

Common Sense Business Regulation (BWC Rules)

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

Rule 4123-17-58 (Rescind and replace)

Rule-4123-17-58.1 (Rescind)

Rule Review

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

Citation: R.C. 4123.34

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

What goal(s): Provide a program that is designed to help Ohio employers prevent occupational injuries attributed to substance abuse. The Drug Free Safety Program (DFSP) will extend eligibility compared to the current program. It will also provide measurable results and will be actuarially sound. Replacement of Rule 4123-17-58 is offered in conjunction with rescission of Rule 4123-17-58.1. BWC seeks to replace two older rules with a less-complicated rule that encourages drug-free programs in employer safety efforts.

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.

If no, explain:

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
Drug Free Safety Program
Rules 4123-17-58 and 4123-17-58.1

Introduction

Rules 4123-17-58 and 4123-17-58.1 describe the Drug-Free Workplace Discount Program (DFWP) and the Drug-Free Workplace Discount Program for small employers (DFWP-EZ) were adopted in 1997 and 2002, respectively.

Background Law

Pursuant to Revised Code 4123.34(E), the Administrator may grant a discount on premium rates to an eligible employer that meets the requirements of the DFWP.

Proposed Change

Based on interested parties comments on the current program and responses to the Division of Safety and Hygiene's staff recommendations, management is recommending rescinding 4123-17-58.1 and rescinding 4123-17-58. 4123-7-17-58 would be replaced by rules governing a program called the Drug Free Safety Program (DFSP).

The DFSP would have a "Basic" and "Advanced" level. Both levels require components of a safety program, written substance policy, employee education, supervisor training, drug and alcohol testing, and employee assistance.

Stakeholder Involvement

Division of Safety and Hygiene met with interested parties in September, 2009 to review the current program and collect comments for improvements. In January, 2010, the same group met to react to the program components for a new Drug Free Safety Program.

The rule has been circulated to stakeholders, and the response matrix is included in the materials.

Number of DFWP participants and discounts received for Fiscal 2009 and 2010

| Year ending 6/09 | Group | Non-Group |
|-------------------------|--------------|--------------|
| Level 1 (10% disc) | 1,386 | 1,164 |
| Level 2 (15% disc) | 1,143 | 1,234 |
| Level 3 (20% disc) | 209 | 223 |
| total | 2,738 | 2,621 |

| Year ending 6/10 | Group | Non-Group |
|-------------------------|--------------|--------------|
| Level 1 (10% disc) | 1,092 | 1,384 |
| Level 2 (15% disc) | 724 | 1,396 |
| Level 3 (20% disc) | 102 | 228 |
| total | 1,918 | 3,008 |

So for 2009 there were 5,359 employers receiving a discount. And for 2010 there are 4,926.

Follow-up to BOD DFSP questions from 2/25/10

During the February meeting of the Medical Services and Safety Committee there was a lengthy discussion of the proposed Drug Free Safety Program. During the discussion, the Directors asked questions about Post Accident testing, termination on a first positive test result, and how the BWC handles employee complaints about the program.

The following comments address those questions:

1. POST ACCIDENT TESTING

- BWC provides a guidebook to employers in the DF program which offers a carefully designed structure for implementing a program, including how to develop a written policy that describes each program element, including testing for alcohol and other drugs under various circumstances.
- The guidebook articulates the circumstances in which testing should occur and focuses on an accident investigation to determine who may have caused or contributed to a work-related accident under “post-accident testing,” following the federal testing model with federally-regulated employers testing after road accidents or where citations are issued.
 - The Guidebook states:
 - Post-accident testing: Accident is defined as an unplanned, unexpected or unintended event that occurs on an employer’s property during the conduct of its business or during working hours, or which involves a motor vehicle used in conducting company business, or is within the scope of employment and which results in any of the following: (1) fatality of anyone involved in the accident; (2) bodily injury to the employee and/or another person that requires off-site medical attention away from company’s place of employment; (3) vehicular damage in apparent excess of [company states the amount]; (4) non-vehicular damage in apparent excess of [company states amount].
- The guidebook encourages employers to use trained managers to do accident investigations that focus on who may have caused or contributed to the accident, whether there is reasonable suspicion, whether any work rules were violated and future accident prevention.

2. TERMINATION BASED ON A FIRST POSITIVE TEST

- BWC encourages participating employers to retain employees who test positive and to offer the highest level of assistance possible.
- Information on termination on a first positive is in the employer’s written policy, and employees know the work rule from receiving the policy and from their education sessions which include reviewing policy and asking questions.
- BWC will consider on a case-by-case basis whether DFSP employers participating in the advanced program may be allowed to terminate on a first positive for good cause. BWC has considered the safety-sensitive nature of an employer’s business and other reasonable concerns (corporate policy, multi-state operations) but insists that our higher-level programs overall contain the employer’s commitment to a second chance.

- Employers are guided to consult with their employment-law legal counsel and language in any current collective bargaining agreements to ensure their programs are in compliance.

3. COMPLAINTS

- BWC has received few complaints (approximately 2 per year) over the past 13 years that an employer is not operating a fair program, tests in a discriminatory manner, or has unfair termination practices.
- Complaints are evaluated to determine whether there is any compliance issues with the program and if appropriate. A program compliance audit may follow.

4123-17-58 Drug-free safety program (DFSP) and comparable program.

Pursuant to division (E) of section 4123.34 of the Revised Code, the administrator may grant a benefit in the form of a discount on premium rates and/or grants to an eligible employer that meets the drug-free safety program (DFSP) requirements under the provisions of this rule.

(A) As used in this rule:

(1) "Program," "Drug-free safety program" or "DFSP" means the bureau's loss prevention and safety program which may offer a benefit to eligible employers for implementing a program encompassing elements that promote occupational safety and health for workers by preventing and reducing the risk of workplace accidents and injuries attributed to the use and abuse of alcohol and other drugs, including prescription, over-the-counter, and illegal drugs.

