

Self-Insuring Employers Evaluation Board



SYNOPSIS OF FORMAL DECISIONS

August 26, 1999 to Present

Donna Owens, Chairman
Commissioner, Industrial Commission of Ohio

James Sharpe, Member
Ohio Self-Insurers Association

Wesley Wells, Member
Ohio AFL-CIO



Self-Insuring Employers Evaluation Board

Synopsis of Formal Decisions

INTRODUCTION

This summary of formal orders represents a synopsis of the disposition of unresolved complaints and administrative concerns presented to the Self-Insuring Employers Evaluation Board (SIEEB), pursuant to the provisions of Section 4123.352 of the Ohio Revised Code from August 26, 1999 to the present. The decisions referenced in this manual were based upon the laws, rules, policies, and procedures in effect at the time the issues were presented. This order summary is designed as a reference guide for self-insuring employers, employees of self-insuring employers, and their authorized representatives. More specifically, it is hoped that this summary will enable Ohio self-insuring employers and their employees to better understand the workers' compensation laws and rules which relate to self-insurance.

This summary may be reproduced and provided to anyone with an interest in the administration of Ohio self-insured claims.

The Self-Insuring Employers Evaluation Board

Donna Owens, Chairman

James Sharpe, Member

Wesley Wells, Member



- Chapter 1:** Average Weekly Wage
- Chapter 2:** Claim Suspension
- Chapter 3:** Death Benefits
- Chapter 4:** Failure to Assist the Injured Worker
- Chapter 5:** Failure to Respond
- Chapter 6:** Lump Sum Settlement
- Chapter 7:** Medical Bills
- Chapter 8:** Medical Reports
- Chapter 9:** Medical Treatment
- Chapter 10:** Notice of Complaint
- Chapter 11:** Overpayment
- Chapter 12:** Permanent Partial Disability Compensation
- Chapter 13:** Permanent Total Disability Compensation
- Chapter 14:** Reconsideration
- Chapter 15:** Rehabilitation
- Chapter 16:** Taxes Withheld
- Chapter 17:** Temporary Total Disability Compensation
- Chapter 18:** Wage Loss Compensation

Chapter 1

Average Weekly Wage



Self-Insuring Employers Evaluation Board



This matter came before the Board for an informal conference on Complaint No. 12800 alleging that the employer improperly calculated the injured worker's average weekly wage. The employer's position was presented by counsel and after due consideration of the evidence, the Board makes the following findings and recommendations.

This dispute involves whether certain sums paid to the injured worker for expense reimbursement should be included in the calculation of the injured worker's average weekly wage. The disputed payments are designated separately from earnings on the injured worker's check stubs. The employer excluded the disputed payments and the injured worker filed both a self-insured complaint and an appeal with the Industrial Commission. The Self-Insured Department agreed with the injured worker that the average weekly wage was improperly calculated and found a valid complaint.

The Board finds that the nature of the disputed payments and whether such payments should be included as wages for purposes of the average weekly wage calculation is a substantive claims dispute. The employer has presented sufficient documentation to support the presence of a substantive issue and bona fide dispute. As a result, the determination of the average weekly wage was within the sole jurisdiction of the Industrial Commission.

The Board further notes that an order was issued by the Industrial Commission on the issue. The employer's representative assured the Board that the employer was in compliance with the order.

The Board finds that the complaint should be dismissed for lack of jurisdiction over the issue presented.

Chapter 2

Claim Suspension



Self-Insuring Employers Evaluation Board



An informal conference was held concerning Complaint No. 12773 on June 25, 2003. The injured worker filed the complaint alleging that the employer improperly suspended the claim due to the injured worker's failure to schedule a medical examination. The employer's representative presented the employer's position to the Board. After due consideration of the evidence presented, the Board makes the following findings and recommendations:

By letter dated November 13, 2002, the injured worker was notified of an independent medical examination by the employer's representative. The examination was scheduled for December 2, 2002. For reasons unclear in the record, the injured worker failed to appear for the examination. The employer then unilaterally suspended the claim and terminated wage loss compensation. The injured worker filed the self-insured complaint on December 10, 2002. The employer responded on December 19, 2002 and notified the injured worker and the Bureau of Workers' Compensation that the claim had been suspended pursuant to Memo No. U.16 of the Industrial Commission Hearing Officer Manual. The Self-Insured Department found the complaint valid and the matter was referred to the Board for further review.

Memo No. U.16 (now Memo S.9) of the Hearing Officer Manual provides for the unilateral suspension of a claim by a self-insuring employer. However, the memo also provides that the employer shall provide the injured worker or the injured worker's representative timely notice of the suspension. In the present matter, there is no record that any notice was given until the employer responded to the self-insured complaint on December 19, 2002. The Board therefore finds that the notice was not timely. As a result, the injured worker did not have a reasonable opportunity to request an immediate hearing and show good cause for his failure to attend the examination.

The Board affirms the finding of a valid complaint. A copy of this order shall be placed in the Self-Insured Department's file.



This matter came before the Board on April 14, 2004, for an informal conference regarding Complaint No. 13285. After careful consideration of the evidence and the statements of the parties, the Board makes the following findings and recommendations:

This complaint involves the injured worker's allegation that the employer failed to provide the injured worker with notice of an independent medical examination scheduled for June 6, 2003. The employer provided evidence that the notice letter for the examination was mailed to an address previously authorized by the injured worker, that being his mother's address. The injured worker had received two earlier notices for examinations scheduled for March 7, 2003 and March 28, 2003, which were mailed to the same address. Additionally, there is a letter in the file from the employer's human resources manager to the injured worker indicating that mail being sent to the injured worker at the (address redacted) address was being returned. Accordingly, the Board does not find it unreasonable to provide notification at the address of the injured worker's mother which he effectively authorized in a letter to the third-party administrator dated March 7, 2003.

The injured worker indicated at hearing that the day before the examination scheduled for June 6, 2003, he was in the employer's personnel office and was not verbally informed of the examination. While it is regrettable that the medical examination the following day was not mentioned in passing, the Board finds the legally required notice had been given.

The Board finds the complaint invalid.

Chapter 3

Death Benefits



Self-Insuring Employers Evaluation Board



Self-Insuring Employers Evaluation Board
Synopsis of Formal Decisions

Death Benefits
Complaint No. 9181
May 15, 2000

As a result of a formal hearing held April 24, 2000, before the members of the Self-Insuring Employers Evaluation Board, concerning a complaint filed against the employer, the Board makes the following findings and recommendations:

The Board finds that the issue presented is whether the employer improperly withheld payment of compensation/benefits to the widow-claimant, who died on January 12, 1990. The Board finds that the Ohio Supreme Court specifically decided this issue on July 28, 1999 in State, ex rel. Nossal v. Terex Division of I.B.H. (1999), 86 Ohio St.3d 175, establishing that when the Industrial Commission awards death benefits to the surviving spouse of the deceased employee but the spouse dies before the funds are disbursed, accrued benefits for the period between the deceased employee's death and the spouse's death shall be paid to the spouse's estate.

The Board further finds that pursuant to Nossal v. Terex, on August 30, 1999 the Industrial Commission issued an order which directed that the self-insuring employer award accrued death benefits to the administrator of the estate of the widow-claimant, for a closed period from July 24, 1985 through January 11, 1990, the date before the death of the widow, at a rate of \$298.00 per week. The Board has further determined that on or about April 10, 2000, a check for \$69,519.14, the amount in dispute in this matter, was paid from the employer to the widow-claimant, in care of the law firm representing the widow-claimant's estate.

After a review of the facts relating to the complaint and the testimony elicited at hearing, the Board, by a vote of two-to-one, finds that the validity of the subject complaint must be upheld. The Board further finds that the employer's failure to make timely payment to the estate of the deceased employee is a violation of Ohio Adm. Code 4121-19-03(L)(5). By a vote of two-to-one, the Board determined that the self-insured complaint against the employer was valid, and a copy of said complaint shall be placed in the employer's self-insurance file. The Board further determined that no penalty shall be assessed against the employer for this violation.

Chapter 4

Failure to Assist the Injured Worker



Self-Insuring Employers Evaluation Board



An informal conference was held on June 30, 2004, concerning Complaint No. 12283. The injured worker filed the complaint alleging that the employer had failed to timely approve or deny requests for treatment, failed to send her notice of approval or denial of treatment, and approval of her request to change physicians, failed to timely pay medical bills, and failed to assist her with her workers' compensation claim. After due consideration of the evidence presented, the Board makes the following findings and recommendations:

The injured worker asserts that the employer failed to timely respond to requests for treatment, and failed to timely pay bills submitted by medical providers. However, the bills and requests referred to by the injured worker are not properly before the Board. They were the subject of another self-insured complaint, which was found to be invalid. Further, there has been no evidence presented by the injured worker that the employer has failed to comply with Ohio Adm.Code 4123-19-03(K)(5), which provides the timeline for self-insuring employer approval or denial of treatment, approval of requests for change of physician, and payment of bills. The injured worker in this case appears to dispute the employer's decisions to deny requested treatment and/or payment of certain bills. However, such a dispute should be addressed by the Industrial Commission in the hearing process. The Board lacks jurisdiction to adjudicate such disputes.

The injured worker also contends that, contrary to her requests, the employer failed for a time to send its decisions regarding authorization of treatment and change of physician directly to the injured worker. Ohio Adm.Code 4123-19-03(K)(5) requires a self-insuring employer to approve or deny requested treatment within ten days of receipt of the request, and to approve a request for change of physician within seven days of receipt. The rule does not require that notification of the employer's decisions on these issues be sent directly to the injured worker, even if the injured worker requests such notification. Rather, notice to the injured worker's legal representative is sufficient, since the representative is obligated to notify the injured worker regarding the decision. There is no dispute that the employer's decisions regarding authorization of treatment and change of physician in this case were timely sent to the injured worker's attorney. Therefore, the self-insuring employer complied with Ohio Adm.Code 4123-19-03(K)(5).

Finally, the injured worker asserts that the employer failed to give her a claim number after she reported her industrial injury to the employer, and therefore failed to assist her in her worker's compensation claim. Since self-insuring employers do not assign claim numbers to workers' compensation claims, this assertion is not itself sufficient to give rise to a valid self-insured complaint. Further, the injured worker has presented no evidence to the Board that would otherwise lead the Board to conclude that the employer failed to assist the injured worker with her claim.

For the above stated reasons, the Board finds the self-insured complaint invalid.



This matter came before the Board on August 31, 2004, for formal hearing on Complaint No. 13542, filed by the injured worker, Sharon Dunigan. After careful consideration of the evidence, the Board makes the following findings and recommendations.

The injured worker's complaint, filed with the Self-Insured Department of the Bureau of Workers' Compensation on November 24, 2003, alleges that the self-insuring employer, Wal-Mart Stores, Inc., refused to approve diagnostic testing requested by the injured worker, and then failed to respond to the injured worker's requests that the employer approve the diagnostic testing. The Self-Insured Department eventually found the complaint to be valid on grounds that the employer had failed to assist the injured worker in applying for benefits, and failed to provide information to the injured worker regarding the processing of her claim and request for benefits, in violation of Ohio Adm.Code 4123-19-03(I)(2)-(3).

The injured worker's claim was certified by the employer on April 17, 2003. On April 22, 2003, the employer sent the injured worker a letter providing the injured worker with information detailing her rights in regard to her claim. Specifically, the letter advised the injured worker that she had the right to request a hearing on any disputed issue that pertains to her claim, and explained how to obtain the forms necessary to request a hearing before the Industrial Commission.

Shortly after her injury, the injured worker moved to another state. Thereafter, on July 21, 2003, the injured worker left a voice-mail message for a claims representative for the employer, asking how she could obtain treatment with a physician in her new state of residence. A claims representative returned the injured worker's telephone call and left the injured worker a voice-mail message advising her that she has the right to select a physician of her choice, but that she must still obtain pre-approval of treatment.

Thereafter, the injured worker's treating physician submitted a C-9 form requesting authorization of an EMG of the right upper extremity. The employer denied this request within two days of receipt, on grounds that the request was based on non-allowed conditions. The injured worker then contacted the employer's claims representative again and asked how she could have her request approved. She was informed by the claims representative that her treating physician must submit a new C-9 listing only the allowed conditions in the claim. Subsequently, the C-9 was resubmitted, but without change. The employer again denied the request. Thereafter, the injured worker filed this self-insured complaint.

The Board finds that it lacks jurisdiction to address the propriety of the employer's timely denial of the request for diagnostic testing. The Industrial Commission of Ohio possesses exclusive jurisdiction to adjudicate disputed requests for treatment and diagnostic testing. In this regard, the Board notes that the injured worker filed a motion with the Industrial Commission on December 2, 2003. Her request for diagnostic testing was denied by the Industrial Commission on January 16, 2004.

The Board also finds that the employer did not violate Ohio Adm.Code 4123-19-03(I)(2)-(3), which requires self-insuring employers to provide assistance and information to injured workers



Self-Insuring Employers Evaluation Board

Synopsis of Formal Decisions

Failure to Assist
Complaint No. 13542
Continued

regarding the processing of claims and benefits. By its letter dated April 22, 2003, the employer clearly explained the injured worker's rights in regard to obtaining a hearing regarding disputed matters in her claim. The injured worker's filing of a motion with the Industrial Commission, seeking to have the treatment dispute adjudicated by the Industrial Commission, indicates that the injured worker received from the April 22, 2003, letter the information and assistance necessary to aid her in the processing of her request for diagnostic testing.

For the foregoing reasons, the Board finds the injured worker's self-insured complaint to be invalid.

Complaint No. 13542 is found to be invalid. A copy of this order shall be placed in the Self-Insured Department's file.

Chapter 5

Failure to Respond



Self-Insuring Employers Evaluation Board



A formal hearing was held on June 29, 2000 before the members of the Self-Insuring Employers Evaluation Board concerning a complaint filed against the employer, and the Board makes the following findings and recommendations:

Self-insured complaint number 8615 was filed by the injured worker on or about May 5, 1999, alleging that compensation payments in the claim were not made in a timely manner. Pursuant to this complaint, the Bureau of Workers' Compensation Self-Insured Department mailed out a notice of filing of self-insured complaint to the employer on May 26, 1999 seeking a written response to the complaint within thirty days of receipt of the correspondence, in accordance with Ohio Adm. Code 4123-19-09. On August 5, 1999, the Bureau of Workers' Compensation Self-Insured Department sent a second correspondence to this employer informing them that a timely response had not been received from the employer and the complaint was found to be valid. This August 5, 1999 correspondence to the employer also stated, "If a written response to this complaint has not been received in our office by Thursday, August 12, 1999 this matter will be referred to the Self-Insuring Employers Evaluation Board for further review." No such response was received from the employer and accordingly the matter was referred to the Self-Insuring Employers Evaluation Board.

On January 24, 2000, correspondence from the Bureau of Workers' Compensation Self-Insured Department was sent to the employer informing them that complaint number 8615 was deemed valid and the matter will be referred to the Self-Insuring Employers Evaluation Board. On May 15, 2000, the Self-Insuring Employers Evaluation Board sent written correspondence to the employer informing them that if no response is received within the next fifteen days, the matter would be set for a formal hearing before the Self-Insuring Employers Evaluation Board. No timely response was received and on June 12, 2000 a notice of formal hearing was sent by the Bureau to this self-insuring employer informing them that a formal hearing was scheduled for June 29, 2000 before the Self-Insuring Employers Evaluation Board, pursuant to R.C. 4123.352.

At this June 29, 2000 record hearing, representatives for the employer did not make a personal appearance but submitted a written correspondence stating the employer's justification for the delays in paying compensation and the repeated failure to respond to Self-Insured Department correspondence.

After a review of the facts related to the complaint and both written and oral testimony elicited at hearing, the Board finds that the employer is in violation of Ohio Adm. Code 4123-19-09(A) by failing to respond to complaint number 8615 within thirty days of receipt of notification thereof as required by the rule. The Board decided that this matter should be referred to the Self-Insured Department for a determination of the merits after considering the employer's response received prior to the hearing. The Board further ordered that a copy of this order be placed in the employer's self-insurance file.



Self-Insuring Employers Evaluation Board
Synopsis of Formal Decisions

Failure to Respond
Complaint No. 8872
August 2, 2000

As a result of a formal hearing held on June 29, 2000, before the members of the Self-Insuring Employers Evaluation Board concerning self-insured complaint number 8872, filed against the employer, the Board makes the following findings and recommendations:

On or about August 6, 1999, the injured worker filed self-insured complaint number 8872 against the employer alleging that medical bills in her allowed claim were not paid in a timely manner, as required by Ohio Adm. Code 4123-19-03(L)(5). Pursuant to the self-insured complaint being filed, the Bureau of Workers' Compensation Self-Insured Department mailed a notice of filing of self-insured complaint request for response to the employer on or about October 1, 1999. On January 14, 2000, the Bureau of Workers' Compensation Self-Insured Department mailed correspondence to the employer citing a failure to respond to self-insured complaint number 8872 within thirty days, as required by Ohio Adm. Code 4123-19-09. Accordingly, the Bureau's January 14, 2000 correspondence found the underlying complaint to be valid and referred the matter to the Self-Insuring Employers Evaluation Board for further review.

On May 15, 2000, the Self-Insuring Employers Evaluation Board sent written correspondence to the employer informing them that if no response is received within the next fifteen days, the matter would be set for a formal hearing before the Self-Insuring Employers Evaluation Board. No timely response was received and on June 12, 2000 a notice of formal hearing was sent by the Bureau to this self-insuring employer informing them that a formal hearing was scheduled for June 29, 2000 before the Self-Insuring Employers Evaluation Board.

A formal record hearing was conducted on June 29, 2000 with oral and written testimony submitted by representatives of both parties.

After a review of the facts relating to the complaint and testimony elicited at hearing, the Board finds that the employer's failure to respond timely to self-insured complaint number 8872, despite several written notices to do so, constitutes a violation of Ohio Adm. Code 4123-19-09(A). The Board decided that this matter should be referred to the Self-Insured Department for a determination of the merits after considering the employer's response received prior to the hearing. The Board further ordered that a copy of this order be placed in the employer's self-insurance file.

Chapter 6

Lump Sum Settlement



Self-Insuring Employers Evaluation Board



As a result of a formal hearing held August 31, 2000 before the Self-Insuring Employers Evaluation Board concerning complaint number 9117, regarding the employer's default on the agreed full and final settlement filed with the Bureau of Workers' Compensation on September 22, 1999, the Board makes the following recommendations:

The relevant facts are as follows: On September 22, 1999, the Bureau of Workers' Compensation received a Self-Insured Joint Settlement Agreement and Release form signed by the injured worker and her authorized representative on September 13, 1999. The employer signed the agreement on September 20, 1999. The employer's position was that it only entered into that agreement based upon its understanding that the Bureau of Workers' Compensation would reduce or release an outstanding Letter of Credit on file with the Bureau of Workers' Compensation for the company. The employer documented its request to reduce the Letter of Credit by letter dated May 3, 1999 to the Self-Insured Department. In another letter to the Self-Insured Department, dated July 29, 1999, the employer indicated it had settled two of six claims previously included in the employer's reserves. The letter specifically stated, "One is a significant claim, the (name redacted) claim." The employer indicated the reduction in the Letter of Credit would impact their settlement of the claim. Specifically, the letter stated, "if an annuity settlement would satisfy the State's concern, we would like to process the same as quickly as possible." As of September 8, 1999 this matter was still unresolved. The employer, in a letter dated September 8, 1999, indicated that it had "agreed to Plaintiff's demand to settle the claim in the amount of \$125,000. Our attorneys are currently preparing the necessary settlement documents. Please advise that (name redacted) wishes to have the State draw down on the Letter of Credit for the (name redacted) claim, and then release the balance of the Letter of Credit, which will allow additional capacity on our line." In response, on September 24, 1999, the Self-Insured Department advised the employer that until the Bureau of Workers' Compensation received the employer's 1998 audited financial statements, consideration of the employer's request to reduce the Letter of Credit could not move forward. On February 28, 2000, the Self-Insured Department wrote to the authorized representative of the employer advising that the Bureau of Workers' Compensation was not willing to reduce the amount of the Letter of Credit on file, and explained the reason for the Bureau of Workers' Compensation's denial. Under a cover letter dated August 2, 2000, the Bureau of Workers' Compensation received additional information that enabled the Actuarial Section to proceed with the evaluation of the employer's request for a reduction in the Letter of Credit. On August 28, 2000, the Self-Insured Department received the conclusion of the Actuarial Section that the Letter of Credit could be reduced. On August 29, 2000, the Bureau of Workers' Compensation advised the employer that the request for a reduction in the Letter of Credit had been granted in the amount of \$98,000. It is noteworthy to mention that the employer reinstated the injured worker's Permanent Total Disability benefits on October 28, 1999, and paid all benefits in arrears as of that date.

After a review of the facts related to the complaint and both written and oral testimony elicited at the hearing, the Board finds the validity of the subject complaint must be upheld. The Board further finds that the employer's failure to timely pay the Lump Sum Settlement in the agreed amount of \$115,000 is unacceptable claims administration. The employer's request for a reduction in the amount of the Letter of Credit held by the Bureau of Workers' Compensation has



nothing to do with the manner in which an employer granted the privilege of self-insurance administers a workers' compensation program. The Board was particularly concerned that the employer's action placed the injured worker in a position of financial hardship. The Board finds no merit in the employer's argument that it only entered into the settlement agreement because of the expected reduction in the Letter of Credit held by the Bureau of Workers' Compensation. R.C. 4123.65(C) specifically addresses the process in self-insured claims, providing that either party may withdraw their consent to the settlement during the 30-day period following the signing of the settlement agreement. If the employer was effectively managing its workers' compensation program, the employer could have withdrawn its consent to the settlement immediately upon receipt of the Self-Insured Department's September 24, 1999 letter and been well within the 30-day period established by law.

The Board determined that the self-insured complaint against the employer was valid and a copy of said complaint shall be placed in the self-insurance file of the employer. The Board further determined that the employer is required to honor the settlement agreement, as filed with the Bureau of Workers' Compensation on September 22, 1999. Verification of said payment must be supplied to the Board within 30 days of the date of mailing of this order. The Board agreed that should the employer fail to comply with the Board's order to pay the settlement within 30 days, there will hereby be retroactively assessed a civil penalty, in the amount of \$10,000, which will then be immediately due. Payment of the penalty should be made to the Ohio Bureau of Workers' Compensation Guaranty Fund. Failure to comply with the order of the Self-Insured Employers Evaluation Board shall result in a referral of the employer to the Administrator for review and consideration of their continued self-insurance.

Chapter 7

Medical Bills



Self-Insuring Employers Evaluation Board



Self-Insuring Employers Evaluation Board
Synopsis of Formal Decisions

Medical Bills
Complaint No. 8294
October 18, 2000

As a result of a formal hearing held August 31, 2000 before the Self-Insuring Employers Evaluation Board concerning complaint number 8294, regarding the injured worker's request for a hearing on the validity of the complaint, the Board makes the following recommendations:

The relevant facts are as follows: On October 19, 1998, the injured worker's representative filed a complaint alleging the employer failed to pay compensation and medical benefits. The Self-Insured Department found the complaint to be valid and the employer in violation of Ohio Adm. Code 4123-19-03(L)(5) as a result of the employer's suspension of benefits. The complaint was determined to be unresolved and was referred to the Self-Insuring Employers Evaluation Board for further consideration. The employer's representative filed a request for reconsideration of the valid finding on January 19, 1999, and on June 28, 1999 the Administrator's designee reversed the finding of a valid violation and dismissed the complaint.

