4123-6-01 **Definitions.**

As used in the rules of this Chapter of the Administrative Code:

(A) "Authorization" or "prior authorization" means:

Notification by the MCO, that a specific treatment, service, or equipment is medically necessary for the diagnosis and/or treatment of an allowed condition, except that the bureau may reserve the authority to authorize or prior authorize the following services: caregiver services, home and vehicle modifications, and return to work management services pursuant to paragraph (D) of rule 4123-6-04.6 of the Administrative Code..

(B) "Bureau certified provider" means:

A credentialed provider who is approved by the bureau for participation in the HPP.

(C) "Certification" or "recertification" means:

A process by which the bureau approves a provider or MCO for participation in the HPP.

(D) "Credentialing" or "recredentialing" means:

A process by which the bureau validates or reviews the completed and signed application of a provider for certification or recertification.

(E) "Dispute resolution" means:

Procedures for the resolution of medical disputes prior to filing an appeal under section 4123.511 of the Revised Code.

(F) "Emergency" means:

Medical services that are required for the immediate diagnosis and treatment of a condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency, but is necessary to determine whether an emergency exists.

(G) "Employee" means:

As used in the rules of this chapter, the term "employee" includes the terms "injured worker" and "claimant" and all employees of employers covered under HPP.

(H) "Formulary" means:

A list of medications determined to be safe and effective by the food and drug administration which the bureau shall consider for reimbursement. The list shall be regularly reviewed and updated by the bureau to reflect current medical standards of drug therapy.

(I) "Health care provider" or "provider" means:

A physician or practitioner, or any person, firm, corporation, limited liability corporation, partnership, association, agency, institution, or other legal entity licensed, certified,or approved by a professional standard-setting body or by medicare or medicaid to provide medical services or supplies, including, but not limited to a qualified rehabilitation provider.

(J) "Health partnership program" or "HPP" means:

The bureau of workers' compensation's comprehensive managed care program under the direction of the chief of medical services as provided in sections 4121.44 and 4121.441 of the Revised Code.

(K) "Hospital" means:

An institution that provides facilities for surgical and medical diagnosis and treatment of bed patients under the supervision of staff physicians and furnishes twenty-four hour-a-day care by registered nurses.

(1) For the purposes of the rules of this chapter of the Administrative Code relating to hospitals, "inpatient" means:

An injured worker is considered to be an inpatient when he or she has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. An injured worker is considered an inpatient if there is a formal order for admission from the physician. The determination of an inpatient stay is not based upon the number of hours involved. If it later develops during the uninterrupted stay that the injured worker is discharged, transferred to another inpatient unit within the hospital, transferred to another hospital, transferred to another state psychiatric facility or expires and does not actually use a bed overnight, the order from the attending physician addressing the type of encounter will define the status of the stay.

(2) For the purposes of the rules of this chapter of the Administrative Code relating to hospitals, "outpatient" means:

The injured worker is not receiving inpatient care, as "inpatient" is defined in paragraph (K)(1) of this rule, but receives outpatient services at a hospital. An

outpatient encounter cannot exceed seventy-two hours of uninterrupted duration.

(L) "Injury" means:

For the purposes of the rules of this chapter of the Administrative Code only, an injury as defined in division (C) of section 4123.01 of the Revised Code or an occupational disease as defined in division (F) of section 4123.01 of the Revised Code.

(M) "Managed care organization" or "MCO" means:

A vendor as defined under section 4121.44 of the Revised Code who has contracted with the bureau to provide medical management and cost containment services as provided in sections 4121.44 and 4121.441 of the Revised Code. As used in these rules, a managed care organization is not a health care provider.

(N) "Medical management and cost containment services" means:

Those services provided by an MCO pursuant to its contract with the bureau, including return to work management services, that promote the rendering of high quality, cost effective medical care that focuses on minimizing the physical, emotional, and financial impact of a work related injury or illness and promotes a safe return to work.

(O) "Medically necessary" means:

Services which are reasonably necessary for the diagnosis or treatment of disease, illness, and injury, and meet accepted guidelines of medical practice. A medically necessary service must be reasonably related to the illness or injury for which it is performed regarding type, intensity, and duration of service and setting of treatment.

(P) "Medication" means:

The same as drug as defined by division (E) of section 4729.01 of the Revised Code.

(Q) "Non-bureau certified provider" means:

A provider who is not approved by the bureau for participation in the HPP, or whose certification has lapsed and has not been reinstated pursuant to rule 4123-6-02.4 of the Administrative Code.

(R) "Physician" means:

(1)

(a) A doctor of medicine, doctor of osteopathic medicine or surgery, or doctor of podiatric medicine who holds a current, valid certificate of licensure to practice medicine or surgery, osteopathic medicine or surgery, or podiatry under Chapter 4731. of the Revised Code;

(b) A doctor of chiropractic who holds a current, valid certificate of licensure to practice chiropractic under Chapter 4734. of the Revised Code;

(c) A doctor of mechanotherapy who holds a current, valid certificate of licensure to practice mechanotherapy under Chapter 4731. of the Revised Code and who was licensed prior to November 3, 1985;

(d) A psychologist who holds a current, valid certificate of licensure to practice psychology under Chapter 4732. of the Revised Code; or

(e) A dentist who holds a current, valid certificate of licensure to practice dentistry under Chapter 4715. of the Revised Code.

(S) "Physician of record" or "attending physician" means:

For the purposes of Chapters 4121. and 4123. of the Revised Code, the authorized physician chosen by the employee to direct treatment.

(T) "Practitioner" means:

A physician, or a physical therapist, occupational therapist, optometrist, or any other person currently licensed and duly authorized to practice within his or her respective health care field.

(U) "Provider certification application and agreement" means:

A bureau form providers complete that requests background information and documentation necessary for certification and which, if completed and signed by the provider and approved by the bureau, constitutes a written, contractual agreement between the bureau and the provider.

(V) "Provider outcome measurement" means:

A medical management analysis tool used by the bureau or MCO which at a minimum, utilizes line item detail from a medical bill and employee specific information including, but not limited to, demographics, diagnosis allowances, return to work and remain at work statistics, and other data regarding treatment, to evaluate a health care provider on the basis of cost, utilization and treatment outcomes efficiency and compliance with bureau requirements.

(W) "Qualified health plan" or "QHP" means:

A health care plan sponsored by an employer or a group of employers which meets the standards for qualification under section 4121.442 of the Revised Code and is certified as a qualified health care plan with the bureau.

(X) "Recertification application and agreement" means:

A bureau form certified providers complete as part of the provider recertification process that requests background information and documentation necessary for recertification and which, if completed and signed by the provider and approved by the bureau, constitutes a written, contractual agreement between the bureau and the provider.

(Y) "Remain at work services" means:

Services to support an injured worker in continued employment where the injured worker is experiencing difficulties performing a job as a result of conditions related to an allowed medical only claim.

(Z) "Return to work services" means:

Services to support an injured worker in returning to employment where the injured worker is experiencing difficulty as a result of conditions related to an allowed lost time claim.

(AA) "Transitional work" means:

A work-site program that provides an individualized interim step in the recovery of an injured worker with job restrictions resulting from the allowed conditions in the claim. Developed in conjunction with the employer and the injured worker, or with others as needed, including, but not limited to the collective bargaining agent (where applicable), the physician of record, rehabilitation professionals, and the MCO, a transitional work program assists the injured worker in progressively performing the duties of a targeted job..

(BB) "Treatment guidelines" means:

Guidelines of medical practice, developed through consensus of practitioner representatives, that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions.

(CC) "Urgent care facility" means:

A facility where ambulatory care is provided outside a hospital emergency department and is available on a walk in, non-appointment basis.

(DD) "Utilization review" means:

The assessment of an employee's medical care by the MCO. This assessment typically considers medical necessity, the appropriateness of the place of care, level of care, and the duration, frequency or quality of services provided in relation to the allowed condition being treated.

Replaces: 4123-6-01

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies:	4121.12, 4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 9/5/96, 1/1/99, 1/1/01, 3/29/02, 2/14/05, 2/1/10

TO BE RESCINDED

4123-6-01 **Definitions.**

As used in the rules of this chapter and Chapter 4123-7 of the Administrative Code:

(A) "Health partnership program" or "HPP" means:

The bureau of workers' compensation's comprehensive managed care program under the direction of the chief of medical services as provided in sections 4121.44 and 4121.441 of the Revised Code.

(B) "Qualified health plan" or "QHP" means:

A health care plan sponsored by an employer or a group of employers which meets the standards for qualification under section 4121.442 of the Revised Code and is certified as a qualified health care plan with the bureau.

(C) "Managed care organization" or "MCO" means:

A vendor as defined under section 4121.44 of the Revised Code who has contracted with the bureau to provide medical management and cost containment services as provided in sections 4121.44 and 4121.441 of the Revised Code. As used in these rules, a managed care organization is not a health care provider.

(D) "Physician" means:

A doctor of medicine, doctor of osteopathic medicine or surgery, or doctor of podiatric medicine who holds a current, valid certificate of licensure to practice medicine or surgery, osteopathic medicine or surgery, or podiatry under Chapter 4731. of the Revised Code; a doctor of chiropractic who holds a current, valid certificate of licensure to practice chiropractic under Chapter 4734. of the Revised Code; a doctor of mechanotherapy who holds a current, valid certificate of licensure to practice mechanotherapy under Chapter 4731. of the Revised Code and who was licensed prior to November 3, 1985; a psychologist who holds a current, valid certificate of licensure to practice psychology under Chapter 4732. of the Revised Code; or a dentist who holds a current, valid certificate of licensure to practice dentistry under Chapter 4715. of the Revised Code. A physician licensed pursuant to the equivalent law of another state shall qualify as a physician under this rule.

(E) "Physician of record" or "attending physician" means:

For the purposes of Chapters 4121. and 4123. of the Revised Code, the authorized physician chosen by the employee to direct treatment.

(F) "Practitioner" means:

A physician, or a physical therapist, occupational therapist, optometrist, or any other person currently licensed and duly authorized to practice within his or her respective health care field.

(G) "Health care provider" or "provider" means:

A physician or practitioner, or any person, firm, corporation, limited liability corporation, partnership, association, agency, institution, or other legal entity licensed, certified, or approved by a professional standard-setting body or by medicare or medicaid to provide medical services or supplies, including, but not limited to a qualified rehabilitation provider.

(H) "Credentialing" or "recredentialing" means:

A process by which the bureau validates or reviews the application of a provider for certification or recertification.

(I) "Certification" or "recertification" means:

A process by which the bureau approves a provider or MCO for participation in the HPP.

(J) "Provider application and agreement" means:

A bureau form which requests background information and documentation necessary for credentialing and which, if completed and signed by the provider and approved by the bureau, constitutes a written, contractual agreement between the bureau and the provider.

(K) "Recertification application and agreement" means:

A bureau form sent to bureau certified providers as part of the provider recredentialing and recertification process which requests background information and documentation necessary for recredentialing and which, if completed and signed by the provider and approved by the bureau, constitutes a written, contractual agreement between the bureau and the provider.

(L) "Bureau certified provider" means:

A credentialed provider who has completed and signed a provider application and agreement or recertification application and agreement with the bureau and is approved by the bureau for participation in the HPP.

(M) "Non-bureau certified provider" means:

A provider who has not completed and signed a provider application and agreement or recertification application and agreement with the bureau and is not approved by the bureau for participation in the HPP, or whose certification has lapsed and has not been reinstated pursuant to rule 4123-6-02.4 of the Administrative Code.

(N) "Employee" means:

As used in the rules of this chapter, the term "employee" includes the terms "injured worker" and "claimant" and all employees of employers covered under HPP.

(O) "Emergency" means:

Medical services that are required for the immediate diagnosis and treatment of a condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency, but is necessary to determine whether an emergency exists.

(P) "Medical management and cost containment services" means:

Those services provided by an MCO pursuant to its contract with the bureau, including return to work management services, that promote the rendering of high-quality, cost-effective medical care that focuses on minimizing the physical, emotional, and financial impact of a work-related injury or illness and promotes a safe return to work.

(Q) "Medically necessary" means:

Services which are reasonably necessary for the diagnosis or treatment of disease, illness, and injury, and meet accepted guidelines of medical practice. A medically necessary service must be reasonably related to the illness or injury for which it is performed regarding type, intensity, and duration of service and setting of treatment.

(R) "Authorization" or "prior authorization" means:

Notification by the MCO that a specific treatment, service, or equipment is medically necessary for the diagnosis and/or treatment of an allowed condition, except that the bureau reserves the authority to authorize or prior authorize the following services: caregiver services, home and van modifications, and return to work management services pursuant to paragraph (D) of rule 4123-6-04.6 of the Administrative Code.

(S) "Dispute resolution" means:

Procedures for the resolution of medical disputes prior to filing an appeal under section 4123.511 of the Revised Code.

(T) "Provider outcome measurement" means:

A medical management analysis tool used by the bureau or MCO which at a minimum, utilizes line item detail from a medical bill and employee specific information including, but not limited to, demographics, diagnosis allowances return to work and remain at work statistics, and other data regarding treatment to evaluate a health care provider on the basis of cost, utilization and treatment outcomes efficiency and compliance with bureau requirements.

(U) "Utilization review" means:

The assessment of an employee's medical care by the MCO. This assessment typically considers medical necessity, the appropriateness of the place of care, level of care, and the duration, frequency or quality of services provided in relation to the allowed condition being treated.

(V) "Treatment guidelines" means:

Guidelines of medical practice developed through consensus of practitioner representatives that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions.

(W) "Formulary" means:

A list of medications determined to be safe and effective by the food and drug administration which the bureau shall consider for reimbursement. The list shall be regularly reviewed and updated by the bureau to reflect current medical standards of drug therapy.

(X) "Medication" means:

The same as drug as defined by division (D) of section 4729.01 of the Revised Code.

(Y) "Injury" means:

For the purposes of the rules of this chapter and Chapter 4123-7 of the Administrative Code only, an injury as defined in division (C) of section 4123.01 of the Revised Code or an occupational disease as defined in division (F) of section 4123.01 of the Revised Code.

(Z) "Return to work services" means:

Services to support an injured worker in returning to employment where the injured worker is experiencing difficulty as a result of conditions related to an allowed lost time claim.