(2) "Comparable program" means a program referred to in Section ~~153.01~~153.03 of the Revised Code required for construction contractors and subcontractors with elements that are, generally, similar to those of the bureau's DFSP and which qualify employers in the construction industry to provide labor services and/or supervision of such labor services on state of Ohio public improvement projects.

(3) "Safety-sensitive position or function" means any job position or work-related function or job task designated as such by the employer, which through the nature of the activity could be detrimental or dangerous to the physical well-being of the employee, co-workers, customers or the general public through a lapse in attention or judgment. The safety-sensitive position or function may include positions or functions where national security or the security of employees, co-workers, customers, or the general public may be seriously jeopardized or compromised through a lapse in attention or judgment.

(4) "Supervisor" means an employee who supervises others in the performance of their jobs, has the authority and responsibility to initiate reasonable suspicion testing when it is appropriate, and has the authority to recommend or perform hiring or firing procedures.

(5) "Consortium" means a pool of employers and their employees established to provide services to employers to help the employers meet DFSP requirements. A consortium may contract with laboratories certified by the U.S. department of health and human services/substance abuse and mental health services administration and will operate in concert with established standardized protocols and procedures that are consistent with current federal guidelines for testing.

(B) Application process.

The bureau shall provide application and renewal forms to be completed by employers seeking to participate in the DFSP and shall have final authority to approve a state fund employer's participation in this program. Self-insuring employers and state-fund employers not participating in the DFSP should submit an application for a comparable program if they bid on or provide labor for state of Ohio public improvement/construction projects. An employer's participation and renewal of participation in a DFSP shall be on a ~~policy~~program year basis.

(1) A private employer shall apply no later than the last business day of April for the ~~policy~~program year beginning July first of that year except that, for the ~~policy~~program year beginning July 1, 2010, a private employer shall apply no later than the last business day in ~~May~~June, and shall apply no later than the last business day of October for the program year beginning January first of the following year.

(2) A public employer taxing district shall apply no later than the last business day of October prior to the policyprogram year beginning January first of the following year.

(3) An employer may withdraw its application for enrollment in the DFSP at any time prior to the start of the policyprogram year. When an employer becomes aware that it is unable to meet the requirements of the DFSP level at which the employer is participating, the employer shall notify the bureau and the bureau shall withdraw the employer from the program. The employer shall return any monetary benefits for any policyprogram year for which a program requirement was not fully met.

(C) Eligibility requirements.

Eligibility for program benefits is limited to state-fund employers. Self-insuring employers and state-fund employers desiring a comparable program shall identify this intent on the DFSP application form and shall satisfy all of the eligibility requirements of this rule or of Section ~~153.01~~153.03 of the Revised Code. An employer that is found to be ineligible for participation in the DFSP may reapply for a subsequent policyprogram year. An employer may implement a DFSP that exceeds the minimum requirements for the program level (basic or advanced) approved by the bureau.

(1) The employer shall be current at the time of bureau review of application for the DFSP and throughout the policyprogram year. Current means an employer is not more than forty-five days past due on any and all premiums, assessments, penalties or monies otherwise due to any fund administered by the bureau, including amounts due for retrospective rating.

(2) The employer may not have cumulative lapses in workers' compensation coverage in excess of forty days within the twelve months preceding the original application deadline or subsequent anniversary deadline wherein the employer seeks renewal for the DFSP.

(3) The employer shall be in an active, reinstated, or debtor-in-possession policy status at the time of bureau review of application for the DFSP.

(4) The employer shall continue to meet all eligibility requirements during participation in the program, when applying for renewal, and during each subsequent year of participation in the program.

(D) General program requirements.

The chief executive officer or designated management representative of the employer shall sign and certify the application form that the employer shall meet, at a minimum, the DFSP requirements for which the employer has applied. The signature certifies that the employer shall return any monetary benefits associated with any benefits received, should the employer fail to implement or meet the requirements of the DFSP for which it has applied and been approved.

(E) Program requirements – basic program level.

To receive a benefit as specified in paragraph (I) of this rule for implementing a basic DFSP, an employer shall fully implement, at a minimum, the following program elements by the applicable dates:

(1) Safety – The DFSP requires a participating employer to integrate safety into its DFSP including, but not limited to:

(a) Completing and submitting the bureau's online safety assessment within the time-frame specified by the bureau;

- (b) Ensuring each supervisor completes, one time at a minimum, accident-analysis training within the time-frame specified by the bureau; and
- (c) Utilizing online accident-analysis reporting on the bureau's website within the time-frame specified by the bureau from the date of the accident or the date the employer first becomes aware of the accident.

(2) Policy – Employers are required to put in place a written DFSP policy which shall, at minimum, provide a full and fair disclosure of the reasons for implementing a DFSP, the program provisions and procedures, the responsibilities and rights of all employees subject to the provisions and procedures of the program, the consequences of an employee's failure to comply with the provisions and procedures of the program, that the DFSP applies to all employees, and that the employer is committed to employee health.

(3) Employee education – The DFSP shall include education for all employees and supervisors to promote awareness and understanding of the content of the employer's DFSP written policy, and the safety, security and health risks as well as declining productivity associated with the use of alcohol and other drugs in the workplace. The training shall be provided during the initial year of participation and annually thereafter.

(4) Supervisor skill-building training – The DFSP shall include skill-building training for all supervisors in support of enforcing the employer's written DFSP policy and procedures during the initial year of participation and annually thereafter.

(5) Drug and alcohol testing – The DFSP program shall include alcohol and other drug testing which conforms to the federal testing model. The employer shall implement and pay for alcohol and other drug testing required by DFSP participation other than for re-testing requested by an employee and follow-up testing. Alcohol and other drug testing shall occur as specified by the bureau and shall be applied to, at minimum, the following categories:

- (a) Pre-employment/new-hire drug testing;
- (b) Post-accident alcohol and other drug testing;
- (c) Reasonable suspicion alcohol and other drug testing; and
- (d) Return-to-duty and follow-up alcohol and other drug testing.