The injured worker's representative addressed several bills during the hearing, indicating the bills remained unpaid. Several of the bills were for services rendered in 1997 and 1998. The employer's most recent authorized representative addressed the difficulty she had with correlating medical documentation in the claim file, inherited from a prior representative, to the dates of service with an outstanding balance. She further indicated some of the bills in question had been paid. A review of the evidence confirmed there has been extensive correspondence between the employer's representative, medical providers, and the injured worker's representative regarding the release of medical records, as well as attendance at an employer's medical examination. Multiple issues involving the administration and processing of this claim were discussed. It was evident that there are outstanding issues remaining that need to be addressed.

After a review of the facts related to the complaint, and both written and oral testimony elicited at the hearing, the Board finds the employer admittedly failed to timely process and pay medical bills. The Board finds the fact that medical bills from 1997 and 1998 remained unpaid as of the date of the hearing is not acceptable. The Board further finds that the injured worker contributed to the confusion of these issues by failing to timely provide the employer with the necessary medical release. This fact was confirmed by the February 22, 2000 District Hearing Officer's order that affirmed the suspension of the claim as of February 22, 2000 and stated it would not be lifted until "written proof from the parties" was provided.

The Board finds that the employer is in violation of Ohio Adm. Code 4123-19-03(L)(5) by failing to timely process and pay medical bills. The finding of a valid violation against the employer for the untimely payment of medical bills is to be placed in its self-insurance file. The Board further orders that proof of payment of all outstanding medical bills addressed at hearing be submitted to the Board within 30 days of the date of this order. It is the Board's strong recommendation that the employer take the appropriate steps to ensure the compliance and effectiveness of their self-insured program. Failure to comply with the order of the Self-Insuring Employers Evaluation Board may result in a referral of the employer to the Administrator for review and consideration of their continued self-insurance.



Self-Insuring Employers Evaluation Board
Synopsis of Formal Decisions

Medical Bills
Complaint No. 8802
July 3, 2000

As a result of an informal hearing held on Monday, March 30, 2000, before the members of the Self-Insuring Employers Evaluation Board concerning a complaint filed against the employer, the Board makes the following findings and recommendations:

The Board finds that the issue presented is whether the employer failed to make timely payment on bills for certain prescription medications following a District Hearing Officer order, which was not appealed. On or about August 13, 1999, the injured worker, through counsel, filed a complaint alleging that the employer failed to pay medical bills within thirty days of receipt and failed to comply with a District Hearing Officer order which was not appealed.

A review of the pertinent documents demonstrates that a hearing took place before a District Hearing Officer on a motion filed by the injured worker. The District Hearing Officer issued an order authorizing payment for a four-month period for the medications of "Prozac, Dexedrine, Naprosin, and Methedone as prescribed by Drs. (name redacted) and or (name redacted)..." The employer did not appeal the decision of the District Hearing Officer.

Upon submission of the actual bills to the employer, the employer refused to pay. It is the employer's position that the injured worker failed to follow Industrial Commission and Bureau of Workers' Compensation guidelines with respect to submission of bills. Specifically, the employer asserts that the consultation with Dr. (name redacted) was never requested or authorized. Secondly, the employer asserts that the prescribing physician was not the physician of record at the time that the expenses were incurred. Finally, the employer asserts that the services required pre-authorization, as they were not emergency and the injured worker never requested the prescription expenses be paid prior to the hearing.

The complaint was found valid by the Self-Insured Department. Thereafter, the employer requested reconsideration of the matter. On or about December 20, 1999, a decision upholding the validity of the complaint was issued on behalf of the Administrator. The Bureau found the employer to be in violation of Ohio Adm. Code. 4123-19-03(L)(5), which requires payment of medical bills within thirty days. In addition, the Bureau noted that Ohio Adm. Code 4123-7-23(B) permits a physician other than the physician of record to prescribe medications. Specifically, the rule authorizes that prescriptions may come from a consulting physician as well. Finally, it is the Bureau's position that any issues which the employer had with regard to any consultations or prescriptions were, in fact, before the District Hearing Officer when its decision was rendered. The complaint, while valid, is, in fact, resolved. On or about August 31, 1999, the employer issued a check in the amount of \$5,564.28 in payment of the subject prescriptions. However, the employer has retained its right to argument.

After a review of the facts relating to the complaint and the testimony elicited at hearing, the Board finds the validity of the subject complaint must be upheld. The Board further finds that the employer's failure to make timely payment to be a violation of Ohio Adm. Code. 4123-19-03(L)(5), which requires payment of all medical bills within thirty days. The Board determined that the self-insuring complaint against the employer was valid, and a copy of said complaint shall be placed in the the employer's self-insurance file. The Board further determined that no penalty shall be assessed against the employer for this violation.



This matter was referred for formal hearing on June 27, 2001 before the Self-Insuring Employers Evaluation Board on complaint number 9983 filed by the injured worker's representative regarding the employer's alleged failure to pay medical bills pursuant to a Staff Hearing Officer order. Upon consideration of evidence and arguments of counsel, the Board makes the following findings and recommendations pursuant to R.C. 4123.352:

The relevant facts are as follows: The employer contested the claim and on June 26, 2000 a District Hearing Officer denied the claim. On August 2, 2000 a Staff Hearing Officer vacated the District Hearing Officer's decision and granted the FROI-1 filed April 20, 2000 to the extent of the order. The Staff Hearing Officer allowed the claim for acute internal derangement of the right knee and sprain of the right knee, relying on the treating physician. Temporary total disability compensation was awarded for a closed period, April 6, 2000 through August 6, 2000. The injured worker testified that he planned to return to light duty work on August 7, 2000. Otherwise, temporary total disability compensation was to continue upon receipt of an update from the treating physician. The employer paid the closed period of compensation on August 11, 2000. The employer appealed the Staff Hearing Officer's order and, on August 24, 2000, the Industrial Commission denied their appeal. The employer subsequently appealed the issue into the Cuyahoga County Common Pleas Court. This matter was still pending as of the date of the hearing before the Board.

On January 31, 2001 the injured worker's representative submitted Dr. (name redacted)'s medical bills to the employer for payment. As the employer indicated at the hearing, prior treatment requests had been denied due solely to the contested status of the claim. On February 2, 2001 the employer's representative again declined payment indicating that the matter was on appeal to the Cuyahoga County Court of Common Pleas and that no payment was due until after the final adjudication of the matter. On February 8, 2001 the injured worker's representative filed a complaint alleging the employer wrongfully denied payment of medical bills in an allowed claim.

The Self-Insured Department notified the employer that a complaint had been filed and requested the employer provide a written response to the allegations. The employer's position was that medical treatments were requested on C-9 forms prior to the allowance of the claim and that the treatment was clearly in dispute. The employer stated that most of the treatment and the surgery were provided after the District Hearing Officer's denial of the claim and before the Staff Hearing Officer allowed the claim. The employer further contended that the Industrial Commission speaks through its orders and that an order to pay medical bills was never issued. The employer was of the opinion that since the Staff Hearing Officer's order granted the allowance "to the extent of this order" and nothing was written in the order regarding payment of the medical bills, there was no legal requirement to pay the medical bills.

On March 29, 2001 the Self-Insured Department found the complaint to be a valid unresolved violation of R.C. 4123.511(I) and Ohio Adm. Code 4123-19-03(L)(5). The employer was given 14 days to pay the medical bills and provide evidence of payment to the Self-Insured Department. The employer did not pay the medical bills. Instead, they asked that this matter be reconsidered and dismissed or referred to the Self-Insuring Employers Evaluation Board for a hearing.



It was the injured worker's position that the Staff Hearing Officer's allowance of the claim required the employer to pay the medial bills for services rendered in treatment of the allowed conditions. The injured worker further asserted that the employer has never contested the validity of the medical bills, indicating that all the employer did was to respond that they were fighting this claim. The employer stated at the hearing that the medical bills had not even been reviewed to determine the propriety of the treatment. No objection or motion was ever filed regarding the medical bills. In the injured worker's opinion, it is tortured reading of Ohio's workers' compensation law to say that an injured worker must suffer the indignities of having to be deluged with calls about collection and bills when they have an allowed claim.

After a review of the evidence submitted and testimony elicited at the hearing, the Board finds that the issue before them is whether or not the employer's refusal to pay or adjudicate medical bills rendered in treatment of the conditions allowed by the Staff Hearing Officer is a violation of R.C. 4123.511(I), which states:

- (I) No medical benefits payable under this chapter. . . . of the Revised Code are payable until the earlier of the following:
 - (1) the date of the issuance of staff hearing officer's order under division (D) of this section. (Emphasis added).

In this instance, the Staff Hearing Officer allowed the injured worker's claim. After the decision of the Staff Hearing Officer, the employer had a statutory duty to determine whether the medical bills were for reasonable and necessary treatment related to the allowed conditions in the claim and, if so, proceed with payment. The failure to properly adjudicate and pay the medical bills under these circumstances is clearly in violation of R.C. 4123.511(I)(1) and Ohio Adm. Code 4123-19-03(L)(5). The Board finds that the validity of the complaint must be upheld.

At the hearing, the employer presented numerous arguments in support of its position. The employer first asserted that the Staff Hearing Officer order allowing the claim did not order the payment of medical bills though the C-9 request for treatment authorization put the matter in issue prior to the hearing. The Board finds no merit in this argument. The medical bills in question had not yet been submitted to the employer for initial adjudication prior to the Staff Hearing Officer hearing allowing this claim. There was no substantive treatment issue before the Staff Hearing Officer. Pursuant to R.C. 4123.511(I), once the claim was allowed by a Staff Hearing Officer, the employer had a duty to determine whether any and all medical bills were for reasonable and necessary medical treatment for the allowed conditions in the claim. The Board rejects the notion that a self-insuring employer is free to ignore the statute and deny payment simply because a claim has been appealed to court. The employer's argument that it can ignore this duty until payment is expressly ordered by the Industrial Commission is equally untenable. Otherwise, a Commission hearing would be necessary for every medical bill submitted to a self-insuring employer.

The employer also argues that R.C. 126.30 and Ohio Adm. Code 4123-7-31 excuse payment of medical bills until there is a final adjudication. The Board rejects this argument. R.C. 126.30 establishes due dates for obligations of the state insurance fund and provides for interest to be



paid on past due obligations by the Bureau of Workers' Compensation. The statute does not supercede R.C. 4123.511(I), expressly or otherwise, nor does it apply to the obligations of self-insuring employers. Ohio Adm. Code 4123-7-31 contains terms similar to those in the statute and does apply to self-insuring employers. This rule specifically states that it does not supercede any faster timetable in any section of the Revised Code. Therefore, R.C. 4123.511(I) is clearly applicable under the circumstances.

The employer's last argument was that the "Workers' Compensation Guide for Self-Insuring Employers and their Employees," published by the Bureau of Workers' Compensation instructs that "[m]edical payments are not made until the appeals process is complete." While regrettably inaccurate, this "Guide" does not have the force of law and does not change the employer's statutory obligation. Accordingly, the Board rejects this contention.

The Board finds that the employer abused their administrative discretion by failing to comply with a Staff Hearing Officer's order and adjudicate the medical bills submitted by the injured worker. The Board finds that the complaint against the employer in accordance with R.C. 4123.511(I)(1) and Ohio Adm. Code 4123-19-09(L)(5) is valid and a copy of this finding will be placed in the employer's risk file for review at the time of renewal. The Board further finds that the matter is unresolved and that within 30 days of receipt of this order the employer must appropriately adjudicate the medical bills in question and provide to the Board proof of the action taken. Failure to comply with the Board's recommendation may, without further hearing, result in the assessment of a civil penalty against the employer in an amount up to \$10,000, as provided by law.



This matter came before the Board for a formal hearing on July 24, 2003. Complaint No. 12395, filed by the injured worker on August 5, 2002, alleges that the employer improperly refused to pay temporary total disability, failed to pay medical bills timely, and did not assist the injured worker with the claim. After due consideration of the evidence and arguments of counsel, the Board makes the following findings and recommendations.

The injured worker sustained a low back injury on January 8, 1991. On February 4, 2002 a District Hearing Officer additionally allowed the claim for C6-7 cervical degenerative disc disease and depressive disorder. This order was affirmed by a Staff Hearing Officer on March 26, 2002.

On February 14, 2002, the injured worker submitted to the employer C-84's certifying disability based on the newly allowed conditions. On March 6, 2002, the employer objected to the request for temporary total disability. A second request for temporary total disability was submitted on April 4, 2002 and the employer again objected.

On May 6, 2002, the employer filed a C-86 motion with the Industrial Commission requesting a determination that the injured worker had reached maximum medical improvement even though no hearing had been held on the prior requests for temporary total disability. The employer's correspondence accompanying the C-86 requested that the C-86 be heard with the prior objections to temporary total disability.

On July 20, 2002, the employer's C-86 was denied by a District Hearing Officer. The issue raised by the C-86 was the only issue listed on the hearing notice and the District Hearing Officer order. The request for temporary total disability was not listed nor was any waiver of notice set forth in the order. Additionally, the District Hearing Officer did not expressly order the payment of temporary total disability. On August 21, 2002, a Staff Hearing Officer modified the District Hearing Officer order and attempted to state jurisdictional grounds for the temporary total disability issue but still did not expressly order payment. Thereafter, the employer reinstated temporary total disability on September 5, 2002, within twenty-one days of the Staff Hearing Officer order.

The majority of the Board finds the injured worker's complaint to be invalid insofar as the payment of temporary total disability is concerned. The employer was never expressly ordered by the Industrial Commission to pay temporary total disability prior to September 5, 2002. While the Board agrees that all of the elements for the payment of temporary total disability were set forth in the July 20, 2002 District Hearing Officer order, proper notice was not given on the issue of temporary total disability. Absent an express waiver of notice of the temporary total disability issue in the order, there could be no valid order requiring payment of compensation within twenty-one days.



Self-Insuring Employers Evaluation Board

Synopsis of Formal Decisions

Medical Bills
Complaint No. 12395
Continued

That portion of the injured worker's complaint that the employer failed to timely pay or timely respond to requests for the payment of medical bills is also found invalid. There has been no adjudication of any request for treatment or for the payment of medical bills before the Industrial Commission. It is not within the province of the Board to make final determinations on claims disputes. Inasmuch as the employer apparently denied the requests for payment, any determination that a bill is due and owing must be determined by the Commission.

The final issue raised by the injured worker's complaint is whether the employer has properly responded to the submission of medical bills or assisted the injured worker. A review of the numerous responses to medical bills by the employer in this file reveals several serious problems. A response for bills for psychological services rendered from January 24, 2002 through February 7, 2002 generated on March 25, 2002 indicates that the reason for nonpayment is that further review is required by the Industrial Commission. The employer did not notify the injured worker of the right to appeal the decision nor did it disclose any substantive reason for denying payment. Such a response totally ignores an employer's duty to effectively administer its claims. Even more alarming is that the response clearly indicates that no copy was provided to the injured worker or her representative as required by Ohio Admin. Code 4123-19-03(K)(5). Furthermore, the file is replete with responses to medical bills where notice was not provided to the injured worker. None of the responses indicate that the injured worker may appeal to the Industrial Commission even if she were provided with a copy. Finally, on most of the responses, a date of service is not listed so it is not possible in every instance to identify the bill being considered.

For the foregoing reasons, the Board finds that the complaint is valid as it relates to the employer improperly responding to the request for payment of medical bills and failure to notify, let alone assist the injured worker in filing for payment of benefits and compensation. The Board is extremely concerned about this lack of adherence to such fundamental requirements.

The Board finds the complaint to be valid as stated above. The Board further recommends that an audit be performed to assess the employer's capability of effectively administering its workers' compensation claims. A copy of this order shall be placed in the employer's Self-Insured Department file.



This matter came before the Board for formal hearing on Complaint No. 12865 brought by (name redacted), D.C. through the Bureau of Workers' Compensation Legislative Information Department. Upon consideration of the evidence and arguments, the Board makes the following findings and recommendations:

This complaint involves the allegation of Dr. (name redacted) that the employer failed to timely pay treatment bills. The issue of the subject treatment was previously before the Industrial Commission as a result of a motion filed by the injured worker. The relevant Industrial Commission order at issue before the Board is the order of the Staff Hearing Officer from the hearing of November 13, 2002, received by the employer on November 19, 2002. The order states in pertinent part "payment for therapy rendered by Dr (name redacted) to date is to be paid by the self-insured employer." On the date of the Staff Hearing Officer hearing, the employer had not received any treatment bills or office notes from Dr. (name redacted). The initial motion involved a request for twenty treatments by Dr. (name redacted). On November 14, 2002, the employer received invoices for treatment by Dr. (name redacted) for dates prior to the Staff Hearing Officer hearing. The employer responded to these treatment bills with a request for office notes from Dr. (name redacted). After a long delay, Dr. (name redacted) provided the office notes and/or chart on or about February 14, 2003 and the bills in question were paid on February 21, 2003.

Ohio Admin. Code Section 4123-19-03(K)(5) requires that an employer pay medical bills within thirty (30) days of an order of the Commission to do so. In a case where there is no order from the Commission, the Board recognizes that an employer may deny payment pending receipt of supporting documentation. A problem arises however where, as here, an order to pay is issued by the Commission without proper supporting documentation. While such a circumstance is regrettable, the law is clear that payment within thirty days is the only remaining option available to the employer upon receipt of the order.

The foregoing determination does not leave the employer without remedies. The medical records are subject to discovery while the issue was still pending before the Commission. Furthermore, subsequent receipt of the records may present grounds to invoke the Commission's continuing jurisdiction should the corresponding treatment bills be proven erroneous in some detail. In any case, however, timely payment cannot be withheld based on an employer's assertion of an error in the underlying Commission order. The Board therefore finds that the employer was required to pay Dr. (name redacted)'s bills for dates of service prior to the hearing within thirty days of receipt of the November 13, 2002 Staff Hearing Officer order. The majority of the Board finds the complaint to be valid. The Board notes that the matter is resolved and a copy of this order will be placed in the employer's file.

DISSENTING OPINION: I respectfully dissent from the majority opinion of the Board. There is no evidence before the Board that any provider bills were in the file on the date of the Staff Hearing Officer hearing. Furthermore, the Staff Hearing Officer order does not specifically identify the dates of treatment to be paid or cite any evidence to support the order. As a result, I disagree with the majority's position that the employer was required to pay any treatment bills submitted by Dr. (name redacted) without supporting documentation.



This matter came before the Board on April 14, 2004, for an informal conference regarding Complaint No. 13228. After careful consideration of the evidence and the statements of the parties, the Board makes the following findings and recommendations:

On April 8, 2002, the injured worker sustained a work injury and received related medical treatment on April 12, 2002. Originally, the bill in the amount of \$93.00 for treatment rendered by Dr. (name redacted) of Medical Associates of Mid-Ohio was submitted to the injured worker's private insurance. Over a year later, on June 25, 2003, a copy of a subsequent statement and bill for the treatment was submitted to the employer for payment under the injured worker's claim. Neither the statement nor the bill contained a claim number and no accompanying office record was provided. The employer informed the injured worker's representative of the procedure for which a medical bill must be submitted in order to be processed and paid under the claim. Soon thereafter, on July 2, 2003, this self-insured complaint was filed.

The Board does not find the injured worker's complaint valid. The bill submitted did not contain the necessary information for processing by the employer's third-party administrator and instructions were conveyed to the injured worker's representative as to the steps needed to be taken. Even if a proper bill had been submitted, the complaint was filed prior to the expiration of the thirty day period in which the employer would be required to act. While a self-insuring employer must give timely written notice to the injured worker and the Bureau or make timely payment on proper bills submitted with the necessary information, no such circumstance was present in this instance.

By vote of two-to-zero, with one Board member abstaining, the Board finds the complaint to be invalid.



An informal conference was held on June 30, 2004, concerning Complaint No. 12283. The injured worker filed the complaint alleging that the employer had failed to timely approve or deny requests for treatment, failed to send her notice of approval or denial of treatment, and approval of her request to change physicians, failed to timely pay medical bills, and failed to assist her with her workers' compensation claim. After due consideration of the evidence presented, the Board makes the following findings and recommendations:

The injured worker asserts that the employer failed to timely respond to requests for treatment, and failed to timely pay bills submitted by medical providers. However, the bills and requests referred to by the injured worker are not properly before the Board. They were the subject of another self-insured complaint, which was found to be invalid. Further, there has been no evidence presented by the injured worker that the employer has failed to comply with Ohio Adm.Code 4123-19-03(K)(5), which provides the timeline for self-insuring employer approval or denial of treatment, approval of requests for change of physician, and payment of bills. The injured worker in this case appears to dispute the employer's decisions to deny requested treatment and/or payment of certain bills. However, such a dispute should be addressed by the Industrial Commission in the hearing process. The Board lacks jurisdiction to adjudicate such disputes.

The injured worker also contends that, contrary to her requests, the employer failed for a time to send its decisions regarding authorization of treatment and change of physician directly to the injured worker. Ohio Adm.Code 4123-19-03(K)(5) requires a self-insuring employer to approve or deny requested treatment within ten days of receipt of the request, and to approve a request for change of physician within seven days of receipt. The rule does not require that notification of the employer's decisions on these issues be sent directly to the injured worker, even if the injured worker requests such notification. Rather, notice to the injured worker's legal representative is sufficient, since the representative is obligated to notify the injured worker regarding the decision. There is no dispute that the employer's decisions regarding authorization of treatment and change of physician in this case were timely sent to the injured worker's attorney. Therefore, the self-insuring employer complied with Ohio Adm.Code 4123-19-03(K)(5).

Finally, the injured worker asserts that the employer failed to give her a claim number after she reported her industrial injury to the employer, and therefore failed to assist her in her worker's compensation claim. Since self-insuring employers do not assign claim numbers to workers' compensation claims, this assertion is not itself insufficient to give rise to a valid self-insured complaint. Further, the injured worker has presented no evidence to the Board that would otherwise lead the Board to conclude that the employer failed to assist the injured worker with her claim.

For the above stated reasons, the Board finds the self-insured complaint invalid.

Chapter 8

Medical Reports



Self-Insuring Employers Evaluation Board



Self-Insuring Employers Evaluation Board
Synopsis of Formal Decisions

Medical Reports
Complaint No. 11325
February 20, 2002

A formal hearing took place before the members of the Self-Insuring Employers Evaluation Board on January 10, 2002. The issue before the Board was self-insured complaint number 11325, whether the self-insuring employer violated Ohio Admin. Code 4123-3-09(C)(5)(a), in refusing to provide the results of a vocational assessment examination to the injured worker.

The Board makes the following findings of fact: The injured worker filed an application for permanent and total disability and the employer scheduled the injured worker for a vocational assessment examination to determine whether the injured worker was capable of engaging in any sustained remunerative employment. The injured worker completed a portion of the examination on April 3, 2001 but did not complete the entire examination due to an unrelated medical condition that arose during the examination. A final report was not prepared and when the self-insuring employer failed to provide the office notes from this partially completed vocational assessment, the injured worker filed a self-insured complaint. On August 20, 2001, the Bureau of Workers' Compensation Self-Insured Department dismissed the complaint.

Upon a reconsideration request by the injured worker's counsel, on October 12, 2001 the Bureau of Workers' Compensation Legal Operations Department reversed the finding of the Self-Insured Department and found a violation of Ohio Admin. Code 4123-3-09(C)(5)(a), reasoning that an employer who schedules a vocational assessment in a means similar to a medical examination under Ohio Admin. Code 4123-3-09 must submit a report of the vocational finding. The employer then appealed the finding of the Bureau of Workers' Compensation Legal Operations Department to the Self-Insuring Employers Evaluation Board.

After a formal record hearing on this matter and a review of the position statements and other documentation submitted by both parties, the Board finds this complaint to be invalid and overturns the finding of the Bureau of Workers' Compensation Legal Operations Department. The Board determines that Ohio Admin. Code 4123-3-09(C)(5)(a) applies only to medical examinations conducted by medical doctors and that a vocational assessment report is not included in Ohio Admin. Code 4123-3-09. Accordingly, it is the finding of the Board that self-insured complaint number 11325 should be determined to be invalid and should be dismissed.