(AA) "Remain at work services" means:

Services to support an injured worker or employee in continued employment where the injured worker is experiencing difficulties performing a job as a result of conditions related to an allowed medical only claim.

(BB) "Transitional work" means:

A work-site program that provides an individualized interim step in the recovery of an injured worker with job restrictions resulting from the allowed conditions in the claim. Developed in conjunction with the employer and the injured worker, or with others as needed, including, but not limited to the collective bargaining agent (where applicable), the physician of record, rehabilitation professionals, and the MCO, a transitional work program assists the injured worker in progressively performing the duties of a targeted job.

(CC) "Hospital" means:

An institution that provides facilities for surgical and medical diagnosis and treatment of bed patients under the supervision of staff physicians and furnishes twenty-four hour-a-day care by registered nurses.

(1) For the purposes of the rules of this chapter of the Administrative Code relating to hospitals, "inpatient" means:

An injured worker is considered to be an inpatient when he or she has been admitted to a hospital for bed occupancy for purposes of receiving inpatient

hospital services. An injured worker is considered an inpatient if there is a formal order for admission from the physician. The determination of an inpatient stay is not based upon the number of hours involved. If it later develops during the uninterrupted stay that the injured worker is discharged, transferred to another inpatient unit within the hospital, transferred to another hospital, transferred to another state psychiatric facility or expires and does not actually use a bed overnight, the order from the attending physician addressing the type of encounter will define the status of the stay.

(2) For the purposes of the rules of this chapter of the Administrative Code relating to hospitals, "outpatient" means:

The injured worker is not receiving inpatient care, as "inpatient" is defined in paragraph (CC)(1) of this rule, but receives outpatient services at a hospital. An outpatient encounter cannot exceed seventy-two hours of uninterrupted duration.

(DD) "Urgent care facility" means:

A facility where ambulatory care is provided outside a hospital emergency department and is available on a walk in, non-appointment basis.

Replaces: 4123-6-01

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 9/5/96, 1/1/99, 1/1/01, 3/29/02, 2/14/05, 2/1/10

4123-6-02 **Provider access to the HPP - generally.**

(A) The bureau is authorized to ~~credential and~~ certify a provider who wishes to participate in the HPP. The bureau is authorized to ~~recredential and~~ recertify a provider at least every ~~two~~ one to three years. The bureau may, but is not required to, ~~recredential and~~ recertify providers on a staggered basis, in order of the provider's initial certification date or such other criteria as the bureau determines appropriate.

(B) A provider shall be certified or recertified by the bureau to treat injured workers if the provider is a direct service provider; meets and maintains basic credentialing criteria under rule 4123-6-02.2 of the Administrative Code; meets and maintains all other applicable criteria under the workers' compensation statutes and rules; and completes and signs a provider application and agreement or recertification application and agreement with the bureau.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/5/99, 1/1/01, 3/29/02, 2/1/10

4123-6-02.2 **Provider access to the HPP - provider ~~credentialing~~ certification criteria.**

(A) The bureau shall establish minimum ~~credentialing~~ criteria for provider certification. Providers must meet all licensing, certification, or accreditation requirements necessary to provide services in Ohio. A provider licensed, certified or accredited pursuant to the equivalent law of another state shall qualify as a provider under this rule in that state. However, if an individual provider's professional license is under revocation or suspension in any state, or is subject to disciplinary restrictions in any state that affect the provider's ability to treat patients or that compromise patient care, the provider shall be ineligible to participate in the health partnership program.

(B) The minimum ~~credentials~~ criteria for a provider, where applicable based upon the type of provider, are as follows. The provider shall:

(1) Be currently licensed to practice, as applicable, without disciplinary restrictions ~~(including, but not limited to, disciplinary restrictions related to chemical dependency or substance abuse)~~ that affect the provider's ability to treat patients or that compromise patient care, including, but not limited to, disciplinary restrictions related to chemical dependency or substance abuse.

(2) Meet other general certification requirements for the specific provider type, as provided in paragraph (C) of this rule.

(3) Possess a current and unrestricted drug enforcement agency registration, unless it is not required by the provider's discipline and scope of practice.

(4) ~~Be~~Not be currently ~~eligible for~~ excluded from participation in medicare~~,~~ or medicaid ~~or the Ohio workers' compensation system~~ for cause.

(5) Not have a history of a felony conviction in any jurisdiction, a conviction under a federal controlled substance act, a conviction for an act involving dishonesty, fraud, or misrepresentation, a conviction for a misdemeanor committed in the course of practice or involving moral turpitude, or court supervised intervention or treatment in lieu of conviction pursuant to section 2951.041 of the Revised Code or the equivalent law of another state.

(6) Attest to and maintain adequate, current professional malpractice and liability insurance, and provide proof of such coverage to BWC upon request. The bureau shall establish the appropriate amount of such insurance coverage for

each provider type. In establishing the appropriate amount of insurance coverage for out of state providers, the bureau may consider the regulations or the community standards of the provider's state of practice.

(7) Provide documentation of the provider's malpractice history for the previous five years.

(8) Not have any outstanding provider overpayment or other indebtedness to the bureau which has been certified to the attorney general for collection.

(9) Provide proof of and maintain workers' compensation coverage to the extent required under Ohio law or the equivalent law of another state, as applicable.

(10) Not have been excluded or removed from participation in other health plans for cause, or have lost hospital privileges for cause.

(C) The following minimum credentials apply to the providers listed below as provided in this rule.

(1) Adult day care facility: Ohio department of aging PASSPORT adult day care provider agreement.

(2) Alcohol and drug counseling clinic: certified by Ohio department of ~~alcohol~~ mental health and ~~drug~~ addiction services ~~to administer outpatient counseling~~.

(3) Ambulance, ambulette, or air ambulance service: license from Ohio medical transportation board if private; approved by the centers for medicare and medicaid services (CMS) for medicare if government/public.

(4) Ambulatory surgical center: license from Ohio department of health and approved by the centers for medicare and medicaid services (CMS) for medicare.

(5) Anesthesiologist assistant: certificate of registration from Ohio state medical board.

(6) Athletic trainer: license from Ohio occupational therapy, physical therapy, and athletic trainer board.

(7) Audiologist: license from Ohio board of speech-language pathology and audiology.

(8) Certified nurse practitioner: certified by American nurses credentialing center or other certifying agency ~~recognized~~ approved by the Ohio board of nursing.

(9) Certified registered nurse anesthetist (CRNA): certified by national council on certification of nurse anesthetists or other certifying agency ~~recognized~~ approved by the Ohio board of nursing.

(10) Certified shoe retailer: certified by pedorthic footwear association.

~~(10)~~(11) Chiropractic physician (D.C.): license from Ohio state chiropractic board.

~~(11)~~(12) Clinical nurse specialist: certified by American nurses credentialing center or other certifying agency ~~recognized~~ approved by the Ohio board of nursing.

~~(12)~~(13) Comprehensive pain management services program: (free standing) CARF accreditation; (hospital based) CARF or joint commission accreditation.

~~(13)~~(14) Dentist: license from Ohio state dental board.

~~(14)~~(15) Dialysis center: license from Ohio department of health and approved by the centers for medicare and medicaid services (CMS) for medicare.

~~(15)~~(16) Durable medical equipment supplier (excludes orthotics, prosthetics and pedorthics): state vendors license; approved by the centers for medicare and medicaid services (CMS) for medicare or, in the alternative, accredited by a recognized independent accreditation organization approved by CMS and submission to the bureau of a surety bond in the amount of fifty thousand dollars from a company approved by the bureau and authorized to do business in the state of Ohio by the Ohio department of insurance; and Ohio respiratory care board home medical equipment certificate of registration.

~~(16)~~(17) Employment specialist (may provide job placement, job development, job seeking skills training, job club, and job coach services only):

(a)

(i) Certification for ~~american~~ American board of vocational experts (ABVE), certified rehabilitation counselor (CRC), certified case manager (CCM), global career development facilitator (GCDF), associate certified coach (ACC), professional certified coach (PCC), master certified coach (MCC), certified disability

management specialist (CDMS), or commission on accreditation of rehabilitation facilities (CARF) accreditation for employment and community services in job development or employment supports; or

(ii) Evidence of completion of three or more courses, seminars or workshops prior to application for certification, totaling a minimum of eighty hours and approved by the bureau or by an entity offering a certification referenced in paragraph (16)(a)(i) of this rule, in at least two of the following domain areas: job development, job placement, and career and lifestyle development; vocational consultation and services for employers; professional roles and practices, ethics, and utilization of community resources; or

(iii) Evidence of bureau reimbursement to the provider for job placement, job development, job seeking skills training, job club, and/or job coaching services to injured workers for dates of service beginning not less than eighteen months prior to the effective date of this rule.

(b) Employment specialists certified pursuant to paragraph (C)(16)(a)(ii) or (C)(16)(a)(iii) of this rule must complete twenty hours of continuing education, including three hours of ethics, every two years to maintain certification under this rule.

~~(17)~~(18) Ergonomist: certification for certified professional ergonomist (CPE), certified human factors professional (CHFP), associate ergonomics professional (AEP), associate human factors professional (AHFP), certified ergonomics associate (CEA), certified safety professional (CSP) with "ergonomics specialist" designation, certified industrial ergonomist (CIE), certified industrial hygienist (CIH), assistive technology practitioner (ATP), or rehabilitation engineering technologist (RET).

~~(18)~~(19) Hearing aid dealer: license from Ohio hearing aid dealers and fitters licensing board.

~~(19)~~(20) Home health agency: approved by the centers for medicare and medicaid services (CMS) for medicare, joint commission accreditation, or community health accreditation program (CHAP) accreditation, or accreditation through an organization that has been granted deeming authority by the centers for medicare and medicaid services (CMS).

~~(20)~~(21) Hospice: license from Ohio department of health, and approved by the centers for medicare and medicaid services (CMS) for medicare or medicaid certification.

~~(21)~~(22) Hospital: approved by the centers for medicare and medicaid services (CMS) for medicare or obtained national accreditation (joint commission accreditation, or American osteopathic association healthcare facilities accreditation program (HFAP), or commission on accreditation of rehabilitation facilities (CARF) for rehabilitation hospitals). The following facility types shall be credentialed and certified as hospitals: short-term general and specialty hospitals; long-term care hospitals; rehabilitation hospitals; psychiatric hospitals; hospital (provider) based urgent care facilities or clinics as designated on the hospital's medicare cost report.

~~(22)~~(23) Independent diagnostic testing facility (IDTF): approved by the centers for medicare and medicaid services (CMS) for medicare.

~~(23)~~(24) Laboratory: valid clinical laboratory improvement amendments (CLIA) certificate.

~~(24)~~(25) Licensed professional clinical counselor (LPCC) or licensed professional counselor (LPC): license from Ohio counselor, social worker, and marriage and family therapist board.

~~(25)~~(26) Licensed social worker (LSW) or licensed independent social worker (LISW): license from Ohio counselor, social worker, and marriage and family therapist board.

~~(26)~~(27) Massage therapist: certified by Ohio state medical board.

~~(27)~~(28) Non-physician acupuncturist: certificate of registration from Ohio state medical board.

~~(28)~~(29) Nursing home: license from Ohio department of health or approved by the centers for medicare and medicaid services (CMS) for medicare.

~~(29)~~(30) Ocularist: license from Ohio optical dispensers board.

~~(30)~~(31) Occupational rehabilitation-comprehensive programs (work hardening): CARF accreditation.

~~(31)~~(32) Occupational therapist: license from Ohio occupational therapy, physical therapy, and athletic trainer board.

~~(32)~~(33) Optician: license from Ohio optical dispensers board.

~~(33)~~(34) Optometrist: license from Ohio board of optometry.

~~(34)~~(35) Orthotist, prosthetist or pedorthist: license from Ohio state board of orthotics, prosthetics and pedorthics.

~~(35)~~(36) Physical therapist: license from Ohio occupational therapy, physical therapy, and athletic trainer board.

~~(36)~~(37) Physician (M.D. or D.O.): license from Ohio state medical board.

~~(37)~~(38) Physician assistant: certified by national commission on certification of physician assistants and certificate to practice from Ohio state medical board.

~~(38)~~(39) Podiatric physician (D.P.M.): license from Ohio state medical board.

~~(39)~~(40) Psychologist: license from Ohio state board of psychology.

~~(40)~~(41) Radiology services (free-standing) state licensing, registration or accreditation; (mobile) state, county or city registration, or approved by the centers for medicare and medicaid services (CMS) for medicare or medicaid certification.

~~(41)~~(42) Residential care/assisted living facility: license from Ohio department of health.

~~(42)~~(43) Sleep laboratory: certified by the American academy of sleep medicine and approved by the centers for medicare and medicaid services (CMS) for medicare.

~~(43)~~(44) Speech pathologist: license from Ohio board of speech pathology and audiology.

~~(44)~~(45) Telemedicine: telemedicine certificate from Ohio state medical board.

~~(45)~~(46) Traumatic brain injury (TBI) program: CARF accreditation for brain injury services (acute or post-acute).

~~(46)~~(47) Urgent care facility (free standing): approved by the centers for medicare and medicaid services (CMS) for medicare.

~~(47)~~(48) Vocational rehabilitation case managers: certification for American board of vocational experts (ABVE), occupational health nursing (COHN(S)), certified rehabilitation counselor (CRC), certified disability management specialist (CDMS), certified vocational evaluator (CVE), certified rehabilitation nurse (CRRN), or certified case manager (CCM).

~~(48)~~(49) Vocational rehabilitation case management interns:

(a) Vocational rehabilitation case management may be provided by a bureau-certified intern. An intern is a non-credentialed individual who provides vocational case management services and is supervised by a credentialed vocational case manager, as identified in paragraph ~~(C)(47)~~ (C)(48) of this rule.

(b) To become eligible for bureau certification and provide service as an intern, the intern must:

(i) Enroll with the bureau as an intern.

(ii) Qualify to take one of the examinations to become credentialed, as identified in paragraph ~~(C)(47)~~ (C)(48) of this rule.

(c) Bureau certification of vocational rehabilitation case management interns shall be for a period of four years.

