

BWC Medical Guide



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Foreword

The Health Partnership Program (HPP) is our program for managing workers' compensation health care for injured workers employed by state-fund employers. BWC employees, business leaders, labor representatives and health-care providers designed HPP.

BWC and private sector managed care organizations (MCOs) certified to participate in HPP work together to help manage workers' compensation claims and coordinate medical services with an emphasis on returning injured workers to work safely and efficiently. BWC and the MCOs' shared goal is to provide the best service possible for employers and their injured workers. This includes forging relationships with doctors and medical providers, rewarding employers who run safe workplaces and opening new opportunities for injured workers.

Return to work — A key factor in return-to-work success is HPP's focus on quality. While a certain medical procedure may incur a higher up-front cost, the impact on a more timely and safe return to work often offsets that cost. An injured worker's physician and MCO will work together to determine the optimal return-to-work date for full or modified duty based on the injury and type of work.

Often times, going back to work mid-week allows injured workers more time to readjust to their original job demands without being worn out by a full work week. It also improves the chances of injured workers remaining at work. For employers, the benefits include reducing the cost of replacing injured workers and the total cost of the claim. In addition, it results in lower employer reserves, helping to prevent a medical-only claim from becoming a lost-time claim.

Presumptive authorization — This process allows a physician to provide basic treatment for the most common work-related injuries up to 60 days from the date of injury.

Vocational rehabilitation services — The longer an injured worker is off work the more difficult it becomes for that worker to return to work. MCOs work with injured workers, employers and medical providers with the goal of promoting an early and safe return to work. Vocational rehabilitation services help return the injured worker to the original job whenever possible or to a different job with the same employer. If that is not possible these services help the injured worker secure a similar job with another company or a different job with a different employer.

Remain at work — A workplace injury does not have to result in a long absence. Managed by the employer's MCO, the remain-at-work program provides injured workers with rehabilitation services that help reduce or eliminate the number of days they are off work and keeps medical-only claims from becoming lost-time claims.

Transitional work — Studies have shown the likelihood of injured workers returning to work after six months is 50 percent. This figure drops to 25 percent after one year and almost zero after two years off the job. A transitional work program uses real job duties to accommodate injured workers' medical restrictions for a specified time to return them gradually to their original jobs.

Your role is vital during this period. While providing your specialized skills, you have the opportunity to reinforce return-to-work expectations. You also can encourage injured workers to actively facilitate their recovery and return to the job. We may cover telephone consultation codes if the physician contacts the employer and discusses the injured worker's job restrictions/possibilities (see BWC's medical documentation policy for details of when the code is payable).

The American Academy of Orthopedic Surgeons and the American Association of Orthopedic Surgeons believe safe, early return-to-work programs are in the patients' best interest. Return to light-duty, part-time or modified-duty programs are important in preventing the onset of psychological and other behavior patterns that get in the way of injured workers successfully returning to work and to normal lives.

As a critical player in the HPP design, providers must understand the basis and goals of return-to-work strategies and optimal return-to-work expectations for injured workers. It also is important to understand the roles BWC and MCOs play in this partnership.

BWC responsibilities

- Make claim determinations and allowances
- Pay compensation
- Educate injured workers, employers and providers about HPP
- MCO oversight

MCOs responsibilities

- Report claims
- Assist injured workers in securing appropriate medical treatment from an approved, BWC-certified provider
- Medical case management, including reviewing treatment requests and making treatment decisions
- Initiates the ADR process upon receipt of a written medical dispute
- Bill review and payment
- Educate and assist employers and providers regarding return-to-work initiatives and HPP.

Ohiobwc.com

Ohiobwc.com is BWC's e-business method to communicate with primary providers. It allows us to use technology to provide our customers with consistent, customized, streamlined service 24 hours a day, seven days a week.

Log on to ohiobwc.com and find out how fast, efficient and easy it is to have all of your workers' compensation information and services at your fingertips.

- **BWC library** — Take a guided tour to learn more about processes and policies. Get answers to frequently asked questions and definitions for workers' compensation terms in the provider glossary.
- **Medical bill payment look-up** — Providers can view medical bill payment information. You can also customize bill searches to verify we received your bills from the MCO and made provider payments to MCOs.
- **Billing and reimbursement** — Access and download the online *Provider Billing & Reimbursement Manual* (BRM). You can also view or print reimbursement policies/procedures and periodic updates. We issue a newsletter titled *BWC Provider Update* to notify providers about updates to the BRM and includes supplemental educational information. The current and previous three editions of the newsletter appear online at the bottom of the BRM chapter page.
- **Claim documents** — Providers who meet our security criteria can access Claim documents, a repository of imaged documents from individual claim files for claims for which they are the physician of record (POR) or treating provider.

Additionally, with ohiobwc.com, providers can:

- View basic claims information, including International Classification of Diseases, Ninth revision (ICD-9) codes, claim status, date of injury, accident description and the assigned MCO;
- Find other BWC-certified providers through the BWC provider look-up;
- Determine an employer's MCO with BWC Employer/MCO look-up;
- View the BWC Provider Fee Schedule;
- Download BWC forms, including the *First Report of an Injury, Occupational Disease or Death* (FROI), *Physician's Request for Authorization of Medical Services or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) and *Request for Temporary Total Compensation* (C-84). Then, users can print these forms, complete and submit them via mail, fax or in person;
- File the FROI electronically, this allows us to assign a claim number immediately;
- Download BWC Diagnosis Determination Guidelines, a reference guide, to provide criteria for diagnosis determination/coding decisions between BWC and MCOs for the most frequently used diagnosis/ICD-9 codes;
- File a Physician's Report of Work Ability (MEDCO-14), which lists an injured worker's restrictions, but also says what he or she is medically able to do;
- See posted educational training materials and videos to assist you and your staff.

Remember, to ensure confidentiality, you must create a primary account before accessing injured worker information. You can create secondary users from this account so each of your employees can have individual passwords.

The service offering, Group provider relationship administration, is available on ohiobwc.com. It makes accessing claim information easier for physician of record (POR) providers associated with group practices.

Group provider relationship administration gives POR provider types with e-accounts the ability to delegate or revoke their e-account privileges to a group provider type (provider type 12). POR providers may not delegate e-account privileges to any other providers.

Provider groups with multiple POR providers will find this offering helpful. Once each POR provider delegates e-account privileges to a group, any person logged on under that group provider number can access the same information as the POR provider.

For more information about provider services or for help creating a BWC provider e-account (user ID and password), call 1-800-OHIOBWC, and listen to the options. You also can e-mail the provider relations department at Feedback.medical@bwc.state.oh.us.

E-business revolutionizes how we do business, but it does not replace people with technology. Customers who prefer dealing with a person have the option of doing so. In addition, since the system frees our employees from many time-consuming tasks, it allows us to provide more efficient customer service.

Provider communications

For ongoing provider communications, we publish periodic updates to the BRM on our website. To obtain a BWC Law Book or BWC Rule Book, call 1-800-OHIOBWC, and listen to the options, or e-mail your request to form-pub@bwc.state.oh.us. Some publications are available only on our website.

