

**OHIO BUREAU OF WORKERS' COMPENSATION
BOARD OF DIRECTORS -- SELF-ASSESSMENT**

SUMMARY OF DIRECTOR RESPONSES

Dated: JULY 25, 2008

The following questions were ranked on a scale from 1 – 5

Key: 1=Room for improvement 3=Satisfied 5=Area of considerable strength

Note: Following each rating table is a summary of director comments with respect to the rated topic.

The Governance Committee of the Board of Directors of the Ohio Bureau of Workers' Compensation (BWC) hereby submits, for consideration by the BWC Board of Directors, a summary of director responses to the self-assessment process voluntarily undertaken by the Board and related action steps. The self-assessment process included the use of a numerical rating system and input was solicited from all Board members. The summary reflects an overall assessment rating for FY 2007/2008 of 4.56 on a rating scale in which 5.0 = "Area of considerable strength" and 3.0 = "Satisfied." The objective of the self-assessment process was for the Board to take time to be introspective and then use the individual Director responses to be proactive in recommending action steps in an effort to continuously improve the Board's processes and effectiveness.

1. I believe I am well informed about the BWC's:

	None	1	2	3	4	5	Rating
Mission and strategic plans				x	xxx	xxxxxxx	4.5
Insurance business				xxxx	xxx	xxxx	4.0
Actuarial soundness				xx	xxxx	xxxxxx	4.3
Investment portfolio				xxx	xx	xxxxxxx	4.3
Financial performance				xxxx	xxx	xxxx	4.0
Cumulative Rating							4.2

The directors generally believe that they have worked hard to assimilate much information on diverse topics in order to understand a complex organization. The educational sessions by the BWC Staff have been very helpful in making progress. Some directors feel unsure of their grasp of certain topics and some would like to see further refinement of financial reporting in order to better evaluate financial performance. Questions were noted as to whether the BWC should be evaluated as an insurance business and whether the mission of the BWC is primarily that of a social insurance agency as opposed to an insurance business.

2. I believe the information I am sent for Board and Committee meetings is:

	None	1	2	3	4	5	Rating
Timely			x	xx	x	xxxxxxx	4.3
Complete			x	xxx	x	xxxxxx	4.1
Understandable				xx	xx	xxxxxxx	4.5
Cumulative Rating							4.3

The directors were generally very complimentary of the efforts of the Administrator and Staff in providing relevant information of good quality in a timely fashion prior to meetings. Several directors

would like more information and more time for review in advance of meetings. Some frustration was expressed regarding situations where information has been provided shortly before or at a meeting where decisions are expected to be made or positions taken on that matter at the meeting.

3. I believe I receive information of sufficient clarity and quality to enable me to understand BWC’s business and financial risks.

Rating	None	1	2	3	4	5	Rating
Tally				xx	xxxxx	xxxx	4.2

The directors generally believe that they understand the business and financial risks of the BWC much better today than they did a year ago. The quality and clarity of the information provided was commended. Some found that the volume of information can be difficult to fully assimilate. Concerns were expressed as to obtaining a better understanding of the nuances of the BWC’s business and financial risks. Reference was made to expectations regarding the forthcoming Deloitte study as providing guidance regarding key business and strategic issues. In terms of subject matter, a concern was expressed regarding gaining a better understanding of the Ohio Industrial Commission.

4. I believe management’s regular presentations on various aspects of the BWC’s business are:

	None	1	2	3	4	5	Rating
Clear and understandable					xxxx	xxxxxxx	4.6
Helpful in providing an accurate picture of the BWC’s performance					xxx	xxxxxxx	4.7
Cumulative Rating							4.7

The directors were generally very complimentary of the ability of BWC management to effectively communicate an accurate picture of the BWC’s performance in understandable terms in presentations and Q&A sessions. A suggestion was made that the Administrator’s report be moved to the front of the agenda for Board meetings, with ample time allotted for Q&A. Another suggestion was made that management should consider including in presentations and reports, where appropriate, opposing views and potential negatives.

5. The process by which the Board evaluates the Administrator’s performance works well.

Rating	None	1	2	3	4	5	Rating
Tally					x	xxxxxxxxxxx	4.9

The directors were united in their strong expression of satisfaction with the process by which the Board evaluated the Administrator’s performance. This speaks well of the care and attention devoted to the process by the Governance Committee, and to the active involvement of all eligible directors in the evaluation process.

6. I believe the rationale for proposed Board and Committee actions is adequately explained prior to action being taken.

Rating	None	1	2	3	4	5	Rating
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Tally				x	xxxxx	xxxxx	4.4
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The directors were generally firm in their belief that the rationale for Board and Committee actions is adequately explained prior to action being taken. Several directors remarked on the thoroughness of the discussion and debate that takes place prior to action being taken. In the context of Committee meetings, a concern was expressed that some actions may require more time for reflection after discussions at the meeting.

7. The pre-meeting reading materials are generally helpful and relevant.

Rating	None	1	2	3	4	5	Rating
Tally					xxxxxx	xxxxx	4.5

The directors generally believe that the pre-meeting reading materials are helpful and relevant. Suggestions included consideration of organizing material by subject matter and continuing the recent practice of transmitting material for major presentations to the directors in advance of the complete Board book.

8. I am satisfied with the conduct of Board meetings in these respects:

	None	1	2	3	4	5	Rating
Agendas				x		xxxxxxxxxxx	4.8
Opportunity for discussion				x		xxxxxxxxxxx	4.8
Frequency						xxxxxxxxxxx	5.0
Cumulative Rating							4.9

The directors strongly expressed satisfaction with the conduct of the Board meetings, the meeting agenda and the frequency of the meetings. The leadership of the Board Chair in setting the tone for the meetings was acknowledged. One director indicated reports of satisfaction with the Board meetings by BWC stakeholders. A concern was voiced that individual directors may not have sufficient input into the meeting agendas unless they are Committee chairs.

9. Overall, I believe each of the Board’s committees work well:

	None	1	2	3	4	5	Rating
Actuarial Committee					xx	xxxxxxxxxxx	4.8
Audit Committee					x	xxxxxxxxxxx	4.9
Investment Committee					x	xxxxxxxxxxx	4.9
Governance Committee					x	xxxxxxxxxxx	4.9
Cumulative Rating							4.9

The directors were united in their strong expression of satisfaction with the workings of the Board Committees. Directors remarked favorably on the attendance of Committee meetings by non-Committee directors, which fosters cross-committee understandings of what other Committees are doing. One director remarked that the Committee meetings are significant in laying the major groundwork for issues addressed by the Board.

10. I believe the Board’s review of the BWC’s audit, audit process, accounting policies and financial statements enables me to gain a clear picture of the state of BWC’s overall health.

Rating	None	1	2	3	4	5	Rating
Tally				xxx	xx	xxxxxxx	4.3

The directors were somewhat divided regarding whether they have gained a clear picture of the state of the BWC's overall soundness through the review of the BWC audit, audit process, accounting policies and financial statements. Some directors who did not provide the highest rating in this category expressed their expectation that, over time and with more study and fine-tuning of financial reporting, the picture would become clearer.

11. Overall, I believe I am provided the resources and tools I need to effectively exercise my fiduciary and oversight responsibilities.

Rating	None	1	2	3	4	4.5	5	Rating
Tally					xxxxx	x	xxxxxx	4.5

The directors were generally united in their satisfaction that they are provided the resources and tools needed to effectively exercise their fiduciary and oversight responsibilities. One director noted the abundance of resources available and was very complimentary of the BWC Staff in responding to information requests from individual Board members.

12. Overall, I believe the Board makes the appropriate use of the skills and experience of its members.

Rating	None	1	2	3	4	5	Rating
Tally					xxx	xxxxxxxxx	4.7

The directors were generally of the strong belief that the Board makes appropriate use of the skills and experience of its members. The diversity of experience and expertise represented on the Board was noted, as well as the balance and strength that those qualities bring to the Board.

13. Overall, I believe the Board engages in full and candid discussions of the issues before it and personally feel comfortable expressing my views at Board and Committee meetings.

Rating	None	1	2	3	4	5	Rating
Tally					x	xxxxxxxxxxx	4.9

The directors were unified in their belief that the Board engages in full and candid discussions of the issues before it. The directors were unanimous in stating that they personally felt comfortable expressing their views at Board and Committee meetings. This was noted as being a strength of the Board. Also noted was the hard work and resulting gratification that comes with service on a diverse Board engaging in free and open discussions while dealing with difficult issues.

14. If there is one change I would make, it is . . .

Summary of Individual Director Comments:

A strong theme running through a majority of the individual comments is the need for more efficient time management. This was expressed as a desire to shorten the total monthly time commitment to BWC Board and Committee service while continuing to be diligent in devoting the proper amount of time to critical areas of study, discussion and action, especially at the Committee level. Other comments included

clarifying the Board's responsibility regarding the oversight of the financial performance and operational efficiency of the BWC, and an observation that the BWC staff should be treated with respect, especially when they are in the public eye presenting to the Board and responding to questions.

Individual Director Comments:

- Keeping our time together to just two days a month if possible.
- The length of the Thursday meeting day consisting of a public forum followed by Committee meetings.
- Time management. Presently, given the newness of this Board we need to spend a lot of time getting up to date on numerous items. But, over time we need to carefully consider the time requirement of Board members as well as the time for staff to prepare for Board meetings.
- The time for committee meetings needs to be longer and allow more items and fuller discussion. Perhaps we could start committee meetings earlier on Thursday and allow the chairs to request more than 2 hours.
- Clarification of the process of the oversight of the financial performance and operational efficiency of the BWC.
- Keeping meetings and education sessions to 2 days per month. It is difficult to be in Columbus 3 days per month.
- I want to make sure that staff are not treated inappropriately. They should always be treated with respect, understanding also that there is a certain way that directors are to be treated and addressed.
- That we could move faster!
- Allowing for breaks between the committee meetings.
- Honestly, at this time I cannot think of any. The manner in which this board has assimilated itself, in such a short time, is amazing. We seem to improve, change and correct course as we go.

