

**BOARD OF DIRECTORS  
OHIO BUREAU OF WORKERS' COMPENSATION  
EDUCATION TOPICS  
FY 2009**

The following indicates activities completed by the Board of Directors during FY 2009 to complete the education requirements of ORC 4121.12(F)(16)

***Required Areas Specified in HB 100:***

***New Director Orientation (completed for new appointee)***

- Review of HB 100 issues
- Administrative issues
- Review of fiscal reports
- Open meeting basics
- Understanding the monthly financial statement
- Annual budget process
- Overview of BWC's internal audit function

***Duties and Responsibilities***

- Review of duties and other responsibilities of Board members
- Rule-making process
- Duties and responsibilities of committees, especially review of best practices for Audit Committee

***Ethics***

- Ethics training by David Freel, Executive Director of the Ohio Ethics Commission
- Fraud, Ethics and Internal Control referral process

***Fiduciary Responsibilities***

- Fiduciary responsibility of board members with fiduciary counsel Ron O'Keefe

***Governance Process & Procedures***

- Review and update Governance Guidelines and Committee charters

***Compensation & Benefits***

- Rule reviews for rehabilitation of injured and disabled workers, claims process, provider and service fee schedule, vocational rehabilitation services fee schedule, HPP dispute resolution

***Investments***

- Overview of current investment policy and market influences
- Investment reports and critical elements of an investment policy statement

- Securities lending overview
- Asset allocation review of State Insurance Fund
- Asset classes
- Various Investment Topics, Mercer Investment Consulting, Inc.
- Derivatives education
- Completed Asset/Liability model for State Insurance Fund

### ***Actuarial Soundness***

- Medical cost increases: discussion of impact on rates and reserves
- Rate indicators, rate making, group rating, and experience rating and credibility tables for private employers, public employers and state agencies.
- Discount rate review and adjustment
- Completed comprehensive study required by section 512.50 of HB100 (Deloitte study)

### **Other areas not specified in HB100**

- Medical cost trends
- IT readiness and emergency plans
- Development of net asset policy
- Computer security

Reviewed July 30, 2009

**FY 2010 Proposed Education Plan  
BWC Board of Directors  
July, 2009**

ORC 4121.12 states: [The board of directors shall]

(F)(16) Develop and participate in a bureau of workers' compensation board of directors education program that consists of all of the following:

- (a) An orientation component for newly appointed members;
- (b) A continuing education component for board members who have served for at least one year;
- (c) A curriculum that includes education about each of the following topics:
  - (i) Board member duties and responsibilities;
  - (ii) Compensation and benefits paid pursuant to this chapter and Chapters 4123., 4127., and 4131. of the Revised Code;
  - (iii) Ethics;
  - (iv) Governance processes and procedures;
  - (v) Actuarial soundness;
  - (vi) Investments;
  - (vii) Any other subject matter the board believes is reasonably related to the duties of a board member.

(17) Submit the program developed pursuant to division (F)(16) of this section to the workers' compensation council for approval;

(18) Hold all sessions, classes, and other events for the program developed pursuant to division (F)(16) of this section in this state.

Staff recommends the following:

- (a) An orientation component for newly appointed members  
Since four directors were reappointed this year, there is no need for an orientation component.
- (b) A continuing education component for board members who have served for at least one year  
*The Directors believe presentations during the year will satisfy this requirement*
- (c) A curriculum that includes education about each of the following topics:
  - (i) Board member duties and responsibilities  
*The August, 2009 meeting will include a presentation by fiduciary counsel*
  - (ii) Compensation and benefits paid pursuant to this chapter and Chapters 4123., 4127., and 4131. of the Revised Code  
*Beginning in September, 2009, the Directors will receive a comparative study of rates and benefits*

(iii) Ethics

*David Freel will conduct a two hour ethics training session on August 28, 2009*

(iv) Governance processes and procedures;

*The Board will complete this process as part of their annual review of the Governance Guidelines and Committee charters during the fall of 2009*

(v) Actuarial soundness;

*Beginning in January 2010, the Board will review staff recommendations to convert the rating classification system to the NCCI.*

*Our actuarial consulting firm (Deloitte) will present at least 4 briefings during the year on their reserve estimates*

*Actuarial soundness is also a major topic during the rate approval discussions*

(vi) Investments;

*As the Directors complete the transition to a portfolio mix of 70% bonds and 30% equities, there will be a number of presentations by Mercer Consulting (BWC investment consultant) and BWC Investment Division staff concerning different approaches to meeting this new investment mix*

(vii) Any other subject matter the board believes is reasonably related to the duties of a board member.

Recommendations: *discount rate, net asset policy*

Additionally, the four (4) public forums sponsored by the Board provide an opportunity for the Directors to learn of additional policies for their consideration.

## FY 2010 Calendar of Education topics

Dates	Activity	Topic and citation
July 30/31, 2009	Reserve Audit update and actuarial soundness	Actuarial soundness 4121.12(F)(16)(c)(v)
	Net Asset policy	Additional subject matter 4121.12(F)(16)(c)(vii)
	Implementation strategy for transition to Russell 3000 index	Investments 4121.12(F)(16)(c)(vi)
August 27/28, 2009	Ethics training (David Freel)	Ethics 4121.12(F)(16)(c)(iii)
	Fiduciary Responsibilities (Fiduciary Counsel)	Board members duties and responsibilities 4121.12(F)(16)(c)(i)
September 24/25, 2009	Review Governance Guidelines and Comm. Charters	Governance processes and procedure 4121.12(F)(16)(c)(iv)
	Comparative study of rates and benefits	Compensation and Benefits 4121.12(F)(16)(c)(ii)
	Select fixed income managers	Investments 4121.12(F)(16)(c)(vi)
	Projected reserves as of 6/30/09 and actuarial soundness	Actuarial soundness 4121.12(F)(16)(c)(v)
October 29/30, 2009	Review Governance Guidelines and Comm. Charters	Governance processes and procedure 4121.12(F)(16)(c)(iv)
	Review Board member duties and responsibilities	Board member duties and responsibilities 4121.12(F)(16)(c)(i)
	Select ACWI and Russell 3000 managers	Investments 4121.12(F)(16)(c)(vi)
	NCCI split rating plan	
November 19/20, 2009	Reserve Audit update and actuarial soundness	Actuarial soundness 4121.12(F)(16)(c)(v)
December 16/17, 2009	Injured workers' compensation and benefits	Injured workers' compensation 4121.12(F)(16)(c)(ii)
January 28/29, 2010	Key Financial Indicators	Investments 4121.12(F)(16)(c)(vi) Actuarial soundness 4121.12(F)(16)(c)(v)
February 25/26, 2010	Reserve Audit update and actuarial soundness	Actuarial soundness 4121.12(F)(16)(c)(v)

March 25/26, 2010	Discount rate	Additional subject matter 4121.12(F)(16)(c)(vii)
April 29/30, 2010		
May 27/28, 2010	Reserve Audit update and actuarial soundness	Actuarial soundness 4121.12(F)(16)(c)(v)
June 17/18, 2010		

Other topics may be scheduled at the request of a Director or the Administrator.  
Also, individual committees may schedule topics as needed.

## **Common Sense Business Regulation (BWC Rules)**

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

### **Vocational Rehabilitation Provider Fee Schedule**

#### **Rule 4123-18-09**

#### **Rule Review**

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

Citation:     R.C. 4121.61, R.C. 4121.441(A)    

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

What goal(s):     The rule adopts a fee schedule for workers' compensation vocational rehabilitation services in accordance with R.C. 4121.61, R.C. 4121.441(A), 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 provided for review to BWC's Labor-Management-Government Advisory Council (LMG), which is responsible for providing advice and recommendations to BWC on rehabilitation matters (see R.C. 4121.70 and OAC 4123-18-18).    

BWC also provided the proposed fee schedule to the following stakeholder groups: the International Association of Rehabilitation Professionals (IARP), the Ohio Physical Therapy Association (OPTA) and the Ohio Association of Rehabilitation Facilities (OARF) and the Ohio Association for Justice (OAJ). Meetings were held on June 23<sup>rd</sup> and June 25<sup>th</sup> with stakeholders to discuss the fee schedule. IARP attended both of the meetings and OPTA and OARF attended one meeting.

Stakeholders' questions, concerns and feedback resulted in productive revisions to the proposed rules.

9.  The rule was reviewed for clarity and for easy comprehension.
10.  The rule promotes transparency and predictability of regulatory activity.
11.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.
12.  The rule is not unnecessarily burdensome or costly to those affected by rule.  
  
If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_
13.  The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

**BWC Board of Directors**  
**Executive Summary**  
**BWC Vocational Rehabilitation Provider Fee Schedule Rule**  
**OAC 4123-18-09**

**Introduction**

Chapter 4123-18 of the Ohio Administrative Code contains BWC rules providing for the vocational rehabilitation of injured workers in the Ohio workers' compensation system. The rules were first published as Industrial Commission (IC) rules in the early 1980's, and were converted to BWC rules in the early 1990's when H.B. 222 transferred authority over vocational rehabilitation services from the IC to BWC.

BWC reviewed revised the vocational rehabilitation rules in 2001, following the implementation of the Health Partnership Program (HPP), and again in 2004 and 2009, pursuant to five-year rule review.

**Background Law**

Ohio Revised Code (O.R.C.) 4121.61 provides that the Administrator, with the advice and consent of the BWC Board of Directors, shall "adopt rules, take measures, and make expenditures as it deems necessary to aid claimants who have sustained compensable injuries or incurred compensable occupational diseases . . . to return to work or to assist in lessening or removing any resulting handicap."

O.R.C. 4121.441(A) provides that the Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP "to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease . . . ."

Prior to the 10<sup>th</sup> 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 vocational rehabilitation provider fee schedule 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."

However, pursuant to the Court of Appeals' decision in the *OHA* case, BWC is now required to adopt changes to its provider fee schedules, including the vocational rehabilitation provider fee schedule, via the O.R.C. Chapter 119 rulemaking process. BWC has undergone a systematic revision of its vocational rehabilitation provider fee schedule and, now proposes to adopt the newly revised vocational rehabilitation provider fee schedule as an Appendix to newly enacted OAC 4123-18-09.

**Proposed Changes**

The major substantive changes proposed for the vocational rehabilitation fee schedule include:

- There are currently a total of 76 vocational rehabilitation fee codes with a recommendation to add code W0513 for Ergonomic Implementation for a total of 77.
- Fee increases are proposed in 50 of the 77 codes representing the following 5 services:

1. Vocational Rehabilitation Case Management (39 codes)
  2. Travel and Wait Time for case managers (4 codes)
  3. Mileage for case managers and other providers (4 codes)
  4. Occupational Rehabilitation – Comprehensive (2 codes)
  5. Work Conditioning (1 code)
- There are a total of 9 codes with proposed changes to the Unit of Service (UOS). These changes may impact the overall price paid for 7 of the codes:
    1. Ergonomics (2 codes)
    2. Work Adjustment (2 codes)
    3. Job Analysis (1 code)
    4. Job Seeking Skills Training (1 code)
    5. Job Placement/Development (1 code)
  - The change in UOS for 2 codes will have no fee impact:
    1. Vocational Evaluation (1 code)
    2. Vocational Screening (1 code)
  - There are proposed changes to the definitions for Other Provider Travel and Other Provider Mileage (4 codes) to allow for reimbursement of Travel and Mileage to providers of Transitional Work, Ergonomic Study, Ergonomic Implementation and Job Analysis.
  - There are a total of 18 codes with no changes recommended.

## **Stakeholder Involvement**

The proposed fee schedule was provided for review to BWC's Labor-Management-Government Advisory Council (LMG), which is responsible for providing advice and recommendations to BWC on rehabilitation matters (see R.C. 4121.70 and OAC 4123-18-18).

BWC also provided the proposed fee schedule to the following stakeholder groups: the International Association of Rehabilitation Professionals (IARP), the Ohio Physical Therapy Association (OPTA) and the Ohio Association of Rehabilitation Facilities (OARF) and the Ohio Association for Justice (OAJ). Meetings were held on June 23<sup>rd</sup> and June 25<sup>th</sup> with stakeholders to discuss the fee schedule. IARP attended both of the meetings and OPTA and OARF attended one meeting.

Stakeholders' questions, concerns and feedback resulted in productive revisions to the proposed rules.

## **4123-18-09 Vocational rehabilitation provider fee schedule. (New)**

(A) Pursuant to sections 4121.441 and 4121.61 of the Revised Code, the bureau shall adopt rules for the provision of vocational rehabilitation services to injured workers. The administrator hereby adopts the vocational rehabilitation provider fee schedule indicated in the attached appendix A, developed with stakeholder input, effective November 15, 2009.

(B) Whether the MCO has elected to retain a provider panel or not, an MCO may contract with vocational rehabilitation 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

VOCATIONAL REHABILITATION PROVIDER FEE SCHEDULE

EFFECTIVE NOVEMBER 15, 2009

Effective: 11/15/2009

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.441, 4121.61, 4121.62, 4123.53, 4123.66

Prior Effective Dates:

# **BWC 2009 Proposed Vocational Rehabilitation Services Provider Fee**

## **Medical Service Enhancements**

Prompt, effective medical and vocational 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 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, and employers, means the availability of quality, cost-effective treatment provided on the basis of medical and/or vocational necessity. It facilitates faster recovery and a prompt, safe return to work.

The Medical Services Division has focused on improving its core medical services functions. Our goals are as follows: enhance our medical and vocational 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.

## **Vocational 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 over 3600 vocational providers who are either independent providers or affiliated with a vocational rehabilitation service entity. An appropriate fee schedule is integral to maintaining an effective and comprehensive network of providers. An equitable and competitive fee for the right vocational service is essential to maintain a quality provider network across the wide range of necessary provider disciplines. Thus, the guiding principle is to ensure access to high-quality vocational services by establishing an appropriate Benefit plan and Terms of service with a competitive fee schedule which, in turn, enhances BWC's vocational provider network.

BWC's vocational services have operated under an unchanged fee schedule policy since 1999. As a result, BWC Medical Services undertook a comprehensive review of the benefit plan and corresponding vocational fee schedule. The process for the comprehensive review included:

- A.** Reviewing specific service coverage statuses relative to indicators of vocational needs, and revising accordingly.
- B.** Assessing the existing number of service units for all services in relation to expected patterns of service delivery, and revising accordingly.
- C.** Evaluating current established fees for services, and adjusting accordingly.
- D.** Review proposed service fees and unit recommendations against other payers.

In applying the above process, the Rehabilitation Policy staff reviewed 76 local codes.

The method BWC uses to determine which services will be within the coverage plan and the fee schedule for those services is detailed below.

### **Determination of Coverage and Units of Services**

BWC performed an assessment to determine what rehabilitation services are needed to include and/or exclude from the vocational benefit plan. Consideration is given to whether particular services are in line with BWC's objectives which are providing services that most effectively facilitate an injured worker's return to work, or remain at work. Based on this review a decision is made to add, keep or remove any particular rehabilitation service.

BWC gathered information from several sources to complete this assessment. Sources included feedback from stakeholders and/or providers, data on trends in vocational rehabilitation services taken from seminars, literature reviews etc., and data research of services provided in other state's workers' compensation systems.

At the same time, BWC determined for each benefit plan service, what the appropriate number of units or range of units for that service should be.. Importance was placed on ensuring the injured worker gets the right treatment at the right time and in sufficient quantity to maximize positive outcomes without creating program inefficiencies.

### **Setting Fees**

The fees for vocational rehabilitation services were also reviewed, and evaluated against the guiding principle as set forth above. As a result of that evaluation determinations were made whether fees should be increased, remain the same or decreased. Fees for any new services were also set during this step. The reimbursement level for any service took into account the Ohio environment, the existing fees and the determination of what change in fees would facilitate the achievement of the guiding principle.