For a complete listing of MCO contact information, go online to ohiobwc.com. We will incorporate any revisions to this MCO directory list online at ohiobwc.com.

If you wish to sign up for BWC's provider list serve, which is open to providers and interested parties, send us the applicable information below to the e-mail address Provlistserv@bwc.state.oh.us, or call us at 1-800-644-6292, and select option 0-3-0. Please provide:

1. Interested party/provider name, title, board specialty (i.e., JohnSmith, M.D., board certified family practice 1999);
2. Address, phone number where we can reach you 614-000-0000;
3. Name of group organization you are affiliated with, practicespecialty (Smith Family Practice – family medicine office);
4. Address and phone number (if it's different than above) 614-000-0000;
5. Your e-mail address.

Sensitive data

We deem certain information sensitive. We will encrypt communications containing that information (example: password protected e-mail attachments). This prevents unauthorized disclosure of information we have deemed sensitive. The Ohio Administrative Code Rules also support compliance with sensitive data and confidentiality.

Provider certification

In HPP, there are three provider categories:

1. **BWC-certified provider** — A provider we have approved for participation in HPP and who signs a BWC-provider agreement;
2. **MCO panel provider** — A BWC-certified provider included within a BWC-certified MCO provider network;
3. **Non-BWC-certified provider** — A provider we have enrolled only for participation in HPP and who has not signed, or been required to sign, a provider agreement with us.

With the exception of the following circumstances, you must be a BWC-certified provider to receive reimbursement for your services:

- Ongoing treatment of an injured worker with date of injury before Oct. 20, 1993, that began prior to HPP. The injured worker may continue treatment with a non-certified physician. However, an MCO will manage the care;
- Emergency treatment;
- Initial treatment. Non-BWC-certified providers must have a BWC provider number to receive reimbursement for these services. If the injured worker changes physicians, he or she must select a BWC-certified provider or the injured worker will be responsible for payment;
- Specific provider types listed on Application for *Provider Enrollment Non-Certification* (MEDCO-13-A).

BWC certification is an ongoing process to accept new providers in the system. The first step to becoming BWC certified is to complete the *Application for Provider Enrollment and Certification* (MEDCO-13). Defined provider types (see Application) must complete the Declaration regarding Material Assistance/Non Assistance to a Terrorist Organization (DMA) as required by the Ohio Department of Public Safety/Homeland Security. These provider types must register at the Ohio Business Gateway, <http://obg.ohio.gov>.

To obtain an application, call 1-800-OHIOBWC, and select option 0-3-0, or download the application from ohiobwc.com.

If you meet the enrollment and credentialing criteria and sign the provider agreement, we will certify you to participate in the HPP. The provider agreement is the last section of the MEDCO-13 application.

When you sign BWC's provider agreement, you agree to:

- Comply with Ohio's workers' compensation laws and rules, and any applicable Ohio ethics/conflict of interest/election laws;
- Maintain malpractice coverage;
- Practice in a managed care environment and comply with utilization review determinations;
- Bill only for services and items performed or provided and medically necessary, cost-effective and related to the claim or allowed condition;
- Inform the injured worker of his or her liability for payment for non-covered services prior to delivery;
- Charge no more than the usual fee billed to non-industrial patients for the same service;
- Accept reimbursement and not divide/unbundle charges into separate procedure codes when a single procedure code is more appropriate;
- Not bill the injured worker or employer for balances;
- Injured workers are not required to contribute a co-payment and do not have to meet deductibles;
- Maintain workers' comp coverage as applicable.

Provider enrollment data

To ensure you receive timely payment for approved medical treatments and other information, you must keep your provider enrollment information up-to-date within 30 days of changes. BWC and MCOs use this information regularly to process bills and make payments.

To change provider enrollment data and tax identification numbers, complete the *Request to Change Provider Information* (MEDCO-12), or submit the changes in writing on letterhead to Ohio Bureau of Workers' Compensation, Provider Enrollment Unit, and P.O. Box 182031, Columbus, OH 43218-2031. You also may fax your changes to 614-621-1333.

When requesting a change to provider enrollment data and tax identification numbers, provide the following information in writing:

- Provider name and number;
- Effective date;
- Telephone number;
- Signature of individual assigned to the specific provider number.

If you're submitting address changes, please specify:

- Physical locations;
- Pay-to address;
- Correspondence address.

You also must request in writing changes to tax identification numbers. Please specify when the changes will become effective. If ownership has changed, please complete a new provider application form. We plan to recertify providers on a biennial basis.

NPI - National Provider Identifier

Providers wishing to incorporate the use of their NPI into their Ohio workers' compensation billing must have provided their information with verification to BWC provider enrollment. Providers wishing to use NPI in billing should submit a copy of their NPI confirmation received from the issuing Enumerator to the fax or address below.

Ohio BWC Provider Enrollment
Fax: (614) 621-1333
Or mail to:
Ohio Provider Enrollment
P.O. Box 182031
Columbus, OH 43218-2031

Reporting injuries

Providers must report a worker's injury to us or the appropriate MCO within 24 hours, or within one business day of the initial treatment or visit. Since 24-hour reporting is a legal and contractual requirement, non-compliance can result in punitive action, such as loss of BWC certification, removal from an MCO's panel or both.

Reporting an injury within 24 hours has a number of advantages, such as helping us expedite the claims process. Generally, the sooner you report a claim, the sooner we can allow it. If we do not allow a claim, we don't issue payments for either the injured worker's compensation or medical bills.

We encourage providers to file the FROI online at ohiobwc.com. When you file the FROI online, you will receive a claim number immediately. You also may call the employer's MCO, or complete and fax the FROI to the MCO's toll-free number found in the MCO Directory on ohiobwc.com. If you do not know the MCO assigned to the employer, ask the injured worker or employer. You also can check the Employer/MCO look-up feature on ohiobwc.com.

MCOs must transmit 70 percent of the injury reports to BWC electronically within three business days after receiving notice of an injury. MCOs must transmit 100 percent of these reports within five business days. The MCOs rely heavily on providers to supply important medical information, including BWC-required data elements, and may contact providers to gather any additional required information.

What happens after you report an injury?

After receiving an injury report — from you, the injured worker or employer — the MCO electronically transmits important information about the injury to BWC.

Upon receiving initial notification of an injury, we automatically assign a claim number to the reported injury. If you file the claim online, you will receive a claim number immediately. The injured worker and employer will receive written notice of the claim number. If the MCO received the provider number and submitted it to us, the provider who reported the injury also will receive written notice from us.

Provide the data elements listed below to MCOs when you report a new injury.

