



Instructions

Please specify if you are requesting certification or re-certification and submit all of the information requested in this application in the order specified. Where attachments are necessary, clearly indicate the application requirement being addressed (i.e. a document labeled "Item D2" would refer to the list of providers that the employer has arrangements for the provision of health-care services). Please submit your application and attachments via mail or email to:

Ohio Bureau of Workers' Compensation
Self-Insurance, 22nd Floor
30 West Spring St.
Columbus, Ohio 43215-2256
Email: SIINQ@bwc.state.oh.us

- Certification (check one)
QHPs that successfully complete the application process will be certified. To become certified, QHP must:
- Ensure their panel providers have obtained BWC certification;
- For those QHP applicants submitting providers who need certified, the potential QHP shall submit individual provider applications for each provider requiring certification.

Re-certification

QHP Identification

1. Identify the employer and name of the QHP

Form with fields for Employer name, Employer policy number, QHP name, Federal tax ID number, Contact name, Title, Street address, P.O. box/suite number, City, State, ZIP code, Phone number, Fax number, E-mail address.

2. Identify the structure of the QHP (check one)

- Self-administered: The self-insuring employer has all the resources and tools, and will administer the QHP in house.
Vendor administered: The self-insuring employer will contract with a medical-management vendor to provide all of the services necessary for its QHP. A vendor may be any party providing any part of the employer's medical management, including a BWC-certified managed care organization. A third party administrator (TPA) may not provide medical management services for the QHP.
Partial vendor administration: The self-insuring employer has some of the resources and tools necessary, and will administer some of the QHP in-house. The self-insuring employer will contract with a medical-management vendor to provide the remainder of the services necessary for its QHP. A TPA may not provide medical management services for the QHP.
Other: (Please define)

Organization

1. Attach a description of the QHP's structure.

- Please submit a description of the role of each vendor that will be a component of the QHP, including, but not limited to, TPAs and other medical management vendors.
- Please submit a table of organization of your QHP, placing all vendors (if applicable) on the chart who are performing functions of your QHP. Describe your plan of oversight for all outsourced functions.

2. Identify the individual who will serve as the day-to-day administrator of the QHP.

Name		
Title		
Street address		P.O. box/suite number
City	State	ZIP code
Phone number	Fax number	E-mail address

3. Identify the individual who will serve as Medical Director or Physician Consultant of the QHP (attach a copy of the physician's license and curriculum vitae).

Name		
Specialty		
Street address		P.O. box/suite number
City	State	ZIP code
Phone number	Fax number	E-mail address

4. Identify all places of business where the program will be administered and records/claim files maintained. Include contact person (please include any vendors that will be maintaining records/claim files). Do not list a post office box.

Network of health care providers

1. Indicate the counties in which the employer is seeking certification.

2. Attach a list of the providers with whom the employer has arrangements for the provision of health care services.

The following data elements must be included for each provider within the list and whether they are a company-based provider or network provider:

- Provider name (primary sort key);
- BWC provider number;
- Federal tax identification number;
- Provider type;
- Provider specialty;
- Provider address;
- Provider telephone number; and
- Provider fax number.

Include the above provider data elements and a description of the role of each individual company based provider, as distinguished from QHP network providers. An employer may limit the number of providers on its panel based upon objective data demonstrating the fundamental needs of the employer and employees are met. The employer shall not discriminate against any category of health-care provider when establishing categories of providers for participation pursuant to Ohio Administrative Code (OAC) Rule 4123-6-59.

- 3. Attach a description of the process, including timeframes, used by the QHP to credential and re-credential medical providers within its panel, or the medical providers seeking to join the panel.**
- 4. Attach a description of the employer's policies and procedures for sanctioning and terminating providers in the panel. Include a description of the QHP's process for notifying BWC, the employer and employees of network changes.**
- 5. Attach a description of the employer's plans for distributing provider directories and updates to BWC, the employer and employees.**

Medical management and utilization management

- 1. Attach a description of the employer's methodology for medical management and utilization management to coordinate the delivery of quality, cost-effective medical treatment and to promote an appropriate return to work plan. The description should include the following:**
 - Explain in narrative form the process for treatment from the point of injury to resolution; include process for referring cases for medical management, including catastrophic cases.
 - Identify any medical case management tools utilized for treatment decisions (i.e. nationally accepted treatment guidelines, DoDM, etc.).
 - Describe your Alternative Dispute Resolution (ADR) process per rule 4123-6-69 for medical disputes. Please submit copies of your determination letters.
 - Describe the role of the Medical Director or Physician Consultant as it relates to participation with the case management process and the ADR process.
 - Pursuant to OAC 4123-6-54 (C) (10), describe the employer's plan in the event that certification of the QHP is revoked or refused by BWC. Specifically, the plan should address the continuity of care to injured workers and payment to providers for medical services rendered prior to the revocation or refusal to certify.

