

Chapter 1 - Ohio Workers' Compensation System - Table of Contents

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A. WORKERS' COMPENSATION SYSTEM

The Ohio workers' compensation system consists of two agencies: The Ohio Bureau of Workers' Compensation (BWC) and the Industrial Commission of Ohio (IC). Both are governed by the Ohio Revised Code. BWC processes claims and pays compensation benefits. BWC also administers safety programs to help prevent work-related accidents and provides rehabilitation services to assist injured workers in returning to gainful employment. The IC resolves disputes over the validity of claims, payment of compensation and medical benefits and determines permanent total disability (PTD). The workers' compensation system includes both state-fund and self-insuring employers. BWC and the IC monitor self-insuring employers who process their own workers' compensation claims.

1. State-Fund Claims

On March 1, 1997, BWC, in partnership with private sector managed care organizations (MCOs), implemented a managed-care program, the Health Partnership Program (HPP) for state-fund employers. Transition of the medical management of new and existing claims to the MCOs occurred in three phases:

- Phase one - MCOs managed state-fund claims with dates of injury on or after March 1, 1997;
- Phase two - On Sept. 1, 1997 state-fund claims with dates of injury between Oct. 20, 1993 and Feb. 28, 1997, were transferred into HPP;
- Phase three - On Dec. 15, 1997, MCOs began medically managing all state-fund claims.

Prior to each transition, BWC mailed a letter to the injured worker and any active providers (i.e., those treating the injured worker) indicating when to forward medical bills to the MCO.

Ohio employers have the opportunity to change their MCO during open enrollment periods, conducted every two years beginning in 1998. Providers may determine the MCO for a particular employer by visiting our website at www.ohiobwc.com and accessing the BWC Employer/MCO Lookup.

NOTE: HPP does not affect fee bills for Marine Fund or Black Lung claims, family caregivers, and BWC/IC examinations. BWC retains responsibility for payment of these services. In addition, SXC Health Solutions, BWC's Pharmacy Benefits Manager (PBM), handles pharmacy bills for all state-fund claims. For additional PBM information, refer to Outpatient Medication, Chapter 3.

2. Self-Insuring Claims

The self-insuring employer is responsible for authorizing and determining medical necessity in self-insuring employers' claims. Except for emergency situations, the self-insuring employer must approve medical services in advance, including, but not limited to:

- Physical medicine services, including chiropractic/osteopathic manipulative treatment and acupuncture
- Consultations
- Dental
- Diagnostic Testing
- Durable Medical Equipment
- Home/Auto/Van modifications
- Home Health Agency services
- Hospital inpatient treatment, including surgery and outpatient/ASC surgery
- Injections
- Non-emergency ambulance services
- Skilled Nursing Facility (SNF)/Extended Care Facility (ECF)
- Vision services
- Vocational rehabilitation

The provider of record is responsible for contacting the appropriate self-insuring employer for authorization guidelines. Send fee bills and medical documentation to the self-insuring employer. Include the injured

worker's Social Security number and the employer's name on every bill you submit. If the provider bills BWC, the bills will be processed and denied with the following explanation of benefits (EOB) and message:

EOB 253: Self-insuring employers pay their own bills directly. Re-bill the self-insuring employer.

BWC will not forward the bill to the self-insuring employer. It is the provider's responsibility to ensure that the appropriate party is billed. Self-insuring employers are required to pay a medical bill within 30 days of receipt. The self-insuring employer may request additional medical documentation to determine reimbursement eligibility for fee bills. Upon receipt of the requested medical documentation, the self-insuring employer has an additional 30 days to pay or deny the bill.

Self-insuring employers may choose to form their own Qualified Health Plans (QHP) to deliver medical services to their employees, however, they are not required to do so. Should the self-insuring employer with a certified QHP deny a bill, a dispute resolution process resolves the medical dispute within 30 days. If the self-insuring employer is not part of a QHP, the injured worker may file a C-86 motion with BWC to request a hearing before the Industrial Commission.

For questions about self-insuring employers' claims please call BWC's Self-Insured Department at 1-800-OHIOBWC. Providers filing a complaint against a self-insured employer should do so through BWC's Department of Government and Media Affairs/Constituent Affairs.

B. MCO/BWC SCOPE OF ADMINISTRATIVE SERVICES

The following is a matrix of responsibilities for MCO-managed claims:

SERVICE	MCO RESPONSIBILITIES	BWC RESPONSIBILITIES
Provider Network	MCO credentials provider network panel based upon the geographic area the MCO wishes to compete within. MCOs will be allowed to limit the number of providers on their panels, but must do so based upon objective data without discrimination by provider type. Provider network must provide full range of medical services/supplies for injured workers and demonstrate the ability to provide access for specialized services.	All providers will be offered the opportunity to sign an agreement to meet the terms of BWC to be registered with HPP. BWC will certify all providers who are in compliance with the BWC requirements.
Inpatient utilization review	MCO performs inpatient UR for all claims for employers selecting MCO.	BWC provides oversight and monitors performance measures and utilization trends.
Outpatient surgery and high- cost diagnostic utilization review	MCO performs outpatient UR for all claims managed by an MCO.	BWC provides oversight and monitors performance measures and utilization trends.
Physical medicine review includes chiropractic	MCO performs physical medicine review for all claims for employers selecting the MCO.	BWC provides oversight and monitors performance measures and utilization trends.
Peer review	MCO performs peer review process for network and non-network UR and treatment issues. MCO has peer review processes for discussing/educating/disciplining providers who are identified as outliers of normal treatment patterns based on profiling and utilization trends. MCO has credentialing committee and decertification processes for network providers.	Due process and conflict resolution processes must be established by BWC to decertify and remove providers from HPP. BWC maintains physician peer review processes for initial claim determinations.
Dispute resolution process (Medical issues)	MCO must complete timely dispute resolution process, regarding medical and treatment issues. The MCO must have a medical dispute resolution process that includes one level of peer review.	BWC issues final order with MCO's recommended decision
Dispute resolution process (network issues)	MCO must complete timely dispute resolution processes with credentialing,	BWC must establish due process and conflict resolution processes to decertify MCOs and

	disciplining and terminating providers from their network.	remove providers from HPP.
Quality assurance (QA)	MCO must maintain credentialing committee and quality assurance committee for network. MCO must maintain QA standards.	BWC maintains medical policy committee for workers' compensation general medical policies, as necessary.
Remain at Work	MCO is responsible for identifying injured workers and employers to participate in the remain at work program and developing a case management plan, as appropriate.	BWC staffs the claim after the injured worker has received 45 days of Remain at Work services to assure appropriateness of case direction.
Return to Work	MCO is responsible for documenting and implementing a case management plan which addresses RTW planning on all lost-time claims where the IW has not returned to work regardless of DOI.	BWC staffs claims with MCO and other parties as needed 30 days after optimal RTW date. BWC makes recommendations for case resolution.
HPP satisfaction surveys	MCO will perform and report on injured worker, employer and provider surveys as a component of their quality assurance and improvement practices.	BWC will contract with an objective vendor to complete random (must be similar populations) sampling of injured worker, employer, and provider satisfaction surveys. Results of the surveys will be used in incentive payment determinations. BWC will assist in the development of the survey instruments.
Provider profiling and bill data	MCO will capture all pertinent data on both in-network and out-of-network providers, and maintain provider profiles, claim records and other data. MCOs will be required to share aggregate and other data with both employers and the BWC.	BWC will have complete access to all MCO claim data, paid bill information and provider profiling information. BWC gathers data and completes HPP program analysis and overall monitoring. BWC measures MCO performance based on established performance measures.
Confidentiality	MCO will maintain data and individual claim information confidentiality standards.	BWC will establish confidentiality standards for MCOs and ensure that standards are met. BWC maintains internal data and individual claim information confidentiality standards.
Payment methodology	MCOs will negotiate their own fee schedules with their network providers. The MCO will not directly benefit financially from reducing fees to providers. MCOs will pay non-panel providers the lesser of the BWC fee schedule or billed charges by the provider.	BWC will develop and maintain a statewide provider fee schedule with stakeholder input. BWC will pay the MCO for payment to the MCO network provider the lesser of the BWC fee schedule, MCO fee schedule or billed charges by the provider. BWC will pay the MCO for payment to non-network providers (BWC-certified providers) the lesser of the BWC fee schedule or billed charges by the provider.
Provider payments	The employer's MCO will pay all in- and out-of-network provider claims once BWC has paid the MCO. MCO must maintain standards for timely payment to providers.	Once the fee bill has been approved, BWC will pay the MCO. BWC must maintain standards for timely payment to MCOs.
Bill review	MCO performs bill review and clinical editing functions to ensure relatedness, appropriateness, compliance with UR and treatment guidelines. MCO is required to have a nationally recognized medical bill editing criteria package.	BWC is responsible for overall claims audit of the bills paid by the MCOs. BWC will not routinely audit individual claim fee bills, but, at its discretion, reserves the right to do so based on CPT®, CPT Assistant, and ICD-9.
Retrospective bill audit	MCO performs detailed retrospective bill audit, as necessary. MCOs review all inpatient hospital payments of more than \$20,000.	BWC is responsible for all overall claims audit of the bills paid by the MCOs. BWC will not routinely audit individual claim fee bills, but reserves the right to do so at its discretion.
Provider relations and education	MCO maintains network provider	BWC educates MCOs regarding workers'

	relations and education process, including information specific to workers' compensation issues. MCO educates providers on the MCO's operations and how to interact with the MCO.	compensation issues, medical policies and HPP rules, etc. BWC and stakeholders educate non-network providers on general HPP information and requirements.
Treatment standards/guidelines	MCO maintains national standards for UR functions and maintains treatment guidelines. MCO staff began using Official Disability Guidelines (ODG) in making their treatment authorization decisions effective April 1, 2004..	BWC utilizes the Official Disability Guidelines (ODG) and Mercy Chiropractic Guidelines as case management resources and for the Alternative Dispute Resolution process.
Injury prevention	MCO will identify safety/injury concerns based on types and frequency of injuries and communicate with the employer. MCO will notify BWC's Division of Safety and Hygiene so it can inform the employer of available services.	BWC maintains safety and hygiene programs and employer services functions.
Health-care provider fraud detection	MCO will cooperate with BWC and employer efforts in provider investigations.	BWC maintains identification, investigation and process functions.
Early notification of injury	MCO is required to report injury by electronic notification processes to BWC. MCO is required to report injury to employer.	BWC maintains injury notification process and claim allowance process.
Case management	<p>MCO must interface and coordinate with the customer service teams. MCO is responsible for implementing URAC Case Management Organization Standards for case management services and achieving full accreditation. MCOs that subcontract case management programs to an MCO with an accredited case management program are required to become accredited in URAC's Core Standards.</p> <p>The case management plan is action oriented and time bound and identifies the intervention(s) and resources to be used in order to assist the injured worker to achieve the goals specified within each phase of the plan. The case management plan is formed by a compilation of all information that the case manager has gathered from the injured worker, the physician and the employer as well as any other pertinent sources that impact the progress and successful outcome of the claim resolution.</p>	<p>BWC is responsible for claim eligibility determinations. BWC maintains and performs functions for overall management of the claim.</p> <p>BWC shares responsibility for successful management of the claim and presents important communication linkages. These include: the Claim Service Specialist (CSS), Medical Service Specialists (MSS), CAT nurses, Medical Claim Specialist (MCS/Med only claims) and Disability Management Coordinator (DMC).</p> <p>Other sources, such as family members, specialty providers, community agencies, etc. should be included as they emerge and are identified in the case.</p>
Medical case management	Medical case management is an essential component in effecting a successful claim outcome. Because the MCOs share claim operations duties with BWC, it is essential that the role, responsibilities and activities of the MCOs be clearly defined so that each will be able to interact effectively to reach optimal results.	BWC maintains Medical Policy Committee for workers' compensation general medical policies, as necessary. BWC provides oversight and monitors performance measures.