Self-Insuring Employers Evaluation Board

Synopsis of Formal Decisions

Medical Reports
Complaint No. 13308
April 14, 2004

This matter came before the Board on November 19, 2003 for formal hearing on Complaint No. 13308 brought by the injured worker. Upon consideration of the evidence and arguments, the Board makes the following findings and recommendations:

The complaint alleges that the employer failed to timely provide the injured worker with the medical report of Dr. (name redacted), which was prepared as a result of an independent medical examination on July 3, 2002. The employer received the report on July 22, 2002 but because of a change in personnel at the employer's third party administrator, the report was not immediately forwarded to the injured worker or her representative. There is no evidence that the injured worker ever requested a copy of the report before it was ultimately provided. The injured worker's representative did receive the report on or about April 9, 2003, and the Industrial Commission hearing on the issue to which the report concerned was held on May 27, 2003.

The Board first notes that an employer is required by law to provide the report of an independent medical examiner to the injured worker. However, no provision in the Revised Code or the Administrative Code prescribes a specific time within which a report must be provided. In the setting of a self-insured complaint, which may involve a penalty for serious violations of the law, the Board feels a strict construction of the law and a clear violation must be present in order to find a valid complaint. Such has not occurred in this instance, and the Board does not find the complaint to be valid.

The Board wishes to emphasize that a self-insuring employer has a duty to effectively administer its workers' compensation claims and this would include providing an injured worker with timely information and reports. The Board takes a dim view of the excuse that an administrator inadvertently forgot. Inadvertence does not equate to effective administration and the Board would encourage the employer to take every necessary step to avoid any such delays in the future.

Chapter 9

Medical Treatment



Self-Insuring Employers Evaluation Board



This matter came before the Board on April 10, 2003 for formal hearing on Complaint No. 11553 and Complaint No. 11867 filed by the injured worker against the self-insuring employer. After further consideration of the evidence and arguments presented, the Board makes the following findings and recommendations:

Complaint No. 11553 involves whether a self-insuring employer may elect not to affirmatively respond to a treatment request within the ten (10) day period required by Ohio Adm. Code Sec. 4123-19-03(K)(5). The employer does not dispute that it failed to respond within ten (10) days to the C-9 request from Dr. (name redacted) dated June 4, 2001. The employer simply asserts that because the rule provides for the approval of treatment, if there is a failure to respond, the failure to respond is an authorized method of approval.

The Board rejects this argument for two reasons. First, Ohio Adm. Code Sec. 4123-19-03(K)(5) clearly states that “[t]he employer shall approve or deny a written request for treatment within ten days of the receipt of the request.” The rule does not provide an option to remain “silent.” To hold otherwise would require an investigation by the injured worker or his physician on every treatment request to determine whether there was a “silent” approval. Such a result is unacceptable.

The majority of the Board finds Complaint No. 11553 is valid. A copy of this finding shall be placed in the employer’s file.

DISSENTING OPINION:

I respectfully dissent from the majority decision in Complaint No. 11553. The C-9 form provided for use by the Bureau of Workers’ Compensation (BWC) specifically states that the form shall be faxed or mailed to the treating physician within ten (10) days of receipt or the authorization for treatment shall be deemed granted. The operative word is “or.” At the very least, the BWC’s own form implies that either action is sufficient for approval of treatment. For this reason I cannot join in finding this complaint against the employer to be valid.

Complaint No. 11867 also involves essentially undisputed facts. The employer received a C-9 request for treatment from Dr. (name redacted) dated August 29, 2001 requesting authorization for treatments that had been performed from May 2 through August 27, 2001. The employer approved this treatment. The employer returned the approved C-9 to Dr. (name redacted) along with a letter requesting the office records for this treatment. Dr. (name redacted) did not provide these records.

On November 2, 2001, Dr. (name redacted) submitted another C-9 requesting authorization for treatment from August 30, 2001 through November 30, 2001. The employer again approved the C-9 request. On November 19, 2001, the employer received Dr. (name redacted)’s bill for dates of service from August 30, 2001 through October 24, 2001. On November 29, 2001, the employer requested a summary/status report from Dr. (name redacted) concerning her treatment of the injured worker. On January 3, 2002, the employer received a bill with a letter from Dr. (name redacted) concerning treatments on October 30, November 1, and November 20, 2001. All



Dr. (name redacted)'s bills were paid on January 29, 2001, more than thirty days after the initial receipt.

The employer's position is that the Bureau of Workers' Compensation (BWC) Provider Billing and Reimbursement Manual permits the employer to request medical documentation in support of fee bills and extends the time for payment to thirty days after the document is received. The employer also cites to Ohio Adm. Code Secs. 4123-7-08(E) and 4123-6-20(C)(4) as permitting request of medical documentation for determining the appropriateness of bill payment.

The Deputy Administrator found the complaint to be valid because the BWC takes the position that the provision in the Provider Billing and Reimbursement Manual referenced by the employer does not apply to bills for which treatment has been preauthorized such as here.

The Board agrees with the BWC. Though the Provider Billing and Reimbursement Manual is not abundantly clear on this issue, it only permits a thirty-day extension where the medical documentation is requested to determine reimbursement eligibility. In this case, the reimbursement eligibility of bills in question was determined when the C-9 was approved. Thus, while any further request for medical documentation was permitted by the Administrative Code, such a request would not effect the requirement for payment of approved medical bills within thirty days. The Board therefore, finds that the employer's failure to pay Dr. (name redacted)'s bills for preauthorized treatment within thirty days of receipt was contrary to Ohio Admin. Code Sec. 4123-19-03(K)(5).

The majority of the Board finds Complaint No. 11867 valid. A copy of this finding shall be placed in the employer's file.



An informal conference was held on June 30, 2004, concerning Complaint No. 12283. The injured worker filed the complaint alleging that the employer had failed to timely approve or deny requests for treatment, failed to send her notice of approval or denial of treatment, and approval of her request to change physicians, failed to timely pay medical bills, and failed to assist her with her workers' compensation claim. After due consideration of the evidence presented, the Board makes the following findings and recommendations:

The injured worker asserts that the employer failed to timely respond to requests for treatment, and failed to timely pay bills submitted by medical providers. However, the bills and requests referred to by the injured worker are not properly before the Board. They were the subject of another self-insured complaint, which was found to be invalid. Further, there has been no evidence presented by the injured worker that the employer has failed to comply with Ohio Adm.Code 4123-19-03(K)(5), which provides the timeline for self-insuring employer approval or denial of treatment, approval of requests for change of physician, and payment of bills. The injured worker in this case appears to dispute the employer's decisions to deny requested treatment and/or payment of certain bills. However, such a dispute should be addressed by the Industrial Commission in the hearing process. The Board lacks jurisdiction to adjudicate such disputes.

The injured worker also contends that, contrary to her requests, the employer failed for a time to send its decisions regarding authorization of treatment and change of physician directly to the injured worker. Ohio Adm.Code 4123-19-03(K)(5) requires a self-insuring employer to approve or deny requested treatment within ten days of receipt of the request, and to approve a request for change of physician within seven days of receipt. The rule does not require that notification of the employer's decisions on these issues be sent directly to the injured worker, even if the injured worker requests such notification. Rather, notice to the injured worker's legal representative is sufficient, since the representative is obligated to notify the injured worker regarding the decision. There is no dispute that the employer's decisions regarding authorization of treatment and change of physician in this case were timely sent to the injured worker's attorney. Therefore, the self-insuring employer complied with Ohio Adm.Code 4123-19-03(K)(5).

Finally, the injured worker asserts that the employer failed to give her a claim number after she reported her industrial injury to the employer, and therefore failed to assist her in her worker's compensation claim. Since self-insuring employers do not assign claim numbers to workers' compensation claims, this assertion is not itself insufficient to give rise to a valid self-insured complaint. Further, the injured worker has presented no evidence to the Board that would otherwise lead the Board to conclude that the employer failed to assist the injured worker with her claim.

For the above stated reasons, the Board finds the self-insured complaint invalid.



This matter came before the Board on November 17, 2004, for formal hearing on Complaint No. 13395, filed by the injured worker. The complaint alleges that the employer improperly denied authorization of future prescription medications. After careful consideration of the evidence, the Board makes the following findings and recommendations.

On August 12, 2003, the employer mailed the injured worker a letter stating in pertinent part that, based on a file review conducted on behalf of the employer by (name redacted), the employer would no longer authorize prescription medications that had previously been paid by the employer.

On September 13, 2003, the injured worker filed a self-insured complaint alleging that the “employer terminated my medicine based on letter from a doctor it chose. No hearing. No referral to the BWC for a hearing. No weaning off period provided.” The injured worker sought a hearing with the Industrial Commission, which eventually authorized the continuation of all but one of the medications.

The injured worker argues that the employer’s unilateral denial of authorization of future medication was unfair to the injured worker. However, the injured worker was unable to identify a statute, rule or order of the Bureau of Workers’ Compensation that was violated by the employer in denying authorization of future medications. The injured worker’s primary argument at hearing was that the employer’s actions violate the injured worker’s due process rights. However, the Board lacks jurisdiction to address alleged constitutional violations.

The injured worker also argued that Ohio Adm.Code 4123-19-03(K)(5) should be read to require an employer to advise the injured worker of her right to a hearing before terminating authorization of future medications. However, that rule, by its terms, only addresses an employer’s decision to contest a bill received by the employer. It does not address withdrawal of authorization for future medication.

The Board can identify no statute, rule or order of the Bureau of Workers’ Compensation that prohibits a self-insuring employer from denying authorization of future prescription medication based upon the opinion of a medical expert. The injured worker’s remedy when the employer takes such action is to request a hearing before the Industrial Commission, which the injured worker did in this case. For this reason, the Board finds the self-insured complaint to be invalid.

For the foregoing reasons, by majority vote, Complaint No. 13395 is found to be invalid.

A copy of this order shall be placed in the Self-Insured Department’s file.

Chapter 10

Notice of Complaint



Self-Insuring Employers Evaluation Board



Self-Insuring Employers Evaluation Board
Synopsis of Formal Decisions

Notice of Complaint
Complaint No. 12589
June 26, 2003

This matter came before the Board on April 10, 2002 for formal hearing on Complaint No. 12589. Upon consideration of the evidence and arguments presented, the Board makes the following findings and recommendations:

As a preliminary matter, the employer objected to going forward with this hearing because the matter had not previously been heard by the Deputy Administrator. In support of this request, the employer asserted that the original notice of complaint had not been mailed to the correct third party administrator. As a result, the complaint had not been responded to timely and the matter was deemed unresolved. The unresolved complaint was then referred to the Board for hearing. The employer notes that when the appropriate employer's representative received notice of the complaint, a response was prepared and forwarded to the Self-Insured Department. This response had not been considered by the Self-Insured Department or the Deputy Administrator prior to the Board's hearing.

The Board took the employer's request under advisement and the hearing went forward.

After the hearing, it was evident that the notice of the complaint was mailed to the employer's Springfield, Ohio location, which is now closed. The required notices were never mailed to the employer's workers' compensation administrator. The majority of the Board finds that the failure to mail the original notice to the proper company designee renders the entire process to this date defective. This matter is therefore referred back to the Self-Insured Department for reconsideration after notice of the complaint has been mailed to:

(Name and Address Redacted)

The Board notes that the employer has made payment of living maintenance benefits to the injured worker pending a further determination and the impact of any delay therefore is minimized.

This matter is referred to the Self-Insured Department for further action consistent herewith.

Chapter 11

Overpayment



Self-Insuring Employers Evaluation Board



This matter came before the Board on October 14, 2004 for formal hearing on Complaint No. 13360, filed by the injured worker, (name redacted). After careful consideration of the evidence, the Board makes the following findings and recommendations.

Following an internal audit of the injured worker's workers' compensation claim, the self-insuring employer, (name redacted), determined that temporary total disability compensation had been paid in the claim at an incorrect rate for a portion of a closed period paid between March 14, 2001 and August 17, 2003. The employer determined that, due to this error, \$2,169.30 was overpaid to the injured worker.

On August 29, 2003, the employer's third-party administrator sent the injured worker a letter stating, "according to our payment records, Workers Compensation benefits were paid to you from 3/14/01 to 8/17/03. This means you were overpaid Workers Compensation benefits in the amount of \$2169.30." A breakdown of the payments and overpayments was also apparently sent to the injured worker with this letter. The letter directed the injured worker to complete an enclosed payroll deduction form immediately, or pay the full amount by check or money order within thirty days. However, shortly thereafter, the employer collected the entire amount of the overpayment from a payment of temporary total disability compensation due the injured worker.

On September 8, 2003, the injured worker filed the present self-insured complaint alleging that the employer improperly collected the overpayment at a rate of 100% from a future compensation award.

It appears undisputed that the \$2,169.30 overpayment resulted from a clerical error made by the self-insuring employer in paying temporary total disability compensation at the full weekly rate, as opposed to the average weekly rate for a certain time period. The injured worker acknowledges as much in her self-insured complaint. Because authority exists for collection of payments made on the basis of a clerical error from future compensation awards, see, State ex rel. Delong v. Indus. Comm. (1988), 40 Ohio St.3d 345 the Board does not find the self-insured employer's collection of the overpayment in this case to be unlawful.

However, the Board finds that the employer did act unlawfully by directing the injured worker in its August 29, 2003 letter to repay the overpayment personally. The Board further finds that in collecting the overpayment from the injured worker, the employer failed to comply with Ohio Adm.Code 4123-19-03(I)(2)-(3), by failing to assist and provide information to the injured worker regarding her claim and benefits.

There is no legal authority for the proposition that a self-insuring employer may recoup an overpayment of workers' compensation benefits directly from an injured worker, rather than from future compensation awards, or from the self-insured guaranty fund. See, R.C. 4123.511(J); R.C. 4123.512(H); Delong, supra. See also State ex rel. Weimer v. Indus. Comm. (1980), 62 Ohio St.2d 159. Therefore, the employer's August 29, 2003 letter directing the injured worker to repay the overpaid compensation personally was unlawful, even if the overpayment was not ultimately recouped directly from the injured worker.



The employer also violated Ohio Administrative Code 4123-19-03(I)(2)-(3) in several ways. First, the employer collected the overpayment from a future compensation award without first informing the injured worker of its intention to do so. Second, the employer failed to clearly inform the injured worker as to how the employer arrived at the overpayment. Finally, the employer failed to inform the injured worker that she had the right to contest the overpayment by requesting a hearing before the Industrial Commission. For these reasons, the Board finds a failure on the part of the employer to provide necessary information and assistance to the injured worker regarding her claim and benefits.

The employer has argued that the form of the letter used by the employer to notify the injured worker of the overpayment was approved by Bureau of Workers' Compensation auditors during an unrelated audit in October, 2002. There is no written evidence of this approval. Further, the fact that auditors from the Bureau of Workers Compensation may have verbally approved the form of the letter does not excuse the employer from complying with its independent obligation to act lawfully pursuant to the rules governing self-insuring employers. Therefore, the Board rejects this argument.

The majority of the Board finds Complaint No. 13360 to be valid. A copy of this order shall be placed in the Self-Insured Department's file.

DISSENTING OPINION:

I respectfully submit my dissenting opinion and find that the self-insuring employer was following the direction of the Self-Insured Department auditors when it sent its August 29, 2003 letter to the injured worker.



This matter came before the Board for formal hearing on June 30, 2004, on Complaint No. 13529, alleging that the self-insuring employer improperly sought to recoup an overpayment of temporary total disability compensation from the injured worker directly, and failed to provide information requested by the injured worker regarding the overpayment. The Board makes the following findings and conclusions:

On May 9, 2003, the injured worker sustained an injury, which was eventually certified by the employer on July 25, 2003. The injured worker was off work from May 15, 2003 through June 3, 2003, at which time she returned to work. On August 15, 2003, the employer paid temporary total disability compensation for the time period beginning May 15, 2003, and ending July 6, 2003. The total paid to the injured worker was \$4,876.00.

On September 2, 2003, the employer sent the injured worker a letter advising her that workers' compensation benefits were overpaid in her claim in the amount of \$3,036.00. This apparently represented the time period from June 3, 2003 through July 6, 2003, although the letter did not provide this information to the injured worker, or otherwise explain the basis of the overpayment. The employer advised the injured worker in the letter to complete a payroll deduction form for repayment of the compensation or, in the alternative, to pay the entire amount by personal check or money order within thirty days. The letter did not advise the injured worker of her right to dispute the overpayment, or to have the overpayment collected from future awards of compensation in lieu of direct repayment.

On September 17, 2003, the injured worker, through her legal counsel, requested documentation from the employer regarding the overpayment. When this information was not provided, the injured worker filed this self-insured complaint on November 18, 2003. The complaint alleged that the employer's September 2, 2003, letter improperly sought repayment of the overpaid compensation. The complaint also cited the employer's failure to provide documentation relating to the overpayment.

With regard to the allegation that the employer failed to respond to the injured worker's request for documentation regarding the overpayment, the Board finds that the information sought by the injured worker was eventually provided. The injured worker has not contested the finding of the Deputy Administrator that the complaint is invalid in this regard. Therefore, the Board finds this portion of the complaint to be invalid.

With regard to the employer's attempt to recoup its overpayment from the injured worker, the employer argues that it was not bound by R.C. 4123.511(J) to recoup its overpayment from future awards pursuant to the repayment schedule contained in that statute. The employer argues that, because it overpaid temporary total disability compensation due to a clerical error, and its unilateral declaration of an overpayment was not the result of a reversal of a prior order to pay compensation, the employer was not restricted to recouping the overpaid compensation under R.C. 4123.511(J).



Although the employer has not presented any direct evidence that the overpayment of compensation on August 15, 2003, was the result of a clerical error, the Board concludes from the documentation provided by the employer that the payment of compensation through July 6, 2003, where the injured worker had returned to work on June 3, 2003, did in fact result from a clerical error. However, the conclusion that the overpayment resulted from a clerical error does not end the analysis.

Assuming that R.C. 4123.511(J) does not apply to the overpayment declared by the employer in this case, the question still remains as to whether the employer acted properly in attempting to recover the overpayment directly from the injured worker. The Board finds that the employer did not act properly or lawfully in this regard.

No right exists under Ohio law for a self-insuring employer to unilaterally recoup overpayments of workers' compensation benefits directly from their employees, via payroll deduction, personal check, or otherwise. In the absence of such a right, the employer acted unlawfully in this case by demanding such payment from the injured worker. See, e.g., State ex rel. Nestle USA Prepared Foods Div. v. Indus. Comm. (2003), 101 Ohio St.3d 386 (upholding Board decision of valid self-insured complaint on grounds that self-insured employer had no authority to unilaterally terminate temporary total disability compensation); see also, State ex rel. Weimer v. Indus. Comm. (1980), 62 Ohio St.2d 159 (recognizing the right to recoup overpayments caused by clerical error from future compensation awards).

Additionally, a self-insuring employer is required pursuant to Ohio Administrative Code 4123-19-03(I)(3) to provide information to injured workers regarding the processing of their claims and benefits. Because an overpayment declaration, and the collection of the overpayment, seeks to deprive an injured worker of benefits, the injured worker must be provided information necessary to protect her right to such benefits when notified of the overpayment. At a minimum, this includes an explanation of the basis of the overpayment. This also includes information regarding the right to dispute the overpayment, and regarding all of the employee's options regarding collection of the overpayment.

The employer's September 2, 2003 letter to the injured worker in this case fails entirely to advise the injured worker of the basis of the overpayment declared in that letter. Further, the letter fails to advise the injured worker of her right to dispute the overpayment. Finally, the letter did not inform the injured worker that she had the right to have the overpayment recouped from future compensation awards, as permitted by law. By failing to provide the injured worker with information necessary to enable her to make an informed decision regarding the overpayment declared by the employer in this case, the employer failed to fulfill its obligations under Ohio Administrative Code 4123-19-03(I)(3).

Although the employer has argued and presented testimony at hearing that the language used in its September 2, 2003, letter was based on a form that was approved by representatives of the Self-Insured Department of the Bureau of Workers' Compensation during a self-insured audit in



Self-Insuring Employers Evaluation Board
Synopsis of Formal Decisions

Overpayment
Complaint No. 13529
Continued

October, 2002, the employer has failed to provide documentation of this approval. Therefore, the Board does not find the testimony of the employer's representative in this regard to be persuasive.

Further, irrespective of whether Bureau of Workers' Compensation auditors verbally approved the statements contained in the September 2, 2003 letter, the method employed in that letter to collect the overpayment was not authorized by law. Self-insuring employers authorized by the Bureau of Workers' Compensation to administer their employees' claims under the workers' compensation laws of Ohio are required to be familiar with those laws. Approval of unlawful activity by Bureau of Workers' Compensation representatives, actual or perceived, does not make the activity lawful.

For all of the above reasons, the majority of the Board finds Complaint No. 13529 to be valid.

DISSENTING OPINION:

I respectfully submit my dissenting opinion and find that the self-insuring employer was following the direction of the Self-Insured Department auditors. They have provided a detailed explanation as to why R.C. 4123.511(J) does not apply to clerical errors made in self-insured claims.



This matter came before the Board on August 31, 2004, for formal hearing on Complaint No. 13731, filed by the injured worker, (name redacted). After careful consideration of the evidence, the Board makes the following findings and recommendations.

On February 10, 2004, the third-party administrator for the employer, (name redacted), sent the injured worker a letter informing the injured worker of a \$8,746.73 overpayment in his claim. In the letter, the employer informed the injured worker that this overpayment occurred because he was found to have reached maximum medical improvement effective February 26, 2003. The effective date of maximum medical improvement was apparently based on a report from the injured worker's treating physician dated May 20, 2003, indicating that the injured worker had reached maximum medical improvement on February 26, 2003.

In its February 10, 2004 letter, the employer directed the injured worker to complete an enclosed payroll deduction form immediately or pay the entire amount by personal check or money order within the next thirty days. On March 1, 2004, the injured worker filed a self-insured complaint against the employer, asserting that the employer improperly sought reimbursement of the overpayment.

The Board finds that the employer in its February 10, 2004 letter acted without legal authority in attempting to collect the alleged overpayment directly from the injured worker, and violated Ohio Administrative Code 4123-19-03(I)(2)-(3) by failing to assist and provide information to the injured worker regarding his claim and benefits.

The employer defends the self-insured complaint on grounds that the \$8,746.73 overpayment was founded upon a clerical error, and therefore is not governed by R.C. 4123.511(J), which would require collection of the overpayment pursuant to a payment schedule. However, the Board need not address whether R.C. 4123.511(J) applies to this case. The Board finds that, even assuming that R.C. 4123.511(J) does not apply here, the employer acted unlawfully in the manner in which it attempted to collect the overpayment from the injured worker.

The Board notes that the employer at hearing provided no documentation or other proof that the overpayment declared by the employer was actually the result of a clerical error, which would permit recoupment. See, e.g., State ex rel. Delong v. Indus. Comm. (1988), 40 Ohio St.3d 345. The fact that the overpayment resulted from a retroactive declaration of maximum medical improvement by the injured worker's treating physician does not in itself establish a recoupable overpayment. In fact, the Board notes that the Industrial Commission, by staff hearing officer order dated July 23, 2004, has found that the overpayment is not subject to recoupment pursuant to State ex rel. McGinnis v. Indus. Comm. (1991), 58 Ohio St.3d 81. Therefore, the employer arguably has not shown that it was entitled to collect the \$8,746.73 overpayment at all.

In any event, the Board finds that the employer's attempt to collect the overpayment directly from the injured worker is not supported by law. There is no legal authority for the proposition that an employer may recover an overpayment of workers' compensation benefits by demanding payment from the injured worker directly, rather than by collecting the overpayment from future compensation awards, or from the self-insured guaranty fund, if applicable. See, R.C.



