



**Bureau of Workers'
Compensation**

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Procedural Guide for Self-Insured Claims Administration

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Introduction

Welcome to the *Procedural Guide for Self-Insured Claims Administration*. This manual is a reference and training guide for the employers whom BWC has granted the privilege of self-insurance in the state of Ohio.

The rules, regulations, forms and procedures described in this manual are in effect as of the date of this publication. These procedures are subject to change, pending the outcome of court cases and other legal interpretations.

BWC's self-insured department based the content on Ohio laws, rules, policies, legal opinions, etc. This information is available on BWC's website, www.bwc.ohio.gov and the Industrial Commission of Ohio's (IC's) website, www.ic.ohio.gov.

Self-Insurance in Ohio

Ohio Revised Code (ORC) 4123.35 and Ohio Administrative Code (OAC) 4123-19-03 primarily govern self-insurance in Ohio. All employers whom BWC has granted the privilege to pay compensation directly must demonstrate sufficient financial strength and administrative ability to assure that they promptly meet all obligations under section [ORC 4123.35](#).

[OAC 4123-19-03\(I\)](#) states that by accepting the privilege of self-insurance, an employer acknowledges the ultimate responsibility for the administration of workers' compensation claims in accordance with the laws and rules that govern self-insurance.

The self-insuring employer must post a copy of the *Certificate of Employer's Right to Pay Compensation Directly* (self-insured certificate) at each work site. The employer may also post this on an intranet site available to all employees. The name, title and department location of the company individual responsible for administering its workers' compensation program must accompany the certificate. Additionally, the employer must display the *Notice to Employees* and the *Required Posting* addressing rebuttable presumption at all Ohio locations.

Self-Insured Department Contact Information

Phone: 614-466-6773 or 1-800-644-6292
Email: SIINQ@bwc.state.oh.us
Address: 30 W. Spring St. 22nd Floor
Columbus, OH 43215

Self-Insured Administration

Application process

[ORC 4123.35](#), [OAC 4123-19-03](#)

All self-insuring employers must demonstrate sufficient financial strength and administrative ability to assure that it promptly meets all obligations under [ORC 4123.35](#).

Renewal process

[ORC 4123.35](#), [OAC 4123-19-08](#)

The employer must annually renew the privilege to pay compensation, etc., directly. Prior to renewal of the employer's privilege of self-insurance, BWC re-evaluates the employer's financial strength and administrative ability as described in [OAC 4123-19-03](#).

To renew its status as a self-insuring employer, the employer must establish it has fulfilled the minimal level of performance standards that an employer is required to meet before BWC grants permission to pay compensation and benefits directly, as provided in paragraph (K) of [OAC 4123-19-03](#). The employer must have substantially resolved all outstanding complaints filed with BWC and that the employer has achieved a satisfactory rating in its most recent audit report.

BWC notifies a self-insuring employer 120 days prior to the renewal period. The employer must submit the *Application for Renewal of Authorization to Operate as a Self-Insured Risk (SI-7)* online at www.bwc.ohio.gov no later than 90 days prior to the renewal date. Additionally, an employer must submit its most current fiscal years certified financial statements to supplement this application. Upon approval of an employer's self-insured status, BWC mails a *Certificate of Employer's Right to Pay Compensation Directly* no later than 30 days prior to the renewal date.

Self-insured administrator

[ORC 4123.35](#), [OAC 4123-19-03 \(I\)](#)

The self-insuring employer will designate one Ohio employee who is knowledgeable and capable of administering an efficient workers' compensation program. The administrator's duties include:

- Acting as liaison between the employer, BWC and the IC. Providing information upon request;
- Providing assistance to claimants in filing of claims and application for benefits;
- Providing information to claimants regarding the processing of claims and the benefits to which claimants may be entitled;
- Providing the various forms to be used in seeking compensation or benefits;
- Accepting or rejecting claims for benefits;
- Approving payment of compensation and benefits.

If there is a change in the designated administrator, and the newly assigned administrator has less than one year of experience with Ohio self-insurance, BWC may require the new person complete BWC's online orientation program within six months of assignment.

The employer may retain an individual or third-party administrator (TPA) to assist in managing workers' compensation claims and authorizing settlements. However, the ultimate responsibility for the administration and processing of workers' compensation claims resides with the self-insuring employer.

Claim housing requirements

[ORC 4123.35](#), [OAC 4123-19-03 \(K\)\(3\)](#)

The self-insuring employer must keep an individual record of all injuries and occupational diseases resulting in more than seven days of total disability or death as well as all denied claims or claims with contested issues. This can be in an electronic paperless environment or with hard-copy paper files and must include:

- Incident Report and/or *First Report of an Injury, Occupational Disease or Death (FROI)*
- Medical report(s), narrative reports, independent medical exams;

- Service provider medical fee bills with received date clearly documented;
- Notification to claimant/provider if payment of fee bill is delayed, denied or not paid in full;
- Payment verification: must include check number, date of payment, payee, pay period and type of payment. Can be electronic printout or check copy;
- Requests for authorization with received date clearly documented;
- Dated responses to requests for authorization;
- Return-to-work documentation;
- *Request for Temporary Total Compensation (C-84)*;
- *Physician's Report of Work Ability (MEDCO-14)*;
- BWC and IC communication;
- *Motion (C-86)*;
- Payroll information, either printout or *Wage Statement (C-94-A)*;
- Working wage loss documentation and worksheets used to calculate wage loss benefits;
- Written job offer if claimant is working in a modified-duty position;
- Authorization for release of medical information (optional);
- Child support orders, if applicable;
- Change of physician communication, if applicable.

If the injured worker receives medical treatment from a medical provider, and if seven or fewer calendar days of lost time results from the injury, include all medical information obtained from the provider, (diagnosis, period of disability, treatment plan and prognosis, etc.) in the medical-only record.

If the injured worker receives no medical treatment and no lost time results from the injury or occupational disease, BWC recommends the employer retain a FROI or incident report for recordkeeping purposes.

The employer must furnish the injured worker, and upon request must file with BWC and the IC, all medical reports received from the treating physician related to the allowed injury/occupational disease claim. The injured worker provides the employer, and upon request shall file with BWC and/or the IC, medical reports relating to and received from the treating physician(s) who have seen the injured worker for the claim filed. The injured worker will honor the employer's request for appropriate written authorization to obtain medical reports pertaining to the claim.

BWC requires self-insuring employers to house their workers' compensation claim files in one of its Ohio locations. However, BWC's self-insured department may waive this requirement should the self-insuring employer wish to maintain claim files out of state or at a TPA's office.

New self-insuring employers must maintain files at their location for the first year of self insurance. BWC's self-insured department may also waive this requirement. If BWC approves out-of-state housing, the employer must make the files available in Ohio, for any self-insured department audits.

Banking

[ORC 4123.35](#), [OAC 4123-19-03](#)

The self-insuring employer must have an Ohio bank account from which indemnity payments are drawn. If there is no in-state account established, the employer should draw compensation checks on the same bank as the employer's payroll account, or establish an agreement with an Ohio bank that will honor the checks. These checks must clearly note this arrangement.

Reporting paid compensation

[ORC 4123.35](#), [OAC 4123-19-03 \(J\)](#)

All self-insuring employers must file an *Annual Report of Paid Compensation and Reserves* (SI-40), which BWC uses to determine self-insured assessments. The report covers all compensation payments from Jan. 1 through Dec. 31 each year. The employer must submit the SI-40 by Feb. 28 of the following year. The employer must submit it electronically at www.bwc.ohio.gov. It should reflect the consolidated compensation total for all operating entities or locations covered under the self-insurance policy.

BWC also requires self-insuring employers to report claim reserves as part of the SI-40 report. BWC has separated reserve reporting into two time periods, claims with a date of injury prior to 1987 and those 1987 and after. The reserves should reflect the future liability associated for the life of the claim. BWC uses these reserves as part of the determination of additional security requirements. BWC may require additional documentation or independent actuarial support to verify the validity of the self-reported reserves.

Employers who are no longer self-insuring or operating in Ohio must continue to report paid compensation each year until there have been at least 10 years of reported compensation below the annual minimum rate, which OAC 4123-17-32(H) establishes. Once the calendar year paid compensation falls below the minimum rate, the self-insuring employer may request a buyout of future assessment obligations, which BWC's self-insured department reviews for approval. A cancelled self-insuring employer is still responsible for the ongoing administration and payment of claims.

BWC may estimate compensation paid for employers who are late or fail to file the SI-40 report. BWC may adjust the estimate if the employer submits the information at a later date.

Self-insured assessments

[ORC 4123.35](#), [OAC 4123-17-32](#)

Self-insuring employers pay semiannual assessments based on paid compensation. These assessments, which are required of all self-insuring employers include:

- Surplus Fund;
- Administrative Cost Fund (BWC);
- Administrative Cost Fund (IC);
- Division of Safety & Hygiene;
- Guaranty Fund.

There are additional assessments for self-insuring employers that participate in one of the following optional funds:

- Handicap reimbursement;
- Disallowed claim reimbursement;
- Rehabilitation reimbursement.

Employers can find details on the assessment rates for each of these funds [here](#).

In addition, self-insuring employers must reimburse BWC for Disabled Workers' Relief Fund (DWRF) benefits on a semiannual basis. This fund is for permanently and totally disabled employees whose workers' compensation benefits have not kept up with inflation. BWC bills the self-insuring employer dollar for dollar for these costs regardless of the injury date including any PTD claims related to any previous state fund policies.

BWC issues self-insured assessment invoices in January and July of each year based on reported paid compensation from the previous calendar year. For example, the employer must report paid compensation for calendar year 2013 to BWC by February 2014. BWC will issue corresponding invoices in January 2015 with a due date of Feb. 28, 2015, and in July 2015 with a due date of Aug. 31, 2015.

Significant changes

[ORC 4123.35](#), [OAC 4123-19-03 \(M\)](#)

If there is any change involving additions, mergers, or deletions of entities or ownership changes of a self-insuring employer, which would materially affect the administration of the employer's self-insuring program or the number of employees included in such program, the employer must notify BWC's self-insured department within 30 days after the change occurs.

Self-Insured Review Panel

[ORC 4123.35](#), [OAC 4123-19-14](#)

The Self-Insured Review Panel (SIRP) consists of three members with expertise in self-insured matters to provide advice to the administrator and BWC's self-insured department. The SIRP also provides employers with hearings on matters referred to the panel, or as requested by the employer.

BWC refers all unresolved issues involving the financial strength or the administrative ability of the employer to operate a self-insured workers' compensation program to the panel for a hearing.

The administrator may authorize the review panel to consider granting or denying an application for the privilege of self insurance, non-renewals of self-insured status, revocation of self-insuring employer status, issues of a company's adequacy of contribution to the Self-Insuring Employers' Guaranty Fund or the need for additional security.

Self-Insured Claims Policy

Definitions

Injury

[ORC 4123.01](#)

Caused by external accidental means or accidental in character and result, received in the course of, and arising out of, the injured employee's employment

Injury does not include:

- Psychiatric conditions, except where the claimant's psychiatric conditions have arisen from an injury or occupational disease sustained by that claimant or where the claimant's psychiatric conditions have arisen from sexual conduct in which the claimant was forced by threat of physical harm to engage or participate;
- Injury or disability caused primarily by the natural deterioration of tissue and organ or part of the body;
- Injury or disability incurred in voluntary participation in an employer sponsored recreation or fitness activity if the employee signs a waiver of the employee's right to compensation of benefits under this chapter prior to engaging in the recreation or fitness activity;
- A condition that pre-existed an injury unless that pre-existing condition is substantially aggravated by the injury.

Lost-time claim

A claim is considered a lost time claim if eight or more calendar days are lost from the job, due to a work-related injury. The days do not have to be consecutive. If the employer has paid compensation or wages in lieu of compensation, but the injured worker is off work for eight or more days, the claim is still considered as a lost time claim.

Medical-only claim

A medical-only claim is considered as a claim of seven or fewer days of lost time due to a work-related injury with no compensation paid pursuant to [ORC 4123.56](#) (A) and [ORC 4123.56](#) (B), [ORC 4123.57](#) or [ORC 4123.58](#).

Occupational disease[ORC 4123.01\(F\)](#)

An occupational disease (OD) is a disease contracted in the course of employment. Depending on the condition and circumstances, an OD claim can be either medical only or lost time. The Ohio Supreme Court determined in *Brody v. Mihm* 1995 that a pre-existing disease aggravated during employment is not compensable as an OD claim. For an employee to receive compensation for an occupational disease they must have contracted it in the course of employment. [ORC 4123.68](#) lists conditions that are considered occupational diseases.

Overuse injuries

An injury that does not result from a specific incident and develops gradually as a result of the injured worker's job-related duties. [ORC 4123.01](#) (C), *Village v. General Motors* (1984)

Last injurious exposure

When an employee has been exposed to elements causing a respiratory occupational disease while working for multiple employers, the claim is attributed in whole to the employer with whom the employee had the last injurious exposure.

Aggravation of a pre-existing condition

For injuries prior to Aug. 25, 2006, an aggravation of a pre-existing condition occurs if an injury arising in the course of employment makes the condition worse. Compensability of an aggravation of a pre-existing injury or condition depends on whether the subsequent injury or condition is of such character that its consequences can be regarded as the natural result of the original injury.

The self insured employer may allow claims with date of injury on or after Aug. 25, 2006, for substantial aggravation of a pre-existing condition.

Objective diagnostic findings, objective clinical findings or objective test results must document the substantial aggravation. Subjective complaints may be evidence of a substantial aggravation, but they are insufficient to support allowance of a substantial aggravation without objective diagnostic findings, objective clinical findings, or objective test results.

Once the condition has returned to a level that would have existed without the injury, no compensation or benefits are payable for the pre-existing condition. Therefore, a claim for substantial aggravation of a pre-existing condition, may no longer be payable once the condition returns to a level that would have existed without the injury.

Employee

[ORC 4123.01\(A\) \(1\)](#) defines who is an employee for workers' compensation purposes while [ORC 4123.01\(A\) \(2\)](#) defines who is not an employee.

Statute of limitations[ORC 4123.84](#)

Written notice of injury or death to the BWC or the Industrial Commission must be submitted within one year from the date of injury for all injuries occurring after September 28, 2017, and two years for claims occurring on September 28, 2017 and prior.

Occupational disease (OD)[ORC 4123.85](#)

An OD claim must be filed with BWC or the IC within six months of diagnosis, two years from disability due to the disease, whichever is later, or within two years after death occurs due to the disease.

Rebuttable presumption[ORC 4123.54\(B\)](#)

Effective Oct. 13, 2004, House Bill 223 (HB 223) allows employers to seek disallowance of a workers' compensation claim filed by an injured worker who tests positive on a qualifying chemical test, or refuses to be tested. HB 223 creates a rebuttable presumption that an employee's intoxication or being under the influence of a controlled substance (specified in this law, and not prescribed by a physician), as established by a positive alcohol or drug test, or established by proof of a refusal to be tested, is the proximate cause of a work-related injury. Because of this presumption, an employer defending a claim does not have to prove that drugs or alcohol are the cause of the injury. Instead, the injured worker has the burden to prove that the injury was not caused by the drugs or alcohol revealed in his/her system.

If an employer complies with the requirements of the law, it may consider the alcohol or controlled substance the proximate cause of an injury and may contest a workers' compensation claim based on these findings.

Statutory life of a claim[ORC 4123.52](#)

The continuing jurisdiction of the IC and the authority of the administrator of BWC include:

- For all claims prior to Dec. 11, 1967, the statutory time limit is 10 years from the last date of medical or compensation payment;
- For claims from Dec. 11, 1967, to Aug. 24, 2006, the statutory time limit is 10 years from last payment of compensation or medical benefits for lost-time claims and six years from date of last medical payment for medical-only claims;
- For claims on or after Aug. 25, 2006, the statutory time limit is five years from the date of last medical or compensation payment.

Claims management

When an injury or occupational disease has occurred, the employer should complete an incident report. An example of an incident report is located below. The injured worker and/or a company representative can complete the report. BWC suggests an employer have the injured worker sign and date his or her report. BWC recommends the employer retain the report in the claim file as a record-only or incident-only claim. If the injured worker receives medical treatment from a medical provider, and if seven or fewer calendar days of lost time results from the injury, this report becomes the basis for establishing a medical-only claim file.

