

**OBWC Board of Directors  
Board Medical Services**

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## **I. OBWC Focus on Medical Services**

The issues facing health care in the United States are both complex and of extreme importance to everyone. The subset of health care that is workplace injury prevention is facing similar challenges in today's environment. As we renew BWC's focus on medical services, BWC is ready for the challenge with seasoned staff and fresh leadership to make the changes that are needed to align our services with the current needs of our injured workers, employers and stakeholders.

While BWC does not provide direct medical care, we define the threshold for quality and cost-effective treatment for the benefit of both the workers and employers of the State of Ohio. The business model for policy development at BWC utilizes all available resources including the hard working staff of not only the medical services division but of the entire enterprise. Further, medical and claims policy is informed by the provider advisors on the pharmacy and therapeutics committee and the health care quality assurance advisory committee, advisors from Labor, Management, Government advisory council, the MCOs, academic research from around the country as well as our soon to be partnership with the OSU College of Public Health, stakeholder feedback, and finally, by the OBW Board of Directors (Board) itself.

With this policy development model, BWC is continuously updating our philosophy of optimal care through rules, policies, manuals, guidelines, and communication with our customers, stakeholders and internal staff. All the medical services processes and deliverables are subjected to this policy development rigor in areas including medical benefits and pricing, vocational rehabilitation services, pharmacy services, claims management, managed care services, provider credentialing and relations, and provider bill payment. Further Board support in this effort will only improve strategic medical policy development

## **II. Medical Services Designee(s)**

### **A. Introduction**

Through its rule making authority, the Board is the final decision maker for most substantial medical services programs provided by BWC. As an example, that has meant approving the benefit plan and fee schedule. However, many of the granular processes never make it to the Board level but nonetheless contribute to the final policy development.

The idea of creating a Board Designee for medical services sprang from the concept of involving the Board in some of these policy developments closer in time to the inception of an idea to address an issue. This concept has been shown to enhance any business model where the goal is to find the best solution for complex problems. This is accomplished through improved

communication channels, exchange of knowledge and expertise, and acknowledgment of alternative viewpoints.

While, for the Board Designee(s), it may require a large time commitment, it will also allow the development of deeper medical expertise in general and stronger knowledge of BWC medical services specifically. Sub-specialization is required to keep up and stay ahead in any highly technical industry, and medicine is perhaps the best example of that. A Board Designee(s) would certainly add value to medical policy development for both management and the Board.

## **B. Opportunities and Challenges**

### **1. Opportunities**

- a) Facilitates the concept of early exchange of resources
- b) Will develop a higher level of expertise in Board Designee(s)
- c) More efficient use of board resources than a committee
- d) May stimulate more frequent engagement between director(s) and management than other models

### **2. Challenges**

- a) Other board members do not benefit from the process (Although, a reporting requirement to the entire board ensures a complete communication loop and consensus decision making.)
- b) May be burdensome for one board member
- c) BWC-specific medical services knowledge could be lost as the Designee(s) term expires
- d) Presents potential for conflict of interest or perception of a conflict of interest. If a Board member is participating in the development of BWC practices that directly impact his/her constituent base, a conflict of interest may exist for that Board member. Although Board members must address strategic policy of the agency that can impact a constituent base, the Ethics Commission has determined that this inherent conflict of interest created by the statutory scheme of the Board of Directors does not necessarily preclude participation in decision-making processes of the Board. However, it is not equally clear that the Board member participation in the development of BWC practices is acceptable, or whether this type of Board member involvement creates undue influence at BWC.
- e) Increased potential for violation of Open Meetings Act through offline substantive discussion between BWC and Board member (acting on behalf of the Board) intended to

lead to official Board action. If only one Board member is involved with the development of BWC's granular day-to-day processes that lead to BWC medical services policy, then such involvement should be made clear (this may address Open Meeting Act concerns).

- f) Potential exists for overstepping director statutory duties through involvement in day-to-day operational matters.

### **C. Draft Structure of a Designee(s) Approach**

#### **OBWC Board of Directors Medical Services Designee(s)**

##### **Purpose**

The BWC Board Medical Services Designee(s) will assist the BWC Board of Directors (Board) and BWC management in the development of strategic policy as it relates to the provision of safe, cost-effective medical and vocational rehabilitation services for the mutual benefit of injured workers and employers. The Designee(s) serves as a conduit between the Board and management to address these medical services delivery challenges at the earliest opportunity. This will be accomplished through an exchange of information and an interchange of ideas to work toward a consensus on strategic medical and claims policy.

##### **Membership**

The Designee(s) will be a member(s) of the OBWC Board of Directors as determined by the Board.

##### **Duties and Responsibilities**

The Designee(s) shall have the responsibility for regularly communicating with BWC management to gain a more granular knowledge of BWC medical services and policy. In turn, the Designee(s) will communicate to management strategic advice on medical policy. The Designee(s) will report to the Board the date and substance of communications with BWC staff.

The exchange of information and policy discussion shall be in matters regarding the following BWC services:

- The composition of or improvement to BWC's medical provider network and practice guidelines;
- managed care and claims policies including the appropriate disability prevention delivery model;
- treatment guidelines, the benefit plan, formularies, and corresponding fee schedules;
- provider bill payment services, and
- outcome metrics for all of the above.

The Designee(s) appointment is not intended to preclude Board Member access to BWC staff nor, conversely, limit BWC staff access to the Board.

### **III. Medical Services Committee**

#### **A. Introduction**

The Board's charge to BWC's Medical Services Division was to evaluate ideas to leverage the Board's business experience and knowledge as BWC tackles future challenges. The focus of a distinct Board Committee for medical services will provide the Board an opportunity for a deeper understanding of medical information for effective policy development. It also shows a Board understanding of the complex issues that face workplace injury prevention and a commitment to a focus on medical issues. A committee focus would also encourage the board to utilize more of the BWC's resources as needed. (As an alternative, the creation of a medical services sub-committee of the Governance Committee could also be explored.)

While a committee approach could strain valuable Board resources, it could be argued that additional Board resources should be allocated to medical policy development consistent with the BWC mission to protect injured workers and employers from loss as a result of workplace injury. Further, a committee is consistent with the Board's approach for providing its resources toward managing other BWC responsibilities.

#### **B. Opportunities and Challenges**

##### **1. Opportunities**

- a) Greater degree of transparency of Board work
- b) Allows opportunity for more Directors to have direct input on policy-making for medical services
- c) Increased focus and visible commitment to medical issues by the Board

##### **2. Challenges**

- a) May cause a strain on limited Board resources
- b) Early involvement in medical issues by Board is more challenging.
- c) May not add material value over the current governance committee
- d) Potential exists for overstepping statutory duties through involvement in day-to-day operational matters.

## **C. Draft Structure of a Committee Approach**

### **OBWC Board of Directors Medical Services Committee Charter**

*(The purpose of this draft is to target for discussion the core requirements of a Medical Services committee. If adopted, a complete charter would be drafted by the committee members.)*

#### **Purpose**

The Medical Services Committee (Committee) will assist the OBWC Board of Directors (Board) in the development of strategic policy for the provision of safe, cost-effective medical and vocational rehabilitation services for the mutual benefit of injured workers and employers.

#### **Membership**

The Committee will consist of at least \_\_\_\_ Board members.

#### **Meetings**

The Committee shall meet as frequently as needed and will provide activity reports to the Board of Directors at the next regularly scheduled meeting.

#### **Duties and responsibilities**

The Committee shall have the responsibility for ensuring the appropriateness and oversight of policy regarding the following BWC services:

- The composition of or improvement to BWC's medical provider network and practice guidelines;
- managed care and claims policies including the appropriate disability prevention delivery model;
- treatment guidelines, the benefit plan, formularies, and corresponding fee schedules;
- provider bill payment services, and
- outcome metrics for all of the above.

## Medical Management of the Workers' Compensation Claim

Robert Coury, Chief of Medical Services and Compliance

Robert Balchick, Medical Director

## Presentation Objectives

- Briefly review the processes involved in claim management from the medical benefit perspective
  - *Statutorily active claims* = 1,291,455
  - *Active Claims* = 265,000
  - *Tx Auth (C-9s) filed* = 484,582
- Review model(s) to facilitate Board development of strategic medical services policy

## What Happens When an Injury Occurs? Key Process Steps

- Submission of First Report of Injury (FROI) and Medical Documentation
- Determination of Allowed Condition – Causally Related to the reported injury (BWC Function)
- Authorization and coordination of medical treatment consistent with appropriate treatment plan and BWC benefit plan (MCO Function)
  - Medical Case Management
- Alternative Dispute Resolution of Medical Treatment (MCO and BWC sequentially)
- Provider bill payment

## Provider Request for Medical Treatment Authorization

- Injured worker seeks medical treatment from provider of choice
- Medical Provider submits request to MCO together with the treating diagnosis and treatment plan

## MCO Process for Authorization of Medical Services

- Consistent with Miller Criteria (Ohio Supreme Court case (1994))
- Consistent with BWC Benefit Plan allowances
- Consistent with recognized treatment guidelines, for example, those published by the Work Loss Data Institute: “Official Disability Guidelines”

## Comprehensive Medical Case Management Services of MCO

- Certain high risk cases are assigned a medical case manager to work with the injured worker, the employer, and the provider to:
  - assist in treatment delivery
  - promote patient compliance
  - coordinate information
  - facilitate return to work planning
- Criteria for case selection – identify at risk cases
- MCO performs a complete assessment of the injured worker and interacts with BWC claim service office in developing claim management plan
- Vocational rehabilitation

## Medical Billing and Reimbursement

- Providers bill the appropriate MCO
- The bill adjudication process verifies accuracy and compensability
- MCO submits the bill with payment recommendation to BWC
- BWC applies additional edits to the bill and determines final payment; deposits payment into a dedicated MCO provider account; MCO makes provider payment

## **BWC Resources for Medical Policy Development**

- BWC Medical Services Policy Staff
- OSU College of Public Health
- Pharmacy and Therapeutics Committee
- Health Care Quality Assurance Advisory Committees,
- Labor, Management, Government advisory council
- Stakeholder feedback

## Goals for a Board of Directors- Medical Services Collaboration:

- Focus on the core process of delivery of medical services
- Leverage the knowledge and expertise of Board members
- Acknowledge alternative viewpoints
- Improve communication channels
- Allow transparency for our stakeholders

## Possible Models

- Board Designee
- Board Medical Services Committee
- Governance Sub-Committee

## Board Discussion

2009/2010 Committee assignments, Chairs and Vice-chairs are:

Director	Actuarial	Audit	Governance	Investment
Bryan, Charles	X (Chair)			
Caldwell, David	X			X
Falls, Alison			X (Chair)	X (Vice-Chair)
Haffey, Kenneth		X (Chair)		
Harris, James (Board Vice-chair)		X		X
Hummel, James	X		X	
Lhota, William (Board Chair)		X	X	
Matesich, James	X (Vice-chair)	X		
Pitts, Thomas	X		X	
Price, Larry			X (Vice-chair)	X
Smith, Robert		X (Vice-chair)		X (Chair)
<i>Total number of members</i>	5	5	5	5

For discussion purposes:

Director	Actuarial	Audit	Governance	Investment	Medical
Bryan, Charles	X (Chair)				
Caldwell, David	X			X	
Falls, Alison			X (Chair)	X (V-Chair)	
Haffey, Kenneth		X (Chair)		X ( <i>new</i> )	
Harris, James (Board Vice-chair)		X		X	X
Hummel, James	X		X		X
Lhota, William (Board Chair)		X	X		
Matesich, James	X (V-chair)	X			
Pitts, Thomas	X		X		X
Price, Larry			X (V-chair)	X	
Smith, Robert		X (V-Chair)		X (Chair)	
<i>Total number of members</i>	5	5	3	5	3

## Common Sense Business Regulation (BWC Rules)

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

### **Chapter 4123:1-5 Rules**

#### **Rule Review**

1.  The rule is needed to implement an underlying statute.  
Citation:   R.C. 4121.13
2.  The rule achieves an Ohio specific public policy goal.  
What goal(s):   Update and conform to national standards of employee safety in workshops and factories environment.
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.

Proposed changes were submitted to an external review committee consisting of stakeholders representing public and private Ohio employers and employees. The committee included representatives of the American Federation of Labor/Congress of Industrial Organizations, the Ohio Manufacturers Association, American Federation of State, County and Municipal Employees/Ohio Civil Service Employee's Association and the Ohio City/County Management Association. The committee held monthly meetings in April, May, and June of 2009 to review and comment on the proposed changes as well as recommend other appropriate changes that were not identified by DSH's technical advisors' unit.

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**  
**Occupational Safety and Health Rules for**  
**Workshops and Factories**

## **Introduction**

This executive summary outlines the results of the five-year rule review of the Specific Safety Requirements (SSRs) in Ohio Administrative Code (OAC) Chapter 4123:1-5, workshops and factories. The five-year review of all other OAC chapters containing SSRs has been completed. Specifically, the Board has reviewed and approved revisions to OAC Chapter 4123:1-1, operation of elevators, OAC Chapter 4123:1-3, construction, OAC Chapter 4123:1-7, metal casting, OAC Chapter 4123:1-9, steel mills, OAC Chapter 4123:1-11, laundering and dry cleaning, OAC Chapter 4123:1-13, rubber and plastic industries, OAC Chapter 4123:1-17, window cleaning, and OAC Chapter 4123:1-21, fire fighting.

## **Background Law**

The Ohio Constitution, Article II, Section 35 and R.C. 4121.13 empower the BWC to adopt rules which establish worker safety standards. Article II, Section 35 of the Ohio Constitution and R.C. 4121.47 both provide that an injury due to a violation of a specific safety requirement (VSSR) can result in an employer paying a 15% to 50% penalty added to the compensation payable to an injured worker.

The majority of the safety standards contained in Ohio Administrative Code 4123:1-5 on workshops and factories parallel comparable provisions set forth in the federal Occupational Safety and Health Administration (OSHA) regulations (29 C.F.R. 1910).

## **Proposed Changes**

A total of 154 distinct changes to Chapter 4123:1-5 are identified for consideration by the Board. Some of these changes are related to formatting or simply correct administrative code reference numbers. The greatest number of changes are proposed for OAC 4123:1-5-17 on personal protective equipment and OAC 4123:1-5-99.1 on toxic concentration, flash point, boiling point, explosive limits and vapor density of common flammable and toxic liquids and gases. Relative to personal protective equipment, the changes incorporate OSHA's guidelines on testing procedures for eye protection and hard hats, update the body harness and fall protection sections, and amend language regarding respiratory protection. For toxic chemicals, changes are proposed to the Occupational Exposure Limits (OEL) to make them consistent with OSHA's Permissible Exposure Limits (PEL). In some cases, this involves raising the current OEL to be consistent with OSHA's PEL.

## **Stakeholder Involvement**

The DSH's technical advisors unit reviewed OAC Chapter 4123:1-5 and drafted proposed updates and changes. Those changes were then submitted to an external review committee consisting of stakeholders representing public and private Ohio employers and employees. The

committee included representatives of the American Federation of Labor/Congress of Industrial Organizations, the Ohio Manufacturers Association, American Federation of State, County and Municipal Employees/Ohio Civil Service Employee's Association and the Ohio City/County Management Association. The committee held monthly meetings in April, May, and June of 2009 to review and comment on the proposed changes as well as recommend other appropriate changes that were not identified by DSH's technical advisors' unit. Craig Mayton, BWC legal counsel, participated in the committee meetings to address legal questions. Director James Harris, member of BWC's Board of Directors, observed the Committee's May 5, 2009 meeting. The guiding principles used by the assigned technical advisors and the external stakeholders to reach consensus relative to proposed changes were: (1) a commitment to provide clear SSR's for safe workplaces; and (2) the desire to update the rules consistent with current recognized industry standards (such as the American National Standards Institute) and OSHA regulations. Attached is correspondence from the respective stakeholders which expresses their agreement with and support for the proposed changes.

### **Acknowledgements**

The Bureau of Worker's Compensation would like to acknowledge the outstanding contributions of the following individuals and organizations to the review process:

Ms. Dianne Grote Adams from the Ohio Manufacturers Association

Mr. David Anderson from the Ohio City/County Management Association

Ms. Sandra Bell from the American Federation of State, County and Municipal Employees/Ohio Civil Service Employee's Association

Mr. William Crooks from the American Federation of Labor/Congress of Industrial Unions

Mr. David Packer from the American Federation of State, County and Municipal Employees/Ohio Civil Service Employee's Association

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
		<b>4123:1-5-01 Scope and Definitions</b>		
1	4123:1-5	Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference
2	4123:1-5-01(A)	The purpose of this Chapter of the Administrative Code is to provide reasonable safety for life, limb, and health of employees. In cases of practical difficulty or unnecessary hardship, the Ohio bureau of workers' compensation may grant exceptions from the literal requirements of the rules of this chapter to permit the use of other devices or methods when, in the opinion of the bureau, the equivalent protection if thereby secured.	The purpose of this Chapter of the Administrative Code is to provide reasonable safety for life, limb, and health of employees. In cases of practical difficulty or unnecessary hardship, the Ohio bureau of workers' compensation may grant exceptions from the literal requirements of the rules of this chapter to permit the use of other devices or methods when, in the opinion of the bureau, the equivalent protection if <u>is</u> thereby secured.	Typo corrected ("if" to "is").
3	4123:1-5-01(B)(47)	"Exposed to contact" : the location of the material or object which, during the course of operation, is accessible to an employee in performance of his regular or assigned duty.	"Exposed to contact" : the location of the material or object which, during the course of operation, is accessible to an employee in performance of <u>the his-employee's</u> regular or assigned duty.	Language made gender neutral.
4	4123:1-5-01(B)(131)	"Standard guard railing" : a substantial barrier, constructed in accordance with paragraph (E) of rule 4121:1-5-02 of the Administrative Code.	"Standard guard railing" : a substantial barrier, constructed in accordance with paragraph (E) of rule <del>4121</del> 4123:1-5-02 of the Administrative Code.	Typo corrected; deleted rule chapter number 4121 and replaced it with 4123 for correct agency reference.
		<b>4123:1-5-02 Guarding Floor and Wall Openings</b>		
5	4123:1-5-02 (C)(3)(a)(i)	(i) Wall openings shall be guarded by standard railings and toeboards, or with doors or gates or substantial screens which shall extend to a minimum height of fort-two inches measured from the floor or platform level.	(i) Wall openings shall be guarded by standard railings and toeboards, or with doors or gates or substantial screens which shall extend to a minimum height of <u>forty-two</u> inches measured from the floor or platform level.	Typo corrected ("fort-two" to "forty-two")
6	4123; 1-5-02 (C) (3)(b) Wall hole - guarding	Where the is a hazard of materials falling through a wall hole, and the lower edge of the near side of the hole is less than four inches above the floor, and the far side of the hole more than five feet above the next lower level, the hole shall be guarded by a toeboard, or an enclosing screen either of solid construction, or as specified in rule 4124:1-5-99 of the Administrative Code.	Where <u>there</u> is a hazard of materials falling through a wall hole, and the lower edge of the near side of the hole is less than four inches above the floor, and the far side of the hole more than five feet above the next lower level, the hole shall be guarded by a toeboard, or an enclosing screen either of solid construction, or as specified in rule 4123:1-5-99 of the Administrative Code.	Typo corrected ("the" to 'there"; 4121 to 4123)

**OAC 4123:1-5**

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
7	4123:1-5-02 (D) Elevated Platforms, runways and walkways (1) (a)	Elevated platforms, runways and walkways six feet or more above floor or ground level shall be guarded with standard railings and toeboards. All elevated runways, platforms and walkways, regardless of height, located over or adjacent to water, machinery, open vats, open soaking pits or open tanks shall be provided with standard railing and toeboards.	Elevated platforms, runways and walkways <del>six</del> <b>four</b> feet or more above floor or ground level shall be guarded with standard railings and toeboards. All elevated runways, platforms and walkways, regardless of height, located over or adjacent to water, machinery, open vats, open soaking pits or open tanks shall be provided with standard railing and toeboards.	ANSI Std A1264.1-2007 section 5.1 and 29 CFR 1910.23.C (1) [OSHA] general industry rule is 4 feet External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
8	4123:1-5-02 (D) Elevated Platforms, runways and walkways (3) Openings (drainage, ventilation, etc.)	Openings for drainage, ventilation, etc. in floors, elevated runways, platforms and walkways six feet or more above floor or ground level where employees are required to work below, shall not be greater than one inch in width.	Openings for drainage, ventilation, etc. in floors, elevated runways, platforms and walkways <b>four</b> feet or more above floor or ground level where employees are required to work below, shall not be greater than one inch in width.	ANSI Std A1264.1-2007 section 5.2 and 29 CFR 1910.23.C (1)[OSHA] general industry rule is 4 feet External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
9	4123:1-5-02(E)(1)	Top rail and uprights, <del>one-and-one-fourth-inch diameter pipe,</del> or one-and-one-half by one-and-one-half by three-sixteenths-inch angle; intermediate rail, one-by one-fourth-inch bar. Upright spacing not to exceed eight feet.	<b><u>Top rail and intermediate railings, one-and-one-half-inch nominal diameter pipe, or two by two by three-eighths-inch angle. Upright spacing not to exceed eight feet</u></b>	29 CFR 1910.23(e)(3)(ii) [OSHA] 29 CFR 1910.23(e)(3)(iii) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
10	4123:1-5-02(E) Standard Guardrailings, intermediate rail and toeboards (2)Wood	Top rail and uprights shall not be less than one and nine-sixteenths by three and nine-sixteenths inches; intermediate rails shall be not less than nine-sixteenths by five and nine-sixteenths inches. Uprights shall be spaced not to exceed six feet center to center. These measurements are net finished dimensions.	Top rail and uprights shall not be less than <del>two inches by four inches (nominal ) stock</del> , intermediate rails shall be not less than <del>two inches by four inches (nominal ) stock</del> . Uprights shall be spaced not to exceed six feet center to center. These measurements are net finished dimensions.	2x4 nominal size is consistent with OAC Chapter 3 Floors, stairways, railing and 29 CFR1910.23(e)(3)(i) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
11	4123:1-5-02 (E) Standard Guardrailings, intermediate rail and toeboards (3)Toeboards	“Toeboard” means a barrier not less than four inches in height, placed along the edge of a scaffold, platform, runway, floor opening, etc., and securely fastened thereto, with clearance between the bottom of the toeboard and the floor or platform level, not exceeding one-half inch.	A standard toeboard shall be 4 inches nominal in vertical height from its top edge to the level of the floor, platform, runway, or ramp. It shall be securely fastened in place and with not more than 1/4-inch clearance above floor level. It may be made of any substantial material either solid or with openings not over 1 inch in greatest dimension. Where material is piled to such height that a standard toeboard does not provide protection, paneling from floor to intermediate rail, or to top rail shall be provided.	ANSI A1264.1-2007 Section 5.7. Consistent with OAC Chapter 3 Floors, stairways, railings and 29 CFR 1910.23(e)(4) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
12	4123:1-5-02 (I) Handrails	Handrails shall be free of protruding nails or screws and not less than thirty inches, nor more than forty-two inches in height measured vertically above the line in the top surface of the tread over the face of the riser.	Handrails shall be free of protruding nails or screws and not less than thirty inches, nor more than <del>thirty- four</del> inches in height measured vertically above the line in the top surface of the tread over the face of the riser.	ANSI A1264.1-2007 Section 5.8 External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
		<b>4123:1-5-03 Ladders and scaffolds</b>		
13	4123:1-5-03(C)(2)(d)	Conductive or metal ladders shall be prominently marked as Conductive."	Conductive or metal ladders shall be prominently marked as "Conductive."	Quotation mark added.

## OAC 4123:1-5

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
14	4123:1-5-03(C)(4)(a) Stepladders height	Step ladders shall not exceed twenty feet in height.	Step ladders shall not exceed twenty feet in <u>length</u> .	OSHA rule references length, not height. Height is difficult to measure, whereas length can be measured with the stepladder lying on the ground. 29 CFR 1910.26(a)(3)(iii) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
15	4123:1-5-03(C)(4)(b) Spreader	A substantial spreader shall be provided on step ladders to hold the front and back sections in open position	A <u>metal</u> spreader shall be provided on step ladders to <u>securely</u> hold the front and back sections in open position	The OSHA rule is specific that the spreader must be metal and securely hold the front and back sections open. 29 CFR 1910.26(a)(3)(viii) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
16	4123:1-5-03(C)(5)(a) Length	Sectional ladders shall not exceed thirty-seven feet in extended length.	Sectional ladders shall not exceed <u>sixty</u> feet in extended length.	OSHA allows ladders to be up to sixty feet in length. 29 CFR 1910.26(a)(2)(ii) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

## OAC 4123:1-5

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
17	4123:1-5-03(C)(6) Fixed ladders height	All fixed ladders twenty feet or more in length shall be equipped with a ladder cage or ladder well. This requirement does not apply to ladders on smokestacks, towers, tanks, manholes, or bins used for storage or permanent fire ladders.	All fixed ladders <u>more than</u> twenty feet in length shall be equipped with a ladder cage or ladder well. <u>This requirement does not apply to chimney ladders.</u>	29 CFR 1910.27(d)(1)(i) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
18	4123:1-5-03(C)(6)(a)(i)	The minimum step-across distance shall be two and one-half inches. (See figure 4121:1-5-03(C)(6)(a)(i) to this rule.)	The minimum step-across distance shall be two and one-half inches. (See figure 4123:1-5-03(C)(6)(a)(i) to this rule.)	Typo corrected ; Changed chapter number from 4121 to 4123 to show correct agency affiliation.
19	4123:1-5-03(C)(6)(f)(i)	The pitch of fixed shall come in the range of seventy-five degrees and ninety degrees with the horizontal. (See figure 4123:1-5-03 (C)(6)(f)(i) of this rule).	The pitch of fixed <u>ladders</u> shall come in the range of seventy-five degrees and ninety degrees with the horizontal. (See figure 4123:1-5-03 (C)(6)(f)(i) of this rule).	Added missing word "ladders".
20	4123:1-5-03(C)(6)(g)(ii)(e)	Ferrous metal steps not painted or treated or resist corrosion shall have a minimum cross-sectional <u>dimension of one inch</u>	Ferrous metal steps not painted <u>or</u> treated <u>to</u> resist corrosion shall have a minimum cross-sectional <u>dimension of one inch</u>	Changed "or" to "to."
21	4123:1-5-03(C)(8)(a)	The width between the side rails a the the base of the trestle ladder and base sections of the extension trestle ladder shall be not less than twenty-one inches for all ladders and sections up to and including six feet.	The width between the side rails <u>at</u> the <del>the</del> base of the trestle ladder and base sections of the extension trestle ladder shall be not less than twenty-one inches for all ladders and sections up to and including six feet.	Changed "a" to "at", deleted duplicate "the"
22	4123:1-5-03(D)(1)(a)(ii) Dimensions, structural	Planks used in scaffolds shall be a minimum width of ten inches and a minimum thickness of two inches, scaffold grade, and shall be straight, close grained and free of visible defects, such as large knots, decay and shakes. Wooden materials of different sectional dimensions of equal strength or other material of equal strength may be used.	Planks used in scaffolds shall be a minimum width of <u>nine</u> inches and a minimum thickness of two inches, scaffold grade, and shall be straight, close grained and free of visible defects, such as large knots, decay and shakes. Wooden materials of different sectional dimensions of equal strength or other material of equal strength may be used.	OSHA sets the minimum width to be 9 inches. 29 CFR 1910.28(a)(9) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

## OAC 4123:1-5

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
23	4123:1-5-03(D)(1)(c)(iii)	(iii) When it is not practicable to install and use standard guard railing for employee protection on a scaffolds, as required by this paragraph, safety belts which are properly secured to a lanyard and lifeline or a safety net properly installed, may be used instead of standard guard railings.	(iii) When it is not practicable to install and use standard guard railing for employee protection on a <u>scaffold</u> , as required by this paragraph, <u>safety harnesses</u> which are properly secured to a lanyard and lifeline or a safety net properly installed, may be used instead of standard guard railings.	External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
24	4123:1-5-03(D)(1)(d)	Side screen shall be provided on all scaffolds more than ten feet in height that are adjacent to passageways, or where employees are employed within ten feet of the base of the scaffold, and where material is piled adjacent to and higher than toeboards. As a minimum, side screens shall be as high as the maximum height of material to be stored or piled on the scaffold. Side screens shall be made of substantial expanded metal or wire netting not larger than one-half-inch mesh, or other equivalent material, securely fastened in place.	<u>Scaffolds shall be provided with a screen between the toeboard and the guardrail, extending along the entire opening, consisting of No. 18 gauge U.S. Standard Wire one-half-inch mesh or the equivalent, where persons are required to work or pass under the scaffolds. At a minimum, side screens shall be as high as the maximum height of material to be stored or piled on the scaffold. Side screens on scaffolds shall consist of No. 18 gauge U.S. Standard Wire one-half-inch mesh or the equivalent.</u>	29 CFR 1910.28(a)(17) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
25	4123:1-5-03(D)(1)(e)	At least one ladder or ramp shall be provided for access to stationary scaffolds four feet or more in height with the exception of suspended or swinging scaffold.	An access ladder or equivalent safe access shall be provided.	29 CFR 1910.28(a)(12) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
26	4123:1-5-03(D)(1)(j)(ii)	Only treated or protected fiber rope or its equivalent shall be used for on near any work involving the sue of corrosive substances or chemicals.	Only treated or protected fiber rope or its equivalent shall be used for, <u>on or</u> near any work involving the <u>sue use</u> of corrosive substances or chemicals.	Typo corrected ; Changed chapter number from 4121 to 4123 to show correct agency affiliation.
27	4123:1-5-03(D)(1)(k)	The sue of shore scaffolds or lean-to scaffolds is prohibited.	The <u>sue use</u> of shore scaffolds or lean-to scaffolds is prohibited.	Typo corrected (sue to use).
28	4123:1-5-03(D)(1)(m)	Scaffolds shall be secured to permanent structures, through use of anchor bolts, reveal bolts, or other equivalent means. Window cleaners' anchor bolts shall not be used.	Scaffolds shall be secured to permanent structures, through use of anchor bolts, reveal bolts, or other equivalent means. Window cleaners' anchor <u>bolts belts</u> shall not be used.	Spelling error (belts to bolts).

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
29	4123:1-5-03(D)(2)	Manually propelled mobile work platforms (ladder stands) and rolling platforms (towers) shall support at least four times the designed working load. The assembled components of all mobile work platforms (ladder stands) and rolling platforms (towers) shall provide a factor of safety of not less than four. Exposed surfaces shall be free sharp edges, burrs, or other <del>projecting parts</del>	Manually propelled mobile work platforms (ladder stands) and rolling platforms (towers) shall support at least four times the designed working load. The assembled components of all mobile work platforms (ladder stands) and rolling platforms (towers) shall provide a factor of safety of not less than four. Exposed surfaces shall be free <u>from</u> sharp edges, burrs, or other <del>projecting parts</del>	Missing word added (free "from").
30	4123:1-5-03(D)(2)(h)	Only the manufacturer of the scaffold or <del>his</del> qualified designated shall be permitted to erect or supervise the erection of scaffolds exceeding fifty feet in height above the base, unless such a structure is approved in writing by a licensed professional engineer, or erected in accordance with instructions furnished by the <del>manufacturer.</del>	Only the manufacturer of the scaffold or <u>its</u> qualified <del>designated</del> <u>designee</u> shall be permitted to erect or supervise the erection of scaffolds exceeding fifty feet in height above the base, unless such a structure is approved in writing by a licensed professional engineer, or erected in accordance with instructions furnished by the <del>manufacturer.</del>	Typo corrected (designated to designee) and gender neutral (his to its)
		<b>4123:1-5-04 Mechanical power transmission apparatus</b>		
31	4123:1-5-04(C)(1)(a)	(a) If upper part of belt is seven feet or less from floor level, the belt or pulley shall be enclosed on top, sides and ends. Note: In power or power development plants a standard guard railing may be used in lieu of this requirement.	<u>Where both runs of horizontal belts are seven feet or less from the floor level, the guard shall extend to at least fifteen (15) inches above the belt or to a standard height, except that where both runs of a horizontal belt are 42 inches or less from the floor, the belt shall be fully enclosed in accordance with rule 4123:1-5-99 of the Administrative Code. Note: In power or power development plants a standard guard railing may be used in lieu of this requirement.</u>	This change was necessary because compliance with OSHA could violate OAC. Extending a guard 15 inches above the belt is as effective but not the same as "enclosed on top". 29 CFR 1910.219(e)(1)(i)[OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
32	4123:1-5-04(C)(1)(b)	4121:1-5-99	4123:1-5-99	4121 is now 4123.
33	4123:1-5-04(C)(2)	4121:1-5-99	4123:1-5-99	4121 is now 4123.
34	4123:1-5-04(D)(1)(a)	...This does not apply to adjusting gears which do not normally revolve and are not power operated, or to adjusting gears which requires access to the gears for manual manipulation.	...This does not apply to adjusting gears which do not normally revolve and are not power operated, or to adjusting gears which require <del>s</del> access to the gears for manual manipulation.	Typo corrected.
35	4123:1-5-04(D)(1)(b)	4121:1-5-99	4123:1-5-99	4121 is now 4123.