(6) Employee assistance – The DFSP shall include an employee assistance plan. Upon an employee testing positive, in addition to any corrective action deemed appropriate as specified in the employer's written policy, the employer shall, at minimum, explain to the employee what a substance abuse assessment is and, by way of referral, shall provide a list containing names and addresses of qualified substance abuse assessment resources that can administer a substance assessment.

(F) Program requirements – advanced program level.

To receive a benefit as specified in paragraph (I) of this rule for implementing and operating an advanced DFSP, an employer shall fully implement, at a minimum, the following program elements by the applicable dates:

- (1) The employer shall meet all of the requirements of a basic DFSP as provided in paragraph (E) of this rule.
- (2) The employer shall:

- (a) Apply for the DFSP advanced level on the initial participation application or request renewal into the advanced level when completing the self-assessment progress report;
- (b) Ensure that its written DFSP policy clearly reflects how random drug testing will be implemented and how additional employee assistance will be provided;
- (c) Ensure conducting ~~25~~15-per cent or higher random drug testing of the employer's workforce each ~~policy~~program year;
- (d) Pre-establish a relationship for a substance assessment of an employee who tests positive, comes forward voluntarily to indicate he or she has a substance problem, or is referred by a supervisor, with the employer paying for the cost of the assessment;
- (e) Timely submit a safety action plan based on the results of the completed safety assessment which outlines specific safety process improvements the employer intends to implement during the remainder of the ~~policy~~program year; and
- (f) Commit to not terminate the employment of an employee who tests positive for the first time, who comes forward voluntarily to indicate he or she has a substance problem, or who is referred by a supervisor for an assessment.

(G) Progress reporting and renewal requirements.

(1) The employer shall comply with the following requirements for initial participation and annual renewal of DFSP participation within the time-frames specified by the bureau. In order to qualify for renewal, an employer shall have implemented all requirements of its basic or advanced level DFSP by the implementation date specified by the bureau. Comparable employers shall have in place a compliant written DFSP policy and shall have completed employee education and supervisor training for all employees and supervisors that will work on a State of Ohio public improvement project as specified in Sec. ~~153.01~~153.03 of the Revised Code no later than the time the employer provides labor services or on-site supervision of such labor services on such a project.

(2) The employer shall meet reporting requirements which require submission of an annual report on a form provided by the bureau showing that the DFSP requirements were met by the deadline date specified by the bureau for each year of participation in a DFSP. The reporting deadline date for January participants is the last business day in September and, for July participants, is the last business day in March. If the employer is applying for renewal, the employer shall stipulate which DFSP level or comparable program is requested for the following ~~policy~~program year. Reports shall be certified by the chief executive officer or designated management representative of the employer. The employer shall provide information as requested by the bureau regarding each component of its basic or advanced level or comparable program, shall provide any other documentation required by the bureau and shall maintain on-site statistics as required by the bureau. The bureau shall hold the information submitted on or with these annual reports and other information submitted by the employer in meeting DFSP requirements as confidential pursuant to section 149.43 of the Revised Code to avoid revealing an employer's proprietary trade secrets.

(a) Safety – For the DFSP basic level, the employer shall report its progress to the bureau in terms of the required safety assessment, including what was learned through the safety assessment and submission of online accident-investigation information. For DFSP advanced level, the employer shall also report progress on its safety action plan.

(b) Policy – The employer shall certify to the bureau that it has developed a written DFSP policy that meets or exceeds the requirements associated with the DFSP level or

comparable program for which the employer is participating. The employer shall submit a copy of the written policy as required by the bureau.

(c) Employee education – The employer shall provide information to the bureau regarding how employee education requirements have been met.

(d) Supervisor training – The employer shall provide information to the bureau regarding how supervisor training requirements have been met.

(e) Drug and alcohol testing – The employer shall report statistics regarding alcohol and other drug testing to show how testing requirements were met. The employer shall report information about positive tests including the drugs involved and their measured testing values, and the subject employee gender, age, and location of employment.

(f) Employee assistance – For the DFSP basic level, the employer shall provide information regarding number of employees terminated based on a first positive alcohol or other drug test, number of employees referred for an assessment, and other assistance information required by the bureau. For the DFSP advanced level, the employer shall also provide information related to number of employees who tested positive and were given a second chance, number of employees whose employment was terminated and circumstances associated with termination, and additional information as required by the bureau.

(g) Demographics – An employer implementing a DFSP shall report its average annual number of employees and number of new hires since the start of the current DFSP ~~policy~~ program year.

(H) Disqualification from program and reapplication.

The bureau may remove an employer’s participation in the DFSP for failure to fully implement a DFSP in compliance with the approved program level requirements. The bureau shall send written notice of cancellation to the employer and shall require the employer to reimburse the bureau for any benefits received to which the employer was not entitled.

(1) If the bureau removes an employer from the DFSP under this rule for failure to meet program requirements, the employer may reapply for the DFSP for the next ~~policy~~ program year, unless the employer has received a benefit and has failed to reimburse the bureau for the benefit. The bureau may deny the application based on circumstances of previous participation.

(2) When an employer becomes aware that it is unable to fully implement its DFSP by the required implementation date, the employer shall notify the bureau immediately and shall reimburse the bureau for any benefits received for participating during that ~~policy~~ program year.

(I) Benefit requirements.

An employer participating in the DFSP may be eligible to receive a benefit as provided for in this rule and as specified in Appendix A.

(1) Any benefit in the form of a discount to premiums will be applied to the employer’s premium rate, semi-annually or annually depending on the payroll reporting and premium payment cycle of the employer, during the ~~policy~~ program year of participation. It will not be applied to disabled workers’ relief fund assessments or administrative assessments, nor will the benefit alter the employer’s actual experience modifier under rule 4123-17-03 of the Administrative Code.