After establishing the fees, BWC gathered service and reimbursement data from other payers and evaluated the established Ohio fees against the gathered information. The process for gathering comparison data involved performing research of various payers of rehabilitation services and of providers or vendors of equipment and tools. Because of the nature of local service definitions and the differences that can exist in services from one state to another, care was taken in comparing the gather data against Ohio's recommended plan and reimbursement levels. Thus, the evaluation of this data was used to add an additional confidence level check of BWC's recommended benefit plan design including reimbursement levels.

### **2009 Proposed Fee Schedule Updates**

BWC proposes to increase the fees for the following services:

- 39 vocational rehabilitation case management service codes from \$7.00 per six minute unit of service to \$7.50 per six minutes

- vocational case management travel and wait codes from \$3.50 per six minute units of service to \$3.75 per six minutes
- mileage reimbursement for Vocational Rehabilitation case managers and other designated rehabilitation providers from \$.30 per mile to \$.45 per mile
- Occupational Rehabilitation – Comprehensive codes from \$128.25 (for first 2 hours) and \$51.18 (each additional hour) to \$135.95 and \$54.25 respectively
- Work Conditioning from \$37.50 per hour to \$40.00 per hour
- Transitional Work, Ergonomic Study, Ergonomic Implementation and Job Analysis from no allowance of provider travel and mileage to allowance.

BWC proposes the following Unit of Service changes:

- Ergonomic Study and Job Analysis - from “By Report” to a fifteen minute unit of service. Each unit would be reimbursed at \$45.00. In addition a new code is being proposed to allow for an Ergonomic Implementation service.
- Work Adjustment from \$300.00 per week to \$15.00 per hour with a weekly maximum of thirty-five hours or \$525.00 per week.
- Job Seeking Skills Training from \$500.00 per program to \$5.00 per six minute unit of service with a maximum of 150 units of service or \$750.00 maximum per program.
- Comprehensive Vocational Evaluation and Vocational Screening from a one hour unit of service to a six minute unit of service.

### Impact of Recommendation

The impact of the recommended changes is as follows:

1. Estimated \$1.9 million increase or approximately 5.9% over the vocational rehabilitation costs incurred in calendar year 2008,
2. Improvement in provider reimbursement
3. Appropriate provision of benefits necessary to address Ohio’s injured worker’s needs, i.e. returning to work or remaining at work,
4. Fully support the guiding principle: *ensure access to high-quality vocational services by establishing an appropriate Benefit plan and Terms of service with a competitive fee schedule which, in turn, enhances BWC’s vocational provider network.*



**Bureau of Workers' Compensation**

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

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Recommendations for changes to the vocational rehabilitation fee schedule from LMG Advisory Council, International Association of Rehabilitation Professionals (IARP), Ohio Association of Rehabilitation Facilities (OARF), and Ohio Physical Therapy Association (OPTA).

Service Code	Fee Schedule Recommendations	Stakeholder Rationale	BWC Response	Resolution
<b>W3000 - 40 Z3000-40 Vocational Rehabilitation Case Management</b>	IARP recommends that the fee for Vocational Rehabilitation Case Management (VRCM) codes be increased from \$70.00 per hour to \$80.00 per hour.	IARP has recommended that this service fee be increased. IARP further indicated disagreement with BWC's recommendation based on their research and requested the fee be increased to \$80.00 per hour.	BWC agrees with IARP's premise. In determining the appropriate level of change in the fee, BWC evaluated various Ohio market reimbursement levels against the BWC guiding principle of ensuring injured workers' access to quality care. Per that evaluation, BWC determined that an increase in reimbursement was warranted for this service.	BWC is recommending a 7% increase in this fee from \$70.00 per hour to \$75.00 per hour.
<b>W0644 Ergonomic Study</b>	OPTA agrees with the recommendation for using a 15 minute unit of service and with the recommended \$45.00/UOS reimbursement rate for billing purposes.	OPTA notes that the 15 minute increment is typically used by therapists and supports the designation for the code. OPTA believes that the service should be by report as the length of time needed to complete each service varies with the work situation being studied.	BWC agrees with OPTA's perspective and feedback.	BWC is recommending establishing a 15 minute unit of service for this code. BWC recommends reimbursement for W0644 at \$45.00 per unit of service (UOS) up to 28 UOS.
<b>W0513 Ergonomic Implementation</b>	OPTA does not see the necessity of the additional code W0513 for Ergonomic Implementation and believes that the W0644 code is sufficient and should be billed "by report".	OPTA believes that the service should be by report as the length of time needed to complete each service varies with the work situation being studied.	BWC's position is that Ergonomic Implementation services are unique and separate from the Ergonomic Study. The implementation and follow-up services present more variance in activities than the study itself. Thus, a new service code allows for better quality measures and tracking of the implementation and follow-up services.	BWC is recommending the addition of a code for Ergonomic Implementation. BWC is further recommending reimbursement for W0513 at \$45.00 per unit of service up to 16 units.

Service Code	Fee Schedule Recommendations	Stakeholder Rationale	BWC Response	Resolution
<b>W0644</b> <b>Ergonomic Study</b> <b>W0513</b> <b>Ergonomic Implementation</b> <b>W0645</b> <b>Job Analysis</b> <b>W0637</b> <b>Transitional Work</b>	OPTA requests payment of provider travel and mileage to perform these services	OPTA notes that there are a limited number of providers for these codes. They report that the provider sometimes travels several hours to provide the service and would like for this to be compensated.	BWC agrees with the feedback from all stakeholders on this service. BWC evaluated expanding this type of reimbursement for these services against the BWC guiding principle of injured workers' access to quality care. Per that evaluation BWC determined that expanding reimbursement to providers of these services facilitates access to quality care and further helps to keep injured workers on the job.	BWC is recommending that providers of these services be added to the types of providers allowed to be reimbursed under the codes for Travel W3050 and Z3050 and Mileage W3052 and Z3052.
<b>W0644</b> <b>Ergonomic Study</b> <b>W0513</b> <b>Ergonomic Implementation</b> <b>W0645</b> <b>Job Analysis</b> <b>W0637</b> <b>Transitional Work</b>	IARP concurs with OPTA's requests for payment of provider travel and mileage to perform these services		BWC agrees with the feedback from all stakeholders on this service. BWC evaluated expanding this type of reimbursement for these services against the BWC guiding principle of injured workers' access to quality care. Per that evaluation BWC determined that expanding reimbursement to providers of these services facilitates access to quality care and further helps to keep injured workers on the job.	BWC is recommending that providers of this service be added to the types of providers allowed to be reimbursed under the codes for Travel W3050 and Z3050 and Mileage W3052 and Z3052.
<b>W0645</b> <b>Job Analysis</b>	IARP recommends that the 8 unit of service or 2 hour cap that is proposed be increased or softened to allow for the varying complexity of jobs that are being analyzed.	IARP notes that the proposed cap would not cover the full costs of 52% of our past payment for this service. They suggest that this service be "by report" or that there is a mechanism to exceed the proposed cap.	BWC agrees with the premise of the feedback offered, but disagrees with the suggested recommendation. BWC believes the recommended unit of service (UOS) provides an appropriate standard for review for this service, and establishes a more consistent billing mechanism, while providing definition for usual and customary rates for this service. However, where sufficient justification from the provider and pre-authorization of the MCO are submitted, additional UOS will be available.	BWC is recommending increasing the proposed cap from 8 UOS to 16 UOS (4 hours) and allowing the designation of "up to" which reflects the ability to exceed the 16 UOS.

Service Code	Fee Schedule Recommendations	Stakeholder Rationale	BWC Response	Resolution
<p><b>W0645</b> <b>Job Analysis</b></p>	<p>While OPTA agrees with the suggested UOS and the reimbursement rate per UOS, they request that the proposed cap for this service (8 units of service) be removed and that the service continue "by report".</p>	<p>OPTA notes the importance of a functional job analysis to make fitness-for-duty determinations and design more job-specific plans of care. They contend that there is a huge variation in professional time required to perform this service in a manner that supports disability prevention outcomes and believe that the range of case and job complexity supports OPTA's position that recommended caps do not reflect the reality of how they have to do business as providers in the trenches.</p>	<p>BWC agrees with the premise of the feedback offered, but disagrees with the suggested recommendation. BWC believes the recommended unit of service (UOS) provides an appropriate standard for review for this service, and establishes a more consistent billing mechanism, while providing definition for usual and customary rates for this service. However, where sufficient justification from the provider and pre-authorization of the MCO are submitted, additional UOS will be available.</p>	<p>BWC is recommending increasing the proposed cap from 8 UOS to 16 UOS (4 hours) and allowing the designation of "up to" which reflects the ability to exceed the 16 UOS.</p>
<p><b>W0650</b> <b>Job Seeking Skills Training</b></p>	<p>IARP had requested that the unit of service for Job Seeking Skills Training be changed from a per program to 6 minute or hourly fee. They noted that this is proposed in the fee schedule.</p>	<p>This change was requested to more accurately reflect the services provided.</p>	<p>BWC agrees with all stakeholders' feedback regarding this service.</p>	<p>BWC is recommending changing the UOS for Job Seeking Skills Training from "per program" to \$5.00 per 6 minute UOS with maximum of 150 UOS.</p>
<p><b>W0660</b> <b>Job Placement / Job Development</b></p>	<p>IARP recommends that the 13 week limit of Job Placement / Job Development be increased to 26 weeks and that the current 500 UOS (50 hours) be removed or increased in correlation to the extension from 13 to 26 weeks.</p>	<p>IARP notes that this recommendation is based on the current economy. IARP reports that the average duration for unemployment of all individuals at this time is 21.4 weeks and that 27% of workers remain unemployed for 27 weeks or more. IARP contends that a person with a disability generally requires more time to locate employment.</p>	<p>BWC agrees in part with the stakeholder, recognizing the new challenges which injured workers may face in the job market, and that the current time allowed for this service needs to be adjusted.</p>	<p>BWC is recommending increasing the UOS to 800 UOS over a 20 week period and designating the UOS as "up to" rather than "maximum".</p>
<p><b>W0702</b> <b>Occupational Rehab - Comprehensive Initial 2 hrs</b> <b>W0703</b> <b>Occupational Rehab - Comprehensive each add'l hour</b></p>	<p>OPTA recommends that CARF accreditation be removed as a requirement for providers of the Occupational Rehabilitation - Comprehensive (Work Hardening) service. OPTA recommends that APTA's guidelines for this service be used to ensure quality instead.</p>	<p>OPTA believes that CARF is a huge expense that keeps smaller facilities from participating as providers of this service. OPTA contends that there is an access to care issue that is created by this requirement. OPTA states that facilities who can provide exceptional services are not renewing their CARF accreditation due to the cost of accreditation.</p>	<p>BWC research did not result in a finding that injured workers' access to quality care has been undermined. BWC, after hearing a presentation from the national CARF body, concluded that this accreditation provides a tool which ensures quality care for injured workers receiving this service. Using another guideline such as APTA, would require increased staffing and associated costs to create and execute surveys that could ensure quality.</p>	<p>BWC is maintaining CARF accreditation for this service</p>

Service Code	Fee Schedule Recommendations	Stakeholder Rationale	BWC Response	Resolution
<b>W0702</b> <b>Occupational Rehab - Comprehensive Initial 2 hrs</b> <b>W0703</b> <b>Occupational Rehab - Comprehensive each add'l hour</b>	OPTA notes that if BWC is requiring CARF accreditation for Occupational Rehabilitation - Comprehensive, the BWC fee for this service should be higher than any bench-mark entity.	OPTA notes that no other benchmark state requires CARF accreditation for this Work Hardening and they believe that if BWC requires this added burden, then BWC should have the highest level of reimbursement.	In determining the appropriate level of change in the fee, BWC evaluated various Ohio market reimbursement levels against the BWC guiding principle of ensuring injured workers' access to quality care. Per that evaluation, BWC determined that an increase in reimbursement was warranted for this service.	BWC is recommending a 6% increase in the service fee or \$135.95 for 1st 2 hours of service and \$54.25 for each additional hour.
<b>W0703</b> <b>Occupational Rehab - Comprehensive each additional hour</b>	OARF notes that BWC's proposed fee for each additional hour of Occupational Rehabilitation- Comprehensive is well below both the median and the mean when compared to benchmark entities.		In determining the appropriate level of change in the fee, BWC evaluated various Ohio market reimbursement levels against the BWC guiding principle of ensuring injured workers' access to quality care. Per that evaluation, BWC determined that an increase in reimbursement was warranted for this service.	BWC is recommending a 6% increase in the service fee or \$135.95 for 1st 2 hours of service and \$54.25 for each additional hour.
<b>W0702</b> <b>Occupational Rehab - Comprehensive Initial 2 hrs</b> <b>W0703</b> <b>Occupational Rehab - Comprehensive each add'l hour</b>	OARF recommends that CARF accreditation be kept as a requirement for providers of the Occupational Rehabilitation - Comprehensive (Work Hardening) service.	OARF believes that CARF offers a level of quality assurance and review that is good and notes that while some facilities are dropping CARF it is more an issue of lack of referrals than the expense of accreditation.	BWC agrees with the stakeholder feedback.	BWC is maintaining CARF accreditation for this service

Service Code	Fee Schedule Recommendations	Stakeholder Rationale	BWC Response	Resolution
<p><b>W0702</b>  <b>Occupational Rehab - Comprehensive Initial 2 hrs</b>  <b>W0703</b>  <b>Occupational Rehab - Comprehensive each add'l hour</b></p>	<p>IARP agrees with OPTA recommendation that CARF accreditation be removed as a requirement for providers of the Occupational Rehabilitation - Comprehensive (Work Hardening) service.</p>	<p>IARP believes that the CARF requirement is burdensome to the providers which decreases the number of providers in the system and requires injured workers to travel greater distances to obtain services.</p>	<p>BWC research did not result in a finding that injured workers' access to quality care has been undermined. BWC, after hearing a presentation from the national CARF body, concluded that this accreditation provides a tool which ensures quality care for injured workers receiving this service. Using another guideline such as APTA, would require increase staffing and associated costs to create and execute surveys that could ensure quality.</p>	<p>BWC is maintaining CARF accreditation for this service</p>
<p><b>W0710</b>  <b>Work Conditioning</b></p>	<p>OPTA recommends that the local code for Work Conditioning be removed from the Fee Schedule and that services shift to Occupational Rehab - Comprehensive with elimination of the CARF requirement.</p>	<p>OPTA notes that most other benchmarking states reimburse for Work Conditioning using CPT Codes 97545 and 97546. CPT recognizes these codes for both Work Conditioning and Occupational Rehab-Comprehensive. OPTA notes that most benchmark states pay the same fees for both services utilizing these codes. OPTA further notes that from the Therapist's service delivery vantage point there is no difference between the two services. Rather the differences relate to duration and the addition of services in Occupational Rehabilitation - Comprehensive.</p>	<p>BWC, as part of our guiding principle, works to ensure that we have an appropriate benefit plan and terms of service for injured workers. BWC's position is that Work Conditioning is a service that is unique from active therapy and Occupational Rehabilitation Comprehensive, and has positive value for the vocational rehabilitation of injured workers.</p>	<p>BWC is maintaining the Work Conditioning service offering.</p>
<p><b>W0710</b>  <b>Work Conditioning</b></p>	<p>OPTA further recommends that the local code for Work Conditioning be removed and that additional units of service be allowed in the Active Therapy services that may be included as part of a vocational rehabilitation plan.</p>	<p>OPTA reports that by allowing the billing / reimbursement to be provided using Active Therapy codes, a similar conditioning service could be offered but would reimburse the provider for direct one-to one time in their work with the injured worker and for set up of the program for conditioning/work simulation. OPTA believes that Work Conditioning is unnecessary.</p>	<p>BWC, as part of our guiding principle, works to ensure that we have an appropriate benefit plan and terms of service for injured workers. BWC's position is that Work Conditioning is a service that is unique from active therapy and Occupational Rehabilitation Comprehensive, and has positive value for the vocational rehabilitation of injured workers.</p>	<p>BWC is maintaining the Work Conditioning service offering.</p>