Claim files should include, but are not limited to, the following documents:

- Incident report;
- Copy of the FROI (if contested issue);
- Medical report(s);
- Medical fee bill(s) (stamped with date received by employer);
- Payment verification;
- Company payroll printout showing employee's wages or a C-94-A;
- Notification of change of physician;
- Return-to-work date;
- Authorization for the release of medical information (optional);
- *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9)* and responses;
- Copy of hearing notices and orders;
- Copy of appeal notices.

Prior authorization for services

Prior approval by the employer is required for the following services:

- Diagnostic testing (including: MRI, CT scans, bone scans, PET scans);
- Hospitalization (including transfers between facilities);
- Inpatient and outpatient surgery except emergency surgery;
- Therapy (including: physical therapy after the first 10 treatments, therapeutic radio log, work hardening (reconditioning) programs, back school, acupuncture, bio feedback);
- Durable medical equipment (including: rental/purchase of Tens units, continuous passive motion devices, neuromuscular stimulator, bone stimulators in the spine, prosthetic devices and repairs of the device
- Chronic pain/stress programs;
- Nursing care (including: nursing home care, private duty nursing or attendant care, home health nursing care, oxygen services, chelation therapy, respiratory services, traction, outpatient or home IV therapy);
- Dental/orthodontic (including: repair or replacement of dental restorations or prostheses previously approved by BWC, periodontal treatments and services, orthodontic surgeries, orthodontics, dental implants);
- Vocational rehabilitation services;
- Transportation (all non-emergency transportation, including ambulance and air).

Free choice of physician

[OAC 4123-19-03\(K\)\(5\)](#)

An injured worker has the right to change providers. The injured worker must submit a written request to change a physician directly to the self-insuring employer with a reason for the request. The request will include the name of the physician and the proposed treatment. Self-insuring employers must respond to a [Request for Change of Physician \(C-23\)](#), within seven days of receipt. If the employer refuses to grant the change of physician, it must submit a copy of the request to BWC with the reason(s) for the refusal. BWC will refer this issue to the IC for a hearing.

[OAC 4123-6-06.2](#) governs choice of providers for employers.

Recognized physician of record

BWC recognizes the following medical providers as a permitted physician of record for workers' compensation claims:

- Doctor of Medicine;
- Psychiatrist;
- Doctor of Osteopathy;
- Doctor of Chiropractic;
- Doctor of Podiatric Medicine;
- Doctor of Dental Surgery;
- Doctor of Optometry;
- Doctor of Mechanotherapy.

Motions[OAC 4123-3-16](#)

A [C-86](#) form is used whenever a dispute or disagreement arises in an allowed claim and there is no specific application to address the issue. The motion should explain the dispute and action of relief sought. It must include accompanying evidence to support the dispute. If an employer files a motion, the injured worker must be provided a copy along with his or her representative.

A motion may be used on the following issues:

- Payment or termination of compensation;
- Adjustment of wages;
- Request for additional allowance;
- Request for allowance of psychiatric conditions;
- Authorization for medical treatment;
- Payment of medical bills.

Additional allowances

Ohio law allows an injured worker to receive benefits related to new conditions related to a work-related injury. An additional condition may be directly caused by the original injury or may be an aggravation resulting from the original injury.

When medical evidence supports an additional allowance, an employer may accept the new condition(s) and pay benefits accordingly. The employer may also choose to request an independent medical evaluation to help determine if it supports the additional condition. If an employer disputes the request for additional allowances in the claim, it must notify the injured worker in writing. The employer must also notify the injured worker of his or her right to file a C-86 with the IC to address the disputed issue.

Rebuttable presumption[ORC 4123.54](#)

An employer may disallow a claim filed by an injured worker that tests positive for drugs or alcohol or refuses to be tested. This creates a rebuttable presumption that the employee's intoxication is the proximate cause of the injury. This shifts the burden of proof to the injured worker to show that any drugs or alcohol did not cause the workplace injury.

An employer must post BWC's written notice of rebuttable presumption policy before using it as a reason to deny a claim. This notice must be posted in the same area as the certificate of workers' compensation coverage.

Sample Incident Report

Company name	Self-insured number
Address	City/State/ZIP code
Employee name	Social Security number
Address	City/State/ZIP code
Date of injury	
Occupation	
Time of injury <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Date reported to employer
Witness (if any)	
Incident location if different from company location	
Address	City/State/ZIP code
Description of incident – describe in detail: (e.g., approximate weight, size, trip, fall or any substances involved, such as oil, water, etc.)	
Give the exact nature of injury and part of body affected (e.g., fracture of right hand, etc.)	
Was employee treated in the plant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did employee receive outside medical treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Give name of hospital, clinic and/or physician's name	
Last date worked	Return to work (if known)
Did the injury result in death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signing this report does not constitute certification of an industrial claim.	
Employee's signature	
Date	Title
Employer's signature	
Date	Title

Medical-only claims

[OAC 4123-3-03\(D\)](#)

A medical-only claim is categorized as a claim of seven or fewer days of lost time due to a work-related injury with no compensation paid pursuant to [ORC 4123.56](#) (A) or (B), [ORC 4123.57](#), or [ORC 4123.58](#). A medical-only claim is not required to be reported to the BWC unless the employer is disputing the claim. If an employer or injured worker decides to file a medical-only claim with BWC, it must be reported by using the [First Report of Injury, Occupational Disease or Death \(FROI\)](#). BWC will assign a claim number upon receipt of the information and furnish it to the injured worker and self-insuring employer.

Certification

If an injured worker files a medical-only claim with BWC, the employer must certify the claim. If BWC receives no certification information from the employer within 30 days, it will refer the issue to the IC for hearing. BWC interprets no response from the self-insuring employer as a dispute and will forward the issue to the IC for hearing.

The employer must notify the injured worker of the allowed conditions within 30 days of receipt of a certified medical-only claim.

The employer must notify the BWC and the injured worker on any rejected medical-only claims within 30 days of the employer being notified of the claim according to [OAC 4123-19-03\(K\)\(10\)](#). When a dispute exists, all parties receive the IC Notice of Referral (NOR) letter and the claim referred to the IC for hearing.

Medical treatment

[OAC 4123-19-03\(K\)](#)

The employer must furnish or make arrangements for reasonable medical services during all working hours. The focus should be on quality medical services with a goal to safely return the injured worker to work.

The employer must manage medical-only claims following the same statutory requirements for lost-time claims. The employer must maintain a record of all medical-only claims, which it can make available to BWC's self-insured department. The record must include payment history, incident report, return to work documentation, treatment requests, medical bills and explanation of benefits.

It is important that the employer makes all records pertaining to return to work part of the medical-only claim record. If an injured worker is to return to work with restrictions but will be paid full salary, there must be documentation supporting the return to work. This may include a job offer letter outlining the job duties while on modified duty, start date, hours worked and rate of pay. Additionally, payroll history verifying the claimant was working and received pay for the period of modified duty may be necessary. Documentation supporting a full release to work must also be included in the claim record.

If an injured worker's physician releases him or her to work with restrictions, and he or she refuses a written job offer, the injured worker may not be eligible for benefits. The file record must show the job offer documentation. It will still be necessary to pursue a full-duty release for the record.

Medical release

[ORC 4123.651](#)

Self-insuring employers have the right to a copy of medical records relating to an employee's workers' compensation injury or occupational disease. The injured worker can sign the [Authorization for the Release of Medical Information \(C-101\)](#), to formally provide an employer access to pertinent medical

information. This form is not required and any use of it must be limited to requesting records related to the alleged injury or occupational disease.

Treatment authorization

Self-insuring employers must respond to a [Request for Medical Service Reimbursement or Recommendation for Additional Conditions \(C-9\)](#) within 10 days of receipt. A physician may also submit a treatment request on any other physician-generated document that contains the data elements on the C-9 form. If there is no response from the employer within 10 days, BWC deems the request approved according to [OAC 4123-19-03\(K\)\(5\)](#).

Medical bills

[OAC 4123-19-03\(K\)\(5\)](#)

The self-insuring employer must respond to all medical bills incurred by the injured worker within 30 days after receipt of the bill either by the employer or designated representatives. The employer must notify the injured worker and the provider and, only upon request, BWC or the IC, in writing, if it disputes a bill. Written notification must specifically state the reason for the non-payment. Notification to the injured worker must include the injured worker's right to request a hearing with the IC.

[IC resolution R97-1-06](#) addresses signature requirement on physician reports.

Self Insured employers use usual and customary fee guidelines (UCR) for the payment of medical services. Providers covered by these guidelines include, but are not limited to, physicians, dentists, chiropractors, mechano therapists, physiotherapists, neurologists, podiatrists and optometrists. OAC 4123-6-10 (C) (1) indicates that payments to providers shall be equal to or greater than those provided on State Funded claims.

An employer may negotiate payment rates with health-care providers for services and supplies provided in the treatment of workers' compensation claims as permitted by [OAC 4123-6-10](#). An employer also may enter into volume-based contracts with medical providers for services. This includes, but not limited to, the purchase or rental of durable medical equipment and supplies so long as the employer maintains access to quality and convenient medical services or supplies for injured workers.

Providers should file fee bills for services rendered in a claim with BWC, IC or you within one year of the date of service. In disallowed claims that later were allowed, providers should file the fee bills within six months from the date of the mailing of the final order allowing the claim or be barred.

Outpatient medication

[OAC 4123-6-21.1](#)

Medication must be for treatment of an occupational injury or disease in an allowed claim. An 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. The pharmacy provider must bill medication at their usual and customary charge. Reimbursements for medications will at least be equal to BWC's established rate for the medication, unless the employer has a negotiated payment rate with the pharmacy provider pursuant to [OAC 4123-6-46](#). An employer must pay requests for reimbursement within 30 days of receipt of the request.

An employer must obtain a drug utilization review from a physician before terminating payment for current medications. An employer must notify all parties to the claim (including the prescribing physician) that a physician is performing a drug review. The written notice will inform all parties to the claim 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. The employer must 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 independent physician reviewer's report indicates the drug treatment is not medically necessary, the employer may terminate reimbursement for the medications by therapeutic drug class. The termination is effective as of the date of receipt of the independent physician reviewer's report.

For a drug that requires a weaning-off period, the termination is effective at the date as agreed to by the employer and the prescribing physician. If the employer terminates reimbursement for medication, the employer must provide all parties to the claim with a copy of the independent physician reviewer's report. In addition, it must notify the employee, in writing, of the decision to terminate. The notification must also indicate the employee has the right to request a hearing before the IC.

An employer may implement a point-of-service adjudication system to require pharmacy providers to submit bills for medication by an online point-of service authorization terminal or a host-to-host link as a condition of reimbursement. If a point-of-service adjudication system is used, the maximum allowable cost list of the point-of-service adjudication system, which are pharmaceutically and therapeutically equivalent, may be used. This means they contain identical doses of the active ingredient and have the same biological effects as determined by the Food and Drug Administration. Claimants who request a brand-name drug or whose physician specifies a brand-name drug will be liable for the product cost difference. The cost difference will be between the established maximum allowable cost price of the drug product and the average wholesale price, plus or minus BWC's established percentage of the dispensed brand-name drug.

Lost-time claims

[ORC 4123.28](#); [OAC 4123-3-03\(D\)](#)

The employer must report lost-time injuries and occupational diseases to BWC within one week of acquiring knowledge of the injury. However, [OAC 4123-19-03\(K\)\(10\)](#) outlines the following guidelines:

- The employer must notify BWC and the injured worker of recognized and contested conditions within 30 days of notification of an injury resulting in eight or more calendar days of disability;
- Within 30 days of an injury that results in death;
- For all contested claims regardless of whether or not there is lost time.

For occupational disease claims, the employer should notify the injured worker of recognized and contested conditions within 30 days of notice of diagnosis. The employer should advise BWC within 30 days of lost time associated with the occupational disease claim.

Use the [FROI](#) to complete initial application. BWC will assign a claim number upon receipt of the information and furnish it to the injured worker and self-insuring employer. [OAC 4123-3-03\(D\)](#)

Certification

If BWC receives no certification information from the employer within 30 days, it will refer the issue to the IC for hearing. BWC interprets no response from the self-insuring employer as a dispute and will forward the issue to the IC for hearing.

The initial application should list the allowed ICD code(s) and/or conditions certified by the employer. BWC may consider an application certified by the employer as clarification, which does not accept all ICD code(s) and/or conditions listed on the application a dispute. BWC may refer such an application to the IC for hearing.

When the employer does not specify certification/rejection on the application, BWC will send an employer certification request letter to the employer. BWC interprets no response from the self-insuring employer as a dispute and will forward the issue to the IC for hearing. When a dispute exists, all parties to the dispute receive an IC Notice of Referral (NOR), and BWC refers the claim to the IC for hearing within seven days.

BWC will not proactively pursue medical and will not schedule statutory exams unless requested by the IC.

Medical treatment

[OAC 4123-19-03\(K\)](#)

The self-insuring employer must furnish or make arrangements for reasonable medical services during all working hours. The focus should be on quality medical services with a goal to safely return the injured worker to work.

The employer must maintain a record of all medical-only claims, which it can make available to BWC's self-insured department. The record must include payment history, incident report, treatment requests, medical bills and explanation of benefits.

It is important that the employer makes all records pertaining to return to work part of the lost time claim record. If an injured worker returns to work with restrictions but will receive full salary, the employer must provide documentation supporting salary payment while on disability. This may include a job offer letter outlining the job duties while on modified duty, start date, hours worked and rate of pay. Additionally, payroll history verifying the claimant **was working** and received pay for the period of modified duty may be necessary. The employer must also include documentation supporting a full release to work in the claim record.

If a physician releases an injured worker to work with restrictions, and he or she refuses a written job offer, the injured worker may not be eligible for benefits. The claim file must show the job offer documentation. It will still be necessary to pursue a full-duty release for the record.

Medical release

[ORC 4123.651](#)

Employees are entitled to copies of medical records relating to a workers' compensation injury or occupational disease. The injured worker can sign the C-101, to formally provide an employer access to pertinent medical information. This form is not required and any use of it must be limited to requesting records related to the alleged injury or occupational disease.

Treatment authorization

Self-insuring employers must respond to a [C-9](#) within 10 days of receipt. A physician may submit a treatment request on any other physician-generated document that contains the data elements on the C-9 form. If there is no response from the employer within 10 days, BWC deems the request approved according to [OAC 4123-19-03\(K\)\(5\)](#).

Medical bills

[OAC 4123-19-03\(K\)\(5\)](#)

The self-insuring employer will respond to all medical bills incurred by the injured worker within 30 days after receipt of the bill either by the employer or designated representatives. The employer must notify the injured worker and the provider and, only upon request, BWC or IC, in writing, for a disputed bill. Written notification must specifically state the reason for the non-payment. Notification to the injured worker must include the injured worker's right to request a hearing with the IC.

[IC resolution R97-1-06](#) address Signature requirement on physician reports.

BWC uses usual and customary fee guidelines (UCR) for the payment of medical services. Providers covered by these guidelines include, but are not limited to physicians, dentists, chiropractors, mechano therapists, physiotherapists, neurologists, podiatrists and optometrists. OAC 4123-6-10 (C) (1) indicates that payments to providers shall be equal to or greater than those provided on State Funded claims.

An employer may negotiate payment rates with health-care providers for services and supplies provided in the treatment of workers' compensation claims as permitted by OAC 4123-6-10. An employer also 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. The employer must maintain access to quality and convenient medical services or supplies for injured workers.

Providers should file fee bills for services rendered in a claim with BWC, IC or you within one year of the date of service. In disallowed claims that later were allowed, providers should file the fee bills within six months from the date of the mailing of the final order allowing the claim or be barred.

Outpatient medication

[OAC 4123-6-21.1](#)

Medication must be for treatment of an occupational injury or disease in an allowed claim. An 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. The pharmacy provider must bill medication at their usual and customary charge. Reimbursements for medications will at least be equal to BWC's established rate for the medication, unless the employer has a negotiated payment rate with the pharmacy provider pursuant to OAC 4123-6-46. An employer must pay requests for reimbursement within 30 days of receipt of the request.

An employer must obtain a drug utilization review from a physician before terminating payment for current medications. An employer must notify all parties to the claim (including the prescribing physician) that a physician is performing a drug review. The written notice will inform all parties to the claim 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. The employer must 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 independent physician reviewer's report indicates the drug treatment is not medically necessary, the employer may terminate reimbursement for the medications by therapeutic drug class. The termination is effective as of the date of receipt of the independent physician reviewer's report.