Independent medical exams (IME) <ul style="list-style-type: none"> Initial Allowances Extent of Disability including: <ul style="list-style-type: none"> 200 week; 90 day; Other. 	Medical management practices of the MCOs should significantly reduce the need for IMEs overall. MCO will make appropriate referrals for specialist care and obtain second opinions as indicated.	BWC will perform IMEs, as necessary, and as required by statute and rules.
Permanent partial disability (C-92) reviews and exams	In cooperation with BWC, MCO educates treating physicians on necessary medical documentation for request for increase in PPD award.	BWC is responsible for physician education, physician network, scheduling exams, and quality assurance on IMEs and physician reviews for PPD awards.
Sub-acute/long term facility/alternative care management	MCO performs authorization, coordination of care at appropriate level of setting, and provides ongoing monitoring and quality assurance for long term care.	BWC provides oversight and monitors performance measures.
Home and van modifications authorizations	MCO case manager will work closely with the BWC Catastrophic Nurse Advocate to insure coordination of the services. MCO is not responsible for authorizing home and van modifications.	BWC Catastrophic Nurse Advocate (CNA) identifies need for home/vehicle modification as a result of a catastrophic injury. CNA works with MCO case manager and necessary vendors to insure coordination of the services.
Caregiver services authorization	MCO performs authorization of professional nursing services (home health agency) and ongoing monitoring.	BWC performs continued authorization for caregiver (spouse, etc.) services and ongoing monitoring of services for providers authorized prior to 04/01/93 (01/09/95 for spouse caregivers). No new caregiver services are authorized on any claim after 01/09/95.
Out-of-state/out-of-country medical management and provider management	MCO performs medical management, provider payment and provider management services for all claims for employers selecting MCO.	BWC provides oversight functions and monitors performance measures.
Vocational management	MCO provides BWC with initial notification of injured worker eligibility for vocational rehab and determines feasibility for services. MCO manages rehab cases in accordance with Ohio Administrative Code rules and BWC guidelines. MCO educates providers and employers about RTW expectations.	BWC verifies MCO's initial eligibility notification and also may provide rehab referrals. BWC consults with MCO on rehab issues and makes recommendations if injured worker has not RTW 30 days after the optimal RTW date. BWC determines and pays compensation such as Living Maintenance (LM) and LM Wage Loss.
Performance measures	MCO must meet defined data and reporting requirements.	BWC establishes, with stakeholder input, measurement, analysis, evaluation and reporting functions on the performance of MCOs and HPP.
MCO contract management		BWC is responsible for measuring, monitoring and ensuring contract compliance, standards compliance and reporting on outcomes and savings.
Regulatory reporting	MCO must meet defined data and reporting requirements.	BWC performs function.
Communications about HPP program	In cooperation with BWC, the MCO educates injured workers/employers/providers MCO's operations and how to interact with the MCO. MCO prepares provider directory/related information, and maintains 1-800-inquiry line for IW and employers regarding their network and services.	In cooperation with the MCOs, BWC provides high level informational support via its media programs, print communications and seminars.

C. ELIGIBLE PROVIDERS

All providers who meet minimum credentialing criteria and sign a provider agreement, indicating agreement to abide by all HPP and medical rules, will be allowed to participate in HPP. There are three categories of HPP providers:

1. **BWC-Certified Provider** - A credentialed provider who is approved by BWC for participation in HPP and signs a provider agreement with BWC. Providers seeking to enroll to become BWC certified, initially or during recertification, must initially complete the *Application for Provider Enrollment and Certification* (MEDCO-13), or recertification application made available by BWC.
2. **Non-BWC Certified Provider** – A provider who 1) is eligible for BWC certification and meets minimum enrollment requirements per Rule 4123-6-02.21 but is not approved for participation in the HPP, or 2) is not eligible for BWC certification. Provider types ineligible for certification are listed on the Application for Enrollment – Non Certification form (MEDCO 13A). For claims with dates of injury prior to Oct. 20, 1993, the injured worker may continue to be treated by the physician of record (POR) even if the POR is a non-BWC certified provider. However, if, for any reason, the injured worker decides to change physicians, a BWC certified-provider must be selected.

Providers may check on their certification status by:

- ✓ Contacting their MCO(s);
- ✓ Calling 1-800-OHIOBWC;
- ✓ Visiting BWC Online at www.ohiobwc.com and accessing the Medical Provider section. All BWC-certified providers are listed on the web page.

Neither the application for certification, nor the provider agreement located within the application may be altered or modified. These actions will delay certification.

D. PROVIDER ENROLLMENT AND CERTIFICATION

Beginning in April 2007, BWC uses two provider applications for enrollment into BWC's database. BWC has made changes in provider types eligible for certification. A separate application for provider types eligible and ineligible for BWC certification (enrolled only providers) are on the BWC Web site noted as MEDCO 13 Application for Provider Enrollment and Certification, and MEDCO 13A, Application for Provider Enrollment Non Certification. Please review the provider types noted on each application and complete the appropriate one.

A provider must meet minimum enrollment requirements (licensure, accreditation, etc) to be eligible to enroll in BWC's provider database. These requirements are noted under the provider type on the application. A provider must meet the following additional minimum credentialing criteria to **participate in HPP:**

- Have a current license to practice, as applicable;
- Meet other general certification requirements for the specific provider type;
- Possess a current and valid Drug Enforcement Agency (DEA) registration, unless not required by the provider's discipline and scope of practice;
- Be without previous termination from participation in Medicare, Medicaid or the Ohio workers' compensation system;
- Be without a felony conviction in any jurisdiction, a conviction under a federal controlled substance act, or a conviction for an act involving dishonesty, fraud or misrepresentation, no history of conviction for a misdemeanor committed in the course of practice, or court supervised intervention in lieu of conviction;
- Maintain workers' compensation coverage in compliance with Ohio Revised Code 4123.35. Providers outside Ohio must maintain workers' compensation coverage pursuant to the requirements of the state in which they are located.
- Provide proof of a valid current policy of professional liability insurance.
- Answer additional questions on the application applicable to the provider type.

BWC will verify a provider's credentials and determine whether minimum enrollment and credentialing criteria have been met, and review the application type for a signed provider agreement, BWC will send a verification letter of BWC enrollment and/or certification approval status to the provider, based on the provider type.

IMPORTANT: To change provider enrollment data, please complete the Request to Change Provider Information Form (MEDCO-12) or submit the changes, in writing and on letterhead, to:

Ohio Bureau of Workers' Compensation
Provider Enrollment Unit
P.O. Box 182031
Columbus, Ohio 43218-2031
Fax: 614.621.1333

BWC certified providers agree to notify BWC within 30 days of changes in 1) demographic info; 2) provider/NPI numbers 3) tax ID or ownership info or change in provider status regarding credentialing criteria of paragraphs (B) and (C) or OAC 4123-6-02.2. When requesting a change to provider enrollment data in writing, please provide the following information:

- Provider name and number;
- Phone number;
- Signature of individual who is assigned the specific provider number;
- If address change, please specify
 - a) Physical location(s)
 - b) Pay-to address
 - c) Correspondence address.

Changes to tax identification numbers and group affiliations must also be requested in writing. Please specify when the date changes should become effective. See Medco 12 form located at www.ohiobwc.com under Medical Providers Section, Forms, to define if the Medco 12 or a new application is appropriate to submit for tax identification changes. A W9 form is required to be submitted also. Provider status regarding credentialing criteria should contain the above bulleted information and status update details.

Provider enrollment will not accept a PO Box only as a practice location. An actual street address is needed for each location of your practice.

Providers enrolled as BWC provider type 12 - Provider Group Practice: This provider type is only eligible to enroll as a provider who receives payment and may not enroll as a servicing provider. BWC will require any group enrolling to name a certified provider associated with that group (TIN) number, and submit a W9 for IRS purposes to be enrolled only. (This provider type is not designed for enrollment of private service coordinators operating private provider networks). BWC does not require individual providers to be "linked" to group numbers systematically for payment purposes, but requests providers update BWC with accurate demographic information that shows each location where the provider is working.

a) **Provider recertification**

BWC's provider recertification initiative is based on the providers' original certification dates. Periodically, BWC releases recertification applications which include a summary of the information presently on file for the provider.

If a provider does not submit a completed application within 90 days their certification will lapse. Once the provider's certification lapses, bills will not pay for dates of service post lapse unless the MCO decides to authorize payment. The provider may apply for recertification post lapse by submitting a completed application. Once a lapsed provider completes the process they may become recertified and the recertification will be retro---there will be no gap in certification status between initial certification and recertification. The following explanation of benefits (EOB) codes was developed to address non-payment due to non-recertification:

Payment is denied as provider is not eligible for recertification.

All certified providers must be recertified periodically. During the recertification process, a provider will be in one of several in-process statuses until he or she reaches recertified, denied or lapsed status. A provider who no longer meets the requirements for certification will be put in Denied Recertification status. There will be an effective date associated with that status and bills with date of service prior to the effective date will pay. Dates of service after the effective date will deny unless approved by an MCO with override EOB or 756.

448 Payment is denied as provider's certification has lapsed.

All certified providers must be recertified periodically. During the recertification process, a provider will be in one of several in-process statuses until he or she reaches recertified, denied or lapsed status. A provider who fails to respond within 90 days or who requests removal from HPP will be put in Lapsed Status. There will be an effective date associated with that status and bills with date of service prior to the effective date will pay. Dates of service after the effective date will deny unless approved by an MCO with override EOB or 756.

2 National Provider Identifier

BWC will allow providers to incorporate their National Provider Identifier (NPI) into the bureau's billing processes. Providers may incorporate NPI at their own discretion if it fits their business processes.

The bureau does not view NPI as replacements for the BWC provider numbers already assigned. Instead, BWC views NPIs as alternates or additional identifiers providers can use in Ohio workers' compensation billing.

The federal Health Insurance Portability and Accountability Act (HIPAA) protects the privacy of patients' medical records and other health information maintained by covered entities. BWC is not a covered entity under HIPAA. Therefore, the bureau will continue to accept bills containing only BWC legacy (or current) numbers, as well as bills with both the legacy number and the NPI.

The bureau has made changes to add NPI information to its database to cross-reference BWC provider numbers. This will permit BWC to continue processing bills in a way that is accurate and consistent with laws, rules and policies governing payment of workers' compensation medical benefits.

Providers wishing to incorporate NPI into their workers' compensation billing must provide and verify their information with BWC's provider relations department. Providers should submit copies of their NPI confirmation from the enumerator (Fox Systems Inc.) along with their corresponding BWC provider number to the fax number or address below.

Fax to:

BWC Provider Enrollment
(614) 621-1333

Mail to:

Ohio BWC Provider Enrollment
P.O. Box 182031
Columbus, OH 43218-2031.

Once this process is complete, a provider may bill using either his or her BWC provider number or a combination of both the BWC provider number and NPI (and taxonomy code if applicable). Again, BWC does not require providers to use NPIs for billing.

Providers who wish to transition to billing BWC using their NPI information only should first bill using both identifiers (the BWC provider number plus the NPI). BWC will add new explanation of benefit codes to remittances to confirm it has added NPI data to a provider's record. Once confirmed, the provider may choose to bill using the NPI rather than the BWC provider number.

Any provider still needing to obtain an NPI may do so at <https://nppes.cms.hhs.gov>

Please be aware that BWC can only accommodate NPIs on forms for the billing processes noted above. The bureau is looking to accommodate future use of NPIs on other medical documents but is not set up to do so at this time. BWC has instructed managed care organizations to identify medical providers using NPIs on any form other than a bill, attempt to cross-reference their information, and then inform the provider to use its BWC provider number until the bureau can accommodate NPI in other processes.

You may direct questions about submitting NPI information by calling 1-800-OHIOBWC weekdays between 7:30 a.m. and 5:30 p.m. When you call, listen to the options to reach BWC's provider relations contact center.

E. REPORTING AN INJURY (BWC Rules 4123-6-028, 4123-6-20)

1. Provider responsibilities

Prior to HPP, injured workers, providers, and employers filed claims by filing the first Report of Injury (FROI) application. Under HPP it is just as simple – call the employee's MCO to report an injury or complete and file the FROI online at www.ohiobwc.com. File the FROI electronically and you will receive a claim number immediately.

Timely reporting of an injury is one of the most important responsibilities a provider has in HPP. By rule, providers must report the injured worker's injury to the responsible MCO within 24 hours or one business day of the initial treatment or initial visit. Furthermore, all BWC-certified providers have signed a contract obligating them to adhere to all Ohio workers' compensation laws and rules. Since 24-hour reporting is a legal and contractual requirement, non-compliance could result in actions such as loss of BWC certification, removal from an MCO's panel, or both.

Reporting an injury to the MCO within 24 hours has a number of advantages, including assisting BWC in expediting the processing of the claim. Generally, the sooner a claim is reported, the sooner it can be allowed. However, if a claim is not allowed by BWC for any reason, no payments are issued for either injured worker compensation or payment of medical bills. Additionally, a delay in the payment of medical bills can result if they are received by an MCO prior to the claim being reported.

Timely reporting assists providers with receiving billing and reimbursement instructions from the MCO and minimizes the possibility that claim authorizations (e.g., for compensation awards, medical benefits, treatment authorizations, etc.) will be delayed. To facilitate claim authorizations, it is important to provide MCOs with accurate information, including the exact ICD-9 code(s) for which the injured worker is being treated and an opinion of causal relationship between the reported diagnosis code(s) and the industrial accident.

Often, when injured workers first visit a provider or a facility for treatment, they are uncertain of their MCO, which complicates reporting the injury. However, injured workers usually know the name of their employers. Each state-fund employer either chose or was assigned a MCO, so this information is either available from the employer or BWC. If the employer is unable to provide the name of their MCO, this information is available on the BWC website at <http://www.ohiobwc.com>. If you are unable to access the Internet, contact BWC at 1-800-OHIOBWC (644-6292).