Recommendations – Specific Follow-Up Action Steps

After a review and discussion of the summary results, the Governance Committee recommends that the Board affirm the following action steps:

1. The Board would encourage strategic discussions at future Board meetings focused on gaining a better understanding of the nature of the insurance aspects of the BWC's operations, including using insurance business vs. social insurance agency comparisons, while also understanding the implications of this analysis for setting the appropriate goals and metrics.
2. The Board would encourage continued attention to timely delivery of materials. Committees and committee chairs are encouraged to adopt a two-step process for major decisions. This would mean planning such that there is an introduction to the topic with discussion at the first monthly meeting, with any follow up with more detail, further discussion and a decision at the second monthly meeting.
3. The Board would encourage a Board and committee planning process resulting in a schedule of meetings over two rather than three days. This process would involve long-range planning and coordination of committee and Board agendas as well as expansion of the Thursday or Friday time schedule to accommodate the requisite discussion and deliberation.
4. The Board would task the Audit Committee to expand its charter, with an appropriate change in the Committee's name, to include oversight responsibilities for finance as well as audit policies

and processes. At the same time, the Board would continue to devote significant time and attention to the overall financial performance and condition of the BWC.

5. All Board members are encouraged to provide, as they may deem appropriate, input regarding the content and structure of future Board and committee meetings by contacting the Board Chair, the committee chairs or the Board Liaison.
6. The Board would continue to expect Board and Committee meetings to be conducted with decorum and respect for directors and BWC staff, while continuing to encourage an open and candid exchange of views.

4. I believe management's regular presentations on various aspects of the BWC's business are:
- Clear and understandable 1 2 3 4 5
 - Helpful in providing an accurate picture of the BWC's performance. 1 2 3 4 5

Comments:

5. The process by which the Board evaluates the Administrator's performance works well. 1 2 3 4 5

Comments:

6. I believe the rationale for proposed Board and Committee actions is adequately explained prior to action being taken. 1 2 3 4 5

Comments:

7. The pre-meeting reading materials are generally helpful and relevant. 1 2 3 4 5

Comments:

8. I am satisfied with the conduct of Board meetings in these respects:

- | | | | | | |
|------------------------------|---|---|---|---|---|
| • Agendas | 1 | 2 | 3 | 4 | 5 |
| • Opportunity for discussion | 1 | 2 | 3 | 4 | 5 |
| • Frequency | 1 | 2 | 3 | 4 | 5 |

Comments:

9. Overall, I believe each of the Board's committees work well.

- | | | | | | |
|------------------------|---|---|---|---|---|
| • Actuary Committee | 1 | 2 | 3 | 4 | 5 |
| • Audit Committee | 1 | 2 | 3 | 4 | 5 |
| • Investment Committee | 1 | 2 | 3 | 4 | 5 |
| • Governance Committee | 1 | 2 | 3 | 4 | 5 |

Comments:

10. I believe the Board's review of the BWC's audit, audit process, accounting policies and financial statements enables me to gain a clear picture of the state of BWC's financial position. 1 2 3 4 5

Comments:

11. Overall, I believe I am provided the resources and tools I need to effectively exercise my fiduciary and oversight responsibilities. 1 2 3 4 5

Comments:

12. Overall, I believe the Board makes the appropriate use of the skills and experience of its members. 1 2 3 4 5

Comments:

13. Overall, I believe the Board engages in full and candid discussions of the issues before it and personally feel comfortable expressing my views at Board and Committee meetings. 1 2 3 4 5

Comments:

14. If there is one change I would make, it is . . .

Signature (optional)

Key Principles for Restoring Operational Excellence:

BWC will be a stable, performance-focused agency which recognizes and serves its various constituencies while contributing to economic vitality in Ohio;
BWC will have an internal culture that promotes accountability and innovation, and motivates staff to strive for improvement in quality and efficiencies in all aspects of work; and
BWC will be a partner with other Ohio state agencies to achieve efficiencies in support services for the entire enterprise (State of Ohio).

I. Administrator's Flexible Performance Agreement (with Governor Strickland)

- 1. Make Ohio's Workers' Compensation System more competitive regionally and nationally by identifying and applying actuarial principles to all aspects of BWC rates and premium assessments and reducing base rates overall, while also maintaining the highest level of quality care for injured workers.**
 - Complete Group Rating design for 2010 (announce plan to stakeholder groups by Fall '09); continue rate reform efforts (split plan, etc.)
 - Communicate BWC's message of restoring operational excellence: "Stable Costs, Better Services, Accurate Rates, Safe Workplaces"

- 2. Ohio's employers will have access to a robust and informative reserving system, enabling them to better understand the costs associated with workers' compensation claims.**
 - Completed. (Maintenance mode: Continue evaluation of MIRA II, and preparation of system for Split Plan implementation.)

- 3. BWC's administrative expenses will be benchmarked with private insurers and other state funds to determine best practices to ensure lowest assessments consistent with quality service.**
 - Informed by Deloitte findings re: competitive costs, continue to delve into comparison w/ other workers' comp carriers
 - Continue agency-wide process mapping (90% complete at eoFY09)
 - Identify and pursue additional opportunities to centralize non-core services across the Enterprise (State of Ohio)
 - On-board tenants at WGB
 - Implement amendments in HB15 (potential cost increases)

- 4. By 2010, BWC will have created the system capacity to effectively evaluate the quality and costs of the managed care system for injured workers.**
 - In partnership with OSU College of Public Health, expand our medical resources and research capabilities
 - Implement and staff new Board Committee to focus on medical issues

II. Leadership:

- Accomplish BWC FY10 Portfolio of Projects, Tier 1 (Agency-wide goals)
- Align goals throughout all levels of agency
- Continue agency-wide efficiency initiatives

III. Planning:

- Continue development and utilization of Enterprise Reporting Package and associated metrics
- Improve structure/organization of Board meetings; implement changes identified in 2009 BOD Self-Assessment
- Implement specified Deloitte Study recommendations, with guidance of Board of Directors
- Emphasize Safety & Hygiene as integral part of BWC

IV. Interaction with External Parties

- Continue emphasis on visits, interactions, and informal speaking engagements with trade associations, business groups and labor organizations
- Messages: good governance, transparency, actuarially sound and performance-based rates, planned and timely-announced implementation of agency initiatives

V. Integrity and Ethics

- Continue emphasis on ethics training and adherence for all staff
- Promote documentation and controls rigor to encourage sound decision-making
- Emphasize transparency with internal and external stakeholders

VI. Board of Directors

- Enhance strategic discussions; focus on evaluation of Deloitte Study recommendations

To: Governance Committee
Fm: Alison Falls
Re: Committee assignments
Dt: June 10, 2009

The attached background information on BWC Board Committee assignments includes:

- An excerpt from the Governance guidelines re the role of the Governance Committee
- A list of the FY 2009 Committee assignments
- Recommendations for FY 2010 Committee assignments

Since our discussion at the last Governance Committee and the Board meetings in May, I have not received any requests or suggestions for changes in committee leadership and membership assignments. Considering the important policy issues under discussion in every committee, the benefits of continuity as we work to resolve major policy initiative and the input from Board members, I will open our discussion at the June Governance Committee with a proposal that we recommend to the Chair, for his consideration, that there be no changes to the current committee roster for FY 2010.

cc: Board members, Marsha Ryan, James Barnes, Ron O'Keefe, Ann Shannon

Recommendations for Committee Assignments 2009/2010

The Governance Committee Charter dated November 21, 2008 contains the following language under the “Duties and Responsibilities” section:

“2. 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.”

The 2008/2009 Committee assignments were as follows:

Actuarial Committee: Charles Bryan, Chair; James Matesich, Vice-chair; David Caldwell, James Hummel, Thomas Pitts

Audit Committee: Kenneth Haffey, Chair; Robert Smith, Vice-chair; James Harris, William Lhota, James Matesich

Governance: Alison Falls, Chair; Larry Price, Vice-chair; James Hummel, William Lhota, Thomas Pitts

Investment Committee: Robert Smith, Chair; Alison Falls, Vice-chair; David Caldwell, James Harris, Larry Price

Other: Board Chair William Lhota (appointed by Governor)
Board Vice-chair James Harris (approved by Board vote)

The Board Chair, William Lhota, is an ex-officio member of all committees of which the Board Chair is not a member. As an ex-officio Committee member, the Chair may not vote if such vote would create a tie.

The Governance Committee recommendations to the Board Chair for the 2009/2010 Committee assignments, Chairs and Vice-chairs are:

Director	Actuarial	Audit	Governance	Investment
Bryan, Charles	X (Chair)			
Caldwell, David	X			X
Falls, Alison			X (Chair)	X (Vice-Chair)
Haffey, Kenneth		X (Chair)		
Harris, James (Board Vice-chair)		X		X
Hummel, James	X		X	
Lhota, William (Board Chair)		X	X	
Matesich, James	X (Vice-chair)	X		
Pitts, Thomas	X		X	
Price, Larry			X (Vice-chair)	X
Smith, Robert		X (Vice-chair)		X (Chair)

Common Sense Business Regulation (BWC Rules)

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

Rule 4123-6-08

Rule Review

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

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

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

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

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

4. The rule is effective, consistent and efficient.

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

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

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

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

Explain: The proposed fee schedule was placed on www.ohiobwc.com on May 14, 2009 and stakeholders were given until May 22, 2009 to submit comments.

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.