For a drug that requires a weaning-off period, the termination is effective at the date as agreed to by the employer and the prescribing physician. If the employer terminates reimbursement for medication, the employer must provide all parties to the claim with a copy of the independent physician reviewer's report. In addition, it must notify the employee, in writing, of the decision to terminate. The notification must also indicate the employee has the right to request a hearing before the IC.

An employer may implement a point-of-service adjudication system to require pharmacy providers to submit bills for medication by an online point-of service authorization terminal or a host-to-host link as a condition of reimbursement. If a point-of-service adjudication system is used, the maximum allowable cost list of the point-of-service adjudication system, which are pharmaceutically and therapeutically equivalent, may be used. This means they contain identical doses of the active ingredient and have the same biological effects as determined by the Food and Drug Administration. Claimants who request a brand-

name drug or whose physician specifies a brand-name drug will be liable for the product cost difference. The cost difference will be between the established maximum allowable cost price of the drug product and the average wholesale price, plus or minus BWC's established percentage of the dispensed brand-name drug.

Payment of compensation

The self-insuring employer will pay all compensation benefits as required by law without any order from BWC or the IC unless the employer contests the requested benefits. According to [ORC 4123.56\(A\)](#), the employer will pay temporary total (TT) compensation based on medical reports of the physician of record (POR). If the IC awards compensation and/or benefits at hearing, the employer will pay compensation and/or benefits due and payable under an order as provided in [ORC 4123.511](#).

If the employer allows a claim for compensation and/or benefits without a hearing, the employer will pay initial compensation and/or benefits no later than 21 days from acquiring knowledge of the claim or the injured workers filing of the C-84, whichever is later.

Submitted by the injured worker, the C-84/equivalent form notifies BWC that an injured worker continues to be temporarily totally disabled from work due to the injury. The [MEDCO-14](#) or other equivalent medical evidence may also be used as medical evidence to support the initial or subsequent payment of TT compensation. Both forms are available on BWC's website.

According to Ohio Supreme Court case *Bradley v. IC*, payment of TT compensation must be based solely on allowed condition(s) in the claim. The allowed condition(s) cannot combine with non-allowed condition(s) to produce TT disability.

According to [OAC 4123-5-18\(C\)](#), whenever the employer cannot pay compensation due to lack of evidence, the employer should contact the injured worker immediately to advise him or her of the information required to initiate the payment.

The employer should contact the treating physician to obtain any information that is missing or needed to make a decision regarding the requested compensation payment.

The treating physician's signature is required to pay TT compensation. A stamped signature, as well as an electronic signature from the treating physician, is acceptable. The treating physician's designee may also sign for the treating physician and provide his or her own initials. A person given signature authority by a health-care professional can be a non-professional staff member.

- [IC Resolution R97-1-06](#) (effective Aug. 5, 1997) authorizes the IC to accept all reports of health-care providers that the provider or his or her authorized representative has signed.

Return to work

The employer must maintain return-to-work documentation in the file for both full duty and restricted duty. The injured worker must provide medical documentation of restrictions that are a direct result of the allowed conditions in the claim. The physician of record/treating physician is responsible for providing restrictions. [OAC 4121-3-32](#) requires that a written job offer be provided that outlines the job duties, rate of pay and hours if the employer is attempting to terminate benefits as a result of the injured workers' refusal of a job offer. The employer must wait 48 hours of receipt of the job offer before initiating procedures to terminate benefits. The employer should maintain a record of this communication in the claim file.

Wage calculations

Full weekly wage (FWW)

[ORC 4123.61](#)

The first 12 weeks of TT compensation is based on the FWW of the injured worker at the time of the injury or at the date of disability due to the occupational disease. The FWW is based on a comparison of earnings for the first six weeks prior to the date of injury and the first full week of earnings prior to the date of injury. Include all earnings from any other employers during this period. Use the pay ending date (not pay date) to establish the pay periods of prior earnings. The FWW rate is 72 percent of the FWW.

The FWW rate is 72 percent of the weekly rate. If the FWW rate exceeds the statewide average weekly wage (maximum rate) for the year of the injury, the FWW will be set at the maximum rate for the year of the injury.

For injured workers who have worked at least one full week prior to the date of injury, the FWW is the higher amount of:

- The gross wages (including overtime pay) for the six weeks (42 days) prior to the date of injury/disability, divided by six, or;
- The gross wages earned (excluding overtime pay) for the seven days (last pay period) prior to date of injury/disability.

When an injured worker has not worked at least a full week during the six weeks prior to the date of injury, the FWW is the hourly rate multiplied by the number of hours the injured worker was scheduled to work the week the injury occurred.

Do not use earnings for the pay period that includes the date of injury for calculating wages. The earning basis starts with the first full pay period prior to the date of injury. If prior earnings are bi-weekly, use the three full bi-weekly pay periods prior to the date of injury. Do not split in half the last bi-weekly period that includes the date of injury to determine the seven days prior to the date of injury. Use actual earnings (less overtime) in the week prior to the date of injury, or divide the bi-weekly pay prior to the date of injury (excluding overtime) by two.

- **Bi-monthly earnings (twice a month)**

Six weeks prior: Use the earnings (including overtime) for the pay three periods prior to the date of injury. Add the wages from these periods, multiply this figure by seven, and then divide by the number of days in the total pay period (45, 46 or 47 days). Multiply this amount by six. This will provide the six-week average.

Seven days prior: If the seven days prior (less overtime) are not available, use the weekly rate.

- **Monthly earnings**

Add the earnings for the two months prior to the injury, including overtime. Divide this total by the total number of days (59, 60, 61 or 62) and multiply this figure by seven to determine the weekly rate. Multiply this by six to obtain the six week average. This will also be the seven days prior.

- **Quarterly earnings (no monthly or weekly breakdown is provided)**

Six weeks prior: Use the earnings for the quarter prior to the date of injury and divide this amount by the number of days (89, 90, 91 or 92) in the pay period and multiply that figure by seven for a weekly average. Multiply this amount by six to get the six-week total.

Seven days prior: Divide the earnings for the quarter prior (excluding overtime) to the date of injury by the number of days (89, 90, 91 or 92) in the pay period, then multiply that figure by seven for a weekly rate.

Use annual earnings for calculation of FWW only when the injured worker submits no detailed evidence, and the only information available is annual earnings. In this instance, the FWW and average weekly wage (AWW) will be set at the same rate. [See AWW calculation for clarification.](#)

FWW Examples

- **Example 1**

If the injured worker’s earnings for the six weeks prior to the injury were:

\$480 (week prior to the date of injury, includes no overtime)
 \$424.50
 \$480
 \$480
 \$591.04
\$549.40
 $\$3,004.94 \div 6 = \500.82

The FWW is \$500.82, which is the average of the wages earned for the six weeks prior to the date of injury. This is greater than the wages from the week prior to the injury, which was \$480.

The full weekly wage rate is determined by multiplying the FWW by 72 percent (.72).

$\$500.82 \times .72 = \360.59

- **Example 2**

If the injured worker has not been continuously employed for six weeks prior to the date of injury and he or she has not worked at least seven days prior to the date of injury the FWW = hourly rate multiplied by scheduled hours

- **Example 3**

Date of injury July 30, 2006

(A) Begin with the six weeks of gross wages prior to the date of injury and include overtime

Pay period ending	Gross wages
Aug. 4, 2006	\$358.22
July 28, 2006	\$450 (no overtime)
July 21, 2006	\$492.13
July 14, 2006	\$477.20
July, 7, 2006	-0-
June 30, 2006	\$450
June 23, 2006	<u>\$418.22</u>
	$\$2,287.55 \div 6 = \381.26

(B) Determine the wages earned one week prior to the injury and exclude overtime.

July 28, 2006 \$450 (no overtime)

The FWW is the higher of the two figures. In most cases, you should exclude the pay period ending on or after the injury date from the FWW calculation.

$$\text{FWW} = \$450 \times 72\% = \$324 \text{ (full weekly wage rate)}$$

The last day the injured employee worked was July 30, 2006. He or she remained on disability through Aug. 26, 2006, and returned to work on Aug. 27, 2006. This is a total of three and 6/7 weeks of disability (3.857124).

$$3.857124 \times \$324 = \$1,249.70, \text{ the total compensation due}$$

- **Example 4**

Date of injury March 25, 2009

Pay period ending:	Gross wages
March 21, 2009	\$800.37 (w/o OT 674)
March 14, 2009	\$674
March 7, 2009	\$674
Feb. 28, 2009	\$674
Feb. 21, 2009	\$800.37 (w/o OT 674)
Feb. 14, 2009	<u>\$674</u>
	\$4296.74 ÷ 6 = \$716.12 (FWW)

$$\text{FWW} = \$716.12 \times 72\% = \$515.60 \text{ (full weekly wage rate)}$$

The last day worked was April 3, 2009. The injured worker remained on disability through May 27, 2009. The injured worker returned to work on May 28, 2009. This is a total of seven and 5/7 weeks of disability (7.7143)

$$7.7143 \times \$515.60 = \$3,977.49, \text{ the total compensation due}$$

Average weekly wage (AWW)

[ORC 4123.56\(A\)](#), [ORC 4123.61](#) and [ORC 4123.62](#)

The employer will pay compensation after the 12th week of disability at the AWW rate. Determine the AWW by using the total gross earnings for the 52-week period preceding the injury date. Include all earnings from any other employers during this period. Total these wages and divide by the number of weeks worked. If the injured worker began working for the employer(s) and has not worked 52 weeks because of reasons outside of their control, divide the actual wages by the actual weeks worked.

- **Weekly earnings**
 - Use 52 weeks prior to the injury and divide by 52 weeks to determine the weekly average.
- **Bi-weekly earnings (paid every two weeks)**
 - Use the 52 weeks prior to injury, which will be 26 pay periods.
- **Bi-monthly earnings (paid twice per month)**
 - Add the wages from these periods, multiply this figure by seven, and then divide by the number of days in the total pay period. (365 or 366). Multiply this amount by 52 which will provide the 52 week average.
- **Monthly earnings**
 - Use earnings for the 12 months prior to the date of injury, divide by the number of days in the period (365 or 366), then multiply by seven to calculate the AWW.
- **Quarterly earnings**

- Enter the earnings for the four quarters prior to the date of injury and divide by the number of days in the period (365 or 366), then multiply by seven for a weekly rate.
- **Annual earnings**
When submitting earnings annually, the date of injury controls if one year or two years of earnings are required. For dates of injury Dec. 1 through Dec. 31, use only earnings for the year of injury; one year is required. For date of injury Jan. 1 through Jan. 7, use earnings for the year prior to injury; one year is required. For all other dates of injury (Jan. 8 through Nov. 30) the employer apportions earnings for the year of injury and the year prior so there is a combined weekly average for 52 total weeks; two years are required.

AWW examples

- **Example 1**

If the injured worker's earnings for the prior 52 weeks were \$30,000, then $\$30,000 \div 52 = \576.92 . The rate is determined by multiplying the AWW times 66 2/3 percent.

$\$576.92 \times 66 \frac{2}{3} \text{ percent} = \384.63

- **Example 2**

When the injured worker's calculated FWW is higher than the minimum statewide rate, but the full weekly wage rate is not higher than the minimum rate, the injured worker receives the minimum statewide rate.

The statewide minimum rate is \$255.67 for 2009 injuries.

The injured worker's FWW is \$256.60 (above minimum rate).

$\$256.60 \times 72\% = \184.75 (below minimum rate).

The injured worker is paid \$255.67 (the statewide minimum rate).

- **Example 3**

When the injured worker's FWW is less than the minimum statewide rate, the employee receives the calculated FWW. Do not calculate the 72 percent.

The 2009 statewide minimum rate is \$255.67.

The injured worker's FWW is \$175.50 (already below the minimum rate).

The injured worker is paid \$175.50.

Minimum and maximum rates

If the FWW and/or AWW rate is below the minimum rate for the year of the injury, the FWW rate will be set at the minimum rate for the year of the injury. If the FWW and/or AWW is less than the minimum rate, the rate will be FWW or AWW, with no reduction. BWC updates the maximum and minimum rates based on the statewide average weekly wage at the beginning of each year.

BWC provides compensation rate charts at:

<https://www.bwc.ohio.gov/downloads/blankpdf/CompRates.pdf>.

Earnings defined

The employer must consider earnings from all employers for whom the injured worker worked during the 52 weeks prior to the date of injury when setting wages. The employer should have documentation that it sought all earnings. Not all payments to injured workers should be considered as earnings.

- Bonuses may not be included as wages in the FWW calculation but may be included in the AWW. FWW is based on earnings over a limited period of time (seven days or six weeks prior to date of injury). Employees usually earn bonuses over a period of time in the past. To be included in the FWW, you must determine the injured worker earned the bonus (not just paid) in the six-week period prior to the date of injury. To be included in the AWW, you must determine the injured worker earned the bonus during the 52 weeks prior to the date of injury. You must document this in the claim. Always divide by 6 weeks regardless of how many weeks the injured worker actually worked during the period.
- Deductions for deferred compensation are a part of the injured worker's total earnings (gross income). However, disbursements paid to the injured worker from a deferred compensation account earnings may not be considered as earnings.
- Allowances (including travel allowance) may be considered as earnings, but reimbursements (including travel reimbursements) are generally not considered. To be considered an allowance, the employer does not have to require receipts or other proof of payment by the injured worker. A reimbursement is when the injured worker pays first and the employer reimburses the amount the injured worker paid for the service based on proof of payment.
- Per diem payments and stipends earnings may be considered.
- Workers' compensation and unemployment benefits earnings may not be considered.

Special circumstances

- **School employees**

School employees employed for nine months during the academic year may elect to receive their earnings over a prorated 12-month period (summer break). Calculate the AWW for teachers and school employees by dividing the entire salary for 52 weeks. Use this formula whether or not the employee elected to receive pay over nine months or 12 months. Exclude weeks for the summer break only if the employee regularly has other work over summer break, but did not work for reasons outside his or her control (no work was available), or if the employee was disabled for the period.

Teachers and school employees can work and earn wages from other sources during the summer months. Any wages from the other sources/employers are to be included in calculating the AWW.

According to *Crim v. BWC*, a teacher is not entitled to temporary total over the summer months unless he or she can show intent to work during those months. This also applies to other school employees such as cafeteria workers or custodians working a nine-month schedule.

Generally, an injured worker is not entitled to receive both wages in lieu of temporary total and temporary total compensation for the same period. However according to the *Crim* case, if a teacher receives wages in the summer, which he or she earned during earlier periods, temporary total is not offset because the wages were earned during a prior period.

- **Seasonal workers**

If the seasonal employment is the injured worker's choice, then divide the total earnings by 52 weeks to compute the AWW.

- **Occupational diseases**

If there is a date of disability, base the calculation of wages on the 52 weeks prior to the date of disability. If there is not yet a date of disability established in the claim, base the calculation of wages on the 52 weeks prior to the date of disease. If wages have been set and a date of disability is later established, re-calculate wage based on the 52 weeks prior to the date of disability.

Temporary total (TT) disability

The self-insuring employer will pay all compensation and/or medical benefits as required by law without any order from BWC or the IC unless the employer contests the benefits. TT compensation pays an injured worker totally disabled from work on a temporary basis due to the work-related injury or occupational disease. TT is generally the initial award of compensation paid to an injured worker to compensate for lost wages. According to [ORC 4123.56\(A\)](#), the employer will pay TT compensation based on medical reports of the physician of record (POR).

Completed by the injured worker, the [C-84](#)/equivalent reports that an injured worker continues to be temporarily totally disabled from work due to the injury.

The attending physician uses the MEDCO-14 or other equivalent form to provide medical evidence to support the initial or subsequent payment of TT compensation. The POR/treating physician signature must pay TT compensation. A stamped signature, as well as an electronic signature from the POR/treating physician, is acceptable. The POR/treating physician designee may also sign for the POR/treating physician and include his/her own initials on the form. However, while a PA can sign as a POR designee, he or she cannot sign a physician MEDCO-14/equivalent form or certify compensation in his or her own name.

[OAC 4123-5-18\(C\)](#) states that whenever the employer cannot pay compensation due to lack of evidence, the employer must contact the injured worker immediately and advise him or her of the information required to initiate the payment.