Service Code	Fee Schedule Recommendations	Stakeholder Rationale	BWC Response	Resolution
<p><b>W0710</b> <b>Work Conditioning</b></p>	<p>OARF recommends that Work Conditioning continue to be reimbursed by the hourly increments.</p>		<p>BWC agrees with this recommendation.</p>	<p>BWC will maintain the current reimbursement protocols.</p>
<p><b>W0637</b> <b>Transitional Work</b></p>	<p>LMG asked about the discrepancy in BWC's fee for Transitional Work Services and that reported for other states.</p>	<p>The concern was that BWC was paying much higher rates for this service.</p>	<p>In determining the appropriate level of change in a fee, BWC evaluated various Ohio market reimbursement levels against the BWC guiding principle of ensuring injured workers' access to quality care. Per that evaluation, BWC determined that no change in reimbursement was warranted for this service. BWC notes that we require that this service be provided by a licensed therapist, while other states offer this service through the Vocational Rehabilitation Case Manager.</p>	<p>BWC will maintain the current reimbursement levels and protocols.</p>
<p><b>All codes with recommended increases in fee</b></p>	<p>LMG questions providing any increases in BWC fees given the state of the economy and the state budget.</p>	<p>The concern was that in our current economy, nearly all of us are facing budget cuts so it seems counter intuitive to provide "raises" for providers.</p>	<p>In determining the appropriate level of change in the fees, BWC evaluated various Ohio market reimbursement levels against the BWC guiding principle of ensuring injured workers' access to quality care. Per that evaluation, BWC determined that an increase in reimbursement for some services was warranted and recommended.</p>	<p>BWC is recommending changes to 54 service code fees which amounts to an average of 5.8% increase from the levels of all reimbursed service fees.</p>

# OHIO BWC 2009 VOCATIONAL REHABILITATION SERVICES FEE SCHEDULE PROPOSAL

Medical Services Division  
Freddie Johnson, Director, Managed Care Services  
Karen Fitzsimmons, Manager,  
July 29, 2009

# Introduction and Guiding Principles

- Legal Requirements For Fee Schedule Rule
- Proposed Time-line for Implementation
  - Board Presentation July/August
  - Proposed to JCARR – September 1<sup>st</sup>
  - Effective Date – Monday, November 16, 2009
- Guiding Principle:

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

# Fee Schedule Update Methodology

- Reviewed all 76 Vocational Rehabilitation Services codes
- The maximum number of units reimbursable for all codes was reviewed, with some revisions
- Current reimbursement rates were evaluated with some modification
- Benchmarking against other payers

# Recommended Reimbursement Changes

BWC proposes to increase the fees for the following services:

- 39 vocational rehabilitation case management service codes from \$7.00 per six minute unit of service to \$7.50 per six minutes
- Vocational case management travel and wait codes from \$3.50 per six minute units of service to \$3.75 per six minutes
- Mileage reimbursement for Vocational Rehabilitation case managers and other designated rehabilitation providers from \$.30 per mile to \$.45 per mile
- Occupational Rehabilitation – Comprehensive codes from \$128.25 (for first 2 hours) and \$51.18 (each additional hour) to \$135.95 and \$54.25 respectively
- Work Conditioning from \$37.50 per hour to \$40.00 per hour

# Recommended Reimbursement Changes

BWC proposes the following unit and billing of service changes:

- Ergonomic Study and Job Analysis - from “By Report” to a fifteen minute unit of service.
- Comprehensive Vocational Evaluation and Vocational Screening from a one hour unit of service to a six minute unit of service.
- Work Adjustment from \$300.00 per week to \$15.00 per hour with a weekly maximum of thirty-five hours or \$525.00 per week.
- Job Seeking Skills Training from \$500.00 per program to \$5.00 per six minute unit of service with a maximum of 150 units of service or \$750.00 maximum per program.
- Job Placement and Job Development from service limits of 50 hours in 13 weeks to up to 80 hours in 20 weeks.

# Recommended Reimbursement Changes

BWC proposes the following benefit coverage changes:

- Addition of a new service code for Ergonomic Implementation and Follow-up
- Expanding travel and mileage provider reimbursement to also cover providers of Transitional Work, Ergonomic Study, Ergonomic Implementation and Job Analysis services

# Recommendations

- **Modify Reimbursement Rates of 54 Procedure Codes**
  - Case Management
  - Mileage Rate
  - Occupational Rehab – Comprehensive (Work Hardening)
  - Work Conditioning
  
- **Modify Unit of Services on 8 Procedure Codes**
  - 5 Codes with both Price and Unit of Services Modified
  - 3 Codes with only Unit of Services Modified
  
- **Added One New Code**
  - Ergonomic – Implementation/Follow-up
  
- **No Change to 18 Service codes**

# Impacts and Outcomes

- Vocational Services Costs Impact
  - An estimated 5.86% increase in reimbursement
  - Estimated dollar figure is \$1.9 million
- Improvement in Provider reimbursement
- Appropriate Provision Benefits Necessary to Address Ohio's Injured Workers' Needs
- Supports the Guiding Principle of Access to Quality Care

Thank You

## Common Sense Business Regulation (BWC Rules)

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

### **Chapter 4123-6 Qualified Health Plan Rules (24 rules)**

#### **Rule Review**

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

Citation: R.C. 4121.121(B)(21), R.C. 4121.44, R.C. 4121.442(A)(1) through (13)

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

What goal(s): The rules set forth criteria and guidance for the implementation of the Qualified Health Plan (QHP) system for self-insuring employers to provide services and supplies to injured workers in the Ohio workers' compensation system.

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

4.  The rule is effective, consistent and efficient.

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

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

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

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

Explain: BWC's proposed five-year rule review changes to the QHP rules were e-mailed to the BWC stakeholders for review.

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

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

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

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

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

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

**BWC Board of Directors**  
**Executive Summary**  
**QHP Rules**  
**Chapter 4123-6**

## **Introduction**

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Qualified Health Plan (QHP) system for self-insuring employers who choose to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies through a QHP. BWC enacted the 24 Chapter 4123-6 QHP rules (Ohio Administrative Code 4123-6-050 to 4123-6-73) in September 1996. The rules last underwent five-year rule review in 2004.

As part of the current five-year rule review process, the QHP rules have been thoroughly reviewed and numerous changes have been proposed, mostly rescinding unnecessary and/or duplicative rules, or combining them into existing rules. There are 24 rules in this rule package; 5 rules will be amended, 14 rules will be rescinded, and 5 rules are no change rules.

## **Background Law**

Ohio Revised Code 4121.121(B)(21) provides that the Administrator shall “[p]repare and submit to the board information the administrator considers pertinent or the board requires, together with the administrator’s recommendations, in the form of administrative rules, for the advice and consent of the board, for the . . . qualified health plan system, as provided in sections 4121.44 . . . and 4121.442 of the Revised Code.”

Ohio Revised Code 4121.44(L) provides that the Administrator shall permit employers who agree to abide by the QHP rules “to provide services or supplies to or on behalf of an employee for an injury or occupational disease . . . through qualified health plans of the Ohio workers’ compensation qualified health plan system pursuant to section 4121.442 of the Revised Code . . .”

Ohio Revised Code 4121.442(A)(1) through (13) provide that the Administrator shall “develop standards for qualification of health care plans of the Ohio workers’ compensation qualified health plan system to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease” that provide for all of the standards established under the statute.

## **Proposed Changes**

The major substantive changes proposed for the QHP rules pursuant to the five-year rule review:

- Rescind language referring to establishment of the initial QHP certification period, as that period has long since passed. OAC 4123-6-52.
- Remove references to the “employee representative” in the QHP decertification rule, as the only external parties to a QHP decertification are the self-insuring employer and the QHP. OAC 4123-6-55(B)(1), (3).
- Provide that if the QHP utilizes a leased provider network, the QHP shall not apply the discounted payment rates of the leased network to services rendered by the provider in the QHP unless the signed, written consent of the provider has been obtained, mirroring

a similar requirement in the MCO contract for provider networks leased by the MCOs.)AC 4123-6-58.

- Remove references to data reports no longer required per statutory amendments enacted by Senate Bill 7 (SB 7).OAC 4123-6-70.

## **Stakeholder Involvement**

BWC developed and distributed an announcement to stakeholders informing them of the five-year administrative code rule review process regarding the BWC medical rules. The announcement informed stakeholders that BWC would be reviewing medical rules internally and would be periodically sending medical rules, in groups, to the external stakeholders for input. This announcement was distributed through a public e-mail box designed to facilitate distribution of the rules to interested parties and to stakeholder groups. Stakeholders were informed of the opportunity to provide input on the medical rules and the changes proposed by BWC, and the timeline to respond.

In this set of 24 QHP rules, BWC's proposed five-year rule review changes were e-mailed to the following lists of stakeholders for review:

- The Self Insured Division's employer distribution list
- BWC's internal medical provider stakeholder list – 67 persons representing 52 medical provider associations/groups
- Ohio Association for Justice
- Ohio Attorney General's Office, Workers Compensation Section
- BWC's Managed Care Organizations and their Medical Directors
- BWC's Healthcare Quality Assurance Advisory Committee
- Council of Smaller Enterprises (COSE)
- Ohio Manufacturers Association (OMA)
- National Federation of Independent Business (NFIB)

BWC received 7 substantive responses from stakeholders, which are summarized on the Stakeholder Feedback Summary spreadsheet.

## Chapter 4123-6 Health Partnership Program (QHP Rules)

### 4123-6-50 Self-insured employer participation in the QHP system; reporting requirements for non-participating employers. (Rescind)

All self-insured employers that do not participate in the QHP system shall comply with the reporting requirements for participating self-insured employers set forth in rule 4123-6-70 of the Administrative Code. Data collected and stored by the bureau in furtherance of the provisions of this rule and rule 4123-6-70 of the Administrative Code shall be in accordance with section 4123.27 of the Revised Code, paragraph (A) of rule 4121-15-03 of the Administrative Code, and paragraph (A) of rule 4123-15-03 of the Administrative Code for the purpose of ensuring confidentiality and avoiding the appearance of impropriety.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**Comment [a1]:** SI employer reporting of the type discussed by this rule is no longer required per statutory amendments enacted by Senate Bill 7 (SB7).

**4123-6-51 Employer participation in the QHP system - bureau certification of QHPs. (Amend)**

(A) A health plan that satisfies the QHP certification requirements of this chapter shall be certified by the bureau as a QHP to manage medical treatment, direct care or provide services or supplies to or on behalf of an employee for an injury or occupational disease that is compensable under Chapter 4121., 4123., or 4131. of the Revised Code.

(B) An employer may establish a bureau certified QHP, that shall comply with the thirteen standards set forth in divisions ~~(D)(1) to (D)(13)~~ (A)(1) to (A)(13) of section 4121.442 of the Revised Code, ~~Division~~ division (K) of section 4121.44 of the Revised Code, and rules 4123-6-53 and 4123-6-54 of the Administrative Code.

(C) QHP certification by the bureau shall be for a period of three years.

(D) The bureau, at least annually, shall develop and make available information that describes employer and employee rights under QHP.

(E) The bureau shall continue to certify health plans and shall periodically, at least annually, update its list of certified QHPS.

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66  
Prior Effective Dates: 9/5/96

**Comment [a2]:** Amended to update Revised Code citation.

**Comment [a3]:** This language was moved from OAC 4123-6-52, which is being rescinded.

**Comment [a4]:** This language was moved from OAC 4123-6-73, which is being rescinded.

**Comment [a5]:** This language was moved from OAC 4123-6-52(B), as OAC 4123-6-52 is being rescinded.

**4123-6-52 Employer participation in the QHP system - initial QHP certification enrollment period established; length of certification period. (Rescind)**

(A) The bureau shall establish an initial QHP certification enrollment period upon inception of the QHP system to allow health plans to seek certification for participation in the QHP system.

(B) After the initial QHP certification enrollment period upon inception of the QHP system, the bureau shall continue to certify health plans and shall periodically, at least annually, update its list of certified QHPS.

(C) QHP certification by the bureau shall be for a period of three years.

**Comment [a6]:** This language is no longer necessary, as the initial enrollment period for QHPs has long since passed.

**Comment [a7]:** This language was moved to OAC 4123-6-51.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**4123-6-53 Employer participation in the QHP system - QHP quality assurance program required. (No Change)**

(A) Each QHP shall have a quality assurance program that monitors the operation and measures the effectiveness of peer review, utilization review, and dispute resolution within the QHP. Data collected from the quality assurance program shall be used to assist an employer in determining the quality, efficiency and effectiveness of the employer's QHP and the QHP system in accordance with division (D) of section 4121.442 of the Revised Code.

(B) Each quality assurance program shall include a mechanism for monitoring and the methodology for measuring and improving the QHP's compliance with each of the following eleven elements:

- (1) Peer review and evaluation of clinical performance;
- (2) Credentialing and recredentialing and use of provider profiling;
- (3) Utilization management to determine the appropriateness of care;
- (4) Evaluation of employee and provider dispute resolution procedures and outcomes;
- (5) Evaluation of outcomes of care based on clinical data;
- (6) Procedures for remedial action for inappropriate or substandard services;
- (7) Evaluation of employee satisfaction with the plan;
- (8) Evaluation of provider satisfaction with the plan;
- (9) Evaluation of employer satisfaction with the plan;
- (10) Periodic evaluation of medical records and office procedures; and
- (11) Practice patterns compared to accepted medical criteria.

(C) The quality assurance program shall include a quality assurance committee or other mechanism adequate to evaluate the outcomes of each of the eleven elements listed in paragraph (B) of this rule.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**4123-6-54 Employer participation in the QHP system - QHP certification application. (No Change)**

(A) Upon request by an employer or health plan seeking certification, the bureau shall mail the employer or health plan seeking certification a QHP application for certification.

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

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

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

(2) Proof that a self-insured employer has been granted status as a self-insured employer in accordance with section 4123.35 of the Revised Code;

(3) A description of the geographic or regional area of the state of Ohio to be serviced by the QHP, taking into account the unique circumstances of the individual employer, such as multiple locations, and/or the need for a statewide network;

(4) A description of the role of each vendor that will be a component of the QHP including, but not limited to, the following: if an employer uses or anticipates using company-based providers, a description of the role of company-based providers as distinguished from QHP network providers; if an employer uses or anticipates using a third party administrator, a description of the role of the third party administrator;

(5) If an employer contemplates contracting with a vendor that has been certified by the bureau under Chapter 4123-6 of the Administrative Code to provide services under the employer's QHP, proof that certification has been granted by the bureau and that such certification is current;

(6) A description of the structure of the medical management component and the health care provider network to be offered by the QHP;

(7) A description of the QHP's plan and methodology for providing, at least annually, QHP network provider information, by provider type, and updated QHP network provider directories to employees;

(8) A description of the QHP's quality assurance program, including but not limited to, the proposed structure and operation and a description of the mechanism for monitoring and the methodology for measuring and improving the QHP's compliance with the elements listed in paragraph (B) of rule 4123-6-53 of the Administrative Code;

(9) A description of the QHP's employee education program. The description shall include but shall not be limited to: a description of the process to be used to educate employees regarding their rights and responsibilities in the QHP system; a description of the process to be used to explain the time, place and manner of services to be delivered under the QHP; and a description of the process to be used to explain options available to injured workers, including the process for changing providers within the QHP and referral and transfer to the HPP; and

(10) A description of the plan satisfactory to the bureau to be implemented by the QHP in the event a final order to revoke certification, or to refuse to recertify a QHP is issued by the administrator, pursuant to rule 4123-6-55 of the Administrative Code, that includes, but is not limited to, a plan that describes

continuation and continuity of care of injured workers; a plan that describes payment of providers for medical services rendered prior to revocation of certification or refusal to certify. The injured worker may continue receiving medical services from the same provider or may choose a provider in a new approved plan for delivery of medical services, both of whom shall accept medical management of the medical services through the employer's new approved plan.