(2) The application of a DFSP discount shall occur semi-annually or annually in concert with each policy program year of DFSP participation.

(J) Application and renewal rejection.

An employer may appeal application rejection or renewal rejection to the bureau through the specified bureau complaint process.

(K) Hold harmless statement.

Nothing in this rule requires an employer to implement any policies or practices in developing a DFSP that conflict or interfere with existing collective bargaining agreements. However, a collective bargaining agreement that prevents an employer from complying with program requirements may prevent an employer from participating in the DFSP. Where there are legal issues related to development and implementation of a DFSP, it is the employer's responsibility to consult with its legal counsel to resolve these issues. An employer shall certify in its application to the bureau that it shall hold the state of Ohio harmless for responsibility or liability under the DFSP.

(L) Drug-free grants.

Pursuant to section 4121.37 of the Revised Code, the administrator may establish a program of DFSP safety grants associated with reimbursement at specified levels or rates for specified DFSP start-up costs for eligible employers. These grants may be available to only DFSP employers and not to those with a comparable program.

(M) Combinations, partial transfers and successors.

Where an employer that is participating in a basic or advanced level DFSP is combined into another policy, has a partial transfer or is a successor, the bureau shall determine how the employer's DFSP participation should transfer with considerations for whether the involved entity also has a DFSP and the level of the employer's DFSP.

(N) Compatibility with other bureau rate plans.

An employer participating in the DFSP shall be entitled to participate in any other bureau rate program concurrent with its participation in the DFSP, except that an employer may not receive the DFSP benefit in addition to the benefit for participating in the following rate programs:

- (1) EM cap;
- (2) \$15,000 medical only;
- (3) Group-experience rating in conjunction with DFSP basic level;
 - i. Group-experience-rated employers can participate at the advanced level of the DFSP and receive the incremental difference between the basic and advanced level benefits.
- (4) Group-retrospective rating;
- (5) Individual-(paid-loss) retrospective rating;
- (6) Large deductible; and
- (7) One claim.

Effective: 07/1/2010

Promulgated Under: 111.15

Statutory Authority: 4121.12, 4121.121

Rule Amplifies: 4123.29, 4123.34

Prior Effective Dates: 4/1/97, 7/1/98, 5/20/99, 7/1/99, 9/7/99, 3/27/00, 1/1/01, 7/1/01, 1/1/02, 12/1/02, 5/15/03, 7/1/04, 05/21/2009

APPENDIX A

(1) If the benefit for an employer implementing a DFSP is offered in the form of a discount, the discount shall be as follows:

(a) For an employer implementing a basic DFSP, 4 per cent;

(b) For an employer implementing an advanced DFSP, 7 per cent;

(c) For an employer implementing an advanced DFSP and in group-experience rating, 3 per cent;

(d) For an employer implementing a comparable program, no discount.

(2) The application of any discount shall become effective when premium payments are made for the period that begins July first of the ~~policy~~ **program** year for participating private employers and January first of the of the ~~policy~~ **program** year for participating public employers **and private employers.**

**Interested Party Feedback Matrix
DFSP Proposed Rule**

| Rule Section Description of Content | Rule Comments/Suggestions from Interested Parties | Interested Party Rationale | BWC Response and Resolution |
|--|--|--|--|
| 4123-17-58 (B) Application process | <ul style="list-style-type: none"> • Allow semi-annual enrollment (January/July) and allow new employers to enroll within 30 days of new coverage (ALL) • Extend deadline from 5/28 to allow more time to educate employers about new DFSP (ALL) | <ul style="list-style-type: none"> • Semi-annual enrollment will allow new employers who otherwise would have to wait a whole year to participate and would mitigate negative impact on vendor availability and employer access to services | <ul style="list-style-type: none"> • Accommodation in rule will be made to allow January AND July years for private employers and to ensure employer access to vendors and DFSP services. • Accommodation in rule will be made to extend application deadline for first year to 6/30 to allow more time for marketing and education. |
| 4123-17-58 (D) General program requirements | | | |
| -- <u>Alcohol and other drug testing</u> | <ul style="list-style-type: none"> • Reduce random drug testing for advanced program to 15% (ALL) | <ul style="list-style-type: none"> • Objection is not with 25% random testing but increased cost with reduced discounts • Lower percentage of random will still have deterrent effect | <ul style="list-style-type: none"> • BWC will accommodate employers' concerns with cost implications of 25% random drug testing and allow a minimum of 15% random. |
| 4123-17-58 (F)(2)(d) | <ul style="list-style-type: none"> • Remove requirement for employer to pay for cost of assessment to allow shared cost (co-pay) to get employee buy-in for getting help (Vendor) | <ul style="list-style-type: none"> • Some employers will not enroll because of perceived high cost of paying for assessments | <ul style="list-style-type: none"> • BWC will consider circumstances where employer policy or union agreements address co-pays for assessment aimed at employee buy-in to addressing an employee's substance problem. |
| 4123-17-58 (F)(2)(f) | <ul style="list-style-type: none"> • Remove prohibition for termination of employment on a first positive test from rule (Employer) | <ul style="list-style-type: none"> • Some industries must have right to terminate on first positive due to inherent risk | <ul style="list-style-type: none"> • BWC will not change rule but will specify in policy the ability to consider exceptions on a case-by-case basis for employers to terminate on a first positive. |

SOURCE OF SUGGESTION IS REPRESENTED AS EMPLOYER, VENDOR, THIRD-PARTY ADMINISTRATOR OR ALL THREE GROUPS (ALL)