According to [OAC 4123-19-03\(K\)\(5\)](#), if the employer allows a claim for compensation and/or benefits without a hearing, the employer will pay compensation and/or benefits no later than 21 days from acquiring knowledge of the claim or the injured workers' filing of the C-84, whichever is later. The employer will pay ongoing compensation at a minimum of every two weeks. If the IC awards compensation and/or benefits at hearing, the employer will pay compensation and/or benefits due and payable under an order as provided in [ORC 4123.511\(H\)](#). This states that benefits will be paid immediately upon receipt of the order, regardless of whether an appeal is filed

According to [ORC 4123.55](#), the injured worker is not entitled to TT compensation for the first seven days of the disability period unless he or she is disabled for 14 or more consecutive days. If the injured worker is disabled for more than seven days, but less than 14 consecutive days, he or she is entitled to TT compensation for the period beginning day eight. Once the injured worker has been disabled for 14 or more consecutive days, whenever that occurs in the life of the claim, the employer must pay first seven days.

Allowed/non-allowed conditions

According to Ohio Supreme Court case *Bradley v. IC*, the employer must base payment of TT compensation solely on allowed condition(s) in the claim. The allowed condition(s) cannot combine with non-allowed condition(s) to produce TT disability.

If one or several allowed conditions on the MEDCO-14/equivalent or medical report are listed along with a condition(s) that are not allowed and the employer objects to paying TT benefits, the employer must advise the injured worker of the contested issue and continue to pay TT while the issue is in litigation.

Salary continuation

An injured worker can receive regular salary/wages during all or part of the period of disability, in lieu of compensation. BWC still considers the claim lost time if the injured worker was disabled for eight or more calendar days. The employer is only required to report up to the allowed workers' compensation amount. The period in which the employer paid regular (full) salary/wages will count toward the weeks of disability.

The employer must maintain proof of salary/wages paid in lieu of compensation in the official claim file and reported on the annual SI-40. The employer cannot require the injured worker to accept salary continuation.

Volunteers

A volunteer injured worker is not entitled to TT compensation because a volunteer has no lost earnings to replace. However, if the injured worker receives pay for any duties performed as a volunteer, TT compensation may be payable. An example would be when an injured worker's job was with the local volunteer fire department, the employer only considers payment of TT compensation if the injured worker received pay for the number of runs made or other miscellaneous duties performed. Use earnings from the runs and/or other miscellaneous duties to calculate wages. Determine wages by using the hours actually worked per week multiplied by the federal minimum wage. OAC 4123-19-03 (N) permits public self-insuring employer to elect to cover volunteers under the self-insuring policy as regular employees.

Offsets

- **Vacation**

- [OAC 4123-5-20](#)

- An injured worker can receive both vacation pay and TT compensation over the same period. The employer may pay vacation pay in lieu of sick leave, or comp time and TT compensation over the same period. Vacation pay does not offset TT benefits. Treat holiday pay as vacation time unless specifically noted as sick leave.

- **Sick leave**

- [OAC 4123-5-20](#)

- Sick leave payments can offset TT benefits as salary continuation. In addition, the employer cannot pay TT if the employer paid sick leave unless documentation shows the employer paid sick leave as advancement.

- **Disability insurance (S&A)**

- [ORC 4123.56\(A\)](#)

- If an injured worker receives benefits from a non-occupational sick and accident insurance program that the employer of record fully funded, these benefits can offset TT compensation. Any TT benefits later awarded for the same period of time can offset these benefits. The employer must include documentation in the claim file verifying any S&A benefits.

Social Security

In claims with dates of injury on or after Nov. 3, 1989, if an injured worker receives TT or living maintenance compensation and Social Security retirement benefits, the weekly TT or living maintenance benefit amount will not exceed 66 2/3 percent of the statewide average weekly wage (maximum rate). This includes all payments of TT compensation, whether during the first 12 weeks at the FWW rate or later at the AWW rate. Pension benefits or Social Security disability benefits do not offset TT compensation.

Terminating TT benefits

[ORC 4123.56\(A\)](#)

The employer can only terminate TT without a hearing when no conflict or dispute exists for any of the following reasons:

- The injured worker returns to work;
- The injured worker's treating physician has made a written statement that the employee is capable of returning to the former position of employment;
- The injured worker's treating physician indicates the employee has reached maximum medical improvement;
- The injured worker's employer or another employer makes work available within the employee's physical capabilities as determined by the treating physician. The job offer should be in writing. The treating physician must be in agreement with the job offer.

When a conflict or dispute exists with the ongoing payment only the IC can terminate TT benefits. If there is a conflict or dispute with the requested TT compensation payment, BWC refers the conflict/dispute to the IC for hearing.

Opposing medical opinions or any party to the claim objecting to the payment can create a conflict or dispute regarding payment of compensation.

BWC refers an employer's Motion objecting to ongoing TT compensation payment, with or without medical evidence or factual evidence for the objection, to the IC for hearing.

The employer will continue to pay TT compensation with medical documentation supporting the disability until the IC issues a decision.

TT and concurrent payments

The employer can pay the following compensation types concurrently with TT compensation when substantiated by supporting medical evidence:

- Scheduled loss permanent partial (PP);
- Temporary partial (TP) - only if in a different claim involving different body parts and conditions;
- Facial disfigurement (FD);
- Violation of specific safety requirement (VSSR);
- Statutory permanent total feasibility (PTD) - only if the injured worker returned to work and had a new injury resulting in a new claim. TT compensation in the new injury claim concurrently with the statutory PTD in the original claim; the TT compensation for the new injury is not payable in the original claim;
- TT compensation over the same period in the same claim as percentage permanent partial (%PP) only when the employer paid %PP first and the injured worker later requests TT compensation over the same period;
- TT compensation in another claim, but only if paid as a split.

The following compensation types cannot be paid concurrently with TT compensation in the same claim or in a different claim:

- Wage loss (WL);
- Living maintenance (LM);
- Living maintenance wage loss (LMWL);
- PTD - except as noted above.

Court ordered family support

[ORC 4123.67](#)

Workers' compensation benefits are exempt from attachment except as provided under [ORC 3121.03](#), which allows support deductions from a worker's benefits. Support payments deducted from worker's compensation go directly to the central depository designated by the Ohio Department of Job and Family Services (ODJFS). ODJFS distributes any amount to be paid to the family and considers payments voluntarily made directly to the support recipient gifts. The employer cannot credit them to arrearages.

For ongoing weekly workers' compensation benefits, The Federal Consumer Credit Protection Act limits deduction up to 50 percent of disposable income for an obligor/injured worker who currently supports another family, plus 5 percent if the support is in arrears.

It also limits deductions up to 60 percent of disposable income for an obligor/injured worker who is not supporting another family, plus an additional 5 percent if support is in arrears.

Deduction orders apply to weekly compensation benefits. These benefits include TT, LM, LMWL, PTD, PP, and ongoing payments of TP and WL.

Family support orders have the claim on all awards considered lump-sum awards after recoupment of overpayment(s) and payment of attorney fees, as appropriate.

The following types of compensation are considered to be lump-sum awards and require notice to the FSEA and notification to the injured worker attorney, if represented:

- Accrued %PP;
- Initial payment of accrued PP
- Lump-sum settlement;
- FD
- Initial payment of accrued TP;
- Lump-sum advancements, except advancements ordered paid for attorney fees.

If the injured worker desires to have the support payments reduced while receiving compensation, he or she must contact the appropriate support enforcement agency for assistance.

According to [ORC 3121.0311](#) and [OAC 4123-3-10\(A\)\(8\)](#), The employer must notify the injured worker's attorney of any current lump-sum payments of \$150 or more. This gives the attorney the opportunity to request payment directly from BWC for attorney fees/expenses from the current lump-sum award prior to payment of family support obligations to the FSEA. The attorney has 30 days (plus four days for mailing) from notification to submit his or her request for payment and the appropriate supporting documentation. Supporting documentation must include a fee agreement signed by the injured worker and an affidavit signed by the attorney with the requested fee amount, including expenses.

Incarceration

An injured worker incarcerated in any county, state or federal institution cannot receive TT compensation benefits.

Other types of compensation

Percentage of permanent partial

[ORC 4123.57](#)

%PP is compensation awarded for residual impairment resulting from an allowed injury or occupational disease. This permanent impairment may be physical or psychological.

The injured worker uses the [Application for Determination of Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability \(C-92\)](#) to request a percentage of permanent partial impairment award.

The C-92 contains three check boxes to address (%PP) requests. The injured worker will mark the check box that appropriately describes his or her request. The first box is checked when the injured worker is requesting an initial %PP award and no medical is required from the injured worker.

The second box is checked when the injured worker is requesting a %PP award for a newly allowed condition and no new medical is required. This is a C-92-A application.

The third check box is checked when the injured worker is requesting an increase of %PP award and requires that medical evidence that supports an increase over the previously granted percent of impairment be attached to the request. This is also a C-92-A. The last payment of compensation (last paid date) under [ORC 4123.56](#). This would be for the TT payment period end date, not the date of the actual payment. Payments under ORC 4123.56 include TT and WL compensation.

This is for both sections dates of injury prior to June 30, 2006 and after June 30 2006.

[OAC 4123-3-15\(B\)\(1\)](#) states that a C-92-A request must be accompanied by substantial evidence that shows that new and changed circumstances have developed since the time of the hearing on the original or most recent %PP determination. There is no waiting period for a request in an increase in a %PP award after the initial finding. The last payment of compensation (last paid date) under [ORC 4123.56](#). This would be for the TT payment period end date, not the date of the actual payment. Payments under ORC 4123.56 include TT and WL compensation.

This is for both sections dates of injury prior to June 30, 2006 and after June 30 2006.

In claims with dates of injury prior to June 30, 2006, an application for %PP can be filed 40 weeks from:

- The last payment of compensation (last paid date) under [ORC 4123.56](#). Payments under ORC 4123.56 include TT and WL compensation;
- The date of injury or contraction of an occupational disease in absence of payments under ORC 4123.56.

In claims with dates of injury on or after June 30, 2006, the waiting period is 26 weeks from:

- The last payment of compensation (last paid date) under ORC 4123.56. Payments under ORC 4123.56 include TT and WL compensation
- The date of injury or contraction of an occupational disease in absence of payments under ORC 4123.56.

An injured worker may request %PP award on a medical-only claim, with the same time frames.

BWC will schedule an injured worker requesting an initial determination of %PP (C-92) for an examination according to [ORC 4123.57](#). An injured worker requesting an increase in %PP (C-92-A) will have a physician file review. However, the injured worker will be scheduled for an examination in exceptional situations (highly complex injuries or when a psychological exam is necessary), when the injured worker is requesting an increase of 10 percent or greater, or when there is a newly allowed condition(s) for a new part of the body.

The purpose of the C-92 examination is to provide an opinion on the whole person percentage of impairment for an allowance for the injured worker based on the American Medical Association (AMA) Guides. The physician will use the provided medical documentation, history and the physical exam to make a percentage determination. BWC generates reports to identify the appropriate tables or figures from the AMA Guides used to derive at the appropriate conclusions.

BWC will review the examination report/review and any medical documentation in the file. It will issue a Tentative Order granting the %PP award based on the examination/review report, except in cases where there is conflicting medical evidence on file for the C-92 (initial) award.

The parties to the claim have:

- 20 days from receipt to file an objection to the Tentative Order published by BWC. This will generate a referral to the IC to schedule a district hearing officer hearing to address the PPD award;
- 10 days to file reconsideration to the district hearing officer order published by the IC. This will generate a hearing before a staff hearing officer.

PPD examples

- **Example 1**

Hearing order awards a 10-percent PPD

Injured workers' AWW = \$400

2009 statewide minimum AWW = \$255.67

10 percent x 2 = 20 weeks

$\$400 \times 2/3 = \266.67 (exceeds the statewide minimum)

Actual payment to injured worker: 20 weeks x \$255.67 = \$5,113.40

- **Example 2**

Hearing order awards a 10-percent PPD

Injured workers' AWW = \$216.75

2009 statewide minimum AWW = \$255.67

10 percent x 2 = 20 weeks

$\$216.75 \times 2/3 = \144.50

Actual payment to the injured worker: 20 weeks x \$144.50 = \$2,890

Payment does not have to be made until a final decision on appeal allows payment of C-92/C-92-A according to [OAC 4123-3-18\(A\)\(11\)](#).

For claims with a date of injury on or after Jan. 1, 1979, the maximum percentage of %PP is 1/3 of the statewide AWW, not to exceed 2/3 of the injured worker's AWW. An injured worker is awarded two weeks of %PP for each percent of impairment. For example, an injured worker who receives a 5-percent award will receive 10 weeks of compensation.

For any claim with a date of injury before Aug. 22, 1986, with Temporary Partial (TP) payments, the TP payments are deducted from the %PP award. Additional information regarding TP is available [here](#).

When BWC makes a scheduled loss award, it deducts any previous %PP award from the scheduled loss award according to *Maurer v. IC* (1989). If a subsequent %PP award does not attribute any part of the percentage to that which the scheduled loss award covers, it is appropriate to give a percentage for the residual effects according to [ORC 4123.84\(C\)](#).

Permanent partial (scheduled loss)

[ORC 4123.57 \(B\)](#), [OAC 4123-3-15 \(C\)](#), and [OAC 4123-3-37](#)

Scheduled loss awards for loss of or loss of use of specific parts of the body due to an industrial injury or occupational disease. An injured worker generally initiates this when he or she files a motion requesting the award.

If the employer agrees with the scheduled loss, it should file the medical evidence that designates the exact point at which the amputation or ankylosis occurred, or notes the extent of the impairment of vision/hearing with BWC. Evidence can include BWC's [Amputation/Loss of Use Diagram \(C-196\)](#) in lieu of or in addition to other evidence.

The employer may also use an [Agreement as to Compensation for Permanent Partial Disability \(ICGC1\)](#), which is an IC form.

If the employer does not agree with the award, an IC hearing will be scheduled and will proceed to address the award.

For claims occurring on or after Nov. 3, 1989, the compensation rate is 100 percent of the maximum statewide AWW. BWC does not use the injured worker's own calculated AWW in calculating these awards.

For claims occurring between Aug. 22, 1986, and Nov. 2, 1989, the compensation rate is 66 2/3 percent of the injured worker's AWW. It cannot exceed the maximum statewide AWW, nor be less than 40 percent of the statewide AWW for the year in which the injury occurred.

For claims occurring before Aug. 22, 1986, the compensation rate is 66 2/3 percent of the injured worker's AWW. However, this rate should not exceed 50 percent of, nor be less than 25 percent of, the maximum statewide AWW for the year in which the injury occurred.

Scheduled loss awards are payable beginning the date of the loss. The initial check should be for an accrued amount. The balance due should be paid in weekly or biweekly installments until the award is paid. Scheduled loss awards are payable concurrently with TT compensation. Pay multiple scheduled losses for multiple body parts consecutively.

For awards dated from Oct. 12, 2010, to Sept. 9, 2012, the award is paid in a lump sum.

For awards dated after Sept. 9, 2012, the award is paid weekly or biweekly.

Schedule of loss of members

- Arm 225 weeks
- Leg 200 weeks
- Hand 175 weeks
- Foot 50 weeks
- Eye 125 weeks
- 1st finger (thumb) 60 weeks
- ½ 30 weeks
- 2nd finger (index) 35 weeks
- 2/3 23 1/3 weeks
- 1/3 11 2/3 weeks
- 3rd finger (long) 30 weeks
- 2/3 20 weeks
- 1/3 10 weeks
- 4th finger (ring) 20 weeks
- 2/3 13 1/3 weeks
- 1/3 6 2/3 weeks
- 5th finger (little) 15 weeks
- 2/3 10 weeks
- 1/3 5 weeks
- Great toe 30 weeks
- Other toes 10 weeks
- Hearing (one ear) 25 weeks
- Hearing (total) 125 weeks
- Metacarpal 10 weeks

Schedule of loss example

- **Example 1**
 Injured worker's AWW = \$400
 Statewide maximum AWW = \$767
 Injured worker lost 5th finger = 15 weeks

\$767 per week x 15 weeks = \$11,505 payment to injured worker

Amputations

The severance of the body part must have occurred as a result of the work-related injury. An injured worker is entitled to a scheduled loss compensation award when he or she sustains a loss of a body part that is the result of severance, and reattachment of the same body part has not been successful (functional).