(d) Vocational rehabilitation case management interns may not be recertified for additional four-year periods.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/15/99, 3/29/02, 7/14/03, 9/12/04, 4/1/07, 2/1/10, 12/10/12, 4/1/14

4123-6-02.3 **Provider access to the HPP - provider application and ~~credentialing~~ certification criteria.**

(A) The bureau shall make available to each provider ~~via the bureau's internet site~~ a provider certification application and agreement or recertification application and agreement, as applicable, which shall require the provider to furnish ~~credentialing~~ documentation as provided in rule 4123-6-02.2 of the Administrative Code.

(B) The provider application and agreement or recertification application and agreement ~~may~~ shall require the provider to make statements that the provider is without impairments that would interfere with the provider's ability to practice or that would jeopardize a patient's health, and a statement that the application is without misrepresentation, misstatement, or omission of a relevant fact or other acts involving dishonesty, fraud, or deceit. The provider shall provide to the bureau any additional documentation requested, and shall permit the bureau to conduct a review of the provider's practice or facility. The provider shall notify the bureau within thirty days of any change in the provider's status regarding any of the credentialing criteria of paragraph (B) or (C) of rule 4123-6-02.2 of the Administrative Code.

(C) The bureau shall review the application and agreement and all ~~credentialing~~ documentation submitted by the provider. The bureau may cross-check data with other governmental agencies or licensing bodies. The bureau may refer provider certification and malpractice issues ~~relating~~ to ~~malpractice history for review by~~ the bureau's stakeholders health care quality assurance advisory committee for review as provided under rule 4123-6-22 of the Administrative Code.

(D) By signing the provider application and agreement or recertification application and agreement, the provider agrees to, and the bureau may refuse to certify or recertify or may decertify a provider for failure to:

(1) Provide health services that are applicable to a work-related injury, and not to substantially engage in the practice of experimental modalities of treatment.

(2) Acknowledge and treat injured workers in accordance with bureau recognized treatment guidelines.

(3) Acknowledge and treat injured workers in accordance with the vocational rehabilitation hierarchy.

(4) Provide adequate on-call coverage for patients.

(5) Utilize bureau certified providers when making referrals to other providers.

(6) Timely schedule and treat injured workers to facilitate a safe and prompt return to work.

(7) Release information from the national practitioner data bank~~, healthcare integrity and protection data bank~~ or the federation of state licensing boards. The bureau may submit a report to the appropriate state licensing board or data bank as required in the event ~~that the provider's certification is terminated for reasons pertaining to the provider's professional conduct or competence~~ the provider is decertified.

(8) Practice in a managed care environment and adhere to MCO and bureau procedures and requirements concerning provider compliance, outcome measurement data, peer review, quality assurance, utilization review, bill submission, and dispute resolution.

(9) Adhere to the bureau's confidentiality and sensitive data requirements, and use information obtained from the bureau by means of electronic account access for the sole purpose of facilitating treatment and no other purpose, including but not limited to engaging in advertising or solicitation directed to injured workers.

(10) Comply with the workers' compensation statutes and rules and the terms of the provider application and agreement or recertification application and agreement.

(E) Upon review and determination by the bureau that the provider has met bureau credentialing requirements, the bureau shall certify or recertify the provider as a bureau certified provider.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.66, 4123.05, 4123.66
Rule Amplifies:	4121.12, 4121.121, 4121.44, 4121.441
Prior Effective Dates:	2/16/96, 1/15/99, 3/29/02, 2/14/05, 2/1/10

4123-6-02.4 **Provider access to the HPP - provider ~~recredentialing~~ and recertification.**

(A) The bureau shall initiate the ~~recredentialing~~ recertification process by sending certified providers notice and a recertification application and agreement, which must be completed, signed and submitted to the bureau if the provider wishes to be considered for recertification.

(B) Except as otherwise provided in paragraph (E) of this rule, if the bureau receives a completed and signed recertification application and agreement from a provider, the provider's certification shall remain in effect until the bureau issues a final order approving or denying the provider's application for recertification.

(C) If the bureau does not receive a completed and signed recertification application and agreement from the provider within sixty days from the date of the notice sent in accordance with paragraph (A) of this rule, the bureau shall send a second notice to the provider stating that the provider has thirty days from the date of the second notice to complete, sign and submit the recertification application and agreement to the bureau if the provider wishes to be considered for recertification.

(D) If the bureau does not receive a completed and signed recertification application and agreement from the provider within thirty days from the date of the second notice sent in accordance with paragraph (C) of this rule, the provider's certification shall lapse. Such lapse of certification is not an adjudication order and is not subject to appeal pursuant to rule 4123-6-17 of the Administrative Code.

(E) If the bureau receives a completed and signed recertification application and agreement from a provider after the provider's certification has lapsed pursuant to paragraph (D) of this rule, the provider's certification shall remain lapsed until the bureau issues a final order approving or denying the provider's application for recertification.

(F) All recertification ~~application~~ applications and agreements are subject to ~~credentialing~~ review as provided in rule 4123-6-02.3 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	3/29/02, 2/1/10

4123-6-02.5 **Provider access to the HPP - provider not certified.**

(A) A provider not certified or recertified shall cure any defects in the provider application and agreement or recertification application and agreement within thirty days of notice by the bureau.

(B) The administrator of the bureau of workers' compensation, pursuant to rule 4123-6-17 of the Administrative Code, may refuse to certify or recertify or may decertify a provider where the provider has failed to comply with the workers' compensation statutes or rules, or the terms of the provider application and agreement or recertification application and agreement.

(C) Notwithstanding paragraph (B) of this rule, ~~in any case where the administrator finds a serious danger to the public health and safety and sets forth specific reasons for such findings, or , in the case of an individual provider, the bureau receives notice from the appropriate state licensing board that the provider's professional license has been revoked or suspended, or the provider is convicted of or pleads guilty to a violation of sections 2913.48 or 2923.31 to 2923.36 if the Revised Code or any other criminal offense related to the delivery of or billing for health care benefits~~, the administrator may immediately revoke or suspend the certification of a provider~~. The order shall be final unless the provider, within seven days of such order, requests a hearing before the administrator where the provider shall show cause why the order should not be final. The order of the administrator shall remain in force during the pendency of the show cause hearing.~~ other than a hospital, in accordance with section 4121.443 of the Revised Code, if the bureau determines any of the following apply to the provider:

(1) The professional license, certification, or registration held by the provider to practice the provider's profession has been revoked or suspended for an indefinite period of time or for a period of more than thirty days, subsequent to the provider's certification to participate in the health partnership program.

(2) The provider has been convicted of or has pleaded guilty to a violation of section 2913.48 or sections 2923.31 to 2923.36 of the Revised Code or has been convicted of or pleaded guilty to any other criminal offense related to the delivery of or billing for health care services.

(3) The bureau determines, by clear and convincing evidence, that the continued participation by the provider in the health partnership program presents a danger of immediate and serious harm to claimants.

(D) The administrator may impose disciplinary sanctions upon a provider where the provider has failed to comply with the workers' compensation statutes or rules

governing providers or the terms of the provider application and agreement or recertification application and agreement. ~~The administrator may impose a disciplinary sanctions without an adjudication order under rule 4123-6-17 of the Administrative Code.~~ In imposing a disciplinary sanction against a provider the administrator may consider, but is not limited to, suspending all reimbursements to a provider.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Prior Effective Dates:	2/16/96, 1/15/99, 3/29/02, 2/14/05, 2/1/10

4123-6-02.6 **Provider access to the HPP -- selection by an MCO.**

(A) The bureau shall maintain a public list of bureau certified providers. The bureau shall make the list of bureau certified providers available ~~via~~ through the bureau's ~~internet site~~ website.

(B) An MCO may, but is not required to, retain a panel of bureau certified providers. A bureau certified provider is eligible to participate on an MCO's provider panel. A bureau certified provider may participate in a single MCO panel or may participate in more than one MCO panel.

(C) A provider identified by an MCO for temporary privileges in its panel of providers that is not a bureau certified provider shall be assisted by the MCO in applying for bureau provider credentialing and certification.

(D) The bureau or MCO shall not discriminate against any category of health care provider when establishing categories of providers for participation in the HPP. However, neither the bureau nor an MCO is required to accept or retain any individual provider.

(E) The MCO shall include in its panel or its arrangements with providers a substantial number of the medical, professional, and pharmacy providers currently being utilized by employees. An MCO may limit the number of providers on its MCO provider panel or with whom they enter into arrangements, but must do so based upon objective data approved by the bureau, such as reasonable patient access, community needs, the potential number of employees the MCO is applying to service, and other performance criteria, without discrimination by provider type.

(F) A bureau certified provider must follow the medical management and return to work management approaches of the MCO medically managing an employee's claim, whether or not the provider is on the MCO's provider panel, or has an arrangement with the MCO.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/1/01, 3/5/10

4123-6-02.7 **Provider access to the HPP - provider decertification procedures.**

(A) Except as otherwise provided in paragraph (C) of this rule, the administrator ofthe bureau of workers' compensation shall follow the procedures set forth in this rule to terminate the enrollment of and decertify ~~an individual~~ a non-facility provider who has failed to comply with a workers' compensation statute or rule~~, or a term of the provider application and agreement or recertification application and agreement~~.

(1) If the bureau determines a provider has committed three or more reported violations of the same workers' compensation statute or rule~~, or term of the provider application and agreement or recertification application and agreement~~ in a six month period, or five or more reported violations of any workers' compensation statute or rule~~, or term of the provider application and agreement or recertification application and agreement~~ in a six month period, the bureau shall send the provider ~~shall receive~~ written notification ~~from the bureau~~ of the violations by certified mail.

(2) If the bureau determines the provider has committed two or more subsequent reported violations of any workers' compensation statute or rule~~, or term of the provider application and agreement or recertification application and agreement~~ for which the provider previously received notice pursuant to paragraph (A)(1) of this rule, and the subsequent violations occurred any time within the twelve month period following the calendar month in which the provider received notice pursuant to paragraph (A)(1) of this rule, the bureau shall send the provider ~~shall receive~~ written notification ~~from the bureau~~ of the violations by certified mail, which shall include a thirty day ~~implementation~~ period ~~for~~ within which the provider ~~to~~ must submit and implement a correction plan to the bureau ~~and correct the behavior~~. The correction plan shall be entered into the provider's certification file and the provider's certification file shall have the notation "under correction plan" during the twelve month period following the calendar month in which the provider's thirty day implementation period provided above expires.

If the provider fails to submit a correction plan within the thirty day implementation period satisfactory to the bureau, which satisfaction shall not be unreasonably withheld, the bureau shall send the provider ~~shall receive~~ written notification ~~from the bureau~~ of the failure by certified mail, which shall include a notice of proposed enrollment termination and decertification complying with rule 4123-6-17 of the Administrative Code.

(3) If the bureau determines the provider has committed two or more subsequent reported violations of the same workers' compensation statute or rule~~, or term~~

~~of the provider application and agreement or recertification application and agreement~~ for which the provider previously received notice pursuant to paragraph (A)(2) of this rule and submitted a correction plan satisfactory to the bureau, and the subsequent violations occurred any time within the twelve month period following the calendar month in which the provider's thirty day implementation period provided in the notice sent pursuant to paragraph (A)(2) of this rule expires, the bureau shall send the provider ~~shall receive~~ written notification ~~from the bureau~~ of the violations by certified mail, which shall include a notice of proposed enrollment termination and decertification complying with rule 4123-6-17 of the Administrative Code.

(4) If the bureau determines a provider who has twice received written notice pursuant to paragraph (A)(1) of this rule for violation of the same workers' compensation statute or rule~~, or term of the provider application and agreement or recertification application and agreement~~ has committed a subsequent reported violation of the same workers' compensation statute or rule~~, or term of the provider application and agreement or recertification application and agreement~~ within three years of the date written notification was first sent to the provider by the bureau pursuant to paragraph (A) of this rule, the bureau shall send the provider ~~shall receive~~ written notification ~~from the bureau~~ of the violation by certified mail, which shall include a notice of proposed enrollment termination and decertification complying with rule 4123-6-17 of the Administrative Code.

(5) The bureau may, in its discretion, ~~waive strict~~ may consider mitigating circumstances in its application of the procedures set forth in paragraphs (A)(1) to (A)(4) of this rule with regard to an individual provider ~~based on the presence of mitigating~~. Mitigating circumstances~~, which~~ may include, but are not limited to:

(a) The violations related to the provision of emergency treatment;

(b) At the time the violations occurred, the provider was not aware a workers' compensation claim was involved;

(c) The provider was initially bureau certified within six months prior to the violations;

(d) The violations were due to bureau or MCO error;

(e) The provider billed the bureau for goods or services in fewer than five ~~workers~~ workers' compensation claims in the twelve months prior to the violations;

(f) Other documented justification as deemed sufficient by the bureau.

(6) If any notice sent by certified mail pursuant to this rule is returned because the party fails to claim the notice, the bureau shall resend the notice by ordinary mail to the party at the party's last known address appearing in the bureau's records and shall obtain a certificate of mailing.

(B) Providers whose enrollment is terminated and who are decertified pursuant to paragraph (A)(3) or (A)(4) of this rule shall be eligible to apply for and be considered for recertification and reenrollment at any time after two years from the date of the final administrative or judicial order of enrollment termination and decertification.

(C) The procedures set forth in paragraphs (A)(1) to ~~(A)(5)~~ (A)(6) of this rule do not apply to, and the administrator may proceed directly to enrollment termination and/or decertification of a provider for, violation of the following:

(1) The minimum provider ~~credentialing~~ certification criteria set forth in rule 4123-6-02.2 of the Administrative Code.

(2) Acts of misrepresentation, misstatement, or omission of a relevant fact or other acts involving dishonesty, fraud, or deceit on the provider’s provider application and agreement or recertification application and agreement.

(3) Acts involving breach of the bureau's confidentiality and sensitive data requirements, including but not limited to failure to maintain the confidentiality of injured worker medical or claim information.

(4) Acts involving misuse of information obtained from the bureau by means of electronic account access for a purpose other than facilitating treatment, including but not limited to engaging in advertising or solicitation directed to injured workers.

(5) Acts involving advertising or solicitation directed to injured workers in violation of rule 4123-6-02.9 of the Administrative Code.