OHIO BWC 2009 PROFESSIONAL FEE SCHEDULE PROPOSAL

Medical Services Division
Freddie Johnson, Director, Managed Care Services
Jean Graff, Medical Policy Analyst
June 18, 2009

Introduction and Guiding Principles

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

Fee Schedule Update Methodology

- Applied Medicare's 2009 Rates to the following:
 - Current Procedural Terminology (CPT©) - (10,000)
 - Healthcare Common Procedural Coding System (HCPCS) - (3,600)
- Addressed unintentional errors on the 2009 BWC Schedule
- Modified coverage status for selected codes
- Incorporated relevant reimbursement billing modifiers into the schedule

Recommendations

- Adoption of the 2009 Medicare RVU Updates
- Adjust current HCPCS to reflect 2009 Medicare Schedule
 - Medicare's values will be increased by 20%
- Local Codes
 - Decrease Mileage from .51 cents per mile to 0.45 cents per mile
 - Maintain all other local fees

Impacts and Outcomes

- Medical Costs Impact
 - An estimated .2% increase above the estimated current fee schedule impact
 - Estimated dollar figure is \$800,000.00
- Place BWC on same schedule as national reimbursement coding methodologies
 - Maintain a competitive provider and medical services reimbursement rate
- Provided further transparency to BWC billing and reimbursement methodologies
 - Improve consistency of reimbursement across providers

Thank You

Appendix

Proposed CPT© Revisions

Relative Value Units (RVU)

- RVUs updated to Medicare's 2009 Unadjusted RVUs
 - The RVU for each CPT code includes three components:
 - Work - level of difficulty to provide the service
 - Practice Expense - overhead such as staff, rent, utilities
 - Malpractice – level of risk associated with the service
 - Geographical Practice Cost Index (GPCI)

2008 GPCI	2009 GPCI
Work—0.992	Work—1.00
Practice Expense—0.930	Practice Expense—0.927
Malpractice—1.097	Malpractice—1.232

Proposed CPT© Revisions

Conversion Factor (CF)

- Conversion Factor (CF)
 - BWC's assigned price for each category of service

CPT Code 29874 Arthroscopic knee surgery (scope) with removal of loose body

	RVU	x	GPCI	x	CF	= Provider Fee
2008-	13.45027	x	0.9651	x	79.10	= \$1026.79
2009-	13.56602	x	1.0530	x	79.10	= \$1129.94

- Guiding Principle:
 - Ensure **access to high-quality** medical care
 - Medical Management / Return to Work
 - Competitive fee schedule which enhances medical provider network

Proposed CPT© Revisions

Conversion Factors

Current Fee Schedule

2009 Update

Service Grouping	CF	Pct of Medicare	CF	Pct of Medicare
Radiology	\$51.00	134%	\$51.00	141%
Physical Medicine	\$51.00	134%	\$51.00	141%
General Medicine	\$51.00	134%	\$51.00	141%
Surgery (*)	\$79.10	208%	\$79.10	219%
Pathology	Fee Schedule	125%	Fee Schedule	125%
Anesthesia (**)	\$42.50	213%	\$42.50	201%

** Injections paid at \$51.00 CF

*** Anesthesia is currently paid at \$42.50 time the number of base units plus \$42.50 per 15 minutes/2008 Medicare's Anesthesia is base rate is \$19.97. 2009 Medicare's Anesthesia is base rate is \$21.11

HCPCS and Local Codes Revisions

- Adjust current HCPCS to reflect 2009 Medicare Schedule
 - Medicare's values will be increased by 20%
- Local Codes
 - Decrease Mileage from .51 cents per mile to 0.45 cents per mile
 - Maintain all other local fees

BWC Board of Directors Executive Summary BWC Provider Fee Schedule Rule

Introduction

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

Background Law

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

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

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

Pursuant to the Court of Appeals' decision in the *OHA* case, BWC is now required to adopt changes to its provider fee schedule via the O.R.C. Chapter 119 rulemaking process. BWC has undergone a systematic revision of its provider fee schedule, which has not been revised since 2004, and now proposes to adopt the newly revised provider fee schedule as an Appendix to OAC 4123-6-08.

Rule Changes

4123-6-08 Bureau fee schedule.

BWC is proposing to amend current OAC 4123-6-08 to include the updated provider fee schedule itself as an appendix to the rule. The proposed fee schedule updates would become effective September 21, 2009.

4123-6-08 Bureau fee schedule.

(A) Pursuant to division (A)(8) of section 4121.441 of the Revised Code, the administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall develop, maintain, and publish a provider fee schedule for the various types of billing codes. The administrator hereby adopts the fee schedule indicated in the attached appendix A, developed with provider and employer input effective September 21, 2009.

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

Appendix A

BUREAU OF WORKERS' COMPENSATION

PROVIDER FEE SCHEDULE

EFFECTIVE SEPTEMBER 21, 2009

Effective: 9/21/2009

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

BWC 2009 Proposed Professional Provider and Medical Services Fee Schedule Update

Medical Service Enhancements

Prompt, effective medical care makes a big difference for those injured on the job. It is often the key to a quicker recovery and timely return-to-work and quality of life for injured workers. Thus, maintaining a network of dependable medical and vocational rehabilitation service providers ensures injured workers get the prompt care they need. It also ensures access to quality, cost-effective service. Access for injured workers means the availability of appropriate treatment, which facilitates faster recovery and a prompt, safe return to work. For employers, it also means the availability of appropriate, cost-effective treatment provided on the basis of medical necessity.

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

Professional Provider Fee Schedule

Introduction and Methodology

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

The BWC medical fee schedule was revised and adopted by the BWC Board in 2008. Subsequent to the completion of the Chapter 119 rulemaking process the revised schedule was implemented in February 2009.

The Medical Services Division, pursuant to the yearly fee schedule maintenance schedule undertook a review of the new fee schedule with the goal of implementing updated Medicare base data used in BWC's calculations, and identifying corrections to benefit coverage or pricing. The proposed updates to the currently adopted 2009 BWC fee schedule resulted from the following steps:

- A.** The evaluation of the 2009 Ohio Fee Schedule against the 2009 coding publication for the Federal Center for Medicare and Medicaid Services' 2009 fee reimbursements publications;
- B.** A review of the current 2009 Professional Provider and Medical Services fee schedule as adopted to identify benefit coverage errors and/or policy changes.

Calculating Provider Fees Per the CPT codes

BWC currently utilizes the Resource-Based Relative Value Scale (RBRVS) developed in 1992, by the Federal Center for Medicare and Medicaid Services for professional reimbursements associated with the CPT® codes. Each year Medicare updates its CPT fees under the RBRVS approach. The fee schedule includes services such as office visits, hospital care, procedures, etc. Medicare fees are composed of two component parts: the relative value unit (RVU) and a conversion factor (CF). The foundation of RBRVS is a strong, empirical research methodology. BWC has utilized the RBRVS, at least, since 1997.

An individual RVU is calculated for each procedure by looking at the associated relative work and costs of services. RVUs allow comparison of apples to oranges (i.e., surgery to primary care visits) and can relatively and appropriately set the allowable payment for any service in any specialty.¹ Each specific CPT code for a medical service is assigned a RVU based on the degree of service intensity the procedure requires. Further, the RVUs reflect costs for overhead and malpractice. Finally, there is a regional cost adjustment. The regional cost adjustment is called the Geographical Practice Cost Index (GPCI). There is a separate GPCI for work expended, overhead, and malpractice.

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

The following table provides BWCs current CF.

Service Grouping	Current	% over Medicare
Radiology	\$ 51.00	134%
Physical Medicine	\$ 51.00	134%
General Medicine	\$ 51.00	134%
Surgery (*)	\$ 79.10	208%
Pathology (**)	See Below	
Anesthesia (***)	\$ 42.50	213%

* Injections proposed to be paid at \$50.00 CF
 **Pathology is currently paid at 125% of Medicare Fee Schedule
 *** Anesthesia is currently paid at \$42.50 time the number of base units plus \$42.50 per 15 minutes
 Medicare has a single CF of \$36.000 Medicare's Anesthesia base rate is \$19.97

Ohio Bureau of Workers' Compensation

¹ Johnson and Newton, Resource-Based Relative Value Units: A Primer for Academic Family Physicians, Department of Family Medicine, University of North Carolina (2002)

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

Calculating Fee Schedule for a CPT code

Fee Schedule	12001 - simple laceration repair			27447 - total knee replacement		
	RVU	GPCI	Product	RVU	GPCI	Product
Work	1.7200	1.000	1.720	23.0400	1.000	23.040
Practice Expense	1.8600	0.927	1.724	13.5800	0.927	12.589
Malpractice	0.1500	1.232	0.185	3.8000	1.232	4.682
Sum of Products			3.62			40.31
Times Conversion Factor			\$79.10			\$79.10
Reimbursement Rate (Fee Schedule)			\$287.06			\$3,188.54

Ohio Bureau of Workers' Compensation

Calculating Provider Fees Utilizing HCPCS Codes

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

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

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

Calculating Provider Fees Utilizing 170 Local Codes

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

2009 Proposed Fee Schedule Updates Recommendations

Medical Services recommends that BWC adopt Medicare's 2009 RVUs for all relevant CPT codes. In 2009, Medicare's adjusted RVUs for a number of the CPT codes as well as modified the Ohio GPCI for all codes. The GPCI increased for work expended and malpractice, but

decreased for overhead. Those changes have resulted in base line increase in the values of approximately 70% of the covered CPT codes, and a corresponding decrease in 30% of the covered CPT codes.

Medical Services further recommends the adoption of Medicare's 2009 HCPCS fees with a twenty percent (20%) addition. The 2009 HCPCS were marginally adjusted from the 2008 Medicare fees.

Medical services further recommend the updating of the 2009 BWC fee schedule to correct selected services codes' benefit coverage status due to an initial incorrect designation or policy change. Accordingly, this evaluation of the fee schedule codes schedule resulted in a status change from "non-covered" to "covered" for: 112 CPT codes, 104 HCPCS, and 10 local codes.

Projected Impacts and Outcomes

The financial impact to the state fund is minimal and estimated at less than \$1 million or an increase of about .2% over the current 2009 implemented Professional Provider and Medical Services fee schedule.