(D) The bureau shall review the application for certification submitted by the health plan seeking certification. The bureau reserves the right to cross-check data with other governmental agencies or licensing or accrediting bodies.

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**4123-6-55 Employer participation in the QHP system - bureau's authority to ~~revoke certification~~ decertify, to refuse to certify or recertify a QHP. (Amend)**

(A) The bureau is authorized to ~~revoke certification~~ decertify, to refuse to certify or recertify a QHP from participation in the QHP system.

(B) Should the bureau determine that sufficient evidence exists that an employer or QHP has failed to comply with applicable workers' compensation statutes or rules governing QHPs, the bureau shall take one of two courses of action:

(1) The bureau shall notify the employer, ~~employee representative~~ and QHP in writing by certified mail of the facts and issues relating to the bureau's determination that the employer or QHP has failed to comply with applicable workers' compensation statutes or rules governing QHPs. ~~Such notice shall and has set forth~~ a period of time for the employer or QHP to resolve or correct the problem. Failure of the employer or QHP to resolve or correct the problem within the time period shall result in notification from the bureau to the employer and QHP in writing by certified mail of administrative action that might result in a bureau determination to revoke certification, refusal to certify or recertify, and the employer's and QHP's right to a hearing within thirty days of the notice, if requested by the employer or QHP, pursuant to rule 4123-6-17 of the Administrative Code.

**Comment [a8]:** The only parties to a decertification action involving a QHP are the employer and the QHP.

(2) Notify the employer, ~~employee representative~~ and QHP in writing by certified mail of administrative action that might result in a bureau determination to revoke certification, refusal to certify or recertify, and the employer's and QHP's right to a hearing within thirty days of the notice, if requested by the employer or QHP, pursuant to rule 4123-6-17 of the Administrative Code.

~~(3) For the purpose of this rule, "employee representative" does not include the employee's attorney.~~

(C) Notwithstanding paragraph (B) of this rule, in any case where the Administrator finds a serious danger to the public health and safety and sets forth specific reasons for such findings, the administrator may immediately revoke or suspend, ~~or provisionally revoke or suspend~~, the certification of a QHP. The order shall be final unless the employer or QHP, within seven days of such order, requests a hearing before the administrator where the employer or QHP shall show cause why the order should not be final. The order of the administrator shall remain in force during the pendency of the show cause hearing.

**Comment [a9]:** BWC does not provisionally revoke or suspend certification of QHPs.

(D) Upon a final order of the administrator to ~~revoke certification of~~ decertify, refuse to recertify, or revoke or suspend the certification of a QHP, employees and employers shall not receive services from such QHP pursuant to the QHP system.

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66  
Prior Effective Dates: 9/5/96

**4123-6-56 Employee access to the QHP system- choice and change of provider.  
(Rescind)**

Comment [a10]: This language will be combined into choice of provider rule OAC 4123-6-06.2.

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

(B) An employee of an employer that participates in a QHP, who is dissatisfied with the health care services of a provider in the QHP, after written notice to the QHP, may change providers and select another provider of the employee's choice within the QHP. An employee's notice for change of provider within a QHP does not require notification to the bureau. To provide the employer's QHP with data necessary for QHP tracking of employee choice of provider and to provide the bureau with data necessary for recertification of providers, an employee's notice for a change of provider within a QHP shall be in a writing that contains the reasons therefore.

(C) An employee who first has chosen and received health care services from a provider in the employer's QHP, but is dissatisfied with the health care services provided by the employer's QHP, may request and shall be granted a change of provider to a bureau certified provider. An employee's notice for a change of provider to a bureau certified provider in the HPP shall be in a writing to both the employer's QHP and to the administrator of the bureau.

(1) The bureau shall provide all QHPs with a list of bureau certified providers in the employees' area. The QHP shall provide an employee with a list of bureau certified providers upon request. The bureau shall provide an employee, upon request to the bureau, with a list of bureau certified providers within the employee's area.

(2) An employee who first has chosen and received health care services from a provider in the employer's QHP, and who has requested and has been granted a change of provider to a bureau certified provider in the HPP, shall submit a written request to the QHP medically managing the treatment and shall be granted approval to change providers within the HPP. An employee's request for change of provider within the HPP does not require notification to the bureau of the request. An employee who has requested and has been granted a change of provider from an employer's QHP to a bureau certified provider in the HPP shall be permitted to return to the employer's QHP at any time for health care services.

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

(4) To provide the employer's QHP with data necessary for QHP tracking of employee choice of provider and to provide the bureau with data necessary for recertification of providers, an employee's request for a change of provider from a QHP to a bureau certified provider in the HPP, or a change of provider within the HPP, shall state a reason for the request.

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**4123-6-57 Provider access to the QHP system - generally. (Rescind)**

(A) A provider who participates in the QHP system shall be certified by the bureau, pursuant to rules 4123-6-02 to 4123-6-025 of the Administrative Code, and credentialed by the QHP.

(B) Notwithstanding rule 4123-6-02 of the Administrative Code, a provider who is an employee or an independent contractor of an employer that participates in the QHP shall have the provider's credentials reviewed and the bureau shall verify that the provider's credentials meet bureau standards. Such provider may sign a provider agreement set forth in rule 4123-6-02 of the Administrative Code.

(C) A provider who meets the certification requirements as set forth in the administrative code relating to the certification of providers under the HPP, and is certified as a provider eligible to participate in the HPP, shall be eligible to participate in and to treat injured workers under the QHP system.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**Comment [a11]:** This rule is unnecessary. The requirement that BWC certified providers participate in the QHP will be governed by choice of provider rule OAC 4123-6-06.2.

**4123-6-58 Provider access to the QHP system - provider participation in QHP system and other related health care program not linked. (Amend)**

A QHP or vendor that provides medical management and cost containment services shall not require a provider to participate in a workers' compensation network of providers in order to maintain membership in a related health care program. If the QHP utilizes a leased provider network, the QHP shall not apply the discounted payment rates of the leased network to services rendered by the provider in the QHP unless the signed, written consent of the provider has been obtained.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**Comment [a12]:** This mirrors a similar requirement in the MCO contract for provider networks leased by the MCOs.

#### 4123-6-59 Provider access to the QHP system - QHP provider selection. (Amend)

~~(A) The bureau shall maintain a public list of bureau certified providers. The bureau shall make the list of bureau certified providers available to a requesting party at cost.~~

Comment [a13]: This language is duplicative of language in OAC 4123-6-02.6(A).

~~(B)~~ (C) An employer that develops a QHP, a vendor within the QHP system, or a QHP shall develop and implement standards of credentialing of providers in the QHP network that meet but may exceed the bureau credentialing requirements in the HPP.

~~(C)~~ (B) An employer that develops a QHP may selectively contract with providers or contract with a vendor that selectively contracts with providers.

~~(D)~~ (C) Only a bureau certified provider is eligible for selection by an employer that develops a QHP, by a QHP as a QHP panel provider or by a vendor as a panel provider to participate in the QHP system. A provider identified by a QHP for inclusion in its panel of providers that is not a bureau certified provider may be assisted by the QHP in applying for bureau provider credentialing and certification.

~~(E)~~ (D) The bureau, an employer, a QHP or a vendor shall not discriminate against any category of health care provider when establishing categories of providers for participation in the QHP system. However, an employer, a QHP or a vendor is not required to accept or retain any individual provider in the QHP system.

~~(F)~~ (E) The bureau, an employer, a QHP and a vendor shall comply with state and federal laws prohibiting discrimination based on, but not limited to, race, national origin, or color, and shall not discriminate against any health care provider when establishing categories of providers for participation in the QHP system on the basis of race, religion, national origin, color, gender, sexual orientation or age.

~~(G)~~ (F) A QHP shall include in its panel a substantial number of the medical, professional, and pharmacy providers currently being utilized by employees. A QHP may limit the number of providers on its provider panel, but shall do so based upon objective data that demonstrates that the fundamental needs of the employer and employees are met based on reasonable standards such as historical claims data or other geographic information approved by the bureau. In addition, a QHP shall include in its application for QHP certification information including reasonable patient access, the potential number of employees the QHP is applying to service, and other performance criteria, without discrimination by provider type. Subject to the provisions of rules 4123-6-67 and 4123-6-68 of the Administrative Code, a QHP seeking QHP certification may select out-of-state providers as members of the QHP panel.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**4123-6-60 Provider access to the QHP system - medical record keeping. (Rescind)**

(A) Providers who treat injured workers who originate in the QHP system shall develop and/or maintain a system that accomplishes efficient transfer of copies of injured workers' medical records among providers when the following occurs:

- (1) An employee changes provider within or without the employer's QHP network;
- (2) An employer terminates a QHP, or
- (3) An employer transfers to another QHP or the HPP.

(B) Release or transfer of injured workers' medical records shall be in accordance with section 4123.651 of the Revised Code and rule 4121-17-30 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**Comment [a14]:** This rule is unnecessary. Providers' requirements for providing medical records in the workers' compensation system are governed by rules OAC 4123-6-20 and OAC 4123-6-21.

**4123-6-61 Payment in the QHP system - employer responsibility - generally.  
(Rescind)**

An employer utilizing a QHP is responsible for payment of all goods and services that are medically necessary and appropriate for allowed condition(s) in claims for injured workers under a QHP. Within each QHP, all payments shall be in accordance with consistent billing and payment policies and practices established by the QHP and consistent with the provisions contained in paragraph (L)(5) of rule 4123-19-03 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**Comment [a15]:** This rule is unnecessary. Billing and payment procedures for SI employers, with or without a QHP, are governed by OAC 4123-19-03(K)(5).

**4123-6-62 Payment in the QHP system - balance billing prohibited. (Rescind)**

(A) No health care provider shall charge, assess, or otherwise attempt to collect from an employee any amount for covered services or supplies that is in excess of the amount reimbursed by the employer, a vendor, or a QHP.

(B) An employer or QHP shall hold an employee harmless for all balanced billing from providers who are members of the employer's QHP panel or who have signed a provider agreement with a QHP and/or employer.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**Comment [a16]:** This rule is unnecessary. Rule OAC 4123-6-07 already prohibits providers from balance billing for services paid by a QHP.

**4123-6-63 Payment in the QHP system - application of bureau fee schedule in the QHP system. (Rescind)**

**Comment [a17]:** This language will be combined into provider payment rule OAC 4123-6-10.

(A) With the exception of the restrictions recited in rule 4123-6-65 of the Administrative Code, and with the exception that no financial arrangement between an employer or QHP and a provider shall reduce the quality of medical care received by an injured worker, an employer or QHP may pay a provider a rate that is the same, is above or is below the rates set forth in the provider fee schedule developed by the bureau pursuant to division (A)(8) of section 4121.441 of the Revised Code, and nothing in the rules pertaining to the QHP system shall be construed to inhibit employers or QHPs and providers in their efforts to privately negotiate a payment rate.

(B) An employee, dissatisfied with the medical services provided by the employer's QHP, may request and shall be granted a change of provider as provided in rule 4123-6-56 of the Administrative Code. The employee's health care shall be managed by the QHP. In such event, the provider shall be reimbursed by the employer or QHP the lessor of the bureau fee schedule or the billed charges by the provider for services rendered, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider.

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**4123-6-64 Payment in the QHP system - vendor payment to providers. (Rescind)**

A vendor retained by an employer shall not benefit financially from the difference between the fee schedule negotiated with the provider and the rate paid to the provider by the employer.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**Comment [a18]:** This rule is duplicative in intent to rule OAC 4123-6-65, and is being rescinded.

**4123-6-65 Payment in the QHP system - employer payment to vendor that provides medical management and cost containment services and/or QHPs. (No Change)**

The bureau shall not interfere with nor impose restrictions upon an arrangement for payment negotiated between an employer and a vendor that provides medical management and cost containment services and/or a QHP under the QHP system, except that no financial arrangement between an employer and a vendor that provides medical management and cost containment services and/or a QHP shall incentivize a reduction in the quality of medical care received by an injured worker.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**4123-6-66 Payment in the QHP system - authorization and payment for initial emergency medical treatment. (Rescind)**

(A) An employer in the QHP system shall authorize and pay for initial emergency medical treatment for an injury or occupational disease that is an allowed claim or condition provided by a health care provider who is not part of the employer's QHP in accordance with the provisions and limitations contained in this rule.

(B) The employer shall pay a health care provider who is not part of the employer's QHP only for initial-emergency treatment of an employee for a workers compensation injury. The health care provider who is not part of the employer's QHP shall inform the employee upon the initial emergency treatment that the provider is not a participant in the QHP and that the provider will not be paid nor will the employee be reimbursed by the QHP or employer for the cost of further treatment after the initial emergency treatment, unless authorized otherwise by the employer or QHP.

(C) Subsequent emergency medical treatment by a provider who is not part of the employer's QHP for the same injury or occupational disease shall be reviewed by the QHP unless payment is otherwise authorized by the QHP. The employee may continue to obtain treatment from the health care provider who is not part of the employer's QHP, but the payment for the treatment shall be the employee's sole responsibility, except as provided above.

(D) A provider that provides initial emergency medical treatment or subsequent emergency medical treatment for the same injury or occupational disease authorized by the QHP shall be paid in accordance with the rates established in Ohio workers' compensation fee schedule or the provider's billed charges, whichever is less unless an alternate payment arrangement is negotiated between an employer or QHP and a provider.

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66  
Prior Effective Dates: 9/5/96

**Comment [a19]:** This language will be combined into provider payment rule OAC 4123-6-10.

**4123-6-67 Payment in the QHP system - payment to providers in states that border Ohio. (Rescind)**

(A) Out-of-state providers that are certified by the bureau in states that border Ohio shall accept and be paid as payment in full in accordance with the Ohio workers' compensation state fee schedule or the amount billed, whichever is less, unless an alternate provider agreement exists between provider, and employer and/or the QHP. No health care provider shall charge, assess, or otherwise attempt to collect from an employee, employer, a vendor, or a QHP, any amount for covered services or supplies that is in excess of the amount reimbursed by the employer, a vendor, or a QHP.

(B) An employer or QHP shall hold an employee harmless for all balanced billing from out-of-state providers in states that border Ohio and who are a member of a QHP panel or who have signed a provider agreement with a QHP and/or employer.

(C) Payment to out-of-state providers in states that border Ohio who are not certified by the bureau, in the absence of a provider agreement with an employer and/or QHP, shall be the sole responsibility of the employee unless otherwise authorized by the employer or QHP.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**Comment [a20]:** Payment to providers both in state and out-of-state will be governed by provider payment rule OAC 4123-6-10.

**4123-6-68 Providers in states that do not border Ohio - QHP freedom to negotiate; restriction on provider charges to employee. (Rescind)**

(A) A QHP may negotiate all issues with providers in states that do not border Ohio.

(B) Paragraph (A) of this rule notwithstanding, no provider in a state that does not border Ohio shall charge, assess, or otherwise attempt to collect from an employee with an Ohio claim who works in Ohio but who resides in another state any amount for covered services or supplies that is in excess of the amount reimbursed by the employer, a vendor, or a QHP.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**Comment [a21]:** Payment to providers both in state and out-of-state will be governed by provider payment rule OAC 4123-6-10.

**Comment [a22]:** This language is unnecessary. Rule OAC 4123-6-07 already prohibits providers from balance billing for services paid by a QHP.

#### **4123-6-69 QHP dispute resolution process. (No Change)**

(A) This rule shall provide time frames and procedures for review of requests for the delivery of medical services and for the resolution of disputes that may arise between an employee and an employer, an employee and a provider, or an employer and a provider. This rule applies to, but is not limited to, reviews of records, medical disputes arising over issues such as, but not limited to, quality assurance, utilization review, a determination that a service provided to an employee is not covered, is covered or is medically unnecessary; or disputes involving individual health care providers.