Quality assurance and dispute resolution

- Attach a description of the employer's Quality Assurance program, including a mechanism for monitoring and the methodology for measuring and improving the QHP's compliance with the eleven elements set forth in the Health Care Quality Advisory Council (HCQAC) standard agreement and Rule 4123-6-53 (B) of the OAC.
- Attach a description of the process for addressing "administrative" grievances (dispute resolution) that may arise from injured workers, employers and medical providers. Include your procedure for handling complaints, and determining time frames for resolution of issues.

Provider and employee education

- Attach a description of the employer's provider relations and education programs. Please describe how you will educate your providers on your specific QHP program.
- Attach a description of the employer's education program for your employees that are specific to the QHP.

Security, controls and disaster recovery plan

Pursuant to OAC 4123-6-72, the employer must implement policies and procedures that ensure the provider/patient information, including release of medical information, will be kept secure and confidential yet available for transfer as necessary. The employer ensures that it will prevent unauthorized access to any information, including hard copy and electronic.

- Describe how paper copies of confidential medical information will be maintained to ensure that there can be no unauthorized access to the information. (i.e. all files are kept in a locked, fireproof cabinet with access limited to medical staff only.)
- When/if a data processing system is used for information storage, describe the security measures in place for preventing unauthorized access to the information (i.e., restricted passwords, etc.).
- Attach a description of the employer's process for adhering to record retention requirements under Section 4123.52 of the Ohio Revised Code (ORC), including a description of the employer's disaster recovery plan (a disaster is defined as any event that would prevent or hinder the employer from performing the administration of workers' compensation claims. This could be the result of a fire, flood, theft or any other type of event that could interrupt services).
- Provide a medical release form that provides the injured worker with notice of every entity that may potentially receive medical information submitted to the QHP (the employer, the employer's representative [TPA], and any vendors of the QHP, BWC and the IC).
- In the event that the injured worker is willing to release medical information to the employer but not to the vendors, please describe how you would medically manage that claim.

Statements

1. Statement of non-discrimination:

By signing below, the applying employer is indicating that it has not discriminated against any type/category of medical provider in forming its panel.

Signature _____

Date _____

2. Statement of medical provider credentials and information:

By signing below, the applying employer is indicating that medical providers selected for its panel meet or exceed the credentialing criteria used by BWC and set forth in Rule 4123-6-59 of the OAC. Additionally, the employer is indicating that it will notify BWC of changes to the status of a provider's license or changes to the provider's address upon the QHP receiving notification.

Signature _____

Date _____

3. Statement of geographically convenient, timely medical services:

By signing below, the applying employer is indicating that their medical providers are open to accepting new and/or existing workers' compensation patients and providing the initial treatment within 24 hours of the injured worker's request and additional treatments within a reasonable timeframe, as well as indicating the employer's ability to provide access to specialty care that is timely and geographically convenient.

Signature _____

Date _____

4. Statement of virus protection:

By signing below, the applying employer is ensuring that all media and files sent to BWC are free of viruses.

Signature _____

Date _____

5. By signing below, the employer will notify BWC in writing, at least 30 days prior to the date of planned implementation of any changes to the QHP application as submitted, and the QHP as certified.

The Application for Amendment of a Certified QHP should be sent to BWC, Self-Insured Department, L-22, 30 W. Spring St., Columbus, Ohio 43215-2256.

Signature _____

Date _____

6. The application is without misrepresentation, misstatement, or omission of a relevant fact or other acts involving dishonesty, fraud, or deceit. The QHP administrator shall provide to BWC any additional documents requested and shall permit BWC, upon reasonable notice, to conduct an on-site review of the QHP's operations (vendor or employer) as they relate to this application.

Signature _____

Date _____