association (OMA)
 - National Federation of Independent Business (NFIB)
 - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third Party Administrator (TPA) distribution list

**Chapter 4123-7 Payments To Health Care Providers
Self-Insuring Employer Medical Rules**

4123-7-01 Jurisdictional principles applicable to payment of bills for medical services rendered by health care providers. (Rescind)

Comment [a1]: Rule rescinded and combined into OAC 4123-6-23.

Jurisdictional requirements applicable to payment for medical services rendered by a health care provider are as follows:

(A) Bills must be filed within the time as provided in rule 4123-3-23 of the Administrative Code or be forever barred.

(B) In claims where the date of injury is on or after December 11, 1967, and prior to October 11, 2006, there is no jurisdiction to consider payment for medical services, if six years or more have elapsed since the date of the last payment of a medical bill and no compensation has been paid, except as provided in the following cases:

(1) A bill filed within the six-year period for services rendered within the period can be paid after the six-year period in those cases in which, except for the time passage, it would have been paid.

(2) Where an application requesting the payment of medical bills and/or compensation is filed within the six-year period, there is justification to act on the application after the period.

(a) Bills for services rendered within the six-year period can be ordered paid and can be paid after the period. However, such bills must be filed no later than two years after the date that the services were rendered.

(b) Compensation can be ordered paid provided the proof supports an award. If compensation is paid, the claim is opened for an additional ten years for the payment of compensation and bills. Where there has been a payment of compensation under section 4123.56, 4123.57 or 4123.58 of the Revised Code, the claim is active for ten years from the date of the last payment of compensation or ten years from the last payment of a medical bill, whichever is later.

(3) Where wages in lieu of compensation for total disability were paid by the employer within six years of injury, with knowledge of a claimed compensable injury, as provided in section 4123.52 of the Revised Code, amended effective January 1, 1979.

(4) Where a request for authorization of treatment beyond the six-year period is made in an application filed within the six-year period, the authorization for treatment after that period cannot be granted, unless the claim has been opened by the payment of compensation.

(5) There is no jurisdiction to consider the merits of any application filed after the six-year period, even though supporting proof for the application was on file within the period.

(6) A bill filed within the six-year period but requiring an application to reactivate claim cannot be paid when such application is not filed within the period. The same applies to bills filed after the expiration of the six-year period for treatment rendered within that period.

(C) In claims where the date of injury is prior to December 11, 1967, there is no jurisdiction to consider payment for medical services if ten years or more have elapsed since the payment of compensation or

benefits, or ten years have elapsed since the injury in cases in which no compensation has been awarded.

(D) In claims where the date of injury is on or after October 11, 2006, there is no jurisdiction to consider payment for medical services if five years or more have elapsed since the payment of compensation or benefits. The provisions of paragraph (B) of this rule shall apply to the payment of medical bills in claims where the date of injury is on or after October 11, 2006, except that where those provisions reference six year and ten year time limits, the time limits shall be five years.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4123.52, 4123.65
Prior Effective Dates: 1/1/78, 12/21/79, 4/1/07

4123-7-02 Treatment necessary on account of an industrial injury or occupational disease. (Rescind)

Comment [a2]: Rule rescinded and combined into OAC 4123-6-25.

Medical or other services to be approved for payment must be rendered as a direct result of an injury sustained or occupational disease contracted by a claimant in the course of and arising out of employment for which the claim was allowed by an order of the bureau of workers' compensation or of the industrial commission, or for which the claim was recognized by a self-insuring employer. "Claimant," as used in this chapter, is understood to mean:

(A) An employee or a worker who filed an industrial claim, alleging an injury or an occupational disease sustained in the course of and arising out of employment.

(B) An employee or a worker whose industrial claim was allowed for an injury sustained or an occupational disease contracted in the course and arising out of employment.

Promulgated Under: 119.03
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: RC 4121.121, 4121.30, 4121.44
Prior Effective Dates: 1/1/78

4123-7-03 Payment for medical supplies and services. (Rescind)

Comment [a3]: Rule rescinded and combined into OAC 4123-6-25.

(A) Medical supplies and services will be considered for payment by a self-insuring employer when they are medically necessary for the diagnosis and treatment of conditions allowed in the claim, are causally related to the conditions allowed in the claim, and are rendered by a health care provider. Payment for services rendered to a claimant shall be paid to a health care provider only when the provider has either delivered, rendered or directly supervised the examination, treatment, evaluation or any other medically necessary and related services provided to the claimant. By submitting any fee bill to a self-insuring employer, in either hardcopy or electronic format, the health care provider affirms that medical supplies and services have been provided to the claimant as required by this rule.

(B) Services rendered by health care providers are subject to review for coding requirements outlined in paragraph (C) of this rule. Payments to health care providers may be adjusted based upon these guidelines.

(C) Coding systems.

(1) Billing codes.

(a) Practitioners are required to use the most current edition of the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) to indicate the procedure or service rendered to injured workers.

(b) Inpatient and outpatient hospital services must be billed using the national uniform billing committee's revenue center codes.

(c) Outpatient medication services must be billed pursuant to the requirements described in the bureau's provider billing and reimbursement manual.

(d) To insure accurate data collection, the bureau shall adopt a standardized coding structure which shall be adopted by any MCO, QHP or self-insuring employer.

(2) ICD-9 diagnosis codes.

Providers must use the most current edition of the "International Classification of Diseases, clinical modification" to indicate diagnoses.

(D) Prior to services being delivered, the provider must make reasonable effort to notify the claimant, bureau, MCO, QHP or self-insuring employer when the provider has knowledge that the services may not be related to the claimed or allowed condition(s) related to the industrial injury or illness, or that a service is non-covered. The provider may not knowingly bill or seek payment from the bureau, MCO, QHP or self-insuring employer for services that are not related to the claimed or allowed condition(s) related to the industrial injury or illness. The provider may not knowingly mislead or direct providers of ancillary services to bill or seek payment for services that are not related to the claimed or allowed condition.

The provider may not bill or seek payment from the claimant for services determined as medically unnecessary through the use of bona fide peer review based on accepted treatment guidelines.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.30, 4121.44, 4123.66

Prior Effective Dates: 1/1/78, 4/1/07

4123-7-04 Claimant reimbursement. (Rescind)

Comment [a4]: Rule rescinded, substance covered by OAC 4123-6-26.

In cases where the claimant pays for medical services or supplies directly to a health care provider who does not accept assignment as defined in rule 4123-7-30 of the Administrative Code, or if any other person or payor, including a volunteer, makes the payment on behalf of the claimant, and the claim or condition is subsequently allowed, the bureau shall reimburse the payor upon submission of evidence of the service or supply and evidence of the payment for that service or supply. The payor will receive as payment the usual, customary, and reasonable amount that would have been paid by the bureau or self-insuring employer to the health care provider as provided by the rules of this chapter. Where the bureau, in good faith, has already made the payment to the health care provider, the payor shall be informed by the bureau to seek reimbursement from the payee.

Upon request, the bureau shall inform a claimant or payor whether a health care provider has agreed to submit fee bills to the bureau for direct payment and assignment as provided in rule 4123-7-30 of the Administrative Code.

Promulgated Under: 119.03
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: RC 4121.121, 4121.44, 4123.66
Prior Effective Dates: 1/1/78, 11/13/92

4123-7-05 Treatment by more than one physician. (Rescind)

Comment [a5]: Rule rescinded, substance covered by OAC 4123-6-27.

Medical fees shall not be approved for treatment by more than one physician for the same condition over the same period of time, except where a consultant, anesthetist or assistant is required, or where the necessity for treatment by a specialist is clearly shown and approved by the bureau, by the industrial commission or its medical section, or in self-insuring employers' claims by the self-insuring employer, in advance of such treatment, except in cases of emergency. (For definition of "emergency" see rule 4123-7-16 of the Administrative Code.)

(A) The assistance of another physician is not ordinarily considered necessary in the application of a cast or for operation on fingers, thumbs, or toes. If there are any unusual conditions which require such assistance, a fee will be paid to the assistant (or ordered to be paid by the self-insuring employer in self-insuring employers' claims) only on full explanation and upon approval of the industrial commission's medical section.

(B) Reports of consultations and laboratory procedures must be submitted before fees for the same are approved.

(C) In cases where the consultant continues treatment, a fee for first treatment will be paid to the consultant rather than a consultant's fee unless it is affirmatively shown that the referral by the attending physician for treatment by the consultant followed the receipt and evaluation of the consultant's report.

(D) If a licensed practitioner receives a case in which the first treatment has been rendered by another physician, the physician is entitled to the usual, customary and reasonable fee (as determined under rule 4123-7-03 of the Administrative Code) for the first service.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: RC 4121.121, 4121.30, 4121.44

Prior Effective Dates: 1/1/78

4123-7-06 Treatment of more than one condition or to more than one part of the body. (Rescind)

In claims involving treatment of more than one condition or to more than one part of the body, care should be given by the attending physician to report all conditions and all parts of the body treated. Such information may be of major significance in later determination of the extent of disability as a result of the industrial injury or occupational disease. It shall be the duty of the claims examiners and/or claims reviewers to see to it that in claims under their jurisdiction proper steps are taken to obtain the necessary information on the question of extent of injuries or occupational diseases, either through correspondence or investigation, at the earliest possible time.

Promulgated Under: 119.03
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: RC 4121.121, 4121.30, 4121.44
Prior Effective Dates: 1/1/78

Comment [a6]: Rule rescinded and combined into OAC 4123-6-20.

4123-7-07 Filing of bills. (Rescind)

(A) Fee bills for treatment subsequent to the initial care should be filed on a regular, periodic basis, such as once every four to eight weeks. Fee bills should not include services which were a part of a former fee bill. Duplicate bills should not be filed as a substitute for an inquiry, except upon notification from the bureau that there is no record of the original.

(B) In cases where treatment was not authorized in advance, the hearing officer, at the hearing, may, in the hearing officer's discretion, determine that fee bills for such treatment are to be paid retroactively.

(C) The bureau does not pay for failed or missed appointments or procedures. Bills must only contain descriptions of services that have been actually rendered for the actual conditions treated. A provider shall not transmit to the bureau or self-insuring employer any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

Promulgated Under: 119.03
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 1/1/78, 1/15/99

Comment [a7]: Paragraph (A) of Rule rescinded as unnecessary.

Paragraph (B) of Rule rescinded, substance covered by IC rule OAC 4123-17-07.

Paragraph (C) of Rule rescinded, language will be added to final OAC 4123-6-10.

4123-7-08 Obligation for submitting reports. (Rescind)

Comment [a8]: Rule rescinded and combined into OAC 4123-6-20.

(A) As provided in rules 4123-6-02.8 and 4123-6-71 of the Administrative Code, a provider who undertakes treatment in an industrial case assumes the obligation to notify the bureau, MCO, QHP, or self-insuring employer of the injury within twenty-four hours of the initial treatment or initial visit.

(B) Interim medical reports and medical documentation.

Compensation for temporary total disability is payable upon submission of current supporting medical documentation. Interim reports must be filed, on forms provided by the bureau, at least every thirty days while the claimant remains on temporary total disability. Interim reports must include at least:

- (1) The date of the report;
- (2) The date of the last examination;
- (3) The current "International Classification of Disease" diagnosis code(s), including a primary diagnosis code, with a narrative description identifying the condition and specific areas of the body being treated;
- (4) Any reason(s) why recovery has been delayed;
- (5) The date temporary total disability began;
- (6) The current physical capabilities of the claimant;
- (7) An estimated or actual return to work date;
- (8) An indication of need for vocational rehabilitation;
- (9) Objective findings; and
- (10) Clinical findings supporting the above information.

(C) Treatment plan.

(1) Upon allowance of a claim by the bureau, industrial commission, or self-insuring employer, the physician of record and other providers treating the claimant shall provide and continue to update a treatment plan to the MCO, QHP, or self-insuring employer according to the format or information requirements designated by the bureau. A treatment plan should include at least the following:

- (a) Details of the frequency, duration, and expected outcomes of medical interventions, treatments, and procedures;
- (b) The projected or anticipated return to work date; and
- (c) Factors that are unrelated to the work related condition, but are impacting recovery.

(2) Modifications should be made to the initial treatment plan as treatment is extended, changed, completed, added, deleted or canceled. The modification should describe the current prognosis for the injured worker, progress to date, and expected treatment outcomes.

(3) Treatment plans should be updated when significant changes occur in the claim which impact claims management. Changes include:

(a) Additional allowance;

(b) Re-activation;

(c) Authorization of expenditures from the surplus fund;

(d) Return to modified or alternative work;

(e) Maximum medical improvement;

(f) Rehabilitation;

(g) A new injury while receiving treatment in the claim.

(4) Supplemental reports from the attending physician and other providers may be requested by the bureau, industrial commission, employer, MCO, QHP, or by the claimant or representative. These reports shall be used to determine the appropriateness of a benefit or bill payment.

(D) In accepting a workers' compensation case, a medical provider assumes the obligation to provide to the bureau, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer, upon written request or facsimile thereof and within five business days, all medical, psychological, or psychiatric documentation relating causally or historically to physical or mental injuries relevant to the claim required by the bureau, MCO, QHP, or self-insuring employer, and necessary for the claimant to obtain medical services, benefits or compensation. Providers may charge fees for the provision of such records only to the extent permitted under rule 4123-6-20.1 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.44, 4123.57, 4123.66

Prior Effective Dates: 1/1/78, 9/15/81, 2/14/05

4123-7-09 Request for information by the treating physician. (Rescind)

A licensed practitioner, who is treating an industrial injury or occupational disease may, at any time, make a request in writing, fascimile, e-mail, or by telephone for information from the self-insuring employer as to conditions for which the claim was allowed and/or as to conditions which were being contested. Such requests shall be answered by the self-insuring employer within five working days from the date of the receipt of the request

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05

Rule Amplifies: RC 4121.121, 4121.30, 4121.44

Prior Effective Dates: 1/1/78, 2/14/05

Comment [a9]: Rule rescinded and combined into OAC 4123-6-29.

4123-7-10 Free choice of physician and of other medical services. (Rescind)

Comment [a10]: Rule rescinded and combined into OAC 4123-6-06.2.

(A) This rule pertains to employees of self-insuring employers who do not have a QHP.

Choice of provider for employees of self-insuring employers with a QHP is governed by 4123-6-56 of the Administrative Code.

(B) In claims sustained on or after November 2, 1959, employees of self-insuring employers have free choice to select licensed physicians for treatment, as well as other medical services, including, but not limited to, hospital and nursing services.

In claims sustained prior to November 2, 1959, medical services furnished by the self-insuring employer must be utilized.

(C) Emergency treatment shall not constitute an exercise of free choice of physician.

(D) Once an employee of a self-insuring employer goes to a physician for treatment other than on an emergency basis, the employee is deemed to have made a choice of physician and the employee shall notify the employer of a change of physician.

(1) Change of physician requests shall be made to the self-insuring employer in writing, and shall include the name and address of the new physician and the proposed treatment.

(2) Self-insuring employers shall approve written requests for a change of physician within seven days of receipt.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.30, 4121.44, 4123.651, 4123.66

Prior Effective Dates: 1/1/78, 2/14/05

4123-7-12 Payment for physiotherapy treatment. (Rescind)

Comment [a11]: Rule rescinded and combined into OAC 4123-6-30.

(A) "Physical therapy" means the evaluation and treatment of a person by physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating any disability. Physical therapy includes the establishment and modification of physical therapy programs, treatment planning, instruction and consultative services. Physical measures include massage, heat, cold, air, light, water, electricity, sound, and the performance of tests of neuromuscular function as an aid to such treatment. Physical therapy does not include the diagnosis of a patient's disability, the use of Roentgen rays or radium for diagnostic or therapeutic purposes, or the use of electricity for cauterization or other surgical purposes. Physical therapy includes physiotherapy.

(B) Physical therapy (or physiotherapy) treatment may be rendered only upon the prescription of, or the referral by, the doctor of record who is licensed to practice medicine and surgery, dentistry or podiatry, or by a consultant in an industrial claim, who has the same qualifications.

(C) Fees for physical therapy (or physiotherapy) used for treatment of the allowed conditions shall be approved only to such licensed practitioners who hold a valid license to practice physical therapy (or physiotherapy) as physical therapists (or physiotherapists) or as physical therapist assistants.

(D) Fees, as described in paragraph (C) of this rule shall not be approved for more than ten treatments, unless authorized in advance by the bureau, by the industrial commission, or by a self-insuring employer in self-insuring employers' claims. In justifiable cases where the treatments have exceeded ten without prior approval, the case shall be referred to the medical section for a review and possible approval.

(E) Authorization for additional physiotherapy treatment must be requested, in advance, by a doctor of record or a consultant. Such request shall contain, but will not be limited to, the following information:

- (1) An outline as to what has been accomplished by the physiotherapy treatment rendered.
- (2) The reason for the necessity of further physiotherapy treatment, considered in light of the allowed industrial condition.
- (3) The number of additional treatments which are anticipated.

(F) Additional fees for physiotherapy in cases covered by a flat fee are not approved without specific authorization.

Promulgated Under: 119.03
Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05, 4123.66
Rule Amplifies: RC 4121.121, 4121.30, 4121.31 in conjunction with 4123.66 and 4755.40 to 4755.50
Prior Effective Dates: 1/1/78

4123-7-13 Payment for chiropractic treatment. (Rescind)

Comment [a12]: Rule rescinded as unnecessary (language largely duplicates chiropractic practice statutes).

“Practice of chiropractic” or “practice as a chiropractor” means utilization of the relationship between the muscular skeletal structures of the body, the spinal column and the nervous system, in the restoration and maintenance of health, in connection with which patient care is conducted with due regard for first aid, hygienic, nutritional, and rehabilitative procedures and the specific vertebral adjustment and manipulation of the articulations and adjacent tissues of the body. The chiropractor is authorized to examine, diagnose, and assume responsibility for the care of patients. The practice of chiropractic does not permit the chiropractor to treat infectious or contagious diseases, to perform surgery or acupuncture, or to prescribe or administer drugs for treatment. Roentgen rays shall be used only for diagnostic purposes. An individual holding a valid, current certificate of registration to practice chiropractic is entitled to use the title “doctor” or “doctor of chiropractic” and is a “physician” for the purposes of Chapter 4123. of the Revised Code (section 4734.09 of the Revised Code).

(A) Treatment procedures include and permit:

(1) The use of all varieties of specific vertebral adjustments and manipulations of the articulations and adjacent tissues of the body.

(2) Furnishing and fitting of proper orthopaedic appliances and supports.

(B) In cases of prolonged chiropractic treatment or if the charges made for such treatment appear to be excessive, claims shall be referred to the industrial commission's medical section for a review and opinion before a determination is made on the issue or issues raised.

(C) The appropriateness of charges made by chiropractors for treatment rendered in industrial claims shall be determined by the industrial commission's medical section, or self-insuring employer in self-insuring employers' claims, in the manner as provided in rule 4123-7-03 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.30, 4121.31 in conjunction with 4123.66 and 4755.40 to 4755.50

Prior Effective Dates: 1/1/78

4123-7-14 Acupuncture. (Rescind)

Comment [a13]: Rule rescinded and combined into OAC 4123-6-31.

(A) Acupuncture is a recognized method of treatment in Ohio. Such treatment must be pre-authorized by a self-insuring employer in self-insuring employers' claims. It must be administered by a licensed doctor of medicine, doctor of osteopathic medicine and surgery, doctor of podiatric medicine who has completed a course of study in acupuncture under the administration of an approved college of medicine, college of osteopathic medicine and surgery, or a college of podiatric medicine, doctor of chiropractic who holds a certificate to practice acupuncture from the Ohio state chiropractic board, or a registered non-physician acupuncturist.

(B) Services provided by a non-physician acupuncturist must be prescribed by persons licensed under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery or podiatry or Chapter 4734. of the Revised Code to practice chiropractic. A registered non-physician acupuncturist shall perform acupuncture under the general supervision of the injured worker's prescribing physician or chiropractic physician. General supervision does not require that the acupuncturist and the prescribing physician or chiropractic physician practice in the same office.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies: 4121.44, 4121.441, 4123.66
Prior Effective Dates: 1/1/78, 10/10/03, 9/22/08

4123-7-15 Payment for x-rays. (Rescind)

A self-insuring employer shall pay for x-ray examinations (including CT, MRI, and discogram) when medical evidence shows that the examination is medically necessary either for the treatment of an allowed injury or occupational disease, or for diagnostic purposes to pursue more specific diagnoses in an allowed claim. Providers shall follow all bureau prior authorization policies in effect at the time when requesting authorization and payment for such studies.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.30, 4121.31, 4123.66

Prior Effective Dates: 1/1/78, 2/14/05

Comment [a14]: Rule rescinded and combined into OAC 4123-6-31.

4123-7-17 Medical billing in self-insured claims. (Rescind)

Providers billing for services rendered in self-insured claims shall follow the procedures set forth in the bureau's provider billing and reimbursement manual.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05, 4123.66

Rule Amplifies: RC 4121.44, 4123.651, 4123.66

Prior Effective Dates: 1/1/78, 5/18/92, 2/14/05

Comment [a15]: Rule rescinded and combined into OAC 4123-6-25.