(6) Acts of intentional misrepresentation, misstatement, or omission of a relevant fact or other acts involving false, fraudulent, deceptive, or misleading information on reports, information, and/or documentation submitted by the provider, the provider's employees, or the provider's agents to the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer in connection with a workers' compensation

claim.

(7) The reasons for immediate revocation or suspension of a provider's certification set forth in paragraph (C) of rule 4123-6-02.5 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 2/14/05, 2/1/10, 1/1/13

4123-6-02.8 **Provider requirement to notify of injury.**

(A) HPP: Within one working day of initial treatment or initial visit of an injured worker, a provider must report the employee's injury or occupational disease in accordance with either paragraph (A)(1) or (A)(2) of this rule.

(1) A provider may report an injury to the MCO responsible for medical management of the employee's treatment. When reporting the injury to the MCO, the provider shall do so in accordance with procedures established by the bureau.

(2) A provider may report an injury to the bureau ~~via~~ through the bureau's ~~internet site~~ website pursuant to rule 4125-1-02 of the Administrative Code.

(B) QHP: Within one working day of initial treatment or initial visit of an injured worker, a provider must report the employee's injury or occupational disease to the QHP or employer.

(C) Self-insuring employer (non-QHP): Within one working day of initial treatment or initial visit of an injured worker, a provider must report the employee's injury or occupational disease to the self-insuring employer.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/1/01, 2/1/10

4123-6-02.21 **Provider access to the HPP - non-certified provider enrollment.**

(A) The bureau may enroll non-certified providers eligible under rule 4123-6-06.2 or 4123-6-10 of the Administrative Code or division ~~(J)~~ (N) of section 4121.44 of the Revised Code to receive reimbursement for goods and services provided to injured workers, and for this purpose may require such non-certified providers to complete and sign an enrollment application and agreement as the bureau deems appropriate, provided such non-certified providers meet the minimum qualifications for their provider category as set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code.

(B) Persons or entities who do not fall within the provider categories set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code are not eligible for certification as providers. The bureau may enroll such persons or entities to receive reimbursement for goods and services provided to injured workers, and for this purpose may require such persons or entities to complete and sign an enrollment application and agreement as the bureau deems appropriate.

(C) ~~The certification of persons or entities certified as providers prior to the effective date of this rule who do not fall within the provider categories set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code shall expire on a schedule determined by the bureau, and such persons or entities shall not be eligible for recertification as providers.~~ The certification of providers who fall within the provider categories set forth in paragraph (C) of rule 4123-6-02.2 of the Administrative Code shall lapse, and the provider shall be enrolled with the bureau only, if the provider has had no billing activity with the bureau for a period of eighteen months or longer while certified. If the provider submits a bill while the provider's certification is lapsed pursuant to this paragraph, the provider may apply for recertification. However, the provider's certification shall remain lapsed until the bureau issues a final order approving or denying the provider's application for recertification.

(D) The enrollment of a non-certified provider, person, or entity pursuant to ~~paragraph~~ paragraphs (A) ~~or,~~ (B), or (C) of this rule shall expire~~, on a schedule determined by the bureau,~~ if the non-certified provider, person, or entity has had no billing activity with the bureau for a period of ~~two years~~ eighteen months or longer while enrolled as a non-certified provider.

(E) ~~Expiration~~Lapse of provider certification pursuant to paragraph (C) of this rule and expiration of provider certification or enrollment pursuant to paragraph (C) or (D) of this rule ~~does~~ do not constitute an adjudication order and ~~is~~ are not subject to

appeal pursuant to rule 4123-6-17 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	4/1/07, 2/1/10

4123-6-02.51 **Provider access to the HPP -- Denial of provider, entity or MCO enrollment/certification based on criminal conviction or civil action.**

(A) The administrator may refuse to enroll, certify or recertify, or may terminate enrollment, or decertify from participation in the HPP, any provider, entity or MCO that:

(1) Is owned, directly or indirectly, by an individual or entity that has a felony conviction in any jurisdiction, a conviction under a federal controlled substance act, a misdemeanor conviction for an act involving dishonesty, fraud, or misrepresentation, a conviction for a misdemeanor committed in the course of practice, a felony or misdemeanor conviction involving dishonesty, fraud, or misrepresentation related to any compensation or benefits payable under Chapter 4121., 4123., 4127., or 4131. of the Revised Code, or court supervised intervention or treatment in lieu of conviction pursuant to section 2951.041 of the Revised Code or the equivalent law of another state.

(2) Has one or more owners, shareholders, members, partners, managing employees, officers or directors, who have a conviction or court supervised intervention or treatment in lieu of conviction as described in paragraph (A)(1) of this rule; and including any provider, entity or MCO that is no longer so described because of a transfer of ownership or interest to an immediate family member or a member of the person's household in anticipation of or following a conviction or court supervised intervention or treatment in lieu of conviction as described in paragraph (A)(1) of this rule.

(3) Is owned directly, or indirectly, by an individual or entity who has engaged in specific conduct which demonstrates financial irresponsibility. Such conduct shall include, but not be limited to:

(a) Specific examples of insolvency of businesses owned or controlled by the individual or entity;

(b) Specific examples of failures to pay debts or judgments;

(c) Specific examples of activity which has defrauded any person, entity or organization, regardless of whether such activity has resulted in criminal prosecution;

(d) Any finding of fraud in a civil or administrative proceeding related to any

compensation or benefits payable under Chapter 4121., 4123., 4127., or 4131. of the Revised Code or the equivalent laws of another state.

(4) For the purposes of this paragraph:

(a) "Entity" means any sole proprietorship, partnership, corporation, professional association, limited liability company or any other business organization doing business in this or any other state.

(b) "Immediate family member" means a person's spouse; natural or adoptive parent; child or sibling, stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

(c) "Managing employee" means an individual (including a general manager, office manager, business manager, administrator or director) who exercises operational or managerial control over the provider, entity or MCO or part thereof, or directly or indirectly conducts the day-to-day operations of the provider, entity or MCO or part thereof, or is involved in the billing functions of the provider, entity or MCO or part thereof.

(d) "Member of household" means, with respect to a person, any individual with whom they are sharing a common abode.

(e) "Owned directly or indirectly" means having an interest that includes ownership, as an individual or through any other entity or entities, of five percent or more in the provider, entity or MCO at issue.

(B) Notwithstanding and in addition to the provisions set forth in this rule, pursuant to division (C)(1) of section 4121.444 of the Revised Code the administrator may terminate any agreement between the bureau and a person or a health care provider or managed care organization or its owner and cease reimbursement to, decertify and terminate the enrollment of that person, provider, organization, or owner for services rendered if any of the following apply:

(1) The person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization is convicted of or pleads guilty to a violation of sections 2913.48 or 2923.31 to 2923.36 of the Revised Code or any other criminal offense related to the delivery of or billing for health care benefits.

(2) There exists an entry of judgment against the person, health care provider,

managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization and proof of the specific intent of the person, health care provider, managed care organization, or owner to defraud, in a civil action brought pursuant to section 4121.444 of the Revised Code.

(3) There exists an entry of judgment against the person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization in a civil action brought pursuant to sections 2923.31 to 2923.36 of the Revised Code.

(C) No person, health care provider, or managed care organization that has had its agreement with and reimbursement from the bureau terminated by the administrator pursuant to division (C)(1) of section 4121.444 of the Revised Code, or an owner, officer, authorized agent, associate, manager, or employee of that person, health care provider, or managed care organization shall do either of the following:

(1) Directly provide services to any other bureau provider or have an ownership interest, as an individual or through any other entity or entities, of five percent or more in a provider of services that furnishes services to any other bureau provider;

(2) Arrange for, render, or order services for claimants during the period that the agreement of the person, health care provider, managed care organization, or its owner is terminated as described in division (C)(1) of section 4121.444 of the Revised Code;

(D) The administrator shall not terminate the agreement or reimbursement if the person, health care provider, managed care organization, or owner demonstrates that the person, provider, organization, or owner did not directly or indirectly sanction the action of the authorized agent, associate, manager, or employee that resulted in the conviction, plea of guilty, or entry of judgment as described in division (C)(1) of section 4121.444 of the Revised Code.

(E) Nothing in division (C) of section 4121.444 of the Revised Code prohibits an owner, officer, authorized agent, associate, manager, or employee of a person, health care provider, or managed care organization from entering into an agreement with the bureau if the provider, organization, owner, officer, authorized agent, associate, manager, or employee demonstrates absence of knowledge of the action of the person, health care provider, or managed care organization with which that individual or organization was formerly associated that resulted in a conviction, plea of guilty, or entry of judgment as described in division (C)(1) of section

4121.444 of the Revised Code.

(F) Actions taken by the administrator pursuant to this rule shall be subject to rule 4123-6-17 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4123.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4121.444, 4123.66
Prior Effective Dates:	4/1/07, 9/1/13

4123-6-03.2 **MCO participation in the HPP -- MCO application for certification or recertification.**

(A) Upon request by a managed care organization, the bureau shall send the managed care organization an MCO application for certification for the managed care organization to complete and submit to the bureau.

(B) The MCO application submitted to the bureau by the managed care organization shall include a list of bureau certified providers in its provider panel and/or bureau certified providers with which the managed care organization has arrangements.

(C) The MCO application submitted to the bureau by the managed care organization shall include the following, whether the managed care organization elects to retain a provider panel or enters into provider arrangements:

(1) A description of the managed care organization's health care provider panel or provider arrangements, which shall include a substantial number of the medical, health care professional and pharmacy providers currently being utilized by injured workers. The provider panel or provider arrangements shall cover the geographic area in which the managed care organization determines it shall compete, and may include out-of-state providers.

(2) A description of how the managed care organization's provider panel or provider arrangements shall provide timely, geographically convenient access to a full range of medical services and supplies for injured workers, including access to specialized services.

(3) A description of the managed care organization's process and methodology for credentialing providers in the managed care organization's provider panel, if applicable, and the managed care organization's process and methodology for assisting non-bureau certified providers in the managed care organization's provider panel or with which the managed care organization has provider arrangements in applying for bureau provider credentialing and certification.

(4) A description of the managed care organization's process and methodology for payment of providers in the managed care organization's provider panel or under a provider arrangement.

(5) A description of the managed care organization's policies and procedures for sanctioning and terminating providers in the managed care organization's panel, if applicable, and a description of the managed care organization's

methodology to notify the bureau, employers and employees of any changes in the managed care organization's provider panel or provider arrangements.

(6) A description of the managed care organization's methodology for distributing provider panel and provider arrangement directories and directory updates to employers and employees.

(D) The MCO application for certification submitted to the bureau by the managed care organization shall include, at a minimum, the following information and provisions, as more fully detailed within the MCO application for certification itself:

(1) A statement that the application is without misrepresentation, misstatement, or omission of a relevant fact or other representations involving dishonesty, fraud, or deceit.

(2) A description of the geographic area of the state of Ohio for which the managed care organization wishes to be certified by the bureau. The minimum geographic area shall be a county. The bureau shall certify MCO participation on a county basis. The managed care organization may apply for coverage in more than one county or statewide.

(3) A description of the managed care organization that includes, but is not limited to, a profile that includes a disclosure statement regarding the managed care organization's organizational structure, including subsidiary, parent and affiliate relationships, together with historical and current data. The managed care organization must identify its principals; provide the managed care organization's date of incorporation or formation of partnership, or limited liability company, or business trust; provide any trade names or fictitious names the managed care organization is, or has been, doing business under; provide the number of years the managed care organization has operated in Ohio; identify other states in which the managed care organization is doing business or has done business; provide a table of organization with the number of employees; and identify any banking relationships, including all account information with any financial institutions.

(4) A description of the managed care organization's business continuation plan.

(5) A description of the bureau approved treatment guidelines used by the managed care organization, including a description of how the managed care organization shall implement the treatment guidelines.

(6) A description of the managed care organization's utilization review process.

(7) A description of the managed care organization's quality assurance/improvement standards program and process, including the use of satisfaction surveys.

(8) A description of the managed care organization's medical dispute resolution process that meets the requirements of rule 4123-6-16 of the Administrative Code.

(9) A description of the managed care organization's administrative and bill payment grievance processes.

(10) A description of the managed care organization's information system platforms, capabilities and capacities; a description of the managed care organization's system for reporting necessary data elements, including but not limited to those required for performance measurements; and the managed care organization's measures in place to ensure data security, including back-up systems.

(11) A description of the managed care organization's medical case management policies and procedures.

(12) A description of the managed care organization's policies and procedures regarding the protection of confidential and sensitive records.

(13) A description of the managed care organization's policies and procedures regarding retention of information.

(14) A description of the managed care organization's provider relations and education program.

(15) A description of the managed care organization's employer and employee relations and education program, including but not limited to a description of methodologies to be used to explain options available to injured workers, including treatment by non-network providers and the dispute resolution process.

(16) A description of the managed care organization's provider bill payment processes including, but not limited to, clinical editing software (including review criteria, process and methodology).

(17) Attestation of intent to obtain and maintain insurance coverage as required by

the MCO contract, with proof of such coverage to be submitted to the bureau prior to execution of the contract, and current workers' compensation coverage.

(18) Attestation of intent to obtain and maintain professional accreditations as required by the MCO contract, with proof of such accreditations to be submitted to the bureau prior to execution of the contract.

(19) A description of any and all individuals and entities the managed care organization is affiliated with (including, but not limited to, a subcontractor or subcontractee, vendor or vendee, joint venture or other arrangement), and a copy of the MCO's contract or agreement with each individual or entity. For purposes of this rule, "affiliated with the MCO" shall have the same meaning as defined in paragraph (B) of rule 4123-6-03.9 of the Administrative Code.

(20) Other descriptions and requirements as contained in divisions (F)(1) to (F)(10) of section 4121.44 of the Revised Code.

(E) For MCO recertification, prior to the expiration of an MCO's certification, the bureau shall send the certified MCO an application for recertification, which must be completed and returned to the bureau. The MCO must be able to provide proof of delivery of the completed application to the bureau upon request. The MCO application for recertification may be amended from time to time at the bureau’s discretion.

(F) The bureau shall review the application for certification or recertification submitted by the managed care organization. The bureau reserves the right to cross-check data with other governmental agencies or licensing or accrediting bodies.