Prepared by Rick Brown, March 24, 2010

**Interested Party Feedback Matrix
DFSP Proposed Rule**

| Rule Section Description of Content | Rule Comments/Suggestions from Interested Parties | Interested Party Rationale | BWC Response and Resolution |
|---|---|--|---|
| 4123-17-58 (N) Compatibility with other bureau rate plans | <ul style="list-style-type: none"> • Allow group-experience-rated employers to stack DFSP up to the maximum group discount before breakeven factor (TPA) • Allow group-retrospective rating to stack DFSP discounts (TPA) • Allow DFSP employers to use \$15K and salary continuation (TPA) • NEW: Allow employers to be in DFSP and in EVERY other BWC rating program and get a discount regardless of DFSP level (Employer) | <ul style="list-style-type: none"> • Allow more employers in group and basic to participate • Allow employers to be in other bureau rate programs and DFSP | <ul style="list-style-type: none"> • No change to rule will be made. • Compatibility/stacking decisions were made based on actuarial soundness as was the incremental amount that Advanced level employers will be eligible to receive on top of their group credits. • Employers CAN participate concurrently in DFSP and other bureau rating programs but may not stack DFSP discount on top of the benefits of these programs. |
| Appendix A Discounts | <ul style="list-style-type: none"> • Increase discounts to 5% for Basic level and 10% for Advanced level (ALL) • Offer back-end performance-based refunds (e.g., reduced frequency/severity) at 5% for one and 10% for both (ALL) | <ul style="list-style-type: none"> • 4% and 7% discounts would help with DFSP implementation costs but are not sufficient • Many employers will not see the cost/benefit of DFSP which may result in significant drop in enrollment • Reward employers based on performance | <ul style="list-style-type: none"> • No change to rule will be made. • BWC committed to retooling current drug-free programs to make them actuarially justified based on anticipated impact to employers' risk. Discounts that are proposed match recommendations of Deloitte Consulting and underwent a subsequent review by BWC's Actuarial Department before being determined. • Effectiveness/discounts will be evaluated on a continuous basis. • Currently retooling Drug-Free Grant program to offset more start-up costs. |

SOURCE OF SUGGESTION IS REPRESENTED AS EMPLOYER, VENDOR, THIRD-PARTY ADMINISTRATOR OR ALL THREE GROUPS (ALL)

Prepared by Rick Brown, March 24, 2010

Common Sense Business Regulation (BWC Rules)

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

Rule – 4123-3-15

Rule Review

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

Citation: 4121.121, 4123.57

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

What goal(s): **This rule defines the timeframe and processing of a claim that is inactive (no request for action or payments) but is still statutorily open and; processing an application for and payment of compensation pursuant to 4123.57.**

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 to the rules were reviewed with Ohio Association of Justice and OSBA Workers' Compensation Committee. The proposed rule was sent for additional stakeholder review and feedback on February 16, 2010.

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
Chapter 3 Rules
4123-3-15

Introduction

Chapter 3 contains provisions for the administration of claims. Rule 4123-3-15 Claims procedures subsequent to allowance, has been reviewed and changes are being proposed.

Background Law

The statutory authority for the rule provisions are found at ORC 4121.11, 4121.121, 4121.30, 4121.31, 4123.05. Collectively, they provide the general framework for the management of the BWC and the administration of claims. Specifically, 4121.11 grants general rule making authority and provides that the “bureau of workers compensation may adopt its own rules of procedure and may change the same in its discretion”.

Proposed Changes

Section 4123-3-15(A) is being amended to change the timeframe from 13 months to 24 months for a claim to become inactive (no request for action or payments).

The claim reactivation process is essentially a “checkpoint” in the life of the claim where BWC and the MCO will review any requests for allowance of conditions, compensation payments or medical services to ensure causality and medical appropriateness for the allowed conditions in the claim. A claim becomes inactive when there has been a specified lapse in time from the last request for action or payment on the claim. After a thorough evaluation of the 13 month timeframe, the objectives underlying the same, and its system impact, BWC has determined that 13 months is too short of a claim inactivation period. The evaluation showed that the vast majority of reactivation requests after 13 months are granted.

It was further determined that a 24 month specified timeframe will result in increased system efficiency while maintaining the necessary internal control for older claims. Changing the timeframe from 13 months to 24 months will reduce administrative resources required for both BWC and MCOs in reviewing claim reactivation requests and corresponding special processing required. This change will also reduce issuing and mailing of BWC Orders and eliminate delay in treatment to the injured worker and reduce hassle factors for the physician in having to request reactivation during this time period.

External Stakeholder Input

The suggested rule changes resulted from BWC's ongoing rule and claims process review and as the result of injured worker customer service issues as presented by the Ohio Association for Justice (OAJ). The rules have been reviewed and discussed with the OAJ and the (OSBA) Ohio State Bar Association Workers' Compensation Committee the past several months. The rules were sent out for additional stakeholder review and feedback.

4123-3-15 Claim procedures subsequent to allowance.

- (A) Requests for subsequent actions when a state fund claim has not had activity or a request for further action within a period of time in excess of ~~thirteen~~ twenty-four months.
- (1) The bureau shall consider a request for subsequent action in a claim in the following situations:
- (a) Where the employee seeks to have the bureau or commission modify or alter an award of compensation or benefits that has been previously granted; or
 - (b) Where the employee seeks to have the bureau or commission grant a new award of compensation or to settle the claim; or
 - (c) Where the claimant seeks to secure the allowance of a disability or condition not previously considered; or
 - (d) Where the claimant dies and there is potential entitlement for accrued benefits or payment of medical bills, or the decedent's dependent is requesting death benefits due to relatedness between the recognized injury and death.
 - (e) Except for a medical issue relating to a prosthetic device or durable medical equipment as designated by the administrator, the bureau, in consultation with the MCO assigned to the claim, shall issue an order on a medical treatment reimbursement request in a claim which has not had activity or a request for further action within a period of time in excess of ~~thirteen~~ twenty-four months as follows:
 - (i) The MCO shall refer a medical treatment reimbursement request in a claim which has not had activity or a request for further action within a period of time in excess of ~~thirteen~~ twenty-four months to the bureau for an order when the request is accompanied by supporting medical evidence dated not more than sixty days prior to the date of the request, or when such evidence is subsequently provided to the MCO upon request (via "Form C-9A" or equivalent). The bureau's order shall address both the causal relationship between the original injury and the current incident precipitating the medical treatment reimbursement request in a claim and the necessity and appropriateness of the requested treatment. The employer or the employee or the representative may appeal the bureau's order to the industrial commission pursuant to section 4123.511 of the Revised Code.