2. Data elements

Data elements that providers should give to an MCO when reporting an injury include:

- | | | |
|---------------------------------------|---|----------------------------|
| a) Injured worker information: | • Name * | • Gender * |
| | • Address * | • Marital status * |
| | • Telephone number * | • Social Security Number * |
| | • Date of birth * | • Occupation * |
| b) Injury information: | • Type of accident (accident, occupational disease, death) * | |
| | • Date of injury (date of death, if applicable) * | |
| | • Will injury likely result in more than seven days off work? (yes or no) * | |
| | • Accident description (detailed account of how accident | |

happened) *

- Date of initial treatment
- Date last worked and returned to work (estimate return to work if date is unknown)
- ICD-9 diagnosis codes (specific diagnosis description, including primary ICD-9)
- ICD-9 location (right, left, bilateral)
- ICD-9 site (digits or teeth)
- Injury description (body part injured, e.g., first joint of left index finger) *
- Is diagnosis causally related to the industrial accident? (y/ n) *

c) Employer information:

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

d) Provider information:

- Initial treating provider name and BWC provider number (may be a hospital or a physician) *
- Physician of record name and BWC provider number *

* Indicates data elements required for MCOs to meet the requirement of:

- Submitting 70 percent of the initial FROIs to BWC within three business days, and
- Sending 100 percent of the initial FROIs to BWC within five business days

The remaining data elements, if not available at the time of the first report, must be provided to the MCO no later than five calendar days from the initial treatment.

Important: If the BWC provider number is submitted to the MCO, BWC will send the provider who reported the injury or the provider of record a letter that tells the status of the claim and the allowed conditions.

F. PRIOR AUTHORIZATION

The MCO, or the self-insuring employer in self-insuring employers' claims, is responsible for authorizing and determining medical necessity for all claims. The provider of record or treating physician is responsible for contacting the appropriate MCO or self-insuring employer for authorization of services.

1. Penalty Payment

Effective Jan. 1, 2003, the MCO shall pay a penalty of ten dollars (\$10.00) to the provider for every instance in which the MCO denies a provider's bill due to lack of prior authorization and prior authorization either had been granted or was not required per standardized prior authorization and/or presumptive authorization guidelines .

Penalty payments shall be paid from funds appropriated by the MCO and not from its provider bank account. The MCO shall issue payment to the provider within 14 calendar days upon discovery or notification of the inappropriate prior authorization denial.

The following Q&A identifies some potential penalty payment situations:

Q: A provider submitted the same bill 3 times and all 3 bills were erroneously denied for lack of authorization. Is the MCO responsible for one \$10 payment or three \$10 payments (one for each denied bill)?

A: The MCO is required to pay "for every instance of erroneous denial," therefore; the MCO should pay three \$10 penalty payments or \$30.

Q: Is the provider entitled to the \$10 penalty payment if a bill was denied in error but then the provider resubmitted the bill and the MCO paid the bill?

A: Yes, the MCO is required to pay the \$10 penalty even if the bill was subsequently paid. This payment was meant to offset the provider's administrative burden when they are required to follow up with the MCO or resubmit a bill.

Q: Does the \$10 penalty apply when the Industrial Commission orders payment of treatment and the MCO denies the bill for lack of prior authorization?

A: Yes, the MCO is responsible for reviewing hearing orders and paying bills as ordered by the Industrial Commission.

Q: Is it appropriate to deny an office visit or consultation for lack of authorization?

A: Office visits and consultations (except for chronic pain programs and psychological treatment) do not require authorization and therefore should not be denied for lack of authorization. The MCO should utilize a more appropriate EOB to accurately describe the reason for denial. The MCO will be required to pay the \$10 penalty payment for any office visit or consultation denied for lack of prior authorization.

Q: The MCO authorized a surgical procedure and then denied a line item related to that surgical procedure for lack of prior authorization? Is the MCO required to pay the \$10 penalty?

A: Yes, MCOs authorize specific procedures or treatment plans, not specific procedure codes. No procedure code related to the authorized treatment should be denied for lack of prior authorization; however, it may be appropriate to deny the line item with another EOB which accurately describes the reason for denial.

G. TREATMENT GUIDELINES

Treatment guidelines are based on treatment types and provide uniformity to the system. The parameters work for the majority of injured workers, but there may be exceptions. For those exceptions, the MCO and physician must work together to find the most appropriate course of treatment for the injured worker.

1. Official Disability Guidelines

The **Official Disability Guidelines** (ODG) are evidence based treatment guidelines that BWC and the MCOs use extensively. MCO staff began using these guidelines in making their treatment authorization decisions effective April 1, 2004. This web based tool is available to staff at BWC and MCOs on their desktops. BWC and MCO staff can easily search and find pertinent information necessary to everyday issues in claims and medical case management. Pursuant to rule 4123-6-16.2 of the Administrative Code and conducting independent reviews of medical disputes pursuant to rule 4123-6-16 of the Administrative Code, the MCO and the bureau shall refer to treatment guidelines adopted by the bureau. The treatment guidelines adopted by BWC are the Official Disability Guidelines (ODG).

H. REIMBURSEMENT GUIDELINES

Medical providers must bill using the ICD-9 code(s) that describes the condition being treated. The provider should always bill the actual diagnosis (es) treated for data integrity and for medical fee bill auditing purposes. Occasionally it becomes necessary for the provider to treat conditions that are related to the allowed conditions in the claim, but for which an ICD-9 code other than the allowed code(s) will be billed. In those cases, based on documentation supplied by the provider, the MCO may approve payment for the bill if a valid ICD-9 code has been used. If the documentation supports use of a valid ICD-9 code that is not allowed in the injured worker's claim and the MCO approves payment, the provider will receive the explanation of benefits code 776: *"Payment is being made for a non-allowed, but related condition."*

Any ICD-9 code listed in the ICD-9-CM code book may be payable within the first 72 hours of an injury if the injured worker's claim is in an allowed status. After the initial 72 hours from date of injury (DOI) BWC/MCOs will not pay invalid codes.

A valid ICD-9 code is one that can be found in the ICD-9-CM book and is not listed in BWC's invalid ICD-9 codes document which can be found on BWC's web site www.ohiobwc.com

BWC will accept valid "V" codes for the principal diagnosis on all bills. The MCO must utilize the 776 EOB override on all V code bills. BWC will not accept "E" codes for the principal diagnosis. E and V codes can be accepted as the secondary diagnosis on both inpatient and outpatient bills.

1. Reimbursement Obligation

Providers must follow the billing and reimbursement guidelines established by BWC and the MCO that is medically managing the claim. Providers must bill their usual charges for services reported based on CPT® and medical documentation.

a) Payment for allowed condition(s) in MCO managed claims

The MCO is responsible for payment of medical services provided in the treatment of work-related allowed compensable conditions. As a State of Ohio government agency, BWC is exempt from reimbursing any sales tax for services and/or items provided to injured workers.

b) Failed or missed appointments

Reimbursement will not be made for failed appointments. Only medical services provided will be reimbursed. Unbundling or fragmenting charges, duplicating or over-itemizing coding, or engaging in any other practice for the sole purpose of inflating bills or reimbursement is strictly prohibited. Knowingly and willingly misrepresenting services provided to Ohio injured workers is strictly prohibited.

c) Settled Claims

Full settlement of the claim occurs when BWC, with the agreement of the employer and injured worker, pays the injured worker a sum of money. This payment will forever resolve all past, present or future issues or liabilities in the claim. A claim may be settled for medical and/or indemnity benefits. Upon receipt of a settlement request, BWC will send a letter to the physician of record. Providers will have 15 days from the date of the letter to submit unpaid medical bills to the MCO. Once the parties agree to the settlement, the claim is placed in a "Settled Pending" status followed by a 30 days hold/pend period.

During the 30 days hold/pend period:

1.) All benefits shall suspend. That means bills can not be paid and adjustments can not be processed in the BWC billing system. Instead, adjustments for payable bills for dates of service prior to the effective settlement date* will be processed after claim is in the "Final Settled" status. Bills for dates of service after the effective settlement date are the responsibility of the injured worker, Providers may not require payment up front from injured workers whose claim is not in a final settlement status.

2.) C9s for dates of service on or after the effective settlement date shall be dismissed.

3.) C9s for retro services (dates of service prior to the effective settlement date) shall be processed within 30 days per MCO contract requirement. Appeals to MCO decision will be subject to ADR.

* Effective settlement date is defined as the first day of the 30 days hold/pend period.

BWC and the MCOs will work continuously to ensure the resolution of all bills before a claim is settled. However, if you find a bill was not paid prior to the settlement nor included in the settlement agreement for reasons beyond your control, contact the BWC claims service specialist who was managing the claim.

2. Medical Necessity

Workers' compensation reimbursements are founded on the concept of medical necessity. Regardless of any exclusions or limitations placed on medical services, all services and supplies must be medically necessary as determined by the MCO.

3. Injured Worker and Other Liabilities

a) Copayment or deductible

Injured workers are not required to contribute a co-payment and do not have to meet any deductibles. BWC-certified providers are required to bill the appropriate MCO for reimbursable covered services and shall not, in accordance with their provider agreement, request payment from the injured worker.

b) Balance billing (BWC Rule 4123-6-07)

Health-care providers must accept the reimbursement from a MCO, BWC, or the self-insuring employer as payment in full. Neither the injured worker nor the employer may be billed for any difference between the provider's charge and the amount allowed by the MCO, BWC or the self-insuring employer. When a provider renders services for conditions that are not covered by workers' compensation, prior to delivering services, the provider must notify the injured worker that the services are not covered by the MCO, BWC or the self-insuring employer. Therefore, the injured worker will be responsible for payment. Also, prior to delivering services, the injured worker must agree to the provision and understand that the services are not payable by workers' compensation. This, however, does not enable providers to balance bill an injured worker for the difference between the BWC or MCO paid amount and the provider's billed amount for a BWC covered service.

c) BWC Non-Certified Provider Services

Unauthorized services provided by a BWC non-certified provider except as indicated in BWC Rule 4123-6-12 are the sole obligation of the injured worker.

4. HPP Billing

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

- American Dental Association (ADA) Dental Form;
- CMS-1500*;
- UB-04*;
- *Service Invoice* (BWC billing form C-19);

*** Important:** To accommodate the reporting of the National Provider Identifier (NPI), the Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500 (08/05). BWC began accepting the new CMS-1500 beginning Jan. 2, 2007. However, as BWC is not a covered entity under HIPAA, it will accept either the 12/90 or the 08/05 version of the CMS-1500

BWC also began accepting the new UB-04 on March 1, 2007. As required by CMS, starting May 23, 2007, hospitals should use the new UB-04 when submitting bills to BWC. Again, as BWC is not a covered entity under HIPAA, the bureau will accept both UB-04 and UB-92.

Send fee bills and medical documentation to the appropriate MCO following the guidelines described in Chapter 4. The preferred method of submitting bills to the proper MCO is an Electronic Transmission in the **ASC X12 837** format. The implementation documentation for the 837 can be found on BWC's website at the following URL: <http://www.ohiobwc.com/p837>.

Each MCO is responsible for adjudicating all bills for claims currently assigned to that MCO. Payment obligations will not be based on a claim's filing date, date of injury, or the bill's date of service. In the event of any transition (i.e. merger/acquisition, open enrollment, auto-assignment due to contract termination) all bills go to the assigned MCO as of the effective date of the transition. If the former MCO receives a bill after the transition date and has enough information to process the bill then it should process it. BWC's bill payment system will support this procedure and process the bill appropriately. It is the assigned MCO's responsibility to contact the former MCO where the claim was previously assigned in cases where there is not sufficient information to process the bill.

b) Bills received by BWC will be processed and reflected on the provider's weekly remittance advice with one of the following explanation of benefits and message:

241 Payment is denied as some procedures on this bill are for MCO-managed services. Refer to your BRM for billing instructions. Contact BWC or the injured worker for information on the MCO assigned to this claim.

242 Payment is denied as some services billed are for dates when services were MCO-managed. Refer to your BRM for billing instructions. Contact BWC or the injured worker for information on the MCO assigned to this claim.

636-693 BWC no longer uses EOB 243. Now, each EOB contains the name of the MCO where the bill needs to be submitted and the toll-free phone number of that MCO.

BWC does not forward misdirected bills from providers to the Managed Care Organizations (MCOs). It is the provider's responsibility to ensure that the appropriate party is billed. BWC pays compensation and benefits based on injured worker eligibility. Bills can be submitted to the MCOs prior to the allowance of injured worker claims; however, payment will not be made until the claim is allowed.

Within seven days of receiving a bill (or within seven days of the claim's allowance), the MCO will either submit it to BWC or, in the event the bill is not payable, will return it to the provider. Within seven days of receiving the bill from the MCO, BWC will approve payment and electronically transfer funds to the MCO. Within seven days of receiving payment from BWC, the MCO will send the payment to the provider.

NOTE: Refer to the appropriate MCO's billing guidelines for information required for billing medical services.