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
36	4123:1-5-04(E)(2)	4121:1-5-99	4123:1-5-99	4121 is now 4123.
37	4123:1-5-04(E)(8)(C)	When the upper rim of fly wheel protrude through a working floor, it shall be entirely enclosed or surrounded by a standard guard railing and toeboard.	When the upper rim of a fly wheel protrudes through a working floor, it shall be entirely enclosed or surrounded by a standard guard railing and toeboard.	Added missing word ("a" flywheel). Also changed "protrude" to "protrudes"
		<b>4123:1-5-05 Auxiliary Equipment</b>		
38		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference
		<b>4123:1-5-06 Portable explosive-actuated fastening tools</b>		
39	Table 4121:1-5-06(E)		Reformat the table for legibility.	
		<b>4123:1-5-07 Hand tools, hand-held portable powered tools, other hand-held equipment and portable safety containers</b>		
40	4123:1-5-07(H)(1)	Hand-held, power-driven woodworking tools shall be provided with a dead-man control, such as a spring actuated switch, valve, or equivalent device, so that the power will be automatically shut off whenever the operator release the control.	Hand-held, power-driven woodworking tools shall be provided with a dead-man control, such as a spring actuated switch, valve, or equivalent device, so that the power will be automatically shut off whenever the operator releases the control.	Typo corrections ("release" to "releases").
41	4123:1-5-07(H)(3) Use of Compressed Air	The employer shall instruct the employer that compressed air shall not be used	The employer shall instruct the employees that compressed air shall not be used <u>to clean themselves off.</u>	The rule specifies that personal cleaning of the body of employees, not the employer, is not permitted.29CFR 1917.154 [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
42	4123:1-5-07(M) Portable Safety Containers	Portable safety containers shall be provided for handling flammable liquids with a flash point (closed cup) below 138.2 degrees Fahrenheit in quantities of one gallon or more. The containers shall be legibly marked "flammable".	Portable safety containers shall be provided for handling flammable liquids with a flash point (closed cup) below <del>138.2</del> <u>100</u> degrees Fahrenheit in quantities of one gallon or more. The containers shall be legibly marked "flammable".	The definition of a flammable liquid by both OSHA and NFPA is below 100 degrees Fahrenheit, not 138.2. 29 CFR 1910.106(a)(19) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
		<b>4123:1-5-08 Power-driven saws and knives</b>		
43	4123:1-5-08(C) Bandsaws, band resaws, and band knives	All portions of the saw blade or band blade shall be enclosed or guarded, except for the working portion of the blade between the bottom of the guide rolls and the table. Bandsaw wheels shall be fully enclosed. The outside of periphery of the enclosure shall be solid. The front and back of the band wheels shall be either enclosed by solid material, or by wire mesh, or perforated metal, <del>the dimensions and material of which shall be in accordance with rule 4121:1-5-99 of the Administrative Code.</del>	All portions of the saw blade or band blade shall be enclosed or guarded, except for the working portion of the blade between the bottom of the guide rolls and the table. Bandsaw wheels shall be fully enclosed. The outside of periphery of the enclosure shall be solid. The front and back of the band wheels shall be either enclosed by solid material, or by wire mesh, or perforated metal. <u>Such mesh or perforated metal shall be not less than 0.037 inch (U.S. Gage No. 20), and the openings shall be not greater than three-eighths inch.</u>	Remove reference to table 1-5-99 of the Administrative Code as it is in direct conflict with OSHA. Insert specific guarding specs from OSHA. OSHA reference: 29 CFR 1910.213(i)(1) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
44	4123:1-5-08(D)(2)(a)	A hood-type guard shall be provided but need not rest upon the table nor upon the material being cut, but shall extend to a line not more than three-eighths of an inch above the plane formed by the bottom of the top feed rolls.	A hood-type guard shall be provided but need not rest upon the table nor upon the material being cut, but shall extend to a line not more than three-eighths of an inch above the plane formed by the bottom of the top feed rolls. <u>This distance (three-eighths inch) may be increased to three-fourths inch, provided the lead edge of the hood is extended to be not less than 5 ½ inches in front of the nip point between the front roll and the work.</u>	This exception exists in OSHA and causes discrepancy. Add OSHA exception. OSHA reference: 29 CFR 1910.213(f)(1) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
45	4123:1-5-08(D)(3)(a)	A hood-type guard shall be provided that will cover the exposed portion of the saw blade. When in use the hood-type shall automatically adjust to the thickness of and remain in contact with the material being cut when the stock encounters the saw, or may be a fixed or manually adjusted hood or guard, provided the space between the bottom of the guard and the material being cut does not exceed three-eighths of an inch at any time. <del>This requirement shall not apply to circular cross-cut saws with stationary tables where the saw moves forward when cutting.</del>	A hood-type guard shall be provided that will cover the exposed portion of the saw blade. When in use the hood-type shall automatically adjust to the thickness of and remain in contact with the material being cut when the stock encounters the saw, or may be a fixed or manually adjusted hood or guard, provided the space between the bottom of the guard and the material being cut does not exceed three-eighths of an inch at any time.	This exception is not mentioned in OSHA. Recommend deleting. OSHA reference: 1910.213(d)(1) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
46	4123:1-5-08(C)(5)(a)	Each swing cutoff saw shall be provided with a hood that will completely enclose the upper half of the saw the arbor end, and the point of operation at all positions of the saw.	Each swing cutoff saw shall be provided with a hood that will completely enclose the upper half of the saw <u>at</u> the arbor end, and the point of operation at all positions of the saw.	Added missing word ("at" the arbor end).

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
		<b>4123:1-5-09 Wood working machinery</b>		
47		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference
		<b>4123:1-5-10 Mechanical power presses</b>		
48	4123:1-5-10(C)(5)(e)(vii)	Where presses are provided with a selection method of foot or hand controls the selection shall be made by a designated employee and controls other than those selected shall be inoperable.	<u>If foot control is provided, the selection method between hand and foot control shall be separate from the stroking selector and shall be designed so that the selection may be supervised by the employer.</u>	Control by employer. 29 CFR 1910.217(b)(7)(ix) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
49	4123:1-5-10(C)(10) Pressure Vessels	All pressure vessels used in conjunction with power presses shall conform to the requirements of the Ohio department of industrial relations, board of building standards.	<u>All pressure vessels used in conjunction with power presses shall conform to the American Society of Mechanical Engineers Code for Pressure Vessels, 1968 Edition.</u>	Change to agree with OSHA and move to ASME standard for pressure vessels rather than Industrial Relations. 29 CFR 1910.217(b)(12) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
50	4123:1-5-10(D)(3)(c)(v) Safety Distance	The safety distance (Ds) from the sensing field to the point of operation shall be greater than the distance determined by the following formula: $D_s = 63 \text{ inches/second} \times T_s$ ; where: $D_s$ = minimum safety distance (inches); 63 inches/second = hand speed constant; and $T_s$ = stopping time of the press measured at approximately 90° of crankshaft rotation (seconds).	<p>The safety distance (D(s)) from the sensing field to the point of operation shall be greater than the distance determined by the following formula:</p> <p><math>D(s) = 63 \text{ inches/second} \times T(s)</math></p> <p>where:</p> <p><math>D(s) = \text{minimum safety distance (inches); } 63 \text{ inches/second} = \text{hand speed constant;}</math></p> <p>and</p> <p><math>T(s) = \text{stopping time of the press measured at approximately } 90 \text{ degree position of crankshaft rotation (seconds).}</math></p>	<p>Bringing formulas into agreement and correcting typos. 29 CFR 1910.217(c)(3)(iii)(e) [OSHA] External Stakeholder Agreement</p> <p>Date : April 13, 2009</p> <p>In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association )</p> <p>Objecting : None</p>
51	4123:1-5-10(D)(3)(g)(iii) Safety Distance	The safety distance (Ds) from the sensing field to the point of operation shall be greater than the distance determined by the following formula: $D_s = 63 \text{ inches/second} \times T_s$ ; where: $D_s$ = minimum safety distance (inches); 63 inches/second = hand speed constant; and $T_s$ = stopping time of the press measured at approximately 90° of crankshaft rotation (seconds).	<p>The safety distance (D(s)) from the sensing field to the point of operation shall be greater than the distance determined by the following formula:</p> <p><math>D(s) = 63 \text{ inches/second} \times T(s)</math></p> <p>where:</p> <p><math>D(s) = \text{minimum safety distance (inches); } 63 \text{ inches/second} = \text{hand speed constant;}</math></p> <p>and</p> <p><math>T(s) = \text{stopping time of the press measured at approximately } 90 \text{ deg. position of crankshaft rotation (seconds).}</math></p>	<p>Reformatting text and correcting typos</p>

**OAC 4123:1-5**

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
52	4123:1-5-10(D)(3)(h)(iii) Safety Distance	(iii) The safety distance (Dm) between the two-hand trip and the point of operation shall be greater than the distance determined by the following formula: $Dm = 63 \text{ inches/second} \times Tm$ ; where: Dm= minimum safety distance (inches); 63 inches/second = hand speed constant; and Tm= the maximum time the press takes for the die closure after it has been tripped (seconds). (iv) For full revolution clutch presses with only one engaging point, T mis equal to the time necessary for one and one-half revolutions of the crank shaft. For full revolution clutch presses with more than one engaging point, Tmshall be calculated as follows: 1 time necessary to complete $Tm = \{ ? + \frac{1}{\text{Number of engaging crankshaft (seconds) points per revolution}} \} \times \text{one revolution of the crankshaft}$	<u>The safety distance (D(m)) between the two hand trip and the point of operation shall be greater than the distance determined by the following formula: <math>D(m) = 63 \text{ inches/second} \times T(m)</math>; where: D(m) = minimum safety distance (inches); 63 inches/second=hand speed constant; and T(m) = the maximum time the press takes for the die closure after it has been tripped (seconds). For full revolution clutch presses with only one engaging point T(m) is equal to the time necessary for one and one-half revolutions of the crankshaft. For full revolution clutch presses with more than one engaging point, T(m) shall be calculated as follows: <math>T(m) = [1/2 + (1 \text{ divided by Number of engaging points per revolution})] \times \text{time necessary to complete one revolution of the crankshaft (seconds)}</math>.</u>	Reformatting text and correcting typos
		<b>4123:1-5-11 Forging machines, other power machines and machine tools, hydraulic and pneumatic presses, and power press brakes.</b>		
53	4123:1-5-11(C)(2)(a) Safety Cylinder Head	Steam or air hammers shall have a steam cushion, air cushion, spring head, or other effective means to prevent the piston from striking the top cylinder head.	<u>Every steam or airhammer shall have a safety cylinder head to act as a cushion if the rod should break or pull out of the ram.</u>	Agreement with OSHA. 29 CFR 1910.218(d)(1) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

## OAC 4123:1-5

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
54	4123:1-5-11(C)(2)(b) Shutoff Valve	Steam or air hammers shall be provided with a stop valve in the admission pipe line, which can be locked in closed position. The stop valve shall be within easy reach of the operator.	<u>Steam hammers shall be provided with a quick closing emergency valve in the admission pipeline at a convenient location. This valve shall be closed and locked in the off position while the hammer is being adjusted, repaired, or serviced, or when the dies are being changed.</u>	Agreement with OSHA. 29 CFR 1910.218(d)(2) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
55	4123:1-5-11(C)(4)(a) Board-type drophammers Guarding	A guard shall be provided around the boards above the rolls. This requirement shall not apply to hammers that have a clamp.	<u>A suitable enclosure shall be provided to prevent damaged or detached boards from falling. The board enclosure shall be securely fastened to the hammer.</u>	Agreement with OSHA. 29 CFR 1910.218(e)(2)(i) [OSHA] External Stakeholder Agreement Date : April 13, 2009 In Agreement : Diane Grote Adams (OMA), Sandra Bell (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
56	4123:1-5-11(D)(7)(b) Exception	Machinery covered expressly by requirements contained in other codes of specific requirements of the industrial commission of Ohio.	Machinery covered expressly by requirements contained in other codes of specific requirements of the <u>Ohio bureau of workers' compensation.</u>	Correct agency name
57	4123:1-5-11(D)(8)(b)	Machinery covered expressly by requirements contained in other codes of specific requirements of the industrial commission of Ohio.	Machinery covered expressly by requirements contained in other codes of specific requirements of the <u>Ohio bureau of workers' compensation.</u>	Correct agency name
58	4123:1-5-11(D)(10)(b)	Machinery covered expressly by requirements contained in other codes of specific requirements of the industrial commission of Ohio.	Machinery covered expressly by requirements contained in other codes of specific requirements of the <u>Ohio bureau of workers' compensation.</u>	Correct agency name
59	4123:1-5-11(D)(13)(b)	Machinery covered expressly by requirements contained in other codes of specific requirements of the industrial commission of Ohio.	Machinery covered expressly by requirements contained in other codes of specific requirements of the <u>Ohio bureau of workers' compensation.</u>	Correct agency name
		<b>4123:1-5-12 Abrasive grinding and cutting, polishing and wire buffing equipment</b>		
60		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
		<b>4123:1-5-13 Motor vehicles, mobile mechanized equipment, and marine operations</b>		
61	4123:1-5-13(C) General requirements for motor vehicles and mobil mechnaized equipment (3)	Equipment parked on inclines shall have the brakes set, and the blade, bucket,etc., fully lowered if the equipment is unattended (out of sight or more than twenty feet from the operator)	Equipment parked on inclines shall have the brakes set, and the blade, bucket,etc., fully lowered if the equipment is unattended (out of sight or more than twenty-five feet from the operator)	OSHA 1910.178, ANSI B56.1-2005, Section 5.2.10. OAC is more restrictive. Change twenty to twenty-five External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
62	4123:1-5-13 (C) General requirements for motor vehicles and mobil mechnaized equipment (5)	(5) All equipment which can contact power lines shall also comply with the requirements of paragraph (D) of rule 4121:1-5-23 of the Administrative Code.	(5) All equipment which can contact power lines shall also comply with the requirements of paragraph (D) of rule 4123:1-5-23 of the Administrative Code.	Change 4121 references to 4123. No other changes recommended.
63	4123:1-5-13 (D) Overhead protection (2)(a)	Where materials being handled are of such dimensions that objects could fallthrough the above protection, then substantial guarding, such as expanded metal, woven wire, or simular materials, shall be used in addition to the above (see rule 4121:1-5-99 of the Administrative Code).	Where materials being handled are of such dimensions that objects could fall through the above protection, then substantial guarding, such as expanded metal, woven wire, or simular materials, shall be used in addition to the above (see rule 4123:1-5-99 of the Administrative Code).	Change 4121 references to 4123. No other changes recommended.
		<b>4123:1-5-14 Power-Driven Cranes and Hoists</b>		

## OAC 4123:1-5

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
64	4123:1-5-14(C)(1)(a)	A brake designed to hold the maximum rated load at any point of the lift shall be provided on the hoist. A brake shall also be provided for the bridge.	<u> Holding brakes for hoist motors shall have not less than the following percentage of the full load hoisting torque at the point where the brake is applied. • 125 percent when used with a control braking means other than mechanical. • 100 percent when used in conjunction with a mechanical control braking means. • 100 percent each if two holding brakes are provided. Holding brakes on hoists shall be applied automatically when power is removed. </u>	Agreement with OSHA. 29 CFR 1910.179(f)(2) [OSHA] External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
65	4123:1-5-14(C)(1)(b)	A footwalk with standard guard railing and <del>toeboards</del> shall be placed along the cab access side of the bridge.	A footwalk with standard guard railing and <u>toeboards</u> shall be placed along the cab access side of the bridge.	Spelling error ("toeborads" to "toeboards")
66	4123:1-5-14(C)(1)(d)	Bumpers shall be provided on crane bridge to reduce effects of collision. Bumpers shall also be provided when two trolleys are operated on the same rails.	<u> A crane shall be provided with bumpers or other automatic means providing equivalent effect, unless the crane travels at a slow rate of speed and has a faster deceleration rate due to the use of sleeve bearings, or is not operated near the ends of bridge and trolley travel, or is restricted to a limited distance by the nature of the crane operation and there is no hazard of striking any object in this limited distance, or is used in similar operating conditions. The bumpers shall be capable of stopping the crane (not including the lifted load) at an average rate of deceleration not to exceed 3 ft/s/s when traveling in either direction at 20 percent of the rated load speed. A trolley shall be provided with bumpers or other automatic means of equivalent effect, unless the trolley travels at a slow rate of speed, or is not operated near the ends of bridge and trolley travel, or is restricted to a limited distance of the runway and there is no hazard of striking any object in this limited distance, or is used in similar operating conditions. The bumpers shall be capable of stopping the trolley (not including the lifted load) at an average rate of deceleration not to exceed 4.7 ft/s/s when traveling in either direction at one-third of the rated load speed </u>	Agreement with OSHA. 29 CFR 1910.179(e)(2)(i) and 29 CFR 1910.179(e)(3)(i) [OSHA] External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

## OAC 4123:1-5

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
67	4123:1-5-14(D)(2)(a)	A hoist holding brake designed to hold the maximum rated load at any point of the lift shall be provided on all jib cranes.	<p style="color: red;">Holding brakes for hoist motors shall have not less than the following percentage of the full load hoisting torque at the point where the brake is applied. • 125 percent when used with a control braking means other than mechanical. • 100 percent when used in conjunction with a mechanical control braking means. • 100 percent each if two holding brakes are provided. Holding brakes on hoists shall be applied automatically when power is removed.</p>	<p>Agreement with OSHA. 29 CFR 1910.179(f)(2) [OSHA]                      External Stakeholder Agreement                      Date : May 5, 2009                      In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association )                      Objecting : None</p>
68	4123:1-5-14(E)(2)(d)	All power-driven hoists shall be provided with a braking system not dependent upon electrical current. On the hoist, a braking system designed to hold the maximum rated load at any point of the lift shall be provided.	<p style="color: red;">Holding brakes for hoist motors shall have not less than the following percentage of the full load hoisting torque at the point where the brake is applied. • 125 percent when used with a control braking means other than mechanical. • 100 percent when used in conjunction with a mechanical control braking means. • 100 percent each if two holding brakes are provided. Holding brakes on hoists shall be applied automatically when power is removed.</p>	<p>Agreement with OSHA. 29 CFR 1910.179(f)(2) [OSHA]                      External Stakeholder Agreement                      Date : May 5, 2009                      In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association )                      Objecting : None</p>

**OAC 4123:1-5**

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
69	4123:1-5-14(F)(2)(b)(i)	Bumpers and stops shall be installed at both ends of the crane runway.	A crane shall be provided with bumpers or other automatic means providing equivalent effect, unless the crane travels at a slow rate of speed and has a faster deceleration rate due to the use of sleeve bearings, or is not operated near the ends of bridge and trolley travel, or is restricted to a limited distance by the nature of the crane operation and there is no hazard of striking any object in this limited distance, or is used in similar operating conditions. The bumpers shall be capable of stopping the crane (not including the lifted load) at an average rate of deceleration not to exceed 3 ft/s/s when traveling in either direction at 20 percent of the rated load speed. A trolley shall be provided with bumpers or other automatic means of equivalent effect, unless the trolley travels at a slow rate of speed, or is not operated near the ends of bridge and trolley travel, or is restricted to a limited distance of the runway and there is no hazard of striking any object in this limited distance, or is used in similar operating conditions. The bumpers shall be capable of stopping the trolley (not including the lifted load) at an average rate of deceleration not to exceed 4.7 ft/s/s when traveling in either direction at one-third of the rated load speed	Agreement with OSHA. 29 CFR 1910.179(e)(2)(i) and 29 CFR 1910.179(e)(3)(i) [OSHA] External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
<b>4123:1-5-15 Hoistage and Hauling Equipment</b>				
70		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference
<b>4123:1-5-16 Cutting and Welding</b>				
71	4123:1-5-16(E)(3)(i)	The color red shall be used for acetylene and other fuel gas hose. The color green shall be used for oxygen hose. The color black shall be used inert gas and air hose.	The color red shall be used for acetylene and other fuel gas hose. The color green shall be used for oxygen hose. The color black shall be used <u>for</u> inert gas and air hose.	Missing "for" added.

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
72	4123:1-5-16 (E)(3)(a)(ii)	Any length of hose in which a flashback has occurred and burned in the hose shall be taken out of service.	<u>Any length of hose in which a flashback has occurred and burned in the hose shall be taken out of service. Flashback protection shall be provided by an approved device that will prevent flame from passing into the fuel-gas system .</u>	Flashback should never occur. Rather than removing damaged hose after a flashback, take steps to prevent flashback. Remove existing language and replace with OSHA 1910.253(e)(3)(ii)(c)(3) [OSHA] External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
73	4123:1-5-16 (E)(3)(a)(v)	Hose showing leaks, burns, worn places, or other defects rendering it unfit for service shall have damaged portion removed.	<u>Hose showing leaks, burns, worn places, or other defects rendering it unfit for service shall have the damaged portion removed, repaired or replaced .</u>	Change to be consistent with OSHA 1910.253(e)(5)(v) [OSHA] External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
74	4123:1-5-16 (E)(3)(c)(i)	Oxygen and fuel gas pressure regulators, including their related gauges, shall be in proper working order while in use.	<u>(i) Oxygen and fuel gas pressure regulators, including their related gauges, shall be in proper working order while in use.</u>	If recommended change below is added, then this statement must be identified as (i) External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
75	4123:1-5-16 (E)(3)(c)(ii)	None	<u>(ii) Pressure-reducing regulators shall be used only for the gas and pressures for which they are intended .</u>	Consider adding language from OSHA 1910.253 (e)(6)(i) [OSHA] External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
76	4123:1-5-16 (F)(3)	Installation of are welding equipment	Installation of <u>arc</u> welding equipment	Typo ("are" to "arc")
77	4123:1-5-16 (F)(5)(a)	The operator shall report any equipment or defect or safety hazard to his supervisor and the use of the equipment shall be discontinued until its safety has been assured. Repairs shall be made only by authorized personnel.	The operator shall report any equipment or defect or safety hazard to his supervisor and the use of the equipment shall be discontinued until its safety has been assured. Repairs shall be made only by authorized <u>qualified</u> personnel.	Consistent with OSHA 1910.254(d)(9)(i) [OSHA] . There is a significant difference between authorized and qualified. External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
78	4123:1-5-16 (F)(6)(c)(vi)	(vi) Safety blocks	<u>(vi) Safety blocks or pins.</u>	Passage allows for blocks or pins. Add pins to section title. External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
79	4123:1-5-16 (F)(8)	See rule 4124:1-5-17 of the Administrative Code, "Personal protective equipment."	See rule <a href="#">41213</a> :1-5-17 of the Administrative Code, "Personal protective equipment."	Typo. Change code reference to 4123.
		<b>4123:1-5-17 Personal Protective Equipment</b>		
80	4123:1-17 Appendix A	Atomic Hydrogen Welding 12	Atomic Hydrogen Welding <a href="#">10-14</a>	Agreement with OSHA. <span style="float: right;">29</span> CFR 1926.102 [OSHA] External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
81	4123:1-17 Appendix A	See Attached	<a href="#">See Attachment 1</a>	Agreement with OSHA External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
82	4123:1-17 (D)(4)	<p>(a) Impact test. The lens shall withstand a one-inch diameter steel ball (weight approximately 2.4 ounces) dropped in free fall from a height of fifty inches onto the horizontal upper surface of the lens, impinging the lens within a circular area of five-eighths-inch diameter centered at the lens' mechanical center. (b) Penetration resistance test – plastic only. A plastic lens shall withstand a pointed projectile of suitable size, consisting of a new Singer number 25, size 135×7 needle, fastened into a holder weighing approximately 1.56 ounces freely dropped, pointed downward, from a height of fifty inches onto the outer surface of the lens. The projectile may be guided but not restricted in its fall by being dropped through a tube extending to within four inches of the lens.</p>	<p>( 4) Material requirements for eye protection shall meet ANSI Z87.1 – 1968.</p>	<p>External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None</p>
83	4123:1-17 (D)(4)	<p>(c) Frames, flammability test. A section at least one inch long of the plastic components of the frame shall be exposed to a test for determining the flame-propagation rate. For this purpose the frame components (eyewire, temples, and sideshields) shall be ignited individually by holding one end of the specimen horizontally at the top of a luminous three-quarter-inch Bunsen burner flame in a draft-free room. The rate of propagation determined by a stopwatch shall be no less than twenty-four seconds per inch. A faster rate of propagation shall be cause for rejection. (d) Marking (i) Eye and face protection shall be distinctly marked in a permanent, legible manner with the manufacturer's trademark. (ii) Each filter lens shall be marked with the shade designation. Each glass filter lens shall be marked with the letter "H" to indicate treatment for impact resistance.</p>	<p>( 4) Material requirements for eye protection shall meet ANSI Z87.1 – 1968.</p>	<p>External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None</p>

**OAC 4123:1-5**

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
84	4123:1-17 (D)(5)	(5) Laser Protection (a) The employer shall provide laser safety goggles which will protect the employee from direct or reflected laser light equal to or greater than 0.005 watts (five milliwatts). The laser safety goggles shall provide protection for the specific wavelength of the laser and be of optical density (O.D.) adequate for the energy involved. The appendix to this rule lists the maximum power or energy density for which adequate protection is afforded by glasses of optical densities from five through eight. Output levels falling between lines in table shall require the higher density. (b) Labeling of eye protection All protective goggles shall bear a label identifying the following data: (i) The laser wavelengths for which use is intended; (ii) The laser wavelengths for which use is intended; (iii) The visible light transmission.	<del>( 4) Material requirements for eye protection shall meet ANSI Z87.1 – 1968.</del>	External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
85	4123:1-17 (E)	Foot protection shall <del>be made available by the employer and</del> shall be worn by the employee where an employee is exposed to machinery or equipment that presents a foot hazard or where an employee is handling material which presents a foot hazard.	Foot protection shall be worn by the employee where an employee is exposed to machinery or equipment that presents a foot hazard or where an employee is handling material which presents a foot hazard.	Agreement with OSHA 29CFR 1910.136(b) External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
86	4123:1-17 (G)(2)	(2) Protective Helmets (a) Classes of Helmets (i) Protective helmets as defined in paragraph (B) of rule 4121:1-5-01 of the Administrative Code shall be of the following classes: (a) Class A – limited voltage protection. (b) Class B – high voltage protection. (c) Class C – no voltage. (d) Class D – limited voltage protection. Firefighters' service helmets with full brim only. (ii) Class C or any metallic helmet shall not be provided by employers or used by employees except where the other classes would be deteriorated by exposure to chemical action and provided there is no danger of contact with electrical current.	<del>4123:1-17 (G)(1)(a)(i)(a) Where required, head protection shall meet the requirements of ANSI Z89.1 – 1969</del>	External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
87	4123:1-17 (G)(2)	(b) Winter liners and chin straps. (i) All winter liners shall be fabricated of materials that will not support combustion. (ii) Winter liners and chin straps used in conjunction with class B helmets for protection from electricity shall not contain any metallic or other conductive material. (c) Physical requirement for helmets. (i) Impact Resistance Helmets shall be capable of withstanding the impact of an eight-pound steel ball, approximately three and three-quarters inches in diameter, dropped onto a center of the top of the helmet from a height of five feet without transmitting an average force of more than eight hundred fifty pounds.	<a href="#"><u>4123:1-17 (G)(1)(a)(i)(a) Where required, head protection shall meet the requirements of ANSI Z89.1 – 1969</u></a>	External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
88	4123:1-17 (G)(2)	(ii) Crown strap clearance. Crown straps shall not allow the distance between the top of the head and the underside of the helmet to be adjusted to less than one inch when a twenty-five-pound weight is placed on top of the helmet. Unless the manufacturer of that particular helmet specifies otherwise. (iii) Penetration resistance. Class A, B, and D helmets shall not be pierced more than three-eighths inch and class C helmets not more than seven-sixteenths inch, including the thickness of the shell material, when subjected to a one-pound steel plum bob with a point having an included angle of 35+1 degrees and a maximum point radius of 0.010 inch, dropped ten feet vertically onto the top of the helmet.	<a href="#"><u>4123:1-17 (G)(1)(a)(i)(a) Where required, head protection shall meet the requirements of ANSI Z89.1 – 1969</u></a>	External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
89	4123:1-17 (G)(2)	(iv) Insulation resistance. Class A and D helmets shall be capable of withstanding two thousand two hundred volts alternating-current sixty hertz (rms) for one minute, with leakage current not in excess of three milliamperes. This test is not applicable to Class C helmets. Class B helmets shall be capable of withstanding twenty thousand volts alternating-current sixty hertz for three minutes with leakage current not in excess of nine milliamperes.	<a href="#"><u>4123:1-17 (G)(1)(a)(i)(a) Where required, head protection shall meet the requirements of ANSI Z89.1 – 1969</u></a>	External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