- (ii) The MCO may dismiss without prejudice, and without referral to the bureau for an order, a medical treatment reimbursement request in a claim which has not had activity or a request for further action within a period of time in excess of ~~thirteen~~ twenty-four months when the request is not accompanied by supporting medical evidence dated not more than sixty days prior to the date of the request and such evidence is not provided to the MCO upon request (via “Form C-9A” or equivalent).
- (2) Requests which require proof shall conform to the standards required by paragraph (C) of rule 4123-3-09 of the Administrative Code and rules 4123-6-20 and 4123-7-08 of the Administrative Code.
 - (a) Medical evidence is required to substantiate a request for temporary total disability.
 - (b) Medical evidence is required to substantiate the allowance of a disability or condition not previously considered.
- (3) In state fund cases, upon request for subsequent action under paragraph ~~(B)~~(A)(1) of this rule, the bureau shall, upon notification, inform the parties to the claim of the pending action prior to issuing a decision. Upon request, the bureau shall provide a copy of the request and proof to the employer and the claimant, and their representatives, where applicable. Requests in self-insuring employers’ cases shall be submitted to the self-insuring employer which shall accept or refuse the matters sought.
- (4) The bureau or commission may require the filing of additional proof or legal citations by either party or may make such investigation or inquiry as the circumstances may require.
- (5) A state fund employer shall, upon receipt of notification of the request, notify the bureau of any objection to the granting of the relief requested. Such notification must be filed within the time as required by the rules of the bureau and industrial commission.
- (6) Such requests shall be determined with or without formal (public) hearing as the circumstances presented require. If the request is within the jurisdiction of the bureau and the matter is not contested or disputed, the bureau shall adjudicate the request in the usual manner. In all other cases, the request shall be acted upon by the industrial commission’s hearing officer or as otherwise required by the rules of the commission, depending on the subject matter.
- (7) Failure by the employee to furnish information as specifically requested by the bureau or commission shall be considered sufficient reason for the dismissal of

the request. If the employer fails to furnish any information requested by the bureau or commission, the request may be adjudicated upon the proof filed.

(B) “Application for Determination of Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability” pursuant to division (A) of section 4123.57 of the Revised Code in state fund and self-insured claims.

- (1) An “Application for Determination of Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability” shall be completed and signed by the applicant or applicant’s attorney and shall be filed with the bureau of workers’ compensation. An application for an increase in permanent partial disability must be accompanied by substantial evidence of new and changed circumstances which have developed since the time of the hearing on the original or last determination. Unsigned applications shall be dismissed by the bureau. Except where an additional condition has been allowed in the claim and the request is for an increase in permanent partial disability based solely on that additional condition, a request for an increase in permanent partial disability filed without medical documentation shall be dismissed by the bureau. Whenever the applicant or applicant’s representative leaves a question or questions in the application form unanswered, the bureau shall contact the applicant and applicant’s representative to obtain the information necessary to process the application. Should the applicant or applicant’s representative inform the bureau that the failure to provide the information necessary to process the application is beyond the applicant’s control, the bureau shall take appropriate action to obtain such information.
- (2) Upon the filing of the application for either of these requests, the application shall be referred to the bureau for review and processing. The bureau shall mail a copy of the application and any accompanying proof to the employer and the employer’s representative, unless the employer is out of business. The employer shall submit any proof within its possession bearing upon the issue to the bureau within thirty days of the receipt of the claimant’s application.
- (3) Each applicant for a determination of the percentage of permanent partial disability shall be scheduled for an examination by a physician designated by the bureau, and the examining physician shall file a report of such examination, together with an evaluation of the degree of impairment as a part of the claim file. The bureau shall send a copy of the report of the medical examination to the employee, the employer, and their representatives.
- (4) Upon receipt of the examining physician’s report, the bureau shall review the medical evidence in the employee’s claim file and shall make a tentative order as the evidence at the time of the making of the order warrants. If the bureau determines that there is a conflict of evidence, the application, along with the claimant’s file, shall be forwarded to the industrial commission to set the application for hearing before a district hearing officer.

- (5) Where there is no conflict of evidence, the bureau shall enter a tentative order on the request for percentage of permanent partial disability and shall notify the employee, the employer, and their representatives, in writing, of the tentative order and of the parties' right to request a hearing. Unless the employee, the employer, or their representative notifies the bureau, in writing, of an objection to the tentative order within twenty days after receipt of the notice thereof, the tentative order shall go into effect and the employee shall receive the compensation provided in the order. In no event shall there be a reconsideration of a tentative order issued under this division.
- (6) If the employee, the employer, or their representatives timely notify the bureau of an objection to the tentative order, the matter shall be referred to a district hearing officer who shall set the application for hearing in accordance with the rules of the industrial commission. Upon referral to a district hearing officer, the employer may obtain a medical examination of the employee, pursuant to the rules of the industrial commission.
- (7) Where the application is for an increase in the percentage of permanent partial disability, no sooner than sixty days from the date of mailing of the application to the employer and the employer's representative, the applicant shall either be examined, or the claim referred for review by a physician designated by the bureau. Such period may be extended or the processing of the application suspended by the bureau for good cause shown. If the bureau has determined that the employer is out of business the application will not be mailed and the bureau may process the application without waiting the sixty day period. The bureau physician shall file a report of such examination or review of the record, together with an evaluation of the degree of impairment, as part of the claim file. Either the employee or the employer may submit additional medical evidence following the examination by the bureau medical section as long as copies of the evidence are submitted to all parties.
- (8) After completion of the review or examination by a physician designated by the bureau, the bureau may issue a tentative order based upon the evidence in file. If the bureau determines that there is a conflict in the medical evidence, the bureau shall adopt the recommendation of the medical report of the bureau medical examination or medical review.
- (9) The bureau shall enter a tentative order on the request for an increase of permanent partial disability and shall notify the employee, the employer, and their representatives, in writing, of the nature and amount of any tentative order issued on the application requesting an increase in the percentage of the employee's permanent disability. The employee, the employer, or their representatives may object to the tentative order within twenty days after the receipt of the notice thereof. If no timely objection is made, the tentative order shall go into effect. In no event shall there be a reconsideration of a tentative