(B) Initial review and decision upon requests for the delivery of medical services that include, but are not limited to, medical treatment, major diagnostic testing, hospitalization, surgery and physical therapy, shall be completed by the QHP. The employee, employer and provider shall be notified verbally of the outcome of the initial review within forty-eight hours of the request. Within seven working days of the verbal notification, the verbal notification shall be committed to writing and mailed to the employee, employer and provider.

(C) A QHP shall have a dispute resolution process beyond initial review that includes a minimum of two levels of peer review of a medical diagnosis or treatment issue if an individual health care provider is involved in the dispute, or a minimum of two levels of dispute resolution if an individual health care provider is not involved in the dispute.

(D) A QHP dispute resolution process shall be completed and the QHP shall notify the parties to the dispute and their initial written notice of a dispute, unless an extension of time is otherwise agreed to by the parties. Any party appealing a decision to a higher level within a QHP's dispute resolution process shall provide notice of such appeal to all the parties to the dispute within seven working days of notice of decision.

(E) The dispute resolution process shall begin upon written notice of the dispute by the party maintaining the dispute to the parties of the dispute. If an individual health care provider is involved in the dispute, there shall be available at least two levels of peer review if appealed, with at least one level conducted by an individual or individuals licensed pursuant to the same section of the revised code as the health care provider who is a party to the dispute. The other level of peer review shall include, at the discretion of the QHP medical director, one or more of the following: a review conducted by a multi-disciplinary medical panel or board; an independent or agreed upon medical examination; or the use of other resources beneficial to the resolution of the dispute.

(F) A dispute unresolved by a QHP dispute resolution process may be appealed to the industrial commission pursuant to section 4123.511 of the Revised Code. Parties to a dispute shall exhaust the dispute resolution procedures of this rule prior to filing an appeal under section 4123.511 of the Revised Code.

(G) Notwithstanding the requirements set forth in paragraph (F) of this rule, a dispute unresolved by a QHP providing medical management and cost containment services for a state fund employer shall be referred by the QHP to the bureau within seven working days of the final decision rendered within the QHP dispute resolution process. Within fourteen days of receipt of an unresolved medical dispute, the bureau shall conduct an independent review of the unresolved medical dispute received from the QHP

and enter a final bureau order pursuant to section 4123.511 of the Revised Code. This order shall be mailed to all parties and may be appealed to the industrial commission pursuant to section 4123.511 of the Revised Code. Parties to a dispute shall exhaust the dispute resolution procedures of this rule prior to filing an appeal under section 4123.511 of the Revised Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**4123-6-70 Evaluation of the QHP system by the bureau; reporting requirements by employers and QHPs. (Amend)**

(A) To enhance the quality of the QHP system, and pursuant to division (G) of section 4121.44 of the Revised Code, divisions (D)(9) and (G) (A)(9) of section 4121.442 of the Revised Code, and division (D)(2)(d) of section 4121.125 of the Revised Code, the deputy administrator for the division of medical management and cost containment shall require employers and QHPs that participate in the workers' compensation QHP system to report data to be used by the administrator to:

**Comment [a23]:** Amended to remove and update outdated Revised Code citations.

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

(2) Publish and report compiled data to the governor, the speaker of the house of representatives, and the president of the senate every six months to gauge the measures of outcomes and savings of the QHP system.

**Comment [a24]:** These reports are no longer required per statutory amendments enacted by Senate Bill 7 (SB7).

(B) The bureau shall evaluate the effectiveness of the QHP system based on standardized data and reporting requirements developed by the bureau.

(C) The bureau shall receive, define and publish data elements and data collection techniques that meet the thirteen standards set forth in divisions (D)(1) to (D)(13) (A)(1) to (A)(13) of section 4121.442 of the Revised Code and are necessary to evaluate the effectiveness of the QHP system. Performance indicators used by the bureau to evaluate the effectiveness of the QHP system may include, but shall not be limited to, the following: customer satisfaction; system cost drivers; improvements in quality, and cost reductions.

(D) QHPs shall submit to the bureau no more than twice per year, on standardized forms developed by the bureau, data that provide the bureau with information enabling the bureau to determine the effectiveness of the QHP system.

**Comment [a25]:** BWC no longer requires these reports per statutory amendments enacted by Senate Bill 7 (SB7).

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**4123-6-71 Initial report of an injury and reporting requirements by providers and employees in the QHP system. (Rescind)**

(A) A provider who initially becomes aware of an employee's injury or occupational disease, at a minimum, shall notify the QHP or employer of the injury or occupational disease in a standard format no later than one working day after the date the provider becomes aware of the injury or occupational disease.

(B) Providers shall abide by current standard state workers' compensation reporting requirements for treatment of injured workers, pursuant to rule 4123-7-08 of the Administrative Code.

(C) The injured worker, when the injured worker's medical condition does not prohibit him from doing so, shall notify the QHP or employer of the injury or occupational disease as soon as possible after the date the injured worker becomes aware of the injury or occupational disease.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a26]: BWC is proposing to move the relevant language to OAC 4123-6-02.8.

**4123-6-72 Confidentiality. (No Change)**

Subject to the requirements and protections contained in Ohio law pertaining to release of confidential and/or privileged information, in the course of medical management in the QHP system, confidential information may be exchanged among the bureau, the QHPs, an employer and its representative, an employee and his or her representative, and the provider. All parties providing or requiring such confidential information for use in the QHP system shall not provide or use such confidential information for any purpose other than to perform duties required under the QHP system, and shall prevent such information from further disclosure or use by unauthorized persons.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

**4123-6-73 Bureau requirement to develop information describing rights under the QHP system. (Rescind)**

The bureau, at least annually, shall develop and make available information that describes employer and employee rights under the QHP system.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4121.442, 4123.66

Prior Effective Dates: 9/5/96

Comment [a27]: BWC is proposing to move this language to OAC 4123-6-51.



**Bureau of Workers'  
Compensation**

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**Stakeholder comments to the Qualified health Plan (QHP) rules contained in OAC 4123-6**

Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
1	4123-6-50 to 4123-6-73	Gary Shively, PSC Metals, Inc.: Great rule changes.			
2	4123-6-50 to 4123-6-73	Stephanie Kuntz, Knowledge Learning Corp.: We do not have any recommendations for changes to this chapter.			

Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
3	4123-6-50 to 4123-6-73	Jean Sheaks, Crown Equipment Corporation ("Crown"): Please note that Crown has reviewed the QHP rules and can not provide you with any suggestions/changes for clarity.			
4	4123-6-50 to 4123-6-73	Daniel R. Wood, Windstream Communications, Inc.: Please be advised we have reviewed the proposed changes in their entirety and agree with the suggested changes.			
5	4123-6-50 to 4123-6-73	Nancy Krey, RN, BA, Appleton Papers, Inc.: I have read the changes regarding the QHP 5 Year Review Rules document. I have no changes or suggestions to offer. I am fairly new to the SI Arena, and what you have delineated appears to be appropriate and correct to the best of my knowledge.			

Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
6	4123-6-50 to 4123-6-73	Cathy Jackson, Forward Air, Inc.: I have reviewed the rules and have no concerns with the proposed changes.			
7	4123-6-58	Lori Finnerty, CareWorks: Delete the additional requirement that mimics the requirement in the MCO contract "If the QHP utilizes a leased provider network, the QHP shall not apply the discounted payment rates of the leased network to services rendered by the provider in the QHP unless the signed written consent of the provider has been obtained."	The intent of the original legislation was to be able to use networks and apply discounted rates. The requirement for the additional sign off and additional paperwork process does not seem reasonable for a QHP system and process that has been in existence for over 12 years. This seems to be adding an unnecessary paperwork requirement at this time and should not be added to address a perceived MCO issue (not MCO rule requirement but MCO contract requirement).	Provided additional clarification to stakeholder on the proposed amendment to OAC 4123-6-58. The change is intended to make the rule less restrictive than currently written. Stakeholder accepted explanation for the change.	Rule amendment will remain as written.

Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
8	<b>4123-6-69</b>	Lori Finnerty, CareWorks: BWC should review this rule and modify for one level of dispute within the QHP. This would appear to streamline disputed issues. Based on the experience with HPP the second level was found to generally uphold the first level and not provide additional value while delaying the overall process of resolving the dispute, if it could not be resolved with medical management process.	This would appear to streamline disputed issues. Based on the experience with HPP the second level was found to generally uphold the first level and not provide additional value while delaying the overall process of resolving the dispute, if it could not be resolved with medical management process.	BWC has experienced no problems or complaints from QHPs regarding the current process.	Rule amendment will remain as written.
9	<b>4123-6-69(G)</b>	Lori Finnerty, CareWorks: Paragraph (G) should also be removed as it applies to QHP for state fund employer and a process to forward unresolved disputes to the BWC for an order.	The original statutory language for QHP had language concerning state fund employers (although somewhat confusing in the wording), however through the development of the rules and process for the QHPs the self insured employers are the focus of the program. This process and section of the rule does not apply to the QHP process nor has it been used.	The statutory language referred to by Stakeholder is still in place. See O.R.C. 4121.44(L).	Rule amendment will remain as written.

Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
10	4123-6-69(G)	The Ohio State Chiropractic Association respectfully opposes the recently released Chapter 6 rules which govern the Health Partnership Program/Qualified Health Plan Program and Self-Insured employer's related activities.	Many of the rules in this package including 4123-6-56, 4123-6-57, 4123-6-63, 4123-6-66, 4123-6-67, 4123-6-68, 4123-6-71 and 4123-6-73 which are proposed to be rescinded or substantially changed provide critical protections for injured workers and providers. Rescinding these rules without having replacement rules in place (or at the very least drafted for review) makes it impossible for us to give serious consideration to this rules package.	Due to the large number of Chapter 4123-6 and -7 rules, the rules are being presented to the Board and to Stakeholders in two steps. The first step is to present the separate groups of rules as a first reading to the Board. This first step will take place over the months of June, July, August and September. The second step will occur in September/October when the entire set of rules covered over the aforementioned months will be combined into one document and re-shared with the stakeholders for a final review and reconciliation, prior to a second reading and vote by the Board.	Rules will remain as proposed, pending re-review in September/October 2009.
11					

Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
12					
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Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
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Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
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Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
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Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
38					

Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
39					
40					

Line #	Rule #	Draft Rule Comments	Stakeholder Rationale	BWC Response	Resolution
41					























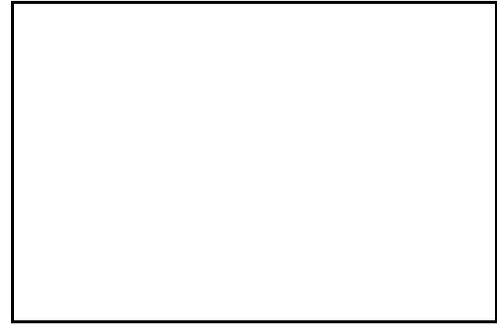












**Common Sense Business Regulation (BWC Rules)**

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

**Chapter 4123-6 Health Partnership Program**

**MCO Operational Rules (24 rules)**

**Rule Review**

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

Citation: R.C. 4121.44(B)(1) and (2), R.C. 4121.441

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

What goal(s): The rules set forth criteria and guidance for implementation of the Health Partnership Program (HPP) and the certification of managed care organizations (MCOs) to provide services and supplies to injured workers in the Ohio workers' compensation system.

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

4.  The rule is effective, consistent and efficient.

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

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

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

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

Explain: BWC's proposed five-year rule review changes to the HPP MCO operational rules were e-mailed to the BWC Medical Division's list of stakeholders for review.

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

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

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

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

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

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

**BWC Board of Directors**  
**Executive Summary**  
**HPP MCO Operational Rules**  
**Chapter 4123-6**

**Introduction**

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including rules governing the operation of managed care organizations (MCOs). BWC enacted the bulk of the Chapter 4123-6 HPP operational rules (Ohio Administrative Code 4123-6-01 to 4123-6-19), including the MCO operational rules, in February 1996. The rules have been periodically updated as needed, and last underwent five-year rule review in 2004.

As part of the current five-year rule review process, the MCO operational rules have been thoroughly reviewed and numerous changes have been proposed. There are 24 rules in this rule package; 3 rules will be rescinded and replaced, 13 rules will be amended, 5 rules will be rescinded, and 3 rules are no change rules.

**Background Law**

Ohio Revised Code 4121.44(B)(1) and (2) provide that, to implement the HPP, the Administrator shall “certify one or more external vendors, which shall be known as ‘managed care organizations,’ to provide medical management and cost containment services” in the HPP for a period of two years beginning on the date of certification, consistent with the standards established under the statute, and that the Administrator may recertify the MCOs for additional two year periods.

Ohio Revised Code 4121.441(A) provides that the Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP “to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease” which shall include, but are not limited to:

- (11) Standards and criteria for the bureau to utilize in certifying or recertifying a . . . vendor [MCO] for participation in the health partnership program;
- (12) Standards and criteria for the bureau to utilize in penalizing or decertifying a . . . vendor [MCO] from participation in the health partnership program.

**Proposed Changes**

The major substantive changes proposed for the HPP MCO operational rules pursuant to the five-year rule review:

- Expand the required components for an MCO application for certification and allow for BWC discretion in the requirements for an MCO application for recertification. OAC 4123-6-03.2 (C)(4), (C)(10), and (E)
- Modify the prohibition on outsourced services to just medical case management for both certification and recertification of MCOs including the removal of grandfathering in outsourcing of medical case management for existing MCOs. OAC 4123-6-03.2 (J).

- Clarify language related to an MCO's ability to place its self at capacity. OAC 4123-6-03.3 (A).
- Expand the grounds for termination of an MCO's contract to include items currently in the MCO contract. OAC 4123-6-03.6.
- Remove language related to "Gamma IME"s, a one-time independent medical exam on a claim with a date of injury before October 20, 1993 and change language related to reflect recent revisions to OAC 4123-6-16 - Alternative dispute resolution for HPP medical issues. OAC 4123-6-04.3 (F).
- Replace language related to MCO marketing practices to reflect the marketing policy in the April 2008 release of Appendix A of the MCO contract. OAC 4123-6-05.1.
- Modify language related to the MCO's ability to reimburse trade or business associations for marketing expenses and add the definition of agents to match the language in the marketing policy in the April 2008 release of Appendix A of the MCO contract. OAC 4123-6-05.3 (B)(2) and (E).
- Expand prohibition on MCO receipt of payment for referrals ("kick-back") to include the referral of employers to individuals or entities for provision of goods or services and referrals of injured workers to providers for provision of goods or services. OAC 4123-6-05.4.
- Modify language to allow the administrator flexibility in determining the methodology used to determine the manner the payments are to be paid and expanded list of performance measure criteria to include process performance measures. OAC 4123-6-13 (A) and (C)(2).
- Expand language relating to confidentiality of records to ensure appropriate protection is in place for BWC data. OAC 4123-6-15.

## **Stakeholder Involvement**

BWC developed and distributed an announcement to stakeholders informing them of the 5-year administrative code rule review process regarding the BWC medical rules. The announcement informed stakeholders that BWC would be reviewing medical rules internally and would be periodically sending medical rules, in groups, to the external stakeholders for input. This announcement was distributed through a public e-mail box designed to facilitate distribution of the rules to interested parties and to stakeholder groups. Stakeholders were informed of the opportunity to provide input on the medical rules and the changes proposed by BWC, and the timeline to respond.

BWC's proposed five-year rule review changes to the HPP MCO operational rules were e-mailed to the following lists of stakeholders on June 26 and June 29, 2009 with comments due back on Thursday, July 9, 2009:

- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
  - Council of Smaller Enterprises (COSE)
  - Ohio Manufacturer's Association (OMA)

- National Federation of Independent Business (NFIB)
  - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third Party Administrator (TPA) distribution list
- Ohio Attorney General's Office – Workers' Compensation Section

BWC received responses from eight stakeholders: two agreed with the proposed changes and the remaining six submitted 15 recommendations or comments. All recommendations and comments are included in the stakeholder feedback summary spreadsheet. The responses covered a number of rules with no identifiable pattern of concern.