4123-7-18 Payment for dental care. (Rescind)

Comment [a16]: Rule rescinded and combined into OAC 4123-6-31.

(A) A self-insuring employer shall pay for dental care in the following cases:

(1) Where an industrial injury or occupational disease either has caused damage or has adversely affected the claimant's natural teeth.

(2) For industrial injuries or occupational diseases sustained prior to January 1, 1979, artificial teeth or other denture must be in place in the worker's mouth at the time of damage or loss.

(3) For industrial injuries or occupational diseases sustained on or after January 1, 1979, the requirements of division (A)(2) of this rule do not apply.

(B) Responsibility for injuries or occupational diseases affecting the claimant's natural teeth is limited to the repair or replacement of those teeth actually injured at the time of the accident, or directly affected by the injury or disease. This responsibility does not include the replacement of teeth which are extracted or repaired for purposes unrelated to the industrial injury or occupational disease.

(C) Replacement of artificial teeth when the injury or occupational disease has resulted in a deformity of the jaw to the extent that artificial teeth cannot be used, is subject to the limitations of paragraphs (A)(2) and (A)(3) of this rule.

(D) Responsibility for the repair of both natural and artificial teeth is limited to the damage done at the time of the accident, or to the damage directly caused by an allowed injury or occupational disease.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66

Rule Amplifies: RC 4123.66

Prior Effective Dates: 1/1/78, 12/21/79, 2/14/05

4123-7-19 Payment for eyeglasses and contact lenses. (Rescind)

Comment [a17]: Rule rescinded and combined into OAC 4123-6-31.

(A) A self-insuring employer shall approve payment to replace eyeglasses or contact lenses when an industrial injury or an industrial accident which not only causes an injury, but also results in the damage or loss of the claimant's eyeglasses or contact lenses.

(1) In the event of injury prior to January 1, 1979, the eyeglasses must be in place on the claimant's face and the contact lenses shall be in place in the claimant's eye(s) at the time of injury.

(2) In the event of injury on or after January 1, 1979, the requirements of paragraph (A)(1) of this rule do not apply.

(B) Contact lenses or glasses are reimbursed when loss of vision is the direct result of an allowed injury or occupational disease.

(C) Refractions will be approved in situations described in paragraph (B) of this rule.

(D) Replacement of glasses with contact lenses is approved when medical evidence indicates a direct need due to an allowed injury or occupational disease.

(E) Glasses or contact lenses will be approved for treatment purposes, when necessary, as a direct result of the allowed injury or occupational disease. Any subsequent adjustment, maintenance supplies, or change in a claimant's glasses or contact lenses, if required for treatment of the allowed injury or occupational disease, will also be approved when supported by evidence of a direct causal relationship.

When eyeglasses and/or contact lenses were damaged or broken in an industrial accident in which an injury was sustained by the claimant and have been replaced, no further replacement will be approved due to subsequent breakage or for any other reason except as provided in this paragraph of this rule.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66

Rule Amplifies: RC 4123.66

Prior Effective Dates: 1/1/78, 12/21/79, 2/14/05

4123-7-20 Payment for hearing aids. (Rescind)

Comment [a18]: Rule rescinded and combined into OAC 4123-6-31.

(A) Where an industrial injury or an industrial accident which causes an injury also damages the claimant's hearing aid(s), a self-insuring employer shall approve payment to replace such hearing aid(s) as follows:

(1) For injuries or accidents sustained prior to January 1, 1979, the hearing aid(s) must be in place in the claimant's ear(s) at the time of the injury or accident.

(2) For injuries or accidents sustained on or after January 1, 1979, the requirements of paragraph (A)(1) of this rule do not apply.

(3) Once hearing aid(s) have been replaced, no further replacement will be approved.

(B) When a partial loss of hearing is the direct result of an allowed industrial injury or occupational disease, payment for hearing aid(s) is justified in order to improve the claimant's ability to hear.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66

Rule Amplifies: RC 4123.66

Prior Effective Dates: 1/1/78, 12/21/79, 2/14/05

4123-7-21 Payment for shoes, braces, and other orthotic devices. (Rescind)

Comment [a19]: Rule rescinded and combined into OAC 4123-6-31.

A self-insuring employer shall approve payment only for those orthotic devices prescribed in writing by the physician of record for treatment of an allowed injury or occupational disease. The use of the orthotic device must be directly related to the allowed industrial injury or occupational disease.

(A) Orthotic devices shall be custom fitted or custom fabricated and delivered to the satisfaction of the prescribing physician and the administrative agencies. Repairs, modifications, and adjustments to secure satisfactory application of the orthotic appliance shall be made within sixty days of fitting and application without additional charge by the supplier of the orthotic device.

(B) No charge shall be made for measurement, transportation, or other expenses incurred by the supplier-orthotist, except when the supplier-orthotist is required to travel beyond the limits of the metropolitan community in which he maintains his place of business by reason of the physical incapacity of the claimant or by reason of direct prescription by the attending physician. The supplier-orthotist shall be paid for traveling expenses on a round-trip basis. Additional charges must be separately specified on the supplier-orthotist's billing, including the points of travel and the name of the physician prescribing the travel. Payment will be made for a maximum of three round-trip calls.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.30, 4123.66

Prior Effective Dates: 1/1/78, 2/14/05

4123-7-23 Payment for outpatient medication. (Rescind)

Comment [a20]: Rule rescinded and new, identical self-insuring employer pharmacy rule OAC 4123-6-21.1 will be created.

(A) Medication must be for treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer.

(B) Medication must be prescribed by the physician of record in the industrial claim or by the treating physician, or by such other treating provider as may be authorized by law to prescribe such medication.

(C) Drugs covered are limited to those that are approved for use in the United States by the Food and Drug Administration and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) A self-insuring employer may approve and reimburse for various drugs as a part of a comprehensive treatment plan submitted by the physician of record or a treating physician when reasonably related to and medically necessary for treatment of the allowed conditions in the claim, provided that such approval and reimbursement shall not constitute the recognition of any additional conditions in the claim even if such drugs are used to treat conditions that have not been allowed in the claim.

(E) Payment for medications to pharmacy providers shall include a product cost component and a dispensing fee component.

(1) The product cost component shall be the lesser of the following: maximum allowable cost established under paragraph (O) of this rule, if applicable, or the average wholesale price of the commonly stocked package size plus or minus a percentage. The percentage amount added or subtracted from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.

(2) The dispensing fee component shall be a flat rate fee determined by the bureau and subject to annual review, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider pursuant to rule 4123-7-39 of the Administrative Code.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN), or other proprietary code that serves to group together pharmaceutically equivalent products (defined as products that contain the same active ingredients in the same strengths, dosage forms, and routes of administration), per rolling twenty-five days. Exceptions to the single dispensing fee are:

(i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;

(ii) Cases where the physician has changed the dosage;

(iii) Cases where the medication did not last for the intended days supply;

(iv) Cases where the medication has been lost, stolen or destroyed;

(v) Controlled substances (which are limited to two dispensing fees per twenty-five days).

(vi) Cases where the self-insuring employer determines the limitations of this paragraph to be unnecessary under the specific circumstances.

(F) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined in paragraph (E) of this rule, unless the self-insuring employer has negotiated a payment rate with the provider pursuant to rule 4123-7-39 of the Administrative Code. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(G) The pharmacy provider is required to follow all applicable line by line billing instructions as published in the bureau's health care provider billing and reimbursement manual. At least thirty days written notice will be given prior to required changes in billing procedures.

(H) Claimant reimbursement for medications shall at least be equal to the bureau's established rate for the medication, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider utilized by the claimant pursuant to rule 4123-7-39 of the Administrative Code, in which case the claimant reimbursement shall be at least the rate negotiated with the provider. Requests for reimbursement must be paid within 30 days of receipt of the request.

(I) Self-insuring employers must obtain a drug utilization review from a physician before terminating payment for current medications, as follows:

(1) Before terminating payment for current medications, the self-insuring employer shall notify all parties to the claim (including authorized representatives) and the prescribing physician, in writing, that a physician drug review is being performed, or has been performed, regarding the necessity and appropriateness of the continued use of current medications (by therapeutic drug class).

(2) The written notice shall inform all parties to the claim (including authorized representatives) and the prescribing physician that they have 21 days from receipt of the notice to provide additional information and/or medical documentation to justify the need for continued use of the medications (by therapeutic drug class).

(3) The self-insuring employer shall provide all medically related information regarding the medications to an independent physician reviewer for review and opinion as to the necessity or appropriateness of the medications. If the self-insuring employer has obtained an independent physician reviewer's report prior to sending the notice required by paragraph (I)(1) of this rule and subsequently receives additional information and/or medical documentation pursuant to paragraph (I)(2) of this rule, the self-insuring employer shall provide the additional information and/or medical documentation to the independent physician reviewer and obtain an addendum. The independent physician reviewer's report (and addendum, if applicable) shall address the medical rationale, necessity and appropriateness of the drug treatment in the control of symptoms associated with the allowed conditions in the claim.

(4) When the independent physician reviewer's report (and addendum, if applicable) indicates the drug treatment is not medically necessary or appropriate for treatment or in the control of symptoms associated with the allowed conditions in the claim, the self-insuring employer may terminate reimbursement for the medications (by therapeutic drug class) effective as of the date of receipt of the independent physician reviewer's report, or addendum if one is obtained, or in the case that a drug is in a therapeutic class that requires a "weaning-off" period, such other date as agreed to by the prescribing physician and self-insuring employer.

(5) In the event the self-insuring employer terminates reimbursement for the medications as set forth in paragraph (I)(4) of this rule, the self-insuring employer or its authorized representative shall provide all parties to the claim (including authorized representatives) and the prescribing physician with a copy of the independent physician reviewer's report (and addendum, if applicable) and the self-insuring employer shall notify the employee and the employee's representative in writing of its decision to terminate. The employer's notification to the employee and employee's representative shall indicate that the employee has the right to request a hearing before the Industrial Commission.

(6) In the event there is a dispute as to whether the drug treatment is medically necessary or appropriate for treatment of the symptoms associated with the allowed conditions in the claim, the disputed matter shall be adjudicated in accordance with Rule 4123-19-03(K)(5) of the Administrative Code.

(J) Self-insuring employers may deny initial requests for a therapeutic class of drugs as not being reasonably related to or medically necessary for the treatment of the allowed conditions in a claim.

(K) Self-insuring employers may utilize medication utilization protocols formulated by the bureau for select conditions or diseases consistent with one or more of the following:

(1) Compendia consistent of the following:

(a) "United States Pharmacopoeia – Drug Information";

(b) "American Medical Association Drug Evaluations";

(c) "Drug Facts and Comparisons"; or,

(2) Peer reviewed medical literature.

Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's or self-insured employer's refusal to reimburse for such medications.

(L) Through internal development or through vendor contracts, self-insuring employers may implement a point-of-service adjudication system. Upon implementation, a self-insuring employer may require pharmacy providers to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the established bill processing system as a condition of reimbursement, and may refuse submission by paper or by tape-to-tape.

(M) Self-insuring employers utilizing a point of service adjudication system may require prior authorization of drugs or therapeutic classes of drugs which appear on BWC's published list of drugs or therapeutic classes of drugs for which prior authorization is required.

(N) Self-insuring employers utilizing a point of service adjudication system may apply the following dispensing limitations, adopted by the bureau, to medications approved and reimbursed by the self-insuring employer:

(1) The bureau may publish a list of drugs identifying those drugs that are considered "chronic" medications. Drugs not identified as chronic medications shall be considered "acute" medications.

(a) Acute medications may be limited by the self-insuring employer to a thirty-four day supply.

(b) Chronic maintenance medications may be limited by the self-insuring employer to a one-hundred-two day supply.

(2) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

(3) Requests submitted that exceed either the days supply limit or maximum quantity limit shall be denied; provided, however, that the pharmacy provider may still fill the prescription up to the days supply limit or maximum quantity limit, as applicable. Denials may be overridden by the self-insured employer in cases where medical necessity and appropriateness have been determined.

(4) Refills requested before seventy-five per cent of the days supply has been utilized will be denied, except in cases where the dosage of a noncontrolled drug has been increased and has a new prescription number. Denials may be overridden by the self-insured employer for the following documented reasons:

(a) Previous supply was lost, stolen or destroyed;

(b) Pharmacist entered previous wrong day supply;

(c) Out of country vacation or travel;

(d) Hospital or police kept the medication.

(O) Self-insuring employers utilizing a point of service adjudication system may apply the maximum allowable cost list of the point of service adjudication system vendor to medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations." Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug.

(P) A self-insuring employer has sufficient grounds to refuse to pay for the dispensing of drugs and other medications when a pharmacy provider fails to observe any state or federal law relating to his or her professional licensure or to the dispensing of drugs and other medication.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30

Rule Amplifies: 4121.44, 4123.66

Prior Effective Dates: 1/1/78, 5/18/92, 1/1/03, 6/1/06

4123-7-24 Payment of hospital bills. (Rescind)

Comment [a21]: Rule rescinded and combined into OAC 4123-6-37.

(A) Direct reimbursement will not be made to members of a hospital resident staff.

(B) Payment for personal comfort items, which include, but are not limited to, telephones, television, and private rooms provided at the patient's request, are not compensable.

(C) Bureau fees for hospital inpatient services.

(1) Bureau fees for hospital inpatient services will be based on usual and customary methods of payment, such as prospective payment systems, including diagnosis related groups (DRG), per diem rates, rates based on hospital costs to charge ratios or percent of allowed charges.

(2) Except in cases of emergency as defined in rule 4123-6-01 of the Administrative Code, prior authorization must be obtained in advance of all hospitalization. The hospital must notify the self-insured employer of emergency inpatient admissions within one business day of the admission.

Failure to comply with this rule shall be sufficient ground for denial of room and board charges by the self-insured employer from the date of admission up to the actual date of notification. Room and board charges denied pursuant to this rule may not be billed to the injured worker.

(D) Bureau fees for hospital outpatient services.

(1) Bureau fees for hospital outpatient services, including emergency services, will be reimbursed in accordance with usual and customary methods of payment which may include prospectively determined rates, allowable fee maximums, ambulatory payment categories (APC), and hospital cost to charge ratios, or a percent of allowed charges, as determined by the bureau.

(2) Treatment in the emergency room of a hospital must be of an immediate nature to constitute an emergency as defined in this chapter. Prior authorization of such treatment is not required. However, in situations where the emergency room is being utilized to deliver non-emergency care, notification will be provided to the injured worker, the hospital, and the provider of record that continued use of the emergency room for non-emergent services will not be reimbursed.

(E) The bureau may establish the same or different fees for in-state and out-of-state hospitals based on the above reimbursement methodologies.

(F) Payment will be made for hospital services based on rules 4123-7-01 and 4123-7-02 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.31, 4121.44, 4123.66

Prior Effective Dates: 1/1/78, 9/1/93, 2/14/05

4123-7-25 Payment for home health nursing services. (Rescind)

Comment [a22]: Rule rescinded and combined into OAC 4123-6-38.

(A) Employment of nursing service.

(1) The need for nursing services must be the direct result of an allowed injury or occupational disease.

(2) Except as described in rule 4123-7-25.1 of the Administrative Code, home health nursing services shall be provided by registered nurses and licensed practical nurses employed by a medicare certified, joint commission on accreditation of healthcare organizations (JCAHO) accredited, or community health accreditation (CHAP) accredited home health agency.

(B) Fees for home health agency nursing services. Fees for home health agency nursing services will be determined by the bureau.

(C) Authorization for home health nursing services.

(1) Authorization for home health nursing services shall be considered by a self-insuring employer only in cases where the claimant, as the direct result of an allowed injury or occupational disease, is bedfast or otherwise confined to the home, is mentally incapable of self-care or requires home care services ordered for hospital discharge follow-up.

(2) The request for authorization from the physician of record or treating physician must identify the reason for home health nursing services, the period of time the services will be required, the specific services and the number of hours per day that are required.

(3) In addition to skilled nursing services provided by a registered nurse or licensed practical nurse, the claimant may be approved for home health aide or attendant services if he/she is unable to independently perform activities of daily living, including, but not limited to, feeding, bathing, dressing, providing personal hygiene, and transferring from bed to chair. Household, personal or other duties such as maintaining a household, washing clothes, preparing meals or running errands are not considered nursing services and will not be reimbursed.

(4) Authorization must be obtained from the self-insuring employer prior to rendering home health nursing services, except in cases of emergency or where the claimant's allowed condition could be endangered by the delay of services.

(D) All covered home health services must be rendered on a part-time or intermittent care basis, in accordance with the written treatment plan and the bureau standard of care. Part-time or intermittent care means that services are generally rendered for no more than eight hours per day. Home health services rendered on a full time or continuous care basis are not covered. More appropriate alternative settings will be considered for claimants requiring more than eight hours per day of care, where medical necessity is documented. Exceptional cases may be reviewed by the self-insuring employer.

(E) A review of the claim or assessment of the injured worker will be conducted by the self-insuring employer at least annually to ensure that nursing services are necessary as a direct result of the allowed injury or occupational disease.

(F) Home health agency providers must maintain records which fully document the extent of services provided to each claimant. All records must be maintained in accordance with the conditions of participation required for medicare certification, joint commission on accreditation of healthcare organizations (JCAHO) accreditation, or community health accreditation (CHAP) accreditation. The provider may be required to furnish detailed hourly descriptions of care delivered to a claimant to review care needs and medical necessity.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/1/78, 12/14/92, 1/9/95, 6/1/05

4123-7-25.1 Payment for nursing and caregiver services provided by persons other than home health agency employees. (Rescind)

Comment [a23]: Rule rescinded and combined into OAC 4123-6-38.1.

(A) Nursing services provided prior to December 14, 1992.

(1) Registered nurses and licensed practical nurses who are not employed by a medicare certified, joint committee on accreditation of healthcare organizations (JCAHO) accredited, or community health accreditation program (CHAP) accredited home health agency may continue to provide authorized services to a claimant if the services began prior to December 14, 1992.

(2) The need for nursing services must be the direct result of an allowed injury or occupational disease.

(3) In the event the registered nurse or licensed practical nurse is no longer able to provide approved services or if services are stopped and later restarted, nursing services shall be provided only by an employee of a medicare certified, joint committee on accreditation of healthcare organizations (JCAHO) accredited, or community health accreditation program (CHAP) accredited home health agency.

(B) Non-licensed caregiver services.

(1) Requests for extension of caregiver services initially provided prior to December 14, 1992.

(a) Prior to December 14, 1992, caregiver services provided by a non-licensed person including claimant's spouse, friend or family member were considered for reimbursement by a self-insuring employer in cases where the claimant, as a direct result of an allowed injury or occupational disease, was bedfast, confined to a wheelchair, had a disability of two or more extremities which prevented the claimant from caring for his/her own body needs or was otherwise unable to take care of his/her own bodily functions. Services include, but are not limited to, feeding, bathing, dressing, providing personal hygiene, and transferring from bed to chair. Household, personal or other duties such as maintaining a household, washing clothes, preparing meals, or running errands, are not considered nursing services, and will not be reimbursed.

(b) Requests for an extension of caregiver services approved by a self-insuring employer prior to December 14, 1992, delivered by a non-licensed person, other than an attendant, aide, or claimant's spouse, but including other family members or friends, will be approved only if:

(i) The claimant does not have a spouse because the claimant is not married, or the claimant's spouse is deceased, or the claimant's spouse is physically or mentally incapable of caring for the claimant; and,

(ii) The approved home health agency is greater than thirty-five miles from the claimant's location and the home health agency refuses to provide services to the claimant.

(c) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a medicare certified, joint committee on accreditation of healthcare organizations (JCAHO) accredited, or community health accreditation program (CHAP) accredited home health agency.

(2) Requests for extension of caregiver services initially provided on or after December 14, 1992 and prior to January 9, 1995.

(a) Requests for approval by a self-insuring employer of caregiver services delivered by a non-licensed person, other than an attendant, aide, or claimant's spouse were considered for reimbursement only if the claimant did not have a spouse or the spouse was physically or mentally incapable of caring for the claimant, or an approved home health agency was greater than thirty-five miles from the claimant's location and the home health agency refused to provide services to the claimant.

(b) Criteria for approval of caregiver services were as indicated in paragraph (B)(1)(a) of this rule.

(c) After January 9, 1995, persons who are not home health agency nurse aides or attendants, but who are currently approved to provide caregiver services to a claimant, may continue to do so until services are no longer medically necessary or unless services are not authorized. After January 9, 1995, approval of caregiver services by a self-insuring employer shall only be considered when services are rendered by a home health agency nurse's aide or attendant.

(d) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a medicare certified, joint committee on accreditation of healthcare organizations (JCAHO) accredited, or community health accreditation program (CHAP) accredited home health agency.