5. MCO's Grievance Conference (OAC 4123-6-044)

In accordance with (OAC 4123-6-044); "The MCO shall review all bills submitted to it for payment by a provider for appropriateness consistent with the MCO's utilization standards and certification requirements. The MCO shall have in place and operating a grievance hearing procedure allowing a provider, employer, or employee to grieve a disputed bill payment."

The BWC rule uses the term "grievance hearings" or "grievance conference" to describe the appeal procedure the MCO must have in place. The MCO's grievance hearing procedures are limited to 1) appeals regarding the recovery of overpayments and 2) bill payment disputes such as denial of payment or reduced payment. Grievance hearings shall not address fee schedule grievances or ADR issues. The grievance hearing gives the disputing party the opportunity to present evidence to support the disagreement and affords due process.

a) Recovery of an Overpayment

Effective March 1, 2000, MCOs implemented a recovery grievance conference that provided due process for the provider and adjudicated disputes regarding recovery of reimbursements in the following manner:

- Provider is notified by MCO an overpayment has been identified and adjustment will be processed to recover the funds.
- The provider may appeal the MCO's decision in writing within 45 calendar days.
- The MCO's recovery grievance conference will allow a provider to grieve the disputed bill payment. The MCO will schedule a recovery grievance conference within 14 days upon receipt of the provider's written appeal. The MCO must notify the provider of the date, time, location of conference, the issue and a statement of fact. The conference will be limited to the stated issue in the letter.
- Upon conclusion of the recovery grievance conference, the MCO will issue a decision, in writing, to the provider within 7 days.
- The provider may appeal the MCO's recovery grievance conference decision to BWC's Administrator's designee. The provider may appeal the MCO's recovery grievance conference decision to BWC Medical Bill Payment Recovery, within 14 days after receiving the decision of the MCO, via email to: Sharon.Kaepfner@bwc.state.oh.us
- The Administrator's designee will review and make the final determination within 14 days.

If an MCO determines an overpayment should be recovered because the service did not meet Miller criteria (medically necessary and appropriate, related to the treatment of the industrial injury and the costs medically reasonable), then the MCO may initiate recovery. However, if the provider appeals that recovery, then the recovery process shall stop and the appeal submitted by the provider should be considered as an ADR appeal. The receipt date of the provider's appeal by the MCO will be day one of the ADR process. The MCO must follow the criteria for appeals received in ADR, for example, the appeal must be signed.

b) Medical Billing Dispute

A medical billing dispute exists when a provider is not satisfied with the amount of payment and explanation of benefits received from an MCO, but does not include dispute of BWC's fee schedule rates. The provider should submit a request for reconsideration to the MCO to begin the bill grievance dispute. The MCO shall review the bill, and determine if the provider is correct and an adjustment is appropriate or if the MCO's initial payment was correct. If the MCO's review determines that the issue is still not resolved, they should proceed to the bill grievance conference process. The MCO must provide the reason and the rationale for the initial medical bill payment decision. Examples of the rationale may include BWC's coverage provisions or coding conventions. The MCO's procedure may be a review by a nurse or supervisor. Once the review is completed, the decision on the review is communicated to the provider in writing.

i. Procedures for Handling Billing Disputes

When a provider disagrees with the denial of payment or a reduced payment a medical billing dispute exists and the following steps shall be taken:

- 1st) The Provider contacts the MCO to inquire about the reimbursed amount or denial of a medical bill via; e-mail, fax, phone, mail. It may be necessary to submit the inquiry, along with supporting documentation, in writing to the MCO. The provider and the MCO should keep detailed notes for his/her records, including the name and phone number of the person to whom he/she spoke, fax confirmations, etc.
- 2nd) It may be necessary for the provider to request to speak to an MCO supervisor to resolve the issue or to escalate the issue to a grievance conference. Most provider billing inquiries can be handled by the MCO on the phone.
- 3rd) The MCO shall acknowledge the inquiry (e-mail, fax, phone, mail) within four (4) calendar days of receipt, and shall resolve or initiate resolution of the inquiry within seven (7) calendar days of receipt per the MCO contract.
- 4th) If the issue is not resolved with the MCO, the provider should be instructed on how to initiate a medical bill grievance conference with the MCO. The conference may occur in person or via telephone, and shall occur within seven (7) calendar days from the request for the conference. MCO's must document details of all grievances conferences and the outcome.
- 5th) The MCO shall issue a decision, in writing, within seven (7) calendar days from the date of the conference. The MCO's determination letter shall be imaged into the injured workers claim. Imaging documents in the claim will make it possible for BWC to research any subsequent provider complaint that may come into the Provider Contact Center and will provide documentation that the medical bill grievance was addressed.
- 6th) Required Elements for "Bill Dispute Grievance Conference Decision." letter.
 - i. Identification of the specific documentation reviewed at the conference such as the office notes or other documentation;
 - ii. Date, time, place and persons who participated in the conference (MCO and Provider) and the method used for the conference (phone, face to face or email).
- 7th) If the provider does not agree with the MCO's decision, the provider may contact BWC's Provider Contact Center at 1-800-ohiobwc, option 0-3-0 or via email at feedback.medical@bwc.state.oh.us to ask for BWC's assistance in resolving the billing dispute. It is the MCO's responsibility to inform and provide this information to the provider. The BWC Provider Contact Center will ask the provider to document the complaint, which will be researched and tracked. It may be necessary

- for the BWC Provider Contact Center to consult other BWC departments such as, (but not limited to) Medical Policy, Voc Rehab Policy, Medical Director or Legal or for input in making a determination.
- 8th) BWC's provider contact center will refer the provider back to the MCO if the grievance conference has not been held. If the MCO did not conduct a medical bill grievance conference or the documentation has not been imaged into the claim, the provider's request for a medical bill dispute shall be referred by BWC back to the MCO. BWC will educate the provider on the process and the steps that are established to handle such inquires/requests/grievances.
 - 9th) BWC's Provider Contact Center will coordinate a written response to the provider and the MCO and send the response to the IW's claim file. After BWC's determination is rendered, no additional levels of review will be considered.
 - 10th) If at any point during the inquiry/dispute process the MCO or BWC determines that a payment correction is needed, the MCO shall correct or submit an adjustment to BWC within fourteen (14) calendar days of determination. If BWC has reviewed and made a determination to instruct the MCO to pay the provider, the MCO will notify the Provider Contact Center when the payment is released.

6) Medical Overpayment Recovery Policy and Procedure

a) Policy

- i. The recovery of provider payment from providers shall be initiated where payment was made to providers in conflict of law, rule, BWC provider agreement or policy.
- ii. Provider overpayment recovery and MCO overpayment recovery is subject to a time limitation as follows:

The provider or MCO must be notified of the overpayment within two (2) years of the BWC bill system process date. If the provider or MCO is not notified of the recovery demand within such two (2) year time period, no recovery shall be ordered. This two (2) year limitation does not apply to payments where the provider or MCO was aware of the overpayment or became aware within two (2) years of receipt of payment.
- iii. The provider may request review of the recovery decision by the MCO pursuant to the Bill Grievance process. Subsequent review may be requested of BWC Medical Services Division Chief's designee and, upon request, final review by the Administrator's designee.
- iv. Provider payments made as a result of MCO or BWC error and where the provider rendered services and sought reimbursement in good faith shall not be recovered from the provider. BWC shall initiate recovery from the MCO of any overpayment made as a result of MCO error unless overpayment is recovered from the provider. An MCO payment error exists when payment is made to a provider which is inconsistent with current health care provider payment standards and industry practices or in conflict with law, rule, or the MCO contract. The MCO may request review of the recovery decision by BWC Medical Services Division Chief's designee and, upon request, final review by the Administrator's designee.

b) Procedure

- i. The MCO is not responsible for re-payment, and shall not recover from the provider, overpayments resulting from the disallowance of a previously allowed claim or condition. If the MCO authorizes services in error, the MCO shall inform the provider immediately by phone and in writing that service was authorized in error and that the provider will not be paid for any service rendered after the date of notification. The MCO may not withdraw authorization for services that were already authorized and rendered. The MCO shall be responsible for payment of all service rendered prior to and on the day of the notification.

MCOs shall initiate recovery of overpayments only after all appeal periods have been exhausted. All paper correspondence shall be mailed to the provider's correspondence address.

- ii. If a party to the claim files an appeal for services through the ADR process or with the Industrial Commission regarding treatment which has already been rendered, the MCO shall take the following steps:
 - a. Within two (2) business days of learning of the appeal, the MCO shall inform the provider by phone and in writing that services are now under appeal and may be subject to non-payment.
 - b. Bills for service that have already been paid in compliance with Ohio BWC laws and rules shall remain paid. Bills for service that have not been paid shall be pended until appeals through the IC SHO level are exhausted.
 - c. If the final decision from the ADR process or the Industrial Commission allows provider reimbursement for the treatment, bills shall be paid. If the final decision denies the provider reimbursement and the overpayment was due to MCO error, the MCO shall be responsible for reimbursement to the provider or BWC from the MCO administrative account for services authorized and rendered on or before the date the MCO notified the provider of the pending appeal. If no MCO error occurred, pended bills will be denied.
- c) Discovery of an Overpayment and Initial Notification
 - i. Within fourteen (14) calendar days of discovery and verification of provider overpayment, the MCO shall send written notice to the provider informing the provider of the overpayment and the requirement for provider repayment. The notice shall contain a complete and specific rationale for the repayment, including identification of the specific documents supporting the rationale. The notice must include instructions regarding the provider grievance conference process and the forty-five (45) calendar day time period for provider objection.
 - ii. Within fourteen (14) calendar days of the date of original MCO overpayment notification to the provider, the MCO shall contact provider by means other than letter to verify the notification letter was received and discuss whether the provider disputes overpayment.
 - iii. If the MCO's attempts to contact the provider are unsuccessful, an overpayment notification letter shall be sent via certified mail. If the certified letter is returned to the MCO, the MCO shall attempt to contact the provider during the next fourteen (14) calendar days to continue recovery efforts.
 - iv. In the event the provider has ceased operations, the MCO recovery effort will stop and recovery will be referred to Medical Billing and Adjustments-Recovery (MB&A Recovery) via email at MedicalBillPaymentRecovery@bwc.state.oh.us.
- d) Provider agrees with the initial overpayment notification from the MCO
 - i. If the provider agrees with the MCO determination of provider overpayment, the MCO and provider shall further agree on the method and time period for repayment (e.g. provider submitting check or MCO taking payment from future reimbursement). In no case, shall the time period for repayment extend beyond forty-five (45) calendar days from the date of the agreement.

After the overpayment is collected, the MCO shall send the request for adjustment with supporting documentation to MB&A via email at HPP.Adjustments@bwc.state.oh.us or fax to 614-752-6555 within fourteen (14) calendar days. Each state holiday falling within the fourteen (14) calendar day period shall extend the deadline by one (1) calendar day.
 - ii. If payment of requested recovery amount is not received within forty-five (45) calendar days of date of initial agreement, MCO shall contact and send a follow-up letter to provider restating the terms of repayment.
- e) Before a bill adjustment is submitted to BWC by the MCO, the overpayment must be recovered by the MCO and deposited into the MCO's provider account.

f) Recovery from Provider's future payments

The MCO may recover provider overpayment from provider's future payments. If recovery of funds is designated from such future payments, the repayment can be taken from any provider location operating under the same Tax ID number as the original provider. The MCO shall inform the provider in writing that recovery will offset future payments due to overpayment and must provide the set-off amount and reference all prior MCO recovery efforts in this case. A list of all the provider locations from which the recovered amount will be deducted shall be specified in this notice. The MCO must identify the amounts recovered on the provider remit when the overpayment is recovered from future payments.

After the overpayment is collected, the MCO shall send the request for adjustment with supporting documentation to MB&A via email at HPP.Adjustments@bwc.state.oh.us or fax to 614-752-6555 within fourteen (14) calendar days. Each state holiday falling within the fourteen (14) calendar day period shall extend the deadline by one (1) calendar day.

g) No response from provider to MCO request for overpayment recovery

i. If provider does not respond to the MCO's request for recovery within ninety (90) calendar days of date of notification letter sent via certified mail, or subsequent follow-up letter as referenced in section D.2, MCO shall notify MB&A Recovery and submit supporting documentation via e-mail, and track and document the information accordingly (see section I of this procedure). The information must include the following:

- a. Copy of original overpayment recovery request
- b. Copy of 2nd overpayment recovery request sent via certified mail
- c. Copy of certified mail receipt or verification of delivery
- d. Documentation of all recovery efforts

ii. Documentation review by MB&A Recovery

- a. Upon receipt of complete overpayment information, MB&A Recovery will research, review, and determine the appropriateness of recovery. If the MCO information is incomplete, MB&A Recovery will notify the MCO. The MCO must provide the complete information within seven (7) calendar days of notification.
- b. If BWC determines that recovery shall not be made, MB&A Recovery will notify MCO. The MCO must then notify the provider of the decision.
- c. If MB&A Recovery determines that recovery shall be made, MB&A Recovery will send provider a demand for recovery. The demand letter shall provide notification that the provider has forty-five (45) calendar days from date of letter to either reimburse BWC for the overpayment or dispute overpayment determination. The letter will also include details supporting the overpayment determination, instructions for submitting payment to BWC, consequences for non-payment, and provider appeal remedies.