- If a surgeon re-attaches the same severed body part, an award will not be given when medical documentation supports that the reattachment was successful (functional). *State ex rel. Welker v. Industrial Commission of Ohio* (2001), 91 Ohio St.3d 98.
- The injured worker may request an amputation award if the reattachment subsequently becomes unsuccessful.

The treating physician must clearly provide an accurate description of the point of amputation in the medical documentation. An injured worker may be entitled to a scheduled loss compensation award even if he or she receives a prosthetic device to replace the amputated body part. When there is an increase in the scheduled loss compensation due to an additional amputation, the scheduled loss compensation award is paid, but the previously paid award is deducted from the amount.

The loss of one-third or distal phalange of any finger other than the first finger (i.e., the thumb) is considered equal to the loss of one-third of the finger. The amputation must be at or near the joint. The loss of the finger near the proximal interphalangeal joint is equal to the loss of two-thirds of the finger.

The loss of a second, or distal, phalange of the thumb equal to the loss of one-half of the thumb; is considered equal to the loss of more than one-half of the thumb equal to the loss of the whole thumb.

The scheduled loss compensation award for the loss of two or more fingers by amputation or ankylosis cannot exceed the amount for the loss of a hand. The injured worker cannot combine the loss of parts of four fingers to equal the total loss of two fingers, for purposes of qualifying for a total loss of hand award. *State ex rel. Honda of America MFG., Inc. v. Industrial Commission of Ohio*, 183 Ohio App.3d 732 (2009).

If a loss of the arm is payable, the injured worker is not entitled to an additional award for loss of the hand. The award for the arm includes the award for the hand.

If the injured worker's thumb is amputated and replaced with the great toe, BWC will only pay for the amputation of the thumb. It will not pay for the loss of the toe.

Amputation below the elbow joint is considered equal to the loss of the hand. If the amputation is at the elbow, a determination must be made regarding the functionality of the elbow before determining if the injured worker is eligible for the loss of the hand or loss of the arm.

Amputation above the elbow will result in an award for the loss of the arm. A scheduled loss compensation award cannot be granted for partial loss of the arm.

Loss of the great toe up to the interphalangeal joint is equal to one-half loss of the great toe; loss beyond the interphalangeal joint is equal to the loss of the great toe. For other toes, a loss of two-thirds of the toe is required to grant a scheduled loss compensation award. BWC grants no partial loss award for toes other than the great toe.

The loss of two or more toes may result in the total functional loss of the foot, but the injured worker must base his or her request on supporting medical documentation.

When there is an increase in the scheduled loss compensation due to an additional amputation, the amputation is paid less the previously paid amount.

If a loss of the leg is payable, the injured worker is not entitled to an additional award for loss of the foot. The award for the leg includes the award for the foot.

Amputation above the ankle, but below the knee, entitles the injured worker to loss of the foot (*State ex rel. McLean v. Industrial Commission of Ohio* (1986), 25 Ohio St.3d 90). If the amputation point is at the ankle, a determination must be made related to the functionality of the ankle. Amputation above the knee entitles the injured worker to the loss of the leg. If the amputation point is at the knee, a determination must be made related to the functionality of the knee.

Loss of use, including ankylosis

The medical documentation provided must support the loss of use is total and permanent. Permanent impairment of a body part without severance may entitle the injured worker to an award. The treating physician must clearly document the loss of use.

Loss of use of the metacarpophalangeal joint between the proximal phalanx and metacarpal bone is typically considered equal to the loss of use of the whole first finger (i.e., the thumb).

Due to the uniqueness of the first finger (i.e., the thumb), the loss of use of the interphalangeal joint, the joint between the distal and proximal phalanges, is considered equal to the loss of one-half of the first finger (i.e., the thumb). *State ex rel. Riter v. Industrial Commission of Ohio* (2001), 91 Ohio St.3d 89.

Riter v IC does not apply to amputations of the first finger (i.e., the thumb) unless ankylosis of the first finger accompanies the first finger amputation.

The loss of more than the distal and middle phalanges (including loss of the proximal interphalangeal joint) is equal to total loss of the finger. Awards shall not exceed 175 weeks, which is the number of weeks payable for the total loss of the hand.

When there is an increase in the scheduled loss compensation due to an additional loss of use, the previously paid award is deducted from the increased award.

Loss of vision

A loss of vision award on the injured worker's post injury vision prior to correction by glasses, contacts, corneal transplants, or surgical intervention. If an injured worker has an eye injury that will heal without surgery, BWC will not determine the scheduled loss compensation award until the completion of the healing process (*Kroger v. Stover* (1987), 31 Ohio St.3d 229). . However, if the injured worker requires corrective surgery as a result of the injury, the scheduled loss compensation award is determined based on the condition prior to non-restorative surgical correction and healing.

The minimum award for each eye is 25-percent loss of uncorrected vision. Although at least a 25-percent loss of uncorrected vision is required to receive a loss of vision scheduled loss compensation award, the injured worker may have loss of vision of less than 25-percent granted as an allowed condition in the claim.

The percentage needed for loss of vision is the percent of vision loss, not the percentage of whole person impairment.

A loss of vision award requires medical documentation by an ophthalmologist. Documentation should include the injured worker's pre-injury uncorrected vision in addition to post-injury uncorrected vision. It does not require post-injury uncorrected vision for the loss of vision based on psychiatric factors. The employer may seek additional medical evidence to support exceptions.

When the injured worker has permanently lost an eye due to enucleation he or she is entitled to total loss of vision for that eye.

The loss of vision for traumatic cataract is based on the injured worker's post-injury vision prior to correction by glasses, contacts or surgical intervention.

- Cataracts that develop due to prolonged usage of medications, advancing age or other conditions traumatic are not considered.
- Cataracts that develop due to prolonged usage of medication for additional allowance as a flow-through condition as a known side effect of treatment for another allowed condition may be considered. It is important that the employer generally accepts the treatment for the other condition as causing or associated with the development of cataracts.

Loss of vision example

- **Example 1**

Statewide maximum AWW = \$767

Right eye – 45-percent loss of vision

Left eye – 55-percent loss of vision

Right eye = 125 weeks x 45 percent = 56.25 x \$767 = \$43,143.75

Left eye = 125 weeks x 55 percent = 68.75 x \$767 = \$52,731.25

\$95,875 total payment to injured worker

Loss of hearing

BWC shall award scheduled loss compensation for loss of hearing only when the injured worker has permanent and total loss of hearing in one ear or permanent and total loss of hearing in both ears as a result of a work-related injury.

An injured worker may have loss of hearing allowed in a claim, but not be eligible for a scheduled loss compensation award for loss of hearing.

A loss of hearing award requires medical documentation from an ear, nose and throat (ENT) physician (otolaryngologist) except when the injured worker bases the loss of hearing on psychiatric factors. BWC may seek additional medical evidence to support exceptions. The ENT should determine and document that.

Facial disfigurement

BWC grants this award for visible damage to the face or head with the potential to impair the injured worker's ability to secure or retain employment. Facial disfigurement awards are in addition to other types of partial disability compensation or scheduled loss awards paid according to ORC 4123.57. The employer pays this award in a lump sum.

To be eligible for a facial disfigurement award, the disfigurement must:

- Directly result from the injured worker's compensable injury or occupational disease;
- Be visible on the injured workers face or head;
- Impair or have the potential to impair the injured worker's ability to secure or retain employment.

The eligibility determination should be made at a point the facial disfigurement has stabilized. In determining eligibility for a facial disfigurement award, gainful employment by the injured worker in any occupation or trade should not be a factor at the time of determination.

The maximum award for injuries occurring on or before June 29, 2006, is \$5,000.

The maximum award for injuries occurring on or after June 30, 2006, is \$10,000.

When determining eligibility and the amount of an award, the employer should consider the impact of the facial disfigurement on the injured worker's ability to retain or secure employment. Specifically, the severity of the facial disfigurement and its impact should evaluate:

- Shape, color, anatomic location and any evidence of ulceration;
- Depression or elevation;
- Texture (soft and pliable, hard, thin, smooth or rough);
- Attachment, if any to underlying bone, joint, or muscles or other tissue;
- Whether there are disfigurements based on peripheral nerve dysfunction or loss of range of motion;
- Whether a physician can make the disfigurement less visible or conceal it, and whether it is likely to change appearance over time.

Other information relevant to evaluating the impact of the facial disfigurement that the employer may consider includes, but is not limited to:

- Medical evaluations;
- History of the medical condition;
- Results of the most recent medical evaluation;
- Assessment of medical status, prognosis, diagnosis, and treatment plan;
- Photographic, videographic or other visual evidence of the disfigurement;
- Present and planned educational level;
- Prior or planned vocational training;
- Description of present or planned employment;
- Summary of specific vocational assessment;
- Psychological exam/evaluation;
- History of psychological condition;
- Results of most recent psychological evaluation.

Consider maximum awards for the following facial disfigurements:

- Third-degree burns exceeding 1 percent on or about the face or head;
- All skin grafting on or about the face or head;
- "Full thickness" injuries resulting in the removal of multiple layers of flesh on or about the face or head;
- Any facial disfigurement that is so severe that there is massive distortion of the normal facial structure.

If there is a dispute on this award, file a C-86 to bring the issue to a hearing with the IC.

Wage loss compensation

[ORC 4123.56\(B\)](#) and [OAC 4125-1-01](#)

The employer may pay WL compensation to an injured worker who suffers a reduction in earnings as a direct result of physical and/or psychiatric/psychological restrictions from the allowed conditions in the claim. WL is payable in claims with a date of injury or diagnosis on or after Aug. 22, 1986. [OAC 4125-1-01](#) states that the claimant is solely responsible for and bears the burden of producing evidence regarding entitlement to wage loss compensation. However, the employer must provide assistance and guidance to the injured worker relating the injured workers' eligibility for WL benefits. The injured worker must submit a job search with all submissions unless working in modified duty for current employer (or offsite at current employer's direction) or the requirement is waived by the employer. This applies to working and nonworking wage loss. The employer must respond to requests for wage loss within 30 days of receipt. If the employer objects to an initial application or an ongoing submission the employer must refer the issue to the Industrial commission for a hearing to address the contested issue.

To be eligible for WL, there must be loss or diminution in wages and it must be a direct result of the restrictions caused by the allowed conditions in the claim. There is no waiting period for the payment of wage loss benefits pursuant to Industrial Commission policy.

Working wage loss (WWL) is payable when the injured worker returns to employment other than the former position of employment. This includes return to work with the employer of record with different job duties, less hours and/or less pay resulting from the related restrictions.

Non-working wage loss (NWWL) is payable when the injured worker has been released to return to work with restrictions but is unable to find suitable employment.

Injured workers who have not reached maximum medical improvement and are released to return to work with restrictions by their physician, which the employer cannot accommodate, may be eligible for WL. They may also continue to be eligible for TT compensation. It is the injured worker's choice to remain on TT or to file for WL. A release to work with restrictions does not require an injured worker change from TT compensation to WL compensation if the employer cannot accommodate his or her restrictions.

For all claims with a date of injury/date of disease before May 15, 1997, calculate WL based on the greater of the injured worker's AWW or FWW at the date of injury/date of disease. For all claims with a date of injury/date of disease on or after May 15, 1997, calculate WL based on the injured worker's AWW at the date of injury/date of disease. The WL benefit will be 2/3 of the difference between the AWW or FWW when appropriate and the actual earnings for each weekly pay period.

Pay WL as a weekly benefit based on the injured worker's schedule. However a partial week may occur in the initial week of WL or last week when the injured worker returns to work.

For claims with dates of injury on or after Aug. 25, 2006, according to [ORC 4123.56 \(B\)](#), the injured worker may receive a maximum of 200 weeks of WL. However, up to 26 weeks of non working wage loss can be applied to the 200 weeks. The injured worker may be eligible for an additional 26 weeks of non working wage loss (for a total of 52 weeks), which would extend eligibility up to 226 weeks total wage loss. Living maintenance wage loss applies toward the 200 week maximum amount.

Working wage loss

Injured workers who have returned to work with restrictions and who are experiencing a reduction in earnings because of those restrictions may be eligible for WWL. This includes situations where the injured worker returns to a job with different physical requirements or to the same job for a limited number of hours.

Injured workers who request WWL can submit a copy of their pay stub or a payroll report from the employer as proof of earnings. Injured workers should submit proof of earnings at least every four weeks according to [OAC 4125-1-01\(C\)\(5\)\(a\)](#).

Present earnings mean the injured worker's actual weekly earnings generated by gainful employment unless the injured worker has substantial variation of earnings. Present earnings include:

- Vacation pay
- Gross hourly wages;
- Gross salaries;
- Paid sick leave;
- Holiday pay;
- Bonus payments, including stock given as a bonus;
- Commissions on sales;
- Tips;
- Compensatory time;
- Severance pay;
- Overtime pay;
- Shift and holiday differential pay;
- Profit sharing paid to employees as payroll;
- Per Diem and travel allowance – if not paid as a reimbursement of expense;
- Personal time;
- Wage replacement program fully funded by the employer, (i.e. long-term disability program).

Injured workers who have substantial variations in earnings such as commissions or bonuses, or work in sales, may report earnings on a different schedule. These earnings must be apportioned across the period of time it took to complete the sale or earn the commission per [OAC 4125-1-01\(A\)\(16\)](#).

Bonuses paid, not based on performance or attributed to a specified period of time, should be considered as earnings for the week in which the employer paid the bonus. (*Middleburg Hts. v. IC*). When employers pay bonuses on performance over a specified period, apportion the bonus over the same period of time in which the employee earned it.

When an injured worker takes frequent vacations, for long periods, and/or unpaid vacation:

- Vacation – unpaid: Enter no earnings for injured workers who will have an occasional unpaid vacation for the vacation period if the allowed conditions in a claim prevent the worker from working during that period;
- Vacation – unpaid by injured worker's choice: Pay wage loss based on the formula for voluntarily limiting that will result in a payment of wage loss equal to what the injured worker would have received had the vacation been paid;
- Paid time off – If the paid time off is not specifically noted as sick leave, BWC will consider it the same as vacation;

- Sickness related to the injury: Pay WL based on actual earnings unless the sickness is for an extended period and then TT may be more appropriate;
- Days missed for sickness unrelated to the injury: Pay WL based on actual earnings;
- Occasional unpaid days off: Pay WL based on actual earnings unless there is a pattern of abuse;
- Jury duty: Pay WL based on actual earnings, excluding jury duty monies;
- Bereavement time off: Pay injured worker for an occasional bereavement period for immediate family members (spouse, children, stepchildren, mother/mother-in-law, father/father-in-law, sister/sister-in-law, brother/brother-in-law, grandparents) based on actual earnings.

If the injured worker's weekly earnings are higher than the maximum payable amount for the dates of injury/date of disease, or based on the injured worker's AWW (and/or FWW in claims with a date of injury/date of disease prior to May 15, 1997) there is no wage loss. Thus, the employer pays no benefits for that week. The week(s) where wage loss benefits are not paid will not be counted towards the maximum weeks

[OAC 4121-3-32](#) states a good faith proposal of suitable employment within a reasonable proximity (and similar hours) of the injured worker's residence is necessary when an employer expects an injured worker to return to work with restrictions. If the injured worker refuses an oral job offer, and the employer intends to initiate proceedings to terminate TT disability compensation, the employer must give the injured worker a written job offer at least 48 hours prior to initiating proceedings. If the employer files a C-86 with the IC to terminate payment of compensation, a copy of the written offer must accompany the employer's initial filing.

BWC recommends a written offer showing the job duties, start date and hours, and rate of pay be included in the claim file to verify the actual return-to-work date if the injured worker returns to work on restricted duty.

An injured worker cannot be paid TT compensation when he or she has returned to work and is requesting TT compensation for a doctor's appointment and/or medical treatment/services. However, WL compensation may be payable when the injured worker must miss work in order to obtain treatment for the allowed condition(s) that cannot be obtained outside of work hours.

The treating physician must update restrictions every 90 days if temporary and 180 days if permanent.

Pursuant to [OAC 4125-1-01\(F\)\(3\)](#), an injured worker who voluntarily limits earnings by not accepting a good faith job offer or not accepting suitable employment with comparable pay, shall have WL benefits calculated as 66 2/3 percent of the difference between the injured worker's AWW in the former position of employment and the weekly wage the claimant would have earned in the employment he or she refused to accept.