Injured worker information

- Name*
- Gender*
- Address*
- Marital status
- Social Security number
- Telephone number*
- Date of birth*
- Occupation*

Employer information

(The injured worker's employer)

- Employer name*
- Employer address*
- Employer telephone number*

Injury information

- Type of injury (accident, occupational disease or death)*
- Date of injury (date of death, if applicable)*
- Will injury likely result in more than seven days off work? (yes or no)*
- Accident description (detailed account of how accident happened)*
- Date of initial treatment
- Date last worked and returned to work (estimated return to work if exact date is unknown)
- ICD-9 diagnosis codes (specific diagnosis description, including primary ICD-9)
- ICD-9 location (right, left, bilateral)
- ICD-9 site (digits or teeth)
- ICD-9 series E causation code
- Injury description (body part injured); for example, first joint of left index finger)*
- Is diagnosis causally related to this industrial accident? (yes or no)*

Provider information

- Initial treating provider name and BWC provider number (may be a hospital or physician).*
- Name of POR and BWC provider number. (If the MCO receives the BWC provider number and transmits it to BWC, we will send the provider a letter indicating the claim status and the allowed conditions.)*

*Indicates data elements required to report an injury within the 24-hour deadline. You must provide the remaining data elements to the MCO no later than five calendar days from the initial treatment if not available at the time of the first report.

Claims flow chart

Injured worker seeks medical treatment.

Health-care provider files claim online or with the MCO.

BWC issues claim number and investigation begins. If you file online, you will receive a claim number immediately.

BWC allows or denies claim.

Allowed claims

Medical management begins. Injured worker continues treatment from a BWC-certified health-care provider.

MCO and doctor focus on quality health-care services geared to early and safe return to work.

Contested issues

In contested compensation claims, the Industrial Commission of Ohio (IC) hears the dispute.

In medical disputes, the MCO offers a level of alternative dispute resolution before going to the IC (Not on allowed issues).

Remember, assigning a claim number is the first step in the initial determination process. It does not mean we have allowed the claim and will pay medical bills. We will reimburse providers for the injured worker's treatment only when we allow the claim and its related medical conditions. If we disallow the claim, we or the MCO will not pay bills for treatments provided for that injury.

The MCO will work with us to resolve medical and legal issues, assist in an early claim determination and facilitate the injured worker's timely and safe return to work. The MCO may ask you to supply additional medical information to help substantiate the claim or clarify medical issues related to the workers' compensation injury. The MCO will transmit this information to us.

Questions of diagnosis and causal relationship are medical issues that require your opinion before we can resolve them. We must obtain evidence from a physician who has examined or treated the employee for the condition. We will allow a claim only for a work-related injury.

The provider must report the proper diagnosis for which he or she is treating the injured worker. We only pay for injuries causally related to a workplace accident. Causal relationship is a medical determination based on review of the accident description and injury mechanism.

By providing a specific diagnosis to the MCO at the time of the first report of an injury or soon thereafter, we can more quickly consider the diagnosis for allowance. We also need ICD-9 E causation codes when a provider files a claim.

Auto adjudication

Auto adjudication is the electronic review of information received on a FROI. Based on complex, pre-established criteria, auto adjudication automatically allows or approves low-severity claims, and sends notices to injured workers and their employers — all with little or no manual processing. Generally, the sooner we allow a claim, the sooner we will pay medical bills. Once we consider the documentation, we make a decision. We make a decision by applying Ohio law and the evidence presented. Thus, decisions are impartial and objective.

Once we make the decision, our customer service team must issue a BWC order, which is a written legal notice to the injured worker, employer and their representatives.

Along with the BWC order, injured workers and employers receive a contact letter that includes notification information about the claim such as the claim number, the name of the MCO and the assigned medical claims specialist.

Auto adjudication improves service delivery for injured workers and employers by providing our medical claims specialists with additional time to perform more thorough claims investigation and reviews on complicated, higher-severity claims. However, injured workers and employers still have the right to appeal BWC decisions on auto-adjudicated claims.

In addition, we electronically send the claim or medical condition allowance or denial to the MCO. If the MCO received the provider number and submitted it to us, we will send the provider a letter indicating the claim status and allowed conditions.

Our goal is to make claim determinations within 15 days of the initial notification of injury, 13 days earlier than the law requires. This means the injured worker will receive entitled benefits, and we will reimburse you for services more quickly.

A 14-day appeal period may follow this determination. If the injured worker and employer agree, and both waive the appeal period, we formally allow the claim. We may now pay medical benefits and compensation.

If either the injured worker or the employer appeals BWC's determination, the IC will conduct a hearing. The IC's district hearing officer will hear the appeal within 45 days and will issue an order within seven days.

Even when a claim has become inactive (24 months since last treatment date), injured workers, employers and providers can still contact the MCO to request medical services. To ensure appropriate payment for services rendered to an injured worker, providers should make sure a claim is active before scheduling services. Find out if a claim is active by looking up the claim's status and diagnosis information on ohiobwc.com or by contacting the assigned MCO.

Outpatient medication

Pharmacy benefits manager (PBM)

SXC Health Solutions, Inc (SXC) is our pharmacy benefits manager (PBM). The PBM processes outpatient medication bills for state-fund, Black Lung and Marine Industrial Fund claims. The PBM is a single source for accepting and adjudicating prescription drug information and is separate from the MCOs. This program does not apply to claims managed by self-insured employers. Refer questions related to self-insured claims to the injured worker's employer.

As part of the PBM's responsibilities, it:

- Performs online, point-of-service adjudication of outpatient medication bills with prescription information transmitted electronically between a pharmacy and the PBM;
- Maintains an adequate pharmacy network;
- Maintains a prior authorization system for outpatient medications, which BWC identifies;
- Edits prescribed medications for injured workers;
- Performs desktop and on-site audits of pharmacies.

Prior authorization process

Prior authorization is required for medications not typically associated with the treatment of either industrial injuries or occupational diseases, regardless of the date of injury.

The PBM processes prior authorization requests. The prescribing physician must complete the *Request for Prior Authorization of Medication Form* (MEDCO-31) and document the relationship between the prescribed drug and the allowed condition(s) in an injured worker's claim. To access BWC's Relatedness Drug Prior Authorization List, log on to ohiobwc.com, and select Medical Providers, then Pharmacy prior authorization, or call 1-800-OHIOBWC, and listen to the options.

Generic and brand name drugs

We no longer reimburse for brand-name drugs when equivalent generic versions are widely available. If a physician prescribes a brand-name drug, we will require the injured worker to pay the difference in cost between that medication and the maximum allowable cost for its generic equivalent. Alternatively, the physician may allow the pharmacy to dispense a generic equivalent or may prescribe a different drug that is available to the injured worker at no cost.

Other drug coverage issues

You can reference the *BWC Billing and Reimbursement Manual*, Chapter 3, Section D, for compounded medication and other coverage and quantity limitations. Log on to ohiobwc.com to access this publication.

Pharmacy billing

Submitting drug bills for a new claim

When notified by the injured worker of his or her BWC claim, pharmacy providers may submit electronic bills for new injuries online through the bureau's PBM even before the injured worker has a BWC claim number by using his or her Social Security number and date of injury. The pharmacist should transmit at least two of the following three items, along with the other billing information, to the PBM:

- BWC claim number;
- Social Security number;
- Date of injury.