I. Provider Disputes MCO Overpayment Determination

- i. If the provider does not agree with the MCO overpayment determination, the provider may dispute the decision. Provider notification of appeal must be made to the MCO within forty-five (45) calendar days from the date of receipt of the MCO notification of overpayment. Provider appeal must be in writing. If the provider does not appeal the MCO's determination, the MCO shall notify MB&A Recovery as detailed in section G.
- ii. If the provider timely appeals the MCO's determination, the MCO shall schedule a grievance conference in accordance with the "MCO's Grievance Hearings with Providers Policy" as set forth in the MCO Policy Reference Guide (MCOPRG).
- iii. Upon conclusion of the grievance conference, the MCO shall issue a written decision to the provider within seven (7) calendar days. The letter shall contain at least the following:

- a. The date, time, place and participants in the conference,
- b. The MCO's rationale for the decision,
- c. Address for submitting reimbursement to MCO,
- d. Notification that the provider may appeal the MCO's grievance conference decision to BWC management within forty-five (45) calendar days of the date of the grievance conference decision letter by sending their dispute in writing to:

E-mail box: medicalbillpaymentrecovery@bwc.state.oh.us or

Fax: (614) 621-1059 or

Mail: MB&A Recovery
30 W. Spring St. L20
Columbus, OH 43215

- e. If the provider does not appeal the grievance conference decision within forty-five (45) calendar days, the MCO shall notify MB&A Recovery as detailed in section G.
- iv. If the provider disputes the MCO's Grievance Conference decision and submits a timely appeal to MB&A Recovery, the recovery dispute will be staffed by the MB&A Manager and the Medical Services Division Chief's designee. They shall determine whether recovery is appropriate and issue their written decision to the provider within forty-five (45) calendar days of receipt of the appeal. The provider will be notified of the opportunity to appeal their decision to the Administrator's designee within forty-five (45) calendar days of the date of the notification of the decision through the any of the methods identified in section H.3.c.
- v. If the provider appeals the BWC management decision:

The Administrator's designee will review and make the final determination and notify the provider of the final decision within forty-five (45) calendar days of receipt of the appeal. The notification shall be sent to provider via certified mail with copies sent electronically to the MCO.

J. Tracking and Documentation:

- i. Due to the potential of recovery for multiple claims for the same provider, provider recovery information shall not be imaged into the IW's claim nor notes be placed into the IW's claim record. MCOs shall maintain a distinct and separate file for each overpayment recovery case. The file shall contain all relevant documents and communications. Upon request by BWC, the MCO shall provide a copy of the requested recovery file to BWC within seven (7) calendar days.
- ii. MCOs shall identify and track the status of recovery adjustments.
- iii. MB&A Recovery will track all recovery actions through to resolution.

K. Recovery of overpayments due to MCO error:

- i. Upon BWC verification of an MCO error in treatment authorization or bill payment, MB&A Recovery shall notify the MCO via e-mail.
- ii. If the MCO agrees with the determination by MB&A Recovery, the MCO shall make payment from the MCO's administrative account to either the provider or to BWC, as directed by BWC, within fourteen (14) calendar days of the BWC notification.
- iii. If the MCO does not agree with the determination by MB&A Recovery, the MCO may dispute the determination by responding to the e-mail from MB&A Recovery within fourteen (14) calendar days of receipt.
- iv. The dispute will be considered by MB&A Recovery and staffed with other BWC subject matter experts as needed.
- v. The Medical Services Division Chief's designee (designee) shall review the MCO appeal and notify the MCO of the decision via email within forty-five (45) calendar days of receipt of the appeal.

- vi. If the MCO agrees with the decision by the designee, the MCO shall make payment from the MCO's administrative account to either the provider or to BWC, as directed by BWC, within fourteen (14) calendar days of the designee notification.
- vii. If the MCO does not agree with the decision by the designee, the MCO may appeal the decision to Administrator's Designee by responding within fourteen (14) calendar days by email at medicalbillpaymentrecovery@bwc.state.oh.us.
- viii. The Administrator's Designee shall review the appeal, and inform the MCO of the decision within fourteen (14) calendar days of receipt of the appeal via email, and copy the Director, Compliance/Performance Monitoring and the Director, MCO Business & Reporting. MCO must submit documentation supporting completion to BWC Compliance/Performance Monitoring.

7. Retrospective Bill Review of Inpatient Hospital Bills

MCOs will perform retrospective reviews on all inpatient hospital bills which were 1) paid the previous month 2) paid to hospitals with physical locations in Ohio or in states contiguous to Ohio (Indiana, Kentucky, Michigan, Pennsylvania or West Virginia) and 3) were not paid at a DRG rate. (Note: Bills paid at the DRG rate contain EOB 302).

High level bill audits will be conducted for inpatient bills with paid amounts between \$20,000 and \$50,000, using core medical documentation and itemized charges. For high level bill audits, the MCO shall ensure the following documents are imaged or shall request the missing documents from the hospital and ensure they are imaged upon receipt:

- Admission history & physical;
- Emergency department report if patient was admitted through E.R.;
- Operative report if bill contains O.R. charges & patient had surgery;
- Discharge summary if admission was \geq 48 hours in duration;
- Discharge note if admission was < 48 hours in duration

In addition, the MCO shall request the itemized charges for the admission. Itemized charges are not to be routinely forwarded to BWC for imaging

Detailed bill audits will be conducted for inpatient bills with paid amounts greater than \$50,000. The MCOs should review the entire medical record and itemized charges while conducting the detailed audit. For detailed bill audits, the MCO will need to review the entire medical record as well as the itemized charges.

If the entire medical record is not imaged in the repository, the MCO must request the remaining documents from the hospital by contacting its hospital contact to discuss the documents needed and the hospital's preferred method of providing documents (hospital onsite review, fax or mail). The MCO must comply with the hospital's preferred method of providing the information. The MCO shall utilize its existing contact at each hospital when arranging or requesting record reviews unless the hospital identifies another contact.

To document the request for information, the MCO shall create an *MCO Request for Medical Documentation Fax*. The fax shall first list all of the related documents already imaged in the repository, itemized by document name and date of the report. This is so that the hospital does not send duplicate copies of documentation already imaged. The fax shall also briefly document the conversation with the hospital contact, including the name, department, telephone number and fax number of the hospital contact; the hospital's preferred method of submission; and the MCO contact name, telephone number, fax number and/or address where the information should be sent. The MCO shall fax the *MCO Request for Medical Documentation Fax* to the hospital.

Hospitals have 21 calendar days from receipt of the MCO's request to provide the records requested by the MCO on the *MCO Request for Medical Documentation Fax*.

If the hospital does not supply the requested information during this timeframe, the MCO shall contact the hospital contact person, within 7 calendar days after the due date, to inquire as to why the MCO has not received the documentation. The MCO shall have a verbal discussion with the contact or a supervisor in the same department and the MCO shall document the hospital's response in its *MCO Inpatient Hospital Retrospective Review Report*.

The MCO is not required send the entire medical record for imaging at BWC; however, the MCO shall maintain the records as part of the audit file. BWC may request copies of the records for quality reviews. If the review is conducted on site at the hospital, then the MCO shall either make copies of the documents that result in findings or at least make a specific note of the document name, page number and other identifying information.

The MCO will also perform retrospective reviews on selected DRG-priced bills after BWC has additional data from DRG-priced bills.

I. REQUIRED REPORTS (BWC Rule 4123-6-20)

Providers undertaking treatment of an injured worker are required to submit initial and subsequent reports to the MCO. The Ohio Administrative Code authorizes MCOs to medically manage workers' compensation claims on the behalf of BWC. Therefore, all laws, rules, and policies concerning submission of medical documents to BWC also pertain to the MCOs. In addition, as part of becoming BWC-certified, providers are contractually obligated to provide medical documents to the MCOs. By law, filing a workers' compensation claim authorizes BWC and the MCOs to receive medical documents to be used in investigating and determining the claim. Consequently, submitting medical to either BWC or a MCO does not require a release signed by the injured worker.

The provider shall forward medical documentation supporting treatment for both medical-only and lost-time claims to the appropriate MCO. These documents should list the injured worker's claim number in the top right hand corner of the report(s). To reduce the number of duplicate requests from BWC and MCOs to providers for medical documentation and to coordinate faxes coming from providers so that MCO and BWC documents are synchronized, BWC developed a Medical Repository system. Full activation of the Medical Repository began on July 31, 2000. At the end of this section is a list of BWC Forms that are indexed by BWC. MCOs are required to review and act on (approve or deny) the C-9 before forwarding to BWC.

The provider also assumes the obligation to provide and complete all bureau forms required by the MCO. A medical provider may not charge the injured worker, employer, or their representatives, or the MCO, BWC, IC, or a self-insuring employer for the costs of completing the required forms or submitting necessary documentation.

However, effective Jan. 1, 2003, per **4123-6-20.1**, a provider may charge a fee for copies of medical records if the provider had previously filed copies of medical records with the bureau or MCO, or with the SI employer in SI claims, and the bureau had provided access to such medical records electronically. The provider's fee shall be based on the actual cost of furnishing such copies, not to exceed twenty-five cents per page. In addition, providers may charge BWC \$.05 per page for copying medical records in cases where BWC's Special Investigations Department requests records specifically for auditing purposes after having unsuccessfully attempted to obtain the information through the Medical Repository.

Providers must supply medical documentation to MCOs at the time of treatment request. If medical data to support treatment necessity is not included within the C-9 form, such evidence must accompany the C-9 submission as an attachment or obtained via the C-9-A process. The provider must return the form C-9-A and any additional supporting documentation to the MCO within 10 business days.

Equally important to providing requested documentation within ten business days is submitting initial medical reports to the MCO when the First Report of Injury (FROI) is submitted, that is, within 24 hours or one business day of the initial treatment or initial visit.

Providing medical reports (i.e., Emergency Room Report, Physician Statement, Specialist Report, Operative Report, Diagnostic Report, X-ray, MRI, CAT Scan, Accident Report, Physician’s Office Progress Notes) to the MCO within 24 hours has a number of advantages, including assisting BWC in expediting the processing of the claim. The MCO is responsible for gathering and providing medical evidence to support the initial decision in a timely manner. In most cases, the sooner the MCO sends initial medical documentation to the customer care team, the sooner the claim can be allowed.

Timely submission of medical reports also minimizes the possibility that claim authorizations (e.g., for compensation awards, medical benefits, treatment authorizations, etc.) will be delayed. To facilitate claim authorizations, it is important to provide MCOs with accurate information, including the exact ICD-9 codes for which the injured worker is being treated.

In some instances it is necessary for the provider to update the MCO throughout the delivery of care, during the treatment plan. Such instances include IW non-compliance with treatment plan or missed appointments, negative/lack of response to treatment, changes in outcome or goals of treatment, diagnostic testing results, specialist/consultation results, hospital discharge summaries, emergency room reports, operative reports or other situations that indicate a need to alter a treatment plan/plan of care or concurrently monitor the patient's care. In such situations, the provider must submit the update to the MCO within five days of delivery of service or request by MCO. Within five days following completion of an approved treatment plan, or discontinuance of plan, the provider is required to forward progress notes to the MCO.

1. Medical documentation and bill payment

The MCOs are required to maintain integrated case management and bill payment system so they shall not regularly require providers to attach medical documentation to bills for previously approved treatment. MCOs shall not deny payment for previously approved treatment because medical documentation was not attached to a provider invoice, unless such documentation is necessary to price the service (e.g. unclassified/NOC procedures). However, providers must submit medical documentation in cases where services billed do not correspond to treatment that was requested and approved or if the MCO needs information to show what services were provided. For example, for a period not to exceed 60 days following the date of injury, physicians have presumptive approval for providing E/M and consultation services when treating soft tissue and musculoskeletal injuries for allowed conditions in allowed claims. Although the E/M service may be rendered without prior authorization, documentation must be submitted to support the components of the E/M service. To justify payment for the service reported, the documentation must be specific in describing the service that was provided and legible. If the medical record is determined to be illegible by at least two reviewers, the MCO may deny the line item with **EOB 472: Payment is denied as the medical documentation provided is not legible. Payment for these services will be reconsidered once legible documentation is submitted.**

The MCO must maintain documentation of who determined the medical record to be illegible.