(G) During the bureau's review of the application for certification or recertification, the managed care organization shall provide to the bureau any additional documentation requested and shall permit the bureau, upon request and with reasonable notice given, to conduct an onsite review of the managed care organization.

(H) A managed care organization may cure any defects in its application for certification or recertification within thirty days of notice by the bureau of such defect in its application.

(I) The bureau may require that the application be accompanied by an application fee, which shall not exceed the amount sufficient to cover the cost of processing the application.

(J) The bureau shall hold as confidential and proprietary information contained in a managed care organization's application for certification or recertification, and other information furnished to the bureau by a managed care organization for purposes of obtaining certification or to comply with performance and auditing requirements established by the administrator, in accordance with divisions (H)(1) and (H)(2) of section 4121.44 of the Revised Code.

(K) The bureau shall not accept or approve any MCO ~~applications~~ application for certification or recertification in which the managed care organization proposes to subcontract or outsource medical case management services. However, an MCO may subcontract onsite or out-of-state medical case management services with the prior approval of the bureau, provided such services are conducted under the supervision of the MCO.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/1/99, 1/1/01, 2/14/05, 2/1/10, 7/16/12, 6/9/14

4123-6-03.7 **MCO participation in the HPP - bureau's authority to decertify, to refuse to certify or recertify an MCO.**

(A) Should the administrator determine that sufficient evidence exists that an MCO has failed to maintain any of the requirements set forth in division (F) of section 4121.44 of the Revised Code, or to reasonably comply with or to perform in accordance with the terms of a contract between the bureau and the MCO entered into pursuant to division (B)(4) of section 4121.44 of the Revised Code, or has violated a rule adopted under section 4121.441 of the Revised Code, the administrator has the authority to decertify, or refuse to certify or recertify an MCO, in accordance with rule 4123-6-17 of the Administrative Code and Chapter 119. of the Revised Code.

~~(B) In any case where the administrator finds a serious danger to the public health and safety and sets forth specific reasons for such findings, the administrator may immediately decertify an MCO.~~

~~(C)~~(B) Upon a final order of the administrator to decertify, or refuse to recertify an MCO, employees and employers shall not receive services from such MCO pursuant to the HPP.

~~(D)~~(C) Upon a final order of the administrator to decertify or refuse to recertify an MCO, any obligation of a provider to provide services under the HPP pursuant to a contract or agreement with such MCO shall be null and void.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/95, 1/1/99, 2/1/10, 6/9/14

4123-6-03.9 **MCO participation in the HPP - MCO disclosure of relationship.**

(A) If an MCO is affiliated with another individual, corporation, or entity that has had or contemplates activities of any nature with the Ohio workers' compensation system ~~and such~~ including but not limited to third party administrators, medical or vocational rehabilitation providers, professional employer organizations, and/or transitional work developers:

(1) To the extent such relationship creates or presents either the opportunity for a conflict of interest or preferential treatment or the appearance of a conflict of interest or preferential treatment for the managed care organization and/or the other individual, corporation, or entity, the MCO shall provide to the bureau a written description of the resolution of such opportunity for or the appearance of a conflict of interest satisfactory to the bureau; and shall disclose the potential conflict of interest and its resolution to the employers and injured workers assigned to the MCO.

(2) The MCO and the other affiliated corporation or entity shall implement have complete separation of functions, offices, systems, and staff. Complete separation of staff shall include, but not be limited to, medical and vocational rehabilitation case management staff and marketing staff.

(B) For purposes of this rule, an individual, corporation, or entity is "affiliated with an MCO" when it:

(1) Owns, is owned by, or is under common ownership with an MCO, directly or indirectly through one or more intermediaries;

(2) Controls, is controlled by, or is under common control with an MCO, directly or indirectly through one or more intermediaries;

(3) Has a contractual or other business arrangement with an MCO;

(4) Has one or more owners, shareholders, partners, members, officers, directors or other persons who exercise operational or managerial control in common with the MCO.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 10/26/00, 2/1/10, 6/9/14

4123-6-04.3 **MCO scope of services - MCO medical management and claims management assistance.**

(A) The MCO shall refer a medical treatment reimbursement request in an inactive claim ~~as provided in rule 4123-3-15 of the Administrative Code, with the MCO's recommendation,~~ to the bureau, with MCO's recommendation, for a determination of both the causal relationship between the original injury and the current incident precipitating the treatment request and the necessity and appropriateness of the requested treatment as provided in rule 4123-3-15 of the Administrative Code.

(B) The MCO, in conjunction with the employer, employee, attending physician, and the bureau claims personnel assigned to the claim, shall provide medical management and cost containment services that provide the injured worker high-quality, cost-effective medical care that focuses on minimizing the physical, emotional, and financial impact of a work-related injury or illness and promotes a safe and timely return to work.

(C) The MCO shall comply with bureau procedures for reporting injuries to the bureau and employers, and shall instruct the provider to forward to the MCO and the bureau, subject to the confidentiality provisions contained in rule 4123-6-15 of the Administrative Code, all necessary data to effectuate medical and claims management.

(D) MCO guidelines may not be more restrictive for a non-panel provider than for an MCO panel provider. An MCO may not create a procedure that restricts an employee's option to change providers.

(E) ~~Except as provided in paragraph (D) of rule 4123-6-04.6 of the Administrative Code, an~~An MCO shall provide medical management and return to work management services for the life of a claim, as long as the employer remains assigned to the MCO, regardless of the date of injury of the claim. In cases where an employee has multiple claims with different employers, each claim shall remain with the associated employer and shall be managed by that employer's current MCO.

(F) Either the MCO or the bureau may schedule an independent medical examination (IME) of the claimant to assist in the alternative dispute resolution (ADR) process under rule 4123-6-16 of the Administrative Code.

(1) An ADR IME shall be limited to issues relating to medical treatment disputes, and shall not include extent of disability issues. An ADR IME shall not be conducted at the request of an employer and does not substitute for an

examination permitted under section 4123.65.1 of the Revised Code.

(2) If an ADR IME is scheduled under this rule, the parties, and their representatives, if any, shall be promptly notified as to the time and place of the examination, and the questions and information provided to the doctor. An electronic copy of the ADR IME report shall be submitted to the claim file. The claimant shall be reimbursed for the claimant's traveling and meal expenses, in a manner and at the rates as established by the bureau from time to time.

(3) If an ADR IME is scheduled under this rule to assist in resolving a medical dispute, the IME and the ADR process shall be completed in accordance with the requirements of rule 4123-6-16 of the Administrative Code.

(4) If a claimant refuses to attend an independent medical examination ~~scheduled by the MCO~~ to assist in the alternative dispute resolution process, the MCO shall refer the issue to the bureau, and the claimant's right to benefits may be suspended during the period of refusal.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/1/99, 3/27/00, 1/1/01, 11/1/04, 2/1/10

4123-6-04.5 **MCO scope of services - bureau claims management.**

(A) Upon receipt of notification of a workers' compensation claim, the bureau shall assign a claim number and shall notify the employee, employer and MCO of that claim number. The bureau shall determine the compensability of the claim and the allowed conditions of the claim pursuant to the provisions of section 4123.511 of the Revised Code. The bureau will notify all parties and the MCO of the allowed conditions in the claim.

(B) Upon referral from an MCO of a medical treatment reimbursement request in an inactive claim ~~as provided in rule 4123-3-15 of the Administrative Code, the bureau will determine~~, after considering the MCO's recommendation the bureau will determine, as provided in rule 4123-3-15 of the Administrative Code, both the causal relationship between the original injury and the current incident precipitating a medical treatment reimbursement request and the necessity and appropriateness of the requested treatment. The bureau will notify all parties and the MCO of its determination.

The employer or employee or representative may appeal the bureau's order to the industrial commission pursuant to section 4123.511 of the Revised Code.

(C) The bureau shall not make medical payments in a disallowed claim or for conditions not allowed in a claim until permitted to do so under the provisions of ~~section~~ sections 4123.511, 4123.512, or 4123.66 of the Revised Code or except as provided by the rehabilitation rules of Chapter 4123-18 of the Administrative Code. The bureau shall notify all parties and the MCO when a claim or conditions are allowed or disallowed and indicate whether treatment rendered therefore may or may not be paid.

(D) During the adjudication process, the provider may continue to render or the MCO may continue to manage medical services on behalf of the employee, but the bureau shall not pay for medical services in a disallowed claim or for disallowed conditions. If the claim or condition is disputed, the MCO shall inform the employee and the provider that the services provided may not be covered by workers' compensation and may be the responsibility of the employee.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 11/1/04, 2/1/10

4123-6-04.6 **~~Thirty-day return~~Return to work assessment.**

(A) The bureau may perform a return-to-work assessment of an injured worker who has a lost time claim as defined in section 4123.52 of the Revised Code and who has not returned to work within an acceptable timeframe as determined by the bureau.

(B) The assessment may include, but is not limited to, the medical case management goals, identification of barriers, return to work plan, medical stability and vocational status of the claim.

(C) All findings and conclusions of the assessment and all recommendations for addressing deficiencies shall be documented in writing to the MCO assigned to the claim. The assigned MCO shall have five business days from receipt of the bureau's findings to initiate or complete the recommended action steps identified by the bureau or propose alternative action steps acceptable to the bureau.

(D) If the assigned MCO does not carry out the recommended action steps or if the MCO fails to propose an acceptable alternative course of action to resolve the return-to-work barriers, the bureau may assume the medical and vocational rehabilitation management of the claim.

~~(E) For any claim assumed pursuant to paragraph (D) of this rule, the bureau may charge the assigned MCO a financial penalty, to include hourly case management fees, in accordance with rule 4123-6-13 of the Administrative Code and the terms of the MCO contract.~~

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	4121.12 , 4121.30 , 4121.31 , 4123.05
Rule Amplifies:	4121.121 , 4121.44 , 4121.441 , 4123.66
Prior Effective Dates:	1/1/01

4123-6-05.4 **Employer access to the HPP; payment for referrals prohibited.**

(A) An MCO shall not solicit, receive, or accept any payment, commission, consideration, money, or other thing of value, including, but not limited to any rebate, premium, or kickback, as an inducement to or in return for the MCO's referral of employers to any sponsoring organization or group for the purpose of participating in a group experience rating program authorized under section 4123.29 of the Revised Code and rules 4123-17-61 to 4123-17-68 of the Administrative Code.

(B) An ~~MOC~~MCO shall not solicit, receive, or accept any payment, commission, consideration, money, or other thing of value, including but not limited to any rebate, premium, or kickback, as a inducement to or in return for the MCO's referral of employers to any individual or entity for the provision of any goods or services.

(C) An MCO shall not solicit, receive, or accept any payment, commission, consideration, money, or other thing of value, including but not limited to any rebate, premium, or kickback, as an inducement to or in return for the MCO's referral of injured workers to any provider for the provision of any goods or services.

(D) An MCO that violates this rule may be subject to decertification and/or termination of its contract pursuant to the rules of this chapter of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	1/30/98 (Emer.), 4/29/98, 1/1/99, 1/1/01, 2/1/10

4123-6-06.1 **Employee access to medical services -- ~~employee~~ education by MCO and employer.**

~~An~~

(A) An MCO selected by an employer and the employer shall educate employees regarding access to and use of services offered by the MCO for injuries resulting from an industrial accident, including information regarding MCO panel providers or providers with whom the MCO has arrangements. Education of the employee shall stress, among other things, the need for the employee to report any accident immediately to the employer, the employee's treating provider, and the bureau, and shall inform the employee how to seek care through the MCO. The MCO may, at the request of the employer or upon its own initiative, provide MCO identification cards to the employer for distribution to each employee.

(B) The MCO shall assist the bureau in educating employers and shall educate providers, whether in-state or out-of-state, as to bureau initiatives, as set forth in the MCO contract.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/1/01, 2/1/10

4123-6-06.2 **Employee access to the HPP - employee choice of provider.**

(A) HPP.

(1) Except as provided in paragraph (A)(2) of this rule, an injured employee may seek medical care for an industrial injury from:

(a) A bureau certified provider; or

(b) A non-bureau certified provider, subject to an employee's payment responsibilities as delineated below.

(2) Except in cases of emergency, an injured employee may not seek medical care for an industrial injury from himself, herself, or an immediate family member. An injured employee may not select as physician of record, himself, herself, or an immediate family member. The MCO, bureau, employer, and industrial commission shall not reimburse treatment to an injured employee delivered, rendered or directly supervised by the injured employee or an immediate family member. "Immediate family member" shall have the same meaning as in paragraph (A)(3)(b) of rule 4123-6-02.51 of the Administrative Code.

(3) At the time of an injury, the employee may seek medical care directly from a provider or may seek assistance from the MCO in selecting a provider. If the employee has not already sought medical care or selected a provider, the MCO may refer the employee to a provider or list of providers. The employee may, but is not required to, seek medical care from the referred provider or providers. The MCO shall not discriminate against any category of health care provider when referring the employee to a provider.

(4) If the employee seeks medical assistance from a provider, the employee shall inform the provider of the employee's MCO and/or employer. The provider shall then report the industrial injury in accordance with rule 4123-6-02.8 of the Administrative Code.

(a) If the provider is a non-bureau certified provider, the MCO shall inform the provider that the care for the first visit will be compensated by the MCO if the claim and the treated conditions are subsequently allowed and that, unless otherwise permitted by paragraph (A)(5)(a) or (A)(5)(b) of this rule, no further treatment will be authorized.

(b) If the provider is a non-bureau certified provider, the provider shall inform the employee upon the initial or emergency treatment that the provider is not a participant in the HPP and that payment will not be made by the bureau, MCO, or employer for the cost of further treatment after the initial or emergency treatment

(5) An injured employee may continue treatment with a non-bureau certified provider under two circumstances:

(a) The MCO has determined that the treatment to be provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider and has authorized the non-bureau certified provider to continue to provide the treatment, or

(b) The employee may continue to treat with the non-bureau certified provider, but at the employee's own expense without recourse against the bureau, MCO, or employer.

(6) Notwithstanding any other provision of this rule, if the employee's date of injury is prior to October 20, 1993 and the employee's physician of record is a non-bureau certified provider, the employee may continue treatment with that non-bureau certified provider. The employer's MCO shall manage the medical care and treatment and return to work services in the claim and shall manage medical payment for the provider. However, if the employee changes the physician of record for any reason, the employee shall select a bureau certified provider as physician of record. If the employee selects a physician of record who is a non-bureau certified provider, payment for the provider shall be governed by the provisions of this rule applicable to non-bureau certified providers.