4123.511(J); R.C. 4123.512(H); State ex rel. Weimer v. Indus. Comm. (1980), 62 Ohio St.2d 159, Delong, supra.

The Board also finds that the employer failed to comply with Ohio Administrative Code 4123-19-03(I)(2)-(3), which requires self-insuring employers to assist injured workers, and provide them with information about the benefits to which they may be entitled. Even assuming that the employer was entitled to seek reimbursement of the overpaid compensation, which has not been shown here, the February 10, 2004 letter to the injured worker failed to provide the injured worker with information necessary to enable him to determine his rights with regard to the alleged overpayment.

First, as explained above, the February 10, 2004 letter misinformed the injured worker as to the manner in which the overpayment could be collected. Second, the letter failed to advise the injured worker of the possibility of having the overpayment collected from future compensation awards. Finally, the letter failed to advise the injured worker that he had the right to object to the declared overpayment, and to have the matter adjudicated by the Industrial Commission. There is no evidence in the record that the employer has ever advised the injured worker in any way of his right to contest an overpayment.

The employer argues that the February 10, 2004 letter was based on a form approved by auditors of the Bureau of Workers' Compensation during a self-insured audit of certain unrelated claims in October, 2002. However, no written documentation of this approval appears to exist. The Board therefore finds the employer's argument in this regard to be unpersuasive. Further, even assuming that Bureau of Workers' Compensation auditors had verbally approved the form of the letter, the employer had an independent obligation to act in accordance with the law in seeking to collect the alleged overpayment. An employer's unlawful actions are not made lawful simply because they are approved by Bureau of Workers' Compensation auditors.

The majority of the Board finds Complaint No. 13731 to be valid. A copy of this order shall be placed in the Self-Insured Department's file.

DISSENTING OPINION:

I respectfully submit my dissenting opinion and find that the self-insuring employer was following the direction of the Self-Insured Department auditors when it sent its February 10, 2004 letter to the injured worker. The employer has provided a detailed explanation as to why R.C. 4123.511(J) does not apply to clerical errors made in self-insured claims.



This matter came before the Board on August 31, 2004, for formal hearing on Complaint No. 13736, filed by the injured worker, (name redacted). After careful consideration of the evidence, the Board makes the following findings and recommendations.

On February 13, 2004, the third-party administrator for the employer, (name redacted), sent the injured worker a letter informing the injured worker of a \$244.57 overpayment in her claim. The employer advised the injured worker that this overpayment resulted because the injured worker was found to have reached maximum medical improvement "effective 1/21/04." The employer in its letter directed the injured worker to complete the enclosed payroll deduction form immediately or pay the entire amount by personal check or money order within the next thirty days. On March 1, 2004, the injured worker filed a self-insured complaint against the employer, asserting that the employer improperly sought reimbursement of the overpayment.

The Board finds that the employer in its February 13, 2004 letter acted without legal authority in attempting to collect the declared overpayment directly from the injured worker, and violated Ohio Administrative Code 4123-19-03(I)(2)-(3) by failing to assist and provide information to the injured worker regarding her claim and benefits.

The employer has failed to provide a cognizable defense to the self-insured complaint. The employer has not provided any evidence showing that the overpayment was the result of a clerical error, which would permit recoupment. See, e.g., State ex rel. Delong v. Indus. Comm. (1988), 40 Ohio St.3d 345.

Further, the Board finds that the employer's attempt in its February 13, 2004 letter to collect the overpayment directly from the injured worker is not supported by law. There is no legal authority for an employer to recover an overpayment of workers' compensation benefits by demanding payment from the injured worker directly, rather than by collecting the overpayment from future compensation awards, or from the self-insured guaranty fund, if applicable. See, R.C. 4123.511(J); R.C. 4123.512(H); State ex rel. Weimer v. Indus. Comm. (1980), 62 Ohio St.2d 159, Delong, supra.

The Board also finds that the employer failed to comply with Ohio Administrative Code 4123-19-03(I)(2)-(3), which requires self-insuring employers to assist injured workers, and provide them with information about the benefits to which they may be entitled. Even assuming that the employer was entitled to seek reimbursement of overpaid compensation, which has not been shown here, the February 13, 2004 letter to the injured worker failed utterly to provide the injured worker with information necessary to enable her to determine her rights with regard to the alleged overpayment.

First, as explained above, the February 13, 2004 letter misinformed the injured worker as to the manner in which the overpayment could be collected. Second, the letter failed to advise the injured worker of her right to have the overpayment collected from future compensation awards. Finally, the letter failed to advise the injured worker that she had the right to object to the declared overpayment, and to have the matter adjudicated by the Industrial Commission. There



is no evidence in the record that the employer has ever advised the injured worker in any way of her right to contest an overpayment.

The employer argues that the February 13, 2004 letter was based on a form approved by auditors of the Bureau of Workers' Compensation during a self-insured audit of certain unrelated claims in October, 2002. However, no written documentation of this approval appears to exist. The Board therefore finds this argument to be unpersuasive. Further, even assuming that Bureau of Workers' Compensation auditors had verbally approved the form of the letter, the employer had an independent obligation to act in accordance with the law in seeking to collect the alleged overpayment. Approval by Bureau of Workers' Compensation auditors does not excuse acts that fail to comply with the law.

The majority of the Board finds Complaint No. 13736 to be valid. A copy of this order shall be placed in the Self-Insured Department's file.

DISSENTING OPINION:

I respectfully submit my dissenting opinion and find that the self-insuring employer was following the direction of the Self-Insured Department auditors when it sent its February 13, 2004 letter to the injured worker. The employer has provided a detailed explanation as to why R.C. 4123.511(J) does not apply to clerical errors made in self-insured claims.

Chapter 12

Permanent Partial Disability Compensation



Self-Insuring Employers Evaluation Board



This matter was referred for formal hearing on December 14, 2000 before the Self-Insuring Employers' Evaluation Board concerning complaint number 9415 regarding the employer's failure to pay compensation pursuant to the April 20, 2000 Staff Hearing Officer's order in the referenced claim. Upon consideration of evidence and arguments of counsel, the Board makes the following findings and recommendations pursuant to R.C. 4123.352:

On September 16, 1994, the injured worker filed a request for an award of permanent partial disability, claiming a fifty-four percent right eye vision loss. The request was heard by a District Hearing Officer (DHO) on November 28, 1995 and an order was issued granting the award for the fifty-four percent loss, as requested. The employer appealed the DHO order. However, the injured worker did not appeal. A Staff Hearing Officer (SHO) affirmed this order on February 7, 1996.

On June 13, 1996, the injured worker filed a motion for a loss of vision award, claiming a total loss of vision due to the loss of his natural lens. This motion was dismissed by a DHO because no proof was attached to the motion. The injured worker again filed a request for total loss of vision on September 16, 1996. The September 16, 1996 motion was denied by a DHO order dated December 27, 1996, on the grounds of *res judicata* based upon the prior award of fifty-four percent. This order was ultimately affirmed administratively on March 19, 1997.

The injured worker then filed a mandamus action contending that the Commission abused its discretion in refusing to exercise continuing jurisdiction over its prior permanent partial disability determination. The Franklin County Court of Appeals denied the injured worker's request for a writ of mandamus. The issue before the court was whether the injured worker's surgical removal of a cataract and insertion of an artificial lens should have been excluded from the determination of the injured worker's post-injury uncorrected vision for purposes of measuring the loss of vision. If the injured worker's uncorrected vision should have been measured prior to surgical replacement of the lens as is legally required for corneal transplants under State ex rel. Kroger v. Stover (1987), 31 Ohio St.3d 229, the injured worker may have been entitled to an award for total loss of vision. Both the magistrate and the court characterized the question as a legal issue. State ex rel. Banks v. Indus. Comm. (September 8, 1998, Tenth Appellate District, Case No. 97APD07-941). The court went on to hold that the injured worker waived this specific issue of law by not raising it before the Commission during the adjudication of his initial request for permanent partial disability and accordingly denied the writ.

Despite the court's ruling, the injured worker again filed a motion for total loss of vision on April 9, 1999. A DHO again found that the issue was precluded by the doctrine of *res judicata* and denied the request. On appeal, a SHO decided on April 20, 2000 that grounds existed for exercising continuing jurisdiction and granted the injured worker's request for total loss of vision. A request for reconsideration of this decision was first denied by the Industrial Commission and then subsequently granted. The Commission order of October 11, 2000, vacated the SHO order concluding that the SHO was without jurisdiction to grant the injured worker's request based on the Court of Appeals decision in State ex rel. Banks.



The Board finds, and the parties agree, that the employer did not pay the additional forty-six percent permanent partial disability award pursuant to the April 20, 2000 SHO order. The Board further finds that the sole issue before it is whether this failure of payment by the employer is a violation of law such that complaint number 9415 is valid.

The employer argues that it was not required to pay the compensation as ordered by the SHO on April 20, 2000 because the SHO was without jurisdiction to render the decision pursuant to State ex rel. Banks, supra. The employer contends that a Commission order rendered without subject matter jurisdiction is void and without legal effect. In support of this contention the employer cites State ex rel. Champion International Corp. v. Indus. Comm. (March 17, 1992), Tenth Appellate District, Case No. 91AP-472.

The Board is very concerned as to whether R.C. 4123.511(H) permits an employer to withhold payment of compensation based on the proposition that the Commission lacked jurisdiction to order the payment. The Board is also concerned that the employer has avoided making payment of compensation to which the injured worker was apparently entitled by virtue of a legal technicality. Furthermore, the employer is presented with other remedies if compensation is paid pursuant to R.C. 4123.511(H), and then subsequently reversed on appeal. As was recently decided in State ex rel. Sysco Food Services of Cleveland, Inc. v. Indus. Comm. (2000), 89 Ohio St.3d 612, the employer may seek reimbursement for such overpaid compensation from the surplus fund. The fact that other remedies are available to the employer is compelling in finding that there is no circumstance justifying the failure of a self-insuring employer to pay compensation timely pursuant to a Commission order as is required by R.C. 4123.511(H). The failure to make the required payment is not excused by the contention that the employer had a strong legal argument, meritorious or otherwise.

It is therefore the finding of the Board, by a two-to-one vote, that the injured worker has presented a valid complaint in this matter. Though this Board is without jurisdiction to order any payment of compensation, the Board directs that a copy of this finding be placed in the employer's records for review at the time of renewal.



A formal hearing took place before the members of the Self-Insuring Employers Evaluation Board on February 20, 2002, concerning self-insured complaint number 11400. The issue before the Board was whether the employer had a right of setoff against the injured workers' permanent partial disability award as a result of its judgment against the injured worker for the full amount of its subrogation interest. After a thorough consideration of the arguments and evidence presented, the Board makes the following findings of fact:

The injured was employed by the self-insuring employer and was involved in motor vehicle accident on July 16, 1996 and subsequently filed the instant claim. The employer rejected this claim but the claim was granted by the Industrial Commission. After appealing this matter into court, the employer admitted to a valid workers' compensation claim but alleged that the injured worker violated the subrogation interest provisions of R.C. 4123.931(B) by failing to notify the employer of an insurance settlement with a third-party. The court agreed and granted the employer judgment for the full amount of its subrogation interest, i.e., \$2,500.00. Subsequent to this litigation, the injured worker was granted a five percent (5%) permanent partial disability by District Hearing Officer order of February 20, 2001, but the employer refused to make payment to the injured worker. The employer asserts that it has an equitable right of setoff against any award of compensation until its statutory interest is satisfied.

On August 9, 2001 the Bureau of Workers' Compensation Self-Insured Department received a complaint filed by the injured worker alleging the employer's refusal to pay a five percent (5%) permanent partial award was a self-insured violation. The Bureau of Workers' Compensation Self-Insured Department found the complaint to be valid on October 29, 2001, and this finding was affirmed by Bureau of Workers' Compensation Deputy Administrator on December 24, 2001. Subsequently the employer appealed this valid finding to the Self-Insuring Employers Evaluation Board.

The Board agrees with the findings of the Deputy Administrator dated December 24, 2001. R.C. 4123.67 precludes any attachment or claimed right of set off by the employer in satisfaction of a judgment against the injured worker. The employer's refusal to pay the injured worker's permanent partial disability award was clearly a violation of the law.

The employer asserts that the Deputy Administrator errantly concluded that the employer could only recoup its subrogation through the application of R.C. 4123.511(J). However, the Deputy Administrator's decision does not so conclude. The decision merely indicates that R.C. 4123.511(J) provides the only legally recognized offset to payment of workers compensation awards. The decision further states that the employer must collect its judgment by other lawful means. The Board agrees with this assessment by the Deputy Administrator and also agrees with the employer that R.C. 4123.511(J) does not provide a means to collect its judgment.

By a two-to-one vote, the Board finds the complaint to be valid. The self-insuring employer is hereby ordered to pay the permanent partial disability compensation within thirty (30) days of the date of this award or a fine will be assessed.



This matter came before the Self-Insuring Employers Evaluation Board on January 10, 2002 concerning complaint number 11487 filed against the employer by the injured worker. The employer's appeal of a finding of a valid complaint by the Self-Insured Department of the Bureau of Workers' Compensation was referred to the Board directly for formal hearing. After a thorough consideration of all the evidence and arguments of the parties, the Board makes the following findings:

On May 25, 2001, the injured worker was awarded an increase of 5% in permanent partial disability by a District Hearing Officer order which stated that the "award is to be paid in accordance with the applicable provisions of the Ohio Revised Code . . ." The employer did not appeal the order or pay the award. Subsequent to this order, the employer filed a motion requesting a determination that the offset provisions of R.C. 4123.56(C) applied to payment of this award. On October 24, 2001, a District Hearing Officer found that the provisions of R.C. 4123.56(C) were inapplicable to this case. Subsequent to the District Hearing Officer order the employer paid the increase in permanent partial disability awarded in the May 25, 2001 District Hearing Officer order.

The injured worker asserts that the increase in permanent partial disability should have been paid within ten days of the May 25, 2001 order absent a request for reconsideration. The injured worker argues that the employer could not base any failure to pay on the offset provisions of R.C. 4123.56(C) because the issue was *res judicata*. In support of this position the injured worker refers to the October 19, 1998 Staff Hearing Officer order where the same issue was decided against the employer as it pertained to the original permanent partial disability award in this claim. The Board does not agree.

Res judicata only applies when there is an identity of issues. State ex rel. B.O. C. Group v. Indus. Comm. (1991), 58 Ohio St.3d 199. The Supreme Court in B.O.C. Group refused to apply the doctrine of *res judicata* to two separate and distinct awards of compensation in the same claim. The Board finds the same scenario to be true in the instant claim. There are two separate awards of compensation; hence there is no identity of issues. The Board therefore finds that the issue was not *res judicata* and the employer was entitled to a determination as to whether the offset provisions of R.C. 4123.56(C) applied to the permanent partial award of May 25, 2001.

Though neither party cites any authority on the question, and the Board is unaware of any, it is reasonable to conclude that a self-insuring employer could apply the offset provisions of R.C. 4123.56 prior to a final adjudication. A self-insuring employer initially adjudicates all claims requests. The May 25, 2001 District Hearing Officer order instructed the employer to pay the award in accordance with the applicable provisions of the Ohio Revised Code. R.C. 4123.56(C) was arguably within the ambit of this order prior to the Staff Hearing Officer's finding on October 24, 2001, that the statute did not apply.

Under these circumstances, the majority of the Board concludes that the actions of the self-insuring employer were not in violation of the order or any law. By a two-to-one vote, the Board finds that the complaint is invalid and it is hereby dismissed. A copy of this order shall be placed in the employer's Self-Insured Department file.



This matter came before the Board for formal hearing of the above referenced complaints alleging the employer refused to pay compensation pursuant to an Industrial Commission order. Upon due deliberation of the evidence and arguments presented, the Board makes the following findings and recommendations:

The complaint of Injured Worker A, involved an Industrial Commission award of 13% permanent partial disability in an order mailed on May 28, 1993. This order was not appealed and within the period required for payment, the employer's representative notified the injured worker's representative that the award was being offset by advance payments of compensation pursuant to R.C. 4123.56(C). Neither party submitted the matter to the Industrial Commission for a decision on the applicability of an offset.

Subsequent to the employer's notification of offset, another permanent partial award for the same injured worker was litigated in the Tenth District Court of Appeals in State ex rel. Bolden v. Indus. Comm., Case No. 95APD03-282, (Ohio App. Jan. 23, 1997). In this mandamus action the Court of Appeals found that the Industrial Commission abused its discretion in finding the offset applicable because the record did not support that the injured worker was disabled during any period where he was paid under his contract of hire. This case, however, is limited in its application to the facts of the specific claim involved. There might very well be an offset applicable to the claim before the Board if the matter had been adjudicated. The Board finds therefore that the Court's decision does not affect the necessity of an adjudication of the asserted offset by the Commission in the claim before the Board.

Subsequent to the Bolden case, the Tenth District Court of Appeals issued another decision in a case involving this employer. In State ex rel. Cleveland Browns, Inc. v. Indus. Comm., Case No. 97APD11-1474 (Dec. 8, 1998, Franklin Cty. App.) (hereinafter referenced to the *Harper Decision*), the Court interpreted the parties' contract to limit the offsets provided for in R.C. 4123.56(C) to workers' compensation awards made during the actual contract period and not all future awards. The employer decided not to appeal this decision, and to pay all such awards to which the decision applied.

On February 9, 1999, the employer's representative instructed the third-party administrator to pay the permanent partial disability award in the claim at issue here pursuant to the Staff Hearing Officer order in this claim. This payment would have been due immediately upon receipt of the Staff Hearing Officer order absent the offset dispute. After the Harper Decision, payment was no longer disputed by the employer. The Board finds therefore that payment was due immediately upon the expiration of the appeal period for the Harper Decision, or January 22, 1999. The Board further finds the complaint valid for the approximately two-month period of delay after January 22, 1999. The Board finds no violation prior to this date because the offset was not adjudicated by the Industrial Commission.

The complaint of Injured Worker B presents the same issues previously set forth with respect to the above complaint. Whether the employer was entitled to an offset in this claim was never adjudicated by the Industrial Commission after the offset was asserted by the employer's letter of December 7, 1995. Payment was therefore not due until January 22, 1999 for the reasons



previously discussed. The award however was not paid until July 9, 1999. The Board therefore finds the complaint of Injured Worker B valid for the nearly six-month delay in paying this award.

The complaint of Injured Worker C also presents the same issues previously discussed. Again the question of offset was never adjudicated by the Industrial Commission. Payment of the permanent partial disability award was made due upon the expiration of the appeal period in the Harper Decision or January 22, 1999. Payment was not made until March 24, 1999. The Board therefore finds the complaint valid due to the two-month delay in payment.

The complaint of Injured Worker D once again presents the same issues. While the offset issue was adjudicated in another claim for this injured worker, it was not in this claim. Both claims involved the offset of permanent partial disability awards made within three months of each other. Again for the reasons previously set forth, payment in this claim was not due until January 22, 1999 and was paid on March 24, 1999. This complaint is therefore valid for the intervening two-month delay.

The final matter before the Board is the complaint of Injured Worker E. In an order dated March 27, 1997, the injured worker was awarded wage loss compensation from October 25, 1995 to continue upon submission of proof of lost earnings. On appeal to a Staff Hearing Officer, this order was modified only to the extent that the offset was found not to apply. Subsequent to these orders, a dispute arose between the parties as to the adequacy of the proof submitted in support of the wage loss. Inasmuch as the award was contingent upon the submission of evidence, any disagreement as to the adequacy of this evidence was within the sole jurisdiction of the Industrial Commission. This Board has no jurisdiction over the dispute. The Board does not find a clear order to pay compensation under these circumstances. The complaint of the injured worker is therefore found invalid.

The Board further finds that the four violations found valid against this employer do not warrant the assessment of any penalty at this time. The employer's representative explained that the Harper Decision applied to a large number of claims that had to be processed for payment. The Board finds this explanation reasonable and a mitigating factor to be considered.

In conclusion, the Board finds that four of the five complaints are valid and one invalid. A copy of this order shall be placed in this employer's file. No further action is required as these matters have long since been resolved.



This matter came before the Board on November 17, 2004, for formal hearing on Complaint No. 12970, filed by the injured worker. The complaint alleges that the employer failed to pay permanent partial disability compensation ordered by the Bureau of Workers' Compensation. After careful consideration of the evidence, the Board makes the following findings and recommendations.

On December 6, 2002, the Bureau of Workers' Compensation issued a tentative order granting the injured worker a 13% permanent partial disability award. On December 18, 2002, the injured worker's attorney sent a letter to the employer's representative asking that a check be forwarded to his office in payment of the award. A copy of the tentative order was not enclosed with the letter.

On January 20, 2003, the employer's representative sent a letter to the injured worker's attorney indicating that they received the December 18, 2002 letter, but that the employer's representative had not received an order awarding permanent partial disability compensation. On January 20, 2003, a representative of the employer's representative also contacted the attorney's office by telephone and left a message indicating that the employer's representative needed a copy of the order. A legal assistant from the injured worker's attorney's office called the the employer's representative representative back on February 27, 2003, and was again told by the the employer's representative representative that the employer's representative needed a copy of the order. On February 27, 2003, the legal assistant faxed a copy of the order to the employer's representative. A check was issued for the award on March 1, 2003. This self-insured complaint was filed on February 25, 2003, two days before the order was faxed to the employer's representative.

On April 23, 2004 a Staff Hearing Officer of the Industrial Commission found that the employer's representative did not receive notice of the Bureau's December 6, 2002 order, and granted relief to the employer pursuant to R.C 4123.522. As indicated above, the employer had already paid the compensation on March 1, 2003. The employer did not contest the tentative order after receiving the order granting relief pursuant to R.C. 4123.522.

Given the findings of the Industrial Commission in the April 23, 2004 order, and the fact that the permanent partial award was paid by the employer within two days of the employer's representative's actual receipt of the tentative order from the injured worker's attorney, the Board finds the self-insured complaint to be invalid.

Complaint No. 12970 is found to be invalid.

A copy of this order shall be placed in the Self-Insured Department's file.



This matter came before the Board on 4/20/2005, for formal hearing on Complaint No. 13963, filed by the injured worker, Marie Brown. After careful consideration of the evidence, the Board makes the following findings and recommendations.

The injured worker's self-insured complaint, filed with the Self-Insured Department of the Bureau of Workers' Compensation on 6/22/2004, alleges that the self-insuring employer, Amsted Industries, Inc./Griffin Wheel Company, failed to timely pay compensation ordered by District Hearing Officer decision dated 5/10/2004. The following facts support the Board's decision:

A C-50 Self-Insured Application for Payment of Compensation and Medical Benefits was filed by the employer on behalf of the injured worker on 10/21/1996. On page two of the document, "Amsted Industries, Inc." was listed as the employer, with an address of "3900 Bixby Road, Groveport, Ohio 43125." The risk number listed for the employer was "SI-0040." Thereafter, the Bureau of Workers' Compensation sent an employer notification letter addressed to: "Amsted Industries, Incorporated, 205 N. Michigan Ave. 44th Floor T.S., Chicago, IL 60601-0000." The listed address was the address contained in Bureau records for Amsted Industries. The employer did not correct this information, and subsequent correspondence and orders in the claim were sent to Amsted Industries at the Chicago address without objection from the employer.

In March, 2004, after sending a tentative order addressing the injured worker's request for permanent partial disability compensation to the Chicago address for Amsted Industries, the Bureau was advised by the postal service of a forwarding order from the Chicago address, directing that mail be forwarded to "4117 Whipple Ave, NW, Suite B, Canton, Ohio 44718." Consequently, the Bureau changed its records to reflect the Canton, Ohio address as the correct address for Amsted Industries.