(C) All covered home health services must be rendered on a part-time or intermittent care basis, in accordance with the written treatment plan and the bureau standard of care. Part-time or intermittent care means that services are generally rendered for no more than eight hours per day. Home health services rendered on a full time or continuous care basis are not covered. More appropriate alternative settings will be considered for claimants requiring more than eight hours per day of care, where medical necessity is documented. Exceptional cases may be reviewed by the self-insuring employer.

(D) A review of the claim or assessment of the injured worker will be conducted by the self-insuring employer at least annually to ensure that nursing services are necessary as a direct result of the allowed injury or occupational disease.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/1/78, 12/14/92, 1/9/95, 6/1/05

4123-7-26 Payment to nursing homes and residential care/assisted living services. (Rescind)

Comment [a24]: Rule rescinded and combined into OAC 4123-6-38.2.

(A) Payment by a self-insuring employer to a nursing home or residential care/assisted living facility for the care of a claimant who sustained an injury or contracted an occupational disease in the course of and arising out of employment shall be made only in cases where the need for such care is the direct result of the allowed industrial condition, as indicated in rule 4123-7-02 of the Administrative Code.

(B) Payment will be made only for care provided in state licensed, medicaid certified nursing homes and residential care/assisted living facilities.

(C) In claims managed by a self-insuring employer, care must be pre-authorized, except when a nursing home or residential care/assisted living facility is used immediately following an approved or emergency hospitalization.

(1) The allowed per diem rate for a claimant shall be no greater than the bureau's fee schedule or the rate negotiated between the nursing home or residential care/assisted living facility and the self-insuring employer.

(2) Nursing home care shall be provided on a semiprivate or ward bed basis, unless a situation exists when the use of a private room is necessary due to the allowed industrial condition. In these cases, the use of such a private room must be preauthorized, except in cases of emergency, as defined in rule 4123-6-01 of the Administrative Code, or where claimant's condition would be endangered by delay.

(3) Fee bills for prescription medication provided to claimants in nursing homes and residential care/assisted living facilities for the treatment of the allowed industrial injury or occupational disease shall be submitted by the providing pharmacy to the self-insuring employer in compliance with rule 4123-7-23 of the Administrative Code.

Promulgated Under: 119.03
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates: 1/1/78, 12/14/92, 6/1/05

4123-7-28 Payment for prosthetic device or other artificial appliances. (Rescind)

Comment [a25]: Rule rescinded and combined into OAC 4123-6-39.

(A) In all cases arising under division (B) of section 4123.57 of the Revised Code, if a claimant requires the purchase or repair of an artificial appliance, the bureau shall pay the cost of purchasing or repairing the artificial appliance out of the surplus fund. The purchase or repair is made regardless of whether the appliance is part of the claimant's vocational rehabilitation, or if the claimant has, or will ever be able, to return to work.

(B) The bureau is responsible for processing requests for prosthetics and travel expenses associated with the prosthetic in all self-insured claims. When a prosthetic device is needed in a self-insured claim, the provider will send a request for the prosthetic and/or request for repair, as well as the subsequent bills, to the bureau.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66

Rule Amplifies: RC 4121.61, 4123.57, 4123.66

Prior Effective Dates: 1/1/78, 4/7/80, 7/10/80, 5/23/94, 2/14/05

4123-7-30 No legal relationship between the industrial commission or self-insuring employer and a health care provider. (Rescind)

Comment [a26]: Rule rescinded and combined into OAC 4123-6-41.

(A) Direct payment to a health care provider or other person authorized by the industrial commission or self-insuring employer for medical care rendered to a claimant under the act does not imply or create a legal relationship between the industrial commission or bureau self-insuring employer and such person where no other legal relationship by contract or otherwise exists.

(B) The services rendered to the claimant are the legal obligation of the patient-claimant.

The direct payment by the self-insuring employer to the health care provider is simply a discretionary method by which the award made to the claimant for medical expenses may be discharged.

(C) Except as prohibited by division (K) of section 4121.44 of the Revised Code and rule 4123-6-62 of the Administrative Code, whether the bureau self-insuring employer chooses to pay money to the claimant, or chooses to discharge claimant's obligation by a direct payment to the creditor-health care provider, the sole legal recourse of such health care provider is against the claimant.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05, 4123.66

Rule Amplifies: 4121.44, 4123.66

Prior Effective Dates: 1/1/78, 11/13/92, 2/14/05

4123-7-33 Medical rules apply to both self-insuring employers and industrial commission. (Rescind)

The rules of this chapter shall govern payments to health care providers in claims before both self-insuring employers and the industrial commission, and shall apply to claims adjudication by both the industrial commission and by self-insuring employers. However, nothing in these rules shall inhibit or diminish the commission's right to establish adjudicatory policy under Chapters 4121., 4123., 4127., and 4131. of the Revised Code, or otherwise prevent the full adjudication of claims properly before the commission or its hearing officers.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05, 4123.66

Rule Amplifies: 4121.121, 4121.30, 4121.44, 4123.66

Prior Effective Dates: 7/16/90, 2/14/05

Comment [a27]: Rule rescinded and combined into OAC 4123-6-01.1.

4123-7-34 Payment for transcutaneous electrical nerve stimulators and neuromuscular electrical stimulators. (Rescind)

Comment [a28]: Rule rescinded and combined into OAC 4123-6-43.

(A) A self-insuring employer may approve payment for a transcutaneous electric nerve stimulator (TENS) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease as provided in this rule and in the bureau's provider billing and reimbursement manual.

(1) The injured worker's physician of record must request prior authorization from the self-insuring employer in order to have a prescribed transcutaneous electrical nerve stimulator (TENS) unit and supplies furnished. Each injured worker who requires a TENS unit will be provided only one unit at a time. For each TENS unit request approved, the unit will be rented for a trial period lasting a minimum of one month but not to exceed four months preceding purchase of the TENS unit, in order to evaluate the medical necessity and effectiveness of the TENS treatment.

(2) The medical necessity and effectiveness of the TENS treatment shall be evaluated each month during the trial period. TENS treatment will be discontinued at the end of any trial period month where the treatment is not proven medically necessary or effective. The bureau will only pay rental costs through the month during the trial period that the TENS unit was actually used before treatment was discontinued.

(3) The self-insuring employer will authorize the purchase of the TENS unit only if the analysis at the end of the trial period establishes that the TENS treatment was medically necessary and effective during the entire trial period. All rental payments previously made by the self-insuring employer will be applied to the purchase price of the TENS unit. A TENS unit purchased by the self-insuring employer and furnished to the injured worker is not the personal property of the worker, however, but remains the property of the self-insuring employer. At its discretion, the self-insuring employer reserves the right to reclaim and recover the TENS unit from the injured worker at the completion of the course of TENS treatment. Once a TENS unit is purchased, the self-insuring employer will reimburse for repair or replacement, at its discretion, upon submission of a request for such from the physician of record, along with medical documentation substantiating the continued medical necessity and effectiveness of the unit. Additionally, while the injured worker continues to use the TENS unit and to order supplies, the physician of record must provide medical documentation annually substantiating the need for continued use of the unit.

(B) Injured workers who have TENS units must complete and submit to the TENS provider a monthly written request for specific supplies needed in the following month. The TENS provider will deliver the supplies and bill the self-insuring employer for them only after the injured worker's written request is received by the TENS provider. The self-insuring employer will not pay TENS providers unless the written request was submitted by the injured worker to the TENS provider prior to delivery of supplies. The provider shall retain the original written request for supplies for a minimum of two years after the date of service for the shipment to which it applies. The TENS provider must bill monthly for each shipment of supplies sent to the injured worker. The bill must indicate the actual date of service reflecting the date that services or supplies were provided. The self-insuring employer may adjust bills upon audit if the audit discloses the provider's failure to comply with this rule.

(C) The TENS provider shall maintain the following records and make them available upon request:

- (1) The injured worker's monthly written requests;
- (2) Records of the provider's wholesale purchase of TENS supplies or equipment; and,
- (3) Records of delivery of supplies to injured workers and of the delivery or return of TENS units.

If records are requested, the provider shall supply copies of the information at no extra cost. Failure to provide the bureau with requested records will result in denial or adjustment of bills related to the records in question.

(D) Self-insuring employers may approve payment for a neuromuscular electrical stimulator (NMNS) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in the bureau's provider billing and reimbursement manual.

Rule promulgated under: RC 119.03
Rule authorized by: RC 4121.121, 4121.30, 4123.05
Rule amplifies: RC 4123.66
Prior Effective Dates: 9/1/93, 3/1/04

4123-7-35 Payment for practitioner services rendered by in-state and out-of state providers. (Rescind)

Payment for in-state and out-of-state practitioner services by self-insuring employers shall be equal to or greater than the fee schedule established by the bureau in state fund claims, unless otherwise negotiated in accordance with rules 4123-6-63 and 4123-7-39 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.44, 4123.66

Prior Effective Dates: 5/23/94, 2/14/05

Comment [a29]: Rule rescinded and combined into OAC 4123-6-44.

**4123-7-39 Standardized or negotiated payment rates for services or supplies.
(Rescind)**

Comment [a30]: Rule rescinded and combined into OAC 4123-6-46.

(A) A self-insuring employer may negotiate payment rates with health care providers for services and supplies provided in the treatment of workers' compensation claims.

(B) A self-insuring employer may enter into volume-based contracts with medical providers for services including, but not limited to, the purchase or rental of durable medical equipment and supplies.

(C) A self-insuring employer may inform injured workers of the availability of services, supplies, or equipment from particular health care providers where the self-insuring employer has a contract for services or supplies, a discount for services or supplies, or where cost-effective payment levels or rates are obtained by the self-insuring employer by contract, so long as access to quality and convenient medical services or supplies is maintained for injured workers.

Promulgated Under: 119.03
Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05, 4123.66
Rule Amplifies: 4121.44, 4121.651, 4123.66
Prior Effective Dates: 5/18/92; 2/14/05

Exhibit 2

OAC Chapter 4123-7 Rules: Payments to Health Care Providers (Self-Insuring Employer Medical Rules) Crossover Document to OAC Chapter 4123-6 Rules

CHAPTER 7 RULE #	CHAPTER 7 TITLE	RULE RESOLUTION AND NEW CHAPTER 6 RULE # IF APPLICABLE
4123-7-01	Jurisdictional principles applicable to payment of bills for medical services rendered by health care providers.	Rule rescinded and combined into 4123-6-23
4123-7-02	Treatment necessary on account of an industrial injury or occupational disease.	Rule rescinded and substance covered in 4123-6-25 Paragraphs (A) and (B) of Rule rescinded, substance covered by 4123-6-01(N).
4123-7-03	Payment for medical supplies and services	Rule rescinded and combined into 4123-6-25
4123-7-04	Claimant reimbursement	Rule rescinded and substance covered by 4123-6-26
4123-7-05	Treatment by more than one physician	Rule rescinded and substance covered by 4123-6-27
4123-7-06	Treatment of more than one condition or to more than one part of the body	Rule rescinded and substance covered in 4123-6-20(B)(3). Second sentence rescinded as outdated.
4123-7-07	Filing of bills	Paragraph (A) of Rule rescinded as unnecessary Paragraph (B) of Rule rescinded, substance covered by IC rule 4121-17-07 Paragraph (C) of Rule rescinded, language added to 4123-6-10
4123-7-08	Obligation for submitting reports	Rule rescinded and combined into 4123-6-20 Provider notification of injury requirement of OAC 4123-7-08(A) is covered in new OAC 4123-6-02.8(C)
4123-7-09	Request for information by the treating physician	Rule rescinded and substance covered in 4123-6-29
4123-7-10	Free choice of physician and of other medical services	Rule rescinded and combined into 4123-6-06.2
4123-7-12	Payment for physiotherapy treatment	Rule rescinded and substance covered in 4123-6-30. Paragraphs (E) and (F) rescinded; treatment authorization requirements covered in 4123-6-16.2

Exhibit 2

OAC Chapter 4123-7 Rules: Payments to Health Care Providers (Self-Insuring Employer Medical Rules) Crossover Document to OAC Chapter 4123-6 Rules

CHAPTER 7 RULE #	CHAPTER 7 TITLE	RULE RESOLUTION AND NEW CHAPTER 6 RULE # IF APPLICABLE
4123-7-13	Payment for chiropractic treatment	Rule rescinded as unnecessary Unnumbered paragraph and paragraph (A) language largely duplicate chiropractic practice statutes Paragraphs (B) and (C) are outdated and do not reflect current practices Paragraph (C) is redundant, as SI employers determine the appropriateness of charges for <u>all</u> treatment, including chiropractic, under OAC 4123-19-03
4123-7-14	Acupuncture	Rule rescinded and combined into 4123-6-31(A)
4123-7-15	Payment for x-rays	Rule rescinded and combined into 4123-6-31(F)
4123-7-17	Medical billing in self-insured claims	Rule rescinded, language added to 4123-6-25 to cover both state-fund and self-insuring claims
4123-7-18	Payment for dental care	Rule rescinded and combined into 4123-6-31(C)
4123-7-19	Payment for eyeglasses and contact lenses	Rule rescinded and combined into 4123-6-31(D)
4123-7-20	Payment for hearing aids	Rule rescinded and combined into 4123-6-31(E)
4123-7-21	Payment for shoes, braces, and other orthotic devices	Rule rescinded and combined into 4123-6-31(B)
4123-7-23	Payment for outpatient medication	Rule rescinded and new, identical self-insuring employer pharmacy rule 4123-6-21.1 created
4123-7-24	Payment of hospital bills	Rule rescinded and combined into 4123-6-37
4123-7-25	Payment for home health nursing services	Rule rescinded and combined into 4123-6-38
4123-7-25.1	Payment for nursing and caregiver services provided by persons other than home health agency employees	Rule rescinded and combined into 4123-6-38.1
4123-7-26	Payment to nursing homes and residential care/assisted living services	Rule rescinded and combined into 4123-6-38.2
4123-7-28	Payment for prosthetic device or other artificial appliances	Rule rescinded and combined into 4123-6-39

Exhibit 2

OAC Chapter 4123-7 Rules: Payments to Health Care Providers (Self-Insuring Employer Medical Rules) Crossover Document to OAC Chapter 4123-6 Rules

CHAPTER 7 RULE #	CHAPTER 7 TITLE	RULE RESOLUTION AND NEW CHAPTER 6 RULE # IF APPLICABLE
4123-7-30	No legal relationship between the industrial commission or self-insuring employer and a health care provider	Rule rescinded and combined into 4123-6-41
4123-7-33	Medical rules apply to both self-insuring employers and industrial commission	Rule rescinded and combined into 4123-6-01.1
4123-7-34	Payment for transcutaneous electrical nerve stimulators and neuromuscular electrical stimulators	Rule rescinded and combined into 4123-6-43
4123-7-35	Payment for practitioner services rendered by in-state and out-of state providers	Rule rescinded and substance covered in 4123-6-10(C)(1)
4123-7-39	Standardized or negotiated payment rates for services or supplies	Rule rescinded and combined into 4123-6-46

**Overview Matrix of Which Chapter 6 Rules Now Incorporates the Rescinded Chapter 7 Rules
Companion to Exhibit 2**

Chapter 7 Rescinded Rules	Chapter 6 Merged Rules - 4123.6																								
	1	1.1	2.8	6.2	10	16.2	20	21.1	23	25	26	27	28	29	30	31	37	38	38.1	38.2	39	41	43	46	
4123.7.01									X																
4123.7.02	(N)									X															
4123.7.03										X															
4123.7.04											X														
4123.7.05												X													
4123.7.06								(B)(3)																	
4123.7.07				X																					
4123.7.08		(C)					X																		
4123.7.09														X											
4123.7.10			X																						
4123.7.12					X										X										
4123.7.14																(A)									
4123.7.15																(F)									
4123.7.17									X																
4123.7.18																(C)									
4123.7.19																(D)									
4123.7.20																(E)									
4123.7.21																(B)									
4123.7.23								X																	
4123.7.24																X									
4123.7.25																	X								
4123.7.25.1																		X							
4123.7.26																			X						
4123.7.28																					X				
4123.7.30																						X			
4123.7.33		X																							
4123.7.34																							X		
4123.7.35				(C)(1)																					
4123.7.39																									X

STAKEHOLDER FEEDBACK GRID

Chapter 4123-6 and 4123-7 Rules

Stakeholder Feedback Grouped by Response Category

Category Key

Category 1

Pages 2 through 11 – any stakeholder feedback that would change the meaning or content of the proposed rule. Responses have been made to these stakeholders.

Category 2

Pages 12 through 20 – Stakeholder general questions and comments regarding processes relating to the rules that *require a response* by the OBWC. Responses have been made to these stakeholders.

Category 3

Pages 21 through 26 - General comments regarding the rules that *require no feedback* by the OBWC, e.g., I agree, sounds okay, etc.

STAKEHOLDER FEEDBACK GRID

Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
4123-6-01 Definitions	1	Attorney Association - Why does the injury definition include occupational disease? I think this will cause problems with the rules.	Not given	While "injury" and "occupational disease" are defined separately in statute and are treated differently for claim allowance purposes, once a claim is allowed the medical management of the claim is the same. This is not a change in this Rule, and has not presented problems heretofore.	No changes to the rule
4123-6-01(D) Definitions	1	Attorney Association - Requests rule be amended in (D) to define a 'physician' to include doctor of physical therapy who holds a valid certificate of licensure to practice physical therapy under Chapter 4755 of the R.C.	Would address semantics and access barriers.	A Physical Therapist is not a 'physician duly licensed' to certify compensation per 4123-5-18, and would not be recognized to do so by the Industrial Commission.	No changes to the rule
4123-6-01.1 Applicability of medical rules	1	Attorney Association - We object to the rules applying to the IC. The IC is an independent adjudicatory body which may interpret the rules but the BWC has no legal authority to govern them. The second paragraph of this rule is contradictory to the first.	As stated	BWC after review has chosen to maintain the recommended language. This language was moved from OAC 4123-7-31 and is not new. Since 2000, the IC has rescinded all but one of its own medical rules (OAC Chapter 4121-17) as duplicative of BWC's medical rules, and follows BWC's substantive medical rules. Per BWC Legal, BWC has statutory authority to adopt rules regarding the furnishing of medical services to injured workers per O.R.C. 4123.66(A). Legal further indicated, that the second paragraph clarifies that the rule is not intended to usurp the authority of the IC to adopt adjudicatory policy as per O.R.C. 4121.03; and thus is not contradictory to the first.	No changes to the rule

STAKEHOLDER FEEDBACK GRID

Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
4123-6-02.2 Employee access to treatment-employee choice of provider	1	Attorney Association - Moral turpitude is not defined. That should be left to the licensing boards and (B)(1) should cover this idea.	TBD	BWC understand the concern presented, and is open to other language recommendations. This language was being used to provide an additional and needed option to address providers whose behavior in or out of the workers compensation system would indicate that such a provider should not continue as an active provider in the system, but such behavior did not rise to the level of being criminal and subject to BWC sanctions. BWC is open to recommendations which facilitate our being able to address the type of situation mention above, which ultimately facilitates the integrity of the workers' compensation system.	TBD
4123-6-02.2 Provider access to the HPP - provider credentialing criteria.	1	Provider Association - Requests that CARF accreditation requirement for medical providers of Occupational Rehabilitation (work hardening) be dropped, eliminating W0710 code and establish more definitive guidelines for work hardening programs within Chapter 4 of Vocational Rehab Services that are consistent with APTA Guidelines for work conditioning and work hardening programs.	As stated	CARF accreditation was reviewed and researched by BWC for work hardening programs and is determined to provide a standard of quality and oversight which BWC finds unilaterally unable to provide as an agency. This method of requiring a recognized national standard is utilized in other facility type enrollment/certification requirements to assure injured workers are receiving quality care.	No changes to rule
4123-6-2.2(B)(1) Provider access to the HPP - provider credentialing	1	Provider Association - The changes are even more restrictive in nature than the original language.	As stated	BWC has contacted the OSMB and clarified the sections in parentheses which OSMB felt could be interpreted more restrictively. Informed them the rewording now allows the substance abuse, etc., to be used as examples of conditions	No changes to rule

STAKEHOLDER FEEDBACK GRID

Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY			Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1	2	3				
criteria.						that could not disqualify certification if they do not impair the providers ability to treat patients or provide patient care as was previously.	
4123-6-02.3 Provider access to the HPP - provider application and credentialing.	1			Attorney Association - We object to reasonable notice being removed prior to auditing and investigation. This totally violates privacy rights.	TBD	BWC understand the objection, and is open to alternative recommendations. BWC feels strongly that auditing and investigations must have this option should the situation require immediate discovery to obtain information consistent with auditing best practices. It should be noted that it is not the standard protocol for BWC to perform an unannounced practice visit. BWC is open to recommendations which support and facilitate addressing the point BWC's presents in the above paragraph.	TBD
4123-6-02.3(D) Provider access to the HPP - provider application and credentialing.	1			Attorney Association - We object to combining the ideas of credentialing and following BWC guidelines.	Not given	BWC after review has chosen to maintain the recommended language. BWC believes physicians must be aware and accepting of BWC's chosen guidelines to provide best care coordination and medical case management of IW.	No changes to the rule
4123-6-06.2 Employee access to treatment-employee choice of provider	1			TPA stakeholder suggested spelling out "HPP" and "QHP" in sections (A) and (B).	Clarity.	The acronyms HPP and QHP are defined in 4123-6-01 and are used throughout Chapter 6.	Keep as is.
4123-6-16.1 HPP medical treatment guidelines	1			Attorney Association - Reviewing physicians should be permitted to use their own practical knowledge, peer review journals and national guidelines from medical	As stated	The basis for this change is to assure medical treatment requests, plans of care and disputed treatments are reviewed under current standards of care. It ensures consistency throughout the plan of care. Evidence based practice is the goal. Thus, this language change is supportive of the	No changes to rule