Proposed 2009.5 Fee Schedule: Provider Feedback Mailbox Comments

Name	Specialty	Summarized Comments	Code(s)	Response	BWC position	Rationale
Kent Eichenauer	Psychologist	Would like to offer suggestions regarding CPT codes on the fee schedule. Feels as though the additions of codes 90847, 96150-96155 would be beneficial. Appreciates opportunity to provide feedback	90847, 96150-96155	Code 90847- Not allowed per policy *96150-96155- Not covered as BWC does not cover psycho-social "injuries"	1-Family Counseling will remain non-covered 2-Health and Behavioral Codes will remain non-covered	1- BWC policy pg 43 MCOPRG 2-MCOPRG Chapter 8 pg 72
Thomas W. Heitkemper	Clinical Psychologist	Would like to maintain rates for CPT codes 90801, 90806, 96101, but feels the change is not that drastic. Primary concern is the elimination of Health and Behavior codes (96150-96155).States that early intervention of psychology has shown to reduce the extent of the disability. The codes have been implemented into fee schedule and the provider has been finding ways to use these codes in practice so that he "can ethically provide the best care to (his) patients". Has much knowledge and experience in Pain Management. Provided an article addressing the issue.	90801, 90806, 96101, 96150 - 96155	96150-96155- The CPT codes for psychological intervention have never been a covered service in the BWC benefit package .	Health and Behavioral Codes will remain non-covered	MCOPRG Chapter 8 pg 72
Jill Cooper	Medical Bill Payment	Why are some codes on this proposed fee schedule when they are the same fee as the current fee schedule?	A4220, J2405, A9579, A6260, A6250, A6025,	Some prices stayed the same for HCPCS codes according to MCR or purchase price. This was reflected in the changes to the fee schedule update	The proposed 2009 fee schedule was an update to accommodate the changes in the RBRVS methodology as well as changes in the Medicare fee schedule for HCPCS codes	Updating fee schedule to be in alignment with 2009 values
Mary Beth Sanford	Unavailable	This is the third change this year and not significant. Still problems on 02/19/09 fee schedule. CPT/HCPCS codes that are covered and BWC system denies with EOB 395 in error.	N/A	Only second time this year for fee schedule changes 2 - Errors from 2/19 fee schedule will be corrected via mass adjustment 3 - Corrections have been made in CAM	The proposed 2009 fee schedule was an update to accommodate the changes in the RBRVS methodology as well as changes in the Medicare fee schedule for HCPCS codes	Updating fee schedule to be in alignment with 2009 values

Name	Specialty	Summarized Comments	Code(s)	Response	BWC position	Rationale
Judy Barrie	Operations Support	There is no ASC pricing for 2/19/09-4/1/09 when new rule takes effect. How are you pricing ASU between 2/19/09 and 4/1/09? How will you pay or deny a code that is billed differently than the fee schedule allows. (Ex. NU,RR, RB options) Will BWC look at the NC codes that are being approved by Medpol for future consideration?	ASC codes, NU,RR,RB codes, NC codes	1-ASC: The proposal fee schedule will not be implemented until Sept per rule. ASC fee schedule is in effect 4/1. 1/19/2009 through 4/1/2009 fee schedules have the ASC group pricing on them 2- HCPCS: Purchase price listed a fee schedule amount when appropriate Policy is rent to purchase, unless an exception is made . If the HCPCS code requires a modifier, it should be submitted with one. The MCOs must verify use of appropriate modifiers. If the bill is incorrect, it should be denied. If there is no modifier for the code, the bill will reimburse without one. 3-This professional fee schedule is an update only. Some additional CPT codes have been determined to be covered.	1-The correct ASC fee schedule information is posted. 2-Modifiers must be appended to HCPCS codes when required. 3-Some coverage changes have been made due to stakeholder feedback.	BWC has adopted HCPCS modifiers to indicate rental, replacement or purchase for DME. The professional fee schedule has been updated to be in alignment with 2009 values and correction to coverage determination
Lori Finnerty	Quality Assurance	Have reviewed and compared fee schedule and are requesting that certain NC codes be covered as they are utilized in appropriate claims for workers' compensation injuries. Noticed that some of the procedure/diagnostic codes are inconsistent with Medicare guidelines with regards to NC total fee and NC TC fee. But with modifier 26 the professional fee is covered and has a fee.		Verbiage in the preamble of the fee schedule addresses non-covered codes which meet Miller criteria as an exception to be reimbursed	Non-covered codes may be reimbursed as an exception according to Miller requirements.	Feedback regarding non-covered codes was taken into consideration. The definition of non-covered has been altered to address services which meet the three prongs of Miller
Kathy	Unavailable	Wants to know why there was such a drastic drop in the price for E0218	E0218	A cold circulating pump is a short term service that is rental only	Short term usage for DME will be reimbursed as a rental only	Cold circulating pumps are typically used for 2 weeks post operatively. BWC will not purchase this equipment.

Name	Specialty	Summarized Comments	Code(s)	Response	BWC position	Rationale
Kathleen A. S. Hofmeister	Unavailable	Concerned that A4927 is not covered and will affect the personal care of injured patients. Feels as though the K series should allow for a purchase price rather than just a rental price.	A4927 2 - K series	1-A4927- 12.31 2009/ NC on updated 2009 professional fee schedule will be covered. NC was posted in error 2- K series: Rental Only -MCR power wheelchairs are designated rental only. Purchase prices will be available to the MCOs via disc.	A4927 will be reimbursed at \$7.50 per box. Power wheelchairs will be rent to purchase items.	Power wheelchairs are designated rent to purchase items in the professional fee schedule. Requests to purchase will be addressed on an individual basis.
Nellie Reinheld	Unavailable	Power wheelchairs should be offered for purchase as they are often customized for the patient. Are you following Medicare's policy? Medicare will choose to purchase the power wheelchair. Does BWC allow for upgrades on the manual wheelchair codes (K0001-K0005)? If you continue to rent this wheelchairs will you approve 10 units (a 10 month date span)? "Here again the risk you expect us to accept will affect type and styles of equipment provided."	K0813-K0898 K0001-K0005	Medicare- Rental Only Prices	2- K series: Rental Only -MCR power wheelchairs are designated rental only. Purchase prices will be available to the MCOs via disc. lws do not have a choice for an upgrade as it is determined through Miller.	Power wheelchairs are designated rent to purchase items in the professional fee schedule. Requests to purchase will be addressed on an individual basis.
Woody Woodward	Chiropractic	Appreciate increases in codes used by chiropractic physicians. However, not significant enough to help with the inflation faced by the physicians. Concerned that the "steerage of injured workers to company-preferred doctors, lack of a reasonable supportive care guideline and a broken claims review system are our hurting membership and making it more difficult to provide Ohio's injured workers with high-quality, cost effective care".	Chiro	Primarily comments on injury management and chiropractic dislike of "company-preferred" doctors	Injury management is not addressed in the professional fee schedule	The professional fee schedule provides reimbursement rates for designated services but does not address utilization management
Bethe Foster	Regulatory Specialist	No comments on new proposed 2009 BWC provider fee schedule. Fact Questions: Why is BWC going through this process when updates just went into effect 2-19-09? And How was the rate increase (thank you) and rate decrease determined? Especially the drop in mileage.		1-Updating fee schedule to be in alignment with 2009 values 2-Mileage has dropped to reflect the current mileage reimbursed by the State of Ohio DAS	Reimbursement for mileage was dropped to 0.45 Per Executive Order 2009-07S	BWC will adopt the mileage reimbursement rate for the State of Ohio

Name	Specialty	Summarized Comments	Code(s)	Response	BWC position	Rationale
Basem Abdelmalak	Staff Anesthesiologist	Concerned that the proposed 2009 payments for pain services are lower than 2008. Inconsistent with other services on fee schedule. Hardship for pain physicians whose practice and malpractice costs have not declined.	Pain	Overall Pain Management decreased per MCR RVUs in the non-facility setting but did increase in the facility setting *Paid @ 51.00 CF (injections) *Anesthesia did not change	Pain management services will continue to be reviewed during the 2010 fee schedule update.	The proposed 2009 fee schedule was an update to accommodate the changes in the RBRVS methodology.
Alan P. Marco	Anesthesiology	Concerned that the proposed 2009 reimbursement for pain services is lower than in 2008. Practice expenses have not decreased, this decline will make it difficult to treat BWC patients.	Pain	Overall Pain Management decreased per MCR RVUs in the non-facility setting but did increase in the facility setting *Paid @ 51.00 CF (injections) *Anesthesia did not change	Pain management services will continue to be reviewed during the 2010 fee schedule update.	The proposed 2009 fee schedule was an update to accommodate the changes in the RBRVS methodology.
Armin Schubert	Anesthesiology	Concerned about cuts in reimbursement for pain physicians. Could result in reduction in access to appropriate pain care for injured Ohio workers. Most other services have a positive update for 2009. These procedures are considered surgical procedures and are listed as such in CPT. Request payment cut be reversed. Costs to pain practices have increased, or at best stayed the same.	Pain	Overall Pain Management decreased per MCR RVUs in the non-facility setting but did increase in the facility setting *Paid @ 51.00 CF (injections) *Anesthesia did not change	Pain management services will continue to be reviewed during the 2010 fee schedule update.	The proposed 2009 fee schedule was an update to accommodate the changes in the RBRVS methodology.
Brenda Lewis	Anesthesiology	Concerned about payment reductions for pain services. Pain services are considered surgical services and are listed in CPT as such, but are treated as medical by BWC. The reduction will make it difficult for pain specialist to practice, and to provide quality care to Ohio's injured workers.	Pain	Overall Pain Management decreased per MCR RVUs in the non-facility setting but did increase in the facility setting. *Paid @ 51.00 CF (injections) *Anesthesia did not change	Pain management services will continue to be reviewed during the 2010 fee schedule update.	The proposed 2009 fee schedule was an update to accommodate the changes in the RBRVS methodology.
John M. Collins	Anesthesiologist and Interventional Pain Specialist	Concerned about reduction in reimbursements for pain services. Expenses to practice continue to rise, pain specialist may need to limit/eliminate chronic pain patients.	Pain	Overall Pain Management decreased per MCR RVUs in the non-facility setting but did increase in the facility setting *Paid @ 51.00 CF (injections) *Anesthesia did not change	Pain management services will continue to be reviewed during the 2010 fee schedule update.	The proposed 2009 fee schedule was an update to accommodate the changes in the RBRVS methodology.