On 4/22/2004, a notice of hearing was issued by the Industrial Commission for a District Hearing Officer hearing set for 5/10/2004 on the injured worker's request for permanent partial disability compensation. This notice was sent to the Canton, Ohio address for Amsted Industries, and was also sent to the employer's legal counsel. Counsel for the employer attended the hearing, and did not raise an objection to the address listed for the employer. The District Hearing Officer's decision awarding 7% permanent partial disability compensation was mailed on 5/13/2004 to the Canton, Ohio address for Amsted Industries, as well as to the employer's legal counsel. It is undisputed that the employer did not pay the permanent partial award until after the present self-insured complaint was filed on 6/22/2004.

The employer argues that, because the District Hearing Officer order was not addressed to Griffin Wheel Company at its address in Groveport, Ohio, the order was not sent to the correct address, and the employer cannot be held to have received the order prior to the self-insured complaint being filed. The Board rejects this argument. The employer in this claim is Amsted Industries. While the injured worker has always worked for the subdivision of Amsted Industries called Griffin Wheel Company, it was not incorrect for Amsted Industries to be listed by the Bureau of Workers' Compensation as the employer in this claim, particularly since the employer itself listed Amsted Industries as the employer on the C-50, and never thereafter attempted to correct this information with the Bureau of Workers' Compensation.



Further, although the Chicago address initially used by the Bureau for Amsted Industries for the mailing of notices and orders was not the address listed on the C-50, it was the address listed for Amsted Industries in the Bureau's records, and Amsted Industries never objected to orders or notices being mailed to this address prior to the filing of the self-insured complaint. The employer did not argue at hearing that previous notices and orders from the Bureau or Industrial Commission were not received by the employer.

The Bureau of Workers' Compensation's change of address for Amsted Industries to the Canton, Ohio address resulted from a forwarding order from the Chicago address. The employer does not argue that the 5/10/2004 hearing order was not received at the Canton, Ohio address. Rather, the employer argues that the Canton, Ohio address is the address for a separate subsidiary of Amsted Industries, American Steel Foundries. However, no evidence was presented at hearing to support the conclusion that American Steel Foundries is a separate entity from Amsted Industries. Significantly, the employer acknowledged at hearing that the self-insured complaint, which was also mailed to the Canton, Ohio address, was received by the employer from that location, after which a timely response was filed.

The Board notes that the employer did not seek relief from the Industrial Commission pursuant to R.C. 4123.522 on the basis that the employer failed to receive the 5/10/2004 District Hearing Officer decision. Further, counsel for the employer acknowledged at hearing that he timely received a copy of the 5/10/2004 decision. It is reasonable under the circumstances to impute receipt of the order by the employer's legal counsel to the employer for purposes of determining when payment pursuant to the order was required.

The Board recognizes that there has been significant confusion in this claim as to the correct address for the employer, and perhaps even the correct employer. However, the Board finds that this confusion, while unintentional, was primarily the fault of the employer in failing to provide correct information to the Bureau of Workers' Compensation. This was detrimental to the injured worker, whose permanent partial award was delayed by several weeks after payment should have been made. Because there is no dispute that the 5/10/2004 order was timely received at the Canton, Ohio address, that the employer's attorney timely received the 5/10/2004 order, and that the employer did not pay the award until after the self-insured complaint was filed on 6/22/2004, the Board finds that the employer violated Ohio Adm.Code 4123-19-03(K)(5) and R.C. 4123.511 by failing to pay the permanent partial award upon receipt of the District Hearing Officer order.

For the foregoing reasons, the Board finds the self-insured complaint to be valid.

As a result of the confusion in this claim, the Board finds that action should be taken by Amsted Industries, its subsidiaries and sub-divisions, to correct errors pertaining to the proper employer and/or proper address for the employer that may currently exist in the Bureau of Workers' Compensation's records for its existing claims. If such action is taken by the employer, as verified by the Bureau's Self-Insured Department, this valid finding will be removed from the employer's record within six months of the date of this order.

Chapter 13

Permanent Total Disability Compensation



Self-Insuring Employers Evaluation Board



As a result of a formal conference held Tuesday, August 26, 1999, before the members of the Self-Insuring Employers Evaluation Board, concerning a complaint filed against the employer, the Board makes the following findings and recommendations:

The Board finds that the issue presented is whether the employer improperly withheld payment of permanent and total disability compensation based on an Industrial Commission order dated March 15, 1994. The Board finds that the Industrial Commission members held a hearing on April 20, 1993. Notice of the April 20, 1993 hearing was sent to the employer and the employer's representative was present at the April 20, 1993 hearing. It is the finding of the Board that while settlement discussions took place between the injured worker and the employer subsequent to the April 20, 1993 hearing no written executed settlement agreement was filed with the Industrial Commission or the Bureau of Workers' Compensation. The Board finds that in an order dated March 15, 1994, the Industrial Commission issued its findings of permanent total disability. While the Commission had previously awarded permanent total disability to the injured worker solely as a result of Claim No. 68-00000, in the March 15, 1994 order, the Commission apportioned 40% of the permanent total disability award to Claim No. 68-00000 and 60% to Claim No. 400000-22. The Commission's March 15, 1994 order was mailed on or about March 18, 1994. It is further the finding of the Board that on or about June 1, 1994, the employer filed a request for reconsideration from the March 15, 1994 order. In an order dated October 31, 1994, that was published on November 7, 1994, the Commission denied the employer's request for reconsideration. It is the finding of the Board that the Commission's order of March 15, 1994, has not been vacated or modified.

On or about April 29, 1999 the Self-Insured Department determined that a complaint against the employer was valid based upon the failure of the employer to pay permanent total disability compensation. On or about July 9, 1999, the Administrator's designee considered the employer's request to reconsider the Self-Insured Department's determination that there was a valid complaint. In a letter dated July 9, 1999, the Administrator's designee denied the employer's request for reconsideration. While a check made payable to the Bureau was tendered at the hearing held on August 26, 1999, no payment of permanent total disability compensation was made by the employer to the injured worker as of the date of this hearing.

After a review of the facts relating to the complaint and the testimony elicited at the hearing, the Board finds that the validity of the subject complaint must be upheld. The Board finds the employer's failure to make any payments to the injured worker over a five-year period is a gross violation of Ohio Adm. Code 4121-19-03(L)(5). Moreover, the Board recommends a penalty in the amount of \$5,000.00 payable into the Self-Insuring Employer's Guaranty Fund as a consequence of its action (or failure to take action), in the above referenced matter. The Bureau shall issue a billing for this penalty to the employer.

Finally, the employer is ordered to make payment directly to the injured worker of any outstanding amounts due and owing under the March 15, 1994 order. Furthermore, the employer must continue to make payments to the injured worker unless and until the March 15, 1994 order is overturned by the Industrial Commission or a court order.



Should the employer fail to comply with any portion of this order within twenty-one (21) days of its receipt thereof, the employer may again be scheduled to come before this Board.

DISSENTING OPINION:

I respectfully dissent from the findings of my colleagues. The facts in this case show that the injured worker was originally found permanently and totally disabled (PTD) in 1992, based solely on his injuries in a state fund claim. Counsel for the employer later received a notice of a PTD hearing with respect to the two self-insured claims as well. The injured worker's counsel advised the Commission, by letter dated April 6, 1993, that he did not wish to pursue the application against the self-insuring employer. Notwithstanding the request by the injured worker's counsel, the Commission went forward with the hearing.

Following a hearing held on April 20, 1993, the claim file was to remain with the Commission pending settlement discussions in claim numbers 400000-22 and 500000-22. The employer has submitted an unexecuted settlement whereby the injured worker was to receive \$500.00 as full and final settlement of both self-insured claims. Nevertheless, without another hearing, the Commission made a finding on or about March 15, 1994, apportioning 60% of the injured worker's PTD to the self-insuring employer.

The self-insuring employer has since secured new counsel, and more recently filed a request for relief from the March 15, 1994 PTD order. Notwithstanding the Motion for relief, the self-insuring employer's counsel appeared at the Self-Insuring Employers Evaluation Board hearing and presented the Board with a check in excess of \$17,000.00 representing monies owed the injured worker as of the time of the Bureau's letter in March.

The Board has chosen to uphold the finding of a valid self-insured complaint against the self-insuring employer based upon its failure to make timely payments in accordance with an Industrial Commission order. In the instant case, it appears to me that payments were not made because of confusion and oversight. However, when issuing a fine, the Board generally looks for a pattern of poor performance and improper behavior or deliberate disregard. I simply do not find these elements present in this case and would therefore find a valid complaint with no fine.



As a result of a formal hearing held November 16, 2000 before the Self-Insuring Employers Evaluation Board concerning complaint number 9385, regarding the employer's alleged unilateral termination of permanent total disability (PTD) compensation without an Industrial Commission order, the Board makes the following recommendations:

The relevant facts are as follows: On December 1, 1994 the Industrial Commission found the injured worker to be permanently and totally disabled. Upon receipt of the Industrial Commission's order awarding PTD compensation the employer initiated compensation at a rate of \$365.00 per week. After making approximately five and a half years of payments to the injured worker, the self-insuring employer discovered the injured worker had also been receiving Social Security Disability benefits, though the injured worker had previously reported receiving such benefits. In a letter dated March 3, 2000 the employer notified the injured worker he had been paid at an incorrect rate, and that the new weekly rate would be \$243.34. This letter advised the injured worker that the overpayment amounted to \$33,122.33 and that he would not receive additional compensation at the corrected rate until the overpayment was recovered. The injured worker filed a complaint with the Self-Insured Department on April 27, 2000 and a Motion (form C-86) with the Industrial Commission on May 17, 2000, requesting reinstatement of PTD compensation.

The Self-Insured Department investigated the injured worker's allegation and confirmed the employer's findings regarding an error in the initial rate of payment. In keeping with BWC policy for collecting overpayments, the employer was advised that they were in violation of R.C. 4123.511(J) by withholding 100% of the injured worker's weekly compensation benefit until the overpayment was collected. The employer was instructed to reinstate payment of PTD compensation and to use the criteria specified in R.C. 4123.511(J) to recoup the overpayment. The employer objected to this decision, filing a request for reconsideration of the Self-Insured Department's decision. On August 10, 2000, the Administrator's designee, modified the Self-Insured Department's findings. The complaint was still found to be valid, although the rationale for the violation differed. It was determined that the employer was not entitled to unilaterally declare an overpayment and then attempt to recoup the alleged overpayment at the rate of 100%. In fact it was the determination of the Administrator's designee that the employer should have requested a hearing on the matter prior to terminating the injured worker's compensation payments. A hearing officer would have invoked the continuing jurisdiction under R.C. 4123.52, modified the award, and declared an overpayment prior to the self-insuring employer's actions in this claim. The employer was instructed to resume payment of PTD compensation as previously ordered by the Self-Insured Department. The employer again failed to reinstate PTD compensation and the matter was referred to the Self-Insuring Employers Evaluation Board as a valid unresolved complaint.

It was the injured worker's position, based on case law, that the employer could only adjust compensation for a back period of two years; and the employer did not have the authority to unilaterally terminate the payment of compensation based on an alleged overpayment without a hearing. The employer's position was that its unilateral termination of PTD compensation did not violate any law. The employer asserted that in order for the complaint to be valid the employer must have violated a clear legal duty. There was no statute, rule, or case law prohibiting the self-



insuring employer from the actions taken in this case. There was no mandate telling the employer how to recoup the overpayment or that required the employer to request a hearing. Lastly, the employer asserted that R.C. 4123.511(J) referred to compensation ordered by a District Hearing Officer and subsequently reversed by a Staff Hearing Officer, indicating that this case clearly did not fall into that situation.

After a review of the evidence submitted and testimony elicited at the hearing, the Board finds that the issue before it is whether or not the unilateral termination of PTD compensation was within the employer's administrative authority as a self-insuring employer. For the reasons herein set forth, the Board finds that the unilateral termination of PTD benefits by the self-insuring employer is a clear violation of Ohio law and complaint number 9385 filed by the injured worker is valid.

R.C. 4123.58 provides that PTD shall be paid for life. "Once this determination has been made, 'the employee shall receive an award to continue until his death'." State ex rel. Smothers v. Mihm (1994), 69 Ohio St.3d 566, 567. As the Supreme Court recognized in Smothers, however, an award of PTD is not immune from later review by the Industrial Commission where circumstances justify the Commission's use of continuing jurisdiction pursuant to R.C. 4123.52. R.C. 4121.35 vests original jurisdiction over PTD applications with Staff Hearing Officers. There is no such grant of jurisdiction to self-insuring employers. As a result, the injured worker in this claim was entitled to continued payment of PTD compensation until the award was modified by the Commission.

Additionally, the issue as to whether a self-insuring employer had inherent authority to correct clerical errors was addressed by the Supreme Court in State ex rel. Baker Material Handling v. Indus. Comm. (1994), 69 Ohio St.3d 202. The Court in Baker clearly and unequivocally denied any such exercise of authority by a self-insuring employer. The Court noted that R.C. 4123.52 applies only to the continuing jurisdiction of the Industrial Commission and there was no comparable statute or rule applying to self-insuring employers. *Id* at 207. Finally, Baker unquestionably limits a self-insuring employer's jurisdiction to the first level of a claim, i.e., the application of initial allowance. It is therefore abundantly clear that in this claim, the actions of the self-insuring employer violated well-established Ohio law.

The Board finds that the employer did not have the authority to unilaterally terminate permanent total disability compensation without an order of the Industrial Commission. The complaint herein is therefore valid and a copy of this finding will be placed in the employer's records for review at the time of renewal.



This matter came before the Board for formal hearing on Complaint No. 12408 in which the injured worker alleged that the employer improperly stopped payment of permanent and total disability compensation. Upon consideration of the evidence and arguments presented, the Board makes the following findings and recommendations:

Initially the Board notes that this matter has been resolved and the injured worker's representative appeared at the hearing and requested that the complaint be withdrawn. Since the matter was before the Board on the employer's appeal, the employer was given an opportunity to present its position to the Board.

The employer first noted that it was no longer taking the position that it was not responsible for payment in this claim. Compensation to the injured worker resumed on October 7, 2002.

The employer explained that the plant where the injured worker was employed had been sold in 1983 to a self-insuring employer with a separate risk number and in accordance with the terms of the sale, the new owner began making payments of compensation in the claim. The new owner subsequently sold the plant to another company who went out of business and ceased payment of compensation. The employer had not administered this claim for nearly twenty years.

The Board notes that the injured worker's complaint was not originally filed against this employer, who was unaware of the claim and the complaint at the time it was notified by the Self-Insured Department. Compensation resumed after the employer had an opportunity to investigate the matter. The Board further notes that the employer has an exemplary record in the administration of its claims.

The majority of the Board finds the complaint to be invalid as to this employer.

Chapter 14

Reconsideration



Self-Insuring Employers Evaluation Board



Self-Insuring Employers Evaluation Board

Synopsis of Formal Decisions

Reconsideration
Complaint No. 9612
September 4, 2001

This matter came before the Self-Insuring Employers Evaluation Board on the employer's July 25, 2001 request for reconsideration of the Board's order mailed July 6, 2001. The employer's request is hereby denied. The Board finds no precedent authorizing any exercise of jurisdiction subsequent to the final order. The Board further notes that the issues raised in the request were previously considered and addressed in the July 6, 2001 order.



Self-Insuring Employers Evaluation Board

Synopsis of Formal Decisions

Reconsideration
Complaint No. 13395
March 16, 2005

This matter came before the Self-Insuring Employers Evaluation Board on the injured worker's February 9, 2005 request for reconsideration of the Board's order mailed January 26, 2005. The injured worker's request is hereby denied. The Board finds no precedent authorizing any exercise of jurisdiction subsequent to the final order. The Board further notes that the issues raised in the request were previously considered and addressed in the January 26, 2005 order.

Chapter 15

Rehabilitation



Self-Insuring Employers Evaluation Board



This matter came before the Board on April 14, 2004 for formal hearing on Complaint No. 13076. After careful consideration of the arguments and evidence presented, the Board makes the following findings and recommendations:

On July 3, 2002, the injured worker filed a motion requesting authorization for physical therapy pursuant to a C-9 signed by Dr. (name redacted) on May 24, 2002, and for “rehabilitation services consistent with the request of his physician.” In addition to the C-9, a Physician’s Report of Work Ability (MEDCO-14) was filed with the motion. The MEDCO-14 did not set forth a physical capacity evaluation or indicate whether the injured worker was capable of any work activity.

The injured worker’s motion was heard by a District Hearing Officer who granted the request for physical therapy but denied the request for rehabilitation. On November 15, 2002, a Staff Hearing Officer granted authorization for rehabilitation services. The order did not reference any rehabilitation plan or cite any medical evidence prescribing any services.

A letter in the file from (new employer – name redacted) dated February 27, 2003 establishes that the injured worker was employed from early November 2002, prior to the Staff Hearing Officer hearing, until at least March 2003. There is no evidence in the file that any request was made by the injured worker or his physician of any specific service until January 29, 2003, when the injured worker refiled his request for rehabilitation services, complete with a rehabilitation plan. The acceptance of this plan was the subject of new hearings before the Industrial Commission on the issue and was not before the Board.

The majority of the Board does not find any violation of law or standard of self-insurance in any failure on the part of the employer to provide rehabilitation services pursuant to the Staff Hearing Officer order of November 15, 2002. There is no feasible way a rehabilitation plan could have been developed with the information provided by the treating physician at the time the order was issued. A self-insured employer is not required to speculate as to what services may be necessary and proceed accordingly. In fact, the injured worker’s motion only requests rehabilitation services consistent with the request of the treating physician. When the motion was filed or even when the order was issued, there is no indication of the injured worker’s physical capacities.

The majority of the Board recognizes that Rule 4123-18-16(C) requires a self-insuring employer to provide case management services. However, such an effort would have been futile at the time of the order given the lack of any indication of the injured worker’s physical capability. This is especially true in light of the fact that the injured worker was working and not otherwise eligible for vocational rehabilitation when the Staff Hearing Officer issued the order.

The majority of the Board finds the complaint invalid with one Board member recusing.

Chapter 16

Taxes Withheld



Self-Insuring Employers Evaluation Board



Self-Insuring Employers Evaluation Board
Synopsis of Formal Decisions

Taxes Withheld
Complaint No. 9045
September 5, 2000

As a result of a formal hearing held August 11, 2000 before the Self-Insuring Employers Evaluation Board concerning complaint number 9045, alleging the employer failed to comply with a District Hearing Officer's order to pay compensation, the Board makes the following recommendations:

The relevant facts are as follows: On September 20, 1999 a District Hearing Officer heard the injured worker's motion requesting the employer be ordered to pay an additional \$1,189.32 in temporary total benefits, found the injured worker "was entitled to temporary total compensation for sixteen and six-sevenths (16 6/7) weeks." This amounted to \$9,119.71, and was to include "all temporary total benefits, all Sickness and Accident benefits in lieu of temporary total, or a combination of the two." The employer's position was they had paid the injured worker "the amount of temporary total compensation less any Sickness and Accident already paid." The employer had determined the amount of temporary total compensation due by using the amount of sickness and accident benefits paid to the injured worker after taxes had been deducted. The employer's position was that the injured worker could file an amended tax return to receive the additional benefits. On November 18, 1999, a Staff Hearing Officer heard the employer's appeal, vacated the September 20, 1999 District Hearing Officer's order and found that the "employer paid the correct amount of temporary total compensation and sickness and accident benefits." On January 6, 2000 the Industrial Commission granted the injured worker's appeal and vacated the Staff Hearing Officer's November 18, 1999 order. The Industrial Commission reinstated, in part, the District Hearing Officer's September 20, 1999 order granting the injured worker's appeal, and vacating the Staff Hearing Officer's order. The injured worker was to be paid temporary total compensation at \$541.00 per week for sixteen and six-sevenths (16 6/7) weeks for a total of \$9,119.71. The injured worker "was to be paid said amount as a net, rather than a lesser amount after deduction from the figure above. This figure may be composed of all temporary total disability benefits, all sickness and accident benefits in lieu of temporary total, or a combination of the two." After a review of the facts related to the complaint and both written and oral testimony elicited at the hearing, the Board finds the validity of the subject complaint must be upheld. The Board further finds the employer's failure to timely pay the additional compensation pursuant to the District Hearing Officer's September 20, 1999 order constitutes a violation of R.C. 4123.511(H), which requires timely payment of all compensation to injured workers. The Board was particularly concerned with the employer's position that the District Hearing Officer's order was ambiguous and the injured worker should obtain the additional compensation by filing an amended tax return. The Board found no merit in the employer's argument that if the employer had paid the additional \$1,189.32, the injured worker would be overpaid. The Board found this reasoning unacceptable. The Board determined that the self-insured complaint against the employer was valid and a copy of said complaint shall be placed in the employer's self-insurance file. The Board further determined that the employer's decision to withhold the injured worker's temporary total compensation was a deliberate action and detrimental to the injured worker. The Board agreed to a civil penalty in the amount of \$5,000. Payment of the penalty should be made to the Ohio Bureau of Workers' Compensation Guaranty Fund, within 14 days of receipt of this order. Failure to comply with the order of the Self-Insuring Employers Evaluation Board shall result in a referral of the employer to the Administrator for review and consideration of their continued self-insurance.

Chapter 17

Temporary Total Disability Compensation



Self-Insuring Employers Evaluation Board



This matter was referred for formal hearing on February 14, 2001 before the Self-Insuring Employers Evaluation Board on complaint number 9219 filed by the injured worker regarding the employer's termination of temporary total disability compensation without a hearing. Upon consideration of evidence and arguments of counsel, the Board makes the following findings and recommendations pursuant to R.C. 4123.352:

The relevant facts are as follows: On February 3, 2000, the Bureau of Workers' Compensation received a complaint alleging the employer failed to pay compensation timely. An investigation into the issue revealed that on April 30, 1999 a District Hearing Officer awarded temporary total disability compensation from August 15, 1990 to February 24, 1991 and from June 1, 1998 to March 11, 1999, with further temporary total disability compensation to be paid upon submission of medical evidence. This decision was affirmed by a Staff Hearing Officer order on June 21, 1999. Evidence supports that the employer paid the closed periods of compensation as ordered and continued to pay temporary total disability compensation through September 20, 1999. At that time the most current C-84 on file certified temporary total disability to August 6, 1999. Therefore, on October 7, 1999, the employer's third party administrator questioned the injured worker's continued disability and wrote to the injured worker's representative. Updated information was requested regarding the continued disability of the injured worker. The payment of temporary total disability compensation was placed in a "pending" status until the requested information was received. On or about October 19, 1999, a C-84 form dated October 4, 1999 was received certifying the injured worker's disability from "1/26/90 to Present". On October 13, 1999 the employer's third party administrator requested the physician's office notes, and payment of compensation was left in a "pending" status. On or about October 26, 1999 a C-84 form was received certifying disability from "8/6/1999 through 11/6/1999". Again the employer's third party administrator requested the physician's office notes, leaving the payment of compensation in a "pending" status. The employer received four additional C-84 forms dated November 9, 1999, November 15, 1999, January 11, 2000 and January 27, 2000, which ultimately extended the injured worker's disability through April 27, 2000.

On July 7, 2000, the Self-Insured Department found the complaint to be valid and unresolved. The violation was the result of the employer's termination of temporary total disability compensation without a hearing officer's order. The employer was instructed to pay the outstanding temporary total disability compensation within seven days of receipt of the determination and advised that failure to do so would result in the matter being forwarded to the Self-Insuring Employers Evaluation Board. On July 21, 2000 the employer objected to the finding. The request was forwarded to the Administrator for reconsideration. On August 24, 2000, the employer provided verification of payment. Copies of checks indicated compensation was paid on July 14, 2000 for the period "9/16/99 TO 01/27/00," on July 24, 2000 for the period "01/27/00 TO 04/27/00" and on August 8, 2000 for the period "04/27/00 to 08/10/00." On October 3, 2000 the Administrator's designee issued a finding upholding the Self-Insured Department's finding of a valid complaint. On October 25, 2000 the employer appealed this decision, requesting a formal hearing before the Self-Insuring Employers Evaluation Board.