STAKEHOLDER FEEDBACK GRID

Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
		organizations.		work we are requesting physicians to perform	
4123-6-20 Provider's obligation for submitting medical documentation and reports	1	TPA stakeholder suggested changing the title to "Obligation for submitting medical information and/or reports".		Agreed.	Title of rule was changed to:"Obligation for submitting medical documentation and reports"
4123-6-20 Provider's obligation for submitting medical documentation and reports	1	MCO stakeholder commented that "Paragraph (A) is deleting the first sentence concerning the requirement for the provider to report an injury and notes it is duplicative of OAC 4123-6-02.8. In referencing this rule on-line the current version of 4123-6-02.8 is directed at the HPP process and reporting to the MCO or the BWC internet site."	"Need to verify with the update to 4123-6-02.8 addresses reporting to the MCO, QHP, or self-insuring employer of the injury. The updated rule was not attached to the packet so are comments are just to ensure this is truly duplicative language."	The updated version of 4123-6-02.8 was sent to the stakeholders for review in April. Section (A) applies to HPP, Section (B) applies to QHP, and Section (C) applies to self-insured, non-QHP employers.	Keep as is. Stakeholder was contacted and her concerns have been addressed.
4123-6-20 Obligation for submitting medical documentation and reports	1	Third Party Administrator: Requested that: a) medical records be attached to provider invoice b) Providers must bill using the diagnostic code for the body part for which they delivered treatment/services c) Providers must bill and provide medical records within 30 days or rendering care d) Providers should	a) complete medical records and all other pertinent patient information are necessary for the reimbursement of the provider b) providers must accurately reflect	The stakeholder feedback was not directed at any particular rule, but rather reflected a number of general issues. BWC staff evaluated the questions against the rules, making some assumptions regarding which rules were pertinent to the stakeholder's concerns and determined that current and/or proposed rule language addresses all of stakeholder's concerns.	a) No change. 4123-6-20 addresses providers' obligations to supply reports b) No change. BWC believes that language in 4123-6-25 addresses this concern c) No change. Language in 4123-3-23 gives providers up to

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY 1 2 3	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
		not require their own special release form before supplying records	the actual body part being treated; thus the fee bill would match the documentation provided c)would like prompt receipt of fee bills and medical records d) providers that have BWC and employers go through additional steps to obtain medical records slow down the claims/treatment/reimbursement process for the workers' compensation system		two years to submit fee bills for reimbursement. Under ORC 4123.52 the Industrial Commission may make any modification, finding or award up to two years prior to the date of filing application. OAC 4121-17-07 additionally gives Industrial Commission hearing officers the discretion to determine fee bills for treatment not authorized in advance be paid retroactively.
4123-6-25(C)(2)	1	Attorney Association - We are concerned that numbers will simply be used to deny treatment and billing.	Diagnosing is not an exact science and this will result in much more inflexibility.	BWC understands the concern as stated and has modified the recommended language. The new proposed language is: <i>“(2) ICD-9 <u>Diagnosis codes. Providers must use the most current edition of the appropriate “International Classification of Diseases, clinical modification” codes for the condition(s) treated to indicate diagnoses.</u>”</i> The intent of the language is not to present any opportunity to deny treatment and/or billing, but to clearly state in BWC’s rule, a standard of practice which providers follow with other payer	

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY 1 2 3	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
				<p>entities. This will not only create consistency in the system, but enhance administrative efficiencies in reviewing and approving claims and reimbursements. Currently, too often, there is delay in approval and reimbursement because of the back and forth between the administrative team and the providers in reconciling what is used on various claims documents versus what is allowed in the claim. BWC is further evaluating other administrative actions related to issues arising as a result of billing ICD code for a non-allowed condition when the application of Miller requires payment for treatment of the non-allowed condition.</p>	
4123-6-27	1	Attorney Association -The rule should be rewritten to permit multidisciplinary care to recognize reality of treatment.	Language should allow for multidisciplinary care to occur in claims when necessary.	BWC has reviewed the rule’s language, and believes that the current language does not prohibit, but clearly stipulates when multidisciplinary care should occur. We believe that the last sentence in the current rule does recognize the reality of multidisciplinary treatment, and how such is normally authorized.	No changes to rule
4123-6-30 Payment for physical medicine	1	Attorney Association - In (C), since a chiropractor is a physician, the phrase chiropractic physician is unnecessary. After the word physician, use (MD, DC, DO). In (D), the treatments to be authorized without prior authorization should be physical medicine treatments, not just physical therapy treatments.	Draft language is duplicative (C). By broadening language to physical medicine would allow for not just physical therapy services (D).	<p>BWC understands that a chiropractor is a physician and feels that additional language clarification is unnecessary.</p> <p>Regarding paragraph (C), previous stakeholder feedback from the Ohio State Chiropractic Association in 2006 requested language be reflected in rules denoting chiropractic physician. BWC added chiropractic physician as a separate category to the provider credentialing rule (OAC 4123-6-02.2) version effective April 1, 2007 and OSCA did not object at that time. This language is consistent with the language in 4123-6-02.2.</p>	No changes to rule

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY 1 2 3	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
				<p>Regarding paragraph (D) Physical Therapy without prior authorization component was is stated within the self-insured rule OAC 4123-7-12. With the proposed rescission of OAC 4123-7-12, BWC wanted to ensure that this physical therapy without prior authorization component was reflected within Chapter 6 rules to bring standardization between both the state fund and self-insured employers.</p>	
<p>4123-6-30 Payment for physical medicine</p>	<p>1</p>	<p>Provider Association - Rule language imposes unnecessary access barriers to licensed physical therapists that are inconsistent with current Ohio law that governs physical therapy practice. Language in (A) confuses services provided by licensed physical therapists and licensed physical therapy assistants with services performed by non-licensed personnel that are incident to care of chiropractors, medical doctors, dentists and podiatrists. Section (B) language limits access to licensed physical therapists- inconsistent with statute 4755.481 which governs physical therapists. (B) is more restrictive than 4123-7-12 which governs self-insured community- PT evaluation is not restricted by the requirement of a prescription or referral by the POR</p>	<p>Rule language imposes unnecessary access barriers to licensed physical therapists that are inconsistent with current Ohio law that governs physical therapy practice.</p>	<p>BWC has reviewed the draft proposed rule and responses are as follows: Language was drafted in (C) to identify who can provide physical medicine services, thus ensuring that services are carried out by a provider practicing within the scope of their license, certification or registration. (B) Per BWC review of 4755.481 R.C. (A) which provides for a physical therapist to evaluate and treat a patient without a prescription as long as the the physical therapist follows additional specific applications within 4755.481 R.C. Additionally, under (B) of the revised code, nothing in sections 4755.40 - 4755.56 R.C. shall be construed to require reimbursement under the health partnership program or qualified health plans for any physical therapy services rendered without the prescription of, or referral by identified entities. BWC believes the draft rule is minimally consistent with 4123-7-12.</p>	

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
		or other treating physician. Language dilutes potential cost savings from direct C-9 initiative proposed by BWC workgroup. Make 6-30 minimally consistent with 7-12.			
4123-6-30 Payment for physical medicine	1	SI Employer <i>As a practicing nurse practitioner in the state of Ohio I am able to prescribe physical therapy. I am also allowed by the state of Ohio to see, evaluate, and treat the injured worker. I am able to prescribe Physical therapy for the injured worker, I believe the physical therapist should be able to bill for the services they provide, based on my prescription. I would recommend the wording be changed to the wording that is in the prescription section that I have highlighted below.</i>	(CNP) requesting proposed change to draft rule language to ensure that as practicing nurse practitioner in the state of Ohio she can continue to prescribe physical therapy as a care intervention for injured workers.	The recommended changes to this component of the rule reflect BWC's objective to ensure quality care is provided by the appropriate provider. BWC is currently researching whether this service is indeed within the scope of practice for this type of provider. At this point we are unable to confirm this assertion. 10-02-09 BWC has determined that physicians are the appropriate providers to perform this service. However, BWC would consider other types of providers to perform the service subsequent to specific language which expressly state that this is within the provider group scope of practice as recognized within the State of Ohio. A review of Ohio laws, as well as the practice rules governing CNPs there is no expressed language indicating this is within the CNP scope of practice. Stakeholder updated 10/01/09	Update will be forthcoming.
4123-6-30 Payment for physical medicine	1	MCO: Keep presumptive approval references general in the rule and develop further details within	Detail can be developed within amended policy,	BWC with feedback and a recommendation from the C-9 QI workgroup, on which the MCO representation was present, choose to propose	No change. Rule 4123-6-30 is being updated with language to reflect

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY 1 2 3	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
		policy.	not necessary to place into rule.	increasing the presumptive authorization visits. The proposed rule update places an increased presumptive authorization requirement into OAC 4123-6-30, where it will be applicable to both self-insured and state fund employers.	standardization of services between state fund and self-insured employers.
<p>4123-6-38 Payment for home health nursing services 4123-6-38.1 Payment for nursing and caregiver services provided by persons other than home health agency employees</p> <p>4123-6-38.2 Payment of nursing home and residential care/assisted living services and</p> <p>4123-6-02.2 Provider access to the HPP-provider credentialing criteria</p>	1	Provider Association - suggests adding "the" to Joint Commission and add an additional accreditation organization, "the accreditation commission for health care" to the rule.	The addition of "the" would be correct to the current title. Additionally, the Ohio Dept. of Health requires home health agencies to go through an accreditation organization to obtain deemed Medicare status.	Input reviewed by BWC. The rule does not need to specifically reflect all other organizations which have been granted deeming authority by Medicare. BWC requires Medicare certification regardless of the agency that had deeming authority to accredit a home care agency,.	No change. Rule 4123-6-02.2 C (11) is being updated with language which reflects organizations granted authority to approve home health agencies to do business with Medicare. BWC believes the language is clear and the rules as proposed adequately address the concerns of the stakeholder.
Chapter 6	1	SI employer: Suggested: include language in proposed 4123-6-10, (A) (2) that an exception is needed for hospitals due to DRG payment methodology. Also requested (B) (1) consider revision that payments	4123-6-10 (A) (2) Requested that an exception was made for hospitals due to the diagnosis related	Input reviewed by BWC. 4123-6-10 (A) (2) Language in the rule indicates that hospitals are excluded, as they are reimbursed under different payment methodologies pursuant to 4123-6-37.1 and 4123-6-37.2 4123-6-10 (B)(1) Currently, the stakeholder has the ability to reimburse the	Keep as is. Stakeholder was contacted and her concerns have been addressed.

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY 1 2 3	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
		<p>will be made based on the Ohio Fee Schedule. Under (B) 6 c revise language to reflect if the provider is not a QHP certified provider, the provider will be asked to comply with the Rules of QHP. 4123-6-20 (B) 3 requested document the specific body parts, including left/right.</p>	<p>group (DRG) payment methodology. 4123-6-10 (B) (1) requested add language that payment will be made based on the BWC fee schedule, as this is current way that the stakeholder reimburses providers.(B) (6) (c) If a provider is not a QHP certified provider, wants that provider to comply with the rules of the QHP. 4123-6-20 (B) 3 requested that the specific body parts being treated by a provider be documented by the provider.</p>	<p>provider via the bureau fee schedule. 4123-6-10 (B)(6)(c) The employer can request that a provider comply with their rules-nothing prohibits this. 4123-6-20 (B) 3 Providers are required to document this information currently.</p>	

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
4123-6-01 Definitions	2	None <i>SI Employer questioned; Can we put something about Mexico physicians not licensed in the USA are not defined as physicians?</i>	Standards of attaining medical licensure in Mexico are not as strict as the US standard.	Current language of Rule is clear on who meets definition of physician. Rule doesn't need to specifically reflect Mexico physicians not licensed in USA are excluded.	No change to Rule
4123-6-06.2 Employee access to treatment	2	None <i>SI-TPA – questioned – Does the SI employer have to approve or acknowledge the change? Do SI employers have the right to refuse the claimants choice?</i>	Not given	The SI employer has to acknowledge and approve a change of physician. SI employers do not have the right to refuse claimants choice of physician, unless the SI employer is has a QHP. If so, a BWC certified provider must be chosen.	No change in Rule.
4123-6-06.2 Employee access to treatment	2	None <i>SI-TPA – questioned – Allowing the employee to choose the “physician” often leads to the employee seeking a provider who will give them the restrictions/treatments the employee wants, more importantly in our experience when a Chiropractor is the POR, we have found that treatment is extend for much longer than necessary (2 years past DOI in one situation for a slip and fall). This results in higher costs for us as the employer as we pay out the claims and enlist</i>	As stated	Input reviewed by BWC. This component of the Rule is focusing on defining POR or attending physician. Controlling patient care decisions is not addressed in this rule. Choice of provider is addressed in 4123-6-06.2 and defines when providers are payable by BWC. Injured workers may choose payable (BWC certified) or non-payable (non BWC certified) providers for ongoing treatment as desired, but would be responsible to pay non BWC certified providers for ongoing care. MCO is responsible to review for appropriateness and medical necessity of care.	

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY 1 2 3	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
		the assistance of our TPA and or our lawyer to help settle the case. If the employee is to have the ability to direct treatment- it should be done under the advice of a internist or general practitioner.			
4123-6-08 MCO ability to negotiated fees	2	None MCO stakeholder did not suggest any changes to this rule but did indicate they would be sending in proposed changes to 4123-6-08 (Provider Fee Schedule) related to the language in Section (A)(7)(a) of this rule.	Clarify process for determining appropriate payment for "by report" and non-covered codes.	Stakeholder indicated they would provide suggested language to be included in the next update of 4123-6-08. BWC will evaluate their suggestion at that time.	Keep as is. Stakeholder was contacted and will submit suggested language to 4123-6-08.
4123-6-10 Non-payment to non-certified providers	2	None TPA – asked several questions: <ul style="list-style-type: none"> • <i>If the provider is not in the MCO panel or have an arrangement with the MCO, how can there be a negotiated MCO fee?</i> • <i>Will an exception have to be made for hospitals?</i> • <i>What is the penalty to the provider for submitting inaccurate bills?</i> • <i>Who is responsible for</i> 			

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
		<p><i>finding the inaccuracies?</i></p> <ul style="list-style-type: none"> • <i>What is the procedure when inaccuracies are suspected?</i> • <i>If an MCO does not audit the invoices it receives, how will that be reflected in its grade on the report card to employers during open enrollment?</i> 			
4123-6-10 Non-payment to non-certified providers	2	<p>None</p> <p>MCO stakeholder posed a question regarding application of Section (A)(5)(b).</p>	IW preference to be treated by family dentist.	Certified providers must be used unless there is an access to care issue. Dentists should not be treated differently than other provider types.	Keep as is. Stakeholder was contacted and the rule discussed. Stakeholder was okay with the rule as drafted after the discussion.
4123-6-20 Provider's obligation for submitting medical documentation and reports	2	<p>None</p> <p>MCO stakeholder commented that "Paragraph (A) is deleting the first sentence concerning the requirement for the provider to report an injury and notes it is duplicative of OAC 4123-6-02.8. In referencing this rule on-line the current version of 4123-6-02.8 is directed at the HPP process and reporting to the MCO or the BWC internet site."</p>	"Need to verify with the update to 4123-6-02.8 addresses reporting to the MCO, QHP, or self-insuring employer of the injury. The updated rule was not attached to the packet so are comments are just to ensure this is truly duplicative	The updated version of 4123-6-02.8 was sent to the stakeholders for review in April. Section (A) applies to HPP, Section (B) applies to QHP, and Section (C) applies to self-insured, non-QHP employers.	Keep as is. Stakeholder was contacted and her concerns have been addressed.

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY			Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1	2	3				
					language."		
4123-6-20 Provider's obligation for submitting medical documentation and reports		2		<p>None</p> <p>TPA questioned;</p> <ol style="list-style-type: none"> 1. <i>What is the recourse when the BWC pays TT without all of the required information?</i> 2. <i>How is this being enforced?</i> 3. <i>What entity does a party notify of the failure of a provider to provide the requested information in a timely manner?</i> 4. <i>Will the BWC not transfer funds to the MCO to pay for services by that provider?</i> 5. <i>Will the provider be re-educated, put on probation or eliminated from the HPP or QHP?</i> 		See pg 5	
4123-6-20 Provider's obligation for submitting medical documentation and reports		2		<p>None</p> <p>SI employer – questioned - <i>Are there going to be any changes to 4123-6-20? I do not see this rule listed / contained within the document, but it is referenced in</i></p>		This stakeholder's feedback was referred to the Self-Insured Department upon receipt, to determine the appropriate response.	

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY 1 2 3	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
		<i>the comment found on 4123-6-28.</i>			
4123-6-20.1 Charges for copies of medical reports	2	<p>None</p> <p>SI-TPA questioned:</p> <p>1. <i>The problem is the employer requests all medical records from the provider, and gets back (for a fee) only the same few forms already submitted, instead of all of the office note, medical history, test results, etc. Asking the IC for a subpoena only works if the claim is scheduled for hearing. To what entity does the employer file a complaint about the provider?</i></p>		This stakeholder’s feedback was referred to the Self-Insured Department upon receipt, to determine the appropriate response.	
4123-6-31(F)	2	<p>None</p> <p>Attorney Association - What are the pre-authorization rules regarding diagnostic tests? There is much confusion among the MCOs on this</p>		<p>Prior authorization protocols are provided to providers and the MCOs as part of the Billing and Reimbursement Manual and MCO Policy Reference Guidelines.</p> <p>Excerpts from the MCO Policy Reference Guidelines, and specifically, language related to diagnostic tests is reflected below.</p> <p>b. Standardized Prior Authorization Table Important: Services listed in the standardized prior authorization table below and not indicated as exceptions will still require prior authorization. Providers must submit a C-9 to indicate services</p>	

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
				<p>to be provided through formal authorization. Requests for medical services that require prior authorization must be submitted by the physician of record or treating physician. Provider types whose signature must appear on the C-9 treatment request include all POR provider types (MD, DO, DC, DDS, DMT, DPM, psychologist), optometrist, advanced practice nurse, physician assistant, independent social worker, and professional clinical counselor. Treatment requests from any other provider type should not be processed.</p> <p>Diagnostic Testing * requires prior authorization (except basic x-rays which do not require PA)</p>	
4123-6-37 Payment of hospital bills	2	None <i>SI-TPA – questioned - This states that Inpatient hospitalizations need to be preauthorized unless it is an emergency admission. If the provider fails to get prior auth, then we can deny the inpatient room and board charges. Are these denials appealable?</i>		This stakeholder’s feedback was referred to the Self-Insured Department upon receipt, to determine the appropriate response.	
4123-6-69	2	None Provider Association - The QHP ADR process needs to be modified and shortened. In its present form, it creates a huge burden on doctors and injured workers.	In its present form, it creates a huge burden and doctors and injured workers.	BWC reviewed the process and believe that the current process as presented, appropriately provides due process for the both the injured worker and the employer to ensure that medical disputes are fairly and adequately determined.	