**Chapter 4123-6 Health Partnership Program  
(MCO Organizational Rules)**

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

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

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 2/19/96, 1/1/99

**Comment [a1]:** Rule is duplicative of language contained in OAC 4123-6-03.4.

**4123-6-03.10 Conflict of interest. (No Change)**

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/1/01

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

**Comment [a2]:** Existing language reorganized for clarity and language added to distinguish between an initial certification and a recertification.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Comment [a3]:** Trade names and fictitious names may be registered with the Secretary of State per Ohio Revised Code 1329.01 to 1329.10.

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

**Comment [a4]:** Added current MCO contract requirement to rule.

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

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

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

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

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

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

**Comment [a5]:** Added current MCO contract requirement and contract requirement effective January 1, 2010.

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

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

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

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

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

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

**Comment [a6]:** Added new requirement to match MCO contract and best billing practices.

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

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

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

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

**Comment [a7]:** Allows BWC flexibility in determining the information the MCOs are required to submit for recertification.

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

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

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

**Comment [a8]:** Language moved from OAC 4123-6-03.4 (E) into this rule, as it relates to the application process.

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

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

**Comment [a9]:** Medical case management services are at the core of MCO responsibilities. As such, it should not be outsourced. Under this amendment, former grandfather allowances for such outsourcing would no longer be sanctioned.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

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

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

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

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

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

**Comment [a10]:** BWC no longer grants conditional certification, if it ever did. Other changes made to clarify the MCOs' option of placing themselves at capacity.

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

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

**Comment [a11]:** Language added from OAC 4123-6-03, which is being rescinded.

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

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

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

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

**Comment [a12]:** This language was moved to the MCO application rule, OAC 4123-6-03.2.

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

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

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

(A) The MCO is insolvent.

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

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

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

(E) Decertification of the MCO.

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

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

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

**Comment [a13]:** These provisions have been added to reflect terms in the MCO contract.

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

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

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/95, 1/1/99

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

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

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 2/16/96, 10/26/00

**Comment [a14]:** Language changed from "related to" to "affiliated with" to match proposed changes to OAC 4123-6-05.1.

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

Comment [a15]: Language combined into OAC 4123-6-04.3.

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

**Comment [a16]:** Language duplicative of OAC 4123-6-02.6 (F) and OAC 4123-6-06.2.

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

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

**Comment [a17]:** Language changed to reflect the MCO's responsibility in this process.

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

**Comment [a18]:** This language moved from OAC 4123-6-04, which is being rescinded.

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

**Comment [a19]:** This language moved to OAC 4123-6-04.5 as it is a BWC function.

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

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

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

**Comment [a20]:** Employers do not execute contracts with MCOs.

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

**Comment [a21]:** Language in this section was changed to reflect recent revisions to OAC 4123-6-16 Alternative dispute resolution for HPP medical issues.

(1) ~~An MCO may obtain only one independent medical examination in a claim with a date of injury prior to October 20, 1993 for the purpose of medical management of the claim. An MCO independent medical examination ADR IME shall be limited to issues relating to the management of medical treatment and medical treatment disputes, and shall not include extent of disability issues. An MCO independent medical examination ADR IME shall not be conducted at the request of an employer and does not substitute for an examination permitted under section 4123.65.1 of the Revised Code.~~

**Comment [a22]:** This provision is no longer necessary, as these examinations are no longer performed.

(2) If the MCO bureau schedules a medical examination an ADR IME under this rule, the bureau and the MCO shall promptly inform the bureau and the parties, and their representatives, if any,

as to the time and place of the examination, and the questions and information provided to the doctor. A An electronic copy of the examination ADR IME report shall be submitted to the bureau, the parties and their representatives upon the MCO's receipt of the report from the doctor claim file. The claimant shall be reimbursed for the claimant's traveling and meal expenses, in a manner and at the rates as established by the bureau from time to time. ~~The MCO shall provide the claimant with a proper form to be completed by the claimant for reimbursement of such expenses.~~

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96, 1/1/99, 3/27/00, 1/1/01, 2/1/04

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

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

**Comment [a23]:** Language moved from OAC 4123-6-04.3 as this is a BWC function.

(B) ~~The employer or employee or representative may appeal the bureau's order to the industrial commission pursuant to section 4123.511 of the Revised Code. Upon referral from an MCO of a medical treatment reimbursement request in an inactive claim as provided in rule 4123-3-15 of the Administrative Code, the bureau will determine, after considering the MCO's recommendation,~~ both the causal relationship between the original injury and the current incident precipitating a medical treatment reimbursement request and the necessity and appropriateness of the requested treatment ~~in a claim which has not had activity or a request for further action within a period of time in excess of thirteen months, as provided in rule 4123-3-15 of the Administrative Code.~~ The bureau will notify all parties and the MCO of its determination.

**Comment [a24]:** Language changed to reflect BWC's responsibility in this process.

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

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

**Comment [a25]:** Language moved from OAC 4123-6-09, which is being rescinded.

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

**Comment [a26]:** Language moved from OAC 4123-6-09, which is being rescinded.

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

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 2/16/96; 11/01/04

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

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

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

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/1/01

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

**Comment [a27]:** Rule changed to reflect changes made to the MCO marketing policy in the April 2008 release of Appendix A of the MCO contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

which are false, fraudulent, deceptive, or misleading, and shall not receive any form of remuneration or "kickback" from the MCO.

(H) An MCO that violates this rule, or on whose behalf any third party administrator or individual or entity affiliated with the MCO has violated this rule, shall be subject to one or more of the following penalties and/or requirements, in the Bureau's discretion: placed at capacity, required to issue a retraction, any employer selection resulting from the violation removed from the MCO, subject to any penalties specified in the MCO contract, and/or subject to decertification and/or termination of its contract pursuant to the rules of this chapter of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96, 1/1/99, 4/5/99, 7/17/00, 1/1/03

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

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96, 1/1/99, 4/5/99, 7/17/00, 1/1/03

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

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

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

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

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

(E) Selection of an MCO by an employer or selection by the bureau shall be until the next open enrollment period. At the bureau's discretion or upon the employer's request, the bureau may reassign an employer from the MCO if the bureau determines that the reassignment is in the best interest of both the employer and the MCO.

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

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

(1) Select a new MCO; or

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

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

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

Promulgated Under: 119.03

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

Rule Amplifies: 4121.44, 4121.441, 4123.66

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

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

(A) In soliciting employers as provided under rule 4123-6-05.1 of the Administrative Code, an MCO, or any ~~parent, subsidiary, affiliated, or related individual or entity affiliated with the MCO as provided by rule 4123-6-05.2 of the Administrative Code, or any agent or person~~ other individual or entity acting on behalf of an MCO or for the benefit of an MCO, shall not:

Comment [a28]: Language changed to match proposed changes to OAC 4123-6-05.1.

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

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

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

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

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

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

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

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

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

Comment [a29]: Language added to match proposed changes to OAC 4123-6-05.1.

(4) The reimbursement of a trade or business association's actual and reasonable expenses during a calendar year shall not exceed sixteen one-hundredths of one per cent (.16%) of the premium of those employers ~~which that~~ are members of the trade or business association and ~~which that~~ have selected the MCO. The premium used in calculating allowable reimbursement

under this rule shall be the premium used by the bureau to calculate payments to the MCO under the payment provisions of the MCO contract.

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

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

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

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

(1) An insurance agent or broker contracted by the MCO and licensed by the Ohio Department of Insurance pursuant to Title 39 of the Revised Code;

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

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

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

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

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

**Comment [a30]:** Definition added for clarity and to match language added to the MCO Marketing policy in the April 2008 release of Appendix A of the MCO contract.

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

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

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

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

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

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 1/30/98 (Emer.), 4/29/98, 1/1/99, 1/1/01

**Comment [a31]:** Rule changed to prohibit kickbacks for other than group rating referrals.

**Comment [a32]:** Prohibition against the MCO receiving a "kickback" for referrals of injured workers and/or employers to any provider, individual, or entity, affiliated with the MCO or not.

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

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

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

Comment [a33]: Language is duplicative of OAC 4123-6-06.2.

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

**Comment [a34]:** Providers are required to submit the First Report of Injury (FROI) and must be aware of possible workers' compensation implications.

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

**Comment [a35]:** Language is duplicative of OAC 4123-6-04.5.

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

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

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

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

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

**Comment [a36]:** Changed to allow for non-premium based payment methodologies such as percentage of activity.

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

**Comment [a37]:** Relevant language moved to paragraph A of the rule.

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

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

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

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96, 1/1/99, 1/1/01

**4123-6-14.1 Records to be retained by MCO. (No Change)**

(A) An MCO shall retain records received from providers and subcontractors that are utilized by the MCO to develop electronic billings to the bureau. The MCO shall retain any records obtained from the providers and subcontractors that are utilized by the MCO to perform its medical management functions or to substantiate the delivery, value, necessity, and appropriateness of goods and services provided to injured workers. The MCO shall retain records relating to a claim so long as the industrial commission and bureau of workers' compensation have continuing jurisdiction over the claim pursuant to section 4123.52 of the Revised Code; however, if the MCO is no longer managing the claim in which the services were provided due to transfer of the management of the claim to another MCO or to the bureau, the MCO shall transfer the claim records to the other MCO or bureau. For records that do not relate to a specific claim, the MCO shall also create, maintain, and retain for a period of three years from the date of the transaction records documenting transactions with the injured worker, providers, and subcontractors.

(B) The failure of an MCO to create, maintain, and retain such records shall be sufficient cause for the bureau to deny payment for goods or services, or for performance fees, or for declaring overpaid previous payments made to the MCO, and may be cause for decertification.

(C) As used in this rule, "records" includes, but is not limited to, "record" and "electronic record" as defined in rule 4125-1-02 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/15/99, 1/1/01

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

**Comment [a38]:** Language was updated to reflect current MCO contract requirements.

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

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

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

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

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

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

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96

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

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

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

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.121, 4121.44, 4121.441, 4123.66

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

**Comment [a39]:** Changed to reflect the language in O.R.C. 4121.44 (H)(3).



**Bureau of Workers' Compensation**

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

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Stakeholder feedback and recommendations for changes to the HPP MCO operational rules Chapter 6, specifically 4123-6-03, 4123-6-03.10, 4123-6-03.2, 4123-6-03.3, 4123-6-03.4, 4123-6-03.6, 4123-6-03.7, 4123-6-03.9, 4123-6-04, 4123-6-04.2, 4123-6-04.3, 4123-6-04.5, 4123-6-04.6, 4123-6-05.1, 4123-6-05.2, 4123-6-05.3, 4123-6-05.4, 4123-6-06, 4123-6-06.1, 4123-6-09, 4123-6-13, 4123-6-14.1, 4123-6-15, 4123-6-16

Line #	Rule # / Subject Matter	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
1	4123-6-03.2 (C)(1) MCO Application	Provider Stakeholder suggested changing "professional" to "health care professional".	Provider Stakeholder stated that the suggested change would appropriately reference that the professionals on the health care provider panel are professionals in health care.	Agree.	Suggestion accepted. Language added.
2	4123-6-03.2 (E) MCO Recertification Application	Stakeholder suggested BWC consider just making a new short sentence about the proof of delivery.	Stakeholder stated: "The phrase "with proof of delivery" is too brief to make sense. Do you mean that the sender must retain proof of delivery (such as a signed receipt)? This could also be read to mean that "proof of delivery" must be submitted with the application or that the BWC must retain proof that the blank application was sent & delivered (which doesn't make sense, but....)"	Agree.	Suggestion accepted. Rule language modified to indicate MCO must be able to provide proof of delivery of the completed application to BWC upon request.
3	4123-6-03.2 (I) MCO Application	MCO Stakeholder suggested adding "and other information furnished the bureau by an MCO for purposes of obtaining certification or to comply with performance and auditing requirements" to match divisions (D) (1) and (D) (2) of section 4121.44 of the Revised Code.	MCO Stakeholder stated this makes the language more consistent with the language and intent of the ORC and should be included with the removal of language in 4123-6-03.2(19) (H) which is being rescinded.	Agree.	Suggestion accepted. Language added.
4	4123-6-04.3 (B) Medical and Claims Management	Provider Stakeholder suggested that "health care provider" would be a more appropriate term than "attending physician".	Provider Stakeholder stated this would be more accurately reflect the goal to provide high quality, cost effective care that focuses on minimizing the physical emotional and financial impact of a work-related injury or illness.	Disagree. BWC will retain "attending physician", as this term is defined in OAC 4123-6-01 Definitions.	Language will remain unchanged.

Line #	Rule # / Subject Matter	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
5	4123-6-04.3 (F) ADR IME	MCO Stakeholder suggested including language that an MCO "may schedule" or request that the Bureau schedule an ADR IME throughout Section (F).	MCO Stakeholder stated it is important not to modify this language as it takes away the MCOs' authority to complete the ADR IME. Need to make the language in the rule permissive as MCOs currently complete the ADR IMEs and if removed this will remove the MCOs' ability to complete this process. This is critical as the implementation with the new BWC process and timeline has not been established and will most likely be after the effective date of this rule change. In addition, items such as obtaining timely IMEs, use of MCO or BWC IME Panel, and implementation of system enhancements consistent with the changes to the ADR rule and proposed changes in the ADR workflow/process have not yet been resolved. The language in the rule should remain permissive until the process is modified, and then the rule can be updated to reflect the final process that is implemented.	Disagree. BWC recognizes the issue and plans to synchronize the effective date of this rule with the effective date of the changes to OAC 4123-6-16 Alternative dispute resolution for HPP medical issues.	The Stakeholder was contacted and BWC's plan to synchronize the effective dates was discussed. The stakeholder agreed that the proposed plan resolved its concern. Language will remain unchanged.
6	4123-6-04.5 (C) Claims Management	MCO Stakeholder suggested the following language remain included in the rule: "The bureau shall notify all parties and the MCO when a claim or conditions are allowed or disallowed and indicate whether treatment rendered therefore may or may not be paid."	MCO Stakeholder stated the language should remain, as it clarifies who notifies of claim determinations concerning claim and condition allowance.	Agree.	Suggestion accepted. Language added.
7	4123-6-04.5 (D) Claims Management	MCO Stakeholder suggested adding "If the claim <u>or condition</u> is disputed...".	MCO Stakeholder stated that "or condition" should be added to paragraph (D), as this is in 4123-6-09 (B) which is being rescinded.	Agree.	Suggestion accepted. Language added.

Line #	Rule # / Subject Matter	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
8	4213-6-05.1 (A) Marketing	State Fund Employer Stakeholder suggested the following modification: "No MCO, or individual or entity affiliated with the MCO <u>or acting on behalf of the MCO</u> , shall directly solicit an employer outside of an open enrollment period as provided in rule 4123-6-05.2 of the Administrative Code."	State Fund Employer Stakeholder stated the removal of this language is problematic as it opens the door to continual solicitations by any person or entity outside the established marketing restrictions placed upon MCOs (currently only during open enrollment periods), creating further confusion and disruption to employers. It is appropriate to ensure this solicitation prohibition remains in OAC.	Agree.	Suggestion accepted. Language added to (A) and, to be consistent, (B), (C), and (D).
9	4123-6-05.1 (A) Marketing	MCO Stakeholder suggested the following modification: "No MCO, or individual or entity affiliated with the MCO <u>or acting on behalf of the MCO</u> , shall directly solicit an employer outside of an open enrollment period as provided in rule 4123-6-05.2 of the Administrative Code."	MCO Stakeholder stated that if the restrictive language is not reinserted into the new rule, many entities and individuals will be permitted to directly solicit employers on a year-round basis.	Agree.	Suggestion accepted. Language added to (A) and, to be consistent, (B), (C), and (D).
10	4123-6-05.1 Marketing	MCO Stakeholder suggested adding the following paragraph: "(H) Should the employer directly contact the MCO, TPA, or other entity and request information regarding the selection of an MCO outside of a recognized open enrollment period, the MCO, TPA or other entity may respond to the employer's request for such information."	MCO Stakeholder stated "Under Paragraph (G) should add paragraph that reads as noted in rule."	Disagree. The language in the second paragraph of Section (F) and language in Section (G) already provides an exception for requests by employers.	The stakeholder was contacted and the language in Sections (F) and (G) was discussed. The stakeholder agreed that the existing language was sufficient to resolve its concern. Language will not be added.