After a review of the facts related to the complaint and both written and oral testimony elicited at the hearing, the Board finds the validity of the subject complaint must be upheld. The Board



further finds that the employer's argument regarding insufficient medical evidence to support payment of temporary total disability compensation is without merit. The employer was ordered to pay continuing temporary total disability compensation upon the submission of evidence. Therefore, upon receipt of the C-84 dated October 4, 1999, the employer should have reinstated temporary total disability compensation pursuant to the April 30, 1999 District Hearing Officer order. Any dispute as to the sufficiency of the evidence or the extent of disability was solely for consideration of the Industrial Commission. If the employer was effectively managing its workers' compensation program, the employer would have filed a Motion (C-86) and had the issue adjudicated. The Board is particularly concerned that the employer's actions were administratively beyond their jurisdiction.

The Board finds that the self-insured complaint against the employer is valid and a copy of said complaint shall be placed in the self-insurance file of the employer. Since the evidence submitted confirmed the employer paid the temporary total disability compensation that was the subject of this complaint, the complaint will be construed as resolved.



This matter was referred for formal hearing on February 14, 2001 before the Self-Insuring Employers Evaluation Board on complaint number 9576, filed by the injured worker regarding the employer's termination of temporary total disability compensation without a hearing. Upon consideration of evidence and arguments of counsel, the Board makes the following findings and recommendations pursuant to Section 4123.352 of the Revised Code:

The relevant facts are as follows: On August 22, 2000, the Bureau of Workers' Compensation received a complaint alleging the employer failed to follow Ohio Adm. Code 4121-3-32, as the employer had terminated temporary total disability compensation without a hearing or a statement from the attending physician indicating the injured worker had reached maximum medical improvement. An investigation into the issue revealed that on March 23, 1999 a District Hearing Officer allowed the claim for contusion left elbow/forearm and reflex sympathetic dystrophy of the left arm. The District Hearing Officer awarded temporary total disability compensation from December 16, 1998 to March 31, 1999, with further temporary total disability compensation to be paid upon submission of medical evidence. The employer continued to pay temporary total disability compensation through June 14, 1999. The injured worker returned to work in a "light duty" capacity, working through June 25, 1999. On August 9, 1999 the employer received a C-84 form certifying the injured worker was again disabled as of July 1, 1999. The employer reinstated temporary total disability compensation, paying through December 20, 1999, when the injured worker was released to return to work with restrictions. The employer testified that since they were unable to "address Dr. (name redacted) recommendations" before the injured worker's scheduled termination date, they paid temporary total disability compensation for the period December 21, 1999 through January 3, 2000. On January 7, 2000, the employer terminated the injured worker's employment for violation of the company's "leave of absence" policy. On or about January 28, 2000, the employer paid temporary total disability compensation for the period of January 4, 2000 through January 7, 2000. It was at this time that the employer notified the injured worker that temporary total disability compensation had been terminated because "Dr. (name redacted) believes you can work with restrictions" advising that she "may be eligible for non-working wage loss since (employer's name redacted) does not have any work consistent with your restrictions."

On November 16, 2000, the Self-Insured Department found the complaint to be invalid based upon the injured worker's release to return to work with restrictions. The injured worker's representative requested a reconsideration of this decision on November 27, 2000, stating that the release to return to work with restrictions was not a release to return to her "former" position of employment. On December 20, 2000, the Deputy Administrator reversed the Self-Insured Department's determination, finding the employer in violation of Ohio Adm. Code 4121-3-32 for terminating temporary total disability compensation without a hearing. The Deputy Administrator's decision referenced State ex rel. Ramirez v. Indus. Comm. (1982), 68 Ohio St.2d 630, which recognizes that temporary total disability for workers' compensation purposes is a disability which prevents an injured worker from returning to his former position of employment. The employer failed to meet the criteria specified by Ohio Adm. Code 4121-3-32(B) for termination of temporary total disability compensation prior to an Industrial Commission hearing.



After review of the facts related to the complaint as well as the written and oral testimony elicited at hearing, the Board finds the validity of the subject complaint must be upheld. The Board further finds the employer's argument that Dr. (name redacted) December 21, 1999 statement that there was "no cure for RSD" did not support the finding of permanency or that the injured worker had reached maximum medical improvement. Though the Board recognizes that State ex rel. Jeep Corp. v. Indus. Comm. (1992), 64 Ohio St.3d 378, authorizes a self-insured employer to terminate temporary total disability compensation upon receipt of a written statement from the physician of record that the injured worker can return to his former job or has reached maximum medical improvement, that simply has not occurred in this claim. If the employer wished to adjudicate the ambiguity of Dr. (name redacted) statement, it should have done so before the Industrial Commission, prior to terminating the injured worker's temporary total disability compensation.

The Board also rejects the employer's contention that Ohio Adm. Code 4121-3-32(B) permits termination of temporary total disability compensation when a treating physician authorized light duty work. The rule permits termination where there is "available suitable employment." In this claim, suitable employment was not "available." In short, there is no legal authority which supports the employer's action.

The Board determined that the self-insured complaint against the employer is valid and a copy of said complaint shall be placed in the employer's self-insurance file. The Board further finds that the Administrator ordered the employer to comply with Ohio Adm. Code 4121-3-32 as it related to the payment of temporary total disability compensation but that temporary total disability compensation has not been appropriately paid. The Board therefore orders that the employer take corrective action and pay all outstanding temporary total disability compensation according to law within thirty days of the date of this order, with confirmation of payment provided to the Board. If corrective action is not taken consistent herewith, a fine in the amount of five thousand dollars (\$5,000.00) will be immediately assessed against and due from the employer on March 30, 2001.



This matter was referred for formal hearing on May 23, 2001 before the Self-Insuring Employers Evaluation Board on complaint number 9612 filed by the injured worker regarding the employer's alleged failure to pay temporary total disability compensation pursuant to a Staff Hearing Officer order. Upon consideration of evidence and arguments of counsel, the Board makes the following findings and recommendations pursuant to R.C. 4123.352:

The relevant facts are as follows: The employer had accepted the claim and paid temporary total disability compensation intermittently during 1998 and 1999. On October 12, 1999 the injured worker was laid off from the employer. The employer filed a motion on November 30, 1999 questioning the injured worker's continued entitlement to temporary total disability compensation. On January 6, 2000 a District Hearing Officer heard the employer's motion, found that employer had failed to show that the injured worker had reached maximum medical improvement, and ordered temporary total disability compensation be continued upon submission of medical evidence. On March 7, 2000 a Staff Hearing Officer heard the employer's appeal and vacated the District Hearing Officer's January 6, 2000 order. The Staff Hearing Officer found that the injured worker was unable to return to his former position of employment, a request for further rehabilitation was pending, and the injured worker had not reached maximum medical improvement. Temporary total disability compensation was ordered to continue upon submission of medical proof. The employer terminated temporary total disability compensation effective February 28, 2000. The injured worker filed a motion on September 5, 2000 requesting the Industrial Commission to order the self-insuring employer to pay temporary total disability compensation from the last date of payment, indicating he believed it was February 28, 2000, because the employer's motion to terminate temporary total had previously been denied. The Industrial Commission forwarded the C-86 Motion to the Self-Insured Department with the notation "[t]his is being construed as a SI Complaint."

The Self-Insured Department sent the employer notification that the issue was being processed as a complaint and requested the employer provide a written response to the allegations. The employer provided two responses. Their position is that the injured worker was not entitled to temporary total disability compensation because they did not have a valid C-84 signed by the injured worker's physician when they ceased payment. The employer indicated they had received a C-84 dated March 20, 2000 that certified the injured worker's disability period as "10/8/98 to 3/22/99." Then they had received a second C-84, also dated March 20, 2000, indicating disability from "10/8/98 to 3/22/00." It is the employer's opinion that the first C-84 had not addressed the period in dispute and the second C-84 had been altered and, therefore, could not be relied upon to support temporary total disability. The employer indicated it was not until some four months after they had ceased their "voluntary payments" of temporary total disability compensation that they received a C-84 dated July 10, 2000, which might have removed questions about the period in dispute. The employer indicated that the gap in submission of medical proof to support payment of compensation "was grounds for the employer not to pay further compensation absent a hearing."

The Self-Insured Department found the employer's explanation for terminating compensation insufficient and contrary to the requirements of Ohio Adm. Code 4121-3-32. The complaint was found to be a valid unresolved violation and the employer was given seven days to pay the



temporary total disability compensation in question. On November 15, 2000 the Self-Insured Department received confirmation of the payment of compensation along with a request for reconsideration of the Self-Insured Department's valid unresolved finding. On March 8, 2001 the Administrator's designee upheld the Self-Insured Department's decision, modifying the determination to reflect that although the complaint was valid, it was now resolved.

In addition to the facts as previously stated, the employer indicated that it appears there is a procedure being followed that is not provided by rule, and is being applied to self-insuring employers, resulting in sanctions being applied that are unpredictable and inconsistent. The employer argued that had the proper procedures been followed there might have been a different situation. The employer asserted that if the Industrial Commission had heard the Motion, there would have been an opportunity to defend their position regarding the dispute. The employer pointed out that response of the Administrator's designee was interesting in that it indicated when a question arises regarding an injured worker's entitlement to temporary total compensation, it is properly addressed by an Industrial Commission hearing officer. The employer argued that this was their point all along and that was what they asked to have done. The employer also indicated that a wage loss application was received during the period in question.

It is the injured worker's position that the employer's March 10, 2000 letter stated that he had been released to return to work on April 12, 1999 with restrictions and that they could no longer accommodate the restrictions. He was informed that he would no longer receive temporary total disability compensation but that he may be entitled to wage loss. This was the reason he filled out the wage loss forms. He further indicated that the employer had paid for the work hardening program he started on April 11, 2000.

After a review of the evidence submitted and testimony elicited at the hearing, the Board finds that the issue before them is whether or not the employer's unilateral termination of temporary total disability compensation was within the employer's administrative authority as a self-insuring employer.

The Board further took into consideration that employers granted permission to pay compensation and benefits directly have the authority to make initial determinations on a variety of issues in accordance with the law. The Board finds that the validity of the complaint must be upheld. Once the employer accepted the obligation or was ordered to pay ongoing temporary total disability benefits, payments were to continue upon the submission of supporting medical evidence unless one of the express grounds for termination set forth in R.C. 4123.56 were met. A dispute over the evidence of temporary total disability is within the exclusive jurisdiction of the Industrial Commission. A short delay in the submission of evidence supporting temporary total disability does not excuse an employer from failing to pay ongoing compensation once the evidence is received. Though the employer argued that all it was asking for was a Commission hearing, the employer never requested one. The Board finds that there is no merit to the employer's argument that the injured worker's motion asking the Commission, in essence, to order the employer to comply with a prior order should have been heard by the Commission. The Board finds that this matter was properly referred to the Self-Insured Department.



The Board finds that the employer did not have the authority to unilaterally terminate temporary total disability compensation without an order of the Industrial Commission. The Board finds that the complaint against the employer for failure to pay temporary total disability compensation in accordance with Ohio Adm. Code 4121-3-32 is valid and a copy of this finding will be placed in the employer's risk file for review at the time of renewal. The Board further finds that the matter is resolved and a penalty is not assessed.

DISSENTING OPINION:

I respectfully dissent from the majority's finding of a valid complaint for the reason that the form C-86 motion filed by the injured worker for payment of compensation was incorrectly converted to a self-insuring complaint against the employer. The injured worker currently had a form C-140 filed requesting wage loss compensation at the same time filing C-84's requesting temporary total compensation. The injured worker's attorney had a discussion with the self-insuring employer asking why they were paying temporary total compensation and not wage loss compensation. A break existed of four months in payment of compensation based on no valid C-84's being filed. The self-insuring employer believed that the C-86 motion on file would be heard before the Industrial Commission and all related issues would be resolved accordingly. As a result, the majority's findings in this matter are premature.



This matter was referred for formal hearing on May 23, 2001 before the Self-Insuring Employers Evaluation Board on complaint number 9769 filed by the injured worker regarding the employer's alleged discontinuance of temporary total disability compensation without an order of the Industrial Commission. Upon consideration of evidence and arguments of counsel, the Board makes the following findings and recommendations pursuant to R.C. 4123.352:

The relevant facts are as follows: On June 1, 2000 the employer discontinued the payment of temporary total compensation for the reason that the injured worker voluntarily accepted an early retirement offer and terminated his employment. In February of 2000 the employer had approached several employees, including the injured worker, regarding Columbia Gas of Ohio's "Voluntary Incentive Retirement Plan (VIRP)." In exchange for a specified sum of money, in addition to other incentives, the employees could elect to participate in the program and retire early. On April 4, 2000, the injured worker accepted the company's offer of an early retirement incentive plan with an effective date of June 1, 2000. The program had a "45-day consideration period" built into it, and within 7 days of executing the Acceptance and Release, he could have withdrawn his agreement to the early retirement plan. In addition, the early retirement program was open to many of their employees. It is, therefore, the employer's position that the injured worker had voluntarily retired and was no longer eligible for temporary total compensation, effective June 1, 2000. On November 3, 2000 the injured worker's authorized representative filed a complaint with the Self-Insured Department seeking correction of the employer's action and reinstatement of temporary total disability compensation.

The Self-Insured Department investigated the allegation and, after reviewing the agreement signed by the injured worker, dismissed the complaint. The decision relied upon R.C. 4123.56, wherein payment of temporary total disability compensation is due when an injury has totally disabled an employee from returning to work. The paperwork from the retirement plan supported the employer's contention that the injured worker was aware that by accepting this offer he was voluntarily terminating his employment. On January 25, 2001 the injured worker's authorized representative filed a request for reconsideration of the dismissal of the complaint. On February 27, 2001 the Administrator's designee, reversed the Self-Insured Department's decision and found the complaint to be valid. He stated that while voluntary retirement may well prevent the injured worker from receipt of temporary total disability compensation, the determination of such a finding was not within the employer's jurisdiction but was a matter to be determined by the Industrial Commission. It was the employer's administrative responsibility to request a hearing before discontinuing payments. The employer was requested to pay temporary total disability compensation in accordance with Ohio Adm. Code 4121-3-32. The employer complied but requested the matter be forwarded to the Board for further consideration.

It is the injured worker's position that a self-insuring employer must continue paying temporary total disability compensation based upon medical reports of the attending physician. Furthermore, if the employer disputes the attending physician's reports, temporary total disability compensation may only be terminated upon application and a hearing before the Industrial Commission. It is the injured worker's position that the Industrial Commission, rather than the employer, must consider all of the evidence and the relevant circumstances in making a determination.



After a review of the evidence submitted and testimony elicited at the hearing, the Board finds that the issue before them is whether or not the employer's unilateral termination of temporary total disability compensation was within the employer's administrative authority as a self-insuring employer. The Board did review the Voluntary Incentive Retirement Plan Acceptance, Release and Agreement as signed by the injured worker and did take into consideration the nature of the employer's offer. The Board recognizes that employers granted permission to pay compensation and benefits directly have the authority to make initial determinations on a variety of issues, most notably where an issue is not in dispute. However, after careful deliberation, it is the Board's determination that whether the injured worker's acceptance of his employer's "Voluntary Incentive Retirement Plan (VIRP)" precluded him from entitlement to ongoing temporary total disability compensation is in dispute and subject to the exclusive jurisdiction of the Industrial Commission.

The Board finds that the employer did not have the authority to unilaterally terminate temporary total disability compensation without an order of the Industrial Commission. The Board finds that the complaint against the employer for failure to pay temporary total disability compensation in accordance with Ohio Adm. Code 4121-3-32 is valid and a copy of this finding will be placed in the employer's risk file for review at the time of renewal. The Board further finds that the matter is resolved and a penalty is not assessed.



A formal hearing was held before the members of the Self-Insuring Employers Evaluation Board on February 20, 2002, concerning self-insured complaint number 11104. The issue to be determined was whether the self-insuring employer violated Rule 4121-3-32 of the Ohio Administrative Code by unilaterally terminating the temporary total disability compensation of the injured worker. After a thorough consideration of the arguments and evidence, the Board finds as follows:

The injured worker was involved in a motor vehicle accident while driving a company vehicle in August of 1996 and the employer fully certified the workers' compensation claim for "neck strain and herniated disc at T7-8." Temporary total disability was paid from the date of injury until January 10, 2001. Temporary total was not paid after January 10, 2001 because there was a twelve-day delay in the receipt of supporting medical evidence. The employer further refused to pay continuing temporary total upon the subsequent C-84 received on January 22, 2001.

The employer's actions in terminating temporary total compensation unilaterally despite the receipt of a C-84 on January 22, 2001 are contrary to law. R.C. 4123.56 states:

In the case of a self-insuring employer, payments shall be made for a duration based on the medical reports of the attending physician. If the employer disputes the attending physician's report, payments may be terminated only upon application and hearing by a district hearing officer . . .

The employer's assertion that the delay in receipt of the attending physician's report was, in effect, a termination of temporary total is rejected. The Board finds that R.C. 4123.56 is clear and unambiguous on this point.

The Board also rejects the employer's argument that the attending physician was basing the requested period of disability on non-allowed conditions. The C-84 in question, dated January 10, 2001, properly lists the allowed condition. Any question of credibility raised by the attending physicians physical findings on the form is a matter to be litigated by the Industrial Commission. This is, again, clearly addressed in R.C. 4123.56.

The employer further argues that it was entitled to terminate temporary total as a result of the injured worker's failure to attend the employer's medical examination scheduled with Dr. (name redacted) on February 16, 2001. The problem with this argument is that the compensation had already been unlawfully terminated. Otherwise, the employer's argument that R.C. 4123.651 permitted it to suspend compensation might have some merit. In any event, this argument is moot because the injured worker attended the rescheduled exam on March 7, 2001.

The Board notes that payment of compensation has been made by the employer and the matter is now resolved. Accordingly, it is the Board's determination that no further action is required. A copy of this order shall be placed in the employer's Self-Insured Department file. The Board finds the complaint against the employer is valid.



A formal hearing was held before the members of the Self-Insuring Employers Evaluation Board on January 10, 2002 concerning self-insured complaint number 11462. The issue to be determined was whether the self-insuring employer violated Ohio Adm. Code 4121-3-32 by unilaterally terminating the temporary total disability compensation. After a thorough consideration of the arguments raised at the formal hearing and evidence submitted, the Board finds as follows:

On January 17, 2000 the injured worker suffered a right shoulder injury, which was certified by the employer for tendonitis of the right shoulder only. The employer voluntarily began to pay temporary total disability compensation and continued payment of compensation, except for three short periods of wage loss compensation, until June 20, 2001 based on C-84s submitted by Dr. (name redacted), the injured worker's treating physician. The C-84 dated May 15, 2000 certified temporary total disability for right shoulder impingement syndrome. Though this condition was not allowed in the claim, the employer did not object to the payment of temporary total disability on that basis. On or about June 20, 2001 the employer terminated temporary total disability compensation because the latest C-84 received as of that date had extended disability to an estimated return to work date of June 20, 2001. The self-insuring employer did not receive an updated C-84 extending disability beyond June 20, 2001 until on or after June 28, 2001.

On August 1, 2001 the injured worker's representative sent written notice to the employer which stated that the injured worker had not received temporary total disability compensation since June 22, 2001 and requested a reinstatement of temporary total disability compensation. When the self-insuring employer refused to honor this request for reinstatement of temporary total disability compensation, the injured worker filed a self-insured complaint, number 11462, on or about August 28, 2001 alleging that the employer improperly terminated compensation without a hearing and without a statement from the attending physician stating that the injured worker had reached maximum medical improvement or was able to return to her former position of employment pursuant to Ohio Adm. Code 4121-3-32. This complaint was reviewed by the Bureau of Workers' Compensation Self-Insured Department who issued formal written findings on October 26, 2001, finding the complaint to be valid and ordering payment of accrued benefits within seven days of receipt of the order. The employer failed to respond to the Self-Insured Department's instruction to pay and the matter was set for hearing on January 10, 2002.

Prior to the January 10, 2002 Self-Insuring Employers Evaluation Board formal hearing, the employer sent a check to the injured worker in the amount of \$1,335.42, mailed on December 4, 2001, which represented a closed period of temporary total disability benefits payable from June 19, 2001 to July 22, 2001.

At issue before the Self-Insuring Employers Evaluation Board at the January 10, 2002 formal record hearing was whether the employer's termination of temporary total disability compensation based on the June 28, 2001 C-84 from the injured worker's physician of record was justified. The injured worker's representative asserted that the employer had a legal obligation to continue paying temporary total disability compensation and that the facts indicate no valid reason for the unilateral termination of compensation.



The self-insuring employer presented several arguments to support its decision to terminate temporary total benefits on June 20, 2001. The employer first argued that the delay in the submission of a new C-84 as occurred here automatically terminates continuing temporary total disability. Under this scenario, the employer contends that the injured worker must initiate a hearing before the Industrial Commission. The Board does not find this position well taken in the context of such a short delay in the submission of an updated C-84. The employer has not submitted, nor is the Board aware of, any legal authority that would support such a notion.

The second argument was that the C-84 dated June 28, 2001 contained a previous examination date of April 23, 2001 and was therefore legally invalid due to the absence of an examination or treatment contemporaneous with the period of requested disability. The Board rejects this argument, finding that the previous examination date was not so remote from the period of disability to render the C-84 facially invalid. The failure of a treating physician to reexamine an injured worker prior to extending a period of disability certainly presents an issue of credibility. However, issues of credibility concerning the termination of temporary total disability are matters solely within the jurisdiction of the Industrial Commission. There is no legal authority to support the unilateral termination of compensation under these circumstances by a self-insuring employer.

The final argument presented by the self-insuring employer was that the June 28, 2001 C-84 certified disability for non-allowed conditions. The Board finds this argument persuasive. The June 28, 2001 C-84 clearly certified temporary total disability for ICD-9 Code 729.1, myalgia/myositis, which is a non-allowed condition. A self-insuring employer has a duty to pay continuing temporary total disability compensation upon the submission of medical evidence of temporary total disability. Medical evidence supporting temporary total disability is, by definition, evidence that the disability is caused solely by the allowed conditions. A C-84 attributing disability to non-allowed conditions is not such evidence and invokes no duty upon the part of a self-insuring employer to pay.

It is therefore the finding of the Board that the employer was justified in not paying temporary total disability compensation based on the C-84 of June 28, 2001 because the physician of record attributed the injured worker's disability to a non-allowed condition. The Board finds that the complaint is invalid and it is hereby dismissed. A copy of this order shall be placed in the employer's Self-Insured Department file.



On December 18, 2002, this matter came before the Board for a formal hearing on Complaint No. 11855 filed by the injured worker against the self-insuring employer. After further deliberation and discussion, the Board makes the following findings and recommendations:

On April 24, 2001, the injured worker sustained an injury in the course of her employment resulting in this claim. On September 19, 2001, a Staff Hearing Officer allowed the claim for partial amputation of the right thumb and temporary total disability compensation was ordered from April 25, 2001 through August 1, 2001 and to continue upon submission of medical proof. On October 25, 2001, the self-insuring employer terminated the injured worker's temporary total disability compensation based on the October 12, 2001 report from the physician of record that released the injured worker to return to light duty work.

The underlying facts, which led to this dispute, involve a positive drug test for the injured worker on the date of the injury. The employer's union contract requires that an employee who tests positive for certain drugs must participate in a rehabilitation program before such employee can be reinstated to any employment with this employer. The extent of the injured worker's participation in rehabilitation is disputed by the parties but the rehabilitation program was apparently not completed prior to the release to light duty work. While admitting at the hearing that a written light duty job offer was not extended to the injured worker, the employer argues that the injured worker's failure to actively and quickly complete rehabilitation was the reason she could not work as of October 25, 2001. The employer's arguments are not well taken.