The PBM will inform the pharmacist that the claim data submitted indicates it is a new claim, deny the bill, but notify the pharmacist of the amount we will reimburse for the prescription if we allow the claim.

At this point, the pharmacist could choose to accept assignment. This means the pharmacist does not charge the injured worker up front because he or she expects to receive direct payment from us. If the pharmacist wants to accept assignment, he or she would submit the bill to PBM with the prior authorization code of 999000000. The injured worker's co-pay field will default to \$0. The PBM will automatically reimburse the pharmacy the fee schedule amount for the prescription, and the dispensing fee of \$6.

Alternately, the pharmacist may advise the newly injured worker of the amount that he/she needs to collect from the injured worker if the pharmacist does not choose to accept assignment. If the injured worker agrees, the pharmacist would then resubmit the bill information with the Prior Authorization Code of 888000000. The PBM then captures and suspends the submitted bill information. The amount the pharmacist will charge the injured worker will appear in the form of a co-payment on the pharmacy receipt. Once the claim that corresponds to the submitted date of injury and Social Security number reaches an Allowed claim status, we adjudicate the captured bill data. If approved, the injured worker receives the same amount the pharmacist charged.

In either case, if we disallow the claim, the bill becomes the injured worker's responsibility. Pharmacy providers should not submit any portion of a bill for a medication used to treat a work-related injury to a private health insurance carrier.

Submitting bills in an existing claim

When billing for a prescription in an existing claim, the pharmacist should transmit at least two of the following three items, along with the other billing information, to the PBM:

- BWC claim number;
- Social Security number;
- Date of injury.

The PBM verifies the information, processes the bill and sends the pharmacist an appropriate message based on the claim's status and allowed conditions. We pay all bills according to our fee schedule. Therefore, when the injured worker has paid for the prescription at the pharmacy's cash customer price and then seeks reimbursement, the injured worker is responsible for the difference between the amount paid and the amount reimbursed. This price is commonly an amount greater than allowed under the fee schedule. It is in the best interest of the injured worker for the pharmacy to submit the bill(s) for outpatient medication to our PBM vendor electronically.

Denied claims

We will not pay for any medication in disallowed claims, claims of a self-insuring employer, or claims of an employer that is actively participating in the \$15,000 Medical-Only Program. Paying for such medication is either the patient's responsibility or the employer's.

Forms

- **MEDCO-31** — The prescribing physician uses this form to request prior authorization for medications not typically used for industrial injuries or occupational diseases.
- **Outpatient Medication Invoice (C-17)** — Injured workers must use the C-17 for reimbursement for prescribed outpatient medication only. Injured workers can obtain all the information needed to complete the C-17 form at their pharmacy.
- **Service Invoice (C-19) or CMS 1500** — MCOs determine reimbursement eligibility for services that injured workers may obtain in a pharmacy. These include durable medical equipment; disposable medical supplies; and home infusion therapy. Contact the MCO for specific requirements for the use of the C-19 and CMS 1500.

Outpatient medication contacts

- **SXC** — Our PBM is prepared to answer inquiries regarding the Outpatient Medication Prior Authorization Program and point-of service billing for outpatient medications. To contact SXC, call 1-800-OHIOBWC, and listen to the options.
- **BWC Pharmacy Department** — Providers may send questions or comments about outpatient drug benefits, the Outpatient Medication Prior Authorization Program or other related matters to BWC's pharmacy department at pharmacy.benefits@bwc.state.oh.us or by mail to: Pharmacy Department Ohio Bureau of Workers' Compensation 30 W. Spring St., 21st floor, Columbus, OH 43215-2256.

Medical management

MCO treatment authorization

MCOs use nationally recognized treatment guidelines to evaluate the necessity and/or effectiveness of medical care. They also use these guidelines to communicate with and educate providers in all decision correspondence.

In reviewing medical treatment reimbursement requests pursuant to rule 4123-6-16.2 of the Ohio Administrative Code (OAC) and conducting independent reviews of medical disputes pursuant to rule 4123-6-16 of the OAC, the MCO and BWC shall refer to treatment guidelines adopted by BWC.

The BWC approved Treatment Guidelines are the Official Disability Guidelines (ODG) for utilization review to evaluate the necessity and/or effectiveness of medical care. ODGs is a Web-based tool, BWC and MCO staff can easily search and find pertinent information necessary to everyday issues in claims and medical case management.

Ohio providers can take advantage of the BWC negotiated price for ODGs by ordering the guidelines through www.WorkLossData.com or by calling the company's toll-free number (800) 488-5548. When ordering online, type "Ohio BWC price" in the free text field under "How did you find out about ODG?" to obtain the negotiated price for your subscription.

Presumptive authorization guidelines

We have established a program giving providers presumptive authorization to provide specific medical services without waiting for prior authorization from the MCO. For a period not to exceed 60 days following the date of injury, physicians have presumptive authorization to provide the following services when treating soft-tissue and musculoskeletal injuries for allowed conditions in allowed claims:

- A maximum of 12 physical medicine visits per injured worker claim. Visits may include any combination of osteopathic manipulative treatment; chiropractic manipulative treatment; and physical medicine and rehabilitation services performed by a provider whose scope of practice includes these procedures. These include, but are not limited to, doctor of chiropractic, doctor of osteopathic medicine, doctor of allopathic medicine, physical therapist, occupational therapist, licensed athletic trainer or massage therapist;
- Diagnostic studies, including X-rays, CAT scans, MRI scans and EMG/NCV;
- Up to three soft tissue or joint injections involving the joints of the extremities (shoulder including acromioclavicular, elbow, wrist, finger, hip, knee, ankle and foot, including toes) and up to three trigger-point injections. Injections of the paraspinal region, including epidural injections, facet injections, and sacroiliac injections are not included in the presumptive approval guidelines;
- Evaluation and management (E/M) services and consultation services.

The provider must meet the following criteria prior to initiating any or all of the aforementioned services:

- The provider will file the FROI with BWC or the MCO;
- The provider will complete and file the C-9 with the MCO. The MCO will notify the provider within three business days acknowledging receipt of the C-9 and that it completed a review to ensure services being rendered are medically necessary for the claim allowance;
- The provider will notify the MCO within 24 hours of treatment if the injured worker will be off work for more than two calendar days.

Please note: This criteria is subject to change. Watch our website and provider updates for future enhancements.

Standardized prior authorization table

Except for emergency care, services listed in the MCO standardized prior authorization table on page 13, require prior authorization if they do not fall within the presumptive approval parameters. Providers must submit a C-9 to indicate services for which they are requesting formal authorization.

Treatment request approval guidelines

To help the MCO consider authorization and expedite medical bill payments, we implemented these guidelines.