Name	Specialty	Summarized Comments	Code(s)	Response	BWC position	Rationale
Vivek Iyer	Pain Physician	Concerned by the lack of increase, or even decrease for pain management services. Seems to me that good pain control long term can be less of a financial burden than surgery. Several interventions other than epidural steroid. Spend time to find sources of pain.	Pain	Overall Pain Management decreased per MCR RVUs in the non-facility setting but did increase in the facility setting *Paid @ 51.00 CF (injections) *Anesthesia did not change	Pain management services will continue to be reviewed during the 2010 fee schedule update.	The proposed 2009 fee schedule was an update to accommodate the changes in the RBRVS methodology.
Ron Harter	Anesthesiology	Concerned that reimbursement for pain services decreased, while in most other specialties' services there was an increase in payment. States that this presents trouble for pain physicians as practice and malpractice costs have not declined.	Pain	Overall Pain Management decreased per MCR RVUs in the non-facility setting but did increase in the facility setting *Paid @ 51.00 CF (injections) . The Geographical Practice Cost Index (GPCI) did include an overall increase in Ohio for 2009. A portion of the GPCI reflects practice and malpractice costs as well as the work involved to perform the service. *Anesthesia rates did not change	Pain management services will continue to be reviewed during the 2010 fee schedule update.	The proposed 2009 fee schedule was an update to accommodate the changes in the RBRVS methodology.
Sue Parkins	Occupational medicine	Writing in regards to BWC new fee schedule that does not allow post op payment to Occupational Physician. Feel this rule inhibits "Occupational Medicine providers to ensure safe, creative and prompt return to work". Believe that specialist are unaware of all the opportunities available for return to work. Occupational Medicine providers would like to continue to treat and evaluate the injured work "during post operative care to monitor progress as it relates to their return to work job and goals". Specialist look to the Occupational medicine provider to complete C84 and C9's. Concerned with the treatment plan. Think it may increase the cost and risk of additional time away from work.	Disallowing post op payment to the Occupational Physician	BWC follows CPT coding guidelines. BWC is using the correct coding regarding global surgical care billing and reimbursement	BWC will continue to follow global surgical guidelines for major(90 days) and minor (10 days) surgical procedures	BRM Chapter 3 page 13
Joseph C. Eshelman	Occupational Medicine	BWC not reimbursing for appropriate administration of Tdap for wound care. Concentra Strive to provide highest quality of medical care and believe it is best practice to follow CDC recommendations. Please read following and reconsider: Tdap should be received in wound management in adults aged 19- 64 who require a tetanus toxoid-containing vaccine instead of Td if they have not previously received Tdap. Td should be administered if Tdap is not available or has previously been administered.	Occ Med	Resolved- Tetanus, Tdap and DT will all be covered at same price \$26.97	Corrected	Diphtheria and pertussis are not work related immunizations but are typically given with tetanus. DT and Tdap will be covered in addition to Tetanus.

Name	Specialty	Summarized Comments	Code(s)	Response	BWC position	Rationale



Common Sense Business Regulation (BWC Rules)

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

Chapter 4123-14 Noncomplying Employers

April 2009

Rule Review

1. The rule is needed to implement an underlying statute.
Citation: R.C. 4123.35 Payment of Premiums by Employers
2. The rule achieves an Ohio specific public policy goal.
What goal(s): The rules provide criteria and guidance on how BWC will pursue collection of premiums from noncomplying employers
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.
OAC 4123-3-14 is recommended for deletion since it is a duplicate of this rule
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: Representatives of Third Party Administrators and the workers' compensation section of the Ohio State Bar Association were sent recommended changes and asked to provide comments. One response was received. No changes were made to the draft rule as a result of that response.
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? N/A
13. The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

**4123-14-01 Noncomplying employers within the meaning of the law.
(TO RESCIND)**

An employer, as defined in division (B) of section 4123.01 of the Revised Code, who either fails to establish industrial coverage and make payments of premiums to the state insurance fund, as required by Chapter 4123. of the Revised Code and the rules of the industrial commission and the bureau of workers' compensation, or fails to comply with the requirements for self-insurance under section 4123.35 of the Revised Code and the rules of the industrial commission or bureau of workers' compensation, shall be regarded as a noncomplying employer.

4123-14-01 Noncomplying employers within the meaning of the law. (NEW)

(A) An employer, as defined in division (B) of section 4123.01 of the Revised Code, ~~who~~ ~~that~~ either fails to establish or maintain industrial coverage, or fails to make payments of premiums to the state insurance fund, as required by chapter 4123. of the Revised Code and the rules of the industrial commission and the bureau of workers' compensation, or fails to comply with the requirements for self-insurance under section 4123.35 of the Revised Code and the rules of the industrial commission or bureau of workers' compensation, shall be regarded as a non-complying employer.

(B) An employer, as defined in division (B) of section 4213.01 of the Revised Code ~~whothat~~, after a final adjudication, has failed to pay an obligation, billing, account or assessment that is greater than one thousand dollars on or before its due date, shall be regarded as a non-complying employer.

(1) For purposes of this rule, due date shall be defined as sixty days after ~~the~~ invoice date of an obligation, billing, account or assessment that is greater than one thousand dollars if no administrative appeal as permitted by law is filed; or sixty days following an administrative or court order that has become final.

(2) Coverage will lapse if ~~an~~ obligation, billing, account or assessment that is greater than one thousand dollars remains unpaid as of the due date as defined in paragraph (B)(1) of this rule.

(C) An employer ~~who is determined~~ found to be a non-complying employer under paragraph (B) of this rule shall have coverage reinstated as ~~of~~ date of payment of an obligation, billing, account or assessment that is greater than one thousand dollars from which no appeal or protest is filed.

(D) An employer ~~who that is determined~~ found to be a non-complying employer under paragraph (B) of this rule and has filed a timely protest or appeal, shall have ~~their~~ coverage reinstated and ~~the~~ non-compliance period vacated, pending final administrative adjudication of that protest or appeal.

4123-14-02 Procedures for the collection of premiums from noncomplying employers. (TO AMEND)

(A) Whenever the bureau of workers' compensation finds that an employer ~~who~~that was subject to division (B)(2) of section 4123.01 of the Revised Code failed to comply with the law in matters of industrial workers' compensation coverage, the bureau shall ~~forthwith~~ notify ~~said~~the employer in writing of such a finding. The notice shall outline the period(s) of time during which the employer was an amenable employer, and ~~further, it~~ shall specify that the employer has twenty days from the ~~receipt~~ service of the notice to furnish the bureau of workers' compensation with the appropriate payroll report and pay the applicable premium or premium security deposit, as required by law.

~~(B) Where the employer is not a resident of the state of Ohio, or conceals its whereabouts or its whereabouts are unknown and cannot be ascertained, and no forwarding address can be found, or where the employer is deceased, the service of process shall be made in accordance with sections 4123.751 to 4123.756 of the Revised Code.~~

~~(C)~~(B) If the employer does not furnish the required payroll report and does not pay ~~to the state insurance fund~~ the applicable premium and/or the premium security deposit within the twenty-day period referred to in paragraph (A) of this rule, the bureau of workers' compensation or its authorized agent shall immediately take the following action:

(1) Make an assessment of the premium due from the employer, in accordance with sections 4123.32 and 4123.37 of the Revised Code ~~and rule 4123-19-07 of the Administrative Code~~. The assessment shall be based on such information as may be in the possession of the bureau of workers' compensation.

~~(2) Under the authority of section 4123.78 of the Revised Code, file with the county recorder of any counties in which such employer's property may be located a certificate of the amount of premium(s) due from such an employer and the amount so due shall be a lien from the date of such filing against the real and personal property of the employer within the county in which such certificate is filed.~~

~~(D)~~(C) The bureau of workers' compensation or its authorized agent shall ~~forthwith~~ give ~~to~~ the employer ~~a~~ written notice of any action taken. The notice shall be mailed to the employer at its residence or usual place of business by certified mail with return receipt requested ~~or as provided in paragraph (B) of this rule~~. ~~Furthermore, the~~ The notice shall inform the employer that unless it files with the bureau of workers' compensation, within twenty days after receipt of said notice, a petition for reassessment in writing, verified under oath by said employer, or its authorized agent having knowledge of the facts, setting forth in detail the items of the assessment

objected to and the reason(s) for the objection, such assessment shall become final and the amount thereof shall be due and payable from the employer so assessed to the state insurance fund.

(D) The bureau of workers' compensation or its authorized agent, under the authority of section 4123.78 of the Revised Code, shall file with the county recorder of any counties in which such employer's property may be located a certificate of the amount of premium(s) due from such an employer and the amount so due shall be a lien from the date of such filing against the real and personal property of the employer within the county in which such certificate is filed.

(E) In the event a petition objecting to the assessment is duly filed by the employer, the matter shall be referred to the administrator of workers' compensation, who may refer the matter to be set for a hearing before the bureau of workers' compensation adjudicating committee. The notice of hearing shall be mailed to the petitioner by certified mail and to its representative, setting forth the date, time and place of the hearing. It will be mailed to the parties, as indicated above, not less than fourteen days before the date of such a hearing. In justifiable cases an emergency hearing may be arranged.

| (F) A copy of the administrator's finding and order ~~of the administrator~~ shall be mailed by certified mail to the party assessed and by regular mail to the representative of such a party.

| (G) If ~~it is the order of~~ the administrator orders ~~that~~ the employer to pay the assessment, payment shall become due ten days after the notice of the finding and order of the administrator was mailed to such employer.

| (H) The employer has the right to appeal the administrator's decision ~~of the administrator~~ to the court of common pleas of Franklin county upon the execution of a bond to the state in double the amount due and ordered paid by the bureau, upon the condition that the employer will pay any judgment and costs rendered against it for the premium(s), as provided in section 4123.37 of the Revised Code.