## OAC 4123:1-5

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
90	4123:1-17 (G)(2)	(v) Helmet shell materials. (a) Materials used in class A and class B helmets shall be water resistant and slow burning. Materials in class D helmets shall be fire resistant (self-extinguishing) and nonconductors of electricity. (b) Class B headgear shall not have any holes of any sort in the shell nor shall it have any metal parts. (d) Bump Caps Bump caps or hats shall never be used as a substitute for safety helmets where there is danger from falling objects, flying particles, or electric shock.	<u>4123:1-17 (G)(1)(a)(i)(a) Where required, head protection shall meet the requirements of ANSI Z89.1 – 1969</u>	External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
91	4123:1-17 (I)(6)	(6) Safety belts, safety harnesses, safety straps, lifelines, and lanyards. (a) When required, lifelines shall be securely fastened to the structure. Safety belts, safety harnesses, safety straps, lifelines and lanyards shall be used only for employee safeguarding and shall sustain a static load of no less than five thousand four hundred pounds. Any safety belts, safety harness, safety strap, lifeline, or lanyard actually subjected to in-service loading, as distinguished from static load testing, shall be removed from service and shall not be used again for employee safeguarding.	<u>6) Safety belts, Harness lifelines and lanyards. (a) Lifelines, safety belts or harnesses and lanyards shall be provided by the employer, and <del>is</del> it shall be the responsibility of the employee to wear such equipment when exposed to hazards of falling where the operation being performed is more than 6 feet above the ground or above a floor or platform, except as otherwise specified in this chapter, and when required to work on stored material in silos, hoppers, tanks, and similar storage areas. Lifelines and safety belts or harnesses shall be securely fastened to the structure and shall sustain a static load of no less than three thousand pounds.</u>	Agreement with OAC 4123:1-3-03 External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
92	4123:1-17 (I)(6) (c)	Safety belt, harness, or strap lanyards shall be a minimum of one-half inch nylon, or equivalent, with a maximum length to provide for a fall of no more than six feet.	Safety belt, harness, or strap lanyards shall be a minimum of one-half inch nylon, or equivalent, with a maximum length to provide for a fall of no more than six feet. <u>The lanyard shall have a breaking strength of no more than three thousand pounds.</u>	Agreement with OSHA 29CFR1926.502(d)(12) and OAC 4123:1-3-03 External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
93	4123:1-17 (I)(6) (e)	All safety belt, harness, or strap and lanyard hardware shall be capable of withstanding a tensile loading of <del>four</del> thousand pounds without cracking, breaking, or becoming permanently deformed.	All safety belt, harness, or strap and lanyard hardware shall be capable of withstanding a tensile loading of <u>three</u> thousand pounds without cracking, breaking, or becoming permanently deformed.	Agreement with OAC 4123:1-3-03 External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
94	4123:1-17 (I)(7) (a)	Safety nets shall be provided when workplaces are more than <del>twenty five</del> feet above the ground, water, or other surface where the use of ladders, scaffolds, catch platforms, temporary floors, safety lines, or safety belts is impractical.	Safety nets shall be provided when workplaces are more than <u>thirty</u> feet above the ground, water, or other surface where the use of ladders, scaffolds, catch platforms, temporary floors, safety lines, or safety belts is impractical.	Agreement with OSHA 29 CFR 1926.502(c) External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
95	4123:1-17 (I)(7) (c)	Nets shall extend eight feet beyond the edge of the work surface where employees are exposed to falling and shall be installed as closed under the work surface as practical but in no case more than twenty-five feet below such work surface with the exception of bridge construction where only one level of nets is required. Nets shall be hung with sufficient clearance to prevent the falling employees' contact with the surface or structures below. Such clearance shall be determined by impact load testing.	Nets shall extend <u>outward from the outermost projection of the work surface in accordance with the following table to this rule</u> and shall be installed as close under the work surface as practical but in no case more than <u>thirty</u> feet below such work surface with the exception of bridge construction where only one level of nets is required. Nets shall be hung with sufficient clearance to prevent the falling <del>employees'</del> <u>employee's</u> contact with the surface or structures below. Such clearance shall be determined by impact load testing.	Agreement with OSHA 29 CFR 1926.502(c) External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
96	4123:1-17 (I)(7) (c)	Table	<u>Table (See Attachment 2 )</u>	Agreement with OSHA 29 CFR 1926.502(c) External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
		<b>4123:1-5-18 Control of Air Contaminants</b>		
97		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Typo corrected
		<b>4123:1-5-19 Manlifts of the endless belt type</b>		
98	4123:1-5-19(C)(2)(c)	Adequate lighting, no less than five lumens, shall be provided at each floor landing at all times when the lift is in operation.	Adequate lighting, not less than 5-foot candles, shall be provided at each floor landing at all times when the lift is in operation.	Agreement with OSHA. 29 CFR 1910.68(b)(6)(iii) External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
99	4123:1-5-19(C)(4)(b)	The rails shall be standard guardrails with toeboards meeting the provisions of rule <del>4124:1-5-02</del> of the Administrative Code.	The rails shall be standard guardrails with toeboards meeting the provisions of rule <u>4123:1-5-02</u> of the Administrative Code.	Change 4121 references to 4123. No other changes recommended.
100	4123:1-5-19(C)(10)(a)	Both runs of the manlift shall be illuminated at all times when the lift is in operation. An intensity of no less than one lumen shall be maintained at all points. (See paragraph (C)(2)(c) of this rule for illumination requirements at landings).	Both runs of the manlift shall be illuminated at all times when the lift is in operation. An intensity of not less than 1-foot candle shall be maintained at all points.	Agreement with OSHA. 29 CFR 1910.68(b)(14)(i) [OSHA] External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
101	4123:1-5-19(D)(3)(a)	Steps shall be less than twelve inches nor more than fourteen inches deep, measured from the belt to the edge of the step	Steps shall be <u>no</u> less than twelve inches nor more than fourteen inches deep, measured from the belt to the edge of the step	Missing "no" added.
102	4123:1-5-19(D)(8)(a)(ii)	The instructions shall read approximately as follows: face of the belt. Use the handholds. To stop – pull rope.”	The instructions shall read approximately as follows: <u>F</u> ace the belt. Use the handholds. To stop – pull rope.”	Agreement with OSHA. 29 CFR 1910.68(c)(7)(i)(b) [OSHA] External Stakeholder Agreement Date : May 5, 2009 In Agreement : Diane Grote Adams (OMA), David Packer (AFSCME/OCSEA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
		<b>4123:1-5-20 Roof car suspended platforms</b>		
103		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference
104	4123:1-5-20(B)(11)	The operating device controlling vertical movement shall operable only when all electrical protective devices and interlocks on the working platform are in normal operating position, and the roof car is at an established operating point.	The operating device controlling vertical movement shall <u>be</u> operable only when all electrical protective devices and interlocks on the working platform are in normal operating position, and the roof car is at an established operating point.	Missing "be" added.

## OAC 4123:1-5

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
105	4123:1-5-20(C)(3)	Where exposed to contact, rotating shafts, drums, couplings, other mechanisms and gears shall be guarded.	Where exposed to contact, rotating shafts, drums, couplings, <u>and</u> other mechanisms and gears shall be guarded.	Missing "and" added.
106	4123:1-5-20(G)	A safety belt or harness with means for attachment to a lifeline on the roof or to the working platform shall be provided for each employee on a working suspended by less than four wire ropes.	<u>Employees on working platforms shall be protected by a personal fall arrest system meeting the requirements of appendix C, Section I, of 29 CFR 1910.66.</u>	Agreement with OSHA. 29 CFR 1910.66 (J) [OSHA] External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
		<b>4123:1-5-21 Storage batteries.</b>		
107		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference
		<b>4123:1-5-22 Confined spaces.</b>		
108		<b>Appendix TO RULE 4121:1-5-22 (12) Confined Space Entry Permit</b>	29 CFR 1910.146 Appendix D - 2 (See attachment 3)	Agreement with OSHA External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
		<b>4123:1-5-23 Electrical conductors and equipment.</b>		
109		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference
		<b>4123:1-5-24 Poles</b>		

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
110		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference
		<b>4123:1-5-25 Vehicle-mounted elevating and rotating work platforms.</b>		
111		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference
		<b>4123:1-5-26 Trenches and excavations.</b>		
112		Table 26-1	Table 21-1 (See Attachment 4)	Agreement with OAC 4123:1-3-13 External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
113		Table 26-2	Table 26-2 (See Attachment 5)	Agreement with OAC 4123:1-3-13 External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
114	4123:1-26 ( C ) (2)	Supporting systems, i.e., piling, cribbing, shoring etc., shall be substantially constructed to prevent cave-in and sliding.	Supporting systems, i.e., piling, cribbing, shoring etc., shall be <b>designed by a qualified person and shall meet accepted engineering requirements.</b>	Agreement with OAC 4123:1-3-13 External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

### OAC 4123:1-5

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
115	4123:1-26 ( C ) (4)	Sides, slopes, and faces of all excavations shall be made safe by scaling, benching, barricading, rock bolting, wire meshing, or equally effective means.	Sides, slopes, and faces of all excavations <u>shall meet</u> <u>accepted engineering requirements</u> by scaling, benching, barricading, rock bolting, wire meshing, or equally effective means.	Agreement with OAC 4123:1-3-13 External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
		<b>4123:1-5-27 Lasers.</b>		
116		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference
		<b>4123:1-5-28 Helicopters.</b>		
117		Change 4121 references to 4123. No other changes recommended.	Change 4121 references to 4123. No other changes recommended.	Corrected section reference
		<b>4123:1-5-29 Explosives and blasting.</b>		
118	4123:1-5-29 (A)(2)	Smoking, firearms, matches, open flame lamps, and other fire, flame, <b>heat</b> or spark-producing devices are prohibited in or within fifty feet of explosive magazines or while explosives are being handled, transported or used.	Smoking, firearms ( <u>except firearms carried by guards</u> ), matches, open flame lamps, and other fire, flame <del>heat</del> or spark-producing devices are prohibited in or within fifty feet of explosive magazines or while explosives are being handled, transported or used.	Agreement with OSHA 29CFR 1910.109(c)(5)(vii) [OSHA] External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
119	4123:1-5-29 (A)(5)	Blasting operations in the proximity of overhead power lines, communications lines, utility services, or other services and structures shall not be carried on until the operators or owners have been notified and measures have been taken to protect the employer's employees.	Blasting operations in the proximity of overhead power lines, communications lines, utility services, or other services and structures , <u>the blaster shall notify the appropriate representatives of such utilities at least 24 hours in advance of blasting, specifying the location and intended time of such blasting. Verbal notice shall be confirmed with written notice.</u>	Agreement with OSHA 29CFR 1910.109(e)(1)(vi) [OSHA] External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

## OAC 4123:1-5

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
120	4123:1-5-29 (A)(8)	Empty boxes, paper, and fiber packing materials which have previously contained high explosives shall not be used again for any purpose but shall be destroyed by burning at a location approved by the blaster, and no employee shall be permitted closer than one hundred feet after the burning has started.	Empty boxes, paper, and fiber packing materials which have previously contained <u>explosive materials shall be disposed of in a safe manner, or reused in accordance with the Department of Transportation's Hazardous Materials Regulations (49 CFR parts 177-180).</u>	Agreement with OSHA 29CFR 1910.109(e)(2)(i) [OSHA] External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
121	4123:1-5-29 (A)(9)	Containers of explosives shall not be opened within fifty feet of any magazine. In opening cases, nonsparking tools shall be used, except that metal slitters may be used for opening fiberboard boxes.	Containers of explosives <u>shall not be opened in any magazine or within fifty feet of any magazine. In opening kegs or wooden cases, no sparking metal tools shall be used; wooden wedges and either wood, fiber or rubber mallets shall be used. Nonsparking metallic slitters may be used for opening fiberboard cases.</u>	Agreement with OSHA 29CFR 1910.109(e)(2)(ii) [OSHA] External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
122	4123:1-5-29 (B)	Any vehicle used to transport explosives on the job site shall have a nonsparking floor and side members and shall carry at least two fire extinguishers approved for the hazard involved. Explosives and blasting caps shall not be transported in the same vehicle except that electric blasting caps in an approved container may be transported in the same vehicle with explosives.	Any vehicle used to transport explosives on the job site shall have a nonsparking floor and side members and shall carry at least two fire extinguishers, <u>each having a rating of at least 10-BC. Blasting caps or electric blasting caps shall not be transported over the highways on the same vehicles with other explosives, unless packaged, segregated, and transported in accordance with the Department of Transportation's Hazardous Materials Regulations (49 CFR parts 177-180).</u>	Agreement with OSHA 29CFR 1910.109(d)(1)(iv) and 1910.109(d)(2)(iii) [OSHA] External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
123	4123:1-5-29 (E)(1)(c)	No blasting cap shall be inserted in the explosive materials without first making a hole in the cartridge for the cap with a nonsparking punch.	No blasting cap shall be inserted in the explosives without first making a hole in the cartridge for the cap with a <u>wooden punch of proper size or standard cap crimper.</u>	Agreement with OSHA 29CFR 1910.109(e)(4)(iv) [OSHA] External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
		<b>4123:1-5-99 Table of standard materials and dimensions.</b>		
124		Replace table with attached.	Replace table with attached. (See Attachment 6)	External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
		<b>4123:1-5-99.1 Toxic concentration, flash point, boiling point, explosive limits and vapor density of common flammable and toxic liquids and gases.</b>		
125	4123:1-5-99.1	Threshold Limit Value, ppm	Occupational Exposure Limit, ppm	Threshold Limit Value is a registered trademark from the American Conference of Governmental Industrial Hygienists and needs to be changed to a generic name for allowable occupational exposure. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
126	4123:1-5-99.1	(C) Benzol (benzene) - skin 10	benzene 1	<p>Many substance names have been changed for consistency to the technical name that OSHA uses in 1910.1000 Tables 1 and 2. The ceiling designation (c) no longer applies after OSHA changed the standard (1910.1028) lowering the allowable concentration from 10 to 1 ppm.</p> <p>External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None</p>
127	4123:1-5-99.1	(n)Butyl alcohol (butanol) - skin 50	(n)Butyl alcohol (butanol) 100	<p>OSHA does not have a skin designation and the current OSHA limit is 100.</p> <p>External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None</p>
128	4123:1-5-99.1	Butyl cellosolve (2-butoxy ethanol)	2-butoxy ethanol (Butyl cellosolve) - skin	<p>The technical name as found in OSHA 1910.1000 Tables 1 and 2 has been placed first. OSHA also has a skin designation for this chemical</p> <p>External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None</p>

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
129	4123:1-5-99.1	Carbon tetrachloride - skin 10	Carbon tetrachloride 10	OSHA does not have a skin designation for this chemical External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
130	4123:1-5-99.1	Cellosolve (2-ethoxyethanol)	2-ethoxyethanol (Cellosolve) - skin	The technical name as found in OSHA 1910.1000 Tables 1 and 2 has been placed first. OSHA also has a skin designation for this chemical External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
131	4123:1-5-99.1	Cellosolve acetate (2-ethoxyethyl acetate) - skin	2-ethoxyethyl acetate (Cellosolve acetate) - skin	The technical name as found in OSHA 1910.1000 Tables 1 and 2 has been placed first. OSHA also has a skin designation for this chemical External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
132	4123:1-5-99.1	Chloroform (trichloromethane) 10	Chloroform (trichloromethane) C50**	OSHA only has a ceiling concentration for this chemical. This is the only chemical on the list with a ceiling concentration, designated with the letter C. The double asterisk defines that the letter C designates a ceiling value for this exposure External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
133	4123:1-5-99.1	(n)Heptane 400	(n)Heptane 500	The current OSHA limit for this chemical is 500 ppm External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
134	4123:1-5-99.1	(n)Hexane 100	(n)Hexane 500	The current OSHA limit for this chemical is 500 ppm External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
135	4123:1-5-99.1	Methyl alcohol (methanol) - skin	Methyl alcohol (methanol)	OSHA does not have a skin designation for this chemical External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
136	4123:1-5-99.1	Methyl butyl ketone (2-hexanone) - skin 25	2-hexanone (Methyl butyl ketone) 100	The technical name as found in OSHA 1910.1000 Tables 1 and 2 has been placed first. OSHA also has a skin designation for this chemical. OSHA does not have a skin designation for this chemical and the OSHA allowable exposure limit is 100 ppm External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

### OAC 4123:1-5

Change #	OAC Citation	Original Language	Recommended Change	Rationale and External Stakeholder Input
137	4123:1-5-99.1	Methyl cellosolve (2-methoxyethanol)	2-methoxyethanol (Methyl cellosolve) -	The technical name as found in OSHA 1910.1000 Tables 1 and 2 has been placed first. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
138	4123:1-5-99.1	Methyl cellosolve acetate -	2-methoxyethyl acetate (Methyl cellosolve acetate)-	Added the technical name as found in OSHA 1910.1000 Table 1 External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
139	4123:1-5-99.1	Methyl ethyl ketone (2-butanone)	2-butanone (Methyl ethyl ketone)	The technical name as found in OSHA 1910.1000 Tables 1 and 2 has been placed first. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
140	4123:1-5-99.1	Methyl isobutyl ketone (Hexone)-skin	2-Hexanone (Methyl isobutyl ketone)	The technical name as found in OSHA 1910.1000 Tables 1 and 2 has been placed first. The misspelling of the technical chemical name has been corrected and OSHA does not have a skin designation for this chemical. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
141	4123:1-5-99.1	Methyl propyl ketone (2-pentanone)	2-pentanone (Methyl propyl ketone)	The technical name as found in OSHA 1910.1000 Tables 1 and 2 has been placed first. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
142	4123:1-5-99.1	Methylene chloride (dichloromethane) 100	Methylene chloride (dichloromethane) 25	The exposure limit for this chemical is currently lower in the OSHA standard. The revised exposure limit is based on this newer value. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
143	4123:1-5-99.1	Natural Gas - Gas - 3.8-6.5 13-17 -	Deleted	OSHA has no exposure limit for natural gas. The methane exposure limit would be valid for this substance. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
144	4123:1-5-99.1	Perchloroethylene (tetrachloroethylene) - skin	tetrachloroethylene (Perchloroethylene)	The technical name as found in OSHA 1910.1000 Tables 1 and 2 has been placed first. OSHA also does not have a skin designation for this chemical External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
145	4123:1-5-99.1	Petroleum distillates Naphtha -	Petroleum distillates Naphtha 500	OSHA has an exposure limit for this chemical which has been added. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
146	4123:1-5-99.1	Safety solvent - 100 & over 300-400 0.8 5.0	Deleted	OSHA has no exposure limit for safety solvent. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
147	4123:1-5-99.1	C Isophorone 5	Isophorone 25	OSHA has no ceiling limit (C) for this chemical. The exposure limit change is OSHA's exposure limit for a full shift exposure. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
148	4123:1-5-99.1	Isopropyl alcohol - skin	Isopropyl alcohol	OSHA does not have a skin designation for this chemical External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
149	4123:1-5-99.1	Toluol (Toluene) - skin 100	Toluene (Toluol) 200	The technical name as found in OSHA 1910.1000 Tables 1 and 2 has been placed first. OSHA also does not have a skin designation for this chemical. The OSHA exposure limit is higher than the current value. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
150	4123:1-5-99.1	Xylol (Xylene) - skin	Xylene	The technical name as found in OSHA 1910.1000 Tables 1 and 2 has been placed first. OSHA also does not have a skin designation for this chemical. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
151	4123:1-5-99.1	None	** C50 is an allowable ceiling concentration of 50 ppm	This text has been added to the footnotes defining a ceiling concentration as C. External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None
		<b>4123:1-5-99.2 Examples of local exhaust ventilation.</b>		

**OAC 4123:1-5**

<b>Change #</b>	<b>OAC Citation</b>	<b>Original Language</b>	<b>Recommended Change</b>	<b>Rationale and External Stakeholder Input</b>
152		See Attachment 7	The previous versions used copywrited material from the ACGIH that we cannot use without permission. The ACGIH has agreed to give us permission to use the materials in exchange for a license fee. We are currently processing the payment of this fee.	External Stakeholder Agreement Date : June 8, 2009 In Agreement : Diane Grote Adams (OMA), Bill Crooks (USW/AFL-CIO), Dave Anderson (Ohio City/County Management Association ) Objecting : None

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

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

**Rule 4123-6-37.1**

**Rule Review**

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

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

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

What goal(s): The rule adopts a discounted hospital inpatient reimbursement methodology based on Medicare's "Medicare severity diagnosis related group" or "MS-DRG" methodology, in accordance with O.R.C. 4121.441(A)(8) and *Ohio Hosp. Assn. v. Ohio Bur. of Workers' Comp.*, Franklin App. No. 06AP-471, 2007-Ohio-1499.

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

4.  The rule is effective, consistent and efficient.

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

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

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

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

Explain: The proposed changes were presented to the Ohio Hospital Association on 9/1/09, with subsequent feedback being provided on 9/10/09. The proposed changes were also posted on BWC's website on 9/11/09, with comments being taken up to 9/24/09.

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

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

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

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

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

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

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

## **Introduction**

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

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

## **Background Law**

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

R.C. 4121.441(A)(8) provides that the BWC Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP “to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies” to injured workers, including but not limited to rules regarding “[d]iscounted pricing for all in-patient . . . medical services.”

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

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

## **Proposed Changes**

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

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

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

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

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

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

## **Stakeholder Involvement**

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

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

# **BWC 2010 Proposed Inpatient Hospital Fees**

## **Medical Service Enhancements**

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

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

## **Inpatient Hospital Fee Schedule Methodology**

### **Introduction**

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

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

### **Methodology**

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

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

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

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

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

### **2010 Proposed Inpatient Fee Schedule Recommendations**

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

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

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

# OHIO BWC 2010 HOSPITAL INPATIENT SERVICES FEE SCHEDULE PROPOSAL

Medical Services Division  
Freddie Johnson, Director, Managed Care Services  
Anne Casto, Casto Consulting  
September 24, 2009

# Introduction and Guiding Principles

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

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

# Fee Schedule Methodology

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

# Calculating Hospital Inpatient Fees

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

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

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

# IPPS CMS Update

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

# MS-DRG Payment Changes for 2010

## Top 10 Medicare MS-DRGs

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

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

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

# MS-DRG Payment Changes for 2010

## Top 10 BWC MS-DRGs

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

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

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

# Recommendation

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

# Impacts

- Model under 2010 IPPS
  - Reimbursement for MS-DRG inliers increase 4.0%
  - Reimbursement for MS-DRG outliers increase 2.4%
  - Reimbursement for Exempt encounters decrease 0.62%
  - Overall increase estimated at 2.9%
    - Impact estimated at \$2.4 million
      - 2.2 million associated with inliers
      - \$200,000 associated with outliers
      - -\$34,000 associated with exempt cases
  
- Maintain competitive fee schedule which ensures injured workers' access to quality care

Thank You

# Appendix

# 2009 Hospital Inpatient Experience\*

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

\*Four months of data

# 2008 Hospital Inpatient Experience

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

# 2007 Hospital Inpatient Experience

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

# Average Charges, Costs and Payment Trends

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

\*Four months of data

# Hospital Acquired Conditions (HAC) Provision

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



**Bureau of Workers' Compensation**

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

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Columbus, OH 43215-2256  
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**Stakeholder feedback and recommendations for changes to the BWC Hospital Inpatient Services Fee Schedule - O.A.C. 4123-6-37.1**

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

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

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

**Chapter 4123-6 Health Partnership Program**

**Provider Payment Rules (41 rules)**

**Rule Review**

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

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

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

What goal(s): The rules adopt standards and criteria governing payment to providers for medical, surgical, nursing, drug, and hospital services and supplies furnished to injured or workers.

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

4.  The rule is effective, consistent and efficient.

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

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

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

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

Explain: BWC's proposed changes to the Chapter 4123-6 provider payment rules were e-mailed to the BWC Medical Division's list of stakeholders for review on August 27 and September 3, 2009 with comments due back on September 7 and September 10, 2009.

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

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

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

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

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

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

**BWC Board of Directors**  
**Executive Summary**  
**HPP Provider Payment Rules**  
**Chapter 4123-6**

## **Introduction**

Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP) for state fund employers, including rules governing payment to providers. BWC enacted the bulk of the Chapter 4123-6 HPP provider payment rules in January and February 1997. The rules have been periodically updated as needed, and last underwent five-year rule review in 2004.

As part of the current five-year rule review process, the Chapter 4123-6 HPP provider payment rules have been thoroughly reviewed and numerous changes have been proposed. There are 41 rules in this rule package; 2 rules are new rules; 18 rules will be amended, 10 rules will be rescinded, 4 rules will be rescinded and replaced, and 7 rules are no change rules.

Perhaps the most significant change BWC is proposing is that the Chapter 4123-6 provider payment rules going forward will apply to both State Insurance Fund (SIF) and self-insuring employer claims, whether the self-insuring employer has a Qualified Health Plan (QHP) or not.

This change is not intended to be substantive, as self-insuring employers are already required to provide medical benefits equal to or greater than those provided in SIF claims. However, it will allow BWC to rescind an entire chapter of Ohio Administrative Code rules (Chapter 4123-7) consisting largely of rules duplicative of Chapter 4123-6 rules.

## **Background Law**

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

R.C. 4121.441(A) provides that the BWC Administrator, with the advice and consent of the BWC Board of Directors, shall adopt rules for implementation of the HPP “to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies” to injured workers.

## **Proposed Changes**

The major substantive changes proposed for the HPP provider payment rules pursuant to the five-year rule review are as follows:

- New rule created to apply Chapter 4123-6 to payments to health care providers in all claims for industrial injuries and/or occupational diseases before the bureau, self-insuring employers, MCOs, QHPs, and the industrial commission. OAC 4123-6-01.1
- Language regarding injured worker choice of provider for HPP, QHP, and self-insuring employers combined into a single rule. OAC 4123-6-06.2

- Language added to new rule OAC 4123-6-06.2 limiting the injured worker's choice of provider and/or provider reimbursement when the provider is the injured worker or an immediate family member. This was added to eliminate potential conflicts of interest. OAC 4123-6-06.2(A)(2)
- Language regarding payment to providers for HPP, QHP, and self-insuring employers combined into a single rule. OAC 4123-6-10
- Language added to new OAC 4123-6-10 regarding the MCOs' authority to negotiate fees with providers. OAC 4123-6-10 (A)(7)
- Language added to OAC 4123-6-14 to reflect that BWC's review of medical bills includes more than verification of claim and condition allowances. OAC 4123-6-14 (A)
- Medical treatment guidelines rule rescinded and replaced with rewritten rule including language to ensure treatment guidelines are utilized at the time of the initial decision and removing specific vendor names, thus providing additional flexibility to BWC in selecting treatment guidelines. OAC 4123-6-16.1
- Language added to OAC 4123-6-20 regarding the provider's responsibility for the accuracy of information provided in workers' compensation claims and in performing independent medical examinations (IMEs) OAC 4123-6-20(A) and (E)
- Language added to OAC 4123-6-20 providing additional clarification for submission of interim medical reports and medical documentation to replace language in OAC 4123-6-28, which is being rescinded. OAC 4123-6-20(B)
- Language added to OAC 4123-6-25 to replace equivalent language in OAC 4123-6-24, which is being rescinded. OAC 4123-6-25
- Language added to OAC 4123-6-29 to provide increased data security. OAC 4123-6-29
- Language added to and/or revised in OAC 4123-6-30 to provide for standardization of physical medicine services between state fund and self-insured employers. The revision reduces administrative burdens for providers and supports the goals of early and safe return to work for Ohio's injured workers.
- New rule for payment of miscellaneous medical services created, combining six rescinded Chapter 4123-6 rules. This change facilitates ease of reading and consolidates payment criteria for services and supplies. OAC 4123-6-31
- Language clarified in OAC 4123-6-38 regarding criteria required for home health agencies to be eligible to receive reimbursement for services provided to injured workers. Language relating to services no longer reimbursable under the BWC fee schedule deleted. OAC 4123-6-38
- Language added to OAC 4123-6-39 to conform to Ohio Revised Code 4123.57(C), thus ensuring that injured workers receive a comprehensive assessment by an appropriate provider when requesting a prosthetic appliance. Language regarding self-insuring employer claims added from OAC 4123-7-28, which is being rescinded. OAC 4123-6-39

- Language added to OAC 4123-6-41 referencing self-insuring employers, as self-insuring employer equivalent rule OAC 4123-7-30 is being rescinded. OAC 4123-6-41
- Language added to OAC 4123-6-42 to clarify which funds are responsible for paying interest on late provider payments. OAC 4123-6-42
- Language in OAC 4123-6-43 modified to update trial rental period and provide clarification on requirements for providers as to the provision and billing for supplies necessary for transcutaneous electrical nerve stimulator (TENS) units, and to include language from OAC 4123-7-34, which is being rescinded. OAC 4123-6-43
- Language in OAC 4123-6-44 modified to broaden application to all providers, not just licensed individuals (practitioners). OAC 4123-6-44
- Language in OAC 4123-6-46 revised to active voice and to include self-insuring employers, as OAC 4123-7-39 is being rescinded. OAC 4123-6-46

### **Stakeholder Involvement**

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

BWC's proposed five-year rule review changes to the HPP provider payment rules were e-mailed to the following lists of stakeholders on August 27 and September 3, 2009 with comments due back on September 7 and September 10, 2009:

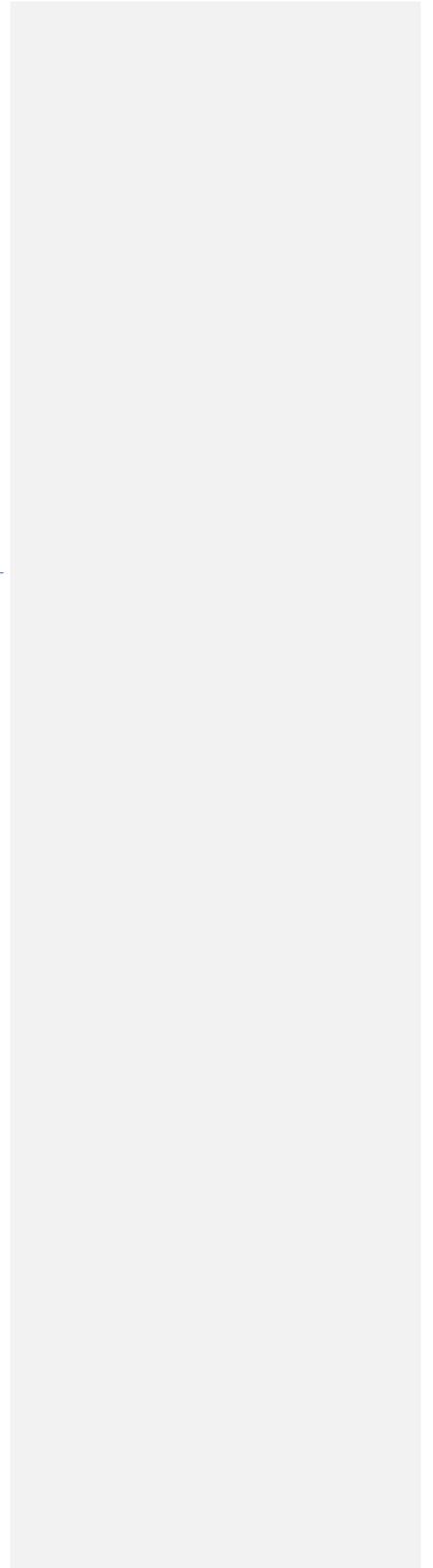
- BWC's Managed Care Organizations and the MCO League representative
- BWC's internal medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
  -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

BWC received several responses with recommendations, which are summarized on the Stakeholder feedback summary spreadsheet.

# Chapter 4123-6 Health Partnership Program

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## HPP Provider Payment Rules



**Chapter 4123-6 Health Partnership Program  
HPP/QHP/Self-Insuring Employer Provider Payment Rules**

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

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

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

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: \_\_\_\_\_

**Comment [a1]:** Clarification of application of Chapter 6 to all relevant entities given that a number of sections were separate under Chapter 7 are now combined within Chapter 6.

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96

**Comment [TAA2]:** Changes made to clarify factors considered in MCO determination of "appropriateness."

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

(A) HPP.

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

(a) A bureau certified provider; or

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

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

**Comment [TAA3]:** Added to eliminate potential conflicts of interest when the provider is treating himself/herself or immediate family members.

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

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

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

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

**Comment [a4]:** Language moved from OAC 4123-6-12, which is being rescinded.

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

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

**Comment [TAA5]:** Language moved from OAC 4123-6-12, which is being rescinded.

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

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

(B) QHP.

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

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

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

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

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

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

(1) In claims with a date of injury on or after November 2, 1959, employees of self-insuring employers have free choice to select licensed physicians for treatment, as well as other medical services, including,

**Comment [a6]:** Language moved from OAC 4123-6-06.3, which is being rescinded. The 10/20/93 "grandfather" date corresponds to the effective date of HB 107.

**Comment [a7]:** Language moved from OAC 4123-6-56 and OAC 4123-6-57, which are being rescinded.

**Comment [a8]:** Language moved from OAC 4123-7-10, which is being rescinded.

**Comment [a9]:** "Grandfather" date prior to which employees of self-insuring employers did not have free choice of providers under Ohio law.

but not limited to, hospital and nursing services. In claims with a date of injury prior to November 2, 1959, medical services furnished by the self-insuring employer must be utilized.