1. The POR or treating physician submits the treatment request to the appropriate MCO prior to initiating any non-emergency treatment. The C-9 is the preferred submission method. However, you may use any other physician-generated document, provided the substitute supporting document contains, at a minimum, data elements on the C-9.
2. The MCO must respond to the physician in writing within three business days with a decision regarding the proposed treatment request. The MCO will authorize or deny a provider's retroactive treatment request within 30 calendar days from receipt, or will keep the request pending.
3. The MCO must fax the authorized, denied or pending treatment request to the physician within the required three business days. If faxing is not feasible, the MCO must call the physician to communicate the decision and follow up in writing via mail or e-mail.
4. If the MCO cannot make a decision within three business days due to the need for additional information, the MCO must notify the physician. In addition, the MCO will send a *Request for Additional Medical Documentation (C-9-A)* to the provider. The MCO has five business days from the date it receives additional information to make a subsequent decision. The MCO may deny the treatment request if the physician does not provide the MCO with requested documentation within 10 business days. The MCO must notify the physician by fax or telephone of the subsequent decision and follow up via mail.
5. If the MCO cannot make a decision within three business days due to the need for a medical review, the MCO must notify the physician. The medical review must take place and a decision made within the five-business-day period. Again, the MCO must notify the physician of the subsequent decision by fax or telephone, and follow up in writing via mail.
6. The provider can consider a treatment request approved, and he or she may initiate treatments when he or she meets all of these criteria:
 - The MCO fails to communicate a decision to the physician within three business days of receipt of an original treatment request or within five business days if the request is pending;
 - The physician has documented the treatment request completely and correctly on a C-9 or other acceptable document;
 - The physician has proof of submission to the appropriate MCO;
 - Treatment is for the allowed conditions;
 - The claim is in a payable status.
7. In instances when the MCO does not respond to the C-9 within three business days and the provider initiates treatment, the MCO will provide concurrent and retro review. If the MCO finds the treatment is not medically necessary for the allowed conditions in the claim, it will notify all parties that it will not pay charges for additional treatment. The MCO will pay charges for services previously rendered.
8. If the claim is inactive, the claim reactivation process may take up to 44 business days to complete. The MCO will have a maximum of 16 business days to respond to the treatment request and refer the claim reactivation issue to BWC. BWC will have a maximum of 28 business days to complete the causality investigation and issue a BWC order.

Under our direction, the MCOs have been working with physicians to manage more effectively injured worker claims.

MCO's monitor providers submitting retro C-9s without just cause, as listed in the billing and reimbursement manual. They report these to us for monthly review and administrative action. MCO's report medical documentation noncompliance issues on a case-by-case basis. Other areas for compliance monitoring are under discussion.

We have teams to review our authorization and compliance process. Watch ohiobwc.com and/or Provider Update newsletters for changes or revisions that may occur related to provider performance.

Standardized prior authorization table

Service	Requirement
Physical medicine services, including chiropractic/osteopathic manipulative treatment and acupuncture	Prior authorization (PA)
Consultations - psychological/chronic pain program only	PA
Chronic pain program including pre-admission evaluation and treatment	PA
Dental	PA
Diagnostic testing	PA (except basic X-rays and urine screens as noted in Chapter 3, of the Billing and Reimbursement Manual under Chronic Pain, which do not require PA)
DME	PA if the purchase price > \$250, PA for all DME rental
Home/auto/van modifications	PA required from BWC
Home health agency services	PA
All inpatient and outpatient hospital services treatment and ambulatory surgery center services	PA except for emergency services.* Emergency inpatient hospitalization may be through the emergency Department or by direct admission
In-home physician services	PA after first visit
Injections	PA
Non-emergency ambulance services	PA
Orthotic and prosthetic devices and/or repair	PA > \$250
Skilled nursing facility (SNF)/Extended care facility (ECF)	PA
TENS and NMES units	PA for both rental and purchase
TENS and NMES monthly supplies	PA for a maximum of six months per authorization
Vision /hearing services	PA > \$100
Vocational rehabilitation - All vocational rehabilitation services, in or out of plan	PA

* Per Ohio Administrative Code 4123-6-01 (O)

Note: PA not required for transitional work on-site therapy services provided by an OT or PT that fall under the presumptive authorization guidelines. Occupational rehabilitation (work hardening) requires CARF accreditation.

Return-to-work initiatives

One of the things that set HPP apart from traditional managed-care programs is the emphasis on return to work. Most injured workers return to work without any assistance, but some require more medical care, resulting in longer recovery and time away from work. Some also require intensive return-to-work and vocational services to return to productive employment.

The optimal return-to-work date is an outcome measurement that measures success and establishes an optimal return-to-work date at the individual level. For example, we expect a construction worker who breaks a leg to be off work longer than an office worker with the same injury because of the way the injury relates to his or her job.

We recognize these differences and plan the best course for the individual worker. The optimal return-to-work date assists us and MCOs in working with the employer, injured worker and physician to set return-to-work expectations.

As a critical player in the HPP design, providers must understand the basis and goals of the return-to-work strategy and optimal return-to-work date. In addition, providers need to manage follow-up office visits and treatment plans with the optimal return-to-work date in mind, enabling injured workers to work (with restrictions, if necessary) as soon as medically feasible.

Our return-to-work services include several programs to ensure injured workers return to work as soon as medically feasible.

Transitional work programs

We encourage employers to develop transitional work programs and will continue to assist organizations in creating their own programs. Developed in conjunction with the employer, collective bargaining agent (where applicable), POR and rehabilitation professionals, transitional work programs are one of the most effective ways to help injured workers progressively perform real job tasks and remain working. An occupational or physical therapist provides on-site therapy to the injured worker at the employer's work site.

These programs are well received by workers who want to protect their employability or ability to work, and by employers who want to maintain an experienced work force and reduce disability-related costs.

The company program is developed by accredited rehabilitation case managers or occupational or physical therapists with experience in developing transitional work programs.

Remain-at-work services

BWC offers remain-at-work services to injured workers with medical-only claims to keep them from becoming lost-time claims. Prior to this initiative, injured workers could only receive these types of services if they were off work for eight or more days. A field vocational rehabilitation case manager may coordinate these services, which the MCO manages and which BWC charges to the employer's risk.

MEDCO-14

The physician must complete this standard form at every re-evaluation visit when the injured worker is under work restrictions or when the injured worker is temporarily very disabled. Similar to forms MCOs or physician offices use, the MEDCO-14 provides a permanent record for the physician's file. The two-part form allows injured workers to receive a copy for their records. After faxing a copy to the MCO, the MCO will inform employers of their injured workers' restrictions and explore work site adaptations/modifications.

This form reduces the need for phone calls requesting information from several parties regarding the injured worker's return-to-work progress. It also provides important information to injured workers about their recovery and work limitations. Injured workers have immediate information they can share with their direct supervisor upon returning to the job. In addition, employers will be informed and see the progress of all injured workers from the beginning of treatment until they are back on the job, and can assist in successful return-to-work practices.

Case-management plans

The MCO case-management plan is an essential tool in managing a claim's allowed conditions. The case manager develops the plan in collaboration with the injured worker, members of the health-care team and employer, if applicable. The plan represents a mutual commitment to the primary goal of return to work or resolution of the claim.