If the injured worker voluntarily limits the number of hours worked while in a restricted duty position, the employer may calculate WL benefits based on the following:

- Determine the pre-injury wage rate for the same number of hours actually worked while on restricted duty (example: if the claimant worked 20 hours while on modified duty, the pre-injury wage rate would be the pre-injury hourly pay rate by 20 hours). Benefits owed will be 66 2/3 percent of the difference between the adjusted wage rate and the actual earnings for the restricted duty position. Or the employer shall have the discretion to establish a reasonable number of hours it will use in the calculation of WL compensation that is consistently applied. The calculation methodology must be available in the claim file and communicated to the injured worker.

Sample job offer letter

Date

Dear Jane:

Your doctor has released you for light-duty employment. Since you have not yet reached maximum medical improvement and cannot return full time to your former position, we would like to include you in our transitional-duty program. Please consider this a formal offer of employment at the ABC Nursing Home. We will place you in a nursing position, but will only expect you to work from 7 to 11 a.m. five days per week. We will modify the duties of the job to be consistent with the restrictions imposed by Dr. Robert Spine.

Your job responsibilities will include: checking patient's blood pressure and temperature; making chart notations; dispensing medication and giving injections; and making appropriate chart notations. In addition, you will answer phones, send and receive faxes, and use the computer for scheduling, sending and receiving work-related emails. We will prohibit you from moving or lifting patients. You cannot lift or work above shoulder level.

The position is available as of July 1, 2013, and you will receive your normal rate of pay. Since this is less than the regular number of working hours, wage loss will supplement your wages through our workers' compensation program. Please sign the bottom of this sheet to acknowledge your acceptance of this position.

If you have any questions, you can reach me at 123-888-9999 or via email at wgreen@abc.com.

Sincerely,

William Green, W.C. Administrator
ABC Nursing Home

I accept the position and terms as described above.

Signed,

Jane Smith [Date]

Non-Working Wage Loss

NWWL is the loss of earnings sustained by the injured worker who has been unable to find suitable employment while on restrictions. To be eligible, the injured worker must submit restrictions related to the allowed conditions in the claim, and conduct a good faith job search and submit a statement of non-earnings. The injured worker is responsible for submitting the *Initial Application for Wage Loss Compensation* (C-140) and *Wage Loss Statement for Job Search* (C-141) per the employer's instruction.

Pay NWWL benefits at 2/3 of the AWW.

The employer may require the injured worker to complete a C-141 for every week that he or she is requesting NWWL. The injured worker must submit a C-141 at least every four weeks per [OAC 4125-1-01\(C\)\(5\)\(a\)](#). The C-141 documents the injured worker's effort to find suitable employment through a good faith job search and provides evidence of non-earnings. The injured worker may use more than one form for each week.

Wage loss examples

- **Example 1**

For claims with a date of injury after Aug. 25, 2006	
Type wage loss	Weeks paid
Non-working	52
Working	<u>174</u>
Total eligible	226

- **Example 2**

Type wage loss	Weeks paid
Non-working	15
Working	<u>200</u>
Total paid	215
Additional eligible of non-working	11

NWWL is limited to 52 total weeks. The first 26 weeks of NWWL are excluded from the 200-week maximum, meaning that if an injured worker receives 200 weeks of WWL and/or LMWL, they are also entitled to an additional 26 weeks of NWWL, making the total wage loss maximum 226 weeks.

- **Example 3**

For claims with a date of injury between Aug. 22, 1986, and Aug. 25, 2006	
Type wage loss	Weeks paid
Non-working	52
LMWL	148
Working	<u>48</u>
Maximum payable	348

- **Example 4**

Type wage loss	Weeks paid
LMWL	200
Working	<u>200</u>
	400

Permanent total disability compensation

PTD is the injured worker's inability to perform sustained remunerative employment due to the allowed condition(s) in the claim. The purpose of PTD benefits is to compensate the injured worker for impairment of earning capacity. [ORC 4123.58](#) authorizes payment of PTD until the injured worker's death. The IC can terminate PTD benefits.

The IC adjudicates applications for PTD. The IC's staff hearing officers have the jurisdiction to hear and decide applications for PTD awards pursuant to [ORC 4123.58](#) and [ORC 4121.35\(B\)\(1\)](#). The injured worker must establish that the disability is permanent and the inability to work is due to the allowed condition(s) in the claim and that he or she is not capable of sustained remunerative employment. Neither age, non-allowed and/or pre-existing conditions, nor permanent partial impairment can be the sole determining factor. The IC will consider the combined effect of allowed physical and psychological conditions.

A PTD award is not only based on the injured worker's inability to work due to work-related conditions, but also on the following other non-medical determination factors as outlined in [OAC 4121-3-34\(D\)\(2\)](#):

- Classifications of work refer to the physical demand the work requires. The IC uses these classifications when considering granting or denying PTD. You can find details regarding the specific types of work classifications in [OAC 4121-3-34\(B\)\(2\)](#);
- Vocational factors, commonly referred to as the "Stephenson Factors," used by the IC to grant or deny the Stephenson Factors include age, educational background and work/skill levels pursuant to [OAC 4121-3-34\(B\)\(3\)](#);
- Residual functional capacity is the maximum capacity the injured worker has for performing sustained physical/mental requirements of a job. Residual functional capacity must be related to the allowed condition;
- Maximum medical improvement is a treatment plateau at which no fundamental functional or physiological change can be expected within reasonable medical probability despite continuing medical or rehabilitative procedures. An injured worker may need supportive treatment to maintain this level of function.

Pursuant to [ORC 4123.58\(D\)\(1\)\(4\)](#), the IC will not grant PTD if the injured worker is unable to engage in sustained remunerative employment due to one or more of the following reasons:

- Conditions unrelated and not allowed in the claim;
- Injured worker's age solely prevents him/her from obtaining employment;
- Injured worker retired for reasons unrelated to allowed injury or occupational disease, thus voluntarily abandoning the workforce;
- Injured worker does not have the educational background to obtain employment and has failed to try to improve employability by participating in educational and/or rehabilitative efforts, unless these efforts are determined to be in vain.

PTD declared rate is based on the weekly wage for the year of the injury or the date of the disability due to an occupational disease, pursuant to [ORC 4123.61](#).

As a general rule, the IC calculated the PTD declared rate for PTD claims with a determination date prior to April, 19, 1999. The SI employer remained responsible for ensuring that the correct rate was paid if there was no rate noted on the initial IC order, and to make appropriate adjustments thereafter as required by ORC 4123.58.

The self-insuring employer calculates the PTD declared rate in PTD claims determined on or after April 19, 1999, based on the amount of Social Security disability (SSD) gross rate, before Medicare deduction, AWW and split percentage, if any. The self-insuring employer should adjust rates for all claims as required by statute, an IC order is not required for claims occurring prior to April 19, 1999.

An injured worker can receive Social Security retirement beginning as early as age 62. It is the employer's responsibility to change an injured worker's SSD benefits to Social Security retirement when the injured worker reaches the full retirement age based on the year of the injured worker's birth. A resource to determine the appropriate full retirement age can be obtained at www.ssa.gov. If the injured worker receives retirement or widow's benefits, PTD benefits are not offset.

The declared PTD rate is set using the following information:

- Injured worker's AWW;
- Maximum PTD rate for the year of the injury;
- PTD offset for the year of the injury;
- Minimum PTD rate for the year of the injury;
- Whether or not the injured worker is receiving SSD benefits.

The PTD declared rate will be 66 2/3 percent of the injured worker's AWW in effect on the date of injury or on the date of the disability due to the occupational disease begins. This will not exceed 66 2/3 percent of the SAWW, and not be less than 50 percent of the SAWW pursuant to [ORC 4123.58\(A\)](#).

If the injured worker's AWW is less than 50 percent of the SAWW at the time of injury, the rate will be the AWW.

If the injured worker is receiving SSD and the injured worker's declared rate, when combined with SSD is equal to or greater than the SAWW, the maximum PTD rate will be 2/3 of the SAWW. This is the offset rate. If the injured worker's rate, when combined with SSD, is less than the SAWW, the declared rate will be the actual rate.

If the injured worker is retired and is receiving Social Security retirement benefits, injured worker's Social Security benefits should not be considered when calculating the PTD rate. The self-insuring employer must re-calculate the PTD rate when the injured worker reaches retirement age, according to ORC 4123.58.

If the injured workers' SSD is reduced or terminated, the employer will re-compute the compensation rate according to [ORC 4123.58\(B\)](#).

BWC provides a PTD rate calculation worksheet, which is available [here](#) under Resources and tools.

PTD examples

- **Example 1**
2005 date of injury
SAWW (max or high maximum) is \$ 678
2/3 SAWW (offset or low maximum) is \$452.
Minimum is \$339.00
 - AWW is \$305 – declared rate would be \$305 (AWW is below the minimum, so we use the minimum).
 - AWW is \$345 – 2/3 is \$230 – declared rate would be \$339 (AWW is above the minimum but 2/3 of the AWW is below, so we use the minimum).

- AWW is \$650 – 2/3 is \$433.33 – declared rate would be \$433.33 (AWW is above the minimum, 2/3 of the AWW is above the minimum, but below the offset (2/3 SAWW), so SSD doesn't affect the calculation, so we use 2/3 of the AWW).
- AWW is \$750 – 2/3 is \$500 – because 2/3 of AWW is above the offset (2/3 SAWW), SSD amount may impact the rate.
- Monthly SSD is \$500, weekly SSD is \$115.38. ($\$452 + \$115.38 = \$567.38$; below SAWW). Declared rate will be \$500.
- AWW is \$750 – 2/3 is \$500 – because 2/3 of AWW is above the offset (2/3 SAWW), SSD amount may impact the rate.
 - Monthly SSD is \$985, weekly SSD is \$227.31. ($\$452 + \$227.31 = \$679.31$; above SAWW). Declared rate will be \$452
- AWW is \$1,050 – 2/3 is \$700 – because 2/3 of AWW is above the offset (2/3 SAWW), SSD amount may impact the rate.
 - Monthly SSD is \$500, weekly SSD is \$115.38. ($\$452 + \$115.38 = \$567.38$; below SAWW). Declared rate will be \$678.
- AWW is \$1,050 – 2/3 is \$700 - because 2/3 of AWW is above the offset (2/3 SAWW), SSD amount may impact the rate.
 - Monthly SSD is \$985, weekly SSD is \$227.31. ($\$452 + \$227.31 = \$679.31$; above SAWW). Declared rate will be \$452.

To calculate the SSD amount, use the SSD effective on the PTD begin date (PTD begins March 23, 2006, the SSD amount for March 2006, is used) no matter when the PTD is granted. Even if the SSD won't affect the rate, we encourage the practice of obtaining the SSD (required if using the rate calculation worksheet).

Re-calculate the PTD rate if the SSD amount decreases and/or stops or starts (originally \$0, but then the injured worker begins receiving). See example below.

- Injured worker not receiving SSD on PTD begin date March 23, 2006, use \$0 SSD.
- Injured worker begins receiving SSD on July 1, 2007, use that amount. Any rate change as a result of the re-calculation is effective July 1, 2007.
- Injured worker SSD decreases effective April 1, 2008, use that amount. Any rate change as a result of the re-calculation is effective April 1, 2008.
- Injured worker SSD increases, do not re-calculate PTD rate.

Along with the PTD benefits, the injured worker may also be entitled to Disabled Workers' Relief Fund (DWRP) benefits based on the PTD rate and the Social Security benefits. BWC pays the injured worker these benefits. As of Aug. 22, 1986, BWC bills all self-insuring employers dollar for dollar for DWRP payments (see ORC 4123.411).

Statutory PTD

The IC can award an injured worker statutory PTD for loss of or loss of use of both hands, both arms, both feet, both legs, both eyes, or any combination of these. According to Ohio Supreme Court case *Thomas v. IC*, the IC can also award statutory PTD when the injured worker has a total loss of or loss of use of an entire limb in claims with dates of injury prior to Aug. 25, 2006. The court held that the injured worker's arm loss entailed separate entities of hand and arm.

The IC will consider the request for statutory PTD after it receives the C-86. According to Ohio Supreme Court case *Adams v. Aluchem*, there is a two-year limit for retroactive payment of PTD benefits asking for statutory PTD. The IC's order will state the pay period.

In claims with dates of injury on or after Aug. 25, 2006, according to [ORC 4123.58\(C\)\(1\)](#), the loss of a limb does not constitute the loss or loss of use of two body parts. Thus, the injured worker is not entitled to statutory PTD, based on *Thomas v. Industrial Commission*.

The injured worker can return to work and continue to receive a statutory PTD award. The employer can pay statutory PTD and TT concurrently only if the injured worker returned to work and had a new injury resulting in a new claim. The employer can pay TT compensation in the new injury claim concurrently with the statutory PTD in the original claim. The TT compensation for the new injury is not payable in the original claim.

Disabled Workers' Relief Fund

[ORC 4123.412](#)

The Disabled Workers' Relief Fund (DWRF) is a separate supplemental fund established to provide relief to an injured worker who is receiving PTD benefits by raising the cost-of-living level. The BWC will consider the injured worker for participation in the Disabled Workers' Relief Fund based on the PTD rate and the amount of SSD the injured worker may be receiving

BWC makes DWRF payments on eligible self-insured claims. It bills the self-insuring employer dollar for dollar, for the DWRF payments on a semi-annual basis. BWC's DWRF unit handles all self-insured PTD claims. The DWRF unit will receive a copy of all IC hearing orders that address PTD. If the order is for an allowed self-insured PTD claim, the DWRF unit will send a letter to the employer requesting information regarding the PTD rate and starting date. Once the unit receives the information the self-insuring employer, the DWRF claims service specialist will determine if the injured worker is eligible.

The DWRF unit will issue an order on all PTD claims to notify the injured worker of his or her eligibility status for DWRF benefits. For claims determined on or after April 19, 1999, this initial DWRF order will contain the weekly PTD declared rate and the weekly rate of Social Security disability benefits. If the injured worker is entitled to DWRF benefits, the order will also contain the weekly DWRF rate.

The DWRF unit will receive the date of birth and/or death (if applicable) from the Social Security Administration. The Social Security Administration also supplies BWC with address information, the type of Social Security the injured worker is receiving (if any), and if the injured worker applied and was denied Social Security benefits. The DWRF unit will get a confirmation that the injured worker's name matches the name the Social Security Administration has for the Social Security number. If the DWRF unit receives a different date of birth or date of death with the Social Security information, the DWRF claims service specialist will contact the employer to verify the information. The DWRF unit uses the Social Security disability and the injured worker's monthly permanent total benefit rate to determine both eligibility and the DWRF payment amount.

It does not consider the Social Security retirement, widow's benefits and/or any other retirement benefit received from an employer in the DWRF calculation. The DWRF unit does consider the SSD benefits under a worker's primary Social Security number in the DWRF calculation. Eligible injured workers are entitled to receive payments, without application, of a monthly amount equal to the lesser of the difference between the annually adjusted DWRF entry level rate and:

- The disability amount received per month from the Social Security Administration or;
- The amount received under workers' compensation laws for PTD (ORC 4123.414).

Lump-sum advancements are deductions taken from compensation payments which reduce the amount of the weekly PTD payment. Lump-sum advancements do not affect the DWRF rate. Pursuant to ORC

4123.417, the injured worker's representative cannot charge a fee for assisting the injured worker in obtaining DWRP benefits. BWC bases the DWRP rate on the original declared rate of PTD.

BWC assesses self-insuring employers for all DWRP benefits in self-insured claims and for state-funded PTD claims for the employer policy preceding the self-insuring inception date.

Death claims

[ORC 4123.59](#), [ORC 4123.60](#), [ORC 4123.66](#) , [OAC 4123-3-07](#), [OAC 4123-5-13](#) and [OAC 4123-5-21](#)

The statute of limitations for filing a death claim is:

- Two years from the date of death for a work related injury, pursuant to [ORC 4123.84](#);
- Two years from the date of death for an occupational disease, pursuant to [ORC 4123.85](#).

For BWC to consider a compensable death claim there must be a proximate connection between the injury or occupational disease and the cause of death.