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY 1 2 3	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
Chapter 6	2	<p>None</p> <p>TPA – made general recommendations for changes to the WC system.</p> <p>1) Providers who expect to be paid for workers' compensation services should provide medical records to the MCO at the same time that they submit their invoice. The medical records should be complete, including the patient's medical history questionnaire and all other information the provider has.</p> <p>2) Providers must bill using the diagnostic code for the body part that they treated, not any ICD-9 code allowed in the claim. For example, chiropractors can't bill for DC treatment for a contusion when the medical records reveal that they are actually treating a sprain/strain. (Some MCOs limit the number of modalities to be paid for one visit.)</p> <p>3) Providers must bill and provide medical records within, at most, 30 days of providing treatment. All parties should have the right to know about all treatments and conditions when there is a hearing</p>			

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY 1 2 3	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
		<p>or a BWC order.</p> <p>4) Providers may not require their own special release form before providing records. One example is the Cleveland Clinic; it's just another hoop the BWC and employers have to jump through to get the records that they are entitled to.</p> <p>5) There should be a procedure for employers or MCOs to file complaints against providers who do not respond completely or in a timely manner to requests for information. An example is a provider who refuses to address questions from the BWC, MCO and/or employer regarding restrictions, if any, for return to work. Another example is the provider who charges for copies, but then sends only the exact same (four) documents already in the claim file.</p>			

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
Chapter 6	2	<p>None</p> <p>SI Employer – questioned</p> <p><i>1) The phrase “with proof of delivery” is too brief to make sense. What does that mean?</i></p> <p><i>2) Why should we have to pay facility and professional fees to an urgent care facility just because it is owned by a hospital? Other providers pay their own overhead out of the allowed fees; urgent care should do the same.</i></p> <p><i>Please do not publish my name or that of my company.</i></p>		This stakeholder’s feedback was referred to the Self-Insured Department upon receipt, to determine the appropriate response.	
Chapter 6 & 7 rules	2	<p>None</p> <p>Provider Association - Requested chapters 6 and 7 rules be provided as one packet when available for review and comment by the association.</p>		Contacted Stakeholder and advised that a single comprehensive rule packet will be provided to the Stakeholder. Also informed that a final hearing date had not yet been set. 09/22/09	
Chapter 6 & 7 rules	2	<p>None</p> <p>SI Employer - requested copy of complete rule packet.</p>		Stakeholder was contacted and informed that a complete rule packet will be sent out to Stakeholders for review/feedback.	
Chapter 7 rules	2	<p>None</p> <p>SI Stakeholder - requested</p>		Contacted Stakeholder and advised they could submit feedback through close of business	

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
		extension for rule review date due to holiday.		9/14/09	
Chapter 7 rules	2	None SI Stakeholder -requested extension for rule review date due to holiday.		Contacted Stakeholder and advised they could submit feedback through close of business 9/14/09	
Chapter 7 rules	2	None SI Stakeholder requested extension for rule review date due to holiday.		Contacted Stakeholder and advised they could submit feedback through close of business 9/14/09	

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY 1 2 3	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
4123-6-20.1 Charges for copies of medical reports	3	None. TPA stakeholder stated that the changes to Section (A)(3) were "good".			

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
Chapter 6 rules	3	None <i>SI Employer – I have read and agree with the proposed changes as outlined on email dated 01/01/09.</i>			
Chapter 6 rules	3	None <i>SI Employer - Agree with proposed rule changes.</i>			
Chapter 6 rules	3	None <i>SI Employer – I have read over the rules and I find them to be in order.</i>			
Chapter 6 rules	3	None <i>Employer Association - No feedback from our membership.</i>			
Chapter 6 rules	3	None <i>MCO - No rule change suggestions or recommendations.</i>			
Chapter 6 rules	3	None. <i>Self-insured employer replies that they "agree with the suggested changes" to the attached rules.</i>			

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
Chapter 6 rules	3	None Employer Association – <i>no feedback is forthcoming</i>			
Chapter 6 rules	3	None HB222 physician – <i>no comments</i>			
Chapter 6 rules	3	None SI Employer – <i>As a self insured employer in Ohio, we have no rule change suggestions or recommendations.</i>			
Chapter 6 Rules	3	None SI Employer – <i>I approve of these suggested changes.</i>			
Chapter 6 Rules	3	None SI Employer – <i>I agree with the suggested changes to Rule 6.</i>			
Chapter 6 Rules	3	None SI Employer – <i>I have no input. I have read the rules. I agree with the changes and updates that have been made.</i>			
Chapter 6 Rules	3	None			

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY			Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1	2	3				
				MCO Organization – <i>The League is fine with the suggested Rule updates.</i>			
Chapter 7 rules		3		None <i>SI Employer was - in agreement with proposed rule changes</i>			
Chapter 7 rules		3		None <i>SI Employer stated – Great rule changes.</i>			
Chapter 7 rules		3		None <i>SI Employer – We do not have any recommendations for changes to this chapter.</i>			
Chapter 7 rules		3		None <i>SI Employer - I have read the changes in your email regarding the QHP5 Year Review Rules 6-11-09 document. I have no changes or suggestions to offer. I am fairly new to the SI Arena, and what you have delineated appears to be appropriate and correct to the best of my knowledge. Thank you for including me in your questionnaire process.</i>			
Chapter 7 rules		3		None			

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Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY			Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1	2	3				
				SI Employer – <i>I would like to inform you that we do not participate in the QHP as an Ohio SI employer.</i>			
Chapter 7 rules		3		None SI Employer – <i>We are not participating in the MCO plan, therefore, we have no recommendations on any rule changes.</i>			
Chapter 6 & 7 rules		3		None SI Employer – <i>I have reviewed and approved the recent changes amendments to the above rules.</i>			
Chapter 6 & 7 rules		3		None MCO - <i>No recommended revisions for the five year rule review.</i>			
Chapter 6 & 7 rules		3		None SI Employer - <i>In agreement with recommended changes</i>			
Chapter 6 & 7 rules		3		None SI Employer - <i>I have reviewed the rules and have no concerns with the proposed changes</i>			
Chapter 6 & 7 rules		3		None			

STAKEHOLDER FEEDBACK GRID

Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
	1 2 3				
		MCO - <i>No rule change suggestions or recommendations.</i>			
Chapter 6 & 7 rules	3	None SI Employer – <i>Please be advised we have reviewed the proposed changes in their entirety and agree with the suggested changes.</i>			
Chapter 6 & 7 rules	3	None SI Employer – <i>Please note that we have reviewed the rules and cannot provide you with any suggestions/changes for clarity.</i>			
Chapter 6 & 7 rules	3	None SI Employer – <i>OK</i>			
Chapter 6 & 7 rules	3	None SI Employer – <i>I have no comments at this time.</i>			
Chapter 6 & 7 rules	3	None TPA – <i>Thank you for allowing us the ability to review this information we have no comments at this time about the proposed rule changes.</i>			

STAKEHOLDER FEEDBACK GRID

Chapter 4123-6 and 4123-7 Rules

Rule # / Subject Matter	CATEGORY 1 2 3	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
Chapter 6 & 7 rules	3	<p>None</p> <p><i>SI Employer – I would recommend that provisions be added requiring MCOs to bill at the appropriate fee schedule amount for service provided, with penalties for failure to do so. Something along the lines of removal of <u>all</u> charges billed at a greater rate than that which the fee schedule allows. It is disingenuous for providers/MCOs to put the onus of monitoring fee schedule amounts on the employer/BWC, when they are the ones who are knowingly submitting expenses for reimbursement specific to a WC claim.</i></p>			
Chapter 6 & 7 rules	3	<p>None</p> <p><i>TPA – I am glad to see BWC specifically states that kickbacks, commissions, and other valuables are forbidden when the MCO is soliciting new business.</i></p>			

BWC Board of Directors
Executive Summary
HPP Provider Certification Rules
Chapter 4123-6

Introduction

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including rules governing the certification of providers to participate in the HPP. The HPP provider certification rules were first promulgated in 1996, prior to the implementation of the HPP in 1997. The rules have been periodically updated as needed, and were substantially amended in 2002, and again in 2007.

As part of the current five-year rule review process, the provider credentialing rules have been thoroughly reviewed and numerous changes have been proposed. There are 14 rules in this rule package; ten rules will be amended, two rules will be rescinded, and two rules are no change rules.

Background Law

Ohio Revised Code 4121.441(A)(11) and (12) provide 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 an employee for an injury or occupational disease" which shall include, but are not limited to:

- (11) Standards and criteria for the bureau to utilize in certifying or recertifying a health care provider or a vendor for participation in the health partnership program;
- (12) Standards and criteria for the bureau to utilize in penalizing or decertifying a health care provider or a vendor from participation in the health partnership program.

Proposed Changes

The major substantive changes proposed for the HPP provider credentialing rules pursuant to the five-year rule review:

- Clarify that the signed provider recertification application and agreement constitutes a written contractual agreement between the bureau and the provider. OAC 4123-6-01(K).
- Add definitions of "hospital," "inpatient," "outpatient," and "urgent care facility" as used within BWC's reimbursement rules currently in place. OAC 4123-6-01(CC)(1)(2) and (DD).
- Clarify that certified providers in BWC's database must be direct providers of services to injured workers and not merely service coordinators. OAC 4123-6-02(B).
- Rescind OAC 4123-6-02.1, as the initial enrollment period for provider certification was established at the HPP program inception and is no longer needed.
- Modify the restriction completely disqualifying providers who have disciplinary restrictions related to chemical dependency or substance abuse from BWC certification to allow

BWC to measure providers with such infractions using criteria relating to patient care and competent delivery of that care. OAC 4123-6-02.2(B)(1).

- Add a restriction disqualifying providers who have a misdemeanor conviction involving moral turpitude from BWC certification, to give BWC consistency with licensing board requirements. OAC 4123-6-(B)(5).
- Update durable medical equipment supplier credentialing requirements to reflect recently enacted Ohio Respiratory Care Board regulation of some home durable medical equipment. OAC 4123-6-02.2(C)(8).
- Clarify home health agency credentialing requirements to recognize Medicare participation by an organization given "deeming" authority from the Centers for Medicare and Medicaid Services (CMS) to grant Medicare participation. OAC 4123-6-02.2(C)(11).
- Update hospital credentialing requirements to reflect the current types of hospitals BWC certifies and to recognize provider based entities as hospitals in BWC's provider database. OAC 4123-6-02.2(C)(12).
- Add telemedicine credentialing requirements to recognize this new licensure type. OAC 4123-6-02.2(C)(35).
- Reinstate urgent care facility credentialing requirements which had been inadvertently deleted in a prior rule revision. OAC 4123-6-02.2(C)(37).
- Add the American Board of Vocational Experts (ABVE) credential to vocational rehabilitation case manager credentialing requirements to recognize ABVE as another acceptable certification. OAC 4123-6-02.2(C)(38).
- Provide that a BWC non-certified provider's enrollment may expire if BWC receives no billing from the provider for two years OAC 4123-6-02.21(D).
- Clarify that the BWC certified provider list is publicly accessible via BWC's website. OAC 4123-6-02.3(A).
- Remove the prior notification requirement for BWC review of the provider's facility or offices by BWC. OAC 4123-6-02.3(B).
- Enumerate conditions agreed to by providers signing the provider application and agreement and recertification application and agreement, including recognition of BWC's treatment guidelines and vocational rehabilitation hierarchy, adherence to BWC's sensitive data policy, and agreement to not misuse e-account access. OAC 4123-6-02.3 D)(1),(2), and (9).
- Clarify that a BWC certified provider whose certification "lapses" due to the provider's failure to timely sign and return a recertification application and agreement shall remain in "lapsed" status until BWC's determination to recertify or deny recertification is completed. OAC 4123-6-02.4.
- Add additional Revised Code sections related to criminal offenses in the delivery or billing of health care benefits to rule regarding immediate suspension or revocation of BWC certification, and remove the reference to provisional revocation or suspension. OAC 4123-6-02.5(C).

- Rescind OAC 4123-6-02.7, as the relevant information is already covered in OAC 4123-6-02.21.
- Clarify that BWC is responsible for establishing injury reporting requirements for providers, and reorganize provider reporting requirements for State Insurance Fund claims and for claims of self-insuring employers, with and without a QHP, into one rule. OAC 4123-6-02.8 (A)(1),(B),(C).
- Clarify and simplify rule language informing providers and MCOs of decertification hearing process requirements. OAC 4123-6-17(several sections).

Stakeholder Involvement

BWC developed and distributed an announcement to stakeholders informing them of the 5-year administrative code rule review process regarding the BWC medical rules. The announcement informed stakeholders that BWC would be reviewing medical rules internally and would be periodically sending medical rules, in groups, to the external stakeholders for input. This announcement was distributed through a public e-mail box designed to facilitate distribution of the rules to interested parties and to stakeholder groups. Stakeholders were informed of the opportunity to provide input on the medical rules and the changes proposed by BWC, and the timeline to respond.

In this initial set of 14 provider credentialing rules, BWC's proposed 5-year rule review changes were e-mailed to the following lists of stakeholders on April 23, 2009 for a two-week review period:

- The Self Insured Division's employer distribution list
- BWC's internal medical provider stakeholder list – 67 persons representing 52 medical provider associations/groups
- Ohio Association for Justice
- Ohio Attorney General's Office, Workers Compensation Section
- BWC's Managed Care Organizations and their Medical Directors
- BWC's Healthcare Quality Assurance Advisory Committee
- Interested party Debbie Lydon (upon request)
- Council of Smaller Enterprises (COSE)
- Ohio Manufacturers Association (OMA)
- National Federation of Independent Business (NFIB)

BWC received 11 responses with recommendations, which are summarized on the Stakeholder feedback summary spreadsheet. The majority of responses requested elimination of the restriction in OAC 4123-6-02.2(B)(1) regarding disciplinary restrictions involving substance abuse or chemical dependency. As written, the existing rule disqualifies a provider from certification in the HPP if the provider is under disciplinary restrictions relating to chemical dependency or substance abuse when the restrictions do not affect the provider's ability to treat patients. BWC has reviewed and revised the rule language to reflect that BWC will continue to monitor these conditions, but provider compliance with the licensing board monitoring agreement and provision of competent patient care will allow the provider to become or remain BWC certified.

Common Sense Business Regulation (BWC Rules)

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

Chapter 4123-6 Qualified Health Plan Rules (24 rules)

Rule Review

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

Citation: R.C. 4121.121(B)(21), R.C. 4121.44, R.C. 4121.442(A)(1) through (13)

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

What goal(s): The rules set forth criteria and guidance for the implementation of the Qualified Health Plan (QHP) system for self-insuring employers to provide services and supplies to injured workers in the Ohio workers' compensation system.

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: BWC's proposed five-year rule review changes to the QHP rules were e-mailed to the BWC stakeholders for review.

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
QHP Rules
Chapter 4123-6

Introduction

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Qualified Health Plan (QHP) system for self-insuring employers who choose to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies through a QHP. BWC enacted the 24 Chapter 4123-6 QHP rules (Ohio Administrative Code 4123-6-050 to 4123-6-73) in September 1996. The rules last underwent five-year rule review in 2004.

As part of the current five-year rule review process, the QHP rules have been thoroughly reviewed and numerous changes have been proposed, mostly rescinding unnecessary and/or duplicative rules, or combining them into existing rules. There are 24 rules in this rule package; 5 rules will be amended, 14 rules will be rescinded, and 5 rules are no change rules.

Background Law

Ohio Revised Code 4121.121(B)(21) provides that the Administrator shall “[p]repare and submit to the board information the administrator considers pertinent or the board requires, together with the administrator’s recommendations, in the form of administrative rules, for the advice and consent of the board, for the . . . qualified health plan system, as provided in sections 4121.44 . . . and 4121.442 of the Revised Code.”

Ohio Revised Code 4121.44(L) provides that the Administrator shall permit employers who agree to abide by the QHP rules “to provide services or supplies to or on behalf of an employee for an injury or occupational disease . . . through qualified health plans of the Ohio workers’ compensation qualified health plan system pursuant to section 4121.442 of the Revised Code . . .”

Ohio Revised Code 4121.442(A)(1) through (13) provide that the Administrator shall “develop standards for qualification of health care plans of the Ohio workers’ compensation qualified health plan system to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease” that provide for all of the standards established under the statute.

Proposed Changes

The major substantive changes proposed for the QHP rules pursuant to the five-year rule review:

- Rescind language referring to establishment of the initial QHP certification period, as that period has long since passed. OAC 4123-6-52.
- Remove references to the “employee representative” in the QHP decertification rule, as the only external parties to a QHP decertification are the self-insuring employer and the QHP. OAC 4123-6-55(B)(1), (3).
- Provide that if the QHP utilizes a leased provider network, the QHP shall not apply the discounted payment rates of the leased network to services rendered by the provider in the QHP unless the signed, written consent of the provider has been obtained, mirroring

a similar requirement in the MCO contract for provider networks leased by the MCOs.)AC 4123-6-58.

- Remove references to data reports no longer required per statutory amendments enacted by Senate Bill 7 (SB 7),OAC 4123-6-70.

Stakeholder Involvement

BWC developed and distributed an announcement to stakeholders informing them of the five-year administrative code rule review process regarding the BWC medical rules. The announcement informed stakeholders that BWC would be reviewing medical rules internally and would be periodically sending medical rules, in groups, to the external stakeholders for input. This announcement was distributed through a public e-mail box designed to facilitate distribution of the rules to interested parties and to stakeholder groups. Stakeholders were informed of the opportunity to provide input on the medical rules and the changes proposed by BWC, and the timeline to respond.

In this set of 24 QHP rules, BWC's proposed five-year rule review changes were e-mailed to the following lists of stakeholders for review:

- The Self Insured Division's employer distribution list
- BWC's internal medical provider stakeholder list – 67 persons representing 52 medical provider associations/groups
- Ohio Association for Justice
- Ohio Attorney General's Office, Workers Compensation Section
- BWC's Managed Care Organizations and their Medical Directors
- BWC's Healthcare Quality Assurance Advisory Committee
- Council of Smaller Enterprises (COSE)
- Ohio Manufacturers Association (OMA)
- National Federation of Independent Business (NFIB)

BWC received 7 substantive responses from stakeholders, which are summarized on the Stakeholder Feedback Summary spreadsheet.

Common Sense Business Regulation (BWC Rules)

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

**Chapter 4123-6 Health Partnership Program
MCO Operational Rules (24 rules)**

Rule Review

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

Citation: R.C. 4121.44(B)(1) and (2), R.C. 4121.441

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

What goal(s): The rules set forth criteria and guidance for implementation of the Health Partnership Program (HPP) and the certification of managed care organizations (MCOs) to provide services and supplies to injured workers in the Ohio workers' compensation system.

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: BWC's proposed five-year rule review changes to the HPP MCO operational rules were e-mailed to the BWC Medical Division's list of stakeholders for review.

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
HPP MCO Operational Rules
Chapter 4123-6**

Introduction

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including rules governing the operation of managed care organizations (MCOs). BWC enacted the bulk of the Chapter 4123-6 HPP operational rules (Ohio Administrative Code 4123-6-01 to 4123-6-19), including the MCO operational rules, in February 1996. The rules have been periodically updated as needed, and last underwent five-year rule review in 2004.

As part of the current five-year rule review process, the MCO operational rules have been thoroughly reviewed and numerous changes have been proposed. There are 24 rules in this rule package; 3 rules will be rescinded and replaced, 13 rules will be amended, 5 rules will be rescinded, and 3 rules are no change rules.

Background Law

Ohio Revised Code 4121.44(B)(1) and (2) provide that, to implement the HPP, the Administrator shall "certify one or more external vendors, which shall be known as 'managed care organizations,' to provide medical management and cost containment services" in the HPP for a period of two years beginning on the date of certification, consistent with the standards established under the statute, and that the Administrator may recertify the MCOs for additional two year periods.

Ohio Revised Code 4121.441(A) 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 an employee for an injury or occupational disease" which shall include, but are not limited to:

- (11) Standards and criteria for the bureau to utilize in certifying or recertifying a . . . vendor [MCO] for participation in the health partnership program;
- (12) Standards and criteria for the bureau to utilize in penalizing or decertifying a . . . vendor [MCO] from participation in the health partnership program.

Proposed Changes

The major substantive changes proposed for the HPP MCO operational rules pursuant to the five-year rule review:

- Expand the required components for an MCO application for certification and allow for BWC discretion in the requirements for an MCO application for recertification. OAC 4123-6-03.2 (C)(4), (C)(10), and (E)
- Modify the prohibition on outsourced services to just medical case management for both certification and recertification of MCOs including the removal of grandfathering in outsourcing of medical case management for existing MCOs. OAC 4123-6-03.2 (J).

- Clarify language related to an MCO's ability to place its self at capacity. OAC 4123-6-03.3 (A).
- Expand the grounds for termination of an MCO's contract to include items currently in the MCO contract. OAC 4123-6-03.6.
- Remove language related to "Gamma IME"s, a one-time independent medical exam on a claim with a date of injury before October 20, 1993 and change language related to reflect recent revisions to OAC 4123-6-16 - Alternative dispute resolution for HPP medical issues. OAC 4123-6-04.3 (F).
- Replace language related to MCO marketing practices to reflect the marketing policy in the April 2008 release of Appendix A of the MCO contract. OAC 4123-6-05.1.
- Modify language related to the MCO's ability to reimburse trade or business associations for marketing expenses and add the definition of agents to match the language in the marketing policy in the April 2008 release of Appendix A of the MCO contract. OAC 4123-6-05.3 (B)(2) and (E).
- Expand prohibition on MCO receipt of payment for referrals ("kick-back") to include the referral of employers to individuals or entities for provision of goods or services and referrals of injured workers to providers for provision of goods or services. OAC 4123-6-05.4.
- Modify language to allow the administrator flexibility in determining the methodology used to determine the manner the payments are to be paid and expanded list of performance measure criteria to include process performance measures. OAC 4123-6-13 (A) and (C)(2).
- Expand language relating to confidentiality of records to ensure appropriate protection is in place for BWC data. OAC 4123-6-15.

Stakeholder Involvement

BWC developed and distributed an announcement to stakeholders informing them of the 5-year administrative code rule review process regarding the BWC medical rules. The announcement informed stakeholders that BWC would be reviewing medical rules internally and would be periodically sending medical rules, in groups, to the external stakeholders for input. This announcement was distributed through a public e-mail box designed to facilitate distribution of the rules to interested parties and to stakeholder groups. Stakeholders were informed of the opportunity to provide input on the medical rules and the changes proposed by BWC, and the timeline to respond.