R.C. 4123.56 provides that payment of temporary total disability compensation shall not be made during the period when an injured worker has returned to work, when an injured worker's treating physician has made a written statement that the injured worker can return to his former position of employment, when work has been made available within the injured worker's physical restrictions, or the injured worker has reached maximum medical improvement. Generally, a self-insuring employer may unilaterally terminate temporary total disability compensation for one of the aforementioned reasons when the issue is not in dispute. In the present claim, the employer never made light duty work available to the injured worker because it was allegedly precluded from doing so by the union contract. This is obviously not a situation where light duty work was indisputably made available to the injured worker as required by R.C. 4123.56 before temporary total disability compensation could be terminated. The argument that the injured worker's own conduct amounted to an abandonment of light duty work which could have been offered otherwise was clearly a matter to be determined at a hearing before the Industrial Commission prior to any termination of temporary total disability compensation.

It is therefore the finding of the Board that the self-insuring employer's unilateral termination of temporary total disability compensation in this case clearly violated the law and the accepted standards for self-insuring employers in the State of Ohio. The Board finds the complaint against the self-insuring employer for failure to pay temporary total disability compensation in accordance with Ohio Adm. Code 4121-3-32 and R.C. 4123.56 is valid and a copy of this finding will be placed in the employer's risk file for review at the time of renewal. The Board notes that payment of compensation has been made by the employer and the matter is now resolved.



On November 13, 2002, this matter came before the Board for a formal hearing on Complaint No. 12014 filed by the injured worker against the self-insuring employer. After due deliberation and discussion, the Board makes the following findings and recommendations:

On April 25, 2001, the injured worker sustained an injury in the course of her employment resulting in this claim, which is allowed for left wrist sprain/strain, tendonitis and left carpal tunnel syndrome. By order of a District Hearing Officer dated July 24, 2001, temporary total disability compensation was awarded beginning May 17, 2001, to continue upon submission of proof, based upon the C-84 report of Dr. (name redacted). On October 12, 2001 and again on November 20, 2001, the employer mailed a request to Dr. (name redacted) asking that he provide light duty work restrictions for the injured worker so that the injured worker could be offered modified light duty work. The written requests were also followed-up by the telephone. The self-insuring employer did not however receive any response from Dr. (name redacted) and proceeded to terminate temporary total disability compensation on November 27, 2001.

R.C. 4123.56 provides that payment of temporary total disability compensation shall not be made during the period when an injured worker has returned to work, when an injured worker's treating physician has made a written statement that the injured worker can return to his former position of employment, when work has been made available within the injured worker's physical restrictions, or the injured worker has reached maximum medical improvement. Generally, a self-insuring employer may unilaterally terminate temporary total disability compensation for one of the aforementioned reasons when the issue is not in dispute. In the present case, none of the statutory requirements for terminating temporary total disability compensation existed and the unilateral termination thereof was a result of the employer's frustration with the injured worker's physician. While in a perfect system, it would be desirable to have cooperation and prompt responses to requests for information between the parties, the present facts do not justify the unilateral termination of temporary total disability compensation.

It is the finding of the Board that the self-insuring employer's unilateral termination of temporary total disability compensation in this case clearly violated the law and the accepted standards for self-insuring employers in the State of Ohio. The Board is extremely concerned with the frequency with which such complaints are occurring. The Board orders that the self-insuring employer be fined one thousand dollars (\$1,000.00) for this violation.



This matter came before the Board on May 25, 2003 for formal hearing on Complaint No. 12158 filed by the injured worker. After careful consideration of the arguments and evidence, the Board makes the following findings and recommendations.

The injured worker originally submitted to the employer requests for temporary total from August 2, 2001 through February 1, 2002, which the employer rejected. The issue was ultimately heard by a Staff Hearing Officer of the Industrial Commission on February 1, 2002. The Staff Hearing Officer granted the injured worker's request and ordered payment of temporary total disability through February 1, 2002, to continue upon submission of evidence of temporary total disability. Subsequent to the Staff Hearing Officer hearing, the injured worker submitted additional C-84 requests for temporary total disability. The first C-84 request extended temporary total disability to March 1, 2002 and was signed by the injured worker's physician, Dr. (name redacted), on January 2, 2002. The second such C-84 was signed on February 28, 2002 and extended temporary total disability to May 1, 2002. The C-84's are both date-stamped by the BWC on April 23, 2002. The injured worker has not submitted any evidence to support when the C-84's were submitted to the employer. The employer's representative stated at hearing that the February 28, 2002 C-84 was received on April 3, 2002 and the January 2, 2002 C-84 was received on April 24, 2002. As a result, temporary total disability was not paid after the February 2, 2002 hearing before the Staff Hearing Officer.

On April 12, 2002, the employer rejected the February 28, 2002 C-84 because the injured worker's physician had not responded to requests for supporting documentation. The issue before the Board then is whether a two-month delay in the submission of medical evidence in and of itself is a termination of continuing temporary total disability such that the referenced C-84's could be rejected without an Industrial Commission hearing.

While this Board has in prior complaints held that a short delay from seven days to three weeks is not sufficient to remove a C-84 from the ambit of an Industrial Commission order granting payment of temporary total disability upon submission of evidence, a two-month delay is more problematic. It is incumbent on an injured worker to submit evidence of disability timely in order to allow the employer to effectively administer the claim. Questions concerning an injured worker's disability status can easily change over a two-month period in a claim involving soft tissue injuries such as this one. This is especially true where, as is true in this claim, an extended period of disability has already passed prior to the time when the submission of evidence has ceased. The Board therefore finds that the employer did not terminate temporary total disability in this claim because it was not timely requested and the employer was within its rights to question the untimely C-84's.

The Board notes for the record that the employer's arguments questioning the C-84's on the basis of which allowed conditions caused the disability and whether the medical records supported the physician's opinion are matters of credibility. As such, those issues are within the province of the Industrial Commission and are not grounds for a self-insuring employer to terminate continuing temporary total disability compensation. Complaint No. 12158 is found to be invalid. A copy of this order shall be placed in the Self-Insured Department's file.



This matter came before the Board for formal hearing on Complaint No. 12193 in which the injured worker alleged that the employer improperly terminated temporary total disability compensation without a hearing. Upon careful consideration of the evidence and arguments, the Board makes the following findings and recommendations:

The instant employer was paying temporary total disability compensation (TTD) to the injured worker in this claim based on C-84's submitted by the treating physician. The last C-84 prior to the discontinuance of TTD was dated July 25, 2001. This C-84 extended the injured worker's disability to December 1, 2001. After December 1, 2001, the employer discontinued TTD because evidence was not submitted in support of continuing disability.

On March 11, 2002, the treating physician submitted a C-84 dated March 5, 2002 that certified TTD from December 1, 2001, the date it was discontinued, to June 1, 2002. The employer denied this request for TTD by letter dated March 28, 2002.

The injured worker asserts that because the employer denied payment on the March 5, 2002 C-84 that it effectively terminated TTD unilaterally. The problem with this argument is that at the time the C-84 was submitted, TTD was not continuing. TTD had been discontinued due to the injured worker's failure to submit evidence of disability on December 1, 2001. This does not amount to a unilateral termination of TTD by the self-insuring employer and is not contrary to law.

The injured worker cites State ex rel. Diamond International Corp. v. Indus. Comm. (Dec. 30, 1988, Franklin Cty. App) 1988 Ohio App. LEXIS 5312, in support of her argument. This case however was decided under prior law and is contrary to the decision of the Supreme Court in State ex rel. M. Weingold & Company v. Indus. Comm. (2002), 97 Ohio St.3d 44. The injured worker's argument is therefore rejected.

A self-insuring employer is not required to pay a new period of disputed TTD prior to receiving an order from the Industrial Commission to that effect. While it is recognized that a self-insuring employer cannot terminate ongoing TTD except as specifically authorized in R.C. 4123.56, TTD was not ongoing as of March 11, 2002. This decision is supported by the lengthy delay in the submission of evidence as well as the fact that the injured worker was apparently not treated by her physician between July 25, 2001 and February 19, 2002 based on the C-84's submitted. It is also interesting to note that the injured worker's treating physician responded to the employer's medical records request by indicating that there were no office notes between April 4, 2001 and May 29, 2002. As a result, it may be questioned whether the injured worker's treating physician was competent to certify ongoing TTD on December 1, 2001.

The Board finds that the complaint against the self-insuring employer is invalid.



This matter came before the Board on May 27, 2004 for formal hearing on complaint no. 12374. The evidence and arguments were carefully considered and the Board's findings and recommendations are as follows:

The injured worker filed this complaint on July 19, 2002, alleging that the employer's unilateral termination of temporary total disability (TTD) compensation was contrary to applicable law. The employer terminated TTD on June 3, 2002 based on the report of Dr. (name redacted) dated April 19, 2002 which indicated the injured worker was permanently and totally disabled. At the time TTD was terminated, the injured worker was receiving TTD pursuant to a C-84 from Dr. (name redacted) dated April 14, 2002.

The employer's argument that Dr. (name redacted) report was sufficient for a finding that the injured worker's condition was permanent is rejected. Dr. (name redacted) report did indicate that it was unlikely the injured worker would be able to return to gainful employment, but it did not find she was maximum medically improved or that her current level of medical impairment was permanent. Additionally, a C-84 signed by a different physician near the same date indicated that the injured worker was temporarily and totally disabled. Consequently, even if Dr. (name redacted) report could be interpreted in a manner consistent with the employer's position, there was conflicting evidence on this issue and TTD could only be terminated after an Industrial Commission hearing. State ex rel. Russell v. Indus. Comm. (1998), 82 Ohio St.3d 516 and State ex rel. Spurgeon (1998), 82 Ohio St3d. 583.

The Board finds the complaint to be valid.



This matter came before the Board for a formal hearing on July 24, 2003.. Complaint No. 12395, filed by the injured worker on August 5, 2002, alleges that the employer improperly refused to pay temporary total disability, failed to pay medical bills timely, and did not assist the injured worker with the claim. After due consideration of the evidence and arguments of counsel, the Board makes the following findings and recommendations.

The injured worker sustained a low back injury on January 8, 1991. On February 4, 2002 a District Hearing Officer additionally allowed the claim for C6-7 cervical degenerative disc disease and depressive disorder. This order was affirmed by a Staff Hearing Officer on March 26, 2002.

On February 14, 2002, the injured worker submitted to the employer C-84's certifying disability based on the newly allowed conditions. On March 6, 2002, the employer objected to the request for temporary total disability. A second request for temporary total disability was submitted on April 4, 2002 and the employer again objected. On May 6, 2002, the employer filed a C-86 motion with the Industrial Commission requesting a determination that the injured worker had reached maximum medical improvement even though no hearing had been held on the prior requests for temporary total disability. The employer's correspondence accompanying the C-86 requested that the C-86 be heard with the prior objections to temporary total disability.

On July 20, 2002, the employer's C-86 was denied by a District Hearing Officer. The issue raised by the C-86 was the only issue listed on the hearing notice and the District Hearing Officer order. The request for temporary total disability was not listed nor was any waiver of notice set forth in the order. Additionally, the District Hearing Officer did not expressly order the payment of temporary total disability. On August 21, 2002, a Staff Hearing Officer modified the District Hearing Officer order and attempted to state jurisdictional grounds for the temporary total disability issue but still did not expressly order payment. Thereafter, the employer reinstated temporary total disability on September 5, 2002, within twenty-one days of the Staff Hearing Officer order.

The majority of the Board finds the injured worker's complaint to be invalid insofar as the payment of temporary total disability is concerned. The employer was never expressly ordered by the Industrial Commission to pay temporary total disability prior to September 5, 2002. While the Board agrees that all of the elements for the payment of temporary total disability were set forth in the July 20, 2002 District Hearing Officer order, proper notice was not given on the issue of temporary total disability. Absent an express waiver of notice of the temporary total disability issue in the order, there could be no valid order requiring payment of compensation within twenty-one days.

That portion of the injured worker's complaint that the employer failed to timely pay or timely respond to requests for the payment of medical bills is also found invalid. There has been no adjudication of any request for treatment or for the payment of medical bills before the Industrial Commission. It is not within the province of the Board to make final determinations on claims disputes. Inasmuch as the employer apparently denied the requests for payment, any determination that a bill is due and owing must be determined by the Commission.



The final issue raised by the injured worker's complaint is whether the employer has properly responded to the submission of medical bills or assisted the injured worker. A review of the numerous responses to medical bills by the employer in this file reveals several serious problems. A response for bills for psychological services rendered from January 24, 2002 through February 7, 2002 generated on March 25, 2002 indicates that the reason for nonpayment is that further review is required by the Industrial Commission. The employer did not notify the injured worker of the right to appeal the decision nor did it disclose any substantive reason for denying payment. Such a response totally ignores an employer's duty to effectively administer its claims. Even more alarming is that the response clearly indicates that no copy was provided to the injured worker or her representative as required by Ohio Admin. Code 4123-19-03(K)(5). Furthermore, the file is replete with responses to medical bills where notice was not provided to the injured worker. None of the responses indicate that the injured worker may appeal to the Industrial Commission even if she were provided with a copy. Finally, on most of the responses, a date of service is not listed so it is not possible in every instance to identify the bill being considered.

For the foregoing reasons, the Board finds that the complaint is valid as it relates to the employer improperly responding to the request for payment of medical bills and failure to notify let alone assist the injured worker in filing for payment of benefits and compensation. The Board is extremely concerned about this lack of adherence to such fundamental requirements.

The Board finds the complaint to be valid as stated above. The Board further recommends that an audit be performed to assess the employer's capability of effectively administering its workers' compensation claims. A copy of this order shall be placed in the employer's Self-Insured Department file.



This matter came before the Board on May 15, 2003 for formal hearing on complaint numbers 12444 and 12609 filed by the injured worker. After careful consideration of the evidence and arguments presented, the Board makes the following findings and recommendations:

In June 2002, the injured worker in this claim was receiving temporary total disability compensation (TTD) as voluntarily awarded by the self-insuring employer, Marriott International, Inc. for a period prior to the date of July 1, 2002. The parties do not dispute that TTD was paid until July 1, 2002 based on C-84's submitted by the injured worker's treating physician, Dr. (name redacted). Dr. (name redacted) then extended TTD to an estimated return to work date of September 1, 2002 by a C-84 dated July 9, 2002. Upon receipt of this C-84, the employer's representative notified the injured worker by letter dated July 23, 2002 that TTD would not be paid based on this C-84. The letter further indicated that no further TTD would be paid until Dr. (name redacted) furnished complete treatment records, a narrative report and submitted a new C-84 with more elaborate responses to each request for explanation on the form. As a result of this refusal to pay TTD, a self-insured complaint (complaint no. 12444) was filed on or about September 4, 2002.

During this period, the injured worker filed a motion for an emergency hearing on the issue of TTD. A District Hearing Officer (DHO) heard this dispute on September 26, 2002 and ordered TTD from July 1, 2002 through the date of the hearing and to continue upon submission of evidence.

Subsequent to this hearing the employer paid TTD from July 1, 2002 through September 1, 2002 based on the July 9, 2002 C-84 from Dr. (name redacted). By letter dated October 22, 2002 the employer informed the injured worker that TTD beyond September 1, 2002 pursuant to Dr. (name redacted)'s C-84 dated September 13, 2002 and the DHO order, would not be paid until the employer received Dr. (name redacted)'s office note for the injured workers September 11, 2002 visit. This refusal to pay TTD generated a second self-insured complaint (complaint no. 12609) filed on or about November 1, 2002.

In each of the complaints before the Board, the Self-Insured Department issued a finding of a valid complaint, which was affirmed by the Deputy Administrator on February 25, 2003. Both the employer and the Deputy Administrator requested that these matters be referred to the Board.

The Board first finds that the C-84's dated July 9, 2002 and September 13, 2002 from Dr. Yoo are facially valid and some evidence supporting TTD. Both C-84's attribute a continuing period of disability solely to the allowed condition and are signed by the treating physician. Inasmuch as TTD was continuing as of July 1, 2002 based on the employer's prior determination to pay, payment of compensation could not be terminated without a hearing except as provided in R.C. 4123.56:

“...payment shall not be made for the period when any employee has returned to work, when an employee's treating physician has made a written statement that the employee is capable of returning to the employee's former position of employment, when work within



the physical capabilities of the employee is made available by the employer or another employer, or when the employee has reached the maximum medical improvement...”

There is no evidence or suggestion that any of the conditions supporting termination of TTD are present in this matter.

The employer argues that where R.C. 4123.56 provides that “payments shall be for a duration” it means for the duration of one C-84. Of course the statute itself contradicts this argument by going on in the same sentence to state “based on the medical reports” (not “a” report) “of the attending physician.” Furthermore, the Supreme Court of Ohio long ago rejected this argument. AT&T Technologies, Inc. v. Indus. Comm. (1993), 68 Ohio St.3d 55. See also, State ex rel. Russell v. Indus. Comm. (1998), 82 Ohio St.3d 516; State ex rel. MTD Products v. Indus. Comm. (1996), 76 Ohio St.3d 593; State ex rel. Jeep Corp. v. Indus. Comm. (1991), 62 Ohio St.3d 64.

The employer also argues that a C-84 is not “some evidence” where it is not supported by the office notes and records of the treating physician. What the employer ignores however is that it is an issue of credibility where a facially valid C-84 may be challenged based on the content of the underlying medical records. Any such credibility issues where TTD is continuing is solely within the jurisdiction of the Industrial Commission. Furthermore the Board notes that a C-84 is the accepted Bureau of Workers’ Compensation form report for certification of TTD and its use is generally accepted throughout the state. The Board rejects the employer’s apparent request to alter the form or change the requirements for certifying TTD.

The Board also rejects the employer’s argument that the failure of the medical provider to abide by the contract with the employer’s QHP renders a C-84 legally defective. Such a contractual dispute does not directly involve an injured worker and is not a ground for terminating TTD.

The Board additionally rejects the employer’s argument that the examination date on the July 9, 2002 C-84 is necessarily too remote. In this case, the injured worker was in physical therapy during the intervening period and her progress may have been available to the physician. Either way, a challenge to a C-84 on the basis must be made before the Industrial Commission and TTD shall continue until there is a determination.

While the employer does not raise any argument in this regard, the Board notes that the July 9, 2002 and September 13, 2002 C-84’s were not submitted on the very date to which TTD was continued by the prior C-84. The delay in each case is minor however and does not render the C-84 defective or undermine the continuing nature of the injured worker’s disability.

The Board finds both of the complaints valid. A copy of this order shall be placed in the employer’s file.



This matter came before the Board for formal hearing on June 30, 2004. Complaint No. 13303, filed by the injured worker on July 29, 2003, alleges that the employer, (name redacted), improperly terminated temporary total disability compensation. After due consideration of the evidence and arguments of counsel at hearing, the Board makes the following findings and conclusions.

The injured worker sustained a neck and shoulder injury in the course of and arising out of her employment with (name redacted) on March 13, 2003. Thereafter, she began receiving temporary total disability compensation, based on C-84s submitted by her treating physician, (name redacted). On March 20, 2003, Dr. (name redacted) had indicated in a "Work Capacity Form" that the injured worker be restricted to work that does not involve activity above shoulder level, with restrictions on pounding with the right hand, and with restrictions on bending of the neck.

On July 14, 2003, a representative of (employer name redacted) by telephone made an oral offer of full-time light duty work to the injured worker. On the same date, (employer name redacted) sent the injured worker a letter confirming the conversation, describing the position, and stating that the job description was within the restrictions established by the injured worker's physician. However, (employer name redacted) had not prior to that time discussed the job description with Dr. (name redacted), nor received any other confirmation from Dr. (name redacted) that the job fell within the injured worker's restrictions.

Thereafter, based on a conversation with the injured worker on July 17, 2003, (employer name redacted) orally modified the job offer to part-time. The job description remained the same. (employer name redacted) apparently advised the injured worker orally that she had until July 18, 2003, to accept the offer. In the meantime, (employer name redacted) had submitted the description of the job duties for the injured worker's light duty job to Dr. (name redacted), asking for his opinion regarding these restrictions.

The injured worker did not respond to the July 17, 2003 offer and on July 18, 2003, (employer name redacted) sent the injured worker a letter stating, in pertinent part: "You were given until close of business on July 18th to either accept or refuse the position. Since at close of business on July 18th you had not called to accept the position (employer name redacted) offered we are considering this a refusal." Also on July 18, 2003, Dr. (name redacted) provided a response to (employer name redacted)'s request that he review the job duties for the offered job. Dr. (name redacted) indicated on that date that the job duties were "okay, as long as work capacity form dated 3-20-03 specifications are met." Coincidentally, on July 18, 2003, the injured worker's attorney responded to the June 14, 2003 letter from (employer name redacted), indicating that she did not consider the offer of full-time work to be a good faith job offer, and that she had instructed her client not to accept the position.

On August 4, 2003, (employer name redacted) sent a letter to the injured worker informing her that the employer had received approval from Dr. (name redacted) regarding the offered job, characterizing the July 18, 2003, letter as a job offer, and advising the injured worker that "due to the fact that you did not accept this offer, your temporary total benefits have been terminated as



of 7/18/03.” In accordance with its letter, (employer name redacted) stopped paying temporary total compensation as of July 18, 2003.

The issue before the Board is whether the employer complied with the requirements of R.C. 4123.56 and Ohio Adm. Code 4121-3-32 when it unilaterally terminated temporary total disability compensation as of July 18, 2003.

R.C. 4123.56(A) provides that with respect to temporary total disability compensation paid by a self-insuring employer, “payments shall be for a duration based upon the medical reports of the attending physician.” The statute further provides:

Payments shall continue pending the determination of the matter, however payment shall not be made for the period when any employee has returned to work, when an employee’s treating physician has made a written statement that the employee is capable of returning to the employee’s former position of employment, when work within the physical capabilities of the employee is made available by the employer or another employer, or when the employee has reached maximum medical improvement.

(Emphasis added).

Ohio Adm. Code 4121-3-32(B) provides, in pertinent part:

(B)(1) Temporary total disability may be terminated by a self-insured employer or the bureau of workers’ compensation in the event of any of the following:

* * *

(b) the employee’s treating physician finds that the employee is capable of returning to his former position of employment or other available suitable employment.

(Emphasis added).

These provisions require that before a self-insuring employer may unilaterally terminate temporary total compensation, the employee’s treating physician must find that the employee is capable of returning to her former position of employment or “other available suitable employment.”

Employment is not made “available” to an injured worker unless it is offered to the injured worker. State ex rel. Nestle USA, Prepared Foods Div. v. Indus. Comm. (2003), 101 Ohio St.3d 386. Further, available employment cannot be considered “suitable” unless and until the injured worker’s treating physician has reviewed the offered job description, and has indicated whether



the job falls within the injured worker's physical capabilities. See, e.g. Ohio Adm. Code 4125-1-01(A)(7).

From the above it is clear that, before a self-insuring employer may terminate temporary total compensation pursuant to Ohio Adm. Code 4121-3-32(B)(1)(b), the employer must make an offer of employment to the injured worker that has been found by the injured worker's treating physician to fall within the injured worker's physical capabilities. See, e.g., State ex rel. Coxson v. Dairy Mart Stores of Ohio (2000), 98 Ohio St.3d 428; State ex rel. Professional Restaffing of Ohio v. Indus. Comm. (10th Dist. 2003), 152 Ohio App. 3d 245. Thus, for purposes of unilateral termination of temporary total disability compensation, an employer is not alone qualified to determine and represent to an injured worker that an offered job fits within an injured worker's restrictions. An injured worker need not rely on an employer's statements to that effect, unless the injured worker is made aware at the time of the offer that the treating physician has found the job duties described in the offer to be suitable.