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

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

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

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

(1) A bureau certified provider

(2) An MCO panel provider; or

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

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

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

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

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

**Comment [a10]:** Language combined into new OAC 4123-6-06.2.

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

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

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

(A) HPP.

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

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

**Comment [a11]:** Hospitals are excluded, as they are reimbursed under different payment methodologies pursuant to OAC 4123-6-37.1 and OAC 4123-6-37.2.

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

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

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

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

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

**Comment [TAA12]:** Language added as companion to language in new OAC 4123-6-06.2(A)(5)(a) to delineate how these services will be reimbursed.

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

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

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

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

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

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

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

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

(B) QHP.

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

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

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

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

**Comment [TAA13]:** Based on language from OAC 4123-63, OAC 4123-6-66, and OAC 4123-6-67, which are being rescinded.

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

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

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

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

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

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

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

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

**Comment [TAA14]:** Includes language moved from OAC 4123-7-07, which is being rescinded.

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: \_\_\_\_\_

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

**Comment [a15]:** Language combined into OAC 4123-6-14.

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96

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

**Comment [a16]:** Language combined into new OAC 4123-6-10.

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

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

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

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

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

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

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 2/16/96, 1/15/99, 1/1/01

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

**Comment [a17]:** Language combined into new OAC 4123-6-06.2 and new OAC 4123-6-10.

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

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

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

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

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

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

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

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

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/16/96, 1/15/99

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

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

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

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

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

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

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

**Comment [TAA18]:** Language added to reflect that BWC's review of medical bills includes more than just verification of claim and condition allowances.

**Comment [a19]:** Language moved from former OAC 4123-6-10.

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

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

Rule promulgated under: RC 119.03

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

Rule amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

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

**Comment [PW20]:** Added to this rule to ensure treatment guidelines are utilized at the time of the initial decision.

**Comment [PW21]:** Specific vendor names have been removed to allow BWC more flexibility to select treatment guidelines.

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

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

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

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

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

**Comment [a22]:** Language added to paragraphs (A) and (E) regarding the provider's responsibility for the accuracy of information provided in workers' compensation claims and in performing independent medical examinations (IMEs).

**Comment [tam23]:** Language removed as duplicative of OAC 4123-6-02.8.

(B) Interim medical reports and medical documentation.

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

**Comment [a24]:** Language changed to be consistent with OAC 4123-5-18(D).

(1) The date of the report;

(2) The date of the last examination;

(3) ~~The~~ current "International Classification of Disease" diagnosis code(s) recognized in the claim for all conditions and all parts of the body being treated that are affecting the length of disability, including a primary diagnosis code, with a narrative description identifying the ~~condition~~ condition(s) and specific ~~areas~~ area(s) of the body being treated;

**Comment [a25]:** Language added from OAC 4123-6-28, which is being rescinded.

(4) Any reason(s) why recovery has been delayed;

(5) The date temporary total disability began;

(6) The current physical capabilities of the claimant;

(7) An estimated or actual return to work date;

(8) An indication of need for vocational rehabilitation;

(9) Objective findings; and

(10) Clinical findings supporting the above information.

(C) Treatment plan.

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

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

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

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

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

(3) Treatment plans should be updated when significant changes occur in the claim which impact claims management. Changes include:

(a) Additional allowance;

(b) Re-activation;

(c) Authorization of expenditures from the surplus fund;

(d) Return to modified or alternative work;

(e) Maximum medical improvement;

(f) Rehabilitation;

(g) A new injury while receiving treatment in the claim.

(4) Supplemental reports from the attending physician and other providers may be requested by the bureau, industrial commission, employer, MCO, QHP, or by the claimant or representative. These reports shall be used to determine the appropriateness of a benefit or bill payment.

(D) In accepting a workers' compensation case, a medical provider assumes the obligation to provide to the bureau, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer, upon written request or facsimile thereof and within five business days, all medical, psychological, or psychiatric documentation relating causally or historically to physical or mental injuries relevant to the claim required by the bureau, MCO, QHP, or self-insuring employer, and necessary for the claimant to obtain medical services, benefits or compensation.

(E) Independent medical examinations.

(1) A provider performing an independent medical examination of a claimant shall create, maintain, and retain sufficient records, papers, books, and documents in such form to fully substantiate the accuracy of the resulting report submitted to the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer in connection with a workers' compensation claim. The provider, the provider's employees, and the provider's agents shall keep such records in accordance with rule 4123-6-45.1 of the Administrative Code, and such records shall be subject to audit pursuant to rule 4123-6-45 of the Administrative Code.

(2) A provider performing an independent medical examination of a claimant shall keep confidential all information obtained in the performance of the independent medical examination, including but not limited

to knowledge of the contents of confidential records of the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer. The provider, the provider's employees, and the provider's agents shall maintain the confidentiality of such records in accordance with all applicable state and federal statutes and rules, including but not limited to rules 4123-6-15 and 4123-6-72 of the Administrative Code.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/27.97, 1/15/99, 1/1/01, 1/1/03

### 4123-6-20.1 Charges for copies of medical reports (Amend)

(A) The purpose of this rule is to provide parties to a workers' compensation claim reasonable access to and reasonable charges for medical records necessary for the administration of the claim.

(B) Except as provided in this rule, a medical provider may not assess a fee or charge the claimant, employer, or their representatives for the costs of completing any bureau form or documentation required under rule 4123-6-20 of the Administrative Code which is required by the bureau, MCO, QHP, or self-insuring employer and is necessary for the claimant to obtain medical services, benefits, or compensation.

(C) A medical provider shall provide copies of medical records to the bureau, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer as provided in paragraph (D) of rule 4123-6-20 of the Administrative Code. A medical provider may not assess a fee or charge the bureau, industrial commission, MCO, QHP, or self-insuring employer for the costs of providing medical records or completing any bureau form or documentation which is required by the bureau, MCO, QHP, or self-insuring employer and is necessary for the claimant to obtain medical services, benefits, or compensation.

(1) The bureau shall provide authorized parties to the claim access to all filed medical records without charge through secure electronic access.

(2) Where the bureau has provided access to medical records electronically and a party requests copies of such medical records, the bureau may charge a fee for the copies in accordance with the Ohio public records laws.

(3) Where a provider has filed copies of medical records with the bureau or MCO and the bureau has provided access to such medical records electronically or the provider has filed copies of medical records with the self-insuring employer, if a party requests such medical records of the provider, the provider may charge a fee for the copies. ~~Where a provider has filed copies of medical records with the self-insuring employer, if a party requests such medical records of the provider, the provider may charge a fee for the copies. The provider's fee shall be based upon the actual cost of furnishing such copies, not to exceed twenty-five cents per page.~~

**Comment [tam26]:** Language deleted as redundant.

(D) As provided in division (B) of section 4123.651 of the Revised Code, a claimant shall promptly provide a current signed release of medical information, records, and reports relative to the issues necessary for the administration of the claim when requested by the employer. The employer shall immediately provide copies of all medical information, records, and reports to the bureau and to the claimant or the claimant's representative upon request.

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30  
Rule Amplifies: 149.43, 3701.741, 4113.23, 4121.121, 4121.44, 4121.441, 4123.651  
Prior Effective Dates: 1/1/03

#### **4123-6-21 Payment for outpatient medication. (No Change)**

(A) Medication must be for the treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer. The bureau may deny a therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of the allowed conditions in a claim.

(B) Medication must be prescribed by the physician of record in the industrial claim or by the treating physician, or by such other treating provider as may be authorized by law to prescribe such medication.

(C) Drugs covered are limited to those that are approved for use in the United States by the Food and Drug Administration and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) The bureau may require prior authorization of certain drugs or therapeutic classes of drugs, and shall publish a list of all such drugs or therapeutic classes of drugs for which prior authorization is required.

(E) Drugs which fall into one of the following categories may be approved and reimbursed by an MCO as part of a comprehensive treatment plan submitted by the physician of record or treating physician:

(1) Drugs for the treatment of obesity;

(2) Drugs for the treatment of infertility;

(3) Drug Efficacy Study Implementation (DESI) drugs or drugs that may have been determined to be identical, similar, or related;

(4) Extemporaneous or simple compounded prescriptions;

(5) Injectable drugs not intended for self-administration;

(6) Drugs used to aid in smoking cessation;

(7) Drugs dispensed to a claimant while the claimant is admitted to a hospital during an approved inpatient admission or during the course of an outpatient visit in a hospital. Drugs approved by the MCO under this rule shall not be reimbursed through the bureau's pharmacy benefits management vendor.

(F) Payment for medications to pharmacy providers shall include a product cost component and a dispensing fee component.

(1) The product cost component shall be the lesser of the following: maximum allowable cost, if applicable, or the average wholesale price of the commonly stocked package size plus or minus a percentage. The percentage amount added or subtracted from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.

(2) The dispensing fee component shall be a flat rate fee, which shall be subject to annual review.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN) per rolling twenty-five days. Exceptions to the single dispensing fee are:

(i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;

(ii) Cases where the physician has changed the dosage;

(iii) Cases where the medication did not last for the intended days supply;

(iv) Cases where the medication has been lost, stolen or destroyed;

(v) Controlled substances (which are limited to two dispensing fees per twenty-five days).

(G) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined by the bureau. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(H) The bureau may establish a maximum allowable cost for medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations." The methodology used to determine a maximum allowable cost for a qualified drug product shall be determined by the medical policy department and shall be subject to annual review. The bureau may choose to utilize the maximum allowable cost list of a vendor or develop its own maximum allowable cost list.

(I) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug.

(J) The following dispensing limitations may be adopted by the bureau:

(1) The bureau may publish a list of drugs identifying those drugs that are considered "chronic" medications. Drugs not identified as "chronic" medications shall be considered "acute" medications.

(2) The bureau may publish supply limitations for acute and chronic drugs which represent the maximum number of days supply that may be dispensed at any one time for a single prescription.

(3) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription

(4) Requests submitted that exceed any published days supply limit or maximum quantity limit shall be denied. Denials may be overridden by the bureau in cases where medical necessity and appropriateness have been determined.

(5) Refills requested before seventy-five per cent of any published days supply limit has been utilized will be denied, except in cases where the dosage of a noncontrolled drug has been increased and has a new prescription number. Denials may be overridden by the bureau for the following documented reasons:

- (a) Previous supply was lost, stolen or destroyed;
- (b) Pharmacist entered previous wrong day supply;
- (c) Out of country vacation or travel;
- (d) Hospital or police kept the medication.

(K) Through internal development or through vendor contracts, an on-line point-of-service adjudication system may be implemented. Upon implementation, pharmacy providers may be required to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the established bill processing system as a condition of provider enrollment or reimbursement. Submission by paper or by tape-to-tape may be refused upon implementation of an on-line point-of-service system.

(L) Claimant reimbursement for medications shall not exceed the bureau's established rate for the medication regardless of the price paid by the claimant. Upon implementation of a point-of-service system, claimant reimbursement may be limited to the following situations:

- (1) Claimants whose claims are not allowed on the date of service;
- (2) Emergency situations where an enrolled pharmacy provider with point-of-service capabilities is not available;
- (3) Claimants who reside out of the country.

(M) The bureau may formulate medication utilization protocols for select conditions or diseases consistent with one or more of the following

(1) Compendia consistent of the following:

- (a) "United States Pharmacopoeia – Drug Information";
- (b) "American Medical Association Drug Evaluations";
- (c) "Drug Facts and Comparisons"; or,

(2) Peer reviewed medical literature. Compliance with the established protocols shall be monitored through the on-line, point-of-service adjudication system. Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's refusal to reimburse for such medications.

(N) A "pharmacy provider" designation and provider number can be obtained by a provider who meets all the following criteria:

- (1) Has a valid "terminal distributor of dangerous drugs" as defined in section [4729.02](#) of the Revised Code if located within Ohio; or an equivalent state license if located outside of Ohio; and,

(2) Has a valid drug enforcement agency (DEA) number; and,

(3) Has a licensed registered pharmacist in full and actual charge of a pharmacy. ; and,

(4) Has the ability and agrees to submit bills at the point of service. All state and federal laws relating to the practice of pharmacy and the dispensing of medication by a duly licensed pharmacist must be observed.

(O) The bureau may contract with a vendor to perform drug utilization review and on-line bill processing, maintain a pharmacy provider network and prior authorization program for medications, and provide management reports. The bureau or its vendor may also contract rebate agreements with drug manufacturers, and be responsible for maintaining a drug formulary. The bureau may utilize other services or established procedures of the vendor which may enable the bureau to control costs and utilization and detect fraud.

(P) The bureau may identify circumstances under which it may consider reimbursement for pharmacist professional services (also known as cognitive services) when payment for such services results in a measurable, positive outcome. The bureau shall be responsible for developing the criteria which will be used to assess the compensability of billed pharmacist professional services. The bureau shall be responsible for developing the structure of the reporting of the measurable outcomes used to justify the payment of pharmacist professional services. The amount that could be reimbursed for pharmacist professional services shall be determined by the bureau's medical policy department.

(Q) The bureau shall secure the services of a pharmacist to assist the bureau in the review of drug bills. The bureau may employ a staff pharmacist on a full or part-time basis or may contract for such services. The pharmacist may assist the bureau in determining the appropriateness, eligibility, and reasonableness of compensation payments for drug services. The bureau may consult with a pharmacy and therapeutics committee, which shall be a subcommittee of the stakeholders' health care quality assurance advisory committee established by rule 4123-6-22 of the Administrative Code, on the development and ongoing annual review of a drug formulary and other issues regarding medications.

(R) The bureau will publish line by line billing instructions in a health care provider billing and reimbursement manual. At least thirty days written notice will be given prior to required changes in billing procedures.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/27/97, 1/1/03, 10/1/05

**4123-6-21.1 Payment for outpatient medication by self-insuring employer. (New)**

**Comment [a27]:** New self-insuring employer pharmacy rule created, identical to former OAC 4123-7-23, which is being rescinded.

(A) Medication must be for treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer.

(B) Medication must be prescribed by the physician of record in the industrial claim or by the treating physician, or by such other treating provider as may be authorized by law to prescribe such medication.

(C) Drugs covered are limited to those that are approved for use in the United States by the Food and Drug Administration and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) A self-insuring employer may approve and reimburse for various drugs as a part of a comprehensive treatment plan submitted by the physician of record or a treating physician when reasonably related to and medically necessary for treatment of the allowed conditions in the claim, provided that such approval and reimbursement shall not constitute the recognition of any additional conditions in the claim even if such drugs are used to treat conditions that have not been allowed in the claim.

(E) Payment for medications to pharmacy providers shall include a product cost component and a dispensing fee component.

(1) The product cost component shall be the lesser of the following: maximum allowable cost established under paragraph (O) of this rule, if applicable, or the average wholesale price of the commonly stocked package size plus or minus a percentage. The percentage amount added or subtracted from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.

(2) The dispensing fee component shall be a flat rate fee determined by the bureau and subject to annual review, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider pursuant to rule 4123-7-39 of the Administrative Code.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN), or other proprietary code that serves to group together pharmaceutically equivalent products (defined as products that contain the same active ingredients in the same strengths, dosage forms, and routes of administration), per rolling twenty-five days. Exceptions to the single dispensing fee are:

(i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;

(ii) Cases where the physician has changed the dosage;

(iii) Cases where the medication did not last for the intended days supply;

(iv) Cases where the medication has been lost, stolen or destroyed;

(v) Controlled substances (which are limited to two dispensing fees per twenty-five days).

(vi) Cases where the self-insuring employer determines the limitations of this paragraph to be unnecessary under the specific circumstances.

(F) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined in paragraph (E) of this rule, unless the self-insuring employer has negotiated a payment rate with the provider pursuant to rule 4123-7-39 of the Administrative Code. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(G) The pharmacy provider is required to follow all applicable line by line billing instructions as published in the bureau's health care provider billing and reimbursement manual. At least thirty days written notice will be given prior to required changes in billing procedures.

(H) Claimant reimbursement for medications shall at least be equal to the bureau's established rate for the medication, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider utilized by the claimant pursuant to rule 4123-7-39 of the Administrative Code, in which case the claimant reimbursement shall be at least the rate negotiated with the provider. Requests for reimbursement must be paid within 30 days of receipt of the request.

(I) Self-insuring employers must obtain a drug utilization review from a physician before terminating payment for current medications, as follows:

(1) Before terminating payment for current medications, the self-insuring employer shall notify all parties to the claim (including authorized representatives) and the prescribing physician, in writing, that a physician drug review is being performed, or has been performed, regarding the necessity and appropriateness of the continued use of current medications (by therapeutic drug class).

(2) The written notice shall inform all parties to the claim (including authorized representatives) and the prescribing physician that they have 21 days from receipt of the notice to provide additional information and/or medical documentation to justify the need for continued use of the medications (by therapeutic drug class).

(3) The self-insuring employer shall provide all medically related information regarding the medications to an independent physician reviewer for review and opinion as to the necessity or appropriateness of the medications. If the self-insuring employer has obtained an independent physician reviewer's report prior to sending the notice required by paragraph (I)(1) of this rule and subsequently receives additional information and/or medical documentation pursuant to paragraph (I)(2) of this rule, the self-insuring employer shall provide the additional information and/or medical documentation to the independent physician reviewer and obtain an addendum. The independent physician reviewer's report (and addendum, if applicable) shall address the medical rationale, necessity and appropriateness of the drug treatment in the control of symptoms associated with the allowed conditions in the claim.

(4) When the independent physician reviewer's report (and addendum, if applicable) indicates the drug treatment is not medically necessary or appropriate for treatment or in the control of symptoms associated with the allowed conditions in the claim, the self-insuring employer may terminate reimbursement for the medications (by therapeutic drug class) effective as of the date of receipt of the independent physician reviewer's report, or addendum if one is obtained, or in the case that a drug is in a therapeutic class that requires a "weaning-off" period, such other date as agreed to by the prescribing physician and self-insuring employer.

(5) In the event the self-insuring employer terminates reimbursement for the medications as set forth in paragraph (I)(4) of this rule, the self-insuring employer or its authorized representative shall provide all parties to the claim (including authorized representatives) and the prescribing physician with a copy of the independent physician reviewer's report (and addendum, if applicable) and the self-insuring employer shall notify the employee and the employee's representative in writing of its decision to terminate. The employer's notification to the employee and employee's representative shall indicate that the employee has the right to request a hearing before the Industrial Commission.

(6) In the event there is a dispute as to whether the drug treatment is medically necessary or appropriate for treatment of the symptoms associated with the allowed conditions in the claim, the disputed matter shall be adjudicated in accordance with Rule 4123-19-03(K)(5) of the Administrative Code.

(J) Self-insuring employers may deny initial requests for a therapeutic class of drugs as not being reasonably related to or medically necessary for the treatment of the allowed conditions in a claim.

(K) Self-insuring employers may utilize medication utilization protocols formulated by the bureau for select conditions or diseases consistent with one or more of the following:

(1) Compendia consistent of the following:

(a) "United States Pharmacopoeia – Drug Information";

(b) "American Medical Association Drug Evaluations";

(c) "Drug Facts and Comparisons"; or,

(2) Peer reviewed medical literature.

Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's or self-insured employer's refusal to reimburse for such medications.

(L) Through internal development or through vendor contracts, self-insuring employers may implement a point-of-service adjudication system. Upon implementation, a self-insuring employer may require pharmacy providers to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the established bill processing system as a condition of reimbursement, and may refuse submission by paper or by tape-to-tape.

(M) Self-insuring employers utilizing a point of service adjudication system may require prior authorization of drugs or therapeutic classes of drugs which appear on BWC's published list of drugs or therapeutic classes of drugs for which prior authorization is required.

(N) Self-insuring employers utilizing a point of service adjudication system may apply the following dispensing limitations, adopted by the bureau, to medications approved and reimbursed by the self-insuring employer:

(1) The bureau may publish a list of drugs identifying those drugs that are considered "chronic" medications. Drugs not identified as chronic medications shall be considered "acute" medications.

(a) Acute medications may be limited by the self-insuring employer to a thirty-four day supply.

(b) Chronic maintenance medications may be limited by the self-insuring employer to a one-hundred-two day supply.

(2) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

(3) Requests submitted that exceed either the days supply limit or maximum quantity limit shall be denied; provided, however, that the pharmacy provider may still fill the prescription up to the days supply limit or maximum quantity limit, as applicable. Denials may be overridden by the self-insured employer in cases where medical necessity and appropriateness have been determined.

(4) Refills requested before seventy-five per cent of the days supply has been utilized will be denied, except in cases where the dosage of a noncontrolled drug has been increased and has a new prescription number. Denials may be overridden by the self-insured employer for the following documented reasons:

(a) Previous supply was lost, stolen or destroyed;

(b) Pharmacist entered previous wrong day supply;

(c) Out of country vacation or travel;

(d) Hospital or police kept the medication.

(O) Self-insuring employers utilizing a point of service adjudication system may apply the maximum allowable cost list of the point of service adjudication system vendor to medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations." Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug.

(P) A self-insuring employer has sufficient grounds to refuse to pay for the dispensing of drugs and other medications when a pharmacy provider fails to observe any state or federal law relating to his or her professional licensure or to the dispensing of drugs and other medication.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30

Rule Amplifies: 4121.44, 4123.66

Prior Effective Dates: \_\_\_\_\_

**4123-6-22 Stakeholders health care quality assurance advisory committee. (No Change)**

The bureau of workers' compensation stakeholders' health care quality assurance advisory committee is hereby created to advise the administrator and the chief of injury management services of the bureau of workers' compensation with regard to medical issues.

(A) A list of physicians who have agreed to serve on the committee shall be developed by approval recommendations from the deans of Ohio's medical and osteopathic schools, presidents of the Ohio state medical association, the Ohio state osteopathic association, the Ohio state chiropractic association, Ohio board specialty associations, the Ohio podiatry association, the Ohio psychology association, the Ohio hospital association, the Ohio pharmacists association, the Ohio dental association, the Ohio state medical board, the Ohio state chiropractic board, the Ohio state psychology board, the Ohio state pharmacy board, the Ohio state dental board, and the industrial commission of Ohio. This list shall be maintained by the bureau's chief of injury management services and additional names may be added as needed or desired.

(B) The appointing authority for members of this advisory committee shall be the administrator or his designees, and shall appoint members of the committee from the lists of approved physicians.

(C) The bureau's chief of injury management services shall be the chairman of the advisory committee, and may be self-designated an ad hoc member of any other subcommittees formed by the advisory committee. The chief of injury management services may delegate these duties to a chairperson elected by the voting members. The chief of injury management services shall be a voting member of the advisory and subcommittees only in case of tie votes.

(D) In addition to the bureau's chief of injury management services, the advisory committee shall consist of at least one M.D., one D.O., one D.C., one clinical psychologist and one pharmacist, each holding a license in good standing in the state of Ohio, and one person representing the Ohio hospital association. The bureau's medical director, the industrial commission's medical director, and one physician chosen by the MCOs may participate in discussions; however, they shall not be voting members.

(E) Terms of membership for individual members of the advisory committee shall be for twelve months, subject to review by the administrator. Vacated terms shall be filled in like manner as for the full term appointments.

(F) The advisory committee shall develop and establish bylaws for the organization and operations of the committee and subcommittees, subject to the requirements of this rule and approval by the administrator and the bureau's chief of injury management services.

(G) The advisory committee may initiate assessment of any medical quality assurance issue impacting the bureau and shall be responsible to respond to requests for assessment of any medical quality assurance issue submitted by the bureau's chief of injury management services, including:

- (1) Reviewing managed care data reporting;
- (2) Recommending system-wide non-coverage policies or determinations that MCOs would be required to follow;
- (3) Interfacing with MCO quality assurance committees;

(4) Reviewing performance measures;

(5) Addressing problems with MCO treatment guidelines;

(6) Providing ongoing peer review of the bureau's MCO and provider certification processes, including making recommendations to the bureau for imposing sanctions or granting or denying certification or recertification of a provider based upon a review of the provider's malpractice history;

(7) Advising the bureau regarding the decertification of providers and MCOs, including making recommendations to the bureau for imposing sanctions or decertification of a provider based upon a review of the provider's malpractice history; and

(8) Review of medical disputes referred to the bureau pursuant to rule 4123-6-16 of the Administrative Code.

(H) The advisory committee shall hold at least quarterly meetings. The advisory committee and all subcommittees shall keep written records of the agenda and minutes of each meeting. The records of all committees shall remain in the custody of the bureau's chief of injury management services.

(I) The advisory committee shall submit an annual report of their activities and recommendations to the administrator. In addition to inclusion in the annual report, all recommendations from the advisory committee and subcommittees shall be submitted to the bureau's chief of injury management services in a timely fashion upon completion and approval by the respective committees.

(J) Each member of the advisory committee and its respective subcommittees may be paid such fees as may be approved by the administrator. The expenses incurred by the advisory committee and its subcommittees and the fees of their members shall be paid in the same manner as other administrative costs of the bureau.

(K) The administrator may request that the advisory committee appoint peer review subcommittees to review and provide recommendations to the administrator on disputes arising over quality assurance issues, determinations that a service provided to a claimant is not covered or is medically unnecessary, or billing adjustments arising from bureau audits or reviews of records involving individual health care providers. For these disputes the appointed panel shall consist of providers licensed pursuant to the same section of the Revised Code and system specialty as the individual health care provider for whom review has been requested. The panel may conduct an informal hearing, and shall advise the administrator, whose decision shall be final.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/27/97, 1/15/99, 6/1/05

### 4123-6-23 Jurisdictional principles applicable to payment of bills for medical services rendered by health care providers (Amend)

Jurisdictional requirements for payment for medical services rendered by a health care provider are as follows:

(A) Bills must be filed within the time provided in rule 4123-3-23 of the Administrative Code.

(B) In claims where the date of injury is on or after December 11, 1967, and prior to ~~October 11, 2006~~ August 25, 2006, there is no jurisdiction to consider payment for medical services, if six years or more have elapsed since the date of the last payment of a medical bill and no compensation has been paid, except as provided in the following cases:

**Comment [tam28]:** Date changes in this rule are a result of *Thornton v. Montville Plastics & Rubber, Inc.*, 121 Ohio St.3d 124, 2009-Ohio-360.

(1) A bill filed within the six-year period for services rendered within the period can be paid after the six-year period when, except for the time passage, it would have been paid.

(2) When an application requesting the payment of medical bills and/or compensation is filed within the six-year period, there is justification to act on the application after the period.

(a) Bills for services rendered within the six-year period can be ordered paid and can be paid after the period. However, these bills must be filed no later than two years after the date that services were rendered.

(b) Compensation can be ordered paid provided that evidence in the claim supports an award. If compensation is paid, the claim is opened for an additional ten years for the payment of compensation and bills. When there has been a payment of compensation under section 4123.56, 4123.57, or 4123.58 of the Revised Code, the claim is active for ten years from either the date of the last payment of compensation, or ten years from the last payment of a medical bill, whichever is later.

(3) Payment for medical services can be made when the claimant has received wages paid by the employer, instead of compensation for total disability. Medical services may be reimbursed when wages have been paid within six years of the date of injury with the employer's knowledge that an allowed claim exists.

(4) When a request for authorization of treatment beyond the six-year period is filed within the six-year period, the authorization for treatment after that period cannot be granted, unless the claim has been opened by the payment of compensation.

(5) There is no jurisdiction to consider the merits of any application filed after the six-year period, even though supporting evidence for the application was on file within the period.

(6) A bill filed within the six-year period that requires reactivation of the claim cannot be paid when an application for reactivation is not filed within the period. This rule also applies to bills filed after the expiration of the six-year period for treatment rendered within that period.

(C) In claims where the date of injury is prior to December 11, 1967, there is no jurisdiction to consider payment for medical services if ten years or more have elapsed since the payment of compensation or benefits, or, when no compensation has been awarded, ten years have elapsed since the date of injury.

(D) In claims where the date of injury is on or after ~~October 11, 2006~~ August 25, 2006, there is no jurisdiction to consider payment for medical services if five years or more have elapsed since the payment

**Comment [tam29]:** Date changes in this rule are a result of *Thornton v. Montville Plastics & Rubber, Inc.*, 121 Ohio St.3d 124, 2009-Ohio-360.

of compensation or benefits. The provisions of paragraph (B) of this rule shall apply to the payment of medical bills in claims where the date of injury is on or after ~~October 11, 2006~~ August 25, 2006, except that where those provisions reference six year and ten year time limits, the time limits shall be five years.

Promulgated Under: 119.03

Statutory Authority: 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.12, 4121.121, 4121.44, 4121.441, 4123.52, 4123.66

Prior Effective Dates: 2/12/97; 04/01/07

**Comment [tam30]:** Date changes in this rule are a result of *Thornton v. Montville Plastics & Rubber, Inc.*, 121 Ohio St.3d 124, 2009-Ohio-360.

**4123-6-24 Treatment necessary due to an industrial injury or occupational disease. (Rescind)**

Medical or other services to be approved for payment must be rendered as a direct result of an injury sustained or occupational disease contracted by a claimant in the course of and arising out of employment. The claim must be allowed by an order of either the bureau of workers' compensation or the industrial commission, or have been recognized by a self-insuring employer.

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 2/12/97

**Comment [a31]:** Language added to OAC 4123-6-25.

## 4123-6-25 Payment for medical supplies and services. (Amend)

(A) Medical or other services to be approved for payment must be rendered as a direct result of an injury sustained or occupational disease contracted by a claimant in the course of and arising out of employment. The claim must be allowed by an order of either the bureau of workers' compensation or the industrial commission, or have been recognized by a self-insuring employer.

**Comment [a32]:** Language moved from OAC 4123-6-24, which is being rescinded.

Medical supplies and services will be considered for payment when they are medically necessary for the diagnosis and treatment of conditions allowed in the claim, are causally related to the conditions allowed in the claim, and are rendered by a health care provider. Payment for services rendered to a claimant shall be paid to a health care provider only when the provider has delivered, rendered or directly supervised the examination, treatment, evaluation or any other medically necessary and related services provided to the claimant. By submitting any fee bill to the bureau, in either hardcopy or electronic format, the health care provider affirms that medical supplies and services have been provided to the claimant as required by this rule.

Providers billing for services rendered shall follow the procedures set forth in the bureau's provider billing and reimbursement manual in effect on the billed date of service.

**Comment [a33]:** Language moved from OAC 4123-7-17, which is being rescinded, and is applicable to all claims, not only self-insuring employer claims.

(B) Services rendered by health care providers are subject to review for coding requirements outlined in paragraph (C) of this rule. Payments to health care providers may be adjusted based upon these guidelines.

(C) Coding systems.

(1) Billing codes.

(a) Practitioners are required to use the ~~most current~~ edition of the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) in effect on the billed date of service to indicate the procedure or service rendered to injured workers.

(b) Inpatient and outpatient hospital services must be billed using the national uniform billing committee's revenue center codes.

(c) Outpatient medication services must be billed pursuant to the requirements described in the bureau's provider billing and reimbursement manual.

(d) To insure accurate data collection, the bureau shall adopt a standardized coding structure which shall be adopted by any MCO, QHP, or self-insuring employer.

(2) ICD-9 Diagnosis codes.

Providers must use the ~~most current edition of the~~ "International Classification of Diseases, clinical modification" codes allowed in the claim to indicate diagnoses.

(D) Prior to services being delivered, the provider must make reasonable effort to notify the claimant, bureau, MCO, QHP or self-insuring employer when the provider has knowledge that the services may not be related to the claimed or allowed condition(s) related to the industrial injury or illness, or that a service is non-covered. The provider may not knowingly bill or seek payment from the bureau, MCO, QHP or self-insured employer for services that are not related to the claimed or allowed condition(s) related to the

industrial injury or illness. The provider may not knowingly mislead or direct providers of ancillary services to bill or seek payment for services that are not related to the claimed or allowed condition.