BWC's proposed five-year rule review changes to the HPP MCO operational rules were e-mailed to the following lists of stakeholders on June 26 and June 29, 2009 with comments due back on Thursday, July 9, 2009:

- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
 - Council of Smaller Enterprises (COSE)
 - Ohio Manufacturer's Association (OMA)

- National Federation of Independent Business (NFIB)
- Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third Party Administrator (TPA) distribution list
- Ohio Attorney General's Office – Workers' Compensation Section

BWC received responses from eight stakeholders: two agreed with the proposed changes and the remaining six submitted 15 recommendations or comments. All recommendations and comments are included in the stakeholder feedback summary spreadsheet. The responses covered a number of rules with no identifiable pattern of concern.

Common Sense Business Regulation (BWC Rules)

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

**Chapter 4123-6 Health Partnership Program
Provider Payment Rules (41 rules)**

Rule Review

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

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

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

What goal(s): The rules adopt standards and criteria governing payment to providers for medical, surgical, nursing, drug, and hospital services and supplies furnished to injured or workers.

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: BWC's proposed changes to the Chapter 4123-6 provider payment rules were e-mailed to the BWC Medical Division's list of stakeholders for review on August 27 and September 3, 2009 with comments due back on September 7 and September 10, 2009.

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
HPP Provider Payment Rules
Chapter 4123-6

Introduction

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including rules governing payment to providers. BWC enacted the bulk of the Chapter 4123-6 HPP provider payment rules in January and February 1997. The rules have been periodically updated as needed, and last underwent five-year rule review in 2004.

As part of the current five-year rule review process, the Chapter 4123-6 HPP provider payment rules have been thoroughly reviewed and numerous changes have been proposed. There are 41 rules in this rule package; 2 rules are new rules; 18 rules will be amended, 10 rules will be rescinded, 4 rules will be rescinded and replaced, and 7 rules are no change rules.

Perhaps the most significant change BWC is proposing is that the Chapter 4123-6 provider payment rules going forward will apply to both State Insurance Fund (SIF) and self-insuring employer claims, whether the self-insuring employer has a Qualified Health Plan (QHP) or not.

This change is not intended to be substantive, as self-insuring employers are already required to provide medical benefits equal to or greater than those provided in SIF claims. However, it will allow BWC to rescind an entire chapter of Ohio Administrative Code rules (Chapter 4123-7) consisting largely of rules duplicative of Chapter 4123-6 rules.

Background Law

R.C. 4123.66(A) provides that the BWC Administrator "shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper," and that the Administrator "may adopt rules, with the advice and consent of the [BWC] board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefor."

R.C. 4121.441(A) provides that the BWC 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.

Proposed Changes

The major substantive changes proposed for the HPP provider payment rules pursuant to the five-year rule review are as follows:

- New rule created to apply Chapter 4123-6 to payments to health care providers in all claims for industrial injuries and/or occupational diseases before the bureau, self-insuring employers, MCOs, QHPs, and the industrial commission. OAC 4123-6-01.1
- Language regarding injured worker choice of provider for HPP, QHP, and self-insuring employers combined into a single rule. OAC 4123-6-06.2

- Language added to new rule OAC 4123-6-06.2 limiting the injured worker's choice of provider and/or provider reimbursement when the provider is the injured worker or an immediate family member. This was added to eliminate potential conflicts of interest. OAC 4123-6-06.2(A)(2)
- Language regarding payment to providers for HPP, QHP, and self-insuring employers combined into a single rule. OAC 4123-6-10
- Language added to new OAC 4123-6-10 regarding the MCOs' authority to negotiate fees with providers. OAC 4123-6-10 (A)(7)
- Language added to OAC 4123-6-14 to reflect that BWC's review of medical bills includes more than verification of claim and condition allowances. OAC 4123-6-14 (A)
- Medical treatment guidelines rule rescinded and replaced with rewritten rule including language to ensure treatment guidelines are utilized at the time of the initial decision and removing specific vendor names, thus providing additional flexibility to BWC in selecting treatment guidelines. OAC 4123-6-16.1
- Language added to OAC 4123-6-20 regarding the provider's responsibility for the accuracy of information provided in workers' compensation claims and in performing independent medical examinations (IMEs) OAC 4123-6-20(A) and (E)
- Language added to OAC 4123-6-20 providing additional clarification for submission of interim medical reports and medical documentation to replace language in OAC 4123-6-28, which is being rescinded. OAC 4123-6-20(B)
- Language added to OAC 4123-6-25 to replace equivalent language in OAC 4123-6-24, which is being rescinded. OAC 4123-6-25
- Language added to OAC 4123-6-29 to provide increased data security. OAC 4123-6-29
- Language added to and/or revised in OAC 4123-6-30 to provide for standardization of physical medicine services between state fund and self-insured employers. The revision reduces administrative burdens for providers and supports the goals of early and safe return to work for Ohio's injured workers.
- New rule for payment of miscellaneous medical services created, combining and rescinding Chapter 4123-6 rules. This change facilitates ease of reading and consolidates payment criteria for services and supplies. OAC 4123-6-31
- Language clarified in OAC 4123-6-38 regarding criteria required for home health agencies to be eligible to receive reimbursement for services provided to injured workers. Language relating to services no longer reimbursable under the BWC fee schedule deleted. OAC 4123-6-38
- Language added to OAC 4123-6-39 to conform to Ohio Revised Code 4123.57(C), thus ensuring that injured workers receive a comprehensive assessment by an appropriate provider when requesting a prosthetic appliance. Language regarding self-insuring employer claims added from OAC 4123-7-28, which is being rescinded. OAC 4123-6-39

- Language added to OAC 4123-6-41 referencing self-insuring employers, as self-insuring employer equivalent rule OAC 4123-7-30 is being rescinded. OAC 4123-6-41
- Language added to OAC 4123-6-42 to clarify which funds are responsible for paying interest on late provider payments. OAC 4123-6-42
- Language in OAC 4123-6-43 modified to update trial rental period and provide clarification on requirements for providers as to the provision and billing for supplies necessary for transcutaneous electrical nerve stimulator (TENS) units, and to include language from OAC 4123-7-34, which is being rescinded. OAC 4123-6-43
- Language in OAC 4123-6-44 modified to broaden application to all providers, not just licensed individuals (practitioners). OAC 4123-6-44
- Language in OAC 4123-6-46 revised to active voice and to include self-insuring employers, as OAC 4123-7-39 is being rescinded. OAC 4123-6-46

Stakeholder Involvement

BWC developed and distributed an announcement to stakeholders informing them of the five-year administrative code rule review process regarding the BWC medical rules. The announcement informed stakeholders that BWC would be reviewing medical rules internally and would be periodically sending medical rules, in groups, to the external stakeholders for input. This announcement was distributed through a public e-mail box designed to facilitate distribution of the rules to interested parties and to stakeholder groups. Stakeholders were informed of the opportunity to provide input on the medical rules and the changes proposed by BWC, and the timeline to respond.

BWC's proposed five-year rule review changes to the HPP provider payment rules were e-mailed to the following lists of stakeholders on August 27 and September 3, 2009 with comments due back on September 7 and September 10, 2009:

- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
 - Council of Smaller Enterprises (COSE)
 - Ohio Manufacturer's Association (OMA)
 - National Federation of Independent Business (NFIB)
 - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third Party Administrator (TPA) distribution list

BWC received several responses with recommendations, which are summarized on the Stakeholder feedback summary spreadsheet.

Common Sense Business Regulation (BWC Rules)

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

**Chapter 4123-7 Payments to Health Care Providers
Rescission of Rules (30 rules)**

Rule Review

1. The rule is needed to implement an underlying statute.
Citation: O.R.C. 4123.66(A); O.R.C. 4123.35(B)
2. The rule achieves an Ohio specific public policy goal.
What goal(s): All thirty rules in Chapter 4123-7 are being rescinded as duplicative of Chapter 4123-6 rules (as amended concurrent with this rule rescission), as the Chapter 4123-6 provider payment rules will also apply to self-insuring employers going forward.
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. The Chapter 4123-7 rules are duplicative of Chapter 4123-6 as amended; this proposed rescission will eliminate the duplication consistent with Executive Order 2008-04S and O.R.C. 119.032.
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: BWC's proposed changes to the Chapter 4123-7 provider payment rules were e-mailed to the BWC Medical Division's list of stakeholders for review on Monday, September 14, 2009 with comments due back on Friday, September 18, 2009.
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.

OBWC Board of Directors Governance Committee Charter

Purpose

The Ohio Bureau of Workers' Compensation Board of Directors has created the Governance Committee under authority granted by RC 4121.12(G)(2). The Governance Committee is a standing committee of the Board of Directors. The Committee shall assist the Board of Directors in fulfilling its oversight responsibilities relating to developing and implementing sound governance policies and practices. The Committee is responsible for:

- reviewing and recommending to the Board the adoption of governance guidelines and committee charters;
- overseeing compliance with federal and state laws, regulations, policies and ethical requirements;
- developing a process for the Board's assessment of its performance and the performance of Board committees;
- overseeing the process for orientation of new Board members and the continuing education program for all Board members;
- making recommendations for Board Vice-Chair, Committee Chairs and Vice-Chairs and Director assignments to Board committees for the Chair's consideration
- coordinating processes and procedures for the Administrator's annual performance review; and
- other duties and responsibilities as assigned by the Board.

In order to constitute the will of the Board of Directors, Committee actions must be ratified or adopted by the Board of Directors to become effective.

Membership

The Committee shall be composed of a minimum of three (3) members. One member shall be the Chair of the Ohio Bureau of Workers' Compensation Board of Directors. The Board, by majority vote, shall appoint at least two (2) additional members of the Board. Bureau management personnel cannot serve as a Committee member. The Chair and Vice-Chair are designated by the Board based on the recommendation of the Board Chair.

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

Members of the Governance Committee serve at the pleasure of the Board, and the Board, by majority vote, may remove any member except the Board chair.

Meetings

The Governance Committee shall meet at least four (4) times annually. The Committee chair will provide a report of the meeting at the next subsequent Board meeting. The Board grants the Committee authority to have additional meetings. Additional meetings may be requested by the Committee chair, 2 or more members of the Committee, or the Board Chair.

A quorum shall consist of a majority of Committee members. Committee meetings will be conducted according to Robert's Rules of Order. All Directors are encouraged to attend the Committee meetings.

The Committee will invite members of management, fiduciary counsel, and/or others to attend meetings and provide pertinent information as needed.

Minutes for all meetings of the Committee will be prepared to document the actions of the Committee in the discharge of its responsibilities.

Duties and Responsibilities

1. The Governance Committee shall assist the Board in meeting the following statutory requirements:

- Assist in the establishment of the Board's annual prospective performance goals and objectives for the Administrator; coordinate and facilitate the process for the Board's annual performance evaluation of the Administrator (RC 4121.12(F)(15)).
- Oversee the BWC orientation process for newly appointed members of the BWC Board and assist the Board in its implementation. The Committee shall also regularly assess the adequacy of and need for additional continuing Director education programs. These requirements include: orientation for new members; continuing education for those Board members who have served for more than one year; Board member duties and responsibilities; injured worker compensation and benefits; ethics; governance processes and procedures; actuarial soundness; investments; and any other subject matter the Board believes is reasonably related to the duties of a Board member (RC 4121.12(F)(16)).
- Make recommendations to the Board for retaining fiduciary counsel. (RC 4121.12 (F)(6)(c)).

- Oversee the process for all statutorily required reports of the Board for submission to the Governor, General Assembly or the Workers' Compensation Council (RC 4121.12(F)(3), 4121.125).
2. At least annually review the Board's Governance Guidelines and the charters of the Board's standing committees, and making such recommendations as the Committee determines necessary, appropriate, and consistent with HB 400Ohio law, including recommendations concerning the structure, composition, membership and function of the Board and its committees, subject to Board approval.
 3. Make recommendations for Board Vice-Chair, Committee Chairs and Vice-Chairs, and Director assignments to Board committees for the Chair's consideration and the Board's approval.
 4. Develop and coordinate the annual self-assessment of the Board and its Committees.
 5. Oversee compliance with laws, regulations, policies and ethical requirements.
 6. Act as the lead committee for rule review and changes with the exception of actuarial rules or other rules assigned to an existing committee. The Committee will follow the process for rule review as outlined in the Governance Guidelines.
 7. Coordinate with other Board committees on issues of common interest.
 8. Create by majority vote a subcommittee consisting of one or more Directors on the Committee. In consultation with the Chair, other Board members may be appointed to the subcommittee as appropriate. The subcommittee shall have a specific purpose. Each subcommittee shall keep minutes of its meetings. The subcommittee shall report to the Board of Directors through the Committee. The Committee by majority vote may dissolve the subcommittee at any time.
 9. Perform such other duties required by law or otherwise as are necessary or appropriate to further the Committee's purposes, or as the Board may from time to time assign to the Committee.

Draft reviewed Oct. 4, 2007 and Oct. 14, 2007
Approved as edited 112107; Alison Falls, Chair
Revised 012308
Revised 092408
Annual Review and Revision 112108
Annual Review and Revision 112009

OHIO BUREAU OF WORKERS' COMPENSATION
BOARD
GOVERNANCE GUIDELINES

2009 Draft

Last Approved by the Board:
Draft for discussion purposes:

November 21, 2008
October 13 2009

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INTRODUCTION AND PURPOSE

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The Ohio Bureau of Workers' Compensation ("BWC") is a state agency that provides medical and compensation benefits to Ohio employees for work-related injuries, diseases and deaths. Ohio employers pay premiums for these benefits to Ohio's State Insurance Fund and/or its specialty funds: Disabled Workers' Relief Fund, Coal-Workers' Pneumoconiosis Fund (CWPF), Public Work-Relief Employees Compensation Fund (PWREF), the Marine Industry Fund (MIF), and the Administrative Cost Fund (ACF). In addition to benefits paid, the BWC makes available and provides loss prevention services to Ohio employers. Ohio's workers' compensation system has the largest state fund in the nation and is the fourth largest underwriter of workers' compensation insurance in the country. Also, the BWC oversees compliance with statutes and rules of employers who choose to self-insure. There is also oversight of the Self-insured Employers Guaranty Fund (SIEGF) which provides payment for workers who were injured while working for self-insured employers who are now bankrupt.

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The BWC Board of Directors ("Board") was created by Ohio law and its authority and responsibilities are set forth in detail in the Ohio Revised Code.¹ The primary areas of Board focus are to establish the overall administrative policy of the BWC, to review the progress of the BWC in meeting its cost and quality objectives and to provide advice and consent regarding actions proposed by the BWC Administrator, who is responsible for the management of the day-to-day operations of the agency.² The Board operates in collaboration with other state entities, including the Office of the Attorney General, the Inspector General, the Workers' Compensation Council, Workers' Compensation Board of Directors Nominating Committee, the State Office of Internal Audit, the Industrial Commission, and the Ombuds Office.

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The Board and its members have fiduciary responsibilities to the BWC. A fiduciary is a person having a duty, created by an undertaking, to act *primarily for the benefit of another* in matters connected with that undertaking. The monies paid into the workers' compensation funds constitute a trust fund for the benefit of employers and employees.³ The members of the BWC Board are obligated by law to adhere to the highest standards of judgment and care when making decisions or taking actions that may affect the financial integrity and soundness of the workers' compensation funds.⁴ In order to properly discharge the Board's fiduciary responsibilities, the Board should be guided by three primary considerations with respect to matters that come before it: (1) the provisions of Ohio law that directly impact the Board's activities; (2) the duty of loyalty to protect the workers' compensation funds and to act in good faith and in the interests of all the stakeholders of the BWC, taken as a whole; and (3) the duty of care in ensuring that all Board decisions and actions are the result of an informed deliberative process in which the significant information items relevant to the proposed decision or action are identified and considered by the Board.

Accordingly, it is incumbent upon the Board to operate with the integrity appropriate to its fiduciary duties as it oversees the business of BWC. The Board aspires to implement the best practices of corporate governance and to incorporate all significant developments in this area into its policies and procedures. The Board has adopted the measures set

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forth in this document to describe the governance structure and guidelines by which the Board shall conduct its business. It is the intention of the Board to review these guidelines at least annually.

ORGANIZATION OF THE BWC BOARD OF DIRECTORS

Board Composition

The BWC Board of Directors consists of eleven (11) members. Board members are appointed by the Governor of Ohio from a list of candidates prepared by the Workers' Compensation Board of Directors Nominating Committee and with the advice and consent of the Ohio Senate. It is provided by statute that one member of the Board shall be a representative of employees; two members of the Board shall be representatives of employee organizations; three members of the Board shall be representatives of employers with one of the three representing self-insuring employers; two members of the Board shall be investments and securities experts; one member of the Board shall be a certified public accountant (CPA); one member of the Board shall be an actuary; and one member of the Board shall represent the public.⁵ The Governor of Ohio selects the Chair of the Board of Directors, who serves at the pleasure of the Governor.

Ohio law established that the members of the Board of Directors will serve staggered three year terms of office. One group consists of the employee representative, one of the employer representatives, and the public representative, The second group consists of another employer representative, one of the employee organization representatives, one of the investment and securities expert and the CPA representative, The third group consists of the third employer representative, the other employee organization representative, the other investment and securities expert, and the actuary representative. There are no term limits. Ohio law sets forth detailed procedures for the filling of vacancies occurring as a result of the expiration of a Board member's term of office or otherwise.⁶ The current Board members and their respective terms of office are listed in a document attached hereto as Exhibit A.

Board members shall aspire to maintain the highest ethical standards and integrity in fulfilling their responsibilities, and shall demonstrate a willingness to act on and be accountable for Board decisions. Members shall strive to utilize their diverse backgrounds, talents and experiences to provide wise, informed and thoughtful counsel to BWC management. Members shall demonstrate loyalty and commitment to the success of the BWC. It is expected that members may hold differing points of view on issues before the Board and are encouraged to express their points of view. Regardless of their particular points of view, members shall at all times act in the best interests of the BWC and its stakeholders as a whole. Members shall devote an appropriate amount of effort in preparation for meetings, participate fully in the activities of the Board and its Committees, and shall strive to be prompt and regular in attendance at Board and Committee meetings. Board members shall be compensated for their attendance at Board and Committee meetings, and shall be reimbursed for all reasonable and necessary expenses while engaged in the performance of their duties, all as provided by statute.⁷

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Duties & Responsibilities

Under Ohio law,⁸ the Board's responsibilities include the following:

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- establish overall administrative policy for BWC;
- review BWC's progress in meeting cost and quality objectives, and its compliance with the Ohio Revised Code;
- meet with the Governor of Ohio annually to discuss the Administrator's performance;
- advise and consent on rules that BWC wishes to pursue;
- contract with an actuarial firm, outside investment consultant and independent fiduciary counsel to assist the Board in fulfilling its duties;
- contract with an actuarial consultant to prepare an annual actuarial report, an actuarial investigation of employers' experience and injured workers' benefits every five years (by 2012), and actuarial analysis of legislation expected to have measurable financial impact on the system;
- review investment policy annually, approve investment policy changes for BWC, prohibit investments that are contrary to Board-approved investment policy, vote to open investment classes, and adopt rules establishing due diligence standards for BWC employees to follow when investing in an open investment class and establish policies and procedures to review and monitor the performance and value of each investment class;
- contract with an independent auditor to conduct a fiduciary performance audit of BWC's investment program at least once every ten years (by 2017).
- review all independent financial audits of BWC;
- submit an annual report to the Ohio General Assembly, the Governor, and the Workers' Compensation Council regarding BWC operations and progress;
- submit an annual report on the performance and value of BWC investments to the Governor and the Ohio General Assembly;
- develop and participate in an education program for the Board members, and submit the education program to the Workers' Compensation Council; and
- study issues as requested by the Governor or the Administrator.

Administrator's Performance Objectives & Evaluation

Annually the Board shall oversee a process for the evaluation of the Administrator's performance and shall also develop prospective performance objectives for the Administrator for the coming fiscal year. At the end of the review year, the Board will examine the Administrator's actual performance against the Board's objectives as well as the Governor's objectives. The Board's process for the Administrator's evaluation shall include (i) a review by the Governance Committee of the Specific Performance Objectives contained in the Administrator's Flexible Performance Agreement with the Governor, as well as leadership attributes that the Board believes are important to an overall evaluation of the Administrator's performance, (ii) the development of an evaluation form to be completed by all qualified Directors, with respect to the Administrator's evaluation, (iii) the review by the Board of the compilation of all Director responses to the evaluation form, (iv) the review, comment and finalization of a

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draft Annual Evaluation Report prepared by the Governance Committee with the assistance of fiduciary counsel, revised to reflect input from individual Board members, (v) the review, comment and finalization of the Annual Evaluation Report by the full Board, and (vi) the discussion of the Annual Evaluation Report first with the Administrator and then with the Governor at a meeting of the Board for that purpose. The final written Annual Evaluation Report shall be made publicly available.