(I) When no petition objecting to the assessment is filed or when a finding is made affirming or modifying such an assessment after hearing, a certified copy of the assessment, as affirmed or modified, shall be filed by the bureau of workers' compensation, not later than twenty days from the date the order has become final, with the clerk of the common pleas court in any county in which the employer has property or in which the employer has a place of business, for the purpose of obtaining a judgment for the state against the employer in the amount shown on the assessment. As soon as the judgment is rendered, proper action shall be taken to levy execution on said judgment.

(J) However, an assessment or judgment, as outlined in the preceding paragraphs of this rule, shall not be a bar to the adjustment of the employer's account upon the employer furnishing his payroll records to the bureau.

(K) In addition to the procedures outlined in paragraphs (A) to (I) of this rule, the administrator of the bureau of workers' compensation shall, in justifiable cases, certify the matter to the attorney general's office with a request that the employer be enjoined from further operation in accordance with section 4123.79 of the Revised Code and/or that criminal proceedings be instituted against the employer for penalties under division (C) of section 4123.99 of the Revised Code. Furthermore, in cases where the employer failed to furnish to the bureau ~~of workers' compensation~~ the annual payroll report and other related information required by section 4123.26 of the Revised Code, a civil action shall be brought against such employer in the name of the state to collect the penalty, as provided in that section.

(L) For counties and public employer taxing districts, the bureau shall keep an individual account showing the amount of money paid into the public insurance fund and the amount of losses incurred against the fund. When any such employer defaults in the payment of sums required to be contributed to such fund or any official fails to perform any act required to be performed in reference to the making of payments, the bureau shall institute the proper proceedings in the court to compel such payment.

4123-14-03 Requests for waiver of a default in the payment of premium, for approval of the original industrial coverage retroactively, and for abatement of penalties.

(NO CHANGE TO AMEND)

(A) The administrator of the bureau of workers' compensation, for good cause shown, may:

(1) Waive a default in the payment of premium by an employer ~~whose~~where ~~industrial workers' compensation~~ coverage has lapsed, if such a default is of less than sixty days duration; if such a waiver is granted, ~~industrial workers' compensation~~ coverage shall be reinstated retroactively;

(2) Approve the original ~~industrial workers' compensation~~ coverage to take effect retroactively;

(3) Abate penalties imposed on employers for failure to comply with the Ohio's workers' compensation statute.

(B) The term "good cause," as used in paragraph (A)(1) of this rule, means a substantial reason, one that affords a legal justification or a legal excuse.

(C) Such requests shall be in writing. They shall be properly signed in handwriting by the employer concerned or by its duly authorized representative. The reason(s) for the relief

sought shall be fully explained. Unsigned requests shall be held in abeyance until they are properly completed, and the applicant shall be notified accordingly.

(D) The administrator may refer such requests to the adjudicating committee, ~~established by the administrator of workers' compensation,~~ for further consideration and for the determination of the issue(s) raised.

4123-14-04 Procedures to recover from a noncomplying employer the amount of money paid out of the state insurance fund for an industrial injury, occupational disease and/or death. (TO AMEND)

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

(B) The bureau shall notify the employer, by mail and within the shortest time possible, of the filing of the application, ~~which notice shall be mailed by certified mail.~~ Such notice shall be accompanied by a copy of the application and a copy of the affidavit, as described in paragraph (A) of this rule, and shall advise the employer that unless it files a timely answer to the application, ~~as required by rules 4121-03-14 and 4123-03-14 of the Administrative Code,~~ the claim ~~shall~~ will be adjudicated upon the filed application ~~that has been filed.~~

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

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

- (1) The employer has paid the amount of all awards made by the commission and/or the bureau;
- (2) There was a final order of disallowance of claim(s);

- (3) The employer has filed a bond or other security in such an amount and with such a surety as the bureau approves, conditioned on the employer's payment of all awards made by the commission and/or the bureau. The bureau may, in its discretion, grant a partial release of the lien, should this be necessary to facilitate the conduct of the employer's business, provided a sufficient security remains to pay any award that may be made in the claim or claims.
- (4) Settlement of employer's liability as provided in rule 4123-14-05 of the Administrative Code.

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

~~(D)~~(E) In all cases of employer's failure to pay the award(s) of compensation and/or benefits, as approved by the commission and/or the bureau, or to furnish a satisfactory bond within ten days after notification of such award(s), payment of the award(s) from the surplus fund and the recovery of the monies so paid by the bureau shall be in accordance with section 4123.75 of the Revised Code.

~~(E)~~(F) The award(s) of compensation and/or benefits, referred to in paragraph (D) of this rule, shall constitute a liquidated claim for damages against the non-complying employer. The bureau shall certify the record to the attorney general to institute a civil action against the employer for collection of the award(s). Such action may be joined with the action to recover premium(s) due from such employer.

**4123-14-05 Settlement of liability of a non-complying employer.
(TO AMEND)**

(A) A non-complying employer may apply to the administrator of the bureau of workers' compensation for settlement of its liability to the state insurance fund. The request shall:

- (1) Be in writing and properly signed in handwriting by the employer concerned or by its duly authorized representative. Unsigned requests shall be held in abeyance until properly completed, and the applicant shall be notified accordingly;
- (2) Clearly set forth the circumstances by reason of which the proposed settlement is deemed desirable;
- (3) Include, but not be limited to, the following information:
 - (a) The size of employer's business - number of employees;
 - (b) The location of the business (Ohio, other states, etc.);

- (c) The length of time the employer has been in business;
 - (d) The nature and type of employer's business for the past five years;
 - (e) A copy of the employer's federal and state income tax return for the past three years;
 - (f) A notarized financial statement of current assets and liabilities;
 - (g) A sworn statement to explain the reason for non-compliance with the "Ohio Workers' Compensation Act";
 - (h) The amount of the requested settlement;
 - (i) Whether ~~Is~~ the employer is in business at the present time and complying with the "Ohio Workers' Compensation Act."
- (B) The administrator may refer the request to the ~~law section~~ legal division of the bureau ~~of workers' compensation~~ for review, preparation of memorandum, and presentation to the adjudicating committee for approval or disapproval of the offer of settlement. The employer's past history with the bureau, if any, as reflected by the records of the bureau or commission, shall be checked and verified. If additional information is needed for proper disposition of the case, the matter may be referred for investigation. In justifiable ~~eases~~ situations, an independent financial statement and employer's credit rating may be obtained.
- (C) The adjudicating committee may accept the offer of settlement if it finds from a preponderance of the evidence that such a settlement ~~is~~ shall be:
- (1) In the best interest of the state insurance fund; or
 - (2) In the best interest of the employees of the employer concerned; or
 - (3) That it will be beneficial to the general welfare of the community; or
 - (4) That it will best serve any other public purpose.

The decision of the adjudicating committee shall be reduced to writing and shall be mailed forthwith to all interested parties. The bureau may structure the payment of settlement with the employer for a period not exceeding twenty-four months. Interest charges for the structured settlement shall be determined in accordance with section 131.02 of the Revised Code.

4123-14-06 Bureau of workers' compensation adjudicating committee.

(TO AMEND)

(A) The administrator of the bureau of workers' compensation may delegate the authority granted to the administrator under Chapters 4121., 4123., and 4131. of the Revised Code and Chapter 4123 of the Administrative Code for determining employer premium, assessment, or penalty obligations or liabilities, eligibility for alternative premium plans or discount programs, or other employer-related disputes or issues as may be authorized under the workers' compensation statutes and rules. For this purpose, the administrator may appoint an adjudicating committee to provide employers with hearings on such matters referred to the committee.

~~(1) An employer shall file with the bureau a request, protest, or petition of a premium, assessment, or penalty obligation or liability, or an application for an alternative premium plan or discount program within the time limit established by the appropriate section of the Revised Code or rule of the Administrative Code for such matter.~~

(1) An employer shall file with the bureau a request for a hearing with the adjudication committee only on a bureau approved form. The form may be filed with the adjudicating committee only after the request, protest, petition, or application has been reviewed by the appropriate bureau business unit and only after the bureau's that business unit has conveyed to the employer in writing the bureau's initial decision regarding the employer's request, protest, petition, or application.

~~(2) The bureau shall notify the employer in writing of its determination on the employer's request, protest, petition, or application.~~

~~(3)~~(2) Unless a different time is provided by the Revised Code or the Administrative Code for such matter, an employer shall file a protest or appeal of the bureau's decision on the request, protest, petition, or application within two years of receipt of the bureau's determination.

~~(4)~~(3) The employer shall state the specific grounds or reasons for the protest or appeal of the bureau's determination, and shall include supporting documentation. The bureau may refuse to grant a hearing to the employer where the employer has failed to state the specific grounds or reasons for the protest or appeal or has failed to provide supporting documentation as required by this rule.

~~(5)~~(4) For the purpose of hearing the protest or appeal, the administrator may appoint an adjudicating committee to provide employers with hearings on such matters referred to the committee.