Line #	Rule # / Subject Matter	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
11	4123-6-05.3 (B)(2) Marketing	State Fund Employer Stakeholder suggested removing the added language and appropriately adjusting OAC 4123-6-05.1 to reflect this adjustment will ensure our members are afforded access to the information necessary to better understand the HPP	State Fund Employer Stakeholder stated "during an open enrollment period," does not recognize the current realities in the marketplace. As you know, the MCO open enrollment period in Ohio is very truncated typically capped at four weeks every two years. However, as NFIB represents approximately 25,000 employers, most of whom are state-fund employers, we have an obligation to educate our members on the HPP/MCO services and selection process.	Agree in part. BWC agrees that the education of employers on workers' compensation processes and topics is important and sees no issue with the MCO reimbursing a trade or business association for general education expenses. However, to be consistent with OAC 4123-6-05.1 and OAC 4123-6-05.2, reimbursement for expenses related to marketing an MCO to its members should be restricted to marketing occurring during an open enrollment period.	Language was modified to allow for MCOs to reimburse trade or business associations for educating their members on the HPP and the MCO selection process outside of open enrollment periods. However, the restriction on limiting reimbursement for marketing expenses to be allowed only for marketing occurring during an open enrollment period was retained.
12	4123-6-05.4 Payment for Referrals	TPA Stakeholder had no suggested changes.	TPA Stakeholder stated: "I am glad to see that the BWC specifically states that kickbacks, commissions, and other "valuables" are forbidden when the MCO is soliciting new business. I am also glad to see the definition of affiliates of the MCO. I will be curious to see how some MCOs will respond to these rules, if enacted."		
13	4123-6-13 (A) Payment to MCOs	Provider Stakeholder suggested clarification to the proposed language.	Provider Stakeholder stated the language as drafted is open to varying interpretations as to whether the administrator will determine all fee payments for medical management and cost containment services for MCOs.	Agree.	BWC removed extraneous language to clarify process.
14	4123-6-14.1 (A) Record Retention by MCOs	TPA Stakeholder suggested the following change to the second sentence of paragraph (A): The MCO shall is required to obtain and retain any all records obtained from the providers and subcontractors that are utilized by the MCO will utilize to perform its medical management functions or to substantiate the delivery, value, necessity, and appropriateness of goods and services provided to injured workers.	TPA Stakeholder stated: "There are too many instances of MCOs authorizing payment for x-rays, MRIs & other diagnostics, and office & therapy visits, without obtaining the records that document the findings of the tests, or proof of the services rendered and the body parts tested or treated. There is no leverage for obtaining the records once the invoice has been paid, and the delay in attempting to get the records can result in an uninformed result at hearing or when administratively adjudicating issues in the claim."	The current MCO contract includes requirements for obtaining specified diagnostic records for claims meeting specified criteria. BWC will consider this suggestion during its review of the payment rules, that are scheduled to be presented to the Board for first reading in September, to determine whether additional steps should be taken.	The rule will remain unchanged pending review of payment rules.

Line #	Rule # / Subject Matter	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
15		Self-Insured Employer Stakeholder suggested that provisions be added requiring MCOs to bill at the appropriate fee schedule amount for services provided, with penalties for failure to do so. Something along the lines of removal of all charges billed at a greater rate than the fee schedule allows.	Self-Insured Employer Stakeholder stated it is disingenuous for providers/MCOs to put the onus of monitoring fee schedule amounts on the employer/BWC, when they are the ones who are knowingly submitting expenses for reimbursement specific to a WC claim.	Disagree. The providers must submit their actual charges. The MCOs and BWC apply the fee schedule as appropriate to determine final payment. In the case of out-patient hospital bills, final payment is a percentage of the submitted charges.	Medical Services has called the Stakeholder and discussed/educated him on the billing process.
16		Self-Insured Employer Stakeholder had no suggested changes.	Self-Insured Employer Stakeholder stated "I have reviewed and agree with the proposed changes as outlined on email dated 07/01/09."		
17		Self-Insured Employer Stakeholder had no suggested changes.	Self-Insured Employer Stakeholder stated: "I have no input. I have read and reviewed the rules. I agree with the changes and updates that have been made."		

**Common Sense Business Regulation (BWC Rules)**

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

**Five Year Rule Review**

**Chapter 4123-9 Rules**

**Rule Review**

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

Citation: R.C. 4121.121, 4121.31

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

What goal(s): These rules describe the overall general organization of BWC offices and functions assigned to the Administrator and BWC.

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 revisions to OAC 4123-9 relate primarily to bureau staff functions. Therefore, no external stakeholder groups were identified or consulted. Should external stakeholder interest develop, it can be addressed through the JCARR hearing process.

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

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

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

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

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

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

**BWC Board of Directors**  
**Executive Summary**  
**General Policy of the Bureau and**  
**General Organization of Bureau Offices**

## **Introduction**

Chapter 4123-9 of the Ohio Administrative Code (OAC) contains rules that describe the organizational structure of the bureau's divisions. Ohio Administrative Code 4123-9-01(A) very generally outlines the primary functions of the bureau.

## **Background Law**

Ohio Revised Code 4121.31(A)(1)(a) provides the statutory basis for the existing Ohio Administrative Code Chapter 4123-9. Specifically, R.C. 4121.31(A)(1)(a) requires that the Bureau adopt rules which set forth the “[a]ssignment to various operational units of any duties placed upon the administrator by statute”. The recommended deletion of OAC Chapter 4123-9 and its replacement by a single rule reduces the description of the Bureau's organizational structure to the statutory duties assigned to operational units as required by R.C. 4121.31(A)(1)(a).

## **Proposed Changes**

The bureau recommends that Chapter 9 be rescinded in its entirety. In its place, the bureau proposes that a single rule be adopted that describes the operational units of the bureau. The proposed rule is sufficiently broad and comprehensive to account for all statutorily mandated functions as well as others deemed appropriate by the administrator for the efficient operation of the bureau.

This proposal complies with the Governor's regulatory reform efforts and the initiative to streamline rules where appropriate and it also provides flexibility and latitude to the administrator to reorganize the operational units of the bureau to achieve the most efficient performance of the functions of those operational units.

The bureau also recommends that the newly developed rule be placed in Chapter 5. It is not appropriate to dedicate an entire chapter to a single rule. Chapter 5 was the most logical place for a general, organizational rule.

Ohio Administrative Code 4123-9-01(A) generally outlines the policy of the bureau. The bureau's current mission statement serves this function more effectively. Therefore, it is recommended that OAC 4123-9-01(A) be rescinded and not replicated in the version of chapter 9 which has been condensed into proposed OAC 4123-5-01.

## **External Stakeholder Involvement**

The proposed revisions to OAC 4123-9 relate primarily to bureau staff functions. Therefore, no external stakeholder groups were identified or consulted. Should external stakeholder interest develop, it can be addressed through the JCARR hearing process.

## CHAPTER 9 FIVE YEAR RULES REVIEW.

### ~~4123-9-01 General functions and organization of the bureau. (Rescind)~~

~~(A) The main functions of the bureau of workers' compensation are of the following:~~

- ~~(1) Prompt payment of compensation and benefits, in accordance with the statutes and rules of the bureau and the industrial commission, for death, injuries, or occupational diseases received in the course of and arising out of employment. Each party shall receive fair, impartial, and equal service.~~
- ~~(2) Maintaining an ongoing program to identify employers subject to the Ohio Workers' Compensation Act and to audit employers to ensure proper premium and assessment payment.~~
- ~~(3) Establishing workers' compensation coverage for employers under the state insurance fund and collecting premium from employers subject to the Ohio Workers' Compensation Act.~~
- ~~(4) Granting qualifying employers the privilege of self-insurance, and auditing and monitoring the programs conducted by self-insuring employers to ensure compliance with the workers' compensation statutes and rules.~~

~~(B) The administrator of workers' compensation may organize the work of the bureau, its divisions, sections, departments, and offices, to the extent necessary to achieve the most efficient performance of the functions of the bureau.~~

### ~~4123-9-02 Legal division of the bureau. (Rescind)~~

~~The duties of the legal division of the bureau shall include, but will not be limited to, the following:~~

~~(A) Providing legal advice and assistance to the administrator and the bureau on issues affecting the administration of the workers' compensation act and the operation of the bureau of workers' compensation;~~

~~(B) Assisting the administrator in the filing of administrative appeals and representation of the interest of the state insurance fund, the statutory surplus fund, and other funds administered by the bureau;~~

~~(C) Assisting the administrator in the investigation of all potential acts of internal and external fraud committed against the bureau.~~

~~(D) Assisting the administrator in security concerns;~~

~~(E) Assisting the administrator by independently reviewing the systems of internal control and recommending improvement when appropriate;~~

~~(F) Conducting investigations of alleged safety violations pursuant to workers' compensation claims.~~

~~(G) Assisting the administrator in the investment and management of the surplus and/or reserves in accordance with the investment philosophy of the workers' compensation oversight commission;~~

~~(H) Monitoring federal and state EEO compliance.~~

### **~~4123-9-03 Finance division of the bureau. (Rescind)~~**

~~The duties of the finance division of the bureau shall include, but will not be limited to, the following:~~

~~(A) Assisting the administrator in maintaining the solvency of the state insurance fund;~~

~~(B) Maintaining accurate records of losses incurred by employers on account of injuries, establishing proper reserves as a factor in the rate calculation process, establishing a merit rating system of employer, and other functions to assist the administrator in the rate making process;~~

~~(C) Assisting the administrator in receiving and disbursing funds from the state insurance fund and other applicable funds in accordance with state and federal laws, rules and regulations;~~

~~(D) Assisting the administrator in preparing the bureau's budget by allocating, auditing, and adjusting appropriations and expenses.~~

### **~~4123-9-04 Information technology division of the bureau. (Rescind)~~**

~~The duties of the information technology division of the bureau shall include, but will not be limited to the following:~~

~~(A) Continually improving the business reliability of the bureau through technical improvement and automation;~~

~~(B) Increasing and enabling flexibility and responsiveness to changing business requirements;~~

~~(C) Providing electronic data and technical system support for each of the bureau's divisions.~~

### ~~**4123-9-05 Government and media affairs division of the bureau. (Rescind)**~~

~~The duties of the government and media affairs division of the bureau shall include, but will not be limited to, the following:~~

~~(A) Preparing, publishing and distributing news releases, reports, pamphlets, articles, and other publications, print or electronic, relating to the bureau's operations.~~

~~(B) Handling all communications with the media.~~

~~(C) Responding to inquiries from the public.~~

~~(D) Monitoring state and federal legislation for impact on the bureau and responding to inquiries from members of the state or federal legislatures.~~

### ~~**4123-9-06 Employer management services division of the bureau. (Rescind)**~~

~~The duties of the employer management services division of the bureau, shall include, but will not be limited to the following:~~

~~(A) Identifying employers subject to Ohio workers' compensation act;~~

~~(B) Conducting periodic review of manual classifications and payroll reports of state fund employers to ascertain that employer premiums have been properly computed and paid;~~

~~(C) Granting, renewing, and revoking the privilege of self insurance; auditing and monitoring self insuring employers to ensure compliance with bureau statutes, rules and policies; handling complaints filed against self insuring employers; managing medical-only and bankrupt self insuring employer claims;~~

~~(D) Auditing and monitoring the safety and hygiene fund;~~

~~(E) Assisting the superintendent of the division of safety and hygiene in researching, investigating, and conducting loss prevention programs and courses for employers;~~

~~(F) Conducting research and analysis.~~

### ~~4123-9-07 Human resources division of the bureau. (Rescind)~~

The duties of the human resources division of the bureau shall include, but are not limited to, the following:

- ~~(A) Administering personnel plans, policies and programs in compliance with state and federal statutes, rules, and regulations;~~
- ~~(B) Providing payroll and benefit services for bureau employees;~~
- ~~(C) Assisting with determining personnel needs of the bureau, posting employment opportunities, and filling position vacancies;~~
- ~~(D) Development of employment policies and monitoring of labor compliance issues;~~
- ~~(E) Providing forms, supplies, and mail service support for each of the bureau's divisions;~~
- ~~(F) Providing delivery and fleet services to bureau divisions.~~

### ~~4123-9-08 Field operations division of the bureau. (Rescind)~~

The duties of the field operations division shall include, but will not be limited to the following:

- ~~(A) Managing claims according to bureau statutes, rules and policies, including medical-only claims, claims filed by out-of-state injured workers and employees of the bureau and industrial commission, special claims, including black lung, marine fund, disabled worker relief fund, and public works relief claims;~~
- ~~(B) Adjudicating non-contested claims by issuing an order to approve or deny the payment of compensation or benefits;~~
- ~~(C) Executing orders of the industrial commission;~~
- ~~(D) Issuing adjustment and overpayment orders;~~
- ~~(E) Approving settlements of claims as authorized by the workers' compensation statutes;~~
- ~~(F) Planning, developing, and implementing relevant employee training programs, including continuing education and the online learning center.~~

### ~~4123-9-09 Quality assurance division of the bureau. (Rescind)~~

~~The duties of the quality assurance division of the bureau shall include, but will not be limited to the following~~

~~(A) Providing an independent assessment of program activities and functions to evaluate them for effectiveness and compliance, using generally accepted auditing standards;~~

~~(1) Assessing program compliance with applicable laws, rules, and policies;~~

~~(2) Assessing objectives of new or ongoing programs for relevance;~~

~~(3) Determining the extent to which a program achieves the desired results;~~

~~(4) Assessing the effectiveness of program components;~~

~~(5) Identifying factors inhibiting satisfactory performance;~~

~~(6) Determining whether more cost-effective alternatives can be implemented;~~

~~(7) Identifying duplication, overlap, or conflicts among related programs;~~

~~(8) Assessing the adequacy of controls;~~

~~(9) Evaluating whether reported measures of effectiveness are valid and reliable;~~

~~(B) Providing written reports and recommendations for improvement.~~

## **~~4123-9-10 Injury management services division of the bureau. (Rescind)~~**

~~The duties of the injury management division services of the bureau shall include, but will not be limited to, the following:~~

~~(A) Implementing the health partnership program (HPP) and qualified health plan (QHP) in accordance with workers' compensation statutes;~~

~~(B) Assessing the compliance of HPP and QHP with workers' compensation statutes, rules and policies;~~

~~(C) Establishing criteria to determine the amount to be paid for medical services, equipment, and supplies;~~

~~(D) Authorizing, denying or adjusting provider payments;~~

~~(E) Developing programs to provide rehabilitation services to claimants in accordance with workers' compensation statutes;~~

- ~~(F) Assuring that claimants' rehabilitation services further return to work objectives;~~
- ~~(G) Developing, implementing and assessing claims, medical and vocational rehabilitation policies and procedures;~~
- ~~(H) Overseeing and consulting for contractual compliance issues regarding managed care organizations;~~
- ~~(I) Enrolling and certifying providers in HPP systems and maintaining disability evaluators panel;~~
- ~~(J) Resolving complaints regarding HPP;~~
- ~~(K) Assisting in provider training;~~
- ~~(L) Recovering medical payments made in excess or in error;~~
- ~~(M) Administering the employee health services for bureau and industrial commission central office employees, as well as the catastrophic nurse advocates program benefiting injured workers who have suffered catastrophic injuries from job-related accidents;~~
- ~~(N) Supporting systems initiatives for management of the bureau's pharmacy benefits program;~~
- ~~(O) Developing requirements for enhancements and coordinating and testing systems for electronic data interchange transactions, related to claims, providers, network and medical billing processes, and for systems relating to claims;~~
- ~~(P) Providing analytical, statistical, and reporting services to internal and external customers, including but not limited to calculating the employer open enrollment report card, managed care organizations' incentive payments, managed care organizations' administrative payment set-offs, and most managed care organizations' related statistics;~~
- ~~(Q) Coordinating medical, claims, and rehabilitation policies, procedures, and programs;~~
- ~~(R) Responding to local and statewide inquiries regarding claim handling practices and procedures.~~

### **~~4123-9-11 Customer service division of the bureau. (Rescind)~~**

~~The duties of the customer service division of the bureau shall include, but will not be limited to, the following:~~

- ~~(A) Supporting state and bureau quality initiatives;~~

~~(B) Planning, developing, and implementing leadership training;~~

~~(C) Planning, developing, and implementing personal development programs.~~

## **~~4123-9-12 Communications division of the bureau. (Rescind)~~**

~~The duties of the communications division of the bureau shall include, but will not be limited to, the following:~~

~~(A) Preparing, publishing and distributing reports, pamphlets, articles, and other publications, print or electronic, relating to the bureau's operations;~~

~~(B) Coordinating the bureau's special events;~~

~~(C) Producing and editing content for broadcast on public access television station;~~

~~(D) Managing the conference center.~~

### 4123-5-01      **Assignment of duties to the bureau's operational units. (New)**

The administrator may reorganize the work of the bureau to the extent necessary to achieve the most efficient performance of its the functions. The duties of the operational units of the bureau include, but are not limited to the following:

(A) A division responsible for the fiscal and planning function will assist the administrator in maintaining the solvency of the insurance fund, establishing policies and procedures for fiscal management, receiving and disbursing funds from the state insurance fund, and preparing the bureau's budget.