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Board Self-Assessment Process

Although not required by Ohio law, the Board of Directors shall engage in a yearly self-assessment process for the purpose of continuous self-improvement. This process provides an occasion for input from all Board members regarding their opinion on a range of Board issues, including receipt of information, discussion and decision-making. The objective is for the Board to take time to be introspective and then use the self-assessment process to be proactive in recommending action steps to continuously develop the Board's processes and effectiveness. The self-assessment will assist the Board members to identify opportunities for improvement, as well as recognition of past areas of success. The self-assessment will contain a balance of both objective and subjective observations. The self-assessment process shall be evaluated on a yearly basis to ensure continued relevancy of all questions posed.

Duty of Oversight

In general, the Board is responsible for approving the strategic direction proposed by BWC management. In order to approve any such plans, it is necessary and appropriate for the Board to develop a depth of knowledge regarding BWC operations that shall enable the Board to analyze the effectiveness and feasibility of the strategic proposals of the Administrator. In addition, the Board shall monitor the performance of BWC as it works to fulfill the business approach adopted by the agency. As the Board monitors BWC performance, it shall be necessary for the Board to review and approve BWC's financial objectives, plans and actions, as well as to review and approve any transactions not in the ordinary course of business. To enable successful fulfillment of BWC objectives, the Board shall ensure that BWC is structured to encourage ethical behavior, to require compliance with the law, and that sound accounting principles, actuarial standards and auditing practices are instituted.

In exercising their fiduciary responsibilities, Board members shall be guided by the specific provisions of Ohio law relative to the Board and the BWC. To assist the Board in fulfilling its fiduciary responsibilities, the Board shall retain independent fiduciary counsel.¹⁰ BWC shall obtain fiduciary liability insurance for the Board.

The Board of Directors may be required to provide information to the Workers' Compensation Council as it fulfills its duties. Such information shall be provided with all due speed. The Board of Directors shall provide its annual report, as well as its actuary report to the Workers' Compensation Council. The Board shall submit its annual education program to the Workers' Compensation Council.

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BOARD PROCEDURES

Board of Directors' Meetings

The Board of Directors conducts its business through open and public meetings in compliance with the Ohio Open Meetings Act. Members of the public and press are invited to attend these meetings. Advance notice of the time and place of all meetings shall be provided to the media and shall be posted on BWC's web site. Notice shall be provided subject to a test of reasonableness. The Chair of the Board shall set the meeting dates of the Board as necessary to perform the duties of the Board. The Board shall meet at least twelve times a year.¹¹ Minutes of all Board and Committee open public meetings shall be taken and maintained. Robert's Rules of Order is generally followed at both Board and Committee meetings. The Chair of the Board presides at Board meetings. In the event that the Chair is unable to attend, the Vice Chair of the Board shall preside at the Board meeting.

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Conduct at Meetings

A Board member desiring to speak shall address the Board Chair and, upon recognition by the Board Chair, shall confine discussion to the issue before the Board and shall observe appropriate courtesy of behavior including: avoiding discussion of personalities or personal matters, avoiding the use of indecorous language, and refraining from personal attacks and verbal abuse. A Board member, once recognized, shall not be interrupted while speaking unless called to order by the Board Chair, unless a point of order is raised by another Board member, or unless the speaker chooses to yield to questions from another member. If a Board member is called to order while speaking, that member shall cease speaking immediately until the question of order is determined. If ruled to be in order, the member shall be permitted to proceed. If ruled to be not in order, the member shall remain silent or make additional remarks in accordance with the rules of the Board.

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A Board member desiring to question a BWC staff member shall address such questions to the Board Chair, the Administrator or the appropriate Board Committee Chair. Such person shall be entitled either to answer the inquiries or to designate some member of the BWC staff for that purpose. Board members shall treat with respect members of the BWC staff, who shall observe the same rules of decorum as the BWC Board members.

Whenever possible, motions and amendments to motions should be in writing and distributed to all Board members prior to the Board and Committee meetings. Formal motions shall be made to approve the minutes of the Board and Committee meetings, and to approve meeting agendas as well as modification to the agendas. To adjourn a Board or Committee meeting, a motion shall also be made.

Agenda Development & Distribution

The Board Chair, in cooperation with the Administrator and/or the Board Liaison, shall prepare the agenda for the Board meeting. Any Board member desiring to do so is encouraged to submit suggestions or requests for agenda topics relevant to the conduct of the Board's duties to the Board Chair. At a minimum of a week prior to each regular

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Board meeting informational material with respect to that meeting shall be delivered to the Board, including a preliminary agenda and supporting documents with respect to the matters to be considered at the meeting. Whenever practical, and particularly for major policy initiatives or major rule changes, background and informational material shall be provided to the members of the Board more than a week in advance of scheduled Board meetings to allow addition time for review and reflection. This same process shall be followed for Committee meetings. A Board member may request that an agenda item be deferred, removed or added by making the request to the Board or Committee Chair. The request to defer, remove or add an agenda item shall be considered by the Board or Committee Chair and implemented where practical. Should the Board member's request to defer, remove or add an agenda item be refused, and the Board member is dissatisfied with the result, the Board member may make a motion to have the Committee or the full Board consider the request by vote.

Reports by Board Committees

At the Board's monthly meeting, the Committee Chairs shall regularly provide a report of the activities of the Committees. This agenda item enables Committee Chairs or designated representatives to report any actions or pending actions taken by Committees and to request Board approval of Committee recommendations as appropriate.

Committee Meetings

Committee meetings are conducted as often as determined necessary by majority vote of the Board of Directors. Only members of the Committee may participate in voting on Committee matters. All members of the Board are encouraged to attend and participate in discussion at Committee meetings. The Committee Chair shall develop the agenda for the Committee meetings. Ample opportunity shall be given for any Board member to submit suggestions or requests for agenda topics to the Committee Chair. Committee agendas and supporting documents shall be provided to the Board and appropriate BWC staff prior to the Committee meeting. Minutes of Committee meetings shall include identification of Committee members and other Board members present, agenda items and official actions taken by the Committee. Committee minutes shall follow all the requirements for minutes for the full Board meetings, as noted below in "Minutes of Board Meetings and Committee Meetings".

Rules/New Business Submittal Process

Generally, BWC staff should submit proposed rules and new business items to the Board Liaison at least two weeks prior to the upcoming Board meeting or Committee meeting. It is recognized that unforeseen circumstances may prevent such advance submission. For issues concerning the various Committees, the Board Chair, with the advice and consent of the Committee Chair, shall determine whether issues are presented to the Board for resolution.

Subject to the Board's discretion, information regarding major policy initiatives or rule changes that may be contemplated by BWC should be submitted for the agendas of the Board and its Committees for a "first reading" and subsequent reporting by the Committee chair to the full Board. The same major policy initiative or rule change would

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then be included on the agendas of the Committee and the Board at a later meeting for a “second reading” and possible approval. The first and second readings provide the Board and its Committee members the opportunity to obtain background information, ask questions of BWC staff members, and engage in discussion regarding the topics that are under consideration. The same major policy initiative or rule change would proceed from a first reading to a second reading at a later Committee meeting before the Board would consider approval. This process of providing both a first and second reading ensures a fully informed vote by the Board concerning a major policy initiative or rule change.

In unusual and extraordinary circumstances, the Board or a Committee may wish to waive a “second reading” of a major policy initiative or rule change. In the event a Committee wishes to waive the second reading of a major policy initiative or rule change, a motion to waive shall be submitted for consideration, and voted upon by roll call vote. If the motion to waive the second reading passes at the Committee level by a majority vote, the Committee may then proceed to consider the underlying major policy initiative or rule change for recommendation to the Board. If the Committee considers the underlying major policy initiative or rule change and by majority vote approves it for recommendation to the Board, both the issue of waiving the second reading and the underlying major policy initiative or rule change can then proceed to the Board to be considered for approval. Once before the Board, a motion to waive the second reading shall be submitted for consideration, and voted upon by roll call vote. If the motion to waive the second reading passes the Board by a majority vote, the underlying major policy initiative or rule change can then be considered for possible approval at that meeting.

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Administrator’s Report

At the Board’s monthly meeting, the Administrator shall regularly provide a report. This agenda item provides an opportunity for the Administrator to present information on issues of interest to the Board and others.

Minutes of Board Meetings & Committee Meetings

There shall be detailed minutes kept of each Board and Committee meeting. The minutes record the formal actions taken by the Board and Committees and a summary of important reports and discussions. These minutes should reflect the length and intensity of the discussion of key issues before the Board or Committee, and also record with precision the actions of the Board or Committee with respect to the matters on which it takes action. Minutes should contain appropriate details of the meetings, and should reflect the Board’s or Committee’s fulfillment of applicable fiduciary standards of conduct. In its decision-making processes, the Board and Committees shall give thoughtful attention to the issues before it; the minutes shall indicate the full consideration given by the Board or Committee. The minutes should also document such matters as whether further follow up was requested from the Administrator or Staff. The minutes shall demonstrate the Board’s or Committee’s adherence to the Governance Guidelines. Board or Committee members may request that specific comments be included in the minutes. Minutes should usually be reviewed and voted on for approval at the next subsequent Board meeting, at which individual Board members may offer

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suggestions of amendment to the minutes. Accordingly, a draft of the Board and Committee minutes, in substantially final form, shall be furnished to the Board members in the next subsequent Board package. The Board shall approve the Board minutes by majority vote; the members of each Committee shall approve the minutes of the respective Committees by majority vote. Once approved, the minutes constitute the official record of the Board's or Committee's actions and decisions.

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Executive Session

Consistent with Ohio law¹¹, the Board and its Committees may move to go into Executive Session (i.e. exclude the public from attendance) under a limited set of circumstances by stating the reason for the executive session and taking a roll call vote, with passage requiring a majority vote. The proper purposes for Executive Session are to discuss any of the following issues:

- personnel (to consider appointment, employment, performance evaluation, dismissal, discipline, promotion, demotion or compensation of a public employee or official, or to consider the investigation of charges or complaints against a public employee or official);
- property (to consider the purchase or sale of property if disclosure of the information would result in a competitive advantage to the other side);
- court action (to discuss pending or imminent court action with legal counsel);
- collective bargaining (to prepare for, conduct or review collective bargaining strategy);
- confidential matters (to discuss matters required to be kept confidential by federal law, rules or state statute);
- security arrangements (to discuss details of security arrangements and emergency response protocols where disclosure could be expected to jeopardize the security of the Board of Directors); and
- As otherwise permitted by law and approved by legal counsel.

No action or any votes may be taken in Executive Session. A motion is required to come out of executive session, with a roll call vote taken in public. Any voting on matters discussed in Executive Session shall be taken in public session. Attendance at Executive Sessions is limited to Board members and others invited by the Board Chair or Committee Chair as necessary.

Director Education Program¹²

The Board of Directors shall develop an education program for its members with the oversight of the Governance Committee. The education program shall contain an orientation component for newly appointed members, as well as a continuing education component for members who have served at least one year. For orientation of new members, information regarding all activities of BWC shall be provided, as well as information regarding the roles of the Board and its Committees. The Board Liaison shall schedule new members for briefing sessions with other Board members, Board legal counsel, as well as BWC staff. The briefing sessions and ongoing education curriculum shall cover the following topics:

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- information about Board member duties and responsibilities;
- information concerning injured worker compensation and benefits paid under Chapters 4121, 4123, 4127, and 4131 of the Ohio Revised Code;
- summary of HB 100 legislation and amendments thereto;
- Ohio ethics statutes and rules, BWC ethics policy, and all ethics opinions from the Ohio Ethics Commission concerning Board members;
- fiduciary responsibility including memorandum from fiduciary counsel;
- governance processes and responsibilities;
- BWC Administrator and agency goals and objectives (e.g. “Restoring Operational Excellence” for fiscal year 2008-09);
- Administrator evaluation process;
- Board self-assessment process;
- Concepts of actuarial soundness;
- Investments;
- Budgeting and financial reporting;
- Auditing processes and procedures;
- any other topic reasonably related to the duties of the Board.

The Board of Directors shall submit the education program it develops to the Workers’ Compensation Council. All sessions, classes, and other events for the education program developed by the Board and approved by the Workers’ Compensation Council shall be held in the State of Ohio. Education sessions can be conducted at Committee or Board meetings, as long as a majority of Board members attend. If a Board member is unable to attend a particular session, that member should attend a “make-up session.” The Board shall review and approve its education program annually and submit it to the Workers’ Compensation Council. At least annually, both the Director of the Ethics Commission as well as Board fiduciary counsel shall be invited to address the Board on their respective areas of subject matter expertise.

Public Forum Process

The Administrator, in consultation with the Board, shall annually create a plan for public forums to solicit views from the public on various issues, to be held periodically throughout the coming year. Each public forum shall address a topic or topics deemed by the Administrator or the Board to be of interest to BWC stakeholders. Members of the public shall be provided notice of and have an opportunity to provide comments and/or register to speak at such forums. The Administrator and the Board may also invite certain stakeholders with an interest in the topic to speak. Appropriate written comments provided during the meeting shall be posted on the BWC web page. The Board and BWC shall follow the Policies and Procedures for Public Forums, as adopted by the Board and attached hereto as Exhibit B.

Communication Guidelines

As a general rule, it is the Board’s position that the BWC Administrator, or BWC management appointed for such purpose by the Administrator, speaks for the agency as a whole.

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Members of the public can provide written submission of comments to BWC's website at OhioBWC.com. Comments on pending legislation should be limited to those necessary to conduct the business of the Board of Directors. Comments beyond that should be directed to members of the Ohio General Assembly or the Workers' Compensation Council. The Chair of the Board of Directors reserves the right to limit comments from the public during meetings.

Communications received directly by Board members from persons outside the BWC shall be forwarded to the Board Liaison. If the communication is to the entire Board, the Board Liaison shall work with the Board Chair and prepare the appropriate response. The response shall be shared with the Board. If the communication is addressed to an individual Board member, the Board member receiving such communication shall work with the Board Liaison to prepare the appropriate response. The original communication and response shall be provided to the entire Board. The Board Liaison shall be responsible for retention of the Board's public records and communications with the public. The Board Liaison shall follow state law and BWC policies for records retention.

BOARD COMMITTEES – COMPOSITION AND RESPONSIBILITIES

By law¹³, the Board of Directors shall establish three Committees: the Actuarial Committee, the Audit Committee, and the Investment Committee. Additional Committees may be established by the Board of Directors as needed.¹⁴ Currently, the Board of Directors has established a Governance Committee and a Medical Services Committee in addition to the statutorily mandated Committees. At least annually, shortly after scheduled Board appointments, the appointment of Committee members, the Committee Chair, and the Committee Vice Chair shall be considered and shall be approved by the majority vote of the Board.

The Committee Chairs shall preside at Committee meetings. In the absence of a Committee Chair, the Vice Chair of the Committee shall preside at the Committee meeting. Additional detail regarding the Board's Committees, including the roles and responsibilities of all Committees, are further defined by the Committee Charters, as approved by the Committees and adopted by the Board. Each Charter shall be reviewed and updated as necessary on an annual basis. The Charters of the Board's Committees are attached hereto as Exhibit C.

Actuarial Committee

Although Ohio law requires a minimum of three members to be part of the Actuarial Committee, the Board has determined that the Actuarial Committee should consist of a minimum of five members of the Board of Directors. One member shall be the member of the Board who is an actuary. The Board, by majority vote, shall appoint additional members of the Board to serve on the Actuarial Committee. The Board may also appoint additional members who may not be on the Board, as the Board determines necessary through majority vote. Members of the Actuarial Committee serve at the pleasure of the

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Board and the Board, by majority vote, may remove any member except the member of the Committee who is the actuary member of the Board.

The Actuarial Committee performs several functions mandated by law. It recommends actuarial consultants for the Board to use for actuarial analysis of BWC funds, and reviews the annual report of the actuarial valuation of the assets, liabilities, and funding requirements of the State Insurance Fund. In addition, the Actuarial Committee reviews the calculations on rate schedules and performance prepared by the actuarial consultants retained by the Board. The Actuarial Committee reviews all administrative code rules proposed for change, rescission, or addition that concern rate making. The Actuarial Committee has actuarial analysis conducted for any legislation expected to have a measurable financial impact on the BWC system. At least once every five (5) years, the Actuarial Committee arranges for an actuarial investigation of: the experience of employers; mortality, service and injury rate of employees; and payment of benefits, in order to update the assumptions on the annual actuarial report. This actuarial investigation shall be conducted next in the year 2012.

Audit Committee

Although Ohio law requires a minimum of three members to be part of the Audit Committee, the Board has determined that the Audit Committee shall consist of a minimum of five members of the Board of Directors. One member shall be the member of the Board who is the certified public accountant. The Board, by majority vote, shall appoint additional members of the Board to serve on the Audit Committee. The Board may also appoint additional members who may not be on the Board, as the Board determines necessary through majority vote. Members of the Audit Committee serve at the pleasure of the Board and the Board, by majority vote, may remove any member except the member of the Committee who is the certified public accountant member of the Board. ▼

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The Audit Committee performs several functions mandated by law. It makes recommendations to the Board regarding the accounting firm that performs BWC's annual audits.¹⁴ It also recommends to the Board the accounting firm(s) that the Board uses when conducting the fiduciary performance audit of BWC's investment program¹⁵, and other management and financial audits that the Board may deem necessary¹⁶ under R.C. §4121.125. The Audit Committee reviews the results of each annual financial audit and management review, assessing and developing appropriate courses of action to correct any problems that may arise. The Audit Committee also monitors the implementation of any action plans it creates, and reviews all internal audit reports on a regular basis. The committee follows the process as described in the "Board Procedures" section of this document. The Audit Committee also oversees the annual and biennial agency budget process by providing initial review to BWC budget materials prior to Board review and approval. The Audit Committee assists the Board in providing oversight of the integrity of BWC's financial statements.

The Audit Committee is responsible for strategic financial policies for assuring the appropriate level of net assets for the appropriate BWC funds. The Audit Committee is

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responsible for an annual review of the funding ratio and the net leverage ratio pursuant to BWC's Net Asset Policy, which is attached hereto as Exhibit D. As part of this policy, the Audit Committee and then the Board shall review BWC staff recommendations in order to establish guidelines for funding ratio and net leverage ratio. The Audit Committee shall also take the lead in the process for establishing the discount rate for reserves. Pursuant to BWC's Reserve Discount Rate Policy, attached hereto as Exhibit E, the Administrator has the responsibility and authority to establish the discount rate for reserves with the review and guidance of the Audit Committee and the concurrence of the Board.

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Investment Committee

Although Ohio law requires a minimum of four members to be part of the Investment Committee, the Board has determined that the Investment Committee shall consist of a minimum of five members. Two of the members shall be the members of the Board who serve as the investment and securities experts on the Board. The Board, by majority vote, shall appoint additional members of the Board to serve on the Investment Committee. The Board may also appoint additional members who may not be on the Board, as the Board determines necessary through majority vote. Each additional non-Board member appointed shall have at least one of the following qualifications: a) experience managing another state's pension or workers' compensation funds; or b) expertise that the Board determines is needed to make investment decisions. Members of the Investment Committee serve at the pleasure of the Board and the Board, by majority vote, may remove any member except the members of the Committee who are the investment and securities expert members of the Board.

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The Investment Committee performs several functions mandated by law. It develops the investment policy for BWC, and submits it to the Board for approval. The Investment Committee must assure that BWC invests in accordance with its investment policy, and that the best possible return on investment is achieved while protecting the solvency of the State Insurance Fund. The Investment Committee monitors implementation by BWC of the investment policy. It recommends an outside investment consultant for the Board. Finally, the Investment Committee reviews the performance of BWC's Chief Investment Officer and the investment consultants retained by BWC.

Governance Committee

The Governance Committee was established by the Board of Directors under its authority to create additional Committees as it deemed necessary.¹⁷ The Governance Committee consists of a minimum of three members. One member is the Chair of the Board of Directors. Members of the Governance Committee serve at the pleasure of the Board and the Board, by majority vote, may remove any member except the member of the Committee who is the Board Chair.

The Governance Committee is responsible for developing governance policies and advising as to best governance practices for the Board. The Governance Committee assists in the establishment of the Board's annual performance objectives for the Administrator and coordinates and facilitates the process for the Board's annual

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performance evaluation of the Administrator. The Governance Committee is responsible for the initial review of rules with the exception of actuarial ratemaking rules and other rules specific to another committee. In addition, the Governance Committee coordinates and facilitates the Board's annual self-assessment process, and monitors any follow up or action steps that may result from that assessment. The Governance Committee oversees the Board's educational programs, recommends the selection of independent fiduciary counsel to the Board for its approval, and makes recommendations to the Board Chair for the Vice Chair of the Board, Committee Chairs, Vice Chairs of the Committees, and Committee memberships.

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Medical Services and Safety Committee

The Medical Services and Safety Committee was established by the Board of Directors under its authority to create additional Committees as it deemed necessary.¹⁷ The Medical Services Committee consists of a minimum of three members. Members of the Medical Services and Safety Committee serve at the pleasure of the Board and the Board, by majority vote, may remove any member.