According to [ORC 4123.59](#) the following are presumed wholly dependent:

- Surviving spouse;
- Children of the decedent under the age of 18 years;
- A dependent child who turns 18 and is pursuing a full-time educational program while enrolled in an accredited educational institution/program, until he/she reaches the age of 25;
- A child physically or mentally incapacitated from earning (no age restriction)
- A surviving natural parent or surviving natural parents living with the decedent at the time of death.

When an injured worker dies as the result of a work-related injury or disease, weekly death benefits or one time awards may be payable to the dependents. The surviving spouse may receive weekly death benefits from the day after the date of death of the injured worker up to the day before the date of remarriage or death.

When the surviving spouse remarries, he or she will receive the weekly compensation amount that he or she was receiving at the date of remarriage in a lump sum, totaling two years (i.e., two-year dowry). The award is payable upon submission of a marriage certificate and starts on the date of remarriage.

The dependent children will receive weekly death benefits from the day after the date of death of the injured worker up through the day before they turn 18.

Weekly benefits are also payable to the dependent child who is 18 years old through the day prior to turning 25, while he or she is pursuing a full-time educational program while enrolled in an accredited educational institution. The employer sends payments to dependent children under the age of 18 in care of the guardian of the dependent children (frequently the surviving spouse). Starting on the 18th birthday, the employer makes payment to the dependent child.

Children, who are physically or mentally incapacitated from having any earnings, are eligible for weekly death benefits regardless of age, so long as the physical or mental incapacity continues.

The employer pays the weekly benefit rate at 66 2/3 percent of the AWW. The weekly rate will not exceed the SAWW for the year of death. The weekly rate will not be less than 50 percent of the SAWW. Benefits are apportioned among all dependents.

Funeral expenses

[ORC 4123.66](#) and [OAC 4123-5-13](#)

For claims with the date of death prior to April 9, 2003, the maximum amount payable is \$3,200 to the person showing proof of payment for funeral expenses or an outstanding bill for funeral expenses. For claims with the date of death on or after April 9, 2003, the maximum amount payable is \$5,500 to the person showing proof of payment for funeral expenses or an outstanding bill for funeral expenses.

In cases where there are no dependents to file a death claim for death benefits, requests for the payment of medical bills and/or funeral expenses may still occur. Payment for medical bills and/or funeral expenses may only occur when the party requesting payment or reimbursement files the claim.

Change of occupation

Change of occupation award reduces an injured worker's exposure to a harmful agent. There are two types:

- An injured worker who has contracted, in the course of employment, silicosis, coal miners' pneumoconiosis, or asbestosis, pursuant to [ORC 4123.57 \(D\)](#). The award is payable up to a maximum of 130 weeks.
- Firefighters or police officers who have contracted, in the course of employment, cardiovascular, pulmonary, or respiratory disease, pursuant to [ORC 4123.57 \(E\)](#). The award is payable up to a maximum of 105 weeks.

Violation of specific safety requirements

[ORC 4121.47\(A\)](#)

No employer will violate a specific safety requirement established by legislation or BWC. The injured worker or dependent (when there has been a fatality) may file an application for a violation of specific safety requirements (VSSR) award if there is evidence that a violation has or may have occurred.

The IC maintains jurisdiction over the application and determination process for a VSSR award. The staff hearing officer adjudicates the request for a VSSR award, and can assess a penalty ranging from 15 percent to 50 percent of the maximum workers' compensation award established by law.

A civil penalty is a fine against the employer and is not part of the VSSR award granted to the injured worker. The staff hearing officer has the authority to issue an order to the employer to correct the violation or to assess a civil penalty against the employer in an amount up to a maximum of \$50,000 for each violation.

Pursuant to [ORC 4121.48](#), BWC's accounts receivable department bills civil penalties assessed by the IC directly to the employer. It deposits payments in the Occupational Safety Loan Fund.

The IC may base VSSR awards on any type of compensation. It bases the calculation for the VSSR award on the maximum SAWW in effect at the time of the injury. The IC determines the percentage of the VSSR award.

The injured worker or his or her dependent(s) must apply for the VSSR award within two years of the date of injury, disease or death, and submit the completed application to BWC.

BWC will notify the employer and set a due date for the employer's response. Once the employer submits evidence, BWC will schedule a site inspection. BWC will schedule a settlement conference with all parties to resolve the matter or obtain additional information after completing the site inspection.

BWC will refer to the IC for a hearing if the matter is not resolved. There is no appeal from an IC order concerning the percentage of the award, but if either party is dissatisfied with the results of the order, they may file a C-86 for a rehearing.

Any VSSR award is in addition to compensation paid under the other provisions of the Workers' Compensation Act. The award will range from 15 percent and 50 percent of the maximum award payable at the time of the injury. The award is calculated based on the percentage awarded multiplied by the statutory maximum rate allowable for the date of the injury. This applies to all types of compensation paid. This award is paid as a lump sum for previous benefits and concurrent with ongoing and future benefits.

The staff hearing officer has the authority to issue an order for the employer to correct a VSSR within a fixed period or assess a civil penalty against the employer up to a maximum of \$50,000 for each violation when there are at least two violations within a two-year period.

When an employee of a temporary employment agency becomes injured while on assignment, and receives a VSSR award, the client employer is responsible to pay the VSSR award. BWC defines the client employer as the employer who contracted with the temporary employment agency for services by a temporary agency employee. The temporary agency must pay compensation and medical benefits, but the client employer pays the VSSR award.

VSSR example

- **Example 1**

Date of injury: Jan. 2, 2006

BWC awards TT compensation for a three-week period, from Jan. 3, 2006, to Jan. 23, 1996, at a rate of \$452 per week. The maximum rate allowable for the year of the injury was \$704 per week. VSSR awarded by the IC is 25 percent

$$\$704 \times 25 \text{ percent} = \$176 \times 3 \text{ weeks} = \$528$$

The first payment accrues to date and issued, and then you should pay the remainder in biweekly installments.

Full and final settlements

[ORC 4123.65](#) and IC Resolution R94-1-16

Lump-sum settlements are under the IC's jurisdiction. The injured worker files settlement applications with the self-insuring employer. Both parties sign the [Self-Insured Joint Settlement Agreement and Release \(SI-42\)](#). The self-insuring employer is responsible for filing the application with the appropriate regional IC office.

The [Acknowledgement of the Self-Insured Joint Settlement and Release \(SI-43\)](#) must be completed and signed by the injured worker and submitted with the final settlement form. Submit both forms within five days of the date of the agreement.

If BWC receives an application for settlement, it forwards the application to the self-insuring employer to address. When the self-insured settlement includes a state-fund claim, file a separate state-fund claim settlement application with the local BWC customer service office. BWC will process it according to the state-fund settlement guidelines.

The date of settlement is the last date the injured worker or employer signed the settlement application (e.g., the injured worker signed the application on Jan. 31, 2001, and the employer signed the application on Feb. 12, 2001). The effective date of the settlement agreement is Feb. 12, 2001. In addition, Feb. 12, 2001, is the start date for the 30-day cooling off period.

Pursuant to [ORC 4123.65](#), all agreed upon settlements, including court-ordered settlements, between the self-insuring employer and the employee are held for a 30-day cooling off period.

For court-ordered settlements, the order establishes the settlement date in the first paragraph of the court order.

[IC Resolution R94-1-16](#) addresses lump-sum settlements.

Lump sum advancements

[ORC 4123.64](#) and [OAC 4123-3-37](#)

Injured workers or a surviving spouse (in case of death) who are receiving PTD, scheduled loss or death benefits may request lump sum advancement (LSA).

The self-insured employer reviews applications for LSAs for meeting financial relief and rehabilitation purposes only. Applications must have supporting documentation attached to the application. BWC will not allow a LSA for luxury items unless evidence supports such a purchase is required for an injured worker's health, well-being or rehabilitation.

Request a LSA on an *Application for Payment of Lump Sum Advancement* ([C-32](#)). Pursuant to [ORC 4123.64](#), the C-32 must be fully completed and notarized.

Applicants (with some restrictions) can choose from four repayment options for the repayment of a LSA. The repayment options are five years, 10 years, 20 years and life expectancy. A tool for calculating the repayment options is available [here](#) under Resources and tools.

After a repayment option begins, that option remains in effect for the remainder of that advancement. The injured worker cannot change it to a different option. Once the injured worker re-pays LSA, the rate shall return to the original rate less any subsequent LSA rate reductions. The restrictions are the 1/3 reduction limit for PTD claims and for death benefits. The LSA cannot exceed the present day value of the two-year dowry.

Employers may not make LSAs on weekly death benefits for dependent children. They may only make LSAs for accrued compensation to dependent children.

Employers can only make LSAs for %PP awards when ordered by the IC, per [IC Resolution R07-1-02](#).

For LSAs approved after Dec. 1, 2004, the injured worker will use a fixed amount of time for a rate reduction for the repayment of the advancement. Once the injured worker re-pays the LSA, the rate shall return to the original rate less any subsequent LSA rate reductions.

Excluding LSAs approved before Dec. 1, 2004, and LSAs for attorney fees, there should be no more than two concurrent LSA rate reductions in a claim.

In PTD claims, a rate reduction, with all previous reductions, (excluding attorney fees) cannot exceed one-third of the original PTD rate. At no time, will reduction periods exceed the life expectancy of the applicant.

LSA example

Injured worker has elected a permanent reduction on an advancement of \$30,000.

Current age is 56

PTD type is OD lung

Original PTD rate is \$300

PV factor for an injured worker at age 56 is 458, with a life expectancy of 13.4 years

$\$30,000/458 = \65.50

The maximum allowable reduction is \$100 ($\300 PTD rate / $1/3$).

This reduces the injured worker's \$300 per week PTD permanently by \$65.50 to \$234.50.

Attorney fees

Determination of attorney fees remains with the IC. Forward all requests for advancement of attorney fees to the IC by filing an (IC-32A).

Pursuant to [IC Resolution R07-1-02](#), maximum attorney fees are limited to \$10,000 with an additional \$1,000 for expenses. The LSA for attorney fees cannot cause a reduction in the injured worker's existing weekly compensation rate of more than 20 percent for PTD and death benefits. For scheduled loss PP, the LSA cannot cause a reduction of more the one third ($33\frac{1}{3}$ percent).

The following IC resolutions address LSAs for attorney's fees: [R95-1-13](#), [R90-1-10](#); and [R07-1-02](#), [R99-1-01](#).

Power of attorney

[Joint IC/BWC Resolution 07-1-01](#) indicates that self-insuring employers must honor a properly completed and submitted power of attorney when issuing benefits.

Overpayments of compensation

Overpayment of compensation occurs in a claim when an injured worker receives benefits to which he or she was not entitled. An overpayment may occur for a variety of reasons, such as clerical error, fraud, maximum medical improvement, return to work, or an IC or Court of Common Pleas reversal of an order.

The employer may recoup all overpayments from any amount the injured worker may receive under any past, present and future claims, per [ORC 4123.511 \(K\)](#) and applicable case law. This includes any reversal that occurs at the district hearing office, staff hearing officer or IC level, or Court of Common Pleas.

[ORC 4123.511 \(K\)](#) provides the percentages to withhold overpaid compensation from any past, present or future workers' compensation claims. An employer may not withhold any overpayments for the first 12 weeks of TT.

Absorption rate	Type of compensation
0 percent	First 12 weeks of TT (except for fraud) *LM (except for fraud)
40 percent	TT (after first 12 weeks) Change of occupation FD PP %PP WL *LMWL *Death benefits (when the dependent is overpaid and lump-sum advancement)
25 percent	PTD (includes lump-sum advancement)
100 percent	* VSSR LSS Any fraud overpayment Balance of PP/SL award *Even adjustments

* Indicates absorption rate according to BWC/IC resolution or BWC policy

An employer may be eligible for reimbursement from BWC on overturned claims. The Sysco Supreme Court decision allowed a self-insuring employer to receive reimbursement on a claim where there is a final administrative or judicial determination that compensation or benefits should not have been paid.

An employer participating in the Claims Reimbursement Fund can submit a request to the self-insured department for reimbursement for the overturned amount.

Vocational rehabilitation

[ORC 4121.61](#) through [ORC 4121.69](#), [OAC 4123-18-01](#) and applicable rules within [OAC 4123-6](#) and [OAC 4123-17](#)

The self-insuring employer has the right to participate in a BWC rehabilitation program and the right to obtain services from a private rehabilitation service provider. Employees of self-insuring employers participating in vocational rehabilitation programs found to be both eligible and feasible are entitled to vocational rehabilitation services equal to or greater in quality and content than services provided by BWC and the managed care organization.

Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker with a lost-time claim who needs assistance in safely returning to work or in retaining employment. Vocational rehabilitation emphasizes restoring or maximizing the injured worker’s abilities and minimizing long debilitating absences from work. When an injured worker quickly returns to work, feelings of self-worth stay high and ties to the job and work community stay strong. An employer may also benefit from vocational rehabilitation services when an experienced worker remains productive, which saves the employers from the costs associated with hiring and training a new employee. If a return to work at the original employer is not possible, rehabilitation services may help the injured worker identify skills and abilities to secure a new job with another employer.

Pursuant to [OAC 4123-18-01](#), BWC is responsible for developing guidelines to aid in rehabilitation service delivery. To provide and receive payment for vocational rehabilitation case management, including the services provided by an intern, the service provider must be BWC-certified and enrolled. [OAC 4123-6-02.2\(C\)\(30\)](#) identifies the type of credentials a vocational/medical case manager must maintain. A nationally recognized accreditation committee must have credentialed the provider in one of the following:

- Certified Rehabilitation Counselor (CRC);
- Certified Disability Management Specialist (CDMS);
- Certified Rehabilitation Registered Nurse (CRRN);
- Certified Vocational Evaluator (CVE);
- Certified Occupational Health Nurse (COHN);
- Certified Case Manager (CCM)

Feasibility for vocational services means that there is a reasonable probability that the injured worker will benefit from services and return to work as a result of the services. An injured worker may be determined eligible for services but may not be feasible to participate.

The vocational case manager assesses and integrates all of the information gathered and develops the initial individual written vocational rehabilitation plan, which the employer authorizes. If the case manager determines the injured worker is not a viable candidate for participation in rehabilitation, the employer must follow standard rehabilitation case closure procedures.

The employer may only re-open cases closed during or after the vocational rehabilitation plan assessment/development phase with justification of significant changes in the injured worker's circumstances. If the employer decides to close the case during the vocational rehab plan assessment/development phase, the employer must issue letters of notification to all parties to the claim. These letters must specifically state why the injured worker is not feasible for services. Due process language in the letter directs the parties to file any objection with the employer. The employer should file a motion to have the issue heard by the IC. The employer must receive the initial rehabilitation plan within 45 calendar days of case manager assignment. Plan services begin after receipt of initial plan.

All self-insuring employers (opted in or opted out) will pay living maintenance, wages in lieu of compensation (salary continuation) directly to the injured workers where necessary while they are participating in a vocational rehabilitation plan.

An injured worker may receive up to a maximum of 200 weeks of LMWL in accordance with [ORC 4121.67\(B\)](#), less any week of WL, provided in accordance with [ORC 4123.56\(B\)](#), which the employer previously paid.

BWC will reimburse self-insuring employers who have not opted out of the surplus fund for all the same rehabilitation services that BWC pays for state-fund employers. Self-insuring employers who have not opted out may request rehabilitation reimbursements from BWC within 180 days from the date of the rehabilitation case closure or opt out. If a self-insuring employer who has not opted out wishes to participate in vocational rehabilitation services, the disability coordinator in the BWC customer service office will approve/disapprove his or her vocational rehabilitation plans and process the reimbursement through the surplus fund

The employer should attempt to return the injured worker to employment to as close to pre-injury wages as possible to prevent increased wage loss. Research has shown the use of the return-to-work hierarchy provides the most cost effective, efficient and permanent re-employment of injured workers. To help facilitate the most appropriate and cost-efficient return to work, the vocational case manager should consider and address each step of this hierarchy sequentially. The case manager should document why he or she can rule out a step in the rehabilitation plan narrative. Skill enhancement, remedial or short-term training may be used at any level of the hierarchy, when appropriate, to aid injured workers in successfully returning to work.

The return-to-work hierarchy – OAC 4123-18-02 – states that the goals of vocational rehabilitation are to return the injured worker to:

- Same job, same employer – The first goal is to return the injured or disabled worker to his or her former employer in his or her original job;
- Different job, same employer – To encourage the employer to modify the original job or to provide employment in a different job with that employer;
- Same job, different employer – To assist the injured worker in finding employment with a different employer in a related industry;
- Different job, different employer – To assist the injured worker in finding a new job in any industry.