(B) QHP.

(1) An employee of an employer that participates in a QHP has freedom of choice of providers within the QHP network of providers established by the employer's QHP. If the employee's date of injury is prior to the establishment of the employer's QHP, and the employee's physician of record is not a provider on the panel of the QHP when established, the employee may continue treatment with that physician of record. The physician of record shall be subject to and participate in the dispute resolution process as provided in rule 4123-6-69 of the Administrative Code. After the establishment of the QHP, the employer's QHP shall manage the medical care and treatment in the claim. If an injured worker changes from the physician of

record who is not in the QHP for any reason, the employee shall select a QHP panel provider as the physician of record.

(2) An employee of an employer that participates in a QHP, who is dissatisfied with the health care services of a provider in the QHP, after written notice to the QHP, may request a change of providers and may select another provider within the QHP, or any bureau certified provider. An employee's request for change of provider does not require notification to the bureau, but shall contain the reasons for the request. The QHP shall approve written requests for a change of provider within the QHP, or to any bureau certified provider, within seven days of receipt

(3) Notwithstanding the provisions contained in paragraph (B)(2) of this rule, an employee who incurs a new medical condition, injury or claim requiring medical treatment, not related to a prior medical condition, injury or claim, shall first seek treatment from a provider on the panel of the injured worker's employer's QHP.

(4) Medical management of all injured workers' claims, whether medical services are provided within or without the QHP network of providers, shall be provided by the employer's QHP.

(5) A provider certified to participate in the HPP shall be eligible to participate in and to treat injured workers under the QHP system.

(C) Self-insuring employer (non-QHP).

(1) In claims with a date of injury on or after November 2, 1959, employees of self-insuring employers have free choice to select licensed physicians for treatment, as well as other medical services, including, but not limited to, hospital and nursing services. In claims with a date of injury prior to November 2, 1959, medical services furnished by the self-insuring employer must be utilized

(2) Emergency treatment shall not constitute an exercise of free choice of physician.

(3) Once an employee of a self-insuring employer goes to a physician for treatment other than on an emergency basis, the employee is deemed to have made a choice of physician and the employee shall notify the employer of a change of physician.

(a) Change of physician requests shall be made to the self-insuring employer in writing, and shall include the name and address of the new physician and the proposed treatment.

(b) Self-insuring employers shall approve written requests for a change of physician within seven days of receipt.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/1/01

4123-6-07 **Services and supplies never covered.**

The following services and supplies are never covered by, and shall not be authorized or reimbursed by, the bureau or MCO:

(A) Services and supplies that are never covered pursuant to other bureau statutes or rules.

(B) The following services and supplies, which are never considered to be durable medical equipment by the bureau:

(1) Home furniture including, but not limited to: reclining chairs, non-hospital beds, water beds, lounge beds (such as adjust-a-sleep adjustable bed, craftmatic adjustable bed, electropedic adjustable bed, simmons beautyrest adjustable bed). The bureau or MCO shall reimburse for a seat lift mechanism when medically necessary and appropriate for an injured worker who requires a mobility aid to stand from a seated position due to physical limitations that are reasonably related to the industrial injury (allowed conditions). However, the bureau or MCO shall not reimburse for the chair (furniture);

(2) A mattress for a non-hospital bed (including, but not limited to: tempur-pedic, angelbed, memory foam mattresses). Reimbursement ~~of~~ for a hospital bed mattress is limited to a twin/single size only. The bureau or MCO will not reimburse for a double, queen or king size mattress for the purpose of accommodating two people;

(3) Home exercise equipment, including but not limited to such equipment as treadmills and exercise bikes;

(4) Home whirlpools, including built-in whirlpools and pumps, portable hydrotherapy pools, jacuzzi tubs, portable saunas and spas, non-portable hot tubs or whirlpools, and therasaunas.

(5) Unsupervised physical reconditioning programs, including but not limited to memberships to or services provided at a health club, YMCA, spa or nautilus facility, except when the criteria have been met for an injured worker who is participating in a vocational rehabilitation or remain at work program.

(C) Self-administered sympathetic therapy/interferential therapy.

(D) Prescription smoking deterrent drugs outside an approved smoking cessation

, except when dispensed while the injured worker is admitted to a hospital during an approved inpatient admission or during the course of an outpatient visit in a hospital.

(E) Drug screening of injured workers performed by employers or performed in the emergency room at the time of injury at the request of the employer.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.12, 4121.44, 4121.444, 4123.66
Prior Effective Dates:	12/11/12

4123-6-10 **Payment to providers.**

(A) HPP.

(1) The MCO shall accumulate medical records and bills for services rendered to employees for provider services and submit the bills electronically to the bureau for payment in a bureau approved format, utilizing billing policies ~~defined by the bureau~~, including but not limited to clinical editing, as set forth in the MCO contract. The MCO shall submit a bill to the bureau within seven business days of its receipt of a valid, complete bill from the provider.

(2) For a provider in the MCO's panel or with whom the MCO has entered into an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider, in accordance with rule 4123-6-14 of the Administrative Code, either the lesser of the bureau fee schedule, the MCO contracted fee, or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

(3) For a bureau certified provider who is not in the MCO's panel or with whom the MCO does not have an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider, in accordance with rule 4123-6-14 of the Administrative Code, either the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

(4) For a non-bureau certified provider who is not in the MCO's panel or with whom the MCO does not have an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider for initial or emergency treatment, in accordance with rule 4123-6-14 of the Administrative Code, either the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

(5) For a non-bureau certified provider who is not in the MCO's panel or with whom the MCO does not have an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider for subsequent treatment after the initial or emergency treatment, in accordance with rule 4123-6-14 of the Administrative Code, either the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this

rule, the MCO negotiated fee, only under the following circumstances:

(a) Where the treatment provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider and the MCO has authorized the treatment pursuant to rule 4123-6-06.2 of the Administrative Code, or

(b) Where the treatment provided by the non bureau certified provider is reasonably available through a like bureau certified provider, the non-bureau certified provider may only be reimbursed for the treatment if the provider becomes bureau certified. If the provider refuses or fails to become bureau certified, the treatment shall not be reimbursed.

(6) For hospital services, the bureau shall electronically transfer to the MCO for payment to the hospital, in accordance with rule 4123-6-14 of the Administrative Code, either the lesser of the applicable amount pursuant to rule 4123-6-37.1 (inpatient) or 4123-6-37.2 (outpatient) of the Administrative Code or the MCO contracted fee, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

(7) The MCO shall have authority to negotiate fees with providers, either by contract or on a case-by-case basis, in the following circumstances:

(a) As permitted under rule 4123-6-08 of the Administrative Code (including the appendix to the rule);

(b) As permitted under rule 4123-6-37.1, 4123-6-37.2 or 4123-6-37.3 of the Administrative Code;

(c) As permitted under rule 4123-18-09 of the Administrative Code;

(d) With non-bureau certified providers outside the state, where the treatment provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider;

(e) With bureau certified providers and non-bureau certified providers within the state, where unusual circumstances justify payment above BWC's maximum allowable rate for the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) level II and level III coded services/supplies, and such circumstances are documented and approved by the bureau.

(8) The bureau shall not pay for missed appointments or procedures. If the provider customarily charges for missed appointments or procedures, the provider shall inform the employee upon the initial or emergency treatment that the provider charges for missed appointments or procedures and that such charges are the responsibility of the employee. Bills must only contain descriptions of services that have been actually delivered, rendered, or directly supervised by the provider for the actual conditions treated. A provider shall not transmit to the MCO or bureau any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

(B) QHP.

(1) Within each QHP, all payments shall be in accordance with consistent billing and payment policies and practices established by the QHP and consistent with the provisions contained in paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.

(2) With the exception that no financial arrangement between an employer or QHP and a provider shall incentivize a reduction in the quality of medical care received by an injured worker, an employer or QHP may pay a QHP panel provider a rate that is the same, is above or, if negotiated with the provider in accordance with rule 4123-6-46 of the Administrative Code, is below the rates set forth in the applicable provider fee schedule rules developed by the bureau. Nothing in the rules pertaining to the QHP system shall be construed to inhibit employers or QHPs and providers in their efforts to privately negotiate a payment rate.

(3) An employer or QHP shall pay a bureau certified non-QHP panel provider other than a hospital the ~~lessor~~ lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.

(4) An employer or QHP shall pay a bureau certified non-QHP panel hospital the applicable amount under rule 4123-6-37.1 (inpatient) or 4123-6-37.2 (outpatient) of the Administrative Code, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.

(5) Employers' financial arrangements with company-based providers remain intact and services provided by company based providers need not be billed

separately through QHP arrangements.

(6) An employer in the QHP system shall authorize and pay for initial or emergency medical treatment for an injury or occupational disease that is an allowed claim or condition provided by a non-bureau certified provider as follows:

(a) The employer shall pay a non-bureau certified provider only for initial or emergency treatment of an employee for a workers' compensation injury, unless the QHP specifically authorizes further treatment. A non-bureau certified provider shall inform the employee that the provider is not a participant in the QHP and that the employee may be responsible for the cost of further treatment after the initial or emergency treatment, unless payment for further treatment is specifically authorized by the QHP. The employee may continue to obtain treatment from the non-bureau certified provider, but the payment for the treatment shall be the employee's sole responsibility, except as provided above.

(b) An employer or QHP shall pay a non-bureau certified provider that provides initial or emergency medical treatment or further medical treatment that has been specifically authorized by the QHP, other than a hospital, the lessor of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.

(7) An employer or QHP shall pay a non-bureau certified hospital that provides initial or emergency medical treatment or further medical treatment that has been specifically authorized by the QHP the applicable amount under rule 4123-6-37.1 (inpatient) or 4123-6-37.2 (outpatient) of the Administrative Code, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.

(8) The employer or QHP shall not pay for missed appointments or procedures. <u>If the provider customarily charges for missed appointments or procedures, the provider shall inform the employee upon the initial or emergency treatment that the provider charges for missed appointments or procedures and that such charges are the responsibility of the employee.</u> Bills must only contain descriptions of services that have been actually delivered, rendered, or directly supervised by the provider for the actual conditions treated. A provider shall not transmit to the employer or QHP any bill containing false

or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

(C) Self-insuring employer (non-QHP).

(1) Payment for medical services and supplies by self-insuring employers shall be equal to or greater than the fee schedule established by the bureau in state fund claims, unless otherwise negotiated with the provider in accordance with rule 4123-6-46 of the Administrative Code. All payments by the self-insuring employer shall be consistent with the provisions contained in paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.

(2) The self-insuring employer shall not pay for missed appointments or procedures. If the provider customarily charges for missed appointments or procedures, the provider shall inform the employee upon the initial or emergency treatment that the provider charges for missed appointments or procedures and that such charges are the responsibility of the employee. Bills must only contain descriptions of services that have been actually delivered, rendered, or directly supervised by the provider for the actual conditions treated. A provider shall not transmit to the self-insuring employer any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 2/1/10

TO BE RESCINDED

4123-6-13 **Payment to MCOs.**

(A) The bureau shall determine fee payments to an MCO for providing medical management and cost containment services and administrative services.

(B) MCO fee payments may be subject to penalties based upon the failure of the MCO to meet predetermined performance criteria set forth in the MCO contract. The bureau may pay an MCO a performance payment and may pay an incentive payment.

(C) In establishing performance measures, the bureau may evaluate an MCO's performance based upon criteria including, but not limited to:

(1) Quality performance measures including, but not limited to, return to work rates and re-injury rates.

(2) Process performance measures including, but not limited to, first report of injury (FROI) timing. FROI accuracy and bill timing.

(3) Total cost measures including, but not limited to, average total paid cost, average incurred cost, and lost-time claims to total claims ratio.

(4) Change in cost measures including, but not limited to, change in average total paid cost, change in average incurred cost, and change in lost-time to total claims ratio.

(5) Customer satisfaction measures including, but not limited to, MCO network utilization rates and employee, employer, and provider satisfaction surveys.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/1/99, 1/1/01, 2/1/10

4123-6-14 **MCO bill submission to bureau.**

(A) ~~The MCO shall submit bills electronically to the bureau.~~ The bureau shall review all bills received from the MCO pursuant to paragraph (A)(1) of rule 4123-6-10 of the Administrative Code for payment eligibility. The bureau's review may include, but not be limited to, verification of the following:

(1) The services were delivered, rendered, or directly supervised by providers who meet bureau credentialing and licensing criteria;

(2) The bills conform to standard clinical editing criteria in effect on the billed date(s) of service, including but not limited to: the bureau's billing and reimbursement manual, the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS), and the national correct coding initiative (NCCI) guidelines.

The bureau shall electronically transfer funds to the MCO for allowed payments after receipt of a proper invoice and after a final adjudication permitting payment for the bill. Upon receipt of funds from the bureau, the MCO shall pay the provider within seven days or less. The MCO shall pay to providers at least the amount electronically transferred by the bureau to the MCO for reimbursement of provider services.

(B) A provider that bills an MCO for services in expectation of payment from the MCO is responsible for the accuracy of all billing data and information the provider transmits to the MCO. The MCO is responsible for the accuracy of translating billing data received from the provider and the accuracy of transmitting billing data to the bureau that results in payment to the MCO or to the provider.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/15/99, 2/1/10

4123-6-15 **Confidentiality of records.**

(A) Subject to sections 2317.02, 4123.27, and 4123.88 of the Revised Code, certain employer premium, payroll, and claim file information is confidential and exempt from the general open records laws of Ohio, as set forth in section 149.43 of the Revised Code.

(B) In the course of medical management in the HPP, some confidential information may be provided by the bureau to the MCO, and/or exchanged among the bureau, the MCO, the employer and its representative, the employee and his or her representative, ~~and~~ the provider, and the provider's employees and agents. All such parties receiving and/or exchanging confidential information for use in the HPP shall ensure transmission of confidential information ~~via~~ through secured methods approved by the bureau, including but not limited to encryption, password protection, ~~transmission over telephone lines (fax to fax)~~ facsimile, and other secure methods.