Forms indexed in BWC’s Medical Repository

Document Type	Description	Rationale
C1	For Payment of Comp or Med Benefits	FROI replaced this form, but a few still come in.
C140	Wage Loss Application	Includes medical restrictions outlined by physician.
C1A	Attending Physician’s Report	See C1.
C2	App for Death Benefits	See C1.
C3	App for Medical Benefits Only	See C1.
C5	Death Benefits	See C1.
C50	SI Claim Application	See C1.
C6	Accrued Compensation	See C1.
C9	Physician's Request for Medical Service	Imaged after responded to by MCO.

	or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease	
C63	Additional Information Request	A V3 letter asking for additional medical information.
C84	Physician's Supplemental Report	This is a statement of medical disability.
C85A	App to Reactivate Claim	Form has medical information attached.
C86	Motion	This is a request for additional medical conditions.
C92	Determination of % of PP Disability	Determination of % of medical disability –medical information is attached.
C92A	Increase in % of PP Disability	Determination of % of medical disability –medical information is attached.
C92EXA	C92/C92A Exams	Determination of % of medical disability –medical information is attached.
DELETED	Deleted Document	To be used by indexers for documents not included in this list.
FROI	First Report of Injury	Primary injury/benefit claim form.
MED	Medical Documents	Medical information that does not fit in the stated categories including Independent Medical Examinations and peer reviews.
MEDCO14	Physician's Report of Work Ability	Form used by physicians for work restriction
MEDCO21	Physician Review	Forms used by physicians for medical assessment.
OD1	Occupational Disease APP	See C1.
OD122	SI Occupational Disease APP	See C1.
REHAB	Rehabilitation Notes	Contains medical documents – supports rehab plan.

NOTE: Medical documentation faxed to self-insuring employers is not captured in the Medical Repository.

2. HIPAA

The final HIPAA privacy and electronic transactions regulations do not directly apply to BWC and the MCOs. BWC and the MCOs (and self-insuring employers' workers' compensation programs) do not qualify as "covered entities" under the HIPAA regulations, since they do not meet the definitions of a "health plan", "health care clearinghouse" or "health care provider" as defined in the rules. In fact, workers' compensation programs are specifically *excluded* from the definition of a "health plan" under the HIPAA regulations.

Under the final HIPAA privacy and electronic transactions regulations, covered entities, including providers, may have "business associates" who perform some tasks or functions for or on behalf of the covered entity (e.g., legal, accounting, etc.) that involve the use or disclosure of health information. In general, covered entities must enter into "business associate agreements" with these "business associates" in which the "business associate" agrees to safeguard the privacy of the information.

BWC and its MCOs are not "business associates" of providers, since BWC and the MCOs generally do not perform any functions "for or on behalf of" providers. This applies to both treating providers and to BWC's Disability Evaluator Panel (DEP) providers.

However, an administrative agent of a DEP provider might be considered a "business associate" of the DEP provider (but not of BWC) under HIPAA. It is the responsibility of the DEP provider to ensure that his/her contract with the administrative agent contains the necessary HIPAA privacy safeguards; therefore, DEP providers should consult their own legal counsel and/or HIPAA consultants as to whether their administrative agent contracts are (or need to be) HIPAA compliant.

Under HIPAA, protected health information may be released by providers in a workers' compensation claim (1) for treatment, payment or health care operations purposes; (2) under a HIPAA exemption for the release of information in compliance with state workers' compensation laws; (3) under a valid HIPAA authorization; and (4) under a valid administrative or judicial order, subpoena, discovery, or other lawful process which meets HIPAA requirements.

Under the final HIPAA privacy regulations, covered entities may use and disclose protected health information for treatment, payment, and health care operations purposes. "Payment" and "Treatment" are defined fairly broadly under HIPAA. Therefore, to the extent that a provider is currently treating a workers' compensation claimant, and the provider is

- requesting authorization for treatment,
 - requesting payment for treatment already rendered, or
 - providing information with regard to the allowance of a workers' compensation claim, or the allowance of an additional condition in an existing claim,
- the provider should be able to release information to BWC or an MCO (or to a self-insuring employer or Qualified Health Plan [QHP] in a SI claim).

If a treating provider is being asked to disclose protected health information to any of the parties listed in **O.A.C. 4123-6-20(D)** (BWC, injured worker, employer, MCO, QHP, or self-insuring employer) for a purpose other than for treatment, payment, or health care operations (e.g., the initial investigation of a claim, the completion of a C-84 form for the worker to receive temporary total compensation, etc.), and the provider is persuaded that the requested documentation "**relat[es] causally or historically to physical or mental injuries relevant to the claim**", is "**required by the bureau, MCO, QHP, or self-insuring employer**", and is "**necessary for the claimant to obtain medical services, benefits or compensation**," the provider may disclose the information.

J. Request for Medical Services

Requests for medical services that require prior authorization must be submitted by the physician of record (POR) or treating physician to the appropriate MCO prior to initiating any non-emergency treatment. The preferred method of submission is the BWC Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9) form; however, any other physician generated document may be used, provided that the substitute document contains, at a minimum, the data elements on the C-9 form. PORs should identify additional conditions to be allowed in the claims on the C-9 form and should spell out additional conditions with supporting documentation.

In order to assist the MCO in effectively medically managing the injured worker's claim, it is important for the POR/treating physician to comply with the request for medical services guidelines, including presumptive approval and standardized prior authorization policies and procedures.

The following guidelines were implemented to help the MCO consider authorization and expedite the payment of medical bills:

- The MCO must respond to the physician within three business days with a decision regarding the proposed treatment request. **Note:** For services provided under the Presumptive Authorization Guidelines, the MCO is required to notify the provider within three business days acknowledging receipt of the C-9 and that a review was completed to ensure that services being rendered are medically necessary for the claim allowance.
- The MCO must return fax of the authorized, denied or pended medical services request back to the physician within the required three business days. If faxing is not feasible, the MCO is required to call the physician in order to communicate the decision and follow-up in writing via mail. The MCO shall assign a tracking number to each treatment reimbursement decision made by the MCO and publish that tracking number on all copies of the decision distributed by the MCO.
- If the MCO is unable to make a decision within three business days due to the need for additional information, the MCO will send a request for Additional Medical Documentation C-9 form (C-9-A) to

the provider. The provider must return the form C-9-A and any additional supporting documentation to the MCO within ten business days. The MCO has five business days from the date additional information is received to make a subsequent decision. The MCO must render a decision to allow or deny the medical services request if the physician does not provide the MCO with any requested documentation within ten business days for all active claims. The physician must be notified by fax or phone of the subsequent decision. **Note:** for inactive claims the MCO may dismiss the C-9 (with no ADR appeal rights) after the 10 days if the C-9-A is not returned

- If the MCO is unable to make a decision within three business days due to the need for a medical review and the physician is notified, the medical review must take place and a decision granted within the five business day period. Again, the physician must be notified by fax or phone of the subsequent decision.

A medical services request will be considered approved and the provider may initiate treatments when all of these criteria are met:

- The MCO fails to communicate a decision to the physician within three business days of receipt of an original medical services request or five business days if the request was pending;
- The physician has documented the medical services request completely and correctly on a C-9 or other acceptable document;
- The physician has proof of submission to the appropriate MCO;
- Medical services are for the allowed conditions;
- The claim is in a payable status.

In instances when a C-9 is not responded to within three business days and the provider initiates treatment, the MCO will provide concurrent and retrospective review of that treatment.

If it is found before, after or during delivery, that any treatment, approved or not approved within three business days, is not medically indicated or necessary, not producing the desired outcomes, or patient is not responding, the MCO will notify the parties of decision to discontinue payment of said treatment. Only charges for treatments already rendered will be paid. If the provider, IW or employer wishes to dispute the decision, they may do so via the ADR process.

The MCO shall authorize, deny, or pend a provider's proposed *retroactive* treatment request (submitted on a C-9 or other appropriate form) within **thirty (30) calendar days** from the MCO's Request for Medical Services request Receipt Date.

When processing a C-9, or other acceptable document, that includes retroactive and future treatment request(s) the MCO must follow the normal 3 business day time frame requirements for each treatment request, including the ability to pend for additional medical documentation/review if necessary.

NOTE: Self-insuring employers are required to approve or deny the C-9, or any other physician generated document that contains the data elements on the C-9 form, within ten days of receipt of the request. If the self-insuring employer fails to respond to the request, the authorization for treatment will be granted. Self-insuring employers are not required to follow BWC's Presumptive Approval or Standard prior authorization tables.

Information used to support requests and authorization for mental health services can also be submitted on the C-9 form.

Important: Ohio law protects the confidentiality of the mental health providers' progress notes; therefore, MCOs cannot request copies of this document. Requests for copies of the progress notes with the deletion of any non-claim related information is also prohibited. However, a detailed summary of the notes can be requested, which can be used to support the C-9.

Authorizations are to be granted for either a specific number of sessions or period of time. **MCOs are prohibited from authorizing “continuous” or “indefinite” mental health treatment.** Once the authorized limits have been reached, a new C-9, accompanied by a detailed summary, must be resubmitted to the MCO for re-evaluation of the treatment.

1. Presumptive Approval

For a period not to exceed 60 days following the date of injury physicians have presumptive approval for providing the following services when treating soft tissue and musculoskeletal injuries for allowed conditions in allowed claims:

- A maximum of 10 physical medicine visits per injured worker claim which may include any combination of osteopathic manipulative treatment, chiropractic manipulative treatment, and physical medicine and rehabilitation services performed by a provider whose scope of practice includes these procedures, including, but not limited to, doctor of chiropractic, doctor of osteopathic medicine, doctor of allopathic medicine (MD), physical therapist, occupational therapist, athletic trainer, or massage therapist;
- Diagnostic studies, including x-rays, CAT scans, MRI scans and EMG/NCV;
- Up to three soft tissue or joint injections involving the joints of the extremities (shoulder including acromioclavicular, elbow, wrist, finger, hip, knee, ankle and foot including toes) and up to three trigger point injections. Injections of the paraspinal region, including epidural injections, facet injections, and sacroiliac injections are not included in the presumptive approval guidelines;
- E/M services and consultation services.

The following criteria must be met prior to initiating any or all of the aforementioned services:

- The provider must file the First Report of Injury (FROI) with the MCO.
- The provider must complete and file the C-9, with documentation, to the MCO.
- The MCO will notify the provider within three business days acknowledging receipt of the C-9 and that a review was completed to ensure that services being rendered are medically necessary for the claim allowance. **NOTE: The MCO shall not deny reimbursement for presumptive approval services solely on the grounds that the provider did not file the C-9 prior to delivering the services. The MCO will contact the provider and explain that the C-9 is necessary in order that a review can be completed to ensure that services rendered were medically necessary for the claim allowance.**
- When the claim or condition for which treatment is being requested is not yet in an allowed status, the MCO may use the disclaimer language when notifying the provider (within three business days) that the MCO received the C-9 and a review was completed to ensure that services being rendered are medically necessary for the claim allowance.
- The provider shall notify the MCO within 24 hours of treatment if the injured worker will be off work for more than 2 calendar days

2. Standardized Prior Authorization Table

Important: Services listed in the standardized prior authorization table below and not indicated as exceptions still require prior authorization. Providers must submit a C-9 to indicate services to be provided through formal authorization.

Standardized Prior Authorization Table

Service	Requirement
Physical medicine services, including chiropractic/osteopathic manipulative treatment and acupuncture	PA
Consultations - Psychological/chronic pain program only	PA
Chronic pain program including pre-admission evaluation and treatment	PA
Dental	PA
Diagnostic Testing	PA (except basic x-rays and urine screens as noted in Chap 3 under Chronic pain which do not require PA)
DME	PA if the purchase price >\$250.00 PA for all DME rental
Home/Auto/Van modifications	PA REQUIRED FROM BWC
Home Health Agency services	PA
All inpatient and outpatient hospital services and ambulatory surgery center services	PA, except for emergency * services. Emergency inpatient hospitalization may be through the emergency department or by direct admission.
In-home physician services	PA after first visit
Injections	PA
Non-emergency ambulance services	PA
Orthotic and prosthetic devices and/or repair	PA >\$250.00
Skilled Nursing Facility (SNF)/Extended Care Facility (ECF)	PA
TENS and NMES units	PA, both rental and purchase
TENS and NMES monthly supplies	PA for a maximum of six months per authorization
Vision /hearing services	PA>\$100.00
Vocational rehabilitation - All vocational rehabilitation services, in or out of plan	PA Note: PA not required for transitional work on-site therapy services provided by an OT or PT that fall under the presumptive authorization guidelines Occupational Rehabilitation (work hardening) requires CARF accreditation

* Per Ohio Administrative Code 4123-6-01 (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.

3. Request for Medical Services Disclaimer

Disclaimers may only be used on a C-9, or any other physician generated request for treatment, when the claim or the condition for which the treatment is being requested is not yet in an allowed status. Disclaimers shall not be used when authorizing treatment for allowed claims and conditions that are within the statute of limitations.

MCOs may use the following disclaimer language only when responding to a C-9 or any other physician generated request for treatment:

"This medical payment authorization is based upon a claim or additional condition that is currently being adjudicated by BWC/IC as of the date of the MCO's signature. If the claim or additional condition is ultimately disallowed, the services /supplies to which this medical payment authorization applies may not be covered by BWC and may be the responsibility of the injured worker."