(B) A division responsible for the medical services function will assist the administrator in establishing and maintaining a quality pool of medical and vocational service providers; developing and maintaining quality medical, vocational rehabilitation, and pharmaceutical benefits plans; developing and overseeing managed care services, and ensuring the proper and timely payment of medical bills.

(C) A department responsible for the special investigations function will conduct investigations of alleged workers' compensation fraud and alleged violations of specific safety requirements pursuant to workers' compensation claims.

(D) A division responsible for the customer service function will assist the administrator in:

- (1) Identifying employers subject to the Ohio Workers' Compensation Act;
  - (2) Conducting periodic reviews of the manual classifications and payroll reports of state fund employers to ensure that employer premium payments have been properly computed and paid
  - (3) Developing and making available alternative premium plans to state fund employers;
  - (4) Managing and settling the claims of injured workers in accordance with applicable statutes, rules and policies;
  - (5) Addressing matters relating to self-insured employers, including but not limited to, privilege status, auditing, monitoring, handling complaints, and managing medical-only and bankrupt self-insuring employer claims;
  - (6) Supporting the superintendent of the division of safety and hygiene on matters relating to work place safety.
- (E) A division responsible for the actuarial function will assist the administrator in ensuring that rates for all employers are calculated based on actuarial principles and standards of practice, ensuring that financial liabilities for compensation and compensation adjustment are calculated based on actuarial principles and standards of practice, and developing and supporting alternative rating options for employers.
- (F) A division responsible for the investment function will assist the administrator in the investment and monitoring of assets of the state insurance fund and other funds administrated by the bureau, and in the implementation and monitoring of the bureau investment policy approved by the board of directors.
- (G) A division responsible for the internal audit function will conduct reviews of divisions and control systems within the bureau, at appropriate intervals, to determine whether they are effectively carrying out their functions of administration, accounting, safeguarding of bureau assets, and control in accordance with management's instructions, policies, and procedures, and in a manner that is in agreement with both agency objectives and high standards of administrative practice; conduct special examinations at the request of management or the bureau of workers' compensation board of directors audit committee; submit an annual audit plan to the administrator and the audit committee for their review and approval.

Replacing Chapter 9.

**OHIO BUREAU OF WORKERS' COMPENSATION  
FY 2009 – BOARD OF DIRECTORS SELF-ASSESSMENT**

**SUMMARY OF DIRECTOR RESPONSES**

**Dated: July \_\_, 2009**

**Rank the following questions 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 individual 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 numerical assessment rating for FY 2009 of 4.58 on a rating scale in which 5.0 = "Area of considerable strength" and 3.0 = "Satisfied." The overall rating for FY 2008 was 4.56 on this scale. 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:**

	Rating
Mission and strategic plans	<b>4.7</b>
Insurance business	<b>4.3</b>
Actuarial soundness	<b>4.5</b>
Investment portfolio	<b>4.7</b>
Financial performance	<b>4.6</b>
Cumulative Rating	<b>4.6</b>

The cumulative rating for this item for FY 2008 was 4.2. The directors generally believe that the Administrator and staff are doing a very good job in providing information to the Board and are comfortable with the level of information received and that significant progress has been made in this regard on all fronts. Also noted were the responsiveness to specific questions of the Administrator and staff, as well as the helpfulness of the presentations by professionals of information and analysis to the Board. Further, the educational sessions conducted by the BWC staff and outside advisors have been very helpful to the Board. Some directors believe that the BWC could do a better job explaining the development of its strategic planning and providing insight as to how issues reach center stage and are implemented. It was also noted that improved competitive information on insurance premiums is very important.

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

	Rating
Timely	<b>4.4</b>
Complete	<b>4.1</b>
Understandable	<b>4.3</b>
Cumulative Rating	<b>4.3</b>

The cumulative rating for this item for FY 2008 was 4.3. The directors were generally very complimentary of the efforts of the Administrator and staff in providing complete and understandable information in the Committee and Board books in advance of the meetings. Although the improvements in providing information over the prior year were noted, the primary criticism centered on the timeliness of the information provided. On the one hand, given the amount of information provided and the unpredictable timing of certain issues coming before the BWC, it is understandable that some information may not be available until the meetings. On the other hand, it was noted that the most important decision-making information is usually received the latest, and that written documentation providing the rationale with respect to recommended actions is the most important information for pre-Board meeting reading, as opposed to power points, which are most helpful for in-meeting presentations. One director suggested, in order to remedy the occasions when significant parts of the board packet aren't provided for review prior to meetings, that this information be transmitted via e-mail or other appropriate means for review prior to meetings.

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

Rating	4.5
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The rating for this item for FY 2008 was 4.2. The comments on this item echo the responses to the prior item. The directors generally believe that the information provided is of sufficient clarity to enable them to understand the business and financial risks of the BWC and that the information is of excellent quality. One director expressed a concern that, while the Committee Chairs appear to understand what is going on at the Committee meetings, there are occasions where the Committee members or the other directors in attendance at the Committee meetings may not share that understanding.

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

	Rating
Clear and understandable	4.3
Helpful in providing an accurate picture of the BWC's performance	4.3
Cumulative Rating	4.3

The cumulative rating for this item for FY 2008 was 4.7. The directors were generally very appreciative of the ability of the Administrator and staff to present information at board and committee meetings and tailoring their presentations to bring about a level of understanding necessary for the Board to adequately comprehend the issues. The improvements in this area were noted, as was the patience of the staff in their willingness to answer questions. The educational presentations and "deep dives" presented by the Chief of Fiscal and Planning in the Audit Committees and Board meetings with respect to the Enterprise Report were seen as indicative of the commitment the staff has to helping the Board understand the intricacies of the BWC. It was further noted that receiving stakeholders' comments with rule reviews is extremely helpful and that including opposing views and/or potential negatives, where applicable, in non-rule presentations would be appreciated. It was also noted that a better job could be done in advising the Board of how the overall strategic planning of the BWC is developed and how this translates into performance.

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

Rating*	4.9
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[\*Note: The 10 directors who participated in the evaluation process responded.]

The rating for this item for FY 2008 was 4.9. The directors were unanimous in the strong expression of satisfaction with the process by which the Board evaluated the performance of the Administrator for FY 2009. The process is seen as efficient and effective. In particular, the leadership of the Governance

Committee was commended, both with respect to the development of the evaluation form and the conducting of the process.

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

Rating	<b>4.3</b>
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The rating for this item for FY 2008 was 4.4. In general, the directors believe that the rationale for proposed Board and Committee actions is explained well. It was noted, however, that occasionally more time needs to be given for explanation and questions on more complicated issues. In a similar vein, it was noted that the first and second reading of motions is extremely beneficial, but there are still times when more Committee time is needed to discuss and understand an issue. Further, the importance of complete and clear documentation of the rationale for recommendations and actions was noted. One director observed that the Committee professionals are very willing to make sure the non-professional members are brought up to speed on the issues before action.

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

Rating	<b>4.5</b>
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The rating for this item for FY 2008 was 4.5. The directors generally believe that the pre-meeting materials are helpful and relevant, subject to comments offered in connection with the items previously addressed regarding timeliness of the information provided. The thorough preparation of the staff for Board meetings is seen as a strength.

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

	Rating
Agendas	<b>4.9</b>
Opportunity for discussion	<b>4.9</b>
Frequency	<b>4.8</b>
Cumulative Rating	<b>4.9</b>

The cumulative rating for this item for FY 2008 was 4.9. The directors strongly expressed satisfaction with the conduct of the Board meetings in terms of the agendas and the opportunity for discussion. Also commended was the leadership of Chairman Lhota and the atmosphere of mutual respect for differing views as expressed by individual directors as well as Board and Committee chairs. As to frequency of meeting, it was noted that the Board meetings are held monthly as required by HB 100; however, the point was made that the frequency of meeting is a considerable time burden on the staff. One director observed that, if progress continues to be made at the BWC, less frequent meetings is a topic that the Board may wish to revisit with the Legislature and the Governor the appropriate time, which was suggested as five years after the passage of HB 100.

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

	Rating
Actuarial Committee	<b>4.7</b>
Audit Committee	<b>4.7</b>
Investment Committee	<b>4.8</b>
Governance Committee	<b>4.9</b>
Cumulative Rating	<b>4.8</b>

The cumulative rating for this item for FY 2008 was 4.9. The directors were united in their strong expression of belief that each of the Board's committees work well. It was specifically mentioned that the committees under the leadership of the professionals work well and the collegial nature of the members is excellent in fulfilling the fiduciary responsibilities of the members of the Committees and Board. Also commended was the high standard of committee process and work that is evident among all committees. One director expressed satisfaction with the changes to realign committee responsibilities, noting that Audit is now able to spend more time on substantive audit and financial issues and that the Governance Committee has dedicated substantial additional time to rules review. The consensus was that all of the committees are well run and the cross-participation provides synergy between the committees. One director noted that the Administrator's suggestion for an additional committee or sub-committee to focus just on the delivery of medical services is an excellent idea that should be explored.

**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	4.5
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The rating for this item for FY 2008 was 4.3. The directors generally believe that the Board is receiving the right level of information and conducting the right level of discussion on financial and audit issues. Several directors commented that the chief financial officer's reports and explanations provided a good comfort level in respect to understanding the financial position of the BWC. It was also noted that there is commendable transparency in the reports given on BWC's financial position and that questions that arise are addressed immediately. The improvement in the format and content of the Enterprise Report was also noted. One director warned against complacency and expressed the belief that, although the Board members are in a better place than they were when the Board started, the emphasis on continual education should not be forgotten.

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

Rating	4.5
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The rating for this item for FY 2008 was 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. Good information in advance and strong dialogue during our meetings were noted as particular strengths. One director noted that it would be helpful to have more informal interaction with staff, to get to know some of the people better and to better understand how each person contributes to the Board's work; it was also noted that this is a developing process.

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

Rating	4.6
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The rating for this item for FY 2008 was 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, all of which ultimately benefit Ohio's employers and workers. The ability of Chairman Lhota to promote a culture of openness for all Board members to provide input and create a constructive dialogue for sound and fully informed decision-making was commended. At least one director believes that this is a developing process that is headed in the right direction, but that more could be done.

**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	4.9
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The rating for this item for FY 2008 was 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 that attendance at Board and Committee meetings has been exceptional.

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

Some directors expressed that they did not see the need for any changes at this time. Others expressed specific comments, as follows:

- We need to address the perception that the Board is too responsive to staff recommendations.
- More frequent public hearings.
- Improvement in the follow-up and updates to the Board as a result of the public hearings, including the actions that staff has taken regarding the issues raised during these hearings.
- Having the opportunity during the Board’s open forums to interact with the presenters rather than just listen to their remarks. The open forums would be much more effective if Board members could ask questions and engage in dialogue with the presenters.
- If and when the Board decides to implement selective active management in the investment portfolio, we will need to provide for additional time for the Investment Committee to be educated, review performance and discuss critical investment options. The work in the Committees is detailed and intensive.
- The Committee Chairs seem to have information that the rest of the Committee doesn’t have, although this may be understandable as the Committee Chairs have to be informed prior to Committee meetings.

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 the Committee Chairs to include in their reports at the Board meetings a more fulsome summary of the matters discussed at the meetings, including information regarding the approximate length of the meeting and the number of non-Committee directors in attendance as well as a summary of the matters addressed with detail, where appropriate, indicating which items spurred robust discussion and providing summaries of those discussions. Further, it is encouraged that the Board minutes reflect this information with respect to each Committee report presented. As a substantial amount of time and effort is devoted by the directors and staff to the affairs of the BWC in Committee meetings, and as many non-Committee Board members are in attendance at the Committee meetings, the purpose of the foregoing recommendations is to provide more clarity and transparency as respects the contributions of the Committee deliberations to the overall decision-making process of the Board.
2. The Board would encourage continued attention to timely delivery of materials to the directors prior to Board and Committee meetings, and would recommend to the Administrator that Board materials that are not included with the monthly Board book due to timing constraints be transmitted to the directors at the earliest possible time thereafter via fax, email or other expedited means when and if appropriate.

3. The Board would encourage, at the public forums, interaction by the directors with the presenters where appropriate, such as asking of questions and engaging in dialogue, while keeping in mind the time limitations with respect to individual presenters.

4. The Board would encourage, at Committee meetings where technical information is being presented, that the presenters who are professionals in the area being discussed (e.g., actuarial, investments, audit) use terminology that is readily understandable to the directors in attendance who are not professionals in that area or, if technical terminology is used, to clearly define those technical terms to promote better understanding and more clarity in these presentations.

DRAFT

### 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	7/10/2009
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	7/10/2009
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	7/10/2009
4123-6-08	2009 Provider & Service Fee Schedule						x		Graff		Apr-09	3/15/09	4/10/09	4/2/09	10-Apr	28-Apr	29-May	
4123-14	Non-complying employer	6	x			x		Yes	D.C. Skinner	2008	May-09			4/30/09	8-May	29-May	29-Jun	7/10/2009
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	TBD	
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	TBD	
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	Jul-09		6/15/09	7/2/09	10-Jul	30-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	TBD	
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	July 2009	Notes
7/30/2009	1. Five Year Rule Review	
	2. Board advisory structure for medical issues	
Date	August 2009	
8/27/2009	1. Five Year Rule Review	
Date	September 2009	
9/23/2009	1. Five Year Rule Review	
	2. 2010 Inpatient Fee schedule	
9/24/2009	1. Governance Guidelines (1 <sup>st</sup> reading)	
	2. Committee Charters (1 <sup>st</sup> reading)	
Date	October 2009	
10/29/2009	1. Five Year Rule Review	
	2. 2010 ASC Fee Schedule	
Date	November 2009	
11/19/2009	1. Governance Guidelines (2nd reading)	
	2. Committee Charters (2nd reading)	
	3. 2010 Hospital Outpatient Fee Schedule	
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	1. Launch Administrator Review	

# 12-Month Governance Committee Calendar

Date	May 2010	Notes
5/27/2010	1. Finalize Administrator Review	
	2. Launch Board Self-assessment	
Date	June 2010	
	1. Finalize Board Self assessment	
	2. Committee Membership recommendations	
	3. Develop Education Plan	
	4. Administrator's objectives for FY11	