(C) All parties receiving and/or exchanging confidential information for use in the HPP shall not use such confidential information for any use other than to perform duties required by the HPP, and shall prevent such information from further disclosure or use by unauthorized persons. MCOs shall not release any confidential information, other than in accordance with rule 4123-3-22 of the Administrative Code, to any third parties (including, but not limited to, parent, subsidiary, or affiliate companies, or subcontractors of the MCO) without the express prior written authorization of the bureau.

(D) MCOs shall comply with, and shall assist the bureau in complying with, all disclosure, notification or other requirements contained in sections 1347.12, 1349.19, 1349.191 and 1349.192 of the Revised Code, as may be applicable, in the event computerized data that includes personal information, obtained by the MCO for use in the HPP, is or reasonably is believed to have been accessed and acquired by an unauthorized person and the access and acquisition by the unauthorized person causes, or reasonably is believed will cause a material risk of identity theft or other fraud.

(E) MCOs shall comply with all electronic data security measures as may be required by Ohio law, Ohio department of administrative services or other state agency directive, executive order of the governor of Ohio, and/or the MCO contract.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/1/96, 2/1/10

4123-6-16 **Alternative dispute resolution for HPP medical issues.**

(A) Pursuant to division (A)(1) of section 4121.441 of the Revised Code, this rule shall provide procedures for an alternative dispute resolution (ADR) process for medical disputes between an employer, an employee, or a provider and an MCO arising from the MCO's decision regarding a medical treatment reimbursement request (on form C-9 or equivalent). An employee or employer must exhaust the ~~dispute resolution~~ ADR procedures of this rule prior to filing an appeal under section 4123.511 of the Revised Code on an MCO's decision regarding a medical treatment reimbursement request.

(B) Within fourteen days of receipt of an MCO decision ~~giving rise to a medical dispute~~, an employee, employer, or provider may ~~submit the~~ dispute the decision in writing (on form C-11 or equivalent) to the MCO. The written medical dispute must contain, at a minimum, the following elements:

(1) Injured worker name.

(2) Injured worker claim number.

(3) Date of initial medical treatment reimbursement request in dispute.

(4) Specific issue(s) in dispute, including description, frequency/duration, beginning/ending dates, and type of treatment/service/body part.

(5) Name of party making written appeal request.

(6) Signature of party making written appeal request or the party's authorized representative.

Written medical disputes that do not contain the minimum elements set forth in this paragraph may be dismissed by the MCO or bureau.

(C) Upon receipt of a written medical dispute, the MCO shall initiate the ADR process. The MCO's ADR process shall consist of one independent level of professional review as follows:

(1) If an individual health care provider eligible to be physician of record would be providing the services requested in the dispute, the independent level of professional review shall consist of a peer review conducted by an individual

or individuals licensed pursuant to the same section of the Revised Code as the health care provider who would be providing the services requested.

(2) Notwithstanding paragraph (C)(1) of this rule, if the MCO has already obtained one or more peer reviews during previous disputes involving the same or similar treatment, the MCO may obtain a different perspective review from a licensed physician who falls outside the peer review criteria set forth above.

(3) If an individual health care provider not eligible to be physician of record would be providing the services requested in the dispute, the independent level of professional review shall consist of a provider review conducted by an individual or individuals eligible to be physician of record whose scope of practice includes the services requested.

(4) If the MCO receives a dispute where the requested treatment appears to be the same as or similar to a previous treatment request for which the MCO conducted a professional review, and the previous treatment request was ultimately denied based on the professional review, the MCO may use the previous professional review to satisfy the independent level of professional review requirement of this paragraph.

(5) The MCO shall submit a copy of the professional review to the bureau, and the bureau shall provide the parties to the claim access to the professional review electronically.

(D) If, upon consideration of additional evidence or after agreement with the party that submitted the written medical dispute, the MCO reverses the decision under dispute or otherwise resolves the dispute to the satisfaction of the party, the MCO may issue a new decision and dismiss the dispute.

(E) Unless the MCO reverses the decision under dispute pursuant to paragraph (D) of this rule, the MCO shall complete the ADR process and submit its recommended ADR decision to the bureau electronically within twenty-one days of the MCO's receipt of the written medical dispute. The MCO may recommend that the employee be scheduled for an independent medical examination. This recommendation shall toll the MCO's time frame for completing the ADR process, and in such cases the MCO shall submit its recommended ADR decision to the bureau electronically within seven days after receipt of the independent medical examination report.

(F) Within two business days after receipt of a recommended ADR decision from the MCO, the bureau shall publish a final order. This order shall be mailed to all parties and may be appealed to the industrial commission pursuant to section 4123.511 of the Revised Code. The provider and the MCO may not file an appeal of the bureau

order.

(G) Notwithstanding paragraph (C) of this rule, the MCO may pend a written medical dispute under the following circumstances:

(1) If the MCO receives a written medical dispute involving a medical treatment reimbursement request that appears to be the same as or similar to a previous treatment request for which the MCO conducted a provider review, and the previous treatment request is pending before the bureau or industrial commission, the MCO may pend the new dispute until the previous treatment request has been resolved. Once the previous treatment request has been resolved, the MCO shall resume the ADR process, and may proceed in accordance with paragraph (C)(4) of this rule if appropriate.

(2) If the MCO receives a written medical dispute involving a medical treatment reimbursement request relating to the delivery of medical services for a condition that is not allowed in the claim, and the issue of the allowance of the additional condition is pending before the bureau or industrial commission, the MCO may pend the dispute until the ~~bureau or industrial commissioin has made a~~ earlier of the final administrative or judicial decision or the industrial commission staff hearing officer decision on the allowance of the additional condition~~. Once the bureau or industrial commission has made a decision on the allowance of the additional condition~~, at which time the MCO shall resume the ADR process.

(H) Notwithstanding paragraph (C) of this rule, an MCO may submit its recommended ADR decision to the bureau electronically without obtaining an independent level of professional review under the following circumstances:

(1) The MCO receives a written medical dispute involving a medical treatment reimbursement request relating to the delivery of medical services that have been approved by the MCO pursuant to standard treatment guidelines, pathways, or presumptive authorization guidelines.

(2) The MCO receives a written medical dispute involving a medical treatment reimbursement request relating to the delivery of medical services for a condition that is not allowed in the claim, and the issue of the allowance of the additional condition is not pending before the bureau or industrial commission.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	4/1/07, 9/25/08, 11/1/09

4123-6-16.2 **Medical treatment reimbursement requests.**

(A) Medical treatment reimbursement requests (on form C-9 or equivalent) must be submitted by ~~the physician of record or eligible treating~~ a provider ~~(on form C-9 or equivalent)~~ eligible to submit such requests to the MCO responsible for medical management of the claim prior to initiating any non-emergency treatment.

~~For purposes of this rule, "eligible treating provider" means a~~The following provider types are eligible to submit medical treatment reimbursement requests to the MCO: ~~physician~~

(1) A physician as defined in rule 4123-6-01 of the Administrative Code ~~and the~~; ~~following non-physician practitioner types: advanced practice nurse, physician assistant, physical therapist, occupational therapist, optometrist, audiologist, licensed independent social worker, licensed professional clinical counselor.~~

(2) following non-physician practitioner types:

(a) Advanced practice nurses;

(b) Physician assistants;

(c) Physical therapists;

(d) Occupational therapists;

(e) Optometrists;

(f) Audiologists;

(g) Licensed independent social workers;

(h) Licensed professional clinical counselors.

(B) Medical treatment reimbursement requests shall be evaluated by the MCO using the following three-part test (all parts must be met to authorize treatment reimbursement):

(1) The requested services are reasonably related to the industrial injury (allowed conditions);

(2) The requested services are reasonably necessary for treatment of the industrial

injury (allowed conditions);

(3) The costs of the services are medically reasonable.

(C) For informational purposes, the bureau may require the provider to include on the medical treatment reimbursement request the applicable codes, from the edition of the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) in effect on the date of the request, for the procedures or services being requested.

However, review of the request shall be directed to the treatment being requested, and shall not be construed as approving or denying payment for the specific codes listed by the provider.

(D) Medical treatment reimbursement requests in inactive claims shall be processed in accordance with the provisions of rule 4123-3-15 of the Administrative Code.

(E) Medical treatment reimbursement requests submitted by a physical therapist or occupational therapist must be accompanied by a prescription as required in paragraph (B) of rule 4123-6-30 of the Administrative Code, and approval of such requests shall be valid for no longer than thirty days unless the approval specifies a longer period and such longer period is supported by the prescription. Approval of all ~~other~~ medical treatment reimbursement requests shall be valid for no longer than six months unless the approval specifies a longer period.

(F) The MCO may dismiss without prejudice medical treatment reimbursement requests under the following circumstances:

(1) The request has been submitted by a provider who is not enrolled with the bureau and who refuses to become enrolled, or who is enrolled but non-certified and is ineligible for payment as a non-certified provider under rule 4123-6-06.2 or 4123-6-10 of the Administrative Code or division ~~(J)~~ (N) of section 4121.44 of the Revised Code.

(2) The request is not accompanied by supporting medical documentation that the submitting ~~physician of record or eligible treating~~ provider has ~~seen and~~ examined the injured worker within thirty days prior to the request, or that the injured worker requested a visit with the provider, and such evidence is not provided to the MCO upon request (~~via~~ through form C-9A or equivalent).

(3) The request duplicates a previous request that has been denied in a final administrative or judicial determination where the new request is not accompanied by supporting medical documentation of new and changed

circumstances impacting treatment, and such evidence is not provided to the MCO upon request (~~via~~ through form C-9A or equivalent).

(4) The underlying claim has been settled, and the dates of service requested are on or after the effective date of the settlement. If the request includes both dates of service on or after the effective date of the settlement and dates of services prior to the effective date of the settlement, the MCO may dismiss without prejudice only that portion of the request relating to dates of service on or after the effective date of the settlement.

(5) The underlying claim has been disallowed or dismissed in its entirety, or the only allowances in the underlying claim are for substantial aggravation of a pre-existing condition, and the conditions have been determined in a final administrative or judicial determination to be in a non-payable status.

(6) The services or supplies being requested are never covered by the bureau pursuant to other bureau statutes or rules.

(7) The MCO has requested ~~supporting medical documentation~~ from the submitting ~~physician of record or eligible treating~~ provider (~~via~~ through form C-9A or equivalent) supporting medical documentation necessary to the MCO's evaluation and determination, and such documentation is not provided to the MCO.

(G) If the MCO determines that any approved medical treatment reimbursement request is not medically indicated or necessary, is not producing the desired outcomes, or the injured worker is not responding, the MCO may notify the parties of its decision to discontinue payment of approved treatment that has not already been rendered.

This decision shall be subject to alternative dispute resolution pursuant to rule 4123-6-16 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.12, 4121.44, 4121.444, 4123.66
Prior Effective Dates:	4/1/07, 7/25/11

4123-6-16.3 **Reimbursement of retroactive medical treatment reimbursement requests.**

(A) Except as otherwise provided in paragraph (D) of this rule, medical treatment reimbursement requests submitted retroactively to the MCO responsible for medical management of claim by ~~an injured worker's physician of record or eligible treating~~ a provider eligible to submit such requests, without just cause, for non-emergency treatment delivered, rendered, or directly supervised by the ~~physician of record or eligible treating~~ provider shall, if approved, be reimbursed at seventy-five per cent of the applicable fee schedule amount, ~~and the physician of record or treating~~ provider may not balance bill the injured worker for the difference in amount.

(B) For purposes of this rule, "just cause" includes, but is not limited to:

(1) The treatment requested was emergency treatment;

(2) The provider was not aware that services were for a workers' compensation claim;

(3) The provider was non-bureau certified and had no established relationship with the injured worker;

(4) The provider was initially bureau certified within six months prior to the treatment request;

(5) The treatment requested was for a pending claim allowance or additional allowance with the bureau or industrial commission;

(6) The treatment provided was within the bureau's presumptive authorization guidelines, or does not require prior authorization per the bureau's provider billing and reimbursement manual;

(7) The treatment request was submitted retroactively due to bureau or MCO error;

(8) Other documented justification as deemed sufficient by the bureau.

(C) Determinations that an approved medical treatment reimbursement request shall be reimbursed at seventy-five per cent of the applicable fee schedule amount pursuant to paragraph (A) of this rule shall be subject to the grievance hearing procedure for

disputed bill payments provided by rule 4123-6-04.4 of the Administrative Code.

(D) Retroactive medical treatment reimbursement requests submitted within seven calendar days of the initiation of treatment or prior to the date of the physician of record or eligible treating provider's next encounter with the injured worker, whichever is earlier, shall not be subject to payment reduction under paragraph (A) of this rule.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4123.66, 4121.441
Rule Amplifies:	4121.12, 4121.121
Prior Effective Dates:	1/1/13

4123-6-17 **Bureau refusal to certify or recertify, action to decertify a provider or MCO - standards and procedures for adjudication hearings.**

(A) The administrator of the bureau of workers' compensation may refuse to certify or recertify or may decertify a provider or MCO as provided in ~~paragraph (B) of rule 4123-6-02.5 of the Administrative Code and paragraph (A) of rule 4123-6-03.7 of the Administrative Code~~ the rules of this Chapter.

(B) The bureau shall monitor and may investigate a provider or MCO, and may participate with other state or federal agencies or law enforcement authorities in gathering evidence for such matters. ~~When the bureau medical services division determines there is sufficient evidence to refuse to certify or recertify or to decertify a provider or MCO, the bureau medical services division shall present this evidence to the administrator with a recommendation for an adjudication order.~~

(C) Prior to the administrator issuing an adjudication order on the matter, the administrator shall afford the provider or MCO an opportunity for a hearing in accordance with the provisions of Chapter 119. of the Revised Code and this rule.