The provider may not bill or seek payment from the claimant for services determined as medically unnecessary through the use of bona fide peer review based on accepted treatment guidelines.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97, 4/1/07

**4123-6-26 Claimant reimbursement. (No Change)**

When the claimant or any other person making payment on behalf of the claimant, including a volunteer, pays for medical services or supplies directly to a health care provider not participating in the HPP or QHP and the claim or condition is subsequently allowed, the payor shall be reimbursed upon submission of evidence of the receipt and payment for that service or supply. The payor will receive the amount that would have been paid to the health care provider as provided by the rules of this chapter of the Administrative Code. When payment has been made to the health care provider, the payor shall be informed to seek reimbursement from the provider.

The bureau shall inform a claimant or payor whether a health care provider participates in the HPP or QHP.

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 2/12/97

**4123-6-27 Treatment by more than one physician. (No Change)**

Medical fees shall not be approved for treatment by more than one physician for the same condition over the same period of time, except where a consultant, anesthetist, or assistant is required, or where the necessity for treatment by a specialist is clearly shown and approved in advance of treatment. This rule does not apply in cases of emergency, or where the physician of record's approved treatment plan indicates the necessity for multidisciplinary services.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97

**4123-6-28 Treatment of more than one condition or to more than one part of the body. (Rescind)**

In claims involving treatment of more than one condition or more than one part of the body, the attending physician must report all conditions and all parts of the body being treated that are affecting the length of disability. The conditions submitted shall include a primary international classification of disease diagnosis code and a description of the condition being treated. This information may be used in the determination of the extent of disability resulting from the industrial injury or occupational disease.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2-12-97; 2-14-05

**Comment [a34]:** Language moved to rule OAC 4123-6-20(B).

### 4123-6-29 Request for information by the treating provider. (Amend)

A provider treating an injured worker may, at any time, make a request in writing, facsimile, or e-mail, or ~~by telephone~~ in accordance with the bureau's confidentiality and sensitive data requirements, for relevant information concerning conditions, treatment or history for the claim. The request for information shall be accompanied by an appropriate patient release of medical information. A prompt response will be given to this request.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97; 2/14/05

**Comment [tam35]:** Language modified to provide heightened data security.

#### 4123-6-30 Payment for physical medicine (Amend)

(A) "Physical medicine is the evaluation and treatment of a claimant by physical measures and the use of rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating any work related disability. Physical medicine includes the establishment and modification of physical rehabilitation programs, treatment planning, instruction, and consultative services. "Physical measures" include massage, heat, cold, air, light, water, electricity, sound, manipulation, and the performance of tests of neuromuscular function as an aid to such treatment. Physical medicine does not include the diagnosis of a patient's disability, the use of roentgen rays or radium for diagnostic or therapeutic purposes, or the use of electricity for cauterization or other surgical purposes. Physical medicine includes, but is not limited to, chiropractic treatments, physiotherapy, and physical therapy.

(B) Physical medicine must be prescribed by the physician of record or other approved treating physician, ~~who is licensed to practice medicine, osteopathy, chiropractic, mechanotherapy, dentistry, or podiatry.~~ Physical medicine may be provided in the physician's office or referred to another licensed provider.

(C) To be eligible for reimbursement, physical medicine services must be provided by a physician, chiropractic physician, physical therapist, occupational therapist, massage therapist, athletic trainer or other qualified non-physician provider practicing within the scope of his or her license, certification, or registration.

(D) Fees for up to twelve physical therapy treatments within sixty days following the date of injury may be reimbursed without prior authorization, provided the treatments are for allowed soft tissue and musculoskeletal conditions in allowed claims and the criteria set forth in paragraphs (B)(1) to (B)(3) of rule 4123-6-16.2 of the Administrative Code are met. Otherwise, physical therapy treatment must be prior authorized.

~~(C)~~(E) Payment for physical medicine used for treatment of the allowed conditions shall be made pursuant to in accordance with rule 4123-6-25 4123-6-10 of the Administrative Code.

~~(D)~~(F) Physical medicine treatments must be provided in conjunction with:

(1) In cases of temporary total disability, interim medical reports and medical documentation meeting the requirements specified in paragraph (B) of rule 4123-6-20 of the Administrative Code.

(2) A current, written treatment plan meeting the requirements specified in paragraph (C) of rule 4123-6-20 of the Administrative Code.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97

**Comment [nj136]:** Standardization of services between state fund and self-insured employers. This reduces the administrative burden for the physician and supports the objective of early and safe return to work for the injured worker.

**4123-6-31 Payment for miscellaneous medical services and supplies. (New)**

(A) Acupuncture.

(1) Acupuncture is a recognized method of treatment in Ohio and must be administered by a licensed doctor of medicine, doctor of osteopathic medicine and surgery, or doctor of podiatric medicine who has completed a course of study in acupuncture under the administration of an approved college of medicine, college of osteopathic medicine and surgery, or college of podiatric medicine, doctor of chiropractic who holds a certificate to practice acupuncture from the Ohio state chiropractic board or a registered non-physician acupuncturist. Such treatment must be prior authorized.

(2) Services provided by a non-physician acupuncturist must be prescribed by persons licensed under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery or podiatry or Chapter 4743. of the Revised Code to practice chiropractic. A registered non-physician acupuncturist shall perform acupuncture under the general supervision of the injured worker's prescribing physician or chiropractic physician. General supervision does not require that the acupuncturist and the prescribing physician or chiropractic physician practice in the same office.

(B) Braces, shoes, and other orthotic devices.

(1) Payment is made only for those orthotic devices prescribed in writing by the physician of record for treatment of an allowed injury or occupational disease. The use of the orthotic device must be directly related to the allowed industrial injury or occupational disease.

(2) Orthotic devices shall be custom fitted or custom fabricated and delivered to the satisfaction of the prescribing physician and the administrative agencies. Repairs, modifications, and adjustments to secure satisfactory application of the orthotic appliance shall be made within sixty days of fitting and application without additional charge by the supplier of the orthotic device.

(3) No charge shall be made for measurement, transportation, or other expenses incurred by the supplier-orthotist, except when the supplier-orthotist is required to travel beyond the limits of the metropolitan community in which he maintains his place of business by reason of the physical incapacity of the claimant or by reason of direct prescription by the attending physician. The supplier-orthotist shall be paid for traveling expenses on a round-trip basis. Additional charges must be separately specified on the supplier-orthotist's billing, including the points of travel and the name of the physician prescribing the travel. Payment will be made for a maximum of three round-trip calls.

(C) Dental care.

(1) Payment for dental care shall be made in the following cases:

(a) Where an industrial injury or occupational disease either has caused damage or has adversely affected the claimant's natural teeth.

(b) For industrial injuries or occupational diseases sustained prior to January 1, 1979, artificial teeth or other denture must be in place in the worker's mouth at the time of damage or loss.

(c) For industrial injuries or occupational diseases sustained on or after January 1, 1979, the requirements of division (C)(1)(b) of this rule do not apply.

**Comment [nj137]:** Six rules were rescinded and combined into new rule for ease of reading and consolidation of payment criteria for these services/supplies.

(2) Responsibility for injuries or occupational diseases affecting the claimant's natural teeth is limited to the repair or replacement of those teeth actually injured at the time of the accident, or directly affected by the injury or disease. This responsibility does not include the replacement of teeth which are extracted or repaired for purposes unrelated to the industrial injury or occupational disease.

(3) Replacement of artificial teeth when the injury or occupational disease has resulted in a deformity of the jaw to the extent that artificial teeth cannot be used, is subject to the limitations of paragraphs (C)(1)(b) and (C)(1)(c) of this rule.

(4) Responsibility for the repair of both natural and artificial teeth is limited to the damage done at the time of the accident, or to the damage directly caused by an allowed injury or occupational disease.

(D) Eyeglasses and contact lenses.

(1) Payment is approved to replace eyeglasses or contact lenses when an industrial injury or an industrial accident not only causes an injury, but also results in the damage or loss of the claimant's eyeglasses or contact lenses.

(a) In the event of injury prior to January 1, 1979, the eyeglasses must be in place on the claimant's face or the contact lenses shall be in place in the claimant's eye(s) at the time of injury.

(b) In the event of injury on or after January 1, 1979, the requirements of paragraph (D)(1)(a) of this rule do not apply.

(2) Contact lenses or glasses are reimbursed when loss of vision is the direct result of an allowed injury or occupational disease.

(3) Refractions will be approved in situations described in paragraph (D)(2) of this rule.

(4) Replacement of glasses with contact lenses is approved when medical evidence indicates a direct need due to an allowed injury or occupational disease.

(5) Glasses or contact lenses will be approved for treatment purposes, when necessary, as a direct result of the allowed injury or occupational disease. Any subsequent adjustment, maintenance supplies or change in a claimant's glasses or contact lenses, if required for treatment of the allowed injury or occupational disease, will also be approved when supported by evidence of a direct causal relationship.

When eyeglasses and/or contact lenses were damaged or broken in an industrial accident in which an injury was sustained by the claimant and have been replaced, no further replacement will be approved due to subsequent breakage or for any other reason, except as provided in this paragraph of this rule.

(E) Hearing aids.

(1) When an industrial injury or an industrial accident which causes an injury also damages the claimant's hearing aid(s), payment to replace the hearing aid(s) is approved as follows:

(a) For injuries or accidents sustained prior to January 1, 1979, the hearing aid(s) must be in place in the claimant's ear(s) at the time of the injury or accident.

(b) For injuries or accidents sustained on or after January 1, 1979, the requirements of paragraph (E)(1)(a) of this rule do not apply.

(c) Once hearing aid(s) have been replaced, no further replacement will be approved.

(2) When a partial loss of hearing is the direct result of an allowed industrial injury or occupational disease, payment for a hearing aid(s) is justified in order to improve the claimant's ability to hear.

(F) X-rays.

Payment for x-ray examinations (including CT, MRI, and discogram) shall be made when medical evidence shows that the examination is medically necessary either for the treatment of an allowed injury or occupational disease, or for diagnostic purposes to pursue more specific diagnoses in an allowed claim. Providers shall follow all prior authorization requirements in effect at the time when requesting authorization and payment for such studies.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.44, 4121.441, 4123.66

Prior Effective Dates: \_\_\_\_\_

**4123-6-31 Payment for acupuncture. (Rescind)**

**Comment [a38]:** Language combined into new OAC 4123-6-31.

(A) Acupuncture is a recognized method of treatment in Ohio and must be administered by a licensed doctor of medicine, doctor of osteopathic medicine and surgery, or doctor of podiatric medicine who has completed a course of study in acupuncture under the administration of an approved college of medicine, college of osteopathic medicine and surgery, or college of podiatric medicine, doctor of chiropractic who holds a certificate to practice acupuncture from the Ohio state chiropractic board or a registered non-physician acupuncturist.

(B) Services provided by a non-physician acupuncturist must be prescribed by persons licensed under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery or podiatry or Chapter 4743. of the Revised Code to practice chiropractic. A registered non-physician acupuncturist shall perform acupuncture under the general supervision of the injured worker's prescribing physician or chiropractic physician. General supervision does not require that the acupuncturist and the prescribing physician or chiropractic physician practice in the same office.

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 9/22/08

**4123-6-32 Payment for x-rays. (Rescind)**

Payment for x-ray examinations (including CT, MRI, and discogram) shall be made when medical evidence shows that the examination is medically necessary either for the treatment of an allowed injury or occupational disease, or for diagnostic purposes to pursue more specific diagnoses in an allowed claim. Providers shall follow all bureau prior authorization policies in effect at the time when requesting authorization and payment for such studies.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97, 10/14/02

**Comment [a39]:** Language combined into new OAC 4123-6-31.

**4123-6-33 Payment for dental care. (Rescind)**

**Comment [a40]:** Language combined into new OAC 4123-6-31.

(A) Payment for dental care shall be made in the following cases:

(1) Where an industrial injury or occupational disease either has caused damage or has adversely affected the claimant's natural teeth.

(2) For industrial injuries or occupational diseases sustained prior to January 1, 1979, artificial teeth or other denture must be in place in the worker's mouth at the time of damage or loss.

(3) For industrial injuries or occupational diseases sustained on or after January 1, 1979, the requirements of division (A)(2) of this rule do not apply.

(B) Responsibility for injuries or occupational diseases affecting the claimant's natural teeth is limited to the repair or replacement of those teeth actually injured at the time of the accident, or directly affected by the injury or disease. This responsibility does not include the replacement of teeth which are extracted or repaired for purposes unrelated to the industrial injury or occupational disease.

(C) Replacement of artificial teeth when the injury or occupational disease has resulted in a deformity of the jaw to the extent that artificial teeth cannot be used, is subject to the limitations of paragraphs (A)(2) and (A)(3) of this rule.

(D) Responsibility for the repair of both natural and artificial teeth is limited to the damage done at the time of the accident, or to the damage directly caused by an allowed injury or occupational disease.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97

**4123-6-34 Payment for eyeglasses and contact lenses. (Rescind)**

**Comment [a41]:** Language combined into new OAC 4123-6-31.

(A) Payment is approved to replace eyeglasses or contact lenses when an industrial injury or an industrial accident not only causes an injury, but also results in the damage or loss of the claimant's eyeglasses or contact lenses.

(1) In the event of injury prior to January 1, 1979, the eyeglasses must be in place on the claimant's face or the contact lenses shall be in place in the claimant's eye(s) at the time of injury.

(2) In the event of injury on or after January 1, 1979, the requirements of paragraph (A)(1) of this rule do not apply.

(B) Contact lenses or glasses are reimbursed when loss of vision is the direct result of an allowed injury or occupational disease.

(C) Refractions will be approved in situations described in paragraph (B) of this rule.

(D) Replacement of glasses with contact lenses is approved when medical evidence indicates a direct need due to an allowed injury or occupational disease.

(E) Glasses or contact lenses will be approved for treatment purposes, when necessary, as a direct result of the allowed injury or occupational disease. Any subsequent adjustment, maintenance supplies or change in a claimant's glasses or contact lenses, if required for treatment of the allowed injury or occupational disease, will also be approved when supported by evidence of a direct causal relationship.

When eyeglasses and/or contact lenses were damaged or broken in an industrial accident in which an injury was sustained by the claimant and have been replaced, no further replacement will be approved due to subsequent breakage or for any other reason, except as provided in this paragraph of this rule.

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 2/12/97

**4123-6-35 Payment for hearing aids. (Rescind)**

**Comment [a42]:** Language combined into new OAC 4123-6-31.

(A) When an industrial injury or an industrial accident which causes an injury also damages the claimant's hearing aid(s), payment to replace the hearing aid(s) is approved as follows:

(1) For injuries or accidents sustained prior to January 1, 1979, the hearing aid(s) must be in place in the claimant's ear(s) at the time of the injury or accident.

(2) For injuries or accidents sustained on or after January 1, 1979, the requirements of paragraph (A)(1) of this rule do not apply.

(3) Once hearing aid(s) have been replaced, no further replacement will be approved.

(B) When a partial loss of hearing is the direct result of an allowed industrial injury or occupational disease, payment for a hearing aid(s) is justified in order to improve the claimant's ability to hear.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97

**4123-6-36 Payment for braces, shoes, and other orthotic devices. (Rescind)**

**Comment [a43]:** Language combined into new OAC 4123-6-31.

Payment is made only for those orthotic devices prescribed in writing by the physician of record for treatment of an allowed injury or occupational disease. The use of the orthotic device must be directly related to the allowed industrial injury or occupational disease.

(A) Orthotic devices shall be custom fitted or custom fabricated and delivered to the satisfaction of the prescribing physician and the administrative agencies. Repairs, modifications, and adjustments to secure satisfactory application of the orthotic appliance shall be made within sixty days of fitting and application without additional charge by the supplier of the orthotic device.

(B) No charge shall be made for measurement, transportation, or other expenses incurred by the supplier-orthotist, except when the supplier-orthotist is required to travel beyond the limits of the metropolitan community in which he maintains his place of business by reason of the physical incapacity of the claimant or by reason of direct prescription by the attending physician. The supplier-orthotist shall be paid for traveling expenses on a round-trip basis. Additional charges must be separately specified on the supplier-orthotist's billing, including the points of travel and the name of the physician prescribing the travel. Payment will be made for a maximum of three round-trip calls.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97; 2/14/05

#### 4123-6-37 Payment of hospital bills. (Amend)

(A) Direct reimbursement will not be made to members of a hospital resident staff.

(B) Payment for personal comfort items, which include, but are not limited to, telephones, television, and private rooms provided at the patient's request, are not compensable.

(C) Bureau fees for hospital inpatient services.

(1) Bureau fees for hospital inpatient services will be based on usual and customary methods of payment, such as prospective payment systems, including diagnosis related groups (DRG), per diem rates, rates based on hospital cost to charge ratios or percent of allowed charges.

(2) Except in cases of emergency as defined in this chapter, prior authorization must be obtained in advance of all hospitalizations. ~~The hospital must notify the bureau, and/or the injured worker's MCO, QHP, or self-insuring employer of emergency inpatient admissions within one business day of the admission. Failure to comply with this rule shall be sufficient ground for denial of room and board charges by the bureau, or MCO, QHP, or self-insuring employer from the date of admission up to the actual date of notification. Room and board charges denied pursuant to this rule may not be billed to the injured worker.~~

**Comment [nj144]:** Language deleted as unnecessary, since definitions are reflected in OAC 4123-6-01.

(D) Bureau fees for hospital outpatient services.

(1) Bureau fees for hospital outpatient services, including emergency services, will be reimbursed in accordance with usual and customary methods of payment which may include prospectively determined rates, allowable fee maximums, ambulatory payment categories (APC), hospital cost to charge ratios, or a percent of allowed charges, as determined by the bureau.

(2) Treatment in the emergency room of a hospital must be of an immediate nature to constitute an emergency as defined in this chapter. Prior authorization of such treatment is not required. However, in situations where the emergency room is being utilized to deliver non-emergency care, notification will be provided to the injured worker, the hospital, and the provider of record that continued use of the emergency room for non-emergent services will not be reimbursed.

(E) The bureau may establish the same or different fees for in-state and out-of-state hospitals based on the above reimbursement methodologies

~~(F) Payment will be made for hospital services based on rules 4123-6-11 and 4123-6-12 in accordance with rule 4123-6-10 of the Administrative Code.~~

**Comment [nj145]:** OAC 4123-6-11 and OAC 4123-6-12 are being combined into OAC 4123-6-10.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97, 3/1/04

## 4123-6-38 Payment for home health nursing services. (Amend)

(A) Employment of nursing service.

(1) The need for nursing services must be the direct result of an allowed injury or occupational disease.

(2) Except as described in rule 4123-6-38.1 of the Administrative Code, home health nursing services shall be provided by registered nurses and licensed practical nurses employed by a ~~medicare-certified, joint-committee on accreditation of healthcare organizations (JCAHO) accredited, or community health accreditation (CHAP) accredited~~ home health agency meeting the qualifications specified in paragraph (C)(11) of rule 4123-6-02.2 of the Administrative Code.

**Comment [nj146]:** Language updated to clarify criteria required for home health agencies to be eligible for reimbursement.

(B) Fees for home health agency nursing services.

Fees for home health agency nursing services will be determined by the bureau. Payment will be made for home health nursing services ~~based on rules 4123-6-11 and 4123-6-12 in accordance with rule 4123-6-10 of the Administrative Code.~~

**Comment [nj147]:** OAC 4123-6-11 and OAC 4123-6-12 being combined into OAC 4123-6-10.

(C) Authorization for home health nursing services.

(1) Authorization for home health nursing services shall be considered only in cases where the claimant, as the direct result of an allowed injury or occupational disease, is bedfast or otherwise confined to the home, is mentally incapable of self-care or requires home care services ordered for hospital discharge follow-up.

(2) The request for authorization from the physician of record or treating physician must identify the reason for home health nursing services, the period of time the services will be required, the specific services and the number of hours per day that are required.

(3) In addition to skilled nursing services provided by a registered nurse or licensed practical nurse, the claimant may be approved for home health aide ~~or attendant~~ services. If he/she is unable to independently perform activities of daily living, including, but not limited to, feeding, bathing, dressing, providing personal hygiene, and transferring from bed to chair. Household, personal or other duties such as maintaining a household, washing clothes, preparing meals or running errands are not considered nursing services and will not be reimbursed.

**Comment [nj148]:** Attendant services are not reimbursable under the BWC fee schedule.

(4) Authorization must be obtained ~~from the MCO~~ prior to rendering home health nursing services, except in cases of emergency or where the claimant's allowed condition could be endangered by the delay of services.

**Comment [nj149]:** Language modified to apply to self-insured and QHP as well as State Insurance Fund claims.

(D) All covered home health services must be rendered on a part-time or intermittent care basis, in accordance with the written treatment plan and the bureau standard of care. Part-time or intermittent care means that services are generally rendered for no more than eight hours per day. Home health services rendered on a full time or continuous care basis are not covered. More appropriate alternative settings will be considered for claimants requiring more than eight hours per day of care, where medical necessity is documented. Exceptional cases may be reviewed by the bureau.

(E) A review of the claim or assessment of the injured worker will be conducted at ~~least least~~ annually to ensure that nursing services are necessary as a direct result of the allowed injury or occupational disease.

(F) Documentation requirements for home health agencies.

Home health agency providers must maintain records which fully document the extent of services provided to each claimant. All records must be maintained in accordance with the conditions of participation required for medicare certification, joint ~~committee on~~ commission accreditation of healthcare organizations (JCAHO) accreditation, or community health accreditation program (CHAP) accreditation. The provider may be required to furnish detailed hourly descriptions of care delivered to a claimant to review care needs and medical necessity.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97; 2/14/05

**4123-6-38.1 Payment for nursing and caregiver services provided by persons other than home health agency employees. (Amend)**

(A) Nursing services provided prior to December 14, 1992.

(1) Registered nurses and licensed practical nurses who are not employed by a medicare certified, joint commission ~~on accreditation of healthcare organizations (JCAHO)~~ accredited, or community health accreditation program (CHAP) accredited home health agency may continue to provide authorized services to a claimant if the services began prior to December 14, 1992.

(2) The need for nursing services must be the direct result of an allowed injury or occupational disease.

(3) In the event the registered nurse or licensed practical nurse is no longer able to provide approved services or if services are stopped and later restarted, nursing services shall be provided only by an employee of a medicare certified, joint commission ~~on accreditation of healthcare organizations (JCAHO)~~ accredited, or community health accreditation program (CHAP) accredited home health agency.

(B) Non-licensed caregiver services.

(1) Requests for extension of caregiver services initially provided prior to December 14, 1992.

(a) Prior to December 14, 1992, caregiver services provided by a non-licensed person including claimant's spouse, friend or family member were considered for reimbursement in cases where the claimant, as a direct result of an allowed injury or occupational disease, was bedfast, confined to a wheelchair, had a disability of two or more extremities which prevented the claimant from caring for his/her own body needs or was otherwise unable to take care of his/her own bodily functions. Services include, but are not limited to, feeding, bathing, dressing, providing personal hygiene, and transferring from bed to chair. Household, personal or other duties such as maintaining a household, washing clothes, preparing meals, or running errands, are not considered nursing services, and will not be reimbursed.

(b) Requests for an extension of caregiver services approved ~~by the bureau~~ prior to December 14, 1992, delivered by a non-licensed person, other than an attendant, aide, or claimant's spouse, but including other family members or friends, will be approved only if:

(i) The claimant does not have a spouse because the claimant is not married, or the claimant's spouse is deceased, or the claimant's spouse is physically or mentally incapable of caring for the claimant; and,

(ii) The approved home health agency is greater than thirty-five miles from the claimant's location and the home health agency refuses to provide services to the claimant.

(c) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a medicare certified, joint commission ~~on accreditation of healthcare organizations (JCAHO)~~ accredited, or community health accreditation program (CHAP) accredited home health agency.

(2) Requests for extension of caregiver services initially provided on or after December 14, 1992 and prior to January 9, 1995.

(a) Requests for approval of caregiver services delivered by a non-licensed person, other than an attendant, aide, or claimant's spouse were considered for reimbursement only if the claimant did not have a spouse or the spouse was physically or mentally incapable of caring for the claimant, or an approved

**Comment [tam50]:** "Grandfather" date arising from 1992 amendments to predecessor rule OAC 4123-7-25.

**Comment [tam51]:** "Grandfather" date arising from 1995 amendments to predecessor rule OAC 4123-7-25.

home health agency was greater than thirty-five miles from the claimant's location and the home health agency refused to provide services to the claimant.

(b) Criteria for approval of caregiver services were as indicated in paragraph (B)(1)(a) of this rule.

(c) After January 9, 1995, persons who are not home health agency home health aides or attendants, but who are currently approved to provide caregiver services to a claimant, may continue to do so until services are no longer medically necessary or unless services are not authorized. After January 9, 1995, approval of caregiver services shall only be considered when services are rendered by a home health agency home health aide or attendant.

(d) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a medicare certified, joint commission ~~on accreditation of healthcare organizations (JCAHO)~~ accredited, or community health accreditation program (CHAP) accredited home health agency.

(C) All covered home health services must be rendered on a part-time or intermittent care basis, in accordance with the written treatment plan and the bureau standard of care. Part-time or intermittent care means that services are generally rendered for no more than eight hours per day. Home health services rendered on a full time or continuous care basis are not covered. More appropriate alternative settings will be considered for claimants requiring more than eight hours per day of care, where medical necessity is documented. Exceptional cases may be reviewed by the bureau.

(D) A review of the claim or assessment of the injured worker will be conducted at least ~~least~~ annually to ensure that nursing services are necessary as a direct result of the allowed injury or occupational disease.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97; 2/14/05

**4123-6-38.2 Payment of nursing home and residential care/assisted living services. (Amend)**

(A) Payment to a nursing home or residential care/assisted living facility for the care of a claimant who sustained an injury or contracted an occupational disease in the course of and arising out of employment shall be made only when the need for such care is the direct result of the allowed conditions in the claim.

(B) Payment will be made only for care provided in ~~state licensed, medicaid certified~~ nursing homes and residential care/assisted living facilities meeting the qualifications specified in paragraph (C)(20) of rule 4123-6-02.2 of the Administrative Code.

(C) ~~In claims managed by an MCO,~~ Nursing home or residential care/assisted living facility care must be pre-authorized, except when a nursing home or residential care/assisted living facility is used immediately following an approved or emergency hospitalization.

(1) The allowed per diem rate for a claimant shall be no greater than the bureau's fee schedule or the rate negotiated between the nursing home or residential care/assisted living facility and the bureau, MCO, QHP, or self-insuring employer.

(2) Nursing home care shall be provided on a semiprivate ~~or ward~~ bed basis, unless a situation exists when the use of a private room is medically necessary due to the allowed industrial condition. In these cases, the use of such a private room must be pre-authorized, except in cases of emergency, as defined in rule 4123-6-01 of the Administrative Code, or where the claimant's condition would be endangered by delay.

(3) Fee bills for prescription medication provided to claimants in nursing homes and residential care/assisted living facilities for the treatment of the allowed industrial injury or occupational disease shall be submitted by the providing pharmacy in compliance with ~~rule 4123-6-24~~ the rules of this chapter of the Administrative Code.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 02/14/2005

**4123-6-39 Payment for prosthetic device or other artificial appliances used by disabled claimants following a loss of member award. (Amend)**

(A) In all cases arising under division (B) of section 4123.57 of the Revised Code, if a claimant requires the purchase or repair of an artificial appliance, as determined by any one of the following: (1) the amputee clinic at the Ohio state university medical center; (2) the rehabilitation services commission; (3) a multidisciplinary amputee clinic or prescribing physician approved by the administrator or the administrator's designee, the bureau shall pay the cost of purchasing or repairing the artificial appliance out of the surplus fund. The purchase or repair is made regardless of whether the appliance is part of the claimant's vocational rehabilitation, or if the claimant has, or will ever be able, to return to work.

**Comment [a52]:** Language added to conform to Ohio Revised Code 4123.57(C), to ensure evaluation is completed by an appropriate provider who will provide a comprehensive assessment specific to the claimant's prosthetic needs.

(B) The bureau is responsible for processing requests for prosthetics and travel expenses associated with the prosthetic in all self-insured claims. When a prosthetic device is needed in a self-insured claim, the provider will send a request for the prosthetic and/or request for repair, as well as the subsequent bills, to the bureau.

**Comment [nj153]:** Language added from rule OAC 4123-7-28, which is being rescinded

Promulgated Under: 119.03  
Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66  
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4121.61, 4123.57, 4123.66  
Prior Effective Dates: 2/12/97; 2/14/05

#### **4123-6-40 Payment of claimant travel expenses. (No Change)**

(A) A claimant's travel expenses shall be paid, upon the filing of a proper request, under the following circumstances:

(1) When the claimant has been ordered or authorized to undergo a medical examination outside of the city or community limits where he resides. The claimant shall be reimbursed for travel only if the travel distance exceeds a mileage distance as periodically determined by the bureau. The minimum mileage distance for reimbursement shall be published periodically by the bureau.

(2) When specialized treatment necessary for the allowed industrial condition cannot be obtained within the city or community where the claimant resides, and the treatment has been pre-authorized and approved. The claimant shall be reimbursed for travel only if the travel distance exceeds a mileage distance as periodically determined by the bureau. The minimum mileage distance for reimbursement shall be published periodically by the bureau.

(3) When the claimant has been requested to undergo a medical examination by a physician of the employer's choice, travel expenses incurred as a result of the examination are to be paid by the employer immediately upon the receipt of the bill. Payment of the bill shall not require an order of the bureau or commission, unless there is a dispute. The employer shall provide the claimant with a proper form to be completed by the claimant for reimbursement of traveling expenses. The minimum mileage provision of paragraphs (A)(1) and (A)(2) of this rule shall not apply for reimbursement of examinations under this paragraph of the rule.

(4) In situations described in paragraphs (A)(1) and (A)(2) of this rule, the following provisions apply:

(a) If the claimant is traveling by automobile, the claimant shall be entitled to a reasonable payment, as established and periodically published by the bureau, on a per mile basis if the mileage exceeds the distance established as provided under paragraph (A) of this rule, portal to portal, using the most direct and practical route.

(b) If the claimant is traveling by airplane, railroad or bus, the claimant shall be entitled to the actual and necessary airplane, railroad or bus fare.

(c) The reasonable cost of necessary meals, based on distance traveled, will be refunded to the claimant. It shall be paid in accordance with a schedule adopted by the bureau and periodically revised.

(d) Necessary hotel bills will be paid at reasonable actual cost. Hotel accommodation must be pre-authorized.

(5) Taxicab fares will be refunded only when the claimant's physical condition requires such transportation for treatment or examination on account of an allowed injury or occupational disease. Taxicabs or other special transportation shall be pre-authorized.

(6) The payment rates for meals, lodging and travel shall be published periodically by the bureau.

(B) Actual payment or refund shall be made in accordance with requirements outlined in this rule.

(C) This rule applies to all claims for industrial injuries and/or occupational diseases, regardless of whether the employer is part of the state fund, is self-insuring, is non-complying, etc.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97, 10/14/02, 6/1/05

**4123-6-41 No legal relationship between the industrial commission or bureau and a health care provider. (Amend)**

(A) Direct payment to a health care provider or other person by the industrial commission, self-insuring employer, bureau of workers' compensation, or their agent, for medical care rendered to a claimant does not imply or create a legal relationship between the provider or person and the commission, self-insuring employer, bureau, or their agent.

**Comment [nj154]:** Language added from OAC 4123-7-30, which is being rescinded.

**Comment [nj155]:** Language added from OAC 4123-7-30, which is being rescinded.

(B) The services rendered to the claimant are the legal obligation of the claimant. The direct payment to the health care provider is a discretionary method by which the award made to the claimant for medical expenses may be discharged.