4. Provider Compliance Education Letter

Per Ohio Administrative Code 4123-6-02.3 (D)(6), BWC-certified providers have agreed to *"practice in a managed care environment and adhere to MCO and bureau administrative procedures, and procedures concerning provider outcome measurement data, peer review, quality assurance, utilization review, billing procedures and dispute resolution, subject to rule 4123-6-16 of the Administrative Code."*

Beginning April 1, 2005, MCOs sent a standardized ADR provider compliance education letter to physicians each time a C-9 or physician generated treatment request was received after the treatment or service has been provided. The standardized letter:

- Must be personalized to the specific physician requesting the C9 or not submitting medical;
- Includes a copy of the retro C-9 or written request for medical;
- Provides a specific MCO provider relations representative as the main contact for information.

On Aug. 1, 2006 MCOs began sending new educational letters to providers indicating that the provider has not identified "just cause" when submitting the retro C-9 more than seven days after the treatment or service has been provided. "Just cause" reasons may include, but are not limited to:

- The treatment requested was emergency treatment;
- The provider was not aware that services were for a workers' compensation claim;
- The provider was non-bureau certified and had no established relationship with the injured worker;
- The provider was initially bureau certified within six months prior to the treatment request;
- The treatment requested was for a pending claim allowance with the bureau or industrial commission;
- The treatment requested was for a pending claim allowance with the bureau or industrial commission;
- The treatment provided was within the bureau's presumptive authorization guidelines;
- The treatment provided does not require prior authorization per the bureau's provider billing and reimbursement manual;
- Other documented justification as deemed sufficient by the bureau.
- As of November 2008, MCOs are now notifying BWC of retro C9s and Medco 14s where providers may not be compliant with prior authorization requests or completing Medco 14 forms appropriately. This information is being analyzed for further education opportunities or compliance initiatives under development.

Ongoing failure to adhere to MCOs' and BWC's administrative procedures may result in reduction in reimbursement and/or decertification

K. RECOMMENDING ADDITIONAL ALLOWANCES

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

In order for BWC to consider a proactive allowance request, please forward the following medical data to the assigned MCO. The MCO will ensure the following information is gathered from the physician and submitted to BWC:

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

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

BWC will not consider proactively allowing psychiatric conditions or conditions that may be the result of natural deterioration, degenerative processes or congenital.

Between 5-28 days from the receipt of the recommendation, BWC will either allow the condition or notify the injured worker or their legal representative to request the condition in writing. BWC will also provide an update to the MCO and the MCO will notify the physician who recommended the additional allowance regarding what action BWC is taking on the proactive allowance.

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

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

Important: Providers may not advise an injured worker to file a C-86 Motion or complete a C-86 Motion requesting an additional condition be allowed in the claim.

L. MEDICAL DISPUTES (BWC Rule 4123-6-16)

All MCOs are required to have an Alternative Dispute Resolution (ADR) process. ADR is intended to handle medical disputes regarding quality assurance, utilization review, medical necessity and other treatment and provider issues. Providers, employers and their representatives, and injured workers and their representatives may initiate ADR for MCO-managed claims by contacting the injured worker's MCO in writing, detailing the issue with the MCO decision, within fourteen calendar days of receipt of written notice of an MCO determination. Providers are encouraged to use the MCO Medical Treatment/Service Decision Appeal form (C-11) to expedite the identification of the issue in dispute and improve efficiency and avoid processing delays. For a copy of the C-11 please log onto www.ohiobwc.com.

The appeal letter or C-11 must be signed by the appellant or their representatives, or by the provider. A signature from the provider's non-professional staff member, with signature authority, is acceptable as long as the staff member signs the provider's name and initials.

MCOs must have a medical dispute resolution process that includes one independent level of review. The independent level of 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. However, 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 pursuant to OAC 4123-6-16 (C) (2). The MCO must complete and submit their recommended decision to BWC within twenty-one calendar days. Effective Nov. 1, 2009 if the MCO recommends that the injured worker be scheduled for an independent medical exam, this recommendation shall toll the MCO's timeframe for completing the ADR process and in such cases the MCO shall submit its recommended ADR decision to BWC electronically within seven days after receipt of the independent medical examination report. Following completion of the independent review and or exam the MCO will forward their recommended decision to BWC. BWC will then issue an order per ORC 4123.511, which may be appealed to the IC by any party to the claim (i.e., injured worker, employer, or their representatives). By law, MCOs and providers are not parties to the claim; therefore, they cannot appeal any BWC order, including those regarding medical issues.

Effective Jan. 1, 2003, the MCO may defer consideration of a dispute when there is a pending appeal and the MCO has previously conducted a peer review for a C-9 that is "same as or similar to" the one received. Previously the MCO was not able to defer consideration of a same or similar dispute when there was a pending appeal. The previous peer review can be used up to 12 months of the date of the review; this is increased from 6 months.

Effective April 1, 2007, per Senate Bill 7 and new OAC 4123-6-16 (F), the ADR process shall NOT be used to resolve disputes concerning medical services rendered that have been approved through standard treatment guidelines, pathways, or presumptive authorization guidelines.

This means all Employer/TPA appeals of approved authorizations will be exempt from the dispute resolution process if the requested services fall within presumptive authorization, pathways, or guidelines.

1. Bills Submitted on Treatment Requests Currently in the ADR Process

Bills submitted on treatment requests currently in the ADR process shall be denied with the appropriate ADR denial EOB code. If the services are later authorized, the MCO shall use the appropriate EOB code and request an adjustment on the denied bills. The MCO should use the following, appropriate EOBs on bills submitted for treatment requests currently in the ADR process include:

EOB 537: MCO Alternative Dispute in process for services requested. Services are not payable at this time.

EOB 538: Treatment reimbursement approved by MCO Alternative Dispute process (no appeal) - adjustment done to process previously disputed services.

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at MCO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 537 EOB. If the services are later authorized at the MCO level, and the decision is not appealed to the BWC, the MCO may use the 538 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.

EOB 539: MCO decision on ADR issue was appealed to the BWC. Services are not payable at this time.

EOB 540: Treatment reimbursement approved by BWC (final determination) - adjustment done to process previously disputed services.

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at BWC level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 539 EOB. If the services are later authorized at the BWC level, and the decision is not appealed to the DHO, the MCO may use the 540 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed

until a final decision is reached.

EOB 541: BWC decision on ADR issue appealed to DHO. Services are not payable at this time.

EOB 542: Treatment reimbursement approved by DHO (final determination) - adjustment done to process previously disputed services.

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at the DHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 541 EOB. If the services are later authorized at the DHO level, and the decision is not appealed to the SHO, the MCO may use the 542 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.

EOB 543 : DHO decision on ADR issue appealed to SHO. Services are not payable at this time.

EOB 544 : Treatment reimbursement approved by SHO (final determination) - adjustment done to process previously disputed services.

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at the SHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 543 EOB. If the services are later authorized at the SHO level the MCO may use the 544 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills.

M. RETURN TO WORK

Early and successful return to work (RTW) benefits everyone. The costs of any disability go far beyond the measurable costs for medical care and compensation payments. Injured workers may encounter:

- Loss of self-esteem;
- Depression;
- Secondary symptoms;
- A complete change in their life style.

Most injured workers return to work without any assistance, but some injured workers require more medical care resulting in longer recovery and time away from work. Some require intensive RTW and vocational services to return to productive employment.

The Optimal Return to Work date is a RTW outcome measurement that BWC implemented in 1999. It is an innovative model, developed by a national health-care consultant, for return to work that measures success and establishes an optimal RTW date at the individual level. For example, a construction worker who breaks a leg is expected to be off work longer than an office worker because of how the injury relates to his or her job.

BWC's efforts recognize these differences and plan the best course for the individual worker. The optimal RTW date assists BWC and MCOs in working with the employer, injured worker and physician to set expectations for RTW. As a critical player in the HPP design, providers must understand the basis and goals of RTW strategy and optimal RTW date and help set RTW expectations of the injured worker. In addition, providers have to manage return office visits and treatment with the optimal RTW date in mind and release injured workers to work (with restrictions, if necessary) as soon as medically feasible.

- **Remain at Work:**

The best way to avoid the need to return to work is to remain at work. In the past, only injured workers who had missed more than seven days of work were eligible for rehabilitation services. The goal is to provide early intervention and minimize the number of days an employee is off work due to an injury.

- **30-Day Return to Work Assessments**

MCOs manage each claim with the goal of an optimal return-to-work date. If an injured worker has not returned to the job 30 days after that optimum date, BWC will become directly involved reviewing the case. BWC and MCO staff will work together to ensure the injured worker is on a

successful path toward a safe return to work. The goal is to make it easier for injured workers to streamline the process and take advantage of return to work interventions.

- **Transitional Work**

BWC's transitional work program offers meaningful, productive work to injured workers with restrictions in helping them remain or return to work sooner. It's a program the employer sets up so injured employees can return to work more quickly and safely — either in their original job or a temporary work assignment until they're ready to resume their original job.

Transitional work helps businesses offer injured employees' strategies to return them to work as soon as safely possible, and before the worker is 100 percent recovered. The program uses real job-related tasks to accommodate the workers' medical restrictions for a specified time period – generally no more than three months – and gradually return them to their original duties.

The program may involve strategies, such as purchasing tools and equipment, modifying the work area, adjusting job tasks or allowing employees to work part time. Employers can help by opening the channels of communication among the employee, the doctor, the employee's immediate supervisor, BWC and their managed care organization (MCO). This increases the odds the worker will stay connected to the job and recover more quickly.

1. Physician's Report of Work Ability (MEDCO-14)

The physician must complete this standard form when the injured worker has been placed under work restrictions, require accommodations, or is temporarily totally disabled. The Medco-14 should be used during evaluation and management services when an injured worker's status is evaluated or re-evaluated by a physician. For instance, it is not intended to be required for manipulation treatments and other therapies when an evaluation and management service was not performed.

The Medco-14 does not replace the Request for Temporary Total Compensation (C-84) form, however, the BWC Customer Service Specialist may use information from the Medco-14 to extend temporary total compensation if the injured worker has completed and signed a C84 form on file. The POR does not need to complete part 2 of the C-84 if they have already completed the Medco-14.

The Medco-14 is similar to forms used by MCO or physician offices and will provide a permanent record for the physician's file. The two-part form allows the injured workers to receive a copy for their records. By faxing a copy to the MCO, employers will be informed of work restrictions and explore work site adaptations/modifications.

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

N. APPLICABLE BWC LAWS AND RULES

BWC guidelines are applicable to any provider treating an Ohio injured worker, regardless of whether the service is rendered in Ohio or another state.

Ohio Revised Code (ORC) 4121.44 Payments to Health Care Providers

ORC 4121.121(16) Duties of the Administrator

4123-6-02 Provider Access to the HPP-Generally

4123-6-02.1 Provider Access to the HPP-Initial Provider Enrollment Period Established

4123-6-02.2 Provider Access to the HPP-Provider Credentialing Criteria

4123-6-02.21 Provider Access to the HPP - Non-Certified Provider Enrollment

4123-6-02.3 Provider Access to the HPP-Provider Application and Credentialing

- 4123-6-02.4 Provider Access to the HPP-Provider Recredentialing and Recertification
- 4123-6-02.5 Provider Access to the HPP-Provider Not Certified
- 4123-6-02.51 Provider Access to the HPP-Denial of Provider, Entity or MCO Certification Based on Criminal Conviction or Civil Action
- 4123-6-02.6 Provider Access to the HPP Selection by an MCO
- 4123-6-02.7 Provider Access to the HPP Eligibility of Non-Bureau Certified Providers
- 4123-6-02.8 Provider Requirement to Notify of Injury
- 4123-6-02.9 Provider Access to the HPP-Provider Marketing
- 4123-6-03 MCO Participation in the HPP-Generally
- 4123-6-03.10 Conflict of Interest
- 4123-6-03.2 MCO Participation in the HPP-MCO Application
- 4123-6-03.3 MCO Participation in the HPP-MCO Conditional Certification Based on MCO Capacity
- 4123-6-03.4 MCO Participation in the HPP-MCO Certification
- 4123-6-03.6 MCO Participation in the HPP-Administrator's Authority to Terminate MCO Contracts
- 4123-6-03.7 MCO Participation in the HPP-Bureau's Authority to decertify, to Refuse, To Certify or Recertify an MCO
- 4123-6-03.9 MCO Participation in the HPP-MCO Disclosure of Relationship
- 4123-6-04 MCO Scope of Services - Generally
- 4123-6-04.2 MCO Scope of Services-Management of Medical Treatment of Provider Selected by Employee
- 4123-6-04.3 MCO Scope of Services - MCO Medical Management and Claims Management Assistance
- 4123-6-04.4 MCO Scope of Services-Fee Bill Review and Audit Process
- 4123-6-04.5 MCO Scope of Services-Bureau Claims Management
- 4123-6-04.6 Thirty-Day Return to Work Assessment
- 4123-6-05.1 Employer Access to the HPP Employer Enrollment Period Established
- 4123-6-05.2 Employer Access to the HPP Employer Enrollment and Selection of MCO
- 4123-6-05.3 Employer Access to the HPP Certain Solicitation Practices by MCOs Prohibited
- 4123-6-05.4 Employer Access to the HPP Payment for Group Rating Referrals Prohibited
- 4123-6-06.1 Employee Access to the HPP Employee Education by MCO and Employer
- 4123-6-06.2 Employee Access to the HPP Employee
- 4123-6-06.3 Employee Access to the HPP Application of Rules to Claims
- 4123-6-06 Employee Access to the HPP Generally
- 4123-6-07 Balance Billing Prohibited
- 4123-6-08 Bureau Fee Schedule
- 4123-6-09 Payment During Adjudication of Claim
- 4123-6-10 MCO Payment to Providers
- 4123-6-11 Payment to Bureau Certified Provider
- 4123-6-12 Payment to Non-Bureau Certified Provider
- 4123-6-13 Payment to MCOs
- 4123-6-14 MCO Bill Submission to Bureau
- 4123-6-14.1 Records to be Retained by MCO
- 4123-6-15 Confidentiality of Records
- 4123-6-16 Dispute Resolution for HPP Medical Issues
- 4123-6-16.1 Bureau Review of HPP Medical Disputes
- 4123-6-16.2 Medical Treatment Reimbursement Requests
- 4123-6-17 Bureau Refusal to Certify or Recertify, Action to Decertify a Provider or MCO-Standards and Procedures for Adjudication Hearings
- 4123-6-18 Data Gathering and Reporting
- 4123-6-19 Remain at Work Program
- 4123-6-20 Obligation for Submitting Reports
- 4123-6-20.1 Charges for Copies of Medical Reports
- 4123-6-21 Payment for Outpatient Medication
- 4123-6-22 Stakeholders Health Care Quality Assurance Advisory Committee
- 4123-6-23 Jurisdictional Principles Applicable to Payment of Bills for Medical Payment of Bills for Medical Services Rendered by Health Care Providers
- 4123-6-24 Treatment Necessary Due to an Industrial Injury or Occupational Disease
- 4123-6-25 Payment for Medical Supplies and Services

