From: Ohio Bureau of Workers' Compensation
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Subject: RepConnect - November 2016

RepConnect

Ohio | Bureau of Workers' Compensation

Lump sum settlement

Recently, a group of BWC employees completed work on revising the lump sum settlement policy, procedures and related forms. The group's goal was to provide clarity, consistency and a more efficient process for everyone engaged in negotiating lump sum settlements. Specific changes include:

- Eliminating requests for duplicative or unnecessary information;
- Requiring the new *Medical History and Disclosure* (C-242) and supporting medical documentation for claims involving permanent total disability or death benefits be submitted **with the *Settlement Agreement and Application for Approval of Settlement Agreement* (C-240)**;
- Requiring, as applicable, the *PTD-Death Settlement Acknowledgment and Waiver* (C-243) and the *Indemnity Only Settlement Acknowledgment and Waiver* (C-245) be filed **with the C-240**;
- Making the C-240 more user-friendly by implementing the following changes:
  - Creating a fillable PDF document;
  - Enlarging the font size for better readability;
  - Including links to all other forms that may be required;
  - Enabling the form to be easily sent to the employer for review and signature *before filing* with BWC.

For more information see the *Lump Sum Settlement* policy by clicking here.

Travel reimbursement

Effective Oct. 1, 2016, BWC increased the travel reimbursement rate for injured worker lodging from a maximum of $89 to $91 per night. BWC still requires pre-approval before reimbursing lodging expenses.

An injured worker should always contact his or her claims service specialist and refer to the *Travel Reimbursement* policy and procedure and the *Injured Worker Reimbursement Rates for Travel Expenses* (C-60A) prior to incurring travel expenses.

Reorganization of the representative toolbox on bwc.ohio.gov

We are in the process of removing outdated information and restructuring the Tools for authorized reps page on bwc.ohio.gov to make it more user-friendly.

The intent of this page is to make it a functional toolbox pertinent for your usage. We welcome your feedback on what you would like to see added to this page. We will evaluate all suggestions submitted to the RepConnect email box.

Requests for medical treatment, C-9, with self-insuring employers

When a self-insuring employer allows or certifies a claim, the employer is agreeing to pay for medical services directly related to the workplace injury. Except for emergency situations, the treating physician must obtain approval for certain medical services in advance, such as hospital or nursing home stays, physical therapy, nursing services and dental work. The employer must approve or deny a request for treatment from the attending physician within 10 days of receipt of the request or the request will be deemed approved and authorized according to Ohio Administrative Code (OAC) 4123-19-03 (K) (5). Additionally, if the self-insuring employer denies a request for treatment, or the treatment is otherwise delayed to obtain a medical opinion or gather other information, the self-insuring employer must provide an updated response within 10 days of receipt of the new information.

If a response to a *Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) is not provided within 10 days of receipt, the self-insuring employer should still submit a response to the C-9 to the provider. OAC 4123-19-03 (I) requires that the employer and the designated administrator are responsible for providing assistance to claimants in filing of claims and applications for benefits as well as providing information to claimants regarding the benefits to which claimants may be entitled. Failure to assist the injured worker in obtaining appropriate medical treatment may jeopardize an employer's self-insured status. This may include a consideration of non-renewal or revocation of self-insured status and a referral to the Self-Insured Review Panel to address an employer's ability to meet the administrative requirements for self-insurance.

When responding to a treatment request, a self-insuring employer should not approve a

modification to the request or provide a response with a disclaimer. If the self-insuring employer believes the requested treatment should be modified based on a medical clinician's opinion, the proposed treatment should be addressed with the requesting physician, and a new treatment may be requested.

For self-insured claims, **prior approval is required** for the following (not all-inclusive):

- Diagnostic testing;
- Surgery;
- Durable medical equipment;
- Physical therapy or chiropractic after first 12 visits;
- Injections;
- Obtain approval after the fact only in emergency situations;
- Hospital or nursing home stays;
- Dental work;
- C-9 retro approval only applies to MCOs.

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