The plan identifies:

- Short- and long-term goals;
- Time frames for response to referrals, follow-up and evaluation;
- Resources to use;
- Collaborative approaches to use;
- Criteria for case closure;
- Anticipated case results.

Rehabilitation programs

Vocational rehabilitation helps injured workers safely return to work or maintain employment through individually tailored services. These services focus on helping the injured worker return to the previous job whenever possible. If that is not possible, the case manager may use other strategies to help the injured worker return to appropriate work. By initiating services as soon as the injured worker can participate, the vocational outcome is more likely to be successful. By providing a structured plan for an early and safe return to work, the injured worker can avoid long debilitating periods off work.

MCOs will work directly with the medical provider, injured worker and employer to find creative ways to allow the injured worker to remain at work or return to work. MCOs will coordinate these interventions, which may include:

- Modifying the work tasks or providing assistive tools and equipment;
- Developing supervised programs, which allow the injured worker to increase gradually hours or workloads;
- Coordinating transitional work programs that provide progressive work-site therapy;
- Providing skills enhancement for the injured worker, if needed;
- Locating appropriate employment for the injured worker in a different type of work, if needed.

As a provider, you may help the MCO coordinate the vocational rehabilitation plan to provide for the safe transition of the injured worker back to the workplace. You may also help identify when the injured worker needs specialized services or assistance in changing jobs. Contact the MCO about specific remain-at-work or return-to-work services. Anyone may refer an injured worker for vocational rehabilitation services. To make a referral, contact the injured worker's MCO or one of our customer service offices.

ADR

ADR facilitates the resolution of disputes in medical issues that arise between the MCO, employer, injured worker and/or provider, without litigation. ADR affords due process regarding conflicts in medical treatment issues, but does not include fee schedule grievances. Recent outcome studies determined BWC agreed with the MCO Level 1 appeal decisions approximately 97 percent of the time. Therefore, we undertook reform of the ADR process to eliminate the redundant BWC Level 2 of the appeal process. We revised OAC 4123-6-16 to support this change.

Providers initiating a medical dispute should contact the MCO directly. Providers must initiate ADR within 14 calendar days of written notification of MCO determination.

The MCO's dispute resolution process must:

- Contain a peer review or IME conducted by an individual(s) licensed and of the same medical specialty;
- Be completed within 21 calendar days of written receipt of notice of a dispute, or within seven days of return of the exam report if the MCO schedules an independent medical examination.

We will notify parties to the claim and their representatives in writing through a BWC order of the dispute-resolution decision at the conclusion of the process. We copy PORs on the order.

If a disagreement still exists, the injured worker, employer or their representatives may file an appeal with the IC within 14 days. The IC will hear the medical dispute only if the parties have been through the prior level of ADR.

The MCO may refer its recommended ADR decision to us without obtaining an independent level of professional review if the services have been approved by the MCO through standard treatment guidelines, pathways, or presumptive authorization guidelines.

Medical documentation

Providers who treat Ohio's injured workers assume an obligation to submit initial and subsequent reports to the MCO on behalf of the injured worker. Providers must supply supporting medical documentation to MCOs at the time of the treatment request and reports on outcomes of treatment.

Providers also assume an obligation to provide and complete forms required by us or the self-insuring employer. Providers may not charge for completing required forms or for submitting necessary documentation. However, providers may charge a fee for copies of medical records if the provider had previously filed copies with us or the MCO, or with the self-insuring employer in self-insured claims, and we had provided access to such medical records electronically. The provider will base his or her fee on the actual cost of furnishing such copies, not to exceed 25 cents per page.

In some instances, it is necessary for the provider to update the MCO throughout the delivery of care during the treatment period. Such instances include:

- Injured worker non-compliance with treatment or missed appointments;
- Negative/lack of response to treatment;
- Changes in outcome or goals of treatment;
- Diagnostic testing results;
- Specialist/consultation results;
- Hospital discharge summaries;
- Emergency room reports, operative reports or other situations that indicate a need to alter a treatment plan/plan of care or concurrently monitor the patient's care. In such situations, the provider must submit the update to the MCO within five days of delivery of service or request by MCO.

By filing a claim for workers' compensation benefits, the injured worker gives BWC or anyone working for us permission to access information related to the claim. Consequently, submitting medical reports to either us or an MCO does not require a release of information signed by the injured worker.

The Health Insurance Portability and Accountability Act (HIPAA) privacy and electronic transactions regulations do not directly apply to us and the MCOs. BWC and the MCOs do not qualify as covered entities under HIPAA regulations.

The provider can release information to us or an MCO (or to a self-insuring employer or Qualified Health Plan in a self-insured claim) if the provider is treating an injured worker and is:

- Requesting authorization for treatment;
- Requesting payment for treatment already rendered;
- Providing information with regard to the allowance of a workers' compensation claim, or the allowance of an additional condition in an existing claim.

MCOs are required to integrate their case management and bill payment systems so they will not require providers to attach medical documentation to bills for previously approved treatment on a regular basis. However, providers must submit medical documentation in cases where services billed do not correspond to requested and approved treatment, or if the MCO needs information to show what services they provided.

For example, for a period not to exceed 60 days following the date of injury, physicians have presumptive approval for providing E/M and consultation services when treating soft tissue and musculoskeletal injuries for allowed

conditions in allowed claims. Although physicians may render the E/M service without prior authorization, they must submit documentation to support the components of the E/M service. To justify payment for the service reported, the documentation must be specific in describing the provided service.

Medical repository: the method to get information into a claim file

Providing medical reports to the MCO within 24 hours has a number of advantages, including helping us expedite claim processing. In most cases, the sooner the MCO sends the initial medical documentation to the customer service team, the sooner we can allow the claim.

Since providers often transmit many of these medical reports and other documents early in the claims process, often before we assign a claim number, they send some documents to the wrong MCO or directly to BWC. In some cases, documents are lost. This often results in misunderstandings for all involved, delaying the overall process.

Our medical repository system reduces duplicate requests from us and MCOs to providers for medical documentation and forms. It also coordinates faxes coming from providers so MCO and BWC records are synchronized. It is the medical information collection method to make up the electronic claim file for an injured worker.

The medical repository process is transparent to providers. Through an automated call-forwarding process, the medical repository stores electronic copies of faxed documents for viewing by BWC and MCO staff. Each MCO can only see documents associated with claims assigned to it.

Providers should continue to fax all documents to MCOs. Please refer to the MCO contact information in the MCO Directory on BWC's website, ohiohwc.com, to obtain the correct toll-free fax number for each MCO.

Send only one fax to the MCO. Do not send a duplicate to BWC. If you receive a request for documentation that you faxed to the MCO, ask the requester to check the medical repository/electronic claim file first.

Include a fax cover sheet for each injured worker. Also, include the injured worker's name and claim number on each page of the fax. Timely submission of these medical documents provides MCOs and us with important information and minimizes the possibility of delayed claim authorizations.