(D) Prior to the administrator entering an adjudication order, the bureau shall send written notice to the provider or MCO by certified mail containing the following information:

(1) A statement of the reasons and a summary of the evidence relied upon for the proposed administrative action concerning the provider or MCO;

(2) A citation of statutes or rules forming the basis for the administrative action;

(3) A statement indicating that the provider or MCO is entitled to a hearing, if requested within thirty days of the time of the mailing of the notice;

(4) A statement indicating that the provider or MCO may appear at the hearing in person, and may be represented by an attorney, or may present its position, arguments or contentions in writing;

(5) A statement that at the hearing the provider or MCO may present evidence and examine witnesses appearing for and against the provider or MCO, and that the provider or MCO may request that the bureau issue subpoenas to compel the attendance of witnesses;

(6) A statement informing the provider or MCO that ~~in the event a hearing is not requested and the request received by~~ if the bureau does not receive a request for a hearingwithin thirty days of the time of mailing of the written notice, the administrator may proceed with an adjudication order concerning the provider or MCO.

(E) If no timely request for a public hearing is made by the provider or MCO, the administrator may issue an adjudication order concerning the provider or MCO. Such order shall be sent by certified mail to the provider or MCO.

(F) If the provider or MCO files a timely request for a hearing, the bureau shall immediately set the date, time, and place for such hearing, not less than seven nor more than fifteen days from the bureau's receipt of the request for hearing. The bureau shall notify the provider or MCO and any representatives of the hearing. The bureau may continue the date of the hearing upon the application of any party or upon its own motion. The hearing shall be held at the bureau central office in Columbus, but if requested by the provider or MCO, the bureau may hold the hearing in the ~~district~~ bureau office closest to the place of business of the provider or MCO.

(G) ~~The~~Conduct of hearing.

(1) The administrator may conduct the hearing personally or may delegate the hearing to a referee, who shall be an attorney at law. The referee may be from the ~~bureau~~ bureau's legal division or an attorney employed by the administrator especially for such purpose. The burden of proof shall be on the bureau to establish cause for taking action against the provider or MCO, and shall be by a preponderance of the evidence. The bureau shall be represented by the attorney general at the adjudication hearing. A stenographic record of the hearing shall be made. ~~Should the hearing be conducted by a referee, the referee shall issue a report and recommendation, a copy of which shall be sent to all parties and representatives by certified mail, and which may be objected to in writing within ten days of receipt of the report and recommendation. The administrator may approve, disapprove, or modify the report and recommendation of the referee, but shall not take such action until the after the expiration of the period for objection to the referee's report. The administrator may order additional testimony. The administrator shall issue a written order and shall send, by certified mail, a certified copy of the order and a statement of the time and method by which an appeal may be perfected to the provider or MCO. The administrator shall also mail a copy of the order to any representative of the provider or MCO.~~

(2) Should the hearing be conducted by a referee, the referee shall issue a report and recommendation, a copy of which shall be sent to all parties and

representatives by certified mail, and which may be objected to in writing within ten days of receipt of the report and recommendation. The administrator may approve, disapprove, or modify the report and recommendation of the referee, but shall not take such action until after the expiration of the period for objection to the referee's report.

(3) The administrator shall issue a written order and shall send, by certified mail, a certified copy of the order and a statement of the time and method by which an appeal may be perfected to the provider or MCO. The administrator shall also mail a copy of the order to any representative of the provider or MCO.

(H) Should the provider or MCO prevail in the adjudicating hearing, the provider or MCO may be entitled to attorney fees. The procedure for determining attorney fees shall be in accordance with section 119.092 of the Revised Code.

(I) Should the provider or MCO be adversely affected by the order of the administrator, the provider or MCO may file a notice of appeal of the decision ~~with the administrator, setting forth the order appealed from and the grounds of the provider's or MCO's appeal. The provider or MCO shall also file a copy of the notice of appeal with the court of common pleas of Franklin county. Notices of appeal shall be filed within fifteen days after the mailing of the order of the administrator. Within thirty days after receipt of the notice of appeal from an order in any case in which a hearing was required, the bureau shall prepare and certify to the court a complete record of the proceedings in the case~~ in accordance with section 119.12 of the Revised Code.

(J) Any adjudicating order of the administrator to decertify, or to refuse to recertify a provider or MCO shall include a clear indication of the beginning date of such action and the specific medical services or dates of medical services or supplies that shall be excluded from payment.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/1/99, 2/14/05, 2/1/10

4123-6-18 **Data gathering and reporting.**

(A) Pursuant to division ~~(H)~~(L) of section 4121.44 of the Revised Code and division (A)(6) of section 4121.441 of the Revised Code, the administrator shall require employees, employers, ~~medical~~ providers, ~~medical vendors (~~MCOs~~)~~, and plans that participate in the workers' compensation system to report data to be used by the administrator to:

(1) Measure and perform comparison analyses of costs, quality, appropriateness of medical care, and effectiveness of medical care delivered by all components of the workers' compensation system.

(2) Compile data to support activities of the MCOs and to measure the outcomes and savings of the HPP.

(3) Publish and report compiled data on the measures of outcomes and savings of the HPP to the governor, the speaker of the house of representatives, and the president of the senate ~~on the first day of each January and July to gauge the measures of outcomes and savings of the HPP~~ with the annual report prepared under division (F)(3) of section 4121.12 of the Revised Code.

(B) The administrator shall compile at least annually and make available electronically to each employer a report that summarizes the performance of each MCO ~~pursuant to the performance criteria described in rule 4123-6-13 of the Administrative Code~~.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	2/16/96, 1/1/99, 2/14/05, 2/1/10

4123-6-19 **Remain at work ~~program~~ services.**

(A) The bureau shall take measures and make expenditures, as it deems necessary, to aid injured workers who have sustained compensable injuries or contracted occupational diseases to remain at work.

(B) Remain at work services.

(1) An injured worker is eligible to ~~participate in a~~ receive remain at work ~~program~~ services when:

(a) The injury results in a medical only claim which is certified by the employer or is allowed pursuant to a bureau or industrial commission order or a lost time claim with eight or more days of lost time due to a work related injury which is certified by the employer or is allowed pursuant to a bureau or industrial commission order, but the injured worker is not receiving and has not been awarded temporary total compensation or salary continuation in the claim; and,

(b) It is documented by the employer, the injured worker, or the physician of record that the injured worker is experiencing problems that are work-related and result from the allowed conditions in the claim.

(2) Services provided shall be charged to the employer's risk.

(3) The MCO shall determine the need for remain at work services.

(4) Within five business days of completion of services, the MCO shall submit a final report to the bureau.

(5) The bureau may audit the MCO's utilization of remain at work services.

(C) Scope of remain at work services.

~~(1) Services provided in a remain at work program.~~

~~(a) The MCO shall submit to the bureau a final report at the completion of services within five business days of final services.~~

~~(b)~~(1) Remain at work services may include ergonomic study, functional capacity evaluation, job analysis, physical therapy (on site), occupational therapy (on

site), physical reconditioning, transitional work, gradual return to work, on the job training, short term training, job modification, tools and equipment, and remain at work case management.

~~(c)~~(2) The bureau will not reimburse an employer for remain at work services that are provided by the employer (e.g., transitional work, on the job training, gradual return to work).

~~(2)~~(3) Remain at work services shall cease upon the occurrence of any of the following:

(a) A bureau, industrial commission or court order subsequently disallowing the claim.

(b) The claim changes to a lost time claim with eight or more days of lost time due to a work related injury and the injured worker receives temporary total compensation or salary continuation in the claim.

~~A claim that changes to a lost time claim with eight or more days of lost time due to a work related injury may be referred for vocational rehabilitation services as provided under Chapter 4123-18 of the Administrative Code.~~

(c) The effective date of lump sum settlement.

~~(3) The bureau may audit the MCO's remain at work program.~~

(4) A claim that changes to a lost time claim with eight or more days of lost time due to a work related injury may be referred for vocational rehabilitation services as provided under Chapter 4123-18 of the Administrative Code if the injured worker is receiving or has been awarded temporary total compensation or salary continuation in the claim.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	10/26/04, 3/1/09, 1/1/01, 2/14/05, 7/1/12

4123-6-20 **Obligation ~~for submitting~~ to submit medical documentation and reports.**

(A) A provider is responsible for the accuracy and legibility of all reports, information, and/or documentation submitted by the provider, the provider's employees, or the provider's agents to the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer in connection with a workers' compensation claim. The provider, the provider's employees, and the provider's agents shall not submit or cause or allow to be submitted to the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer any report, information, and/or documentation containing false, fraudulent, deceptive, or misleading information.

(B) ~~Interim~~Physician's medical reports ~~and medical documentation~~ of work ability.

~~Compensation for temporary total disability is payable upon submission of current supporting medical documentation. While the claimant remains on temporary total disability, interim reports must be filed in accordance with paragraph (D) of rule 4123-5-18 of the Administrative Code. Interim reports must include at least:~~

Physicians treating claimants shall complete, sign, and submit to the MCO a physician's report of work ability on form MEDCO-14 or equivalent upon every claimant encounter, unless the claimant has been awarded compensation for permanent total disability or the treating physician has previously released the claimant to return to the claimant's former position of employment without restrictions on form MEDCO-14 or equivalent. The physician's report of work ability must include at a minimum the following:

(1) The date of the report;

(2) The date of the last examination;

(3) The "International Classification of Disease" diagnosis code(s) recognized in the claim for all conditions and all parts of the body being treated that are affecting the length of disability, including a primary diagnosis code, with a narrative description identifying the condition(s) and specific area(s) of the body being treated;

(4) Any reason(s) why recovery has been delayed;

(5) The date temporary total disability began;

(6) The current physical capabilities of the claimant;

(7) An estimated or actual return to work date;

(8) An indication of need for vocational rehabilitation;

(9) Objective findings; and

(10) Clinical findings supporting the above information.

(C) Treatment plan.

(1) Upon allowance of a claim by the bureau, industrial commission, or self-insuring employer, the physician of record and other providers treating the claimant shall provide and continue to update a treatment plan to the MCO, QHP, or self-insuring employer according to the format or information requirements designated by the bureau. A treatment plan should include at least the following:

(a) Details of the frequency, duration, and expected outcomes of medical interventions, treatments, and procedures;

(b) The ~~projected or anticipated~~ estimated return to work date; and

(c) Factors that are unrelated to the ~~work-related~~ work-related condition, but are impacting recovery.

(2) Modifications should be made to the initial treatment plan as treatment is extended, changed, completed, added, deleted or canceled. The modification should describe the current prognosis for the injured worker, progress to date, and expected treatment outcomes.

(3) Treatment plans should be updated when significant changes occur in the claim ~~which~~ that impact claims management. Changes include:

(a) Additional allowance;

(b) Re-activation;

(c) Authorization of expenditures from the surplus fund;

(d) Return to modified or alternative work;

(e) Maximum medical improvement;

(f) Rehabilitation;

(g) A new injury while receiving treatment in the claim.

(4) Supplemental reports from the attending physician and other providers may be requested by the bureau, industrial commission, employer, MCO, QHP, or by the claimant or representative. These reports shall be used to determine the appropriateness of a benefit or bill payment.

(D) In accepting a workers' compensation case, a ~~medical~~ provider assumes the obligation to provide to the bureau, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer, upon written request or facsimile thereof and within five business days, all medical, psychological, ~~or~~ psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to the claim required by the bureau, MCO, QHP, or self-insuring employer, and necessary for the claimant to obtain medical services, benefits or compensation.

(E) Independent medical examinations.

(1) A provider performing an independent medical examination of a claimant shall create, maintain, and retain sufficient records, papers, books, and documents in such form to fully substantiate the accuracy of the resulting report submitted to the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer in connection with a workers' compensation claim. The provider, the provider's employees, and the provider's agents shall keep such records in accordance with rule 4123-6-45.1 of the Administrative Code, and such records shall be subject to audit pursuant to rule 4123-6-45 of the Administrative Code.

(2) A provider performing an independent medical examination of a claimant shall keep confidential all information obtained in the performance of the independent medical examination, including but not limited to knowledge of the contents of confidential records of the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring

employer. The provider, the provider's employees, and the provider's agents shall maintain the confidentiality of such records in accordance with all applicable state and federal statutes and rules, including but not limited to rules 4123-6-15 and 4123-6-72 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.30, 4121.31, 4123.05
Rule Amplifies:	4121.121, 4121.44, 4121.441, 4123.66
Prior Effective Dates:	1/27/97, 1/15/99, 1/1/01, 1/1/03, 2/1/10

4123-6-20.1 **Charges for copies of medical reports.**

(A) The purpose of this rule is to provide parties to a workers' compensation claim reasonable access to and reasonable charges for medical records necessary for the administration of the claim.

(B) Except as provided in this rule, a medical provider ~~may~~ shall not assess a fee or charge the claimant, employer, or their representatives for the costs of completing any bureau form or documentation required under rule 4123-6-20 of the Administrative Code which is required by the bureau, MCO, QHP, or self-insuring employer and is necessary for the claimant to obtain medical services, benefits, or compensation.

(C) A medical provider shall provide copies of medical records to the bureau, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer as provided in paragraph (D) of rule 4123-6-20 of the Administrative Code. A medical provider ~~may~~ shall not assess a fee or charge the bureau, industrial commission, MCO, QHP, or self-insuring employer for the costs of providing medical records or completing any bureau form or documentation which is required by the bureau, MCO, QHP, or self-insuring employer and is necessary for the claimant to obtain medical services, benefits, or compensation.

(1) The bureau shall provide authorized parties to the claim access to all filed medical records without charge through secure electronic access.

(2) Where the bureau has provided access to medical records electronically and a party requests copies of such medical records, the bureau may charge a fee for the copies in accordance with the Ohio public records laws.

(3) Where a provider has filed copies of medical records with the bureau or MCO and the bureau has provided access to such medical records electronically or the provider has filed copies of medical records with the self-insuring employer, if a party requests such medical records of the provider, the provider may charge a fee for the copies. The provider's fee shall ~~be based upon the actual cost of furnishing such copies, not to exceed twenty-five cents per page~~ not exceed the amount allowable under sections 3701.741 and 3701.742 of the Revised Code.

(D) As provided in division (B) of section 4123.651 of the Revised Code, a claimant shall promptly provide a current signed release of medical information, records, and reports relative to the issues necessary for the administration of the claim when

requested by the employer. The employer shall immediately provide copies of all medical information, records, and reports to the bureau and to the claimant or the claimant's representative upon request.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	4121.12, 4121.30
Rule Amplifies:	149.43, 3701.741, 4113.23, 4121.121, 4121.44, 4121.441, 4123.651
Prior Effective Dates:	1/1/03, 2/1/10