- (B) The adjudicating committee shall consist of three members appointed by the administrator. The members shall consist of persons who shall have expertise or experience in matters relating to employers.
- (C) The adjudicating committee shall hold meetings and hearings to determine matters referred to it by the administrator for adjudication. With the approval of the administrator, the committee members may delegate alternate bureau employees to act on their behalf. The committee may issue decisions without formal hearing, but shall afford an employer the opportunity for a formal hearing before the committee upon request. A prompt, efficient, and expeditious determination of matters coming before the committee shall be ensured to protect the interests of employers and the state insurance fund.
- (D) If an employer requests a hearing before the adjudicating committee, and has complied with (A)(1) of this rule by filing a protest form with the bureau, or the committee determines that a hearing is in the best interests of the employer or the state insurance fund, the committee shall mail a notice of hearing to the employer and its representatives by regular mail, setting forth the date, time and place of the hearing. The notice shall be mailed not less than fourteen days before the date of such hearing. In justifiable cases, an emergency hearing may be arranged with the adjudicating committee.
- (E) The committee shall keep a record of its dockets and proceedings. The committee's decisions shall be reduced to writing and mailed forthwith to all interested parties and shall state the evidence upon which the decision was based and the reasons for the committee's actions. The decision of the committee shall be the decision of the administrator. If the employer files a written appeal within thirty days of the employer's receipt of the committee's decision, the administrator or the administrator's designee shall hear the appeal of the decision of the committee, and shall conduct a hearing for such purpose.
- (F) The administrator may authorize the adjudicating committee to consider the following matters:
- (1) Requests for waiver of a default in the payment of a premium under section 4123.37 of the Revised Code;
 - (2) Requests for settlement of liability of a noncomplying employer under section 4123.75 of the Revised Code;
 - (3) Petitions objecting to assessment of premium under rule 4123-14-02 of the Administrative Code and section 4123.37 of the Revised Code;
 - (4) Employer's request for abatement of penalties under rule 4123-09-07 of the Administrative Code and section 4123.32 of the Revised Code;

- (5) Protests of audit findings, manual classifications, experience ratings, retrospective ratings, or transfers or combinations of risk experience;
- (6) Any other risk or premium matters as authorized and delegated by the administrator under Chapters 4121., 4123., and 4131. of the Revised Code.

BWC Board of Directors
Executive Summary
Noncomplying Employers Rules
Chapter 4123-14
April 2009

Introduction

Rule 4123-14 defines noncomplying employers as those who fail to pay premiums and sets forth procedures on how BWC will pursue collection of such premiums from noncomplying employers.

As part of the current Chapter 4123-14 five year rule review process, this chapter has been thoroughly reviewed and changes have been proposed. There are six rules in Chapter 4123-14 dealing with how BWC will notify a noncomplying employer of their failure to pay, how BWC will make an assessment of the premium due based on information in its possession, and the process for placing liens on an employer's real and personal property, and recording such liens with the county recorder. This rule also identifies appeal options available to an employer seeking a waiver of penalties and the employer's right to an adjudication hearing to determine if the employer has demonstrated "good cause" for such a waiver.

Background Law

Ohio Revised Code 4123.35 defines an employer for the purposes of workers' compensation coverage in Ohio and sets forth how an employer is to pay premiums for workers' compensation coverage.

Ohio Revised Code 4123.32 directs the Administrator to develop rules regarding noncomplying employers.

Pursuant to these statutes, BWC has adopted Ohio Administrative Code Chapter 4123-14, "Noncomplying Employers." The rules in this chapter are scheduled for five year rule review as mandated by Ohio Revised Code 119.032. BWC owns and maintains the revision and update process for this section of the OAC.

Changes were also drafted in response to HB100 which mandated BWC to lapse employers for non-payment of non-premium debt in excess of \$1,000.

Proposed Changes

The major substantive changes proposed for the noncomplying employers' rules pursuant to the five year rule review:

- Clarification and expansion on the definition of noncomplying employers
- Updating rule to reflect mandate from HB 100 on lapsing employers who fail to pay non-premium obligations
- Updating rule to reflect current BWC procedures for the collection of premiums from noncomplying employers

- Updating rule to reflect current BWC procedures for adjudicating employers' requests for relief
- Elimination of OAC 4123-3-14 "Procedure in the original adjudication of noncomplying employers' claims" (this chapter is a duplicate of 4123-14-04)

Stakeholder Involvement

The proposed rule changes were disseminated to external interested parties that included 38 Third Party Administrator representatives and the chair of the workers' compensation section of the Ohio State Bar Association. An announcement was made at a recent BWC event with TPAs in attendance, notifying attendees that proposed changes to Chapter 14 of the OAC would be available for reviewing and comment. Only one response was received from an external stakeholder. That response was evaluated by the Subject Matter Specialists for impact. No changes were made to the draft document as a result of that response.

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.



Bureau of Workers' Compensation

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

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Stakeholder feedback and recommendations for changes to the HPP Provider rules Chapter 6, specifically 4123-6 -01; 4123-6-02; 4123-6-02.1; 4123-6-02.2;4123-6-02.21; 4123-6-02.3; 4123-6-02.4; 4123.6.02.5; 4123-6-02.6; 4123.6-02.7; 4123.6-02.8; 4123.6.02.9; 4123-6-07; 4123-6-17

Line #	Rule #	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
1	4123-6-01 (D) Definitions, (Amend)	SI employer requests section (D) physician definition to include that Mexican physicians not holding US licensure are not included.	The SI employer asserts that medical licensure requirements in Mexico are not as strict as US standards.	Current language of rule is clear on who meets the definition of physician. The rule doesn't need to specifically reflect that Mexico physicians not licensed in USA are excluded.	Rule remains as proposed.
2	4123-6-01 (E) '...the authorized physician chosen by the employee to direct treatment.' Definitions, (Amend)	SI employer : "If employee is to have the ability to direct treatment, it should be done under the advice of a internist or general practitioner".	The SI employer asserts that allowing employees to choose their physician often leads to employees seeking a provider who will give them unnecessary time off, and in this employer's experience, resulting in higher costs.	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 OAC 4123-6-06.2, which 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 injured workers are responsible to pay non-BWC certified providers for ongoing care. The MCO is responsible to review requested care for appropriateness and medical necessity.	Rule section (E) remains unchanged.

Line #	Rule #	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
3	4123-6-01 (G) Definitions, (Amend)	The Ohio Pharmacy Association voiced concerns regarding the striking of pharmacists from the rule OAC 4123-6-01(G) definition of "Health Care Provider" or "Provider".	OPA feels pharmacists may offer added BWC benefit if they were involved in medication management activities, as they do provide this service for Medicare.	Explained to OPA that pharmacists continue to meet the definition of "Health Care Provider" or "Provider", and were only struck as an unneeded example, (as were hospitals and DME suppliers). BWC employs a pharmacist and has a Pharmacy & Therapeutics committee to advise BWC regarding medication management activities.	Rule amendment will remain as written.
4	4123-6-01 (FF) and 4123-6-02.2 (C 12)	SI employer 'likes' (FF) "urgent care" definition, but dislikes the rationale for the change to OAC 4123-6-02.2 (C)(12) - to pay urgent care provider (hospital) based facility fees.	The SI employer states that other providers pay overhead out of allowed fees, so urgent care facilities should do the same.	This change is made to support the hospital's provider based urgent care facilities and clinics because these costs are part of the hospital's costs, therefore is appropriate to pay a facility fee.	Rule remains as proposed.
5	4123-6-02.2 (B)(1) '... related to chemical dependency or substance abuse'.	The Ohio State Medical Board (OSMB) disagrees with excluding medical providers from BWC certification for restrictions "... related to chemical dependency or substance abuse".	OSMB feels providers with substance abuse or chemical dependency issues who are given their license back and are under a consent agreement that involves monitoring restrictions (which last for 5 years) should not be denied BWC certification while they remain compliant with the consent agreement. The providers have defined and agreed-upon restrictions which the Ohio State Medical Board monitor and regulate compliance with.	BWC internal review agrees to modify the rule language. BWC will follow the strict monitoring imposed by the Ohio State Medical Board and any relapse action will dealt with. BWC will continue to review consent agreements involving chemical dependency or substance abuse to determine if practice limitations are imposed or if the provider's ability to treat injured workers is impaired.	BWC will update OAC 4123-6-02.2 (B)(1) to state: "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. "

Line #	Rule #	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
6	4123-6-02.2 (B)(1) '... related to chemical dependency or substance abuse'.	The Ohio Association of Physician Assistants disagrees with excluding physician assistants from BWC certification for restrictions "... related to chemical dependency or substance abuse". OAPA requests that BWC return to the rule language as it existed prior to adopting this clause (2007).	OAPA argues the current rule language is inconsistent with the Ohio State Medical Board's strict requirements for reinstatement, is contrary to BWCs mission of returning injured employees to work, and could violate federal ADA requirements.	BWC internal review agrees to modify the rule language. BWC will follow the strict monitoring imposed by the Ohio State Medical Board and any relapse action will be dealt with. BWC will continue to review consent agreements involving chemical dependency or substance abuse to determine if practice limitations are imposed or if the provider's ability to treat injured workers is impaired.	BWC will update OAC 4123-6-02.2 (B)(1) to state: "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. "
7	4123-6-02.2 (B)(1) '... related to chemical dependency or substance abuse'.	Attorney Deborah Lydon with Dinsmore and Shohl LLP is representing a physician assistant currently under a consent agreement involving chemical dependency and substance abuse who was denied certification by BWC after his license was reinstated. She disagrees with excluding physician assistants from BWC certification for restrictions "... related to chemical dependency or substance abuse". Requests to return to former language of 2007 prior to adopting this clause or reword.	Ms. Lydon argues the current rule language is inconsistent with the Ohio State Medical Board's strict requirements for reinstatement, is contrary to BWCs mission of returning injured employees to work, reduces the number of providers available to treat injured workers, and could violate federal ADA requirements. She suggests removal or rewording of current language so there is no absolute prohibition when the provider's ability to treat patients is not impaired.	BWC internal review agrees to modify the rule language. BWC will follow the strict monitoring imposed by the Ohio State Medical Board and any relapse action will be dealt with. BWC will continue to review consent agreements involving chemical dependency or substance abuse to determine if practice limitations are imposed or if the provider's ability to treat injured workers is impaired.	BWC will update OAC 4123-6-02.2 (B)(1) to state: "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. "