A sample listing of our forms indexed by us appears below. You will notice the C-9 is not one of the documents we index because an MCO must review and either approve or deny information on that form before forwarding it to us. Once the C9 is completed, MCOs image it into the claim and then index it. You can find other BWC forms in the online claim file.

We can only accommodate NPIs on forms for billing. We are working to change this, but currently can only recognize this number for billing if it has previously received this information from the provider (See pg 6).

Paperwork parameters

With HPP, BWC stresses the importance of focusing on issues and actions involved in the claim. Forms, however, are still necessary as we work together to provide injured workers with the services they need. Send all forms to the MCO fax lines as discussed previously. Forms you will most likely use that would also become part of the electronic claim file include:

FROI — The provider may report the injury by completing and sending this form to the MCO. However, the preferred method to file the FROI is online at ohiobwc.com;

C-9 — The POR or treating physician uses this form to submit a treatment request or recommendation for additional condition to the MCO prior to initiating any non-emergency treatment;

MEDCO-14 — Form used by physicians to document work abilities;

Change of Physician (C-23) — The injured worker must sign this form and indicate the physician to which he or she wishes to change and the reason. Send the C-23 to the MCO;

C-84 — The POR must complete specific sections of this form and sign it to indicate the injured worker is unable to work. After the injured worker completes part I of the form, send the C-84 to BWC.

Requesting additional allowances

Periodically, either the treatment of or nature of an injured worker's disability may require us to add additional conditions to the claim. For example, we may allow a claim for a lumbar sprain/strain, but additional diagnosis and treatment reveal a herniated nucleus pulposus is the underlying cause of the injured worker's disability. By law, we must add this condition and pay compensation to the injured worker, and reimburse providers for their services.

The proactive allowance policy establishes guidelines for processing physician recommendations for additional allowances. It also provides for better coordination and communication between us, MCOs and providers on the result of the bureau's proactive allowance consideration.

Our proactive pursuit of additional allowances provides the physician an opportunity to deliver services to an injured worker earlier, resulting in appropriate quality care and the potential for earlier return to work. The policy's primary focus is to improve delivery of services, reduce lost workdays and improve treatment outcomes.

For BWC to consider a proactive allowance request, please forward the following medical data to the assigned MCO. The MCO will ensure it gathers the following information from the physician and submit it to BWC:

- Supporting medical documentation, including clinical examination and diagnostic test findings;
- Current treatment plan;
- ICD-9 diagnosis code for requested diagnosis (include specific diagnosis description, e.g.; 722.10 Lumbar HNP, L4-L5 and identify if primary ICD-9);
- ICD-9 location (right, left or bilateral) when applicable;
- ICD-9 site (digits, teeth or body part) when applicable;
- A causality statement indicating how the mechanism of injury resulted in requested diagnosis (i.e., is the diagnosis causally related to the industrial accident?).

We will consider the physician's recommendation of an additional condition(s) when he or she completes and dates the C-9 and/or medical evidence and the evidence clearly supports the condition. The medical documentation, mechanism of injury and time sequence must be defined clearly and support the additional allowance recommendation.

We will not consider proactively allowing psychiatric or chronic conditions that may be the result of natural deterioration or degenerative processes. These include conditions such as, but not limited to, the following: arthritis, spinal stenosis, spondylolisthesis, degenerative disc disease or aggravation of a pre-existing condition or disease; less specific diagnosis of disorders, such as myalgias, arthalgias or reflex sympathetic dystrophy.

In five to 28 days from the receipt of the recommendation, we will either allow the condition or notify the injured worker or his or her legal representative to request the condition in writing. We will notify the MCO regarding what action it is taking on the proactive allowance. The MCO will provide an update to the physician who recommended the additional allowance

We will not pursue proactive allowance and will always notify injured workers or their legal representatives to request the condition in writing when any of the following occurs:

- Any party in the claim, including the injured worker/ employer representative, disagrees with the allowance of the condition(s);
- The provider finds psychiatric, degenerative or pre-existing conditions;
- The evidence does not clearly establish causality;
- It is determined a BWC physician review/exam is needed.

Important: Providers may not complete a *Motion* (C-86) requesting we allow an additional condition on the claim or advise an injured worker to file one.

By law, providers are not parties to the claim; therefore, they cannot appeal decisions regarding additional allowances to the MCO, BWC or IC. Injured workers, employers or their authorized representatives must initiate appeals.

Billing and reimbursement

There are various methods for submitting bills, and it is the provider's responsibility to ensure he or she bills the appropriate party.

An electronic transmission in the ASCX12 837 format is the preferred method of submitting bills to the proper MCO. You can find implementation documentation for the 837 on ohiobwc.com.

You also can find addresses to submit hard-copy bills to MCOs in the MCO Directory on ohiobwc.com.

Follow the guidelines in chapter four of the *Provider Billing and Reimbursement Manual* when submitting bills to MCOs. You may also view and download the BRM from ohiobwc.com. If you have questions, call 1-800-OHIO BWC, and choose option 0-3-0.

To ensure consistent billing processes and to maintain quality customer service, all BWC-certified MCOs accept the following national and BWC billing forms:

- American Dental Association dental form;
- Centers for Medicare & Medicaid Services CMS 1500;
- Uniform Billing (UB-04);
- Service Invoice (C-19).

Please do not bill the injured worker or the employer for state-fund claims.

When billing BWC or MCOs for services, you must code the service according to the guidelines in the BRM.

Self-insured claims are not part of HPP. Self-insuring employers will continue to pay for their employees' workers' compensation benefits. Please send medical bills directly to the self-insuring employer.

ICD-9-CM and ICD-10-CM

Always follow acceptable ICD-9 coding principles. We recognize the current version of the ICD-9-CM and are planning to adopt ICD-10 requirements effective October 2013. If you have, any questions about the claim status, including diagnosis information, contact the MCO managing the claim or log on to ohiobwc.com.

Until the changeover to ICD-10, group ICD-9-CM codes into numeric sets. We define an ICD-9 group as an injury or condition similar in nature, and/or one involving the same body part, and can contain one or more ICD-9 codes. All codes in that group are interchangeable, and we can use them for reimbursement purposes.

MCOs and BWC may accept valid V diagnosis codes on bills. You may not use E codes except as other diagnosis codes or admitting diagnosis codes on hospital bills. We do not recognize these codes for allowance purposes.

You can view and download copies of our ICD-9 groups and invalid ICD-9s from the medical providers page at ohiobwc.com.

MCOs determine medical reimbursement eligibility in a workers' compensation claim for specific, allowed conditions. Thus, ICD-9 diagnosis codes are required to identify medical conditions providers treat.

The provider must bill the diagnosis code for the condition he or she treats. If we have not allowed the condition in the claim formally, the MCO has the discretion and responsibility to coordinate treatment and decide whether to pay.

For future updates about BWC's adoption of ICD-10 codes please see our website or contact your MCO.

Clinical editing

We have a clinical editing software package from Thomson Reuters. The software will ensure a consistent and well-defined process for reviewing medical bills.