(C) Except as prohibited by division (K) of section 4121.44 of the Revised Code and rule 4123-6-07 of the Administrative Code, ~~whether~~ when payment is made to the claimant, ~~or the claimant's obligation is discharged by a direct payment to the health care provider through payment to the MCO or QHP,~~ the sole legal recourse of the health care provider is against the claimant.

**Comment [tam56]:** Language modified for clarification.

Promulgated Under: 119.03  
Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66  
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 2/12/97; 1/1/99; 2/14/05

**4123-6-42 Payment Interest on late payments for equipment, materials, goods, supplies or services and interest incurred in state insurance fund, public work relief employees' compensation fund, coal workers' pneumoconiosis fund, and marine industry fund claims. (Amend)**

(A) Payment is made for equipment, materials, goods, supplies, or services incurred by the claimant in connection with claims against the state insurance fund, public work relief employees' compensation fund, coal workers' pneumoconiosis fund, or marine industry fund based on in accordance with section 126.30 of the Revised Code. For the purpose of this rule, the required payment date is the date on which payment is due under the terms of a written agreement between the bureau, or its agent, and the provider. Payment will be made either thirty days after the bureau, or its agent, receives a proper invoice for the amount of the payment due, or thirty days after the final adjudication allowing payment of an award to the claimant, whichever is later.

**Comment [a57]:** Language added to clarify which funds are responsible for paying interest on late provider payments.

(1) A "proper invoice" includes but is not limited to the claimant's name, claim number, date of injury or occupational disease, employer's name, provider's name and address and assigned payee number, a description of the service provided, the procedure code for the service provided, the date provided, and the amount of the charge. If more than one item has been included in the invoice, each item is to be considered separately to determine if it is a proper invoice.

(2) If the bureau or its agent determines that an invoice is improper, the bureau or its agent shall send notification to the provider through the MCO or QHP at least fifteen days prior to what would be the required payment date if the invoice did not contain an error. The notice shall describe the error and the additional information needed to correct the error. The required payment date shall be redetermined upon receipt of a proper invoice.

(3) If an invoice is for payment of either a condition not allowed in a claim, or for a claim that is not allowed, the payment date is thirty days after final adjudication of allowance of the condition or claim. As defined in section 126.30 of the Revised Code, "final adjudication" is the date that the decision of the bureau, industrial commission, or court becomes final, with no further right of appeal. If any section of the Revised Code contains a faster timetable for payments, however, such provisions shall not be superseded by this rule.

(B) Interest shall be paid based on division (E) of section 126.30 of the Revised Code. Any interest charges payable under section 126.30 of the Revised Code are to be paid by the bureau of workers' compensation.

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

#### 4123-6-43 Payment for transcutaneous electrical nerve stimulators and neuromuscular electrical stimulators. (Amend)

(A) Payment will be approved for a transcutaneous electric nerve stimulator (TENS) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in this rule and in the bureau's provider billing and reimbursement manual.

(1) ~~Prior authorization may be is required to have a prescribed transcutaneous electrical nerve stimulator for (TENS) unit units and supplies furnished to the claimant. Each claimant who requires a TENS unit will Claimants shall be provided only one TENS unit at a time. For each TENS unit request approved, the unit may shall be rented for a thirty day trial period lasting a minimum of one month but no more than four months before purchase of the TENS unit. This trial period is to evaluate the medical necessity and effectiveness of the TENS treatment. TENS treatment will be discontinued at the end of the thirty day trial period month where the treatment has not proven to be medically necessary or effective. Reimbursement of rental costs will be considered only for the trial period that the TENS unit was actually used before treatment was discontinued. For each TENS unit provided, payment shall be limited to necessary disposable or rechargeable batteries, but not both.~~

**Comment [nj]58:** Language incorporated from OAC 4123-7-34, which is being rescinded.

(2) ~~If the rental of the TENS unit is required prior to purchase, all BWC shall apply all rental payments previously made will be applied to the purchase price of the TENS unit. A TENS unit purchased and furnished to the claimant, is not the personal property of the claimant, but remains the property of the bureau, or self-insuring employer, or their agent. At its discretion, the The bureau, or self-insuring employer, or their agent, reserves the right to reclaim and recover the TENS unit from the claimant at the completion of the course of TENS treatment. Once a TENS unit is purchased, of the bureau, or self-insuring employer, or their agent, will reimburse for repair or replacement of the unit, at its discretion, upon submission of a request from the physician of record. The request must include or treating provider that includes medical documentation substantiating the continued medical necessity and effectiveness of the unit.~~

(B) ~~Claimants who have TENS units must complete and submit to the TENS provider a monthly written request for specific supplies needed in the following month. The written request must be initiated and signed by the claimant, and must be received by the TENS provider prior to the delivery of supplies and/or equipment. The TENS provider shall then deliver the supplies and bill the bureau, MCO, QHP, or self-insuring employer after the claimant's written request is received. The provider shall retain the original written request for supplies in accordance with the time frames set forth in rule 4123-6-45.1 of the Administrative Code. The bill must indicate the actual date of service, reflecting the date that services or supplies were provided. The bureau, MCO, QHP, or self-insuring employer may adjust bills upon audit if the audit discloses the provider's failure to comply with this rule.~~

**Comment [nj]59:** Language incorporated from OAC 4123-7-34, which is being rescinded, and language added to provide clarification on requirements for providers as to the provision and billing for supplies necessary for TENS units

(C) The TENS provider shall maintain the following records and make them available for audit upon request:

- (1) The injured worker's monthly written requests;
- (2) Records of the provider's wholesale purchase of TENS supplies or equipment; and,
- (3) Records of delivery of supplies to injured workers and of the delivery or return of TENS units.

Upon request, the provider shall supply copies of the record information to the requester at no cost. Failure to provide the requested records ~~will~~ may result in denial or adjustment of bills related to these records.

~~(C)~~(D) Payment will be approved for a neuromuscular electrical stimulator (NMNSNMES) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in the bureau's provider billing and reimbursement manual.

R.C. 119.032 review dates: 10/27/2004 and 03/01/2009

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 2/12/97

**4123-6-44 Bureau fees for practitioner provider services rendered by in-state and out-of-state practitioners (Amend)**

Bureau fees for in-state or out-of-state practitioners providers will be established by the administrator of workers' compensation with the assistance of the bureau's medical management and cost containment division. The bureau may establish different fees for in-state and out-of-state practitioners providers. The methods of payment may include rates based on resource based relative value scale (RBRVS), percent of allowed charges, or usual, customary and reasonable fee maximas, as determined by the bureau's medical management and cost containment division. Rates will be reviewed at least annually by the bureau to determine the need for appropriate adjustment.

Payment for practitioner provider services will be made ~~based on rules 4123-6-11 and 4123-6-12 in accordance with rule 4123-6-10~~ of the Administrative Code.

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

**Comment [a60]:** Language was modified to include entities other than licensed individuals- example would be ambulance providers.

**Comment [a61]:** Rules OAC 4123-6-11 and OAC 4123-6-12 are being combined into OAC 4123-6-10.

**4123-6-45 Audit of providers' patient and billing related records. (No Change)**

(A) Providers' patient and billing related records, including but not limited to those records described in rule 4123-6-451 of the Administrative Code, may be reviewed by the bureau or the MCO to ensure workers are receiving proper and necessary medical care, and to ensure compliance with the bureau's statutes, rules, policies, and procedures.

(1) Based on division (B)(16)(c) of section 4121.121 of the Revised Code, provider records may be reviewed before, during, or after the delivery of services. Reviews may be random, with no unreasonable infringement of provider rights, or may be for cause. Reviews may include the utilization of statistical sampling methodologies and projections based upon sample findings. Records reviews may be conducted at or away from the provider's place of business.

(2) Based on division (B)(17) of section 4121.121 of the Revised Code, legible copies of providers' records may be requested. Providers shall furnish copies of the requested records within thirty calendar days of receipt of the request. The bureau shall establish a schedule for payment of reasonable costs for copying records, which shall be published in the health care provider billing and reimbursement manual.

(3) Original records shall not be removed from the provider's premises, except upon court order or subpoena issued by the bureau pursuant to section 4121.15 or 4123.08 of the Revised Code.

(B) Upon any finding of improper or unnecessary medical care, the administrator shall, if requested by the provider, appoint a subcommittee of the stakeholders' health care quality assurance advisory committee to review and advise the administrator as provided in paragraph (K) of rule 4123-6-22 of the Administrative Code. The administrator may sanction, suspend, or exclude a health care provider from participation in the workers' compensation system based on rule 4123-6-17 of the Administrative Code.

(C) The bureau or the MCO may deny payment for services or declare as overpaid previous payments to providers who fail to provide records or access to records to either the bureau or the MCO. The bureau may decertify a health care provider that fails to provide records requested pursuant to Chapters 2913., 4121., and 4123. of the Revised Code.

Promulgated Under: 119.03  
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 2/12/97, 1/15/99

**4123-6-45.1 Records to be retained by provider. (No Change)**

(A) A health care provider shall create, maintain, and retain sufficient records, papers, books, and documents in such form to fully substantiate the delivery, value, necessity, and appropriateness of goods and services provided to injured workers under the HPP or of significant business transactions. The provider shall retain such records for a minimum period of three years from the date of payment for said goods or services, or three years from the date of referral to a certified or non-certified provider, or until any initiated audit or investigation is completed, whichever is longer. The provider shall create and maintain the records at the time the goods or services are delivered or within seven days from the date the service was rendered.

(B) The provider shall retain records documenting the following minimum information concerning the goods or services provided to injured workers:

- (1) Date the service was provided;
  - (2) Description of service, treatment or product provided;
  - (3) Record of patient appointments, if appropriate;
  - (4) Dates where injured worker canceled or failed to appear for a scheduled examination, treatment, or procedure;
  - (5) Treatment plans;
  - (6) Subjective and objective complaints, if the provider is the practitioner or physician of record;
  - (7) Injured worker's progress, if the provider is the practitioner or physician of record;
  - (8) Wholesale purchase records, if goods, products, or prescriptions are delivered;
  - (9) Delivery records, if goods, products, or prescriptions are delivered by way of a third party;
  - (10) The identity and qualifications of any individual involved in the delivery of health care or billing for services to injured workers on behalf of the provider billing for the services.
- (C) A provider's failure to create, maintain, and retain such records shall be sufficient cause for the bureau to deny payment for goods or services, to declare overpaid previous payments made to the provider, or to decertify the provider.

Promulgated Under: 119.03  
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 1/15/99

**4123-6-46 Standardized or negotiated payment rates for services or supplies.  
(Amend)**

(A) The bureau or self-insuring employer may negotiate payment rates with health care providers for services and supplies provided in the treatment of workers' compensation claims.

(B) ~~Volume-based contracts~~ The bureau or self-insuring employer may be made enter into volume-based contracts with medical providers for services including, but not limited to, the purchase or rental of durable medical equipment and supplies.

(C) ~~Injured workers~~ The bureau or self-insuring employer may be informed inform injured workers of the availability of services, supplies, or equipment from particular health care providers with whom a contract for services or supplies, a negotiated ~~a~~ payment rate for services or supplies, or a contract for cost-effective payment levels or rates has been ~~made entered into, so long as. In each case,~~ access to quality and convenient medical services or supplies must be for injured workers is maintained for claimants.

Promulgated Under: 119.03  
Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66  
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.651, 4123.66  
Prior Effective Dates: 2/12/97; 2/14/05

**Comment [a62]:** Language rewritten to active voice for clarification and references to self-insuring employer added, as rule OAC 4123-7-39 is being rescinded.



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Stakeholder feedback and recommendations for changes to the HPP Provider Payment rules Chapter 6, specifically 4123-6-04.4, 4123-6-06.2, 4123-6-06.3, 4123-6-10, 4123-6-11, 4123-6-12, 4123-6-14, 4123-6-20.1 Stakeholder feedback and recommendations for changes to the Health Partnership and HPP Medical Policy rules Chapter 6, specifically 4123-6-01.1; 4123-6-16.1; 4123-6-21; 4123-6-22; 4123-6-23; 4123-6-24; 4123-6-25; 4123-6-26; 4123-6-27; 4123-6-28; 4123-6-29; 4123-6-30; 4123-6-31; 4123-6-32; 4123-6-33; 4123-6-34; 4123-6-35; 4123-6-36; 4123-6-37; 4123-6-38; 4123-6-38.1; 4123-6-38.2; 4123-6-39; 4123-6-40; 4123-6-41; 4123-6-42; 4123-6-43; 4123-6-44; 4123-6-45; 4123-6-45.1; 4123-6-46 Stakeholder feedback and recommendations for changes to Chapter 4123-7 Payments to Health Care Providers

Line #	Rule # / Subject Matter	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
1	4123-6-06.2 / Employee access to treatment-employee choice of provider	TPA stakeholder suggested spelling out "HPP" and "QHP" in sections (A) and (B).	Clarity.	The acronyms HPP and QHP are defined in 4123-6-01 and are used throughout Chapter 6.	Keep as is.
2	4123-6-10 / Non-payment to non-certified providers	None - MCO stakeholder posed a question regarding application of Section (A)(5)(b).	IW preference to be treated by family dentist.	Certified providers must be used unless there is an access to care issue. Dentists should not be treated differently than other provider types.	Keep as is. Stakeholder was contacted and the rule discussed. Stakeholder was okay with the rule as drafted after the discussion.
4	4123-6-20 / Provider's obligation for submitting medical documentation and reports	MCO stakeholder commented that "Paragraph (A) is deleting the first sentence concerning the requirement for the provider to report an injury and notes it is duplicative of OAC 4123-6-02.8. In referencing this rule on-line the current version of 4123-6-02.8 is directed at the HPP process and reporting to the MCO or the BWC internet site."	"Need to verify that the update to 4123-6-02.8 addresses reporting to the MCO, QHP, or self-insuring employer of the injured worker. The updated rule was not attached to the packet so the comments are to clarify if this is duplicative language."	The updated version of 4123-6-02.8 was sent to the stakeholders for review in April. Section (A) applies to HPP, Section (B) applies to QHP, and Section (C) applies to self-insured, non-QHP employers.	Keep as is. Stakeholder was contacted and her concerns have been addressed.
5	4123-6-20 / Provider's obligation for submitting medical documentation and reports	TPA stakeholder suggested changing the title to "Obligation for submitting medical information and/or reports".	Improve clarity of rule's subject matter.	Agreed.	Title of rule was changed to:"Obligation for submitting medical documentation and reports"

Line #	Rule # / Subject Matter	Draft Rule Suggestions	Stakeholder Rationale	BWC Response	Resolution
6	4123-6-38 / Payment for home health nursing services 4123-6-38.1 / Payment for nursing and caregiver services provided by persons other than home health agency employees 4123-6-38.2 / Payment of nursing home and residential care/assisted living services and 4123-6-02.2 /Provider access to the HPP-provider credentialing criteria	Ohio Council on HomeCare suggests adding "the" to Joint Commission title, and to add an additional accreditation organization, "the accreditation commission for health care" to the rule.	The addition of the word "the" would be correct a part of the organization's title. Additionally, listing the recommended accreditation organization simply ensures home health agencies using that accreditation organization would be in compliance with the rule requirement.	Input reviewed by BWC. The rule does not need to specifically reflect each named organization granted deeming authority by Medicare, as this general acceptance of accreditation by deeming authorized entities is reflected in the revision to 4123-6-02.2(C)(11).	No change. Stakeholder contacted and understanding clarified.
7	4123-6-30 / Payment for physical medicine	MCO: Keep presumptive approval references general in the rule and develop further details within policy.	MCOs believe that the reflection of the number of visits in the rule is too specific, and could create challenges when making changes. Thus, details such as number of specific visits could be developed within amended policy, and not necessary to place into rule.	As BWC created the reference language recommendation, consideration was given to the implication of integrating the Self Insured rule on this issue into the Chapter 6 rule. The Self Insured rule specified the number of visits, and it was determined that this continued reflection of the actual number of visits would reduce potential issues for Self Insured users. This would not create any major challenges for future changes.	No change. Rule 4123-6-30 is being updated with language to reflect standardization of services between state fund and self-insured employers.
8	4123-6-30 / Payment for physical medicine	SI Stakeholder-Certified Nurse Practitioner (CNP) requesting change to proposed language to encompass nurse practitioner provider group.	The stakeholder noted that in the state of Ohio a CNP is able to see patients, including the ability to evaluate, treat and write prescriptions. Thus, pursuant to this stakeholder's interpretation of her scope of practice, she should be allowed to prescribe physical therapy; which the language as written would not accommodate.	The recommended changes to this component of the rule reflect BWC's objective to ensure quality care is provided by the appropriate provider type. BWC is currently researching the scope of practice for CNAs. At this point we are unable to confirm this perspective relative to CNAs' scope of practice.	No change to the proposed draft language.

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

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

**Chapter 4123-7 Payments to Health Care Providers**

**Rescission of Rules (30 rules)**

**Rule Review**

1.  The rule is needed to implement an underlying statute.  
Citation: O.R.C. 4123.66(A); O.R.C. 4123.35(B)
2.  The rule achieves an Ohio specific public policy goal.  
What goal(s): All thirty rules in Chapter 4123-7 are being rescinded as duplicative of Chapter 4123-6 rules (as amended concurrent with this rule rescission), as the Chapter 4123-6 provider payment rules will also apply to self-insuring employers going forward.
3.  Existing federal regulation alone does not adequately regulate the subject matter.
4.  The rule is effective, consistent and efficient.
5.  The rule is not duplicative of rules already in existence. The Chapter 4123-7 rules are duplicative of Chapter 4123-6 as amended; this proposed rescission will eliminate the duplication consistent with Executive Order 2008-04S and O.R.C. 119.032.
6.  The rule is consistent with other state regulations, flexible, and reasonably balances the regulatory objectives and burden.
7.  The rule has been reviewed for unintended negative consequences.
8.  Stakeholders, and those affected by the rule were provided opportunity for input as appropriate.  
Explain: BWC's proposed changes to the Chapter 4123-7 provider payment rules were e-mailed to the BWC Medical Division's list of stakeholders for review on Monday, September 14, 2009 with comments due back on Friday, September 18, 2009.
9.  The rule was reviewed for clarity and for easy comprehension.
10.  The rule promotes transparency and predictability of regulatory activity.
11.  The rule is based on the best scientific and technical information, and is designed so it can be applied consistently.
12.  The rule is not unnecessarily burdensome or costly to those affected by rule.  
If so, how does the need for the rule outweigh burden and cost? \_\_\_\_\_
13.  The Chief Legal Officer, or his designee, has reviewed the rule for clarity and compliance with the Governor's Executive Order.

**BWC Board of Directors**  
**Executive Summary**  
**Self-Insuring Employer Provider Payment Rules**  
**Chapter 4123-7**

**Introduction**

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

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

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

**Background Law**

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

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

**Proposed Changes**

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

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

**Stakeholder Involvement**

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

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

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

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

**Chapter 4123-7 Payments To Health Care Providers  
Self-Insuring Employer Medical Rules**

**4123-7-01 Jurisdictional principles applicable to payment of bills for medical services rendered by health care providers. (Rescind)**

**Comment [a1]:** Rule rescinded and combined into OAC 4123-6-23.

Jurisdictional requirements applicable to payment for medical services rendered by a health care provider are as follows:

(A) Bills must be filed within the time as provided in rule 4123-3-23 of the Administrative Code or be forever barred.

(B) In claims where the date of injury is on or after December 11, 1967, and prior to October 11, 2006, there is no jurisdiction to consider payment for medical services, if six years or more have elapsed since the date of the last payment of a medical bill and no compensation has been paid, except as provided in the following cases:

(1) A bill filed within the six-year period for services rendered within the period can be paid after the six-year period in those cases in which, except for the time passage, it would have been paid.

(2) Where an application requesting the payment of medical bills and/or compensation is filed within the six-year period, there is justification to act on the application after the period.

(a) Bills for services rendered within the six-year period can be ordered paid and can be paid after the period. However, such bills must be filed no later than two years after the date that the services were rendered.

(b) Compensation can be ordered paid provided the proof supports an award. If compensation is paid, the claim is opened for an additional ten years for the payment of compensation and bills. Where there has been a payment of compensation under section 4123.56, 4123.57 or 4123.58 of the Revised Code, the claim is active for ten years from the date of the last payment of compensation or ten years from the last payment of a medical bill, whichever is later.

(3) Where wages in lieu of compensation for total disability were paid by the employer within six years of injury, with knowledge of a claimed compensable injury, as provided in section 4123.52 of the Revised Code, amended effective January 1, 1979.

(4) Where a request for authorization of treatment beyond the six-year period is made in an application filed within the six-year period, the authorization for treatment after that period cannot be granted, unless the claim has been opened by the payment of compensation.

(5) There is no jurisdiction to consider the merits of any application filed after the six-year period, even though supporting proof for the application was on file within the period.

(6) A bill filed within the six-year period but requiring an application to reactivate claim cannot be paid when such application is not filed within the period. The same applies to bills filed after the expiration of the six-year period for treatment rendered within that period.

(C) In claims where the date of injury is prior to December 11, 1967, there is no jurisdiction to consider payment for medical services if ten years or more have elapsed since the payment of compensation or

benefits, or ten years have elapsed since the injury in cases in which no compensation has been awarded.

(D) In claims where the date of injury is on or after October 11, 2006, there is no jurisdiction to consider payment for medical services if five years or more have elapsed since the payment of compensation or benefits. The provisions of paragraph (B) of this rule shall apply to the payment of medical bills in claims where the date of injury is on or after October 11, 2006, except that where those provisions reference six year and ten year time limits, the time limits shall be five years.

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: 4123.52, 4123.65  
Prior Effective Dates: 1/1/78, 12/21/79, 4/1/07

**4123-7-02 Treatment necessary on account of an industrial injury or occupational disease. (Rescind)**

**Comment [a2]:** Rule rescinded and combined into OAC 4123-6-25.

Medical or other services to be approved for payment must be rendered as a direct result of an injury sustained or occupational disease contracted by a claimant in the course of and arising out of employment for which the claim was allowed by an order of the bureau of workers' compensation or of the industrial commission, or for which the claim was recognized by a self-insuring employer. "Claimant," as used in this chapter, is understood to mean:

(A) An employee or a worker who filed an industrial claim, alleging an injury or an occupational disease sustained in the course of and arising out of employment.

(B) An employee or a worker whose industrial claim was allowed for an injury sustained or an occupational disease contracted in the course and arising out of employment.

Promulgated Under: 119.03  
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: RC 4121.121, 4121.30, 4121.44  
Prior Effective Dates: 1/1/78

#### **4123-7-03 Payment for medical supplies and services. (Rescind)**

**Comment [a3]:** Rule rescinded and combined into OAC 4123-6-25.

(A) Medical supplies and services will be considered for payment by a self-insuring employer when they are medically necessary for the diagnosis and treatment of conditions allowed in the claim, are causally related to the conditions allowed in the claim, and are rendered by a health care provider. Payment for services rendered to a claimant shall be paid to a health care provider only when the provider has either delivered, rendered or directly supervised the examination, treatment, evaluation or any other medically necessary and related services provided to the claimant. By submitting any fee bill to a self-insuring employer, in either hardcopy or electronic format, the health care provider affirms that medical supplies and services have been provided to the claimant as required by this rule.

(B) Services rendered by health care providers are subject to review for coding requirements outlined in paragraph (C) of this rule. Payments to health care providers may be adjusted based upon these guidelines.

(C) Coding systems.

(1) Billing codes.

(a) Practitioners are required to use the most current edition of the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) to indicate the procedure or service rendered to injured workers.

(b) Inpatient and outpatient hospital services must be billed using the national uniform billing committee's revenue center codes.

(c) Outpatient medication services must be billed pursuant to the requirements described in the bureau's provider billing and reimbursement manual.

(d) To insure accurate data collection, the bureau shall adopt a standardized coding structure which shall be adopted by any MCO, QHP or self-insuring employer.

(2) ICD-9 diagnosis codes.

Providers must use the most current edition of the "International Classification of Diseases, clinical modification" to indicate diagnoses.

(D) Prior to services being delivered, the provider must make reasonable effort to notify the claimant, bureau, MCO, QHP or self-insuring employer when the provider has knowledge that the services may not be related to the claimed or allowed condition(s) related to the industrial injury or illness, or that a service is non-covered. The provider may not knowingly bill or seek payment from the bureau, MCO, QHP or self-insuring employer for services that are not related to the claimed or allowed condition(s) related to the industrial injury or illness. The provider may not knowingly mislead or direct providers of ancillary services to bill or seek payment for services that are not related to the claimed or allowed condition.

The provider may not bill or seek payment from the claimant for services determined as medically unnecessary through the use of bona fide peer review based on accepted treatment guidelines.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.30, 4121.44, 4123.66

Prior Effective Dates: 1/1/78, 4/1/07

**4123-7-04 Claimant reimbursement. (Rescind)**

**Comment [a4]:** Rule rescinded, substance covered by OAC 4123-6-26.

In cases where the claimant pays for medical services or supplies directly to a health care provider who does not accept assignment as defined in rule 4123-7-30 of the Administrative Code, or if any other person or payor, including a volunteer, makes the payment on behalf of the claimant, and the claim or condition is subsequently allowed, the bureau shall reimburse the payor upon submission of evidence of the service or supply and evidence of the payment for that service or supply. The payor will receive as payment the usual, customary, and reasonable amount that would have been paid by the bureau or self-insuring employer to the health care provider as provided by the rules of this chapter. Where the bureau, in good faith, has already made the payment to the health care provider, the payor shall be informed by the bureau to seek reimbursement from the payee.

Upon request, the bureau shall inform a claimant or payor whether a health care provider has agreed to submit fee bills to the bureau for direct payment and assignment as provided in rule 4123-7-30 of the Administrative Code.

Promulgated Under: 119.03  
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: RC 4121.121, 4121.44, 4123.66  
Prior Effective Dates: 1/1/78, 11/13/92

#### **4123-7-05 Treatment by more than one physician. (Rescind)**

**Comment [a5]:** Rule rescinded, substance covered by OAC 4123-6-27.

Medical fees shall not be approved for treatment by more than one physician for the same condition over the same period of time, except where a consultant, anesthetist or assistant is required, or where the necessity for treatment by a specialist is clearly shown and approved by the bureau, by the industrial commission or its medical section, or in self-insuring employers' claims by the self-insuring employer, in advance of such treatment, except in cases of emergency. (For definition of "emergency" see rule 4123-7-16 of the Administrative Code.)

(A) The assistance of another physician is not ordinarily considered necessary in the application of a cast or for operation on fingers, thumbs, or toes. If there are any unusual conditions which require such assistance, a fee will be paid to the assistant (or ordered to be paid by the self-insuring employer in self-insuring employers' claims) only on full explanation and upon approval of the industrial commission's medical section.

(B) Reports of consultations and laboratory procedures must be submitted before fees for the same are approved.

(C) In cases where the consultant continues treatment, a fee for first treatment will be paid to the consultant rather than a consultant's fee unless it is affirmatively shown that the referral by the attending physician for treatment by the consultant followed the receipt and evaluation of the consultant's report.

(D) If a licensed practitioner receives a case in which the first treatment has been rendered by another physician, the physician is entitled to the usual, customary and reasonable fee (as determined under rule 4123-7-03 of the Administrative Code) for the first service.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05

Rule Amplifies: RC 4121.121, 4121.30, 4121.44

Prior Effective Dates: 1/1/78

**4123-7-06 Treatment of more than one condition or to more than one part of the body. (Rescind)**

In claims involving treatment of more than one condition or to more than one part of the body, care should be given by the attending physician to report all conditions and all parts of the body treated. Such information may be of major significance in later determination of the extent of disability as a result of the industrial injury or occupational disease. It shall be the duty of the claims examiners and/or claims reviewers to see to it that in claims under their jurisdiction proper steps are taken to obtain the necessary information on the question of extent of injuries or occupational diseases, either through correspondence or investigation, at the earliest possible time.

Promulgated Under: 119.03  
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: RC 4121.121, 4121.30, 4121.44  
Prior Effective Dates: 1/1/78

**Comment [a6]:** Rule rescinded and combined into OAC 4123-6-20.

**4123-7-07 Filing of bills. (Rescind)**

(A) Fee bills for treatment subsequent to the initial care should be filed on a regular, periodic basis, such as once every four to eight weeks. Fee bills should not include services which were a part of a former fee bill. Duplicate bills should not be filed as a substitute for an inquiry, except upon notification from the bureau that there is no record of the original.

(B) In cases where treatment was not authorized in advance, the hearing officer, at the hearing, may, in the hearing officer's discretion, determine that fee bills for such treatment are to be paid retroactively.

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

Promulgated Under: 119.03  
Statutory Authority: RC 4121.12, 4121.30, 4121.31, 4123.05  
Rule Amplifies: RC 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 1/1/78, 1/15/99

**Comment [a7]:** Paragraph (A) of Rule rescinded as unnecessary.

Paragraph (B) of Rule rescinded, substance covered by IC rule OAC 4123-17-07.

Paragraph (C) of Rule rescinded, language will be added to final OAC 4123-6-10.

**4123-7-08 Obligation for submitting reports. (Rescind)**

**Comment [a8]:** Rule rescinded and combined into OAC 4123-6-20.

(A) As provided in rules 4123-6-02.8 and 4123-6-71 of the Administrative Code, a provider who undertakes treatment in an industrial case assumes the obligation to notify the bureau, MCO, QHP, or self-insuring employer of the injury within twenty-four hours of the initial treatment or initial visit.

(B) Interim medical reports and medical documentation.

Compensation for temporary total disability is payable upon submission of current supporting medical documentation. Interim reports must be filed, on forms provided by the bureau, at least every thirty days while the claimant remains on temporary total disability. Interim reports must include at least:

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

(C) Treatment plan.

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

- (a) Details of the frequency, duration, and expected outcomes of medical interventions, treatments, and procedures;
- (b) The projected or anticipated return to work date; and
- (c) Factors that are unrelated to the work related condition, but are impacting recovery.

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

(3) Treatment plans should be updated when significant changes occur in the claim which impact claims management. Changes include:

(a) Additional allowance;

(b) Re-activation;

(c) Authorization of expenditures from the surplus fund;

(d) Return to modified or alternative work;

(e) Maximum medical improvement;

(f) Rehabilitation;

(g) A new injury while receiving treatment in the claim.

(4) Supplemental reports from the attending physician and other providers may be requested by the bureau, industrial commission, employer, MCO, QHP, or by the claimant or representative. These reports shall be used to determine the appropriateness of a benefit or bill payment.

(D) In accepting a workers' compensation case, a medical provider assumes the obligation to provide to the bureau, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer, upon written request or facsimile thereof and within five business days, all medical, psychological, or psychiatric documentation relating causally or historically to physical or mental injuries relevant to the claim required by the bureau, MCO, QHP, or self-insuring employer, and necessary for the claimant to obtain medical services, benefits or compensation. Providers may charge fees for the provision of such records only to the extent permitted under rule 4123-6-20.1 of the Administrative Code.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.44, 4123.57, 4123.66

Prior Effective Dates: 1/1/78, 9/15/81, 2/14/05

**4123-7-09 Request for information by the treating physician. (Rescind)**

A licensed practitioner, who is treating an industrial injury or occupational disease may, at any time, make a request in writing, fascimile, e-mail, or by telephone for information from the self-insuring employer as to conditions for which the claim was allowed and/or as to conditions which were being contested. Such requests shall be answered by the self-insuring employer within five working days from the date of the receipt of the request

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4123.05

Rule Amplifies: RC 4121.121, 4121.30, 4121.44

Prior Effective Dates: 1/1/78, 2/14/05

**Comment [a9]:** Rule rescinded and combined into OAC 4123-6-29.

**4123-7-10 Free choice of physician and of other medical services. (Rescind)**

**Comment [a10]:** Rule rescinded and combined into OAC 4123-6-06.2.

(A) This rule pertains to employees of self-insuring employers who do not have a QHP.