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The Medical Services and Safety Committee is responsible for assisting the Board of Directors and BWC. The Medical Services and Safety Committee will assist the OBWC Board of Directors (Board) in the development of strategic policy for the provision of quality, cost-effective prevention, treatment, and rehabilitation of workplace injuries for the mutual benefit of injured workers and employers. The Committee will provide review and oversight of BWC's policies with respect to its medical provider network and practice guidelines; managed care and disability prevention delivery models; and outcome metrics for the above.

BOARD GOVERNANCE -- GENERAL

Ethics

The Board of Directors is committed to following ethical standards that promote the integrity of the workers' compensation system in Ohio. The Board is charged to comply fully with all federal and state laws, rules, regulations and policies applicable to the BWC. In particular, it is necessary that Board members become familiar with the applicable ethics requirements in order to ensure compliance with them. These requirements include the provisions of the Ohio Revised Code, the Governor's Executive Orders addressing ethics, and the opinions of the Ohio Ethics Commission pertaining to the BWC Board of Directors, as identified in Exhibit F hereto. The Board Liaison shall provide copies of the ethics requirements within the Ohio Revised Code on a yearly basis to all Board members.

The Board is also subject to BWC's Code of Ethics, as found in the BWC Employee Handbook. To meet its obligations under Ohio law, each Board member shall submit to the Board's legal counsel at the Attorney General's office a copy of the annual Financial Disclosure Statement, required by the Ohio Ethics Commission. The BWC Legal

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Counsel and the Board's legal counsel at the Attorney General's office shall review the statements for potential conflicts of interest. In keeping with the guidance of the Ethics Commission, the Board shall give broad interpretation to the requirements to report any other board membership, fiduciary relationship, business or other association when completing the annual Financial Disclosure Statement. The Board views the requirements of Ohio law and BWC policy with respect to ethics as a minimum measure for its standard of conduct. It is the aspiration of the Board to perform its duties in accordance with the highest ethical standards.

To adhere to these standards, the Board's Directors must avoid conflicts of interest. A conflict of interest is a situation in which a Director has professional or personal interests that compete with the interests of BWC. Because each Director has a duty of loyalty to BWC, a conflict of interest should not be permitted to breach that duty. To avoid any potential conflict each Director should determine if there is a possibility of an actual conflict of interest or the appearance of a conflict of interest with any issues coming before the Board. If there is an actual conflict of interest or even the appearance of a conflict of interest the Director should recuse himself/herself from participating in any way in the decision, including discussions, of the issue creating the conflict of interest or appearance of a conflict of interest. The Director should state for the record the reason for the conflict of interest or appearance of a conflict of interest, and excuse himself/herself from the Committee or Board table for the duration of discussion and possible voting on the issue that created the conflict of interest or the appearance of a conflict of interest. Finally, the record should indicate that the Director in question did not participate in any way on the matter requiring recusal.

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Board Oversight Process Guidelines

In order for the Board to fulfill its fiduciary responsibilities regarding oversight of the BWC, it must receive accurate and reliable information from the Administrator and BWC staff. Further, the Board must do its part in promoting the provision of quality information by making sure that measures are in place to ensure, to the extent practicable, that it is receiving the best information available. A related responsibility of the BWC, as an Ohio state governmental agency, is to develop, implement, and enforce policies and procedures that prevent or reduce the risk of wrongful acts and omissions by its officers and employees. In furtherance of the Board's oversight role, the Board has regularly scheduled meetings in which information exchange between it and BWC takes place. In addition, Charters have been established for all Committees and the Governance Committee was created to oversee governance issues. Furthermore, information exchange between the Board and the Inspector General's ("IG") office has been established. The Board Chair shall periodically contact the IG to invite sharing of information regarding IG investigations relative to the BWC. It was acknowledged in this connection that, in some cases, the IG may not be able to share information due to the confidentiality and other constraints imposed by statute on the IG's office. The Board Oversight Process Guidelines are attached hereto as Exhibit G.

As detailed in its charter, the Audit Committee is the arm of the Board that has the formal responsibility of interacting with the Auditor of State, the State Office of Internal Audit, and other agencies within the Ohio and federal governmental systems. In the event there

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is an internal BWC investigation which is not referred to the deputy IG, and the Administrator has determined that there is no need for confidentiality with respect to such matter, the Audit Committee shall be informed of such matter at a regular meeting. If there is a need for confidentiality, as determined by the Administrator, in consultation with the Board Chair, the Audit Chair shall be informed of such matter, and the Audit Chair shall make a judgment as to whether or not there is a need to inform others on the Board regarding the investigation. The policy underlying this procedure is that, in any such event, either the Board, the Board Chair, or the Audit Chair shall know what is occurring.

There are several reports mandated by law that the Board of Directors must submit to various bodies. In order to coordinate the preparation, review and release of these reports, the Board has asked the Governance Committee to assume appropriate oversight of the general process and assign responsibility to the various Committees for oversight of specific reporting processes. Generally speaking, no Board of Director reports that are required by statute may be released without express Board review and approval. The Governance Committee of the Board provides general oversight of this process. However, the respective committees with specific expertise with respect to any such report will provide the supervision necessary for completion of the report. The various committees will work with BWC staff, review the report product, and provide any feedback necessary for finalization of the documents to be released. The timetables for completion of these reports shall be established by the committee responsible for the report, and the responsible parties shall comply with any mandatory due dates set forth therein or with respect thereto. A document detailing the division of responsibility and accountability for each report, as well as a general timetable for completion has been established called "Board of Directors Schedule of Mandatory Reports," which has been adopted by the Board of Directors and is attached hereto as Exhibit H.

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Referral Process for Wrongdoing

The Board of Directors is fully committed to the detection, investigation and prevention of wrongdoing at BWC. In the event a Board member receives information concerning possible wrongdoing at BWC, it is the member's obligation to promptly notify the Board Chair and the Administrator of the information so that the matter can be fully investigated and handled. In some instances, matters may be referred to the IG's office for investigation.

The Board of Directors shall comply with BWC's Employee Handbook regarding requirements for the reporting of wrongdoing. In addition, the Board shall also follow the Governor of Ohio's requirements for the reporting of wrongdoing, as contained in the memorandum from the Governor's Chief Legal Counsel Kent Markus dated October 11, 2007, which is attached hereto as Exhibit I.

BWC staff is responsible for keeping the Board of Directors fully informed of investigations and their outcomes. To this end, the Administrator shall provide updates to the Board as necessary. In some instances, updates regarding investigations of wrongdoing shall be provided in executive session, as permitted by Ohio law.

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R.C. § 124.341 establishes the procedures and responsibilities incumbent upon all state agency employees with respect to the reporting of wrongdoing, as well as the responsibilities of supervisory personnel within state agencies with respect to whistleblowing occurrences, including referral of the report to the appropriate authority and the protection of the whistleblower. The Board shall similarly follow such procedures and observe the requirements of Ohio law regarding whistleblowing.

¹ [Ohio Revised Code Section 4121.12 \(F\)](#)

² [Ohio Revised Code Section 4121.121 \(B\)](#)

³ [Ohio Revised Code Section 4123.30](#)

⁴ [Ohio Attorney General Opinion No. 89-033 \(1989\)](#)

⁵ [Ohio Revised Code Section 4121.12 \(A\)](#)

⁶ [Ohio Revised Code Section 4121.12 \(C\)](#)

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⁷ [Ohio Revised Code Section 4121.12 \(D\)](#)

⁸ [Ohio Revised Code Section 4121.12 \(F\)](#)

⁹ [Ohio Ethics Commission Opinion dated July 30, 2007 provides that a Director who receives compensation to represent clients on matters before the BWC is disqualified from any matters before the Board that directly affect an individual official or employee of the BWC. For example, a Director who is an attorney representing clients before BWC is disqualified from participating in the evaluation of the Administrator's performance.](#)

¹⁰ [Ohio Revised Code Section 4121.12 \(F\) \(6\) \(c\)](#)

¹¹ [Ohio Revised Code Section 4121.12 \(D\)\(4\)](#)

¹¹ [Ohio Revised Code Section 121.22](#)

¹² [Ohio Revised Code Section 4121.12\(F\)\(16\)](#)

¹³ [Ohio Revised Code Section 4121.129](#)

¹⁴ [Ohio Revised Code Section 4121.12 \(G\)\(2\)](#)

¹⁴ [Ohio Revised Code Section 4123.47](#)

¹⁵ [Ohio Revised Code Section 4121.125\(I\)](#)

¹⁶ [Ohio Revised Code Section 4121.125\(B\)](#)

¹⁷ [Ohio Revised Code Section 4121.12 \(G\) \(2\)](#)

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Guard/ Safeguard Discussion and Recommendation

At the April 28, 2009 meeting of the Bureau of Workers' Compensation Board of Directors Governance Committee, an issue was raised concerning the use of the terms "guard/ing" and "safeguard/ing" in the context of the BWC Division of Safety and Hygiene administrative code rules. The Committee asked the Division of Safety and Hygiene, working with an external stakeholder committee, to recommend to the Board on how to define and use the words "guard" and "safeguard" .

The current definitions in Ohio Administrative Code 4123:1-5 -01, Scope and Definitions, state as follows:

"Guard" : the covering, fencing, railing, or enclosure which shields an object from accidental contact (See also "safety guard")

"Guarded" : means that the object is covered, fenced, railed, enclosed, or otherwise shielded from accidental contact

The term "safeguard" is not defined in 4123:1-5. However, the term is found in the rule identifying the need for guarding of power presses, industrial trucks, and other general provisions.

The word "guard" appears 57 times in the workshops and factories rules (4123:1-5), 26 times in the construction rules (4123:1-3) and 15 times in the other safety rules (e.g. steelmaking), for a grand total of 98 references in our safety rules. The word "safeguarding" appears 3 times in 4123:1-5 and 2 times in 4123:1-3.

"Safeguarded" occurs 2 times in 4123:1-5. Therefore, the grand total for words that have "safeguard" as a root in the BWC, Division of Safety and Hygiene's rules is 7.

A review of literature in the occupational safety and health field, the Occupational Safety and Health Administration (OSHA) federal standards, the American National Standards Institute (ANSI) standards and the American Society for Testing and Material (ASTM) standards provides insight into the common use of the terms "guarding" and "safeguarding" in the safety literature and reference guides. These documents were reviewed and the commonalities identified. The following paragraphs provide a summary of the results.

According to *The Safety Professionals Handbook*,¹ the term “safeguarding” is defined as “any means of preventing a worker or user from contacting a dangerous part of a machine, product or other device.” Further, a “guard” is defined as “a physical barrier that prevents any body part from contacting the hazard”.

Roger Brauer² states “Guards, one type of machine safeguard, are preferred over other types. Guards on machines are intended to keep people and their clothing from coming into contact with hazardous parts of machines and equipment.” He continues “Safeguards include guards, devices, distance or location.”

Accordingly, both references identify safeguarding as the concept of protecting employees from the hazards of the equipment and processes they are exposed to and guards are just one of the methods used to accomplish that goal. The ANSI R15.06-1999 standard: *Safety Requirements for Industrial Robots and Robot Systems* defines safeguard as “a barrier guard, device or safety procedure designed for the protection of personnel.” It further defines safeguarding as “the act of providing personnel with protection from a hazard.” It also defines a safeguarding device as “A means that detects or prevents access to a hazard”. This is consistent with the definitions provided by Brauer and Mroszczyk.

The OSHA General Industry regulations only defines guard in relation to the mechanical power press section of the code and defines “guard” as meaning “a barrier that prevents entry of the operator's hands or fingers into the point of operation.” This definition is narrower than the current definition in the BWC, Division of Safety & Hygiene rules. The term “guard” and its variations are used in contexts broader than the power press environment in the Division of Safety and Hygiene rules. For example, in Ohio Administrative Code 4123:1-5(C)(1)(a)(i), the term “guarded” is used as follows: “Floor openings, not including hoistway openings, shall be guarded with standard railing or with fixed safety covers with flush hinges.”

The Legal Division of the Bureau of Workers Compensation researched the use of the terms “guarding” and “safeguarding” in other states codes. In 19 of the 50 states, the terms “guard/ing” and “safeguard/ing” are used synonymously. The

¹ John Mroszczyk, *The Safety Professionals Handbook*, ed. Joel M. Haight (American Society of Safety Engineers, 2008), p. 129.

² Roger Brauer, *Safety and Health for Engineers* (Hoboken, N.J.: John Wiley and Sons, 2006).

other 31 states used separate definitions for “guarding” and “safeguarding” or did not define the terms at all.

In particular, the Legal Division closely examined the thirteen states which have programs similar to our VSSR penalty structure. They found that five states use “guard” and “safeguard” synonymously. Those five states are: Arkansas, Illinois, Massachusetts, Missouri, and Utah. The remaining eight states (including Ohio) use separate definitions for “guard” and “safeguard” ; or don’t define the terms at all.

As such, the Division of Safety & Hygiene approached the stakeholder group for input. We asked the stakeholders to consider changing the definition of guard and guarded and the addition of a definition for “safeguard” in all applicable Ohio Administrative Codes.

We offered the following options to our stakeholders:

1. Leave definitions as currently defined.
2. Change the definitions guard/guarded/guarding and add a new definition for safeguard/safeguarded/safeguarding.
3. Develop a new definition based on information from the stakeholder group.
4. Consider only defining the term “safeguard” to clarify the differences between “guard” and “safeguard” .

The staff’s proposed change in definition, based on similar language found in the literature, offered to the stakeholders read as follows:

Guard - a securely attached physical barrier, that is not readily removable, that prevents entry of any part of the body into the point of operation or other hazard area by reaching through, over, under or around the barrier

Guarded – means that the hazard is shielded from accidental contact by a securely attached physical barrier that is not readily removable, that prevents entry of any part of the body into the point of operation or other hazard area by reaching through, over, under or around the barrier

We received three responses from the stakeholder group. They were all consistent and all recommended no change to the current definition of guard, but

expressed support for the concept of defining the term “safeguard” and its permutations.

The response from the Ohio Manufacturer Association representative stated:

“It is my opinion that we should consider only defining the term “safeguard” to clarify the differences between “guard” and “safeguard”. I think we should use the proposed definition of Safeguarding- any means of preventing a worker or user from contacting a dangerous part of a machine, product or other device.”

The attorney with the Industrial Commission who represented public employee groups stated:

“We would open up cans of worms that would take decades to straighten out if we tried to change the usage of ‘guard.’ In particular, making the terms synonymous would be a disaster. A definition of ‘safeguard’ should only be added to clarify the distinction between ‘safeguard’ and ‘guard.’”

Further, internal concern was raised about any significant change in the settled definition of the term “guard”. There is potential for unforeseen consequences for injured workers and employers alike, depending on the way the Industrial Commission hearing officers and the courts interpret a new, untested definition.

Based on the input from the stakeholders and internal concern that changing the definition of guard could have unforeseen consequences, we recommend to the Governance Committee that the definition of the term “guard” not be changed. Based on stakeholder input, we recommend that the term “safeguard” and its derivatives be defined. If this Committee agrees with this recommendation, we will research safety literature to develop a recommended definition of “safeguard” and present it for the consideration of this Committee at the November meeting.

Agency Rule Review

Chapter	Title	# of rules	Legal Authority			Type of Review		JCARR review	Staff Contact	Review due	Proposed Sched	Proposed Timeline						Filed
			S	J	O	5YRR	Non 5 YRR					complete internal review	complete external review	Senior Staff Review Date	BOD Bk. Ddln*	BOD 1st read	BOD Vote	
4123:1-7	Metal casting	14	x			√		Yes	M. Ely	2008	Mar-09	Complete	2/24/09	2/26/09	6-Mar	19-Mar	30-Apr	7/31/2009
4123:1-9	Steel Making, Manuf, & Fabrica.	5	x			√		Yes	B. Loughner	2008	Mar-09	complete	2/15/09	2/26/09	6-Mar	19-Mar	30-Apr	7/31/2009
4123:1-11	Laundry & Dry Cleaning	5	x			√		Yes	R. Gaul	2008	Mar-09	complete	2/24/09	2/26/09	6-Mar	19-Mar	30-Apr	7/31/2009
4123-5	Miscellaneous Provisions	6		x	x	√		Yes	K. Robinson	2009	Apr-09	complete		4/2/09	10-Apr	28-Apr	29-May	7/10/2009
4123-18	Rehab of Inj and Dis Workers	16	x		x	√		Yes	K.Fitsimmons, K Robinson	2008	Apr-09	complete	in process	4/2/09	10-Apr	28-Apr	29-May	7/10/2009
4123:1-1	Elevators	5	x			√		Yes	R. Gaul	2008	Apr-09	complete	2/24/09	4/2/09	10-Apr	28-Apr	29-May	7/31/2009
4123:1-13	Rubber & Plastics	4	x			√		Yes	M. Lampl	2008	Apr-09	complete	3/17/09	4/2/09	10-Apr	28-Apr	29-May	7/31/2009
4123:1-17	Window Cleaning	7	x			√		Yes	D. Feeney	2008	Apr. 09	complete	3/24/09	4/2/09	10-Apr	28-Apr	29-May	7/10/2009
4123-6-08	2009 Provider & Service Fee Schedule						x		Graff		Apr-09	3/15/09	4/10/09	4/2/09	10-Apr	28-Apr	29-May	
4123-14	Non-complying employer	6	x			√		Yes	D.C. Skinner	2008	May-09			4/30/09	8-May	29-May	29-Jun	7/10/2009
4123-18-09	2009 Vocational Rehab Services Fee Schedule						x		K. Fitzsimmons, Graff		Jun-09	4/30/09	5/15/09	5/28/09	10-Jul	30-Jul	28-Aug	9/1/2009
4123-6-01 to 18	HPP- Program	49	x	x	x	√		Yes	F. Johnson, T. Mihaly	2009	Jun-09	4/6/09	5/7/09	5/28/09	5-Jun	18-Jun	30-Oct	
4123-6-50 to 73	HPP/QHP	24	x	x	x	√		Yes	F. Johnson, Leeper	2009	Jul-09	5/1/09	6/14/09	7/2/09	10-Jul	30-Jul	30-Oct	
4123-6-16.2	C9 Rule Change						x		Phillips		Jul-09	5/1/09	6/1/09	7/2/09	10-Jul	30-Jul	28-Aug	
4123-9	General Policy	12	x		x	√		Yes	J. Smith, TK, RM	2008	Jul-09		6/15/09	7/2/09	10-Jul	30-Jul	28-Aug	9/1/2009
4123:1-5	Workshops & Factories	32	x			√		Yes	M. Ely	2008	Aug-09	7/15/09	7/17/09	7/30/09	7-Aug	27-Aug	24-Sep	
4123-6-19 to 46	HPP- Provider	33	x	x	x	√		Yes	F. Johnson	2009	Sep-09			8/27/09	4-Sep	24-Sep	30-Oct	
4123-6-37.1	2010 Inpatient Fee Schedule						x		Graff, Casto		Sep-09	6/1/09	7/25/09	8/27/09	4-Sep	24-Sep	30-Oct	
4123 - 7	Payments to Health Care Prov.	30	x	x	x	√		Yes	F. Johnson	2009	Oct-09	7/15/09	9/15/09	10/1/09	9-Oct	29-Oct	30-Oct	
4123-6-37.3	2010 ASC Fee Schedule						x		Graff, Casto		Oct-09	7/15/09	9/1/09	10/1/09	9-Oct	19-Nov	20-Nov	
4123-6-37.2	2010 Hospital Outpatient Fee Schedule						x		Casto, TBD		Nov-09	8/15/09	9/30/09	10/22/09	31-Oct	19-Nov	17-Dec	
	total rules for 08-09	248																

S=Statutory
J=Judicial
O=Operational

* materials in final form

completed 5 year rule review

12-Month Governance Committee Calendar

Date	October 2009	NOTES
10/29/2009	1. Five year rule review	
	2. 2010 Inpatient Fee schedule (2 nd reading)	
	3. Governance Guidelines (1 st reading)	
Date	November 2009	
11/19/2009	1. Governance Guidelines (2 nd reading)	
	2. Committee Charters (2 nd reading)	
	3. 2010 Hospital Outpatient Fee schedule (1 st reading)	
	4. 2010 ASC Fee schedule (1 st reading)	
Date	December 2009	
12/16/2009		
Date	January 2010	
1/21/2010		
Date	February 2010	
2/25/2010		
Date	March 2010	
3/25/2010		
Date	April 2010	
4/29/2010	1. Launch Administrator Review	
Date	May 2010	
5/27/2010	1. Finalize Administrator Review	
	2. Launch Board and Committee Self-assessment	
Date	June 2010	
6/17/2010	1. Finalize Board and Committee Self-assessment	
	2. Committee membership recommendations	
	3. Develop Education Plan	
	4. Administrator's Objectives for FY 11	
Date	July 2010	
7/29/2010		
Date	August 2010	
8/26/2010		
9/23/2010	September 2010	

12-Month Governance Committee Calendar