OAC 4123-18-04(B) allows an injured worker's medical instability to interrupt a vocational rehabilitation plan in progress. The medical condition causing the instability does not have to relate to the allowed condition. Below are the two types of plan interruption.

A rehabilitation plan may be interrupted for no more than 30 days to allow the injured worker's medical instability to resolve or to collect information about the condition. The vocational rehabilitation case manager will advise as to the appropriateness of continuing LM during this 30-day period based on the injured worker's diagnosis and prognosis. If the vocational rehabilitation case manager determines plan closure, the employer should make other forms of compensation available to the injured worker when possible.

A medical hold is a temporary closure of the rehabilitation plan. It occurs when an injured worker experiences a medical event anticipated to last longer than the medical interrupt. A medical hold will retain the injured worker's eligibility for vocational rehabilitation service for up to a maximum of two years from the date of plan closure.

Closure of a vocational rehabilitation plan should occur after:

- The injured worker has completed a vocational rehabilitation plan; or
- The injured worker has failed to fulfill the responsibilities outlined in the vocational rehabilitation plan; or
- The injured worker cannot attain the goals for the vocational rehabilitation plan; or
- The injured worker has refused, without good cause, to accept an offer of employment within the vocational goal of the rehabilitation plan; or
- The injured worker has died; or
- The injured worker does not agree with the (employer's) managed care organizations or BWC's decision to approve or deny specific vocational rehabilitation plan services; or
- An IC order, its district or staff hearing officers, or a court order subsequently disallows the claim; or
- The claim is settled (medical and/or indemnity); or
- The injured worker chooses not to participate after receiving notification that he or she is eligible/feasible.

The employer will give a written determination on all referrals and will include the reason for the closure and the process to follow should the injured worker appeal the decision. The employer should send notification to all parties to the claim.

Parties to the claim have the right to appeal a rehab case closure decision. During the established appeal period, the employer should take no further action on the vocational rehabilitation case. The IC may

rescind a closure during the appeal time period if the employer and injured worker agree to keep the vocational rehabilitation case open.

Injured workers, who sustain a new injury or an occupational disease while participating in an approved vocational rehabilitation plan, can file a claim. They should only file claims for new injuries or occupational diseases. BWC considers claims filed as a result of an injury sustained while participating in a rehabilitation plan as rehabilitation medical or rehabilitation liability claims.

Prosthetics

BWC is responsible for processing requests for prosthetics and travel expenses associated with the prosthetic in all claims. This includes self-insured claims. BWC issues payment for prosthetics from the surplus fund.

When an injured worker needs a prosthetic device in a self-insured claim, the physician/provider will send in a request for the prosthetic and/or request for repair to BWC's customer care team. The team sends requests for prosthetics involving self-insured PTD claims to the assigned DWRP claims service specialist for processing.

BWC will review and evaluate the request and make a determination and issue the decision by generating the *Authorization Approval letter (C-47)* or the *Authorization Denial letter (C-48)*. If authorized, BWC sends the bill to its medical billing and adjustments department on the *Service Invoice (C-19)*. The department issues payment for the prosthetics from the surplus fund.

Dispute resolution

[ORC 4121.34\(B\)](#) and [ORC 4123.511](#)

The IC has exclusive authority over all disputed/contested issues involving self-insured claims. The IC is the adjudicating body in the Ohio workers' compensation system. The IC adopts rules (OAC sections) governing the conduct of hearings and rendering decisions by any of the three levels of hearings – district hearing officer, staff hearing officer and Commissioners. The rules provide for the following:

- Adequate notice of a hearing to all parties and their representatives so they have the opportunity to attend and present evidence at the hearing;
- Pre-hearing issues such as discovery, depositions and the exchange of claim information;
- Hearings open to the public;
- Appeals impartially assigned to the district hearing officer or staff hearing officer;
- Hearings held in the service office closest to the injured worker's residence.

[OAC 4121-3-13\(A\)](#) defines a disputed issue as any issue that is disputed or disagreed between the injured worker and the self-insuring employer. A party to the claim must put BWC on notice that a dispute exists so that BWC can refer the issue to the IC for hearing. A Motion (C-86) may not be required for a referral to the IC.

BWC may be put on notice of a dispute in the following manner:

- No response to an injured worker request when BWC has sent the Notice on Self- Insuring Employer Claims letter;
- Rejection by a self-insuring employer on an initial or subsequent application (except C-9s);
- A C-86 filed by a party to the claim requesting a hearing on the disputed issue.

[OAC 4123-19-03\(K\)\(10\)](#) states the employer must respond to an initial application within 30 days from the filing of the claim. BWC considers no response or a rejection a dispute. BWC refers disputed initial applications to the IC without an additional C-86.

File disputes involving percentage of permanent partial awards (C-92/C-92-A) on an [Objection to Tentative Order Awarding Permanent Partial Disability \(IC-167-T\)](#). BWC refers these to the IC for hearing.

BWC will forward disputed issues to the IC within seven days.

The parties of the claim (injured worker, employer and authorized representatives) are entitled to receive written notice of any determination, award or hearing according to [ORC 4123.511](#). An IC Order generally provides claim determinations and award notices.

Pursuant to [ORC 4123.522](#), if a party fails to receive notice, he or she may petition the IC to request relief on a [Request for .522/52 Relief \(IC-52\)](#) or may request the IC to grant a continuance using the [Request for Continuance \(IC-51\)](#). The IC hearing administrator, per [ORC 4121.36\(2\)\(c\)\(v\)](#), will review the request and inform the party of the decision by letter. The party has 21 days from the receipt of the letter to take action afforded them by the IC hearing administrator (i.e. file an appeal).

The decisions of the district hearing officer, staff hearing officer or Commissioners according to [ORC 4121.36\(B\)](#), will be in writing and contain the following:

- A description of the claim issues, determined by the order;
- Notation of the notice provided and appearance of the parties;
- Description and nature of the allowed conditions recognized in the claim;
- Signatures of each Commissioner or appropriate hearing officer on the original copy of the decision only, verifying the commissioners' or hearing officer's vote.

The first level of an IC hearing is the district hearing officer. Per [ORC 4121.34\(B\)](#), the district hearing officer has jurisdiction to hear and decide the following issues:

- All appeals to determinations under [ORC 4123.511\(B\)](#);
- All other contested claim matters under ORC 4121; 4123; 4127; and 4131 except those matters under the jurisdiction of the staff hearing officer.

A party to the claim may appeal the district hearing officer's order to the staff hearing officer within 14 days after its receipt.

If a disputed matter is heard by the IC, employers must pay compensation and benefits due and payable under an order as provided in ORC 4123.511. If the allowance of the claim is pending a hearing, the employer does not have to pay compensation and/or medical benefits pending a district hearing officer order. If a party to the claim appeals a district hearing officer order, the employer may hold medical payments. The employer must pay any compensation benefits awarded at a district hearing officer level hearing in accordance with the order even if either party appeals the order. Pursuant to OAC 4123-19-03 (K)(5), the employer must begin paying compensation upon receipt of the order

The second level of an IC hearing is the staff hearing officer. Pursuant to [ORC 4121.35\(B\)](#), the staff hearing officer has jurisdiction to hear and decide the following issues:

- Appealed district hearing officer orders;
- Applications for PTD awards;
- Applications for VSSR awards;
- Applications for reconsideration of compensation awards made under [ORC 4123.57](#).

A party to the claim may appeal the staff hearing officer order to the IC Commissioners within 14 days after its receipt.

The employer must pay any compensation and medical benefits awarded at a staff hearing officer level hearing regardless of appeal status.

The third level of IC hearings is the IC Commissioners. Pursuant to [ORC 4123.511\(E\)](#), the IC Commissioners, at their discretion, will hear appeals to staff hearing officer orders.

If the Commissioners decide to hear an appealed issue they will issue a Notice of Acceptance of Appeal for Hearing letter. The Commissioners will hold a hearing within 45 days after the filing date of the appeal.

A party to the claim can appeal orders issued by the IC Commissioners, with the exception of those determining the extent of disability (compensation awards), to the Court of Common Pleas via a mandamus action.

Pursuant to [ORC 4123.511\(H\)](#), payment of all compensation begins the earlier of the following:

- Fourteen days after the date BWC issues an order under ORC 4123.511(B), unless a party to the claim appeals the order;
- The date when the employer has waived the right to appeal a decision; 4123.511(B).
- If no appeal of an order has been filed under 4123.512, the expiration of the appeal period;
- The date the employer receives the district hearing officer, staff hearing officer or IC order.

Note: Pursuant to [OAC 4123-3-18\(A\)\(11\)](#), payment cannot be made until a final decision on appeal allows payment of C-92/C-92-A.

Pursuant to [ORC 4123.511\(I\)](#), the payment of medical benefits begins the earlier of the following:

- The date the staff hearing officer issues the order;
- The date of the final administrative or judicial determination. This includes the date the employers waive appeal rights.

IC resolutions and the hearing officer's manual provide guidelines for the hearing process. This information is available [IC's website](#).

IC resolutions

- [Joint Resolution R94-1-12](#) addresses requirements for allowance of psychological conditions in a claim.
- [Joint Resolution R07-1-04](#) addresses guidelines for appealing staff hearing officer orders.
- [IC Resolution R10-1-01](#) addresses requests for continuance of scheduled hearings.
- [IC Resolution R94-1-19](#) addresses relief due to lack of notice.
- [IC Resolution R94-1-14](#) addresses the timeframes for self-insured claims.

Self-Insured Audits

Audit process

[ORC 4123.35](#) and [OAC 4123-19-10](#)

BWC is required to audit self-insuring employers to ensure employers are administering programs according to the statutory requirements. The audit process consists of a three-tier program that focuses on the employer's knowledge and implementation of the administrative, reporting and claims-management requirements. The expectation is that self-insuring employers have proper controls in place to ensure compliance with the statutory requirements.

Level 1 assessment audit: BWC's self-insured underwriting unit primarily performs the Level 1 audit as part of an employer's yearly renewal. The data and information BWC audits are currently available via BWC systems or already provided by an employer as part of the program requirements.

Frequency: BWC's self-insured department targets completing a Level 1 audit on all active self-insuring employers on an annual basis. BWC may also perform a Level 1 audit if there is a change in the designated program administrator, or if there is a change from self administration to outsourcing functions to a third-party administrator.

Scope: The audit will include:

- Aggregate reserve reporting;
- *Report of Paid Compensation and Case Reserves (SI-40)* trends, including total lost-time claims, reductions and lifetime claims.

Level 2 compliance audit: Level 2 audits are a more comprehensive review of an employer's claim compliance and SI-40 reporting practice. BWC may schedule and conduct these audits on an as-needed basis based on the following triggers:

- Not in compliance of any area in a Level 1 audit;
- Unexplained significant variances on the SI-40 from one year to the next;
- Inability to provide material support for a reduction reported on previous SI 40s;
- High-risk self-insured employers;
- Concerns noted on prior Level 2 audits;
- Multiple valid complaints in a rolling 12-month period;
- More than four years since last audit.

Frequency: BWC's self-insured department targets completing a Level 2 audit on all active self insured employers every three to four years.

Scope: The audit will include:

- Accuracy of SI-40 reporting;
- Accuracy in calculating wages for TT and PP payments;
- Accuracy in PTD calculation;
- Timeliness of compensation payments;
- Number and type of complaints;
- Aggregate reserves.

Level 3 compliance audit: Level 3 audits review all aspects of an employer's claims administration and reporting practices. BWC may schedule these audits based on the following triggers:

- Any employer that is not-in-compliance in any area of the Level 2 audit;
- Four years or more elapsed since last Level 3 audit;
- Initial six-to-12 month audit for all new self-insured policies;
- Change in administrator requires completion of the online tutorial through the BWC and shortens the four-year timeline to 12 months from the point of turnover;
- Upon finding of a third valid self-insured complaint in any rolling 12-month period;
- Failure of an employer to demonstrate strong working knowledge and consistent practices will result in a repeat Level 3 audit in the following six months to one year.

Frequency: As needed

Scope: The audit will include:

- Timeliness of lost-time claim reporting to BWC;
- Timeliness of certifying claims;
- Timeliness of medical bill payments;
- Reasonableness of medical bill response;
- Timeliness of compensation payments;
- Accuracy of compensation payments;
- Timeliness of responding to treatment requests;
- Availability of claim file;
- Maintaining a complete claim file;
- Proper notification to injured worker on claims process.

Self-Insured Complaints

[OAC 4123-19-09](#)

BWC's self-insured department receives and investigates all complaints against self-insuring employers. BWC evaluates each complaint and takes appropriate action. However, BWC may dismiss a complaint if the events in the allegation occurred more than two years prior to filing the complaint, unless the injured worker could not reasonably know the facts.

An injured worker should submit complaints or allegations in writing with supporting documentation either by letter or on a [Filing of Allegation Against a Self-Insured Employer \(SI-28\)](#). The self-insuring employer has 14 days from the date they receive notification of the complaint to provide BWC with a written response regarding the complaint allegation. BWC attempts to resolve all allegations at the initial level within 30-45 days of receipt, depending on the complexity of the issue. Either party - injured worker or self-insuring employer - may appeal the decision. The Administrator's designee will review the appeal and present a finding to all parties. If the complaint remains unresolved, the issue goes before the Self-Insured Employers Evaluation Board (SIEEB). The written notice of the decision outlines the procedures to all parties.

Self-Insuring Employers Evaluation Board (SIEEB)

[ORC 4123.52](#) and [OAC 4123-19-13](#)

The Self-Insuring Employers Evaluation Board consists of one member of the IC representing the public and serving as chairman. The governor also appoints one member of the Ohio Self-Insurers Association and one member of labor. BWC provides administrative support for the SIEEB.

BWC refers all unresolved complaints or allegations of misconduct against a self-insuring employer to the SIEEB. At the injured worker's request, the SIEEB may elect to hear a complaint that BWC had dismissed.

The SIEEB investigates allegations and issues a written determination. It may order the employer to take corrective action. If after a hearing it determines that an employer has failed to correct deficiencies or is otherwise in violation of the statute, the SIEEB will recommend BWC revoke the employer's self-insurance privilege, or that BWC places the employer on probation. The SIEEB may also recommend a civil penalty, not to exceed \$10,000, for each violation, payable into the self-insuring employers' surety bond fund.

Changing claims incorrectly assigned to a state-fund or self-insured policy

When state-fund claims change to self-insured claims or vice versa and BWC has paid compensation and/or medical bills, adjustments may be necessary to accurately charge the correct employer with the costs associated with the claim. The state fund or self-insuring employer will request a change in policy number by notifying the claims service specialist (CSS), claims assistant, BWC's self-insured department, Employer Services Division or the BWC customer contact center via email. If BWC discovers an incorrect policy number and it is necessary to change the policy number, BWC will change the number after thorough investigation and verification without a request from the employer.

Requests to change the policy number (including internal BWC staff requests received via email) must clearly describe why the change is required and include any supporting documentation. The CSS in coordination with the self-insured department will investigate and gather any additional information to determine the validity of any request to change the claim.

If the employer(s) agree to the policy number change, which means they agree that the claim should be charged to its policy number in its entirety, and there is no dispute or conflict with any claim allowances or payments made in the claim, the CSS will issue a BWC order notifying both employers of the agreement change the policy number, claim allowances, and medical and compensation payment information. The order will include the type of compensation being paid, the amount of compensation being paid and the amount of medical being paid.

If the employer(s) disagree with the policy number change or has a conflict or dispute with claim allowances or payments made in the claim, or files an appeal to the BWC order, BWC will refer the claim to the IC for hearing.

BWC's self-insured department will notify the self-insuring employer and coordinate reimbursement for medical and compensation payments to BWC.

BWC will provide the self-insured employer with all medical billing information. This includes copies of all paid medical bills. BWC provides all medical bills paid out of the Ohio State Insurance Fund on behalf of a state-fund employer to the self-insuring employer for reimbursement to BWC. If the self-insuring employer agrees to reimburse BWC, the bureau will place a debit on file for the claim number and risk Underwriting will make adjustments to claim costs. If the self-insuring employer refuses to reimburse BWC, the self-insured department will determine what further action to take. BWC will credit the Ohio State Fund risk for all payments made in the claim.