Choice of provider for employees of self-insuring employers with a QHP is governed by 4123-6-56 of the Administrative Code.

(B) In claims sustained on or after November 2, 1959, employees of self-insuring employers have free choice to select licensed physicians for treatment, as well as other medical services, including, but not limited to, hospital and nursing services.

In claims sustained prior to November 2, 1959, medical services furnished by the self-insuring employer must be utilized.

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

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

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

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

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.30, 4121.44, 4123.651, 4123.66

Prior Effective Dates: 1/1/78, 2/14/05

**4123-7-12 Payment for physiotherapy treatment. (Rescind)**

**Comment [a11]:** Rule rescinded and combined into OAC 4123-6-30.

(A) "Physical therapy" means the evaluation and treatment of a person by physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating any disability. Physical therapy includes the establishment and modification of physical therapy programs, treatment planning, instruction and consultative services. Physical measures include massage, heat, cold, air, light, water, electricity, sound, and the performance of tests of neuromuscular function as an aid to such treatment. Physical therapy does not include the diagnosis of a patient's disability, the use of Roentgen rays or radium for diagnostic or therapeutic purposes, or the use of electricity for cauterization or other surgical purposes. Physical therapy includes physiotherapy.

(B) Physical therapy (or physiotherapy) treatment may be rendered only upon the prescription of, or the referral by, the doctor of record who is licensed to practice medicine and surgery, dentistry or podiatry, or by a consultant in an industrial claim, who has the same qualifications.

(C) Fees for physical therapy (or physiotherapy) used for treatment of the allowed conditions shall be approved only to such licensed practitioners who hold a valid license to practice physical therapy (or physiotherapy) as physical therapists (or physiotherapists) or as physical therapist assistants.

(D) Fees, as described in paragraph (C) of this rule shall not be approved for more than ten treatments, unless authorized in advance by the bureau, by the industrial commission, or by a self-insuring employer in self-insuring employers' claims. In justifiable cases where the treatments have exceeded ten without prior approval, the case shall be referred to the medical section for a review and possible approval.

(E) Authorization for additional physiotherapy treatment must be requested, in advance, by a doctor of record or a consultant. Such request shall contain, but will not be limited to, the following information:

- (1) An outline as to what has been accomplished by the physiotherapy treatment rendered.
- (2) The reason for the necessity of further physiotherapy treatment, considered in light of the allowed industrial condition.
- (3) The number of additional treatments which are anticipated.

(F) Additional fees for physiotherapy in cases covered by a flat fee are not approved without specific authorization.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.30, 4121.31 in conjunction with 4123.66 and 4755.40 to 4755.50

Prior Effective Dates: 1/1/78

### **4123-7-13 Payment for chiropractic treatment. (Rescind)**

**Comment [a12]:** Rule rescinded as unnecessary (language largely duplicates chiropractic practice statutes).

“Practice of chiropractic” or “practice as a chiropractor” means utilization of the relationship between the muscular skeletal structures of the body, the spinal column and the nervous system, in the restoration and maintenance of health, in connection with which patient care is conducted with due regard for first aid, hygienic, nutritional, and rehabilitative procedures and the specific vertebral adjustment and manipulation of the articulations and adjacent tissues of the body. The chiropractor is authorized to examine, diagnose, and assume responsibility for the care of patients. The practice of chiropractic does not permit the chiropractor to treat infectious or contagious diseases, to perform surgery or acupuncture, or to prescribe or administer drugs for treatment. Roentgen rays shall be used only for diagnostic purposes. An individual holding a valid, current certificate of registration to practice chiropractic is entitled to use the title “doctor” or “doctor of chiropractic” and is a “physician” for the purposes of Chapter 4123. of the Revised Code (section 4734.09 of the Revised Code).

(A) Treatment procedures include and permit:

(1) The use of all varieties of specific vertebral adjustments and manipulations of the articulations and adjacent tissues of the body.

(2) Furnishing and fitting of proper orthopaedic appliances and supports.

(B) In cases of prolonged chiropractic treatment or if the charges made for such treatment appear to be excessive, claims shall be referred to the industrial commission’s medical section for a review and opinion before a determination is made on the issue or issues raised.

(C) The appropriateness of charges made by chiropractors for treatment rendered in industrial claims shall be determined by the industrial commission’s medical section, or self-insuring employer in self-insuring employers’ claims, in the manner as provided in rule 4123-7-03 of the Administrative Code.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.30, 4121.31 in conjunction with 4123.66 and 4755.40 to 4755.50

Prior Effective Dates: 1/1/78

**4123-7-14 Acupuncture. (Rescind)**

**Comment [a13]:** Rule rescinded and combined into OAC 4123-6-31.

(A) Acupuncture is a recognized method of treatment in Ohio. Such treatment must be pre-authorized by a self-insuring employer in self-insuring employers' claims. It must be administered by a licensed doctor of medicine, doctor of osteopathic medicine and surgery, doctor of podiatric medicine who has completed a course of study in acupuncture under the administration of an approved college of medicine, college of osteopathic medicine and surgery, or a college of podiatric medicine, doctor of chiropractic who holds a certificate to practice acupuncture from the Ohio state chiropractic board, or a registered non-physician acupuncturist.

(B) Services provided by a non-physician acupuncturist must be prescribed by persons licensed under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery or podiatry or Chapter 4734. of the Revised Code to practice chiropractic. A registered non-physician acupuncturist shall perform acupuncture under the general supervision of the injured worker's prescribing physician or chiropractic physician. General supervision does not require that the acupuncturist and the prescribing physician or chiropractic physician practice in the same office.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/1/78, 10/10/03, 9/22/08

**4123-7-15 Payment for x-rays. (Rescind)**

A self-insuring employer shall pay for x-ray examinations (including CT, MRI, and discogram) when medical evidence shows that the examination is medically necessary either for the treatment of an allowed injury or occupational disease, or for diagnostic purposes to pursue more specific diagnoses in an allowed claim. Providers shall follow all bureau prior authorization policies in effect at the time when requesting authorization and payment for such studies.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.30, 4121.31, 4123.66

Prior Effective Dates: 1/1/78, 2/14/05

**Comment [a14]:** Rule rescinded and combined into OAC 4123-6-31.

**4123-7-17 Medical billing in self-insured claims. (Rescind)**

Providers billing for services rendered in self-insured claims shall follow the procedures set forth in the bureau's provider billing and reimbursement manual.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.44, 4123.651, 4123.66

Prior Effective Dates: 1/1/78, 5/18/92, 2/14/05

**Comment [a15]:** Rule rescinded and combined into OAC 4123-6-25.

**4123-7-18 Payment for dental care. (Rescind)**

**Comment [a16]:** Rule rescinded and combined into OAC 4123-6-31.

(A) A self-insuring employer shall pay for dental care in the following cases:

(1) Where an industrial injury or occupational disease either has caused damage or has adversely affected the claimant's natural teeth.

(2) For industrial injuries or occupational diseases sustained prior to January 1, 1979, artificial teeth or other denture must be in place in the worker's mouth at the time of damage or loss.

(3) For industrial injuries or occupational diseases sustained on or after January 1, 1979, the requirements of division (A)(2) of this rule do not apply.

(B) Responsibility for injuries or occupational diseases affecting the claimant's natural teeth is limited to the repair or replacement of those teeth actually injured at the time of the accident, or directly affected by the injury or disease. This responsibility does not include the replacement of teeth which are extracted or repaired for purposes unrelated to the industrial injury or occupational disease.

(C) Replacement of artificial teeth when the injury or occupational disease has resulted in a deformity of the jaw to the extent that artificial teeth cannot be used, is subject to the limitations of paragraphs (A)(2) and (A)(3) of this rule.

(D) Responsibility for the repair of both natural and artificial teeth is limited to the damage done at the time of the accident, or to the damage directly caused by an allowed injury or occupational disease.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66

Rule Amplifies: RC 4123.66

Prior Effective Dates: 1/1/78, 12/21/79, 2/14/05

**4123-7-19 Payment for eyeglasses and contact lenses. (Rescind)**

**Comment [a17]:** Rule rescinded and combined into OAC 4123-6-31.

(A) A self-insuring employer shall approve payment to replace eyeglasses or contact lenses when an industrial injury or an industrial accident which not only causes an injury, but also results in the damage or loss of the claimant's eyeglasses or contact lenses.

(1) In the event of injury prior to January 1, 1979, the eyeglasses must be in place on the claimant's face and the contact lenses shall be in place in the claimant's eye(s) at the time of injury.

(2) In the event of injury on or after January 1, 1979, the requirements of paragraph (A)(1) of this rule do not apply.

(B) Contact lenses or glasses are reimbursed when loss of vision is the direct result of an allowed injury or occupational disease.

(C) Refractions will be approved in situations described in paragraph (B) of this rule.

(D) Replacement of glasses with contact lenses is approved when medical evidence indicates a direct need due to an allowed injury or occupational disease.

(E) Glasses or contact lenses will be approved for treatment purposes, when necessary, as a direct result of the allowed injury or occupational disease. Any subsequent adjustment, maintenance supplies, or change in a claimant's glasses or contact lenses, if required for treatment of the allowed injury or occupational disease, will also be approved when supported by evidence of a direct causal relationship.

When eyeglasses and/or contact lenses were damaged or broken in an industrial accident in which an injury was sustained by the claimant and have been replaced, no further replacement will be approved due to subsequent breakage or for any other reason except as provided in this paragraph of this rule.

Promulgated Under: 119.03  
Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66  
Rule Amplifies: RC 4123.66  
Prior Effective Dates: 1/1/78, 12/21/79, 2/14/05

**4123-7-20 Payment for hearing aids. (Rescind)**

**Comment [a18]:** Rule rescinded and combined into OAC 4123-6-31.

(A) Where an industrial injury or an industrial accident which causes an injury also damages the claimant's hearing aid(s), a self-insuring employer shall approve payment to replace such hearing aid(s) as follows:

(1) For injuries or accidents sustained prior to January 1, 1979, the hearing aid(s) must be in place in the claimant's ear(s) at the time of the injury or accident.

(2) For injuries or accidents sustained on or after January 1, 1979, the requirements of paragraph (A)(1) of this rule do not apply.

(3) Once hearing aid(s) have been replaced, no further replacement will be approved.

(B) When a partial loss of hearing is the direct result of an allowed industrial injury or occupational disease, payment for hearing aid(s) is justified in order to improve the claimant's ability to hear.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66

Rule Amplifies: RC 4123.66

Prior Effective Dates: 1/1/78, 12/21/79, 2/14/05

**4123-7-21 Payment for shoes, braces, and other orthotic devices. (Rescind)**

**Comment [a19]:** Rule rescinded and combined into OAC 4123-6-31.

A self-insuring employer shall approve payment only for those orthotic devices prescribed in writing by the physician of record for treatment of an allowed injury or occupational disease. The use of the orthotic device must be directly related to the allowed industrial injury or occupational disease.

(A) Orthotic devices shall be custom fitted or custom fabricated and delivered to the satisfaction of the prescribing physician and the administrative agencies. Repairs, modifications, and adjustments to secure satisfactory application of the orthotic appliance shall be made within sixty days of fitting and application without additional charge by the supplier of the orthotic device.

(B) No charge shall be made for measurement, transportation, or other expenses incurred by the supplier-orthotist, except when the supplier-orthotist is required to travel beyond the limits of the metropolitan community in which he maintains his place of business by reason of the physical incapacity of the claimant or by reason of direct prescription by the attending physician. The supplier-orthotist shall be paid for traveling expenses on a round-trip basis. Additional charges must be separately specified on the supplier-orthotist's billing, including the points of travel and the name of the physician prescribing the travel. Payment will be made for a maximum of three round-trip calls.

Promulgated Under: 119.03

Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66

Rule Amplifies: RC 4121.121, 4121.30, 4123.66

Prior Effective Dates: 1/1/78, 2/14/05

**4123-7-23 Payment for outpatient medication. (Rescind)**

**Comment [a20]:** Rule rescinded and new, identical self-insuring employer pharmacy rule OAC 4123-6-21.1 will be created.

(A) Medication must be for treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer.

(B) Medication must be prescribed by the physician of record in the industrial claim or by the treating physician, or by such other treating provider as may be authorized by law to prescribe such medication.

(C) Drugs covered are limited to those that are approved for use in the United States by the Food and Drug Administration and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) A self-insuring employer may approve and reimburse for various drugs as a part of a comprehensive treatment plan submitted by the physician of record or a treating physician when reasonably related to and medically necessary for treatment of the allowed conditions in the claim, provided that such approval and reimbursement shall not constitute the recognition of any additional conditions in the claim even if such drugs are used to treat conditions that have not been allowed in the claim.

(E) Payment for medications to pharmacy providers shall include a product cost component and a dispensing fee component.

(1) The product cost component shall be the lesser of the following: maximum allowable cost established under paragraph (O) of this rule, if applicable, or the average wholesale price of the commonly stocked package size plus or minus a percentage. The percentage amount added or subtracted from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.

(2) The dispensing fee component shall be a flat rate fee determined by the bureau and subject to annual review, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider pursuant to rule 4123-7-39 of the Administrative Code.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN), or other proprietary code that serves to group together pharmaceutically equivalent products (defined as products that contain the same active ingredients in the same strengths, dosage forms, and routes of administration), per rolling twenty-five days. Exceptions to the single dispensing fee are:

(i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;

(ii) Cases where the physician has changed the dosage;

(iii) Cases where the medication did not last for the intended days supply;

(iv) Cases where the medication has been lost, stolen or destroyed;

(v) Controlled substances (which are limited to two dispensing fees per twenty-five days).

(vi) Cases where the self-insuring employer determines the limitations of this paragraph to be unnecessary under the specific circumstances.

(F) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined in paragraph (E) of this rule, unless the self-insuring employer has negotiated a payment rate with the provider pursuant to rule 4123-7-39 of the Administrative Code. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(G) The pharmacy provider is required to follow all applicable line by line billing instructions as published in the bureau's health care provider billing and reimbursement manual. At least thirty days written notice will be given prior to required changes in billing procedures.

(H) Claimant reimbursement for medications shall at least be equal to the bureau's established rate for the medication, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider utilized by the claimant pursuant to rule 4123-7-39 of the Administrative Code, in which case the claimant reimbursement shall be at least the rate negotiated with the provider. Requests for reimbursement must be paid within 30 days of receipt of the request.

(I) Self-insuring employers must obtain a drug utilization review from a physician before terminating payment for current medications, as follows:

(1) Before terminating payment for current medications, the self-insuring employer shall notify all parties to the claim (including authorized representatives) and the prescribing physician, in writing, that a physician drug review is being performed, or has been performed, regarding the necessity and appropriateness of the continued use of current medications (by therapeutic drug class).

(2) The written notice shall inform all parties to the claim (including authorized representatives) and the prescribing physician that they have 21 days from receipt of the notice to provide additional information and/or medical documentation to justify the need for continued use of the medications (by therapeutic drug class).

(3) The self-insuring employer shall provide all medically related information regarding the medications to an independent physician reviewer for review and opinion as to the necessity or appropriateness of the medications. If the self-insuring employer has obtained an independent physician reviewer's report prior to sending the notice required by paragraph (I)(1) of this rule and subsequently receives additional information and/or medical documentation pursuant to paragraph (I)(2) of this rule, the self-insuring employer shall provide the additional information and/or medical documentation to the independent physician reviewer and obtain an addendum. The independent physician reviewer's report (and addendum, if applicable) shall address the medical rationale, necessity and appropriateness of the drug treatment in the control of symptoms associated with the allowed conditions in the claim.

(4) When the independent physician reviewer's report (and addendum, if applicable) indicates the drug treatment is not medically necessary or appropriate for treatment or in the control of symptoms associated with the allowed conditions in the claim, the self-insuring employer may terminate reimbursement for the medications (by therapeutic drug class) effective as of the date of receipt of the independent physician reviewer's report, or addendum if one is obtained, or in the case that a drug is in a therapeutic class that requires a "weaning-off" period, such other date as agreed to by the prescribing physician and self-insuring employer.

(5) In the event the self-insuring employer terminates reimbursement for the medications as set forth in paragraph (I)(4) of this rule, the self-insuring employer or its authorized representative shall provide all parties to the claim (including authorized representatives) and the prescribing physician with a copy of the independent physician reviewer's report (and addendum, if applicable) and the self-insuring employer shall notify the employee and the employee's representative in writing of its decision to terminate. The employer's notification to the employee and employee's representative shall indicate that the employee has the right to request a hearing before the Industrial Commission.

(6) In the event there is a dispute as to whether the drug treatment is medically necessary or appropriate for treatment of the symptoms associated with the allowed conditions in the claim, the disputed matter shall be adjudicated in accordance with Rule 4123-19-03(K)(5) of the Administrative Code.

(J) Self-insuring employers may deny initial requests for a therapeutic class of drugs as not being reasonably related to or medically necessary for the treatment of the allowed conditions in a claim.

(K) Self-insuring employers may utilize medication utilization protocols formulated by the bureau for select conditions or diseases consistent with one or more of the following:

(1) Compendia consistent of the following:

(a) "United States Pharmacopoeia – Drug Information";

(b) "American Medical Association Drug Evaluations";

(c) "Drug Facts and Comparisons"; or,

(2) Peer reviewed medical literature.

Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's or self-insured employer's refusal to reimburse for such medications.

(L) Through internal development or through vendor contracts, self-insuring employers may implement a point-of-service adjudication system. Upon implementation, a self-insuring employer may require pharmacy providers to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the established bill processing system as a condition of reimbursement, and may refuse submission by paper or by tape-to-tape.

(M) Self-insuring employers utilizing a point of service adjudication system may require prior authorization of drugs or therapeutic classes of drugs which appear on BWC's published list of drugs or therapeutic classes of drugs for which prior authorization is required.

(N) Self-insuring employers utilizing a point of service adjudication system may apply the following dispensing limitations, adopted by the bureau, to medications approved and reimbursed by the self-insuring employer:

(1) The bureau may publish a list of drugs identifying those drugs that are considered "chronic" medications. Drugs not identified as chronic medications shall be considered "acute" medications.

(a) Acute medications may be limited by the self-insuring employer to a thirty-four day supply.

(b) Chronic maintenance medications may be limited by the self-insuring employer to a one-hundred-two day supply.

(2) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

(3) Requests submitted that exceed either the days supply limit or maximum quantity limit shall be denied; provided, however, that the pharmacy provider may still fill the prescription up to the days supply limit or maximum quantity limit, as applicable. Denials may be overridden by the self-insured employer in cases where medical necessity and appropriateness have been determined.

(4) Refills requested before seventy-five per cent of the days supply has been utilized will be denied, except in cases where the dosage of a noncontrolled drug has been increased and has a new prescription number. Denials may be overridden by the self-insured employer for the following documented reasons:

(a) Previous supply was lost, stolen or destroyed;

(b) Pharmacist entered previous wrong day supply;

(c) Out of country vacation or travel;

(d) Hospital or police kept the medication.

(O) Self-insuring employers utilizing a point of service adjudication system may apply the maximum allowable cost list of the point of service adjudication system vendor to medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations." Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug.

(P) A self-insuring employer has sufficient grounds to refuse to pay for the dispensing of drugs and other medications when a pharmacy provider fails to observe any state or federal law relating to his or her professional licensure or to the dispensing of drugs and other medication.

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121, 4121.30

Rule Amplifies: 4121.44, 4123.66

Prior Effective Dates: 1/1/78, 5/18/92, 1/1/03, 6/1/06

**4123-7-24 Payment of hospital bills. (Rescind)**

**Comment [a21]:** Rule rescinded and combined into OAC 4123-6-37.

(A) Direct reimbursement will not be made to members of a hospital resident staff.

(B) Payment for personal comfort items, which include, but are not limited to, telephones, television, and private rooms provided at the patient's request, are not compensable.

(C) Bureau fees for hospital inpatient services.

(1) Bureau fees for hospital inpatient services will be based on usual and customary methods of payment, such as prospective payment systems, including diagnosis related groups (DRG), per diem rates, rates based on hospital costs to charge ratios or percent of allowed charges.

(2) Except in cases of emergency as defined in rule 4123-6-01 of the Administrative Code, prior authorization must be obtained in advance of all hospitalization. The hospital must notify the self-insured employer of emergency inpatient admissions within one business day of the admission.

Failure to comply with this rule shall be sufficient ground for denial of room and board charges by the self-insured employer from the date of admission up to the actual date of notification. Room and board charges denied pursuant to this rule may not be billed to the injured worker.

(D) Bureau fees for hospital outpatient services.

(1) Bureau fees for hospital outpatient services, including emergency services, will be reimbursed in accordance with usual and customary methods of payment which may include prospectively determined rates, allowable fee maximums, ambulatory payment categories (APC), and hospital cost to charge ratios, or a percent of allowed charges, as determined by the bureau.

(2) Treatment in the emergency room of a hospital must be of an immediate nature to constitute an emergency as defined in this chapter. Prior authorization of such treatment is not required. However, in situations where the emergency room is being utilized to deliver non-emergency care, notification will be provided to the injured worker, the hospital, and the provider of record that continued use of the emergency room for non-emergent services will not be reimbursed.

(E) The bureau may establish the same or different fees for in-state and out-of-state hospitals based on the above reimbursement methodologies.

(F) Payment will be made for hospital services based on rules 4123-7-01 and 4123-7-02 of the Administrative Code.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.31, 4121.44, 4123.66

Prior Effective Dates: 1/1/78, 9/1/93, 2/14/05

**4123-7-25 Payment for home health nursing services. (Rescind)**

**Comment [a22]:** Rule rescinded and combined into OAC 4123-6-38.

(A) Employment of nursing service.

(1) The need for nursing services must be the direct result of an allowed injury or occupational disease.

(2) Except as described in rule 4123-7-25.1 of the Administrative Code, home health nursing services shall be provided by registered nurses and licensed practical nurses employed by a medicare certified, joint commission on accreditation of healthcare organizations (JCAHO) accredited, or community health accreditation (CHAP) accredited home health agency.

(B) Fees for home health agency nursing services. Fees for home health agency nursing services will be determined by the bureau.

(C) Authorization for home health nursing services.

(1) Authorization for home health nursing services shall be considered by a self-insuring employer only in cases where the claimant, as the direct result of an allowed injury or occupational disease, is bedfast or otherwise confined to the home, is mentally incapable of self-care or requires home care services ordered for hospital discharge follow-up.

(2) The request for authorization from the physician of record or treating physician must identify the reason for home health nursing services, the period of time the services will be required, the specific services and the number of hours per day that are required.

(3) In addition to skilled nursing services provided by a registered nurse or licensed practical nurse, the claimant may be approved for home health aide or attendant services if he/she is unable to independently perform activities of daily living, including, but not limited to, feeding, bathing, dressing, providing personal hygiene, and transferring from bed to chair. Household, personal or other duties such as maintaining a household, washing clothes, preparing meals or running errands are not considered nursing services and will not be reimbursed.

(4) Authorization must be obtained from the self-insuring employer prior to rendering home health nursing services, except in cases of emergency or where the claimant's allowed condition could be endangered by the delay of services.

(D) All covered home health services must be rendered on a part-time or intermittent care basis, in accordance with the written treatment plan and the bureau standard of care. Part-time or intermittent care means that services are generally rendered for no more than eight hours per day. Home health services rendered on a full time or continuous care basis are not covered. More appropriate alternative settings will be considered for claimants requiring more than eight hours per day of care, where medical necessity is documented. Exceptional cases may be reviewed by the self-insuring employer.

(E) A review of the claim or assessment of the injured worker will be conducted by the self-insuring employer at least annually to ensure that nursing services are necessary as a direct result of the allowed injury or occupational disease.

(F) Home health agency providers must maintain records which fully document the extent of services provided to each claimant. All records must be maintained in accordance with the conditions of participation required for medicare certification, joint commission on accreditation of healthcare organizations (JCAHO) accreditation, or community health accreditation (CHAP) accreditation. The provider may be required to furnish detailed hourly descriptions of care delivered to a claimant to review care needs and medical necessity.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/1/78, 12/14/92, 1/9/95, 6/1/05

**4123-7-25.1 Payment for nursing and caregiver services provided by persons other than home health agency employees. (Rescind)**

**Comment [a23]:** Rule rescinded and combined into OAC 4123-6-38.1.

(A) Nursing services provided prior to December 14, 1992.

(1) Registered nurses and licensed practical nurses who are not employed by a medicare certified, joint committee on accreditation of healthcare organizations (JCAHO) accredited, or community health accreditation program (CHAP) accredited home health agency may continue to provide authorized services to a claimant if the services began prior to December 14, 1992.

(2) The need for nursing services must be the direct result of an allowed injury or occupational disease.

(3) In the event the registered nurse or licensed practical nurse is no longer able to provide approved services or if services are stopped and later restarted, nursing services shall be provided only by an employee of a medicare certified, joint committee on accreditation of healthcare organizations (JCAHO) accredited, or community health accreditation program (CHAP) accredited home health agency.

(B) Non-licensed caregiver services.

(1) Requests for extension of caregiver services initially provided prior to December 14, 1992.

(a) Prior to December 14, 1992, caregiver services provided by a non-licensed person including claimant's spouse, friend or family member were considered for reimbursement by a self-insuring employer in cases where the claimant, as a direct result of an allowed injury or occupational disease, was bedfast, confined to a wheelchair, had a disability of two or more extremities which prevented the claimant from caring for his/her own body needs or was otherwise unable to take care of his/her own bodily functions. Services include, but are not limited to, feeding, bathing, dressing, providing personal hygiene, and transferring from bed to chair. Household, personal or other duties such as maintaining a household, washing clothes, preparing meals, or running errands, are not considered nursing services, and will not be reimbursed.

(b) Requests for an extension of caregiver services approved by a self-insuring employer prior to December 14, 1992, delivered by a non-licensed person, other than an attendant, aide, or claimant's spouse, but including other family members or friends, will be approved only if:

(i) The claimant does not have a spouse because the claimant is not married, or the claimant's spouse is deceased, or the claimant's spouse is physically or mentally incapable of caring for the claimant; and,

(ii) The approved home health agency is greater than thirty-five miles from the claimant's location and the home health agency refuses to provide services to the claimant.

(c) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a medicare certified, joint committee on accreditation of healthcare organizations (JCAHO) accredited, or community health accreditation program (CHAP) accredited home health agency.

(2) Requests for extension of caregiver services initially provided on or after December 14, 1992 and prior to January 9, 1995.

(a) Requests for approval by a self-insuring employer of caregiver services delivered by a non-licensed person, other than an attendant, aide, or claimant's spouse were considered for reimbursement only if the claimant did not have a spouse or the spouse was physically or mentally incapable of caring for the claimant, or an approved home health agency was greater than thirty-five miles from the claimant's location and the home health agency refused to provide services to the claimant.

(b) Criteria for approval of caregiver services were as indicated in paragraph (B)(1)(a) of this rule.

(c) After January 9, 1995, persons who are not home health agency nurse aides or attendants, but who are currently approved to provide caregiver services to a claimant, may continue to do so until services are no longer medically necessary or unless services are not authorized. After January 9, 1995, approval of caregiver services by a self-insuring employer shall only be considered when services are rendered by a home health agency nurse's aide or attendant.

(d) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a medicare certified, joint committee on accreditation of healthcare organizations (JCAHO) accredited, or community health accreditation program (CHAP) accredited home health agency.

(C) All covered home health services must be rendered on a part-time or intermittent care basis, in accordance with the written treatment plan and the bureau standard of care. Part-time or intermittent care means that services are generally rendered for no more than eight hours per day. Home health services rendered on a full time or continuous care basis are not covered. More appropriate alternative settings will be considered for claimants requiring more than eight hours per day of care, where medical necessity is documented. Exceptional cases may be reviewed by the self-insuring employer.

(D) A review of the claim or assessment of the injured worker will be conducted by the self-insuring employer at least annually to ensure that nursing services are necessary as a direct result of the allowed injury or occupational disease.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66

Prior Effective Dates: 1/1/78, 12/14/92, 1/9/95, 6/1/05

**4123-7-26 Payment to nursing homes and residential care/assisted living services. (Rescind)**

**Comment [a24]:** Rule rescinded and combined into OAC 4123-6-38.2.

(A) Payment by a self-insuring employer to a nursing home or residential care/assisted living facility for the care of a claimant who sustained an injury or contracted an occupational disease in the course of and arising out of employment shall be made only in cases where the need for such care is the direct result of the allowed industrial condition, as indicated in rule 4123-7-02 of the Administrative Code.

(B) Payment will be made only for care provided in state licensed, medicaid certified nursing homes and residential care/assisted living facilities.

(C) In claims managed by a self-insuring employer, care must be pre-authorized, except when a nursing home or residential care/assisted living facility is used immediately following an approved or emergency hospitalization.

(1) The allowed per diem rate for a claimant shall be no greater than the bureau's fee schedule or the rate negotiated between the nursing home or residential care/assisted living facility and the self-insuring employer.

(2) Nursing home care shall be provided on a semiprivate or ward bed basis, unless a situation exists when the use of a private room is necessary due to the allowed industrial condition. In these cases, the use of such a private room must be preauthorized, except in cases of emergency, as defined in rule 4123-6-01 of the Administrative Code, or where claimant's condition would be endangered by delay.

(3) Fee bills for prescription medication provided to claimants in nursing homes and residential care/assisted living facilities for the treatment of the allowed industrial injury or occupational disease shall be submitted by the providing pharmacy to the self-insuring employer in compliance with rule 4123-7-23 of the Administrative Code.

Promulgated Under: 119.03  
Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66  
Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66  
Prior Effective Dates: 1/1/78, 12/14/92, 6/1/05

**4123-7-28 Payment for prosthetic device or other artificial appliances. (Rescind)**

**Comment [a25]:** Rule rescinded and combined into OAC 4123-6-39.

(A) In all cases arising under division (B) of section 4123.57 of the Revised Code, if a claimant requires the purchase or repair of an artificial appliance, the bureau shall pay the cost of purchasing or repairing the artificial appliance out of the surplus fund. The purchase or repair is made regardless of whether the appliance is part of the claimant's vocational rehabilitation, or if the claimant has, or will ever be able, to return to work.

(B) The bureau is responsible for processing requests for prosthetics and travel expenses associated with the prosthetic in all self-insured claims. When a prosthetic device is needed in a self-insured claim, the provider will send a request for the prosthetic and/or request for repair, as well as the subsequent bills, to the bureau.

Promulgated Under: 119.03  
Statutory Authority: RC 4121.12, 4121.121, 4121.30, 4121.31, 4123.05, 4123.66  
Rule Amplifies: RC 4121.61, 4123.57, 4123.66  
Prior Effective Dates: 1/1/78, 4/7/80, 7/10/80, 5/23/94, 2/14/05

**4123-7-30 No legal relationship between the industrial commission or self-insuring employer and a health care provider. (Rescind)**

**Comment [a26]:** Rule rescinded and combined into OAC 4123-6-41.

(A) Direct payment to a health care provider or other person authorized by the industrial commission or self-insuring employer for medical care rendered to a claimant under the act does not imply or create a legal relationship between the industrial commission or bureau self-insuring employer and such person where no other legal relationship by contract or otherwise exists.

(B) The services rendered to the claimant are the legal obligation of the patient-claimant.

The direct payment by the self-insuring employer to the health care provider is simply a discretionary method by which the award made to the claimant for medical expenses may be discharged.