order issued under this division. If an objection is timely made, the matter shall be referred to a district hearing officer who shall set the application for a hearing in accordance with the rules of the industrial commission. The employer may obtain a medical examination of the employee and submit a defense medical report at any stage of the proceedings up to a hearing before a district officer.

- (10) Where an award under division (A) of section 4123.57 of the Revised Code has been made prior to the death of an employee, all unpaid installments accrued or to accrue are payable to the surviving spouse, or if there is no surviving spouse, to the dependent children of the employee, and if there are no such children surviving, then to such other dependents as the ~~commission~~ bureau may determine.



Stakeholder feedback and recommendations for changes to the Chapter 3 Rules: 4123-3-15

| Line # | Rule # / Subject Matter | Draft Rule Suggestions | Stakeholder Rationale | BWC Response | Resolution |
|--------|-------------------------|--|---|--|---------------------------------------|
| 1 | 4123-3-15(A) | My law firm fully supports the proposed changes. Gary Plunkett, Hochman & Plunkett Co., L.P.A. | It is policy consistent with the intent of the workers' compensation system and the principles of a common fund system. | No response necessary | Maintain recommendation as submitted. |
| 2 | 4123-3-15(A) | What is the BWC thinking behind the increase in the timing from 13 to 24 months? Karen Agnich, MCO 10026 | | We are proposing the change back to 24 months to realign our business processes to ensure timely treatment, improve process efficiency, reduce costs and eliminate unnecessary barriers for the physician to continue treating injured workers. We also received input from stakeholders that IW's were being denied access to follow up care, because the claim was inactive. We conducted an analysis of the current 13 month timeframe to determine if the "checkpoint" was at the right time in the claim. What the analysis revealed is of the claims reviewed, the request to reactive the claim was granted 97% of the time. The time period right after 13 months to 19 months and thereafter, the requests greatly diminished. So the 13 month timeframe seems to be premature in reviewing causality and medical appropriateness. By 24 months, the requests are minimal and probably more represent the claims that truly need to be reviewed. With SB 7 changing the statute of limitations to 5 years from date of last payment of comp or medical, the 24 month time period seems the more appropriate "halfway" checkpoint in the claim for review. We currently receive over 5,000 requests per year and changing the timeframe to 24 months will reduce the amount of requests that BWC and MCO will have to review to less than 1,000. | Maintain recommendation as submitted. |
| 3 | 4123-3-15(A) | As far as increasing the time frame for inactivity- 24 months gives the IW a lot of time to seek additional treatment— Denise Strum, MCO 10042 | 13 months of inactivity should be sufficient especially since there are lots of claims currently that remain open based on one or two prescriptions that the IW is having filled and there is no medical for a few years just simply the pharmacy bills are being paid. With the increase of the time frame this allows the IW more time to sit and wait and then when is retired, laid off, or leaves an employer can then seek additional treatment against the employer and possibly gain monetary reward. Maybe they could be more strict about allowing claims to reactivate with this new time frame—and require more medical documentation and hold the IW more accountable. | A claim is statutorily open for five (5) years from date of last payment of compensation or medical; therefore, the IW can seek treatment at anytime during this five year period. Depending upon the year of injury the claim may be open up to 10 years. The MCO is responsible to medically manage the claim for the life of the claim, and should be requiring documentation to support requests for treatment and services, throughout the claim life. The claim reactivation process is merely a "checkpoint" during the life of the claim in which to review for causality and appropriateness of medical treatment when there has been a lapse in time. We conducted an analysis of the current 13 month timeframe to determine if the "checkpoint" was at the right time in the claim. What the analysis revealed is of the 380 claims reviewed, the request to reactive the claim was granted 97% of the time. The time period right after 13 months to 19 months and thereafter, the requests greatly diminished. So the 13 month timeframe seems to be premature in reviewing causality and medical appropriateness. By 24 months, the requests are minimal and probably more represent the claims that truly need to be reviewed. With SB 7 changing the statute of limitations to 5 years from date of last payment of comp or medical, the 24 month time period seems the more appropriate "halfway" checkpoint in the claim for review. | Maintain recommendation as submitted. |
| 4 | 4123-3-15(A) | We are strongly opposed to the rule change of extending the current inactive status from 13 months to 24 months: Barbara Wright, MCO 10061 | No claim activity for 13 months identifies that the IW has significantly stabilized, the need for treatment for the medical condition is resolved, and should have to utilize the current re-activation process. | BWC understands comments with regard to stability of the injured worker; however, this was only one component in determining the right "checkpoint" during the claim life. The injured worker may have reached a point of stability at 13 months, however, may still require follow up care at 14-19 months and should not have to overcome the administrative burden of requesting claim reactivation to secure the follow up care. Changing the timeframe to 24 months will ensure timely treatment, improve process efficiency, reduce costs and eliminate unnecessary barriers for the physician to continue treating injured workers. We conducted an analysis of the current 13 month timeframe to determine if the "checkpoint" was at the right time in the claim. What the analysis revealed is of the 380 claims reviewed, the request to reactive the claim was granted 97% of the time. The time period right after 13 months to 19 months and thereafter, the requests greatly diminished. So the 13 month timeframe seems to be premature in reviewing causality and medical appropriateness. By 24 months, the requests are minimal and probably more represent the claims that truly need to be reviewed. With SB 7 changing the statute of limitations to 5 years from date of last payment of comp or medical, the 24 month time period seems the more appropriate "halfway" checkpoint in the claim for review. We currently receive over 5,000 requests per year and changing the timeframe to 24 months will reduce the amount of requests that BWC and MCO will have to review to less than 1,000. | |