This system does not supplant that of the MCO's review of medical. Instead, it provides for a second-level review to create a consistent and standardized approach to the screening and reimbursement of provider medical bills.

Thomson bases the edits included in the methodology on nationally recognized coding standards and protocols. They include those from the American Medical Association, American College of Physicians, Journal of the American Medical Association, Federal Register and the Centers for Medicare and Medicaid Services.

We install edits to our payment system in multiple phases. Please see our Provider Updates and the *Provider Billing and Reimbursement Manual* for more information.

Billing periods

Within seven days, the MCO must either return the bill to the provider, if information is invalid, or edit and price the bill. We return bills denied as improper invoices to the providers for correction/resubmission.

If the MCO approves a bill, it sends the bill to us, which validates the pricing and claim status. We send payment and remittance advice via electronic funds transfer to the MCO. Within seven days of receiving payment from BWC, the MCO pays the provider.

By following this flow, you can expect speed, accuracy and fairness in receiving reimbursement for treatment of injured workers.

National Provider Identifier (NPI)

We comply with the ability to recognize bills received with a provider NPI number. Please refer to provider enrollment information on page 6. We do not view NPI as a replacement of the BWC provider number assigned but as an alternate and additional identifier that providers can use in Ohio workers' compensation billing.

We are not a covered entity under the Health Insurance Portability and Accountability Act and will continue to accept bills containing only BWC legacy (or current) numbers as well as bills containing both the legacy and the NPI.

We have made changes to add provider NPI data effectively into our provider enrollment and eligibility database, then to crosswalk the NPI received on invoices to the BWC Provider ID. This approach permits us to continue to process bills in a way that is accurate and consistent with laws, rules and policies governing the payment of workers' compensation medical benefits.

Billing tips

Do:

- Submit bills to the appropriate MCO;
- Submit bills according to BWC format;
- Bill the actual diagnosis(es) treated;
- Submit documentation in cases where services billed do not correspond to requested and approved treatment or if needed to support services rendered;
- Follow form completion guidelines in chapter 4 of the BRM;
- Attempt to resolve outstanding billing issues with the specific MCO.

Note: You can schedule a grievance conference with the MCO over medical billing disputes with additional appeal to BWC if needed. This does not apply to disputes over our fee schedule rates. All medical disputes regarding treatment denials must follow the ADR process (See page 15).

Do not:

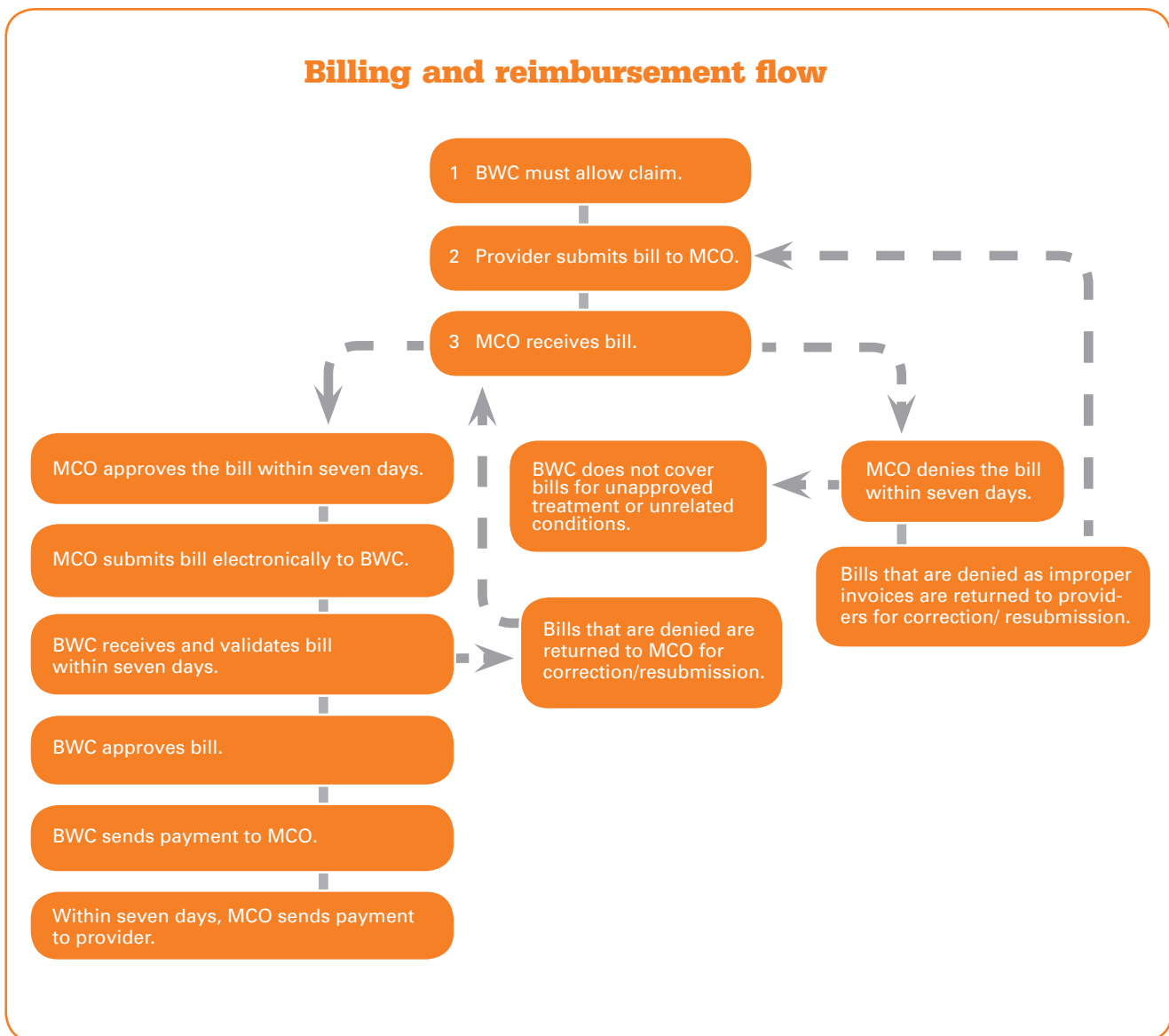
- Submit bills with the FROI;
- Bill the injured worker for the balance, or ask for co-payment;
- Request payment from the injured worker for reimbursable covered services;
- Unbundle services.

Appendix

BWC Provider Fee Schedule

The BWC Provider Fee Schedule is available online at ohiobwc.com. You may download a copy by clicking on Medical Providers, then Forms. You may also access an interactive version of the form by clicking on Medical Providers, Look-ups, and then Fee schedule look-up. We update both versions on our website as changes occur.

We post updates of proposed fee schedule changes and request public feedback from providers prior to the adoption of any new fee schedule. We ask medical provider associations to share this information with their members. BWC's Board of Directors must approve all changes and legal processing required for Ohio Administrative Code Rule updates, which are conducted prior to fee schedule changes becoming effective.



Watch BWC's website, ohiobwc.com, for workflow revisions.