Line #	Rule #	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
8	4123-6-02.2 (B)(1) '... related to chemical dependency or substance abuse'.	Monitoring physician Douglas Linz, MD, with TriHealth Corporate Health responding on behalf of above physician assistant currently under a consent agreement involving chemical dependency and substance abuse who was denied certification by BWC after his license was reinstated. Dr. Linz also disagrees with excluding providers from BWC certification for restrictions "... related to chemical dependency or substance abuse". Dr. Linz requests that BWC return to the rule language as it existed prior to adopting this clause (2007) or reword -see next column.	Dr. Linz feels returning to the prior rule language or rewording the rule as suggested below will allow for safe practitioners treating injured workers, and is in accordance with with TriHealth and BWC's mission of returning injured workers to productive work. Dr. Linz suggests removal or rewording of the current rule language to state "The provider shall be currently licensed to practice as applicable without disciplinary restrictions, including any such restrictions related to chemical dependency or substance abuse, that affect the provider's ability to treat patients or that compromise patient care."	BWC internal review agrees to modify the rule language. BWC will follow the strict monitoring imposed by the Ohio State Medical Board and any relapse action will dealt with. BWC will continue to review consent agreements involving chemical dependency or substance abuse to determine if practice limitations are imposed or if the provider's ability to treat injured workers is impaired.	BWC will update OAC 4123-6-02.2 (B)(1) to state: "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. "

Line #	Rule #	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
9	4123-6-02.2 (B)(1) '... related to chemical dependency or substance abuse'.	The Ohio Council of Behavioral Health & Family Services Providers, representing 180 nonprofit addiction treatment, mental health and family service providers in Ohio, disagrees with excluding providers from BWC certification for restrictions "... related to chemical dependency or substance abuse", and requests that BWC return to the rule language as it existed prior to adopting this clause (2007).	The Council feels that a provider should not be excluded from certification due to being on a monitoring agreement unless the agreement restricts the provider's ability to treat patients.	BWC internal review agrees to modify the rule language. BWC will follow the strict monitoring imposed by the Ohio State Medical Board and any relapse action will be dealt with. BWC will continue to review consent agreements involving chemical dependency or substance abuse to determine if practice limitations are imposed or if the provider's ability to treat injured workers is impaired.	BWC will update OAC 4123-6-02.2 (B)(1) to state: "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. "
10	4123-6-02.2 (B)(1) '... related to chemical dependency or substance abuse'.	The Ohio Nurses Association disagrees with excluding providers from BWC certification for restrictions "... related to chemical dependency or substance abuse", and requests that BWC delete the phrase relative to chemical dependency or substance abuse.	ONA feels the Ohio State Nursing Board's strenuous Alternative Program for Chemical Dependency protects the public from unsafe nursing practice and that BWC's additional restrictions are excessive and punitive.	BWC internal review agrees to modify the rule language. BWC will follow the strict monitoring imposed by the Ohio State Medical Board and any relapse action will be dealt with. BWC will continue to review consent agreements involving chemical dependency or substance abuse to determine if practice limitations are imposed or if the provider's ability to treat injured workers is impaired.	BWC will update OAC 4123-6-02.2 (B)(1) to state: "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. "

Line #	Rule #	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
11	4123-6-02.2 (C 11)	The Ohio Council on Home Care suggests that BWC delete Joint Commission and CHAP from Home Health Agency accrediting organizations and add phrase for any organization given "deeming" authority from CMS (Medicare) to grant Medicare participation.	CMS (Medicare) may grant authority (deem) organizations to approve participation with Medicare at any point. The Council feels BWC's current rule proposal is too narrow, as CMS has granted "deeming" authority to new agency ACHC (Accreditation Commission for Health Care, Inc) in early May.	BWC internal review agrees with adding phrase to rule to recognize any agency that CMS has given "deeming" authority. This will add to BWC's provider base and recognizes Medicare's current process.	Rule updated to reflect input.

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.

Chapter 4123-6 Health Partnership Program

4123-6-01 Definitions. (Amend)

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

Comment [a1]: 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.

(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.

(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 [a2]: 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 [a3]: 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 [a4]: 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 [a5]: 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 [a6]: 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 [a7]: Adding hospital definitions in Rule to increase understanding of BWC application of terms when evaluating reimbursement pursuant to applicable fee reimbursement rules.

Comment [a8]: Adding urgent care facility definition in Rule to increase understanding of BWC application of terms when evaluating reimbursement pursuant to applicable fee reimbursement rules.

4123-6-02 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 [a9]: 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 [a10]: "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 [a11]: 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.~~

Comment [a12]: This recommendation provides BWC flexibility to evaluate all provider problems utilizing the same criteria of patient treatment competency.

(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.

Comment [a13]: This standard is being added to be more consistent with the licensing boards.

(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.

- (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, 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 [a14]: Updated requirements to reflect new state agency regulating home durable medical equipment.

Comment [a15]: Language modified to include organizations granted authority to approve home health agencies to do business with CMS.

Comment [a16]: 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: license from Ohio department of health or medicare participation.

Comment [a17]: Language modified to add medicare participation as is routinely inclusive with Ohio licensure.

(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.

Comment [a18]: This reflects a new provider licensure type and increases access to care.

(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 [a19]: 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 [a20]: 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 or 4123-6-12 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.

(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.

(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

Comment [a21]: This recommendation will facilitate effective maintenance of data in BWC's provider enrollment system.

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 [a22]: 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 [a23]: 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 [a24]: Inserted to require that providers recognize BWCs treatment guidelines.

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

Comment [a25]: 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 [a26]: 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 [a27]: 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 [a28]: 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 [a29]: 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 [a30]: 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 [a31]: 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 [a32]: 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 [a33]: 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 [a34]: 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 [a35]: This language is being added to conform to O.R.C. 4121.444(C)(1).

Comment [a36]: 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 [a37]: 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~~ 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 whether or not the provider is, or is not, on the MCO's provider panel, or has an arrangement with the MCO.

Comment [a38]: This reflects that MCOs may have provider panels or arrangements.

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

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

4123-6-02.7 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 [a40]: 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.

Comment [a41]: BWC establishes reporting requirements, not MCOs.

~~(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.

Comment [a42]: This requirement is moved from OAC 4123-6-71, so that all provider injury reporting requirements are in one rule.

(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.

Comment [a43]: This requirement is moved from OAC 4123-7-08, so that all provider injury reporting requirements are in one 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: 2/16/96, 1/1/01

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

4123-6-07 Balance billing prohibited. (No Change)

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

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

(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 [a44]: 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 [a45]: 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 [a46]: 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 [a47]: 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 [a48]: 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

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			x		Yes	M. Ely	2008	Mar-09	Complete	2/24/09	2/26/09	6-Mar	19-Mar	30-Apr	
4123:1-9	Steel Making, Manuf. & Fabrica.	5	x			x		Yes	B. Loughner	2008	Mar-09	complete	2/15/09	2/26/09	6-Mar	19-Mar	30-Apr	
4123:1-11	Laundry & Dry Cleaning	5	x			x		Yes	R. Gaul	2008	Mar-09	complete	2/24/09	2/26/09	6-Mar	19-Mar	30-Apr	
4123-5	Miscellaneous Provisions	6		x	x	x		Yes	K. Robinson	2009	Apr-09	complete		4/2/09	10-Apr	28-Apr	29-May	
4123-18	Rehab of Inj and Dis Workers	16	x		x	x		Yes	K.Fitsimmons, K Robinson	2008	Apr-09	complete	in process	4/2/09	10-Apr	28-Apr	29-May	
4123:1-1	Elevators	5	x			x		Yes	R. Gaul	2008	Apr-09	complete	2/24/09	4/2/09	10-Apr	28-Apr	29-May	
4123:1-13	Rubber & Plastics	4	x			x		Yes	M. Lampl	2008	Apr-09	complete	3/17/09	4/2/09	10-Apr	28-Apr	29-May	
4123:1-17	Window Cleaning	7	x			x		Yes	D. Feeney	2008	Apr. 09	complete	3/24/09	4/2/09	10-Apr	28-Apr	29-May	
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			x		Yes	D.C. Skinner	2008	May-09			4/30/09	8-May	29-May	29-Jun	
TBD	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	
4123-6-01 to 18	HPP- Program	49	x	x	x	x		Yes	F. Johnson, T. Mihaly	2009	Jun-09	4/6/09	5/7/09	5/28/09	5-Jun	18-Jun	31-Jul	
4123-6-50 to 73	HPP/QHP	24	x	x	x	x		Yes	F. Johnson, Leeper	2009	Jul-09	5/1/09	6/14/09	7/2/09	10-Jul	30-Jul	28-Aug	
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	x		Yes	J. Smith, TK, RM	2008	Nov-08-Jan-09		6/15/09	7/2/09	10-Jul	29-Jul	28-Aug	
4123:1-5	Workshops & Factories	32	x			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	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	x		Yes	F. Johnson	2009	Oct-09	7/15/09	9/15/09	10/1/09	9-Oct	29-Oct	20-Nov	
4123-6-37.3	2010 ASC Fee Schedule						x		Graff, Casto		Oct-09	7/15/09	9/1/09	10/1/09	9-Oct	29-Oct	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

12-Month Governance Committee Calendar

Date	June 2009	Notes
6/18/2009	1. Finalize Board Self- Assessment	
	2. Discussion of Committee Membership Recommendations	
	3. Administrator's objectives for 2009/10	
	4. 2009 Provider and Service Fee Schedule (2 nd Reading)	
	5. HPP program	
Date	July 2009	
7/30/2009	1. Five Year Rule Review	
Date	August 2009	
8/27/2009	1. Five Year Rule Review	
Date	September 2009	
9/23/2009	1. Five Year Rule Review	
9/24/2009	1. Governance Guidelines	
	2. Committee Charters	
Date	October 2009	
10/29/2009		
Date	November 2009	
11/19/2009		
Date	December 2009	
12/16/2009		
Date	January 2010	
1/28/2010		
Date	February 2010	
2/25/2010		
Date	March 2010	
3/25/2010		
Date	April 2010	
4/29/2010		
Date	May 2010	
5/27/2010		