In this case, (employer name redacted) made three separate offers of employment to the injured worker. The first was made orally on July 14, 2003, the second was made in writing on that same date, and the third was made orally on July 17, 2003. Although the Board has no reason to doubt that these offers were made in good faith, and in an attempt to return the injured worker to an available job, they cannot be considered offers of available suitable employment, since at the time the offers were made, the injured worker's treating physician had not found that the offered job fell within the injured worker's physical capabilities, and the injured worker had not been informed of the physician's approval. As indicated above, the injured worker was not required, in order to avoid termination of temporary total compensation by the employer, to accept an offered job the physical requirements of which had not yet been approved by her treating physician.

It was not until July 18, 2003, that (employer name redacted) received confirmation from Dr. (name redacted) that the job duties proposed by (employer name redacted) were suitable for the injured worker. However, no offer of employment was made by (employer name redacted), either orally or in writing, following the employer's receipt of this confirmation on July 18, 2003. The Board does not consider the July 18, 2003 letter from (employer name redacted) to be an offer of employment. There is nothing in that letter that conveys a current offer of employment to the injured worker. In fact, if anything, the letter indicates the employer's lack of an intention to keep any of its previous offers of employment open to the injured worker.

Because (employer name redacted) did not make an offer of suitable employment to the injured worker prior to terminating temporary total compensation, the Board finds that the employer failed to comply with the requirements of R.C. 4123.56 and Ohio Adm. Code 4121-3-32(B)(1)(b). Therefore, by a two-to-one vote, the Board finds the self-insured complaint to be valid.



This matter came before the Board for formal hearing on May 27, 2004. After careful consideration of the arguments and the evidence, the Board makes the following findings and recommendations.

On October 7, 2003 the injured worker filed self-insured complaint no. 13424 alleging that the employer unilaterally terminated temporary total disability compensation (TTD) and did not notify the Bureau of Workers' Compensation, the Industrial Commission or the injured worker's attorney.

The injured worker was receiving TTD pursuant to a Medco-14 form signed by her treating physician on April 6, 2003. The form provided that the injured worker could return to work with restrictions from April 30, 2003 to July 30, 2003 and could work up to three hours daily. The employer paid TTD rather than accommodate the restrictions.

No further evidence supporting TTD was submitted upon the expiration of the estimated return to work date of July 30, 2003, until a subsequent C-84 form dated September 17, 2003. As a result, it is clear that the employer did not unilaterally terminate ongoing TTD because it had no evidence upon which payment could be made. The injured worker's allegation in that regard is unfounded.

With respect to that portion of the complaint alleging that the employer failed to notify the Bureau of Workers' Compensation (BWC), the Industrial Commission or the injured worker, it is not at all clear from the complaint what notice was allegedly required. Ohio Adm. Code § 4123-5-18 addresses the issue of medical proof required for payment of compensation. § 4123-5-18(A) requires a physician's report before payment of compensation is approved. § 4123-5-18(B) sets forth criteria for evaluating whether medical evidence is sufficient. § 4123-5-18(C) then requires that when payment of compensation cannot be made due to a lack of medical proof, the injured worker be "immediately advised of the necessity to submit appropriate medical proof as specified in paragraph (A) of this rule." (Emphasis added.) The clear import of paragraph (C) therefore requires the submission of proof pursuant to paragraph which is being rejected. This is made clearer when considered in connection with § 4123-5-18(D) which places the duty for submission of medical reports supporting TTD squarely on the injured worker. When read in total, § 4123-5-18 does not place a notice requirement upon an employer for the injured worker's failure to submit medical proof. Any other interpretation would be illogical.

The Board notes that the BWC previously engaged in the practice of notifying an injured worker when the last check was being paid pursuant to a physician's report and further proof had not been submitted. The BWC ceased this practice in 2001. The Board also finds that there is no requirement for such a "last check" notice.

The injured worker's complaint is held invalid.



This matter came before the Board for formal hearing on June 30, 2004. Complaint No. 13540, filed by the injured worker on November 28, 2003, alleges that the employer (name redacted) failed to timely pay temporary total disability compensation ordered by a District Hearing Officer, as required by Ohio Adm. Code 4123-19-03(K)(5). After due consideration of the evidence and arguments of counsel and the injured worker at hearing, the Board makes the following findings and conclusions.

On October 16, 2003, a District Hearing Officer of the Industrial Commission ordered payment of temporary total compensation to be made for the time period April 16, 2003, through October 16, 2003, inclusive, and to continue upon submission of medical evidence supporting temporary total disability due to the allowed conditions. The order was mailed October 21, 2003. The employer appealed this order to a Staff Hearing Officer, but later dismissed its appeal.

On November 28, 2003, the injured worker filed a self-insured complaint against the employer, alleging that the employer had not yet paid the ordered compensation. Following notification of the injured worker's self-insured complaint, counsel for the employer responded to the complaint. The employer submitted evidence showing that the employer had received a copy of the District Hearing Officer order on October 24, 2003.

In support of its response to the self-insured complaint, the employer submitted evidence in the form of a computer printout showing that payment of the ordered compensation in the amount of \$4,711.69 was issued on November 13, 2003, and mailed to the injured worker's attorney at (address redacted). The employer also submitted a copy of the form C-230 power of attorney signed by the injured worker on June 13, 2003. The C-230 specifically authorized the employer to mail the compensation check to her attorney at the address listed on the form. The address listed for her attorney, (name and address redacted).

Also in response to the complaint, the employer stated that the check issued on November 13, 2003 was returned due to the injured worker's attorney having moved. Thereafter, a new check in the same amount was issued on December 11, 2003, and mailed directly to the injured worker. The injured worker did not dispute at hearing that she did thereafter receive the check.

Ohio Adm. Code 4123-19-03(K)(5) provides that a self-insuring employer shall "pay compensation due and payable under an order no later than twenty-one days after receipt of the order to do so." The evidence presented by the self-insuring employer in this case shows that the requirements of that rule were met. The computer printout submitted by the employer shows that a check for the compensation ordered in the October 16, 2003 District Hearing Officer decision was mailed on November 13, 2003, less than 21 days after the employer's receipt of the District Hearing Officer order on October 24, 2003. The check was directed to the injured worker's attorney at the address expressly authorized by the injured worker in the C-230 form dated June 13, 2003.

Although the injured worker argued at hearing that the employer had previously, on May 29, 2003, sent a compensation check to her attorney's correct address, and therefore was aware of her attorney's correct address prior to the November 13, 2003 payment, the record reveals that the



Self-Insuring Employers Evaluation Board
Synopsis of Formal Decisions

Temporary Total Disability
Complaint No. 13540
Continued

May 29, 2003 check was paid before the injured worker on June 13, 2003 signed and filed with the self-insuring employer the power of attorney form directing the employer to send her compensation check to the (incorrect) address listed on that form. The Board finds that the employer and/or its third-party administrator was entitled to rely, when making payments of compensation, upon the address provided for the injured worker's attorney in the C-230 form signed by the injured worker.

For the above stated reasons, the Board concludes that the employer fulfilled its responsibilities under Ohio Adm. Code 4123-19-03(K), by mailing the payment of ordered compensation on November 13, 2003 to the address listed for the injured worker's attorney on the C-230 form. Therefore, the Board finds the self-insured complaint to be invalid.



This matter came before the Board on 10/14/2004, for formal hearing on Complaint No. 13601, filed by the injured worker. After careful consideration of the evidence, the Board makes the following findings and recommendations.

The injured worker was diagnosed with carpal tunnel syndrome in 1997. She continued to work for the employer until September, 1999. On 10/20/1999, she filed a workers' compensation claim, which was denied by the Bureau of Workers' Compensation on grounds that the application for benefits was not filed within two years of the injury. The BWC identified the date of injury as 10/01/1997. The injured worker appealed this decision, and her claim was allowed by the Industrial Commission in a final order dated 01/21/2000. The commission order allowed the claim as an occupational disease claim, identified the date of disability as 09/03/1999, and found that the claim was not barred by the statute of limitations.

The employer was a state-fund employer until 04/01/1999, at which time it became self-insured. The employer was recently purchased by another company.

The BWC initially paid benefits and compensation under the belief that the claim was a state-fund claim. However, in an order dated 09/29/2001, the BWC reassigned the claim as a self-insured risk based on the date of disability identified by the commission, and the fact that the employer was self-insured on that date. The injured worker appealed this decision to the commission. However, her appeal was ultimately dismissed by a staff hearing officer of the commission in an order dated 01/17/2002, on grounds that the commission did not have jurisdiction to address matters involving risk assignment. In the same order, the staff hearing officer referred the matter to the BWC adjudicating committee. Thereafter, the adjudicating committee issued an order finding that it had no jurisdiction to address a risk matter that was not brought before it by the employer.

By order dated 11/07/2003, a district hearing officer of the commission awarded temporary total disability compensation to be paid in the claim from 05/02/2003, and to continue upon submission of proof. Although the district hearing officer order listed the incorrect risk number for the claim on the order (listing the state-fund, rather than the self-insured risk number), the order stated at the bottom: "The Self-Insured employer is hereby ordered to comply with the above findings." The order also identified the claim as a self-insured claim by listing the code "LT-OD-SI-COV" at the top of the order.

It is undisputed that the employer did not pay the ordered compensation upon receipt of the order. Rather, in response to a letter from the injured worker's attorney dated 11/26/2003, requesting that the employer pay the compensation, the employer on 12/09/2003 declined to pay the award, stating that the district hearing officer order listed the state-fund risk number on the order, and therefore payment was the responsibility of the BWC.

The Board finds that the employer violated Ohio Administrative Code 4123-19-03(K)(5) and R.C. 4123.511(H) by failing to pay the award of compensation made by the district hearing



officer upon receipt of the order. Ohio Administrative Code 4123-19-03(K)(5) requires self-insuring employers to follow the requirements of R.C. 4123.511. R.C. 4123.511(H) requires that payments of compensation resulting from a commission order shall commence on the “date of receipt by the employer of an order of a district hearing officer.” Thus, the employer in this case was required to pay the compensation upon receipt of the district hearing officer decision ordering payment of compensation, which it failed to do.

The employer argues that it was not required to pay the compensation awarded in the district hearing officer order because the state-fund risk number was listed on the order. However, the Board finds that the typographical error which resulted in the placement of the state-fund risk number instead of the self-insured risk number on the order does not excuse the employer’s failure to comply with the order. The order specifically directs the “self-insured” employer to pay the ordered compensation, and otherwise clearly indicates that the claim is a self-insured claim. The order clearly requires the self-insuring employer, rather than the BWC, to pay the award. Additionally, pursuant to the Board’s request, the employer has submitted a compensation payment history showing that the employer paid compensation in the claim beginning as early as 01/02/2003. Therefore, the Board finds that the employer was well aware of its responsibility to pay compensation pursuant to the 11/07/2003 commission order, despite the typographical error in the order.

Although the employer argues that the BWC applied the incorrect legal standard in reassigning the risk in this claim, this is not a valid defense to the self-insured complaint alleging failure to pay compensation ordered by the commission, particularly when the employer did not attempt to correct the alleged BWC error by bringing the matter before the BWC adjudicating committee in the two years between the 09/26/2001 order issued by the BWC, and the 11/07/2003 award of compensation.

Complaint No. 13601 is found to be valid. The employer has represented that payment of the compensation at issue in this complaint has been made. Therefore, no remedial action will be ordered.

A copy of this order shall be placed in the Self-Insured Department’s file.

Chapter 18

Wage Loss Compensation



Self-Insuring Employers Evaluation Board



This matter was referred for formal hearing on June 27, 2001 before the Self-Insuring Employers Evaluation Board on complaint number 9568 filed by the injured worker regarding the employer's alleged failure to pay wage loss compensation timely and failure to comply with a District Hearing Officer order which was not appealed. Upon consideration of evidence and arguments of counsel, the Board makes the following findings and recommendations pursuant to R.C. 4123.352:

The relevant facts are as follows: On February 8, 2000 the injured worker filed a request for non-working wage loss from January 7, 2000 and to continue. A District Hearing Officer found in an order dated May 26, 2000 that the injured worker's motion was moot. The hearing officer referenced a letter dated May 19, 2000 from the employer's authorized representative, that indicated the employer had no objection to the injured worker's request for non-working wage loss and requested the hearing be cancelled. The self-insured employer was ordered to comply with the findings contained in the order. It should be noted that on May 12, 2000 the injured worker filed at least three pages of job search records and therefore such job search records were available for review at the time of the hearing. On June 5, 2000 the injured worker's representative sent a letter to the employer's representative requesting that wage loss payments be sent to their office in accordance with the power of attorney on file. In response, the employer's representative sent a letter dated July 3, 2000 to the injured worker's representative indicating the employer had accepted the request for wage loss based upon Dr. G's report and indicated that the employer needed the job search statement. With a letter dated July 18, 2000, the injured workers' representative provided the employer's representative the job search forms and again requested payment of the wage loss benefits. On July 25, 2000 the injured worker's attorney faxed the employer's representative six pages of job search forms. Thereafter, on August 4, 2000 the injured worker's representative filed a complaint with the Self-Insured Department. On August 16, 2000 the employer filed a motion pursuant to R.C. 4123.52 requesting a hearing on the objection to wage loss, asserting that the documentation submitted for job search did not show a good faith effort.

The Self-Insured Department notified the employer that a complaint had been filed and requested the employer provide a written response to the allegations. In a letter dated September 28, 2000, the employer's representative responded on behalf of the employer indicating they received the job search forms on July 20, 2000 and believed that the forms did not meet the criteria of supporting documentation for payment of wage loss as outlined in the Bureau rules and regulations. They also stated that a motion had been filed requesting a hearing to determine whether the injured worker was performing a good faith effort with respect to her job search.

On October 13, 2000 a District Hearing Officer denied the employer's motion and awarded the injured worker both working and non-working wage loss. Following receipt of that order, the employer began payment of wage loss compensation. The District Hearing Officer order was affirmed by a Staff Hearing Officer on February 7, 2001.

In a letter dated October 13, 2000 the Self-Insured Auditor found the employer's explanation for non-payment acceptable and dismissed the complaint. On October 24, 2000 the injured worker's representative filed a request for reconsideration and on February 20, 2001 the Administrator's



designee, reversed the Self-Insured Department's decision and found the employer in violation of Ohio Adm. Code 4123-19-03(L)(5). The finding specified that the employer should have paid wage loss within 21 days of their acceptance of the motion for wage loss or within 21 days of the District Hearing Officer's order. The Administrator's designee found that had the employer not seen the job search, it certainly had the right to request a copy of the job search prior to accepting the application for wage loss. Further, had the employer chosen to proceed to the May 26, 2000 hearing, the job search forms were on file at that time. The issue could have been resolved at the May 26, 2000 hearing, but based on the employer's representation and its subsequent failure to pay, the issue was not adjudicated until October 13, 2000.

The employer objected to the finding of the Administrator's designee and requested the matter be presented to the Self-Insuring Employers Evaluation Board. The employer's position is that the injured worker failed to timely provide job search statements and that when the statements were submitted they did not meet the criteria of supporting documentation for payment of wage loss. The employer asserts that the injured worker did not perform what would constitute a good faith job search in that between December 29, 1999 and April 1, 2000, the injured worker only made 17 job contacts, many of which were not within her restrictions. The employer further contends that even with an order to pay wage loss, payment was conditional. The order placed a responsibility on the injured worker to provide information and gave the employer the right to make a judgment call on whether the information provided by the injured worker supported payment of wage loss. The employer asserts they had followed the proper procedures and that there was no validity to either the allegation of non-payment or the allegation of untimely payment.

The injured worker's position is that the May 26, 2000 District Hearing Officer hearing was the opportunity for the employer to question the quantity and quality of the job search. By accepting the request for wage loss, the employer waived their right to object to the payment of wage loss. Furthermore, if the employer did not intend to pay or questioned the job search efforts, they could have filed an objection to the hearing officer's order. As far as timeliness of payment is concerned, a request made in February 2000 resulted in benefits not being paid until October 2000, definitely exceeding the 21 days provided for payment.

After a review of the evidence submitted and testimony elicited at the hearing, the Board finds that the issue before them is whether the employer followed the proper procedures for adjudicating and paying the injured worker's wage loss benefits.

The Board took into consideration that employers granted permission to pay compensation and benefits directly have the authority to make initial determinations on a variety of issues in accordance with the law. Specifically, Ohio Adm. Code 4125-1-01(G)(1) and (2) provides that where the employer is a self-insuring employer, the employer shall adjudicate the initial application for wage loss compensation and all issues which arise with respect to the injured worker's ongoing entitlement to wage loss compensation. Paragraph (G)(3) of that rule provides that the employer shall file a copy of its decision with the BWC or the Industrial Commission for placement within the claim file. The Board finds that the employer's May 19, 2000 letter stating the employer had no objection to the request for wage loss compensation serves as the employer's



adjudication of the initial application for wage loss compensation and the employer's agreement to pay such compensation.

Ohio Adm. Code 4123-19-03(L)(7) provides, in pertinent part, "...[t]he self-insuring employer shall proceed to make payment of compensation or medical benefits without any previous order from the bureau or commission and shall start such payments as required under the Worker's Compensation Act, unless it contests the claim." Ohio Adm. Code Rule 4123-19-03(L)(5) provides in pertinent part, "...[t]he employer shall pay compensation due and payable under an order no later than twenty-one days after receipt of the order to do so."

Once the employer accepted the injured worker's request for wage loss, they had an obligation to make payment within twenty-one days after the District Hearing Officer order as to those periods of wage loss, which were adjudicable as of the date of the hearing. There was an opportunity to assert their concerns regarding the injured worker's job search at the May 26, 2000 hearing and the employer chose not to afford themselves of that opportunity. At the time of the hearing, there were at least three pages from the injured worker's job search records on file. The Board finds that there is no merit to the employer's argument that its acceptance of the request for wage loss was contingent upon the receipt of further documentation. If there was missing information at the time of acceptance of the request for wage loss, the employer had an opportunity to proceed with the hearing and argue the merits of the sufficiency of the job search.

The majority of the Board finds that the employer had an obligation to pay the wage loss compensation within twenty-one days of receipt of the May 26, 2000 District Hearing Officer order. The majority of the Board finds that the complaint against the employer for failure to pay wage loss compensation and to pay it timely in accordance with Ohio Adm. Code 4123-19-05(L)(5) is valid. A copy of this finding will be placed in the employer's risk file for review at the time of renewal. The majority of the Board further finds that the matter is resolved and a penalty is not assessed.

DISSENTING OPINION:

I respectfully dissent from the majority's finding of a valid complaint for the reason that the employer for good cause objected to the payment of non-working wage loss. The employee did not supply valid documentation for the job search and did not show a good faith effort was being made. The employer agreed to the merits that wage loss was an appropriate benefit to be paid and agreed with the C-86. The C-86 requesting non-working wage loss only had a C-140 attached. The employer was waiting for the documents that demonstrated the employee was conducting a good faith job search. It was not till after the employer received the job search documents that it objected to the payment of such a benefit. The employer then filed a C-86 motion for the job search documents to be evaluated by the Industrial Commission. Under these circumstances, I cannot find a valid complaint against the employer.



This matter came before the Board for formal hearing of the above referenced complaints alleging the employer refused to pay compensation pursuant to an Industrial Commission order. Upon due deliberation of the evidence and arguments presented, the Board makes the following findings and recommendations:

The complaint of Injured Worker A, involved an Industrial Commission award of 13% permanent partial disability in an order mailed on May 28, 1993. This order was not appealed and within the period required for payment, the employer's representative notified the injured worker's representative that the award was being offset by advance payments of compensation pursuant to R.C. 4123.56(C). Neither party submitted the matter to the Industrial Commission for a decision on the applicability of an offset.

Subsequent to the employer's notification of offset, another permanent partial award for the same injured worker was litigated in the Tenth District Court of Appeals in State ex rel. Bolden v. Indus. Comm., Case No. 95APD03-282, (Ohio App. Jan. 23, 1997). In this mandamus action the Court of Appeals found that the Industrial Commission abused its discretion in finding the offset applicable because the record did not support that the injured worker was disabled during any period where he was paid under his contract of hire. This case, however, is limited in its application to the facts of the specific claim involved. There might very well be an offset applicable to the claim before the Board if the matter had been adjudicated. The Board finds therefore that the Court's decision does not affect the necessity of an adjudication of the asserted offset by the Commission in the claim before the Board.

Subsequent to the Bolden case, the Tenth District Court of Appeals issued another decision in a case involving this employer. In State ex rel. Cleveland Browns, Inc. v. Indus. Comm., Case No. 97APD11-1474 (Dec. 8, 1998, Franklin Cty. App.) (hereinafter referenced to the Harper Decision), the Court interpreted the parties' contract to limit the offsets provided for in R.C. 4123.56(C) to workers' compensation awards made during the actual contract period and not all future awards. The employer decided not to appeal this decision, and to pay all such awards to which the decision applied.

On February 9, 1999, the employer's representative instructed the third-party administrator to pay the permanent partial disability award in the claim at issue here pursuant to the Staff Hearing Officer order in this claim. This payment would have been due immediately upon receipt of the Staff Hearing Officer order absent the offset dispute. After the Harper Decision, payment was no longer disputed by the employer. The Board finds therefore that payment was due immediately upon the expiration of the appeal period for the Harper Decision, or January 22, 1999. The Board further finds the complaint valid for the approximately two-month period of delay after January 22, 1999. The Board finds no violation prior to this date because the offset was not adjudicated by the Industrial Commission.

The complaint of Injured Worker B presents the same issues previously set forth with respect to the above complaint. Whether the employer was entitled to an offset in this claim was never adjudicated by the Industrial Commission after the offset was asserted by the employer's letter of December 7, 1995. Payment was therefore not due until January 22, 1999 for the reasons



previously discussed. The award however was not paid until July 9, 1999. The Board therefore finds the complaint of Injured Worker B valid for the nearly six-month delay in paying this award.

The complaint of Injured Worker C also presents the same issues previously discussed. Again the question of offset was never adjudicated by the Industrial Commission. Payment of the permanent partial disability award was made due upon the expiration of the appeal period in the Harper Decision on January 22, 1999. Payment was not made until March 24, 1999. The Board therefore finds the complaint valid due to the two-month delay in payment.

The complaint of Injured Worker D once again presents the same issues. While the offset issue was adjudicated in another claim for this injured worker, it was not in this claim. Both claims involved the offset of permanent partial disability awards made within three months of each other. Again for the reasons previously set forth, payment in this claim was not due until January 22, 1999 and was paid on March 24, 1999. This complaint is therefore valid for the intervening two-month delay.

The final matter before the Board is the complaint of Injured Worker E. In an order dated March 27, 1997, the injured worker was awarded wage loss compensation from October 25, 1995 to continue upon submission of proof of lost earnings. On appeal to a Staff Hearing Officer, this order was modified only to the extent that the offset was found not to apply. Subsequent to these orders, a dispute arose between the parties as to the adequacy of the proof submitted in support of the wage loss. Inasmuch as the award was contingent upon the submission of evidence, any disagreement as to the adequacy of this evidence was within the sole jurisdiction of the Industrial Commission. This Board has no jurisdiction over the dispute. The Board does not find a clear order to pay compensation under these circumstances. The complaint of the injured worker is therefore found invalid.

The Board further finds that the four violations found valid against this employer do not warrant the assessment of any penalty at this time. The employer's representative explained that the Harper Decision applied to a large number of claims that had to be processed for payment. The Board finds this explanation reasonable and a mitigating factor to be considered.

In conclusion, the Board finds that four of the five complaints are valid and one invalid. A copy of this order shall be placed in this employer's file. No further action is required as these matters have long since been resolved.