| Line # | Rule # / Subject Matter | Draft Rule Suggestions | Stakeholder Rationale | BWC Response | Resolution |
|--------|-------------------------|---|---|---|---------------------------------------|
| 5 | 4123-3-15(A) | We have reviewed the proposed changes to the OAC Chapter 3 rules and do not believe there are any areas of concern from the physician's' perspective. John F. Wills, Executive Director, Ohio Osteopathic Association | | No response necessary | Maintain recommendation as submitted. |
| 6 | 4123-3-15(A) | We have a concern with these new rules changing the timeframe from 13 to 24 months for inactivity. John Dumas, Sheakley | Efforts need to be made to reduce the amount of time claims can remain active since the majority of claims do not require reactivation. It seems as though we are creating a situation where we are making policy on the needs of the few instead of the needs of the many. | A claim is statutorily open for five (5) years from date of last payment of compensation or medical; therefore, the IW can seek treatment at anytime during this five year period. Depending upon the year of injury the claim may be open up to 10 years. We conducted an analysis of the current 13 month timeframe to determine if the "checkpoint" was at the right time in the claim. What the analysis revealed is of the 380 claims reviewed, the request to reactive the claim was granted 97% of the time. If the sampling is extrapolated over all inactive claims and the findings hold true we are indeed addressing the needs of the many. | Maintain recommendation as submitted. |
| 7 | 4123-3-15(A) | The length of time that an MCO may act unilaterally should be shortened, not lengthened. Michael J. Hickey | Small employers will be harmed by the current proposal in that they often are not aware of the import of actions taken by MCOs. Such actions may result in claims remaining open for longer periods of time; being allowed for additional conditions; and having inappropriate treatment allowed. All such events will increase claims costs and the reserves charged to employers. The Bureau's involvement earlier rather than later is preferable. Please do not increase the time period to 24 months. Ohio employers do not need further economic burdens. Thank you. Michael J. Hickey | A claim is statutorily open for five (5) years from date of last payment of compensation or medical; therefore, the IW can seek treatment at anytime during this five year period. Depending upon the year of injury the claim may be open up to 10 years. The MCO is responsible to medically manage the claim for the life of the claim, and should be requiring documentation to support requests for treatment and services, throughout the claim life and communicating with the employer on its actions. The claim reactivation process is merely a "checkpoint" during the life of the claim in which to review for causality and appropriateness of medical treatment when there has been a lapse in time. Increasing the time period, will actually reduce administrative costs because BWC and the MCO will be processing fewer requests to reactivate a claim. We conducted an analysis of the current 13 month timeframe to determine if the "checkpoint" was at the right time in the claim. What the analysis revealed is of the 380 claims reviewed, the request to reactive the claim was granted 97% of the time. The time period right after 13 months to 19 months and thereafter, the requests greatly diminished. So the 13 month timeframe seems to be premature in reviewing causality and medical appropriateness. By 24 months, the requests are minimal and probably more represent the claims that truly need to be reviewed. With SB 7 changing the statute of limitations to 5 years from date of last payment of comp or medical, the 24 month time period seems the more appropriate "halfway" checkpoint in the claim for review. We currently receive over 5,000 requests per year and changing the timeframe to 24 months will reduce the amount of requests that BWC and MCO will have to review to less than 1,000. | Maintain recommendation as submitted. |

12 - Month Medical Services & Safety Calendar

| Date | March 2010 | Notes |
|----------|---|-------|
| 3/25/10 | 1. OAC 4123-3-15 claim procedure subsequent to allowance - amend rule to change claim inactivity designation and streamline rule (2 nd Read) | |
| | 2. Create rule to outline injured workers' loss of use or loss by amputation payments pursuant to ORC 4123.57 (B) (2 nd Read) | |
| | 3. Drug-free Safety Program Rule 4123-17-58 (2 nd Read) | |
| Date | April 2010 | |
| 4/29/10 | 1. Pharmacy overview | |
| | 2. MCO-Voc Rehab referral report | |
| | 3. Change OPPS effective date (possible waiving of 2 nd read) | |
| Date | May 2010 | |
| 5/27/10 | 1. Medical & Service Provider Fee Schedule (1st read) | |
| Date | June 2010 | |
| 6/17/10 | 1. Medical & Service Provider Fee Schedule (2nd read) | |
| Date | July 2010 | |
| 7/28/10 | | |
| | | |
| Date | August 2010 | |
| 8/26/10 | | |
| | | |
| Date | September 2010 | |
| 9/23/10 | 1. Inpatient Hospital Fee Schedule (1st read) | |
| | 2. Vocational Rehab fee schedule (1 st read) | |
| Date | October 2010 | |
| 10/21/10 | 1. Outpatient Hospital Fee Schedule (1st read) | |
| | 2. Inpatient Hospital Fee Schedule (2nd read) | |
| | 3. Vocational Rehab fee schedule (2nd read) | |
| Date | November 2010 | |
| 11/18/10 | 1. Outpatient Hospital Fee Schedule (2nd read) | |
| Date | December 2010 | |
| 12/15/10 | 1. Update Medical and Service Provider Fee Schedule to conform with new Medicare rates (possible waive 2 nd read) | |
| | | |
| 2011 | | |
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| Date | January 2011 | |
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| Date | February 2011 | |
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