(C) Except as prohibited by division (K) of section 4121.44 of the Revised Code and rule 4123-6-62 of the Administrative Code, whether the bureau self-insuring employer chooses to pay money to the claimant, or chooses to discharge claimant's obligation by a direct payment to the creditor-health care provider, the sole legal recourse of such health care provider is against the claimant.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.44, 4123.66

Prior Effective Dates: 1/1/78, 11/13/92, 2/14/05

**4123-7-33 Medical rules apply to both self-insuring employers and industrial commission. (Rescind)**

The rules of this chapter shall govern payments to health care providers in claims before both self-insuring employers and the industrial commission, and shall apply to claims adjudication by both the industrial commission and by self-insuring employers. However, nothing in these rules shall inhibit or diminish the commission's right to establish adjudicatory policy under Chapters 4121., 4123., 4127., and 4131. of the Revised Code, or otherwise prevent the full adjudication of claims properly before the commission or its hearing officers.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.121, 4121.30, 4121.44, 4123.66

Prior Effective Dates: 7/16/90, 2/14/05

**Comment [a27]:** Rule rescinded and combined into OAC 4123-6-01.1.

#### **4123-7-34 Payment for transcutaneous electrical nerve stimulators and neuromuscular electrical stimulators. (Rescind)**

**Comment [a28]:** Rule rescinded and combined into OAC 4123-6-43.

(A) A self-insuring employer may approve payment for a transcutaneous electric nerve stimulator (TENS) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease as provided in this rule and in the bureau's provider billing and reimbursement manual.

(1) The injured worker's physician of record must request prior authorization from the self-insuring employer in order to have a prescribed transcutaneous electrical nerve stimulator (TENS) unit and supplies furnished. Each injured worker who requires a TENS unit will be provided only one unit at a time. For each TENS unit request approved, the unit will be rented for a trial period lasting a minimum of one month but not to exceed four months preceding purchase of the TENS unit, in order to evaluate the medical necessity and effectiveness of the TENS treatment.

(2) The medical necessity and effectiveness of the TENS treatment shall be evaluated each month during the trial period. TENS treatment will be discontinued at the end of any trial period month where the treatment is not proven medically necessary or effective. The bureau will only pay rental costs through the month during the trial period that the TENS unit was actually used before treatment was discontinued.

(3) The self-insuring employer will authorize the purchase of the TENS unit only if the analysis at the end of the trial period establishes that the TENS treatment was medically necessary and effective during the entire trial period. All rental payments previously made by the self-insuring employer will be applied to the purchase price of the TENS unit. A TENS unit purchased by the self-insuring employer and furnished to the injured worker is not the personal property of the worker, however, but remains the property of the self-insuring employer. At its discretion, the self-insuring employer reserves the right to reclaim and recover the TENS unit from the injured worker at the completion of the course of TENS treatment. Once a TENS unit is purchased, the self-insuring employer will reimburse for repair or replacement, at its discretion, upon submission of a request for such from the physician of record, along with medical documentation substantiating the continued medical necessity and effectiveness of the unit. Additionally, while the injured worker continues to use the TENS unit and to order supplies, the physician of record must provide medical documentation annually substantiating the need for continued use of the unit.

(B) Injured workers who have TENS units must complete and submit to the TENS provider a monthly written request for specific supplies needed in the following month. The TENS provider will deliver the supplies and bill the self-insuring employer for them only after the injured worker's written request is received by the TENS provider. The self-insuring employer will not pay TENS providers unless the written request was submitted by the injured worker to the TENS provider prior to delivery of supplies. The provider shall retain the original written request for supplies for a minimum of two years after the date of service for the shipment to which it applies. The TENS provider must bill monthly for each shipment of supplies sent to the injured worker. The bill must indicate the actual date of service reflecting the date that services or supplies were provided. The self-insuring employer may adjust bills upon audit if the audit discloses the provider's failure to comply with this rule.

(C) The TENS provider shall maintain the following records and make them available upon request:

- (1) The injured worker's monthly written requests;
- (2) Records of the provider's wholesale purchase of TENS supplies or equipment; and,
- (3) Records of delivery of supplies to injured workers and of the delivery or return of TENS units.

If records are requested, the provider shall supply copies of the information at no extra cost. Failure to provide the bureau with requested records will result in denial or adjustment of bills related to the records in question.

(D) Self-insuring employers may approve payment for a neuromuscular electrical stimulator (NMNS) unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in the bureau's provider billing and reimbursement manual.

Rule promulgated under: RC 119.03  
Rule authorized by: RC 4121.121, 4121.30, 4123.05  
Rule amplifies: RC 4123.66  
Prior Effective Dates: 9/1/93, 3/1/04

**4123-7-35 Payment for practitioner services rendered by in-state and out-of state providers. (Rescind)**

Payment for in-state and out-of-state practitioner services by self-insuring employers shall be equal to or greater than the fee schedule established by the bureau in state fund claims, unless otherwise negotiated in accordance with rules 4123-6-63 and 4123-7-39 of the Administrative Code.

Promulgated Under: 119.03

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

Rule Amplifies: RC 4121.121, 4121.44, 4123.66

Prior Effective Dates: 5/23/94, 2/14/05

**Comment [a29]:** Rule rescinded and combined into OAC 4123-6-44.

**4123-7-39 Standardized or negotiated payment rates for services or supplies.  
(Rescind)**

**Comment [a30]:** Rule rescinded and combined into OAC 4123-6-46.

(A) A self-insuring employer may negotiate payment rates with health care providers for services and supplies provided in the treatment of workers' compensation claims.

(B) A self-insuring employer may enter into volume-based contracts with medical providers for services including, but not limited to, the purchase or rental of durable medical equipment and supplies.

(C) A self-insuring employer may inform injured workers of the availability of services, supplies, or equipment from particular health care providers where the self-insuring employer has a contract for services or supplies, a discount for services or supplies, or where cost-effective payment levels or rates are obtained by the self-insuring employer by contract, so long as access to quality and convenient medical services or supplies is maintained for injured workers.

Promulgated Under: 119.03

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

Rule Amplifies: 4121.44, 4121.651, 4123.66

Prior Effective Dates: 5/18/92; 2/14/05

**Overview Matrix of Which Chapter 6 Rules Now Incorporates the Rescinded Chapter 7 Rules  
Companion to Exhibit 2**

**Exhibit 1**

Chapter 7 Rescinded Rules	Chapter 6 Merged Rules - 4123.6																						
	1.1	6.2	10	20	21.1	23	25	26	27	28	29	30	31	37	38	38.1	38.2	39	41	43	44	46	
4123.7.01						X																	
4123.7.02							X																
4123.7.03							X																
4123.7.04								X															
4123.7.05									X														
4123.7.06				X																			
4123.7.07			X																				
4123.7.08				X																			
4123.7.09										X													
4123.7.10		X																					
4123.7.12													X										
4123.7.13													X										
4123.7.14													X										
4123.7.15													X										
4123.7.17							X																
4123.7.18													X										
4123.7.19													X										
4123.7.20													X										
4123.7.21													X										
4123.7.23					X																		
4123.7.24														X									
4123.7.25															X								
4123.7.25.1																X							
4123.7.26																	X						
4123.7.28																		X					
4123.7.30																			X				
4123.7.33	X																						
4123.7.34																					X		
4123.7.35																						X	
4123.7.39																							X

## Exhibit 2

### OAC Chapter 4123-7 Rules: *Payments to Health Care Providers* (Self-Insuring Employer Medical Rules) Crossover Document to OAC Chapter 4123-6 Rules

CHAPTER 7 RULE #	CHAPTER 7 TITLE	RULE RESOLUTION AND NEW CHAPTER 6 RULE # IF APPLICABLE
<b>4123-7-01</b>	Jurisdictional principles applicable to payment of bills for medical services rendered by health care providers.	Rule rescinded and combined into 4123-6-23
<b>4123-7-02</b>	Treatment necessary on account of an industrial injury or occupational disease.	Rule rescinded and combined into 4123-6-25
<b>4123-7-03</b>	Payment for medical supplies and services	Rule rescinded and combined into 4123-6-25
<b>4123-7-04</b>	Claimant reimbursement	Rule rescinded and substance covered by 4123-6-26
<b>4123-7-05</b>	Treatment by more than one physician	Rule rescinded and substance covered by 4123-6-27
<b>4123-7-06</b>	Treatment of more than one condition or to more than one part of the body	Rule rescinded and combined into 4123-6-20
<b>4123-7-07</b>	Filing of bills	Paragraph (A) of Rule rescinded as unnecessary Paragraph (B) of Rule rescinded, substance covered by IC rule 4123-17-07 Paragraph (C) of Rule rescinded, language added to 4123-6-10
<b>4123-7-08</b>	Obligation for submitting reports	Rule rescinded and combined into 4123-6-20
<b>4123-7-09</b>	Request for information by the treating physician	Rule rescinded and combined into 4123-6-29
<b>4123-7-10</b>	Free choice of physician and of other medical services	Rule rescinded and combined into 4123-6-06.2
<b>4123-7-12</b>	Payment for physiotherapy treatment	Rule rescinded and combined into 4123-6-30
<b>4123-7-13</b>	Payment for chiropractic treatment	Rule rescinded as unnecessary (Rule language largely duplicates chiropractic practice statutes)
<b>4123-7-14</b>	Acupuncture	Rule rescinded and combined into 4123-6-31
<b>4123-7-15</b>	Payment for x-rays	Rule rescinded and combined into 4123-6-31
<b>4123-7-17</b>	Medical billing in self-insured claims	Rule rescinded, language added to 4123-6-25 to cover both state-fund and self-insuring claims

## Exhibit 2

### OAC Chapter 4123-7 Rules: *Payments to Health Care Providers* (Self-Insuring Employer Medical Rules) Crossover Document to OAC Chapter 4123-6 Rules

CHAPTER 7 RULE #	CHAPTER 7 TITLE	RULE RESOLUTION AND NEW CHAPTER 6 RULE # IF APPLICABLE
<b>4123-7-18</b>	Payment for dental care	Rule rescinded and combined into 4123-6-31
<b>4123-7-19</b>	Payment for eyeglasses and contact lenses	Rule rescinded and combined into 4123-6-31
<b>4123-7-20</b>	Payment for hearing aids	Rule rescinded and combined into 4123-6-31
<b>4123-7-21</b>	Payment for shoes, braces, and other orthotic devices	Rule rescinded and combined into 4123-6-31
<b>4123-7-23</b>	Payment for outpatient medication	Rule rescinded and new, identical self-insuring employer pharmacy rule 4123-6-21.1 created
<b>4123-7-24</b>	Payment of hospital bills	Rule rescinded and combined into 4123-6-37
<b>4123-7-25</b>	Payment for home health nursing services	Rule rescinded and combined into 4123-6-38
<b>4123-7-25.1</b>	Payment for nursing and caregiver services provided by persons other than home health agency employees	Rule rescinded and combined into 4123-6-38.1
<b>4123-7-26</b>	Payment to nursing homes and residential care/assisted living services	Rule rescinded and combined into 4123-6-38.2
<b>4123-7-28</b>	Payment for prosthetic device or other artificial appliances	Rule rescinded and combined into 4123-6-39
<b>4123-7-30</b>	No legal relationship between the industrial commission or self-insuring employer and a health care provider	Rule rescinded and combined into 4123-6-41
<b>4123-7-33</b>	Medical rules apply to both self-insuring employers and industrial commission	Rule rescinded and combined into 4123-6-01.1
<b>4123-7-34</b>	Payment for transcutaneous electrical nerve stimulators and neuromuscular electrical stimulators	Rule rescinded and combined into 4123-6-43
<b>4123-7-35</b>	Payment for practitioner services rendered by in-state and out-of state providers	Rule rescinded and combined into 4123-6-44
<b>4123-7-39</b>	Standardized or negotiated payment rates for services or supplies	Rule rescinded and combined into 4123-6-46

## Public Forum Topics

### **2007**

November    Group rating

### **2008**

April        Medical Services (access and delivery)

June        Medical Services (benefits, medical payments and managed care delivery)

September    Self-insured program

### **2009**

February    Paperwork Reduction

April        Medical Issues

August      Open Mic

October     Safety programs

Policies and Procedures for Public Forums  
Board of Directors  
Ohio Bureau of Workers' Compensation

The Board of Directors of the Ohio Bureau of Workers' Compensation is committed to providing an opportunity for members of the public to share information directly with the Board of Directors. They will also solicit comments and suggestions for the efficient and effective administration of the bureau and its programs. Public forums will be scheduled on a regular basis with the approval of the Board.

I. Purpose

The purpose of this policy is to encourage public comment in a fair, consistent and informative manner.

II. Coverage

This policy, upon approval by the Board of Directors, shall remain in effect until such time as it is altered, modified, or rescinded by the Board.

III. Procedure

- a. Anyone desiring to speak at the public forum is encouraged to register in advance of the meeting. Electronic advance registration will be available, or participants may register in person up to 15 minutes after the forum begins.
- b. Every effort will be made to call the speakers in the order in which they registered.
- c. Speakers will be allotted between 3 and 5 minutes, depending on the number of registrants and the time available. The Board chair has the authority and the discretion to adjust the time allocation.
- d. Speakers should direct any questions during their testimony to the Chair, who may, at the Chair's discretion, solicit response from the appropriate staff person.
- e. Directors may ask questions of the speaker to clarify the presentation.
- f. The Chair has the authority and discretion to invite experts to speak during the public forum in lieu of or in addition to public testimony.

IV. Post Forum

As appropriate, staff will inform Directors of actions taken to address concerns raised by presenters within two weeks of the forum.

## **Charter and Governance Guidelines Annual Review Process**

The Governance Guidelines and Committee Charters were reviewed and changes approved at the November, 2008 meetings.

Each committee charter states: “ At least annually, this charter must be reviewed by the \_\_\_\_\_ Committee, and any proposed changes submitted to the Governance Committee and the Board for approval.”

The Board of Directors’ Governance Guidelines states “ It is the intention of the Board to review these guidelines annually” (Pg. 4).

The schedule for the 2009 review is as follows:

### **September:**

1. The Governance Committee reviews all charters and suggests changes, if any.

### **October:**

1. The individual committees review the suggestions of the Governance Committee, and make additional suggested changes, if any.
2. The Governance Committee reviews and suggests changes to the Governance Guidelines.

### **November:**

1. Governance Committee review and approve Committee Charter changes.
2. Governance Committee approves changes to the Governance Guidelines.
3. Board review and approve Committee charter changes as recommended by the Committees.
4. Board review and approve Governance Guideline changes as recommended by the Governance Committee.

Copies of the Committee charters, with recommended changes, follow.

# **OBWC Board of Directors Governance Committee Charter**

## **Purpose**

The Committee shall assist the Ohio Bureau of Workers' Compensation Board of Directors in fulfilling its oversight responsibilities relating to developing and implementing sound governance policies and practices. The Committee is responsible for:

- reviewing and recommending to the Board the adoption of governance guidelines and committee charters;
- overseeing compliance with federal and state laws, regulations, policies and ethical requirements;
- developing a process for the Board's assessment of its performance and the performance of Board committees;
- overseeing the process for orientation of new Board members and the continuing education program for all Board members;
- making recommendations for Board Vice-Chair, Committee Chairs and Vice-Chairs and Director assignments to Board committees for the Chair's consideration; and
- coordinating processes and procedures for the Administrator's annual performance review.

In order to constitute the will of the Board of Directors, Committee actions must be ratified or adopted by the Board of Directors to become effective.

## **Membership**

The Committee shall be composed of a minimum of five (5) members. One member shall be the Chair of the Ohio Bureau of Workers' Compensation Board of Directors. The Chair and Vice-Chair of the Governance Committee are designated by the Board based on the recommendation of the Board Chair.

The Committee Chair will be responsible for scheduling all meetings of the Committee and providing the Committee with a written agenda for each meeting. The Committee encourages all Board members to attend its meetings. The Governance Committee is a standing committee of the Ohio Bureau of Workers' Compensation (BWC) Board of Directors. The Committee will have a staff liaison designated to assist it in carrying out its duties. This Board liaison will be responsible for all communication, handling of responses and public record requests of the Board.

## **Meetings**

The Committee shall meet at least four times annually or more frequently as it shall determine is necessary to carry out its duties and responsibilities. The Committee Chair will schedule regular meetings; additional meetings may be held at the request of two or more members of the Committee, or the Chair of the Board. A majority of the members shall constitute a quorum.

Committee meetings will be conducted according to Robert's Rules of Order. At least one meeting shall be in executive session for the purpose of the performance review of the Administrator.

### **Duties and Responsibilities**

In carrying out its oversight responsibilities, the Committee shall:

1. At least annually review the Board's Governance Guidelines and the charters of the Board's standing committees, and making such recommendations as the Committee determines necessary, appropriate, and consistent with ~~HB-100~~[the Ohio Revised Code](#), including recommendations concerning the structure, composition, membership and function of the Board and its committees, subject to Board approval.
2. Make recommendations for Board Vice-Chair, Committee Chairs and Vice-Chairs, and Director assignments to Board committees for the Chair's consideration and the Board's approval.
3. Develop and coordinate the annual self-assessment of the Board and its Committees.
4. Make recommendations to the Board for retaining fiduciary counsel.
5. Oversee the process for all statutorily required reports of the Board for submission to the Governor, General Assembly or the Workers' Compensation Council.
6. Oversee compliance with laws, regulations, policies and ethical requirements.
7. Oversee the BWC orientation process for newly appointed members of the BWC Board and assist the Board in its implementation. The Committee shall also regularly assess the adequacy of and need for additional continuing Director education programs. At a minimum, the education components must meet the requirements of RC 4121.12(F)(16). These requirements include: orientation for new members; continuing education for those Board members who have served for more than one year; Board member duties and responsibilities; injured worker compensation and benefits; ethics; governance processes and procedures; actuarial soundness; investments; and any other subject matter the Board believes is reasonably related to the duties of a Board member.
8. Assist in the establishment of the Board's annual prospective performance goals and objectives for the Administrator; coordinate and facilitate the process for the Board's annual performance evaluation of the Administrator.
9. Consult with the Administrator and recommend to the Board the appointment of the Superintendent of Safety and Hygiene.
10. Act as the lead committee for rule review and changes with the exception of actuarial rules or other rules specific to an existing committee. Will follow the process for rule review as outlined in the Governance Guidelines.
11. Make reports to the Board following its meetings.
12. Coordinate with other Board committees on issues of common interest.
13. Perform such other duties required by law or otherwise as are necessary or appropriate to further the Committee's purposes, or as the Board may from time to time assign to the Committee.
14. Create by majority vote a subcommittee consisting of one or more Directors on the Committee. In consultation with the Chair, other Board members may be appointed to the

subcommittee as appropriate. The subcommittee shall have a specific purpose. Each subcommittee shall keep minutes of its meetings. The subcommittee shall report to the Board of Directors through the Committee. The Committee by majority vote may dissolve the subcommittee at any time.

Draft reviewed Oct. 4, 2007 and Oct. 14, 2007  
Approved as edited 112107; Alison Falls, Chair  
Revised 012308  
Revised 092408  
Annual Review and Revision 112108

# **OBWC Board of Directors Actuarial Committee Charter**

## **Purpose**

The Actuarial Committee has been established to assist the Ohio Bureau of Workers' Compensation Committee Board of Directors in fulfilling its responsibilities through:

- monitoring the actuarial soundness and financial condition of the funds and reviewing rates, reserves and the level of net assets
- monitoring the integrity of the actuarial audit process
- monitoring compliance with legal and regulatory requirements
- monitoring the design and effectiveness of the actuarial studies
- confirming external actuarial consultants' qualifications and independence
- reviewing any independent external actuarial work product

In order to constitute the will of the Board of Directors, Committee actions must be ratified or adopted by the Board of Directors to become effective.

## **Membership**

The Committee shall be composed of a minimum of five (5) members. One member shall be the appointed actuary member of the Board. The Board, by majority vote shall appoint four additional members. The Board may also appoint additional members who may or may not be on the Board. Members of the Actuarial Committee serve at the pleasure of the Board and the Board, by majority vote, may remove any member except the member of the committee who is the actuary member of the Board.

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

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

## **Meetings**

By majority vote the Committee will recommend to the Board of Directors its meeting schedule. There shall be not less than nine (9) meetings each year. Reports shall be made to the Board after each meeting. The Committee also has the authority to convene additional meetings, as circumstances require. The Committee will invite members of management, external actuarial firms, internal actuarial staff and/or others to attend meetings and provide pertinent information, as necessary. Committee meetings will be conducted according to Robert's Rules of Order. A quorum will be a majority of the Committee members.

## **Duties and Responsibilities**

The Actuarial Committee shall have responsibility for the following:

1. Recommending actuarial consultants for the Board to use for the funds specified in the Ohio Revised Code.
2. Reviewing the calculation of rate schedules prepared by the actuarial consultants with whom the Board contracts.
3. Reviewing administrative code rules regarding rate making for recommendation to the Board.
4. Supervising for the Board's consideration the preparation of an annual report of the actuarial valuation of the assets, liabilities and funding requirements of the state insurance funds to be submitted to the Workers' Compensation Council and the Senate and House.
5. Coordinating with other Board Committees on issues of common interest.
6. At least once every five (5) years, contracting for an actuarial investigation of experience of employers; mortality, service and injury rate of employees; and payment of benefits in order to update the assumptions on the annual actuarial report. (RC 4121.125(F), effective 2007)
7. Arranging for an actuarial analysis prepared of any legislation expected to have measurable financial impact on the system, within 60 days after introduction of the legislation.
8. Consulting in the appointment of and overseeing the work of any actuarial firm engaged by Ohio Bureau of Workers' Compensation to complete actuarial studies.
9. Recommending retention and oversight of consultants, experts, independent counsel and actuaries to advise the Committee on any of its responsibilities or assist in the conduct of an investigation.
10. Seeking any information it requires from Bureau employees – all of whom are directed to cooperate with the Committee's requests, or the request of internal or external parties working for the Committee. These parties include the internal actuaries, all external actuaries, consultants, investigators and any other specialties working for the Committee.
11. Making recommendations to the Board of Directors of the Ohio Bureau of Workers' Compensation for Board decisions.
12. At least annually, reviewing this charter and submitting any proposed changes to the Governance Committee and to the Board for approval.
13. Creating, by majority vote, a subcommittee consisting of one or more Directors on the Committee. In consultation with the Chair, other Board members may be appointed to the subcommittee as appropriate. The subcommittee shall have a specific purpose. Each subcommittee shall keep minutes of its meetings. The subcommittee shall report to the Board of Directors through the Committee. The Committee by majority vote may dissolve the subcommittee at any time.

Actuarial Committee Charter.doc  
Draft 092607  
Review & Approved 112107, Chuck Bryan, Chair  
Revised 012408  
Revised 092408  
Annual Review and Revision 112108

# **OBWC Board of Directors Audit Committee Charter**

## **Purpose**

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

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

In order to constitute the will of the Board of Directors, Committee actions must be ratified or adopted by the Board of Directors to become effective.

## **Membership**

The Committee shall be composed of a minimum of five (5) members. One member shall be the appointed certified public accountant member of the board. The Board, by majority vote, shall appoint four additional members to serve on the Audit Committee and may appoint additional members, who may or may not be Board members, as the Board determines necessary. Members of the Audit Committee serve at the pleasure of the board and the board, by majority vote, may remove any member except the member of the committee who is the certified public accountant member of the board.

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

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

## **Meetings**

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

## **Duties and responsibilities**

The Audit Committee shall have responsibility for the following:

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

18. Seek any information it requires from employees—all of whom are directed to cooperate with the Committee's requests, or the requests of internal or external parties working for the Committee. These parties include, but are not limited to internal auditors, all external auditors, consultants, investigators and any other specialists working for the Committee.
19. Coordinate with the other Board Committees on items of common interest, especially discussions and decisions concerning the net asset policy and the annual review of guidelines for a funding ratio and a net leverage ratio.
20. At least annually, this charter must be reviewed by the Audit Committee and any proposed changes submitted to the Governance Committee and to the Board for approval.
21. At least annually, meet with General Counsel and Chief of Internal Audit to review BWC Code of Ethics to ensure that it is adequate and up-to-date. Report on review and recommended changes, if necessary, to the Board.
22. The Committee by majority vote may create a subcommittee consisting of one or more Directors on the Committee. In consultation with the chair, other board members may be appointed to the subcommittee as appropriate. The subcommittee shall have a specific purpose. Each subcommittee shall keep minutes of its meetings. The subcommittee shall report to the Board of Directors through the Committee. The Committee by majority vote may dissolve the subcommittee at any time.

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

# **OBWC Board of Directors Investment Committee Charter**

## **Purpose**

The purpose of the Investment Committee is to ensure that the assets of the Ohio Bureau of Workers' Compensation (OBWC) are effectively managed in accordance with the laws of the State of Ohio, and the Ohio Bureau of Workers' Compensation Statement of Investment Policy and Guidelines. The Investment Committee:

- assists the Board of Directors in the review and oversight of the State Insurance Fund and each ~~Ancillary~~ Specialty Fund (collectively the Funds) assets; and
- develops and monitors the implementation of the BWC's investment policy.

In order to constitute the will of the Board of Directors, Committee actions must be ratified or adopted by the Board of Directors to become effective.

## **Membership**

The Committee shall be composed of a minimum of five (5) members. Two of the members shall be the members of the Board who serve as the investment and securities experts on the Board. The Board, by majority vote, shall appoint three additional members to serve on the Investment Committee and may appoint additional members, either from the Board or someone not on the Board. Each additional non-Board member appointed must have at least one of the following qualifications: a) experience managing another state's pension funds or workers' compensation funds; or b) expertise that the Board determines is needed to make investment decisions.

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

Members of the Investment Committee serve at the pleasure of the Board and the Board, by majority vote, may remove any member except the members of the Committee who are the investment and securities expert members of the Board.

## **Meetings**

The Investment Committee will meet at least nine (9) times annually; additional meetings may be scheduled as the Committee or its chairperson deem advisable. The Investment Committee is governed by the same rules regarding meetings, notice, quorum and voting requirements as are applicable to the Board. Committee meetings will be conducted according to Robert's Rules of Order. A quorum at any Investment Committee meeting will consist of a majority of the Committee members.

The Chair of the Committee will be responsible for establishing the agendas for the meetings of the Committee. An agenda, together with information/background materials, will be sent to members of the Committee prior to each meeting. Minutes for all meetings of the Committee will be prepared to

document all actions of the Committee's discharge of its responsibilities. The Committee will have a staff liaison designated to help it carry out its duties.

### **Duties and Responsibilities**

The Investment Committee is charged with overseeing all investment-related matters and activities of the BWC. The Committee evaluates proposals requiring Board action and makes recommendations for consideration by the Board. The Committee shall:

1. Develop and recommend the strategic asset allocation and investment policy for the Funds and submit to the Board for approval. Periodically review the investment policy in light of any changes in actuarial variables, market conditions, etc. and make recommendations for any changes, as appropriate to the Board for approval. Assist the Board to assure that the investment policy is reviewed and approved at least annually, published, and copies are made available to interested parties.
2. Evaluate and recommend an outside investment consultant to assist the Investment Committee in its duties. Submit a contract with the recommended investment consultant to the Board for approval.
3. Review the annual report on the investment performance of the funds and the value of each investment class and submit to the Board for approval. Once approved, this report must be submitted to the Governor, the president and Minority Leader of the Senate, and the Speaker and Minority Leader of the House of Representatives.
4. Provide advice and consent to the Administrator on the appointment of the Chief Investment Officer.
5. Recommend investment counsel to the Board for engagement.
6. Recommend to the Board for approval the criteria and procedures for the selection of the Investment Managers and General Partners. Approve the final selection, funding and termination of all Investment Managers and General Partners.
7. Monitor implementation of the investment policy by the Administrator and the Chief Investment Officer. Review performance of the Chief Investment Officer and any investment consultants retained by the BWC to assure compliance with the investment policy and effective management of the Funds.
8. Develop and recommend rules on due diligence standards for employees of BWC to follow when investing in each asset class. Develop and recommend policies and procedures to review and monitor the performance and value of each asset class. Submit these recommendations to the Board for approval.
9. Monitor and review the investment performance of the Funds on a quarterly basis to determine achievement of objectives and compliance with this investment policy.
10. Recommend prohibited investments, on a prospective basis, the Committee finds to be contrary to the investment objectives of the Funds and submit to the Board for approval.
11. Recommend the opening and closing of each investment class and submit to the Board for approval.

12. Report all activities/recommendations to the Board following each meeting of the Investment Committee.
13. Coordinate with other Board committees on items of common interest.
14. At least annually, review this charter and submit any proposed changes to the Governance Committee and to the Board for approval.
15. Create, by majority vote, a subcommittee consisting of one or more Directors on the Committee. In consultation with the Chair, other Board members may be appointed to the subcommittee as appropriate. The subcommittee shall have a specific purpose. Each subcommittee shall keep minutes of its meetings. The subcommittee shall report to the Board of Directors through the Committee. The Committee by majority vote may dissolve the subcommittee at any time.

InvestmentCommitteeCharter.doc  
Draft 092607  
Review & Approved 112107, Bob Smith, Chair  
Revised 012408  
Revised 092408  
Annual Review and Revision 112108

## Correspondence Protocol

BWC Governance Guidelines state:

### Communication Guidelines

*As a general rule, it is the Board's position that the BWC Administrator, or BWC management appointed for such purpose by the Administrator, speaks for the agency as a whole.*

*Members of the public can provide written submission of comments to BWC's website at OhioBWC.com. Comments on pending legislation should be limited to those necessary to conduct the business of the Board of Directors. Comments beyond that should be directed to members of the Ohio General Assembly or the Workers' Compensation Council. The Chair of the Board of Directors reserves the right to limit comments from the public during meetings.*

*Communications received directly by Board members shall be forwarded to the Board Liaison. The Board member receiving such communication shall work with the Board Liaison to prepare the appropriate response. The Board Liaison shall be responsible for retention of the Board's public records and communications with the public.*

**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	7/31/2009
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	7/31/2009
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	7/31/2009
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		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	7/31/2009
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	7/31/2009
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
4123-18-09	2009 Vocational Rehab Services Fee Schedule						x		K. Fitzsimmons, Graff		Jun-09	4/30/09	5/15/09	5/28/09	10-Jul	30-Jul	28-Aug	9/1/2009
4123-6-01 to 18	HPP- Program	49	x	x	x	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		Yes	J. Smith, TK, RM	2008	Jul-09		6/15/09	7/2/09	10-Jul	30-Jul	28-Aug	9/1/2009
4123:1-5	Workshops & Factories	32	x			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	September 2009	Notes
9/24/2009	1. Five Year Rule Review	
	2. 2010 Inpatient Fee Schedule (1 <sup>st</sup> reading)	
	3. Committee Charters (1 <sup>st</sup> reading)	
Date	October 2009	
10/29/2009	1. Five year rule review	
	2. 2010 ASC Fee schedule (1 <sup>st</sup> reading)	
	3. 2010 Inpatient Fee schedule (2 <sup>nd</sup> reading)	
	4. Governance Guidelines (1 <sup>st</sup> reading)	
Date	November 2009	
11/19/2009	1. Governance Guidelines (2 <sup>nd</sup> reading)	
	2. Committee Charters (2 <sup>nd</sup> reading)	
	3. 2010 Hospital Outpatient Fee schedule (1 <sup>st</sup> reading)	
	4. 2010 ASC Fee schedule (2 <sup>nd</sup> reading)	
Date	December 2009	
12/16/2009		
Date	January 2010	
1/21/2010		
Date	February 2010	
2/25/2010		
Date	March 2010	
3/25/2010		
Date	April 2010	
4/29/2010	1. Launch Administrator Review	
Date	May 2010	
5/27/2010	1. Finalize Administrator Review	
	2. Launch Board and Committee Self-assessment	
Date	June 2010	
6/17/2010	1. Finalize Board and Committee Self-assessment	
	2. Committee membership recommendations	
	3. Develop Education Plan	
	4. Administrator's Objectives for FY 11	

# 12-Month Governance Committee Calendar

7/29/2010	July 2010	NOTES
8/26/2010	August 2010	