- 4123-6-26 Claimant Reimbursement
- 4123-6-27 Treatment by More Than One Physician
- 4123-6-28 Treatment of More Than One Condition or to More Than One Part of the Body
- 4123-6-29 Treatment of Request for Information by the Treating Provider
- 4123-6-30 Payment for Physical Medicine
- 4123-6-31 Payment for Acupuncture
- 4123-6-32 Payment for X-Rays
- 4123-6-33 Payment for Dental Care
- 4123-6-34 Payment for Eyeglasses and Contact Lenses
- 4123-6-35 Payment for Hearing Aids
- 4123-6-36 Payment for Shoes, Braces and Other Orthotic Devices
- 4123-6-37 Payment of Hospital Bills
- 4123-6-37.1 Payment of hospital inpatient services
- 4123-6-38 Payment for Home Health Nursing Services
- 4123-6-38.1 Payment for Nursing and Caregiver Services Provided by Persons Other Than Home Health Agency Employees
- 4123-6-38.2 Payment of Nursing Home and Residential Care/Assisted Living Services
- 4123-6-39 Payment for Prosthetic Device or Other Artificial Appliances
- 4123-6-40 Payment of Claimant Travel Expenses
- 4123-6-41 No Legal Relationship Between the Industrial Commission or Bureau and a Health Care Provider
- 4123-6-42 Payment for Equipment, Materials, Goods, Supplies or Services and Interest Incurred
- 4123-6-43 Payment for Transcutaneous Electrical Nerve Stimulators
- 4123-6-44 Bureau Fees for Practitioner Services Rendered by In-State and Out-Of-State Practitioners
- 4123-6-45 Audit of Providers' Patient and Billing Related Records
- 4123-6-45.1 Records To Be Retained by Provider
- 4123-6-46 Standardized or Negotiated Payment Rates for Services or Supplies
- 4123-6-50 Self-Insured Employer Participation in the QHP System; Reporting Requirements for Non-Participating Employers
- 4123-6-51 Employer Participation in the QHP System - Bureau Certification of QHPs
- 4123-6-52 Employer Participation in the QHP System-Initial QHP Certification Enrollment Period Established; Length of Certification Period
- 4123-6-53 Employer Participation in the QHP System-QHP Quality Assurance Program Required
- 4123-6-54 Employer Participation in the QHP System-QHP Certification Application
- 4123-6-55 Employer Participation in the QHP System-Bureau's Authority to Revoke Certification, to Refuse to Certify or to Recertify a QHP
- 4123-6-56 Employee Access to the QHP System - Choice and Change of Provider
- 4123-6-57 Provider Access to the QHP System - Generally
- 4123-6-58 Provider Access to the QHP System - Provider Participation in the QHP System and Other Related Health Care Program not Linked
- 4123-6-59 Provider Access to the QHP System - QHP Provider Selection
- 4123-6-60.1 Provider Access to the QHP System - Medical Recordkeeping
- 4123-6-61 Payment in the QHP System - Employer Responsibility - Generally
- 4123-6-62 Payment in the QHP System - Balance Billing Prohibited
- 4123-6-63 Payment in the QHP System Application of Bureau Fee Schedule in the QHP System
- 4123-6-64 Payment in the QHP System-Vendor Payment to Providers
- 4123-6-65 Payment in the QHP System-Employer Payment to Vendor that Provides Medical Management and Cost Containment Services and/or QHPs
- 4123-6-66 Payment in the QHP System Authorization and Payment for Initial Emergency Medical Treatment
- 4123-6-67 Payment in the QHP System-Payment to Providers in States that Border Ohio
- 4123-6-68 Providers in States that Do Not Border Ohio-QHP Freedom to Negotiate; Restriction on Provider Charges to Employee
- 4123-6-69 QHP Dispute Resolution Process
- 4123-6-70 Evaluation of the QHP System by the Bureau; Reporting Requirements by Employers and QHPs
- 4123-6-71 Initial Report of an Injury and Reporting Requirements by Providers and Employees in the QHP System
- 4123-6-72 Confidentiality

To access to the latest versions of the Ohio Administrative Code (OAC) and the Ohio Revised Code (ORC), relative to workers' compensation, go to www.ohiobwc.com, BWC Library, Policies and Procedures.

O. MEDICAL CODING REQUIREMENTS

1. International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

Effective Oct. 1, 2008 BWC recognizes the 2009 version of the International Classification of Diseases (ICD-9-CM). An ICD-9-CM code is a 3 - 5 digit numeric code that represents a uniform, international classification system of coding diseases and injury diagnoses.

a) Primary ICD-9

Primary ICD-9 codes must be specified for all claims. Use of a primary diagnosis code improves claims management through the identification of the condition driving the claim. BWC requires the identification of a primary ICD-9 on the *First Report of Injury, Occupational Disease or Death* (FROI) application, treatment plans, subsequent reports, and the *Request for Temporary Total Compensation* (BWC form C-84). Although a claim may have multiple ICD-9 codes, only one primary diagnosis can be identified per claim. The provider must bill the condition(s) treated, regardless of the primary ICD-9. Additionally, the primary diagnosis should be:

- Determined by the physician of record;
- Included on the FROI form;
- Included on the treatment plan;
- Identified for allowed conditions only;
- Able to change as medical conditions driving the claim change.

b) EOB 200

To avoid delays in payment, providers should enter **only** one ICD-9-CM code or reference number from Block 21 of the CMS 1500 on each line in block 24 E. If there is more than one ICD-9-CM code or reference number in block 24 E, the MCO has the discretion to either pick the first code or reject the bill with EOB 200 - PAYMENT IS DENIED AS ONLY ONE DIAGNOSIS CODE MAY BE BILLED PER LINE.

2. Procedure Coding

To report procedures and/or services provided to injured workers, providers are required to use the Health Care Financing Administration's Common Procedure Coding System (HCPCS). This system is comprised of HCPCS Level 1 procedure codes from the AMA's Current Procedural Terminology (CPT®) book, including additional definitions in CPT® Assistant, and HCPCS Level 2 codes and HCPCS Level 3 codes.

a) HCPCS Level 1

Effective for dates of service beginning Jan. 1, 2009, BWC and MCOs accept 2009HCPCS Level I (CPT®) billing codes. 2009 HCPCS Level I (CPT®) billing codes are established by the American Medical Association (AMA). HCPCS Level I Codes are descriptive codes for reporting medical services and procedures. Anesthesia CPT® codes (00100-01999) are recognized and required.

b) HCPCS Level 2

Effective for dates of service beginning Jan. 1, 2009, BWC and MCOs accept 2009 HCPCS Level II billing codes as established by Centers for Medicare & Medicaid Services (CMS). Level II codes are descriptive codes for reporting durable medical equipment, dental, vision and other services.

c) HCPCS Level 3

Effective for dates of service beginning Jan. 1, 2009, BWC and MCOs accept 2009 HCPCS Local Level III billing codes. Local Level III codes are descriptive terms and identifying codes for services and equipment specific to Ohio workers' compensation and are published in Chapter 2 of this manual.

3. Hospital Services

The preferred method of submitting bills to the proper MCO is an Electronic Transmission in the **ASC X12 837** format. The implementation documentation for the 837 can be found on BWC's website at the following URL: <http://www.ohiobwc.com/p837>. All hospital services, billed hardcopy, must be billed on the UB-04 using revenue center codes. Professional services may NOT be billed on the UB-04. For some outpatient hospital services, the Physician's Current Procedural Terminology (CPT®) codes must be used in addition to the revenue center codes. An ICD-9-CM diagnosis code(s) indicating the reason(s) for the outpatient treatment is required on each invoice. For outpatient services, a date of service is required on each line of the UB-04 for each service rendered.

For additional information on hospital services, including covered and non-covered revenue center codes, please refer to Chapter 3 of your *Billing & Reimbursement Manual*.

4. Outpatient Medications

Outpatient medications are reported using National Drug Codes. SXC Health Solutions serves as the sole drug bill processor for state-fund, Black Lung and Marine Industrial Fund employers' claims. SXC does not process bills for self-insured or federal workers' compensation claims. All outpatient pharmaceuticals for self-insuring employers must be billed using the BWC Outpatient Medication Invoice, C-17. For information on Outpatient Medication, refer to Chapter 3 of your *Billing & Reimbursement Manual*.

P. PROVIDER COMMUNICATION

BWC's e-business system allows us to leverage waves of technology to provide our customers with consistent, customized, streamlined service 24 hours a day, seven days a week. Log on to www.ohiobwc.com find out how fast, efficient and easy it is to have all of your workers' compensation information and services at your fingertips. With our e-business system, you can:

- View basic claims information, including International Classification of Diseases (ICD-9) codes, claim status, date of injury, accident description, BWC and MCO claim notes, and the assigned MCO.
- Verify BWC-certified providers with BWC-Certified Provider Lookup;
- Determine the managed-care organization (MCO) for a particular employer with BWC Employer/MCO Lookup;
- View the BWC Fee Schedule;
- Download various BWC forms, including the First Report of Injury (FROI), Physician's Report/Treatment Plan for Industrial Accident or Disease (C-9) and Request for Temporary Total Compensation (C-84). Then, users can print those forms, fill them out and submit them via mail, fax or in person.
- File an FROI electronically and receive a claim number immediately;
- Look-up an injured worker's claim history;
- Access information 24 hours a day, 7 days a week.
- BWC library — Take a guided tour to learn more about processes and policies. Find answers to frequently asked questions and definitions for workers' compensation terms in the provider glossary.
- Medical bill payment look-up — Servicing or pay-to providers can view medical bill payment information. Bill searches also can be customized to verify receipt of your bills from the managed care organization (MCO) to BWC, and provider payments made to MCOs.
- Billing and reimbursement — Access the online *Provider Billing & Reimbursement Manual (BRM)* to download, view or print reimbursement policies/procedures and quarterly updates.
- Claim documents — Providers who meet BWC's security criteria can access claim documents, a repository of imaged documents from individual claim files.
- View Provider Education/Training section, which includes video presentations of information relevant to new providers doing business with BWC and other educational offerings

To ensure confidentiality, you must create a primary account before accessing injured worker information. You can create secondary users from this account so that each of your employees or vendor employees can have individual passwords. E-business revolutionizes how BWC does business but it does not replace people with technology. Customers who prefer dealing with a person will always have the option of doing so. To get more information about e-business provider services, or for help creating a BWC provider e-account (user ID and

password), call 1-800-OHIOBWC. You also can e-mail the provider relations department at Feedback.medical@BWC.state.oh.us.

Q. CLAIM NUMBER IDENTIFICATION and BWC’s New Sensitive Data Policy

BWC assigns claim numbers in the following format, 95-123456. The two-digit prefix corresponds to the year of injury, followed by six digits. Listed on the next page are types of claims and descriptions for assignments issued prior to the new claim numbering scheme.

Type of Claim	Description	Sample
Medical-Only (State Fund)	Two alpha prefix, begins with “M”	MT234561
Lost-Time (State Fund)	Prefix is year of injury	92-1234
Old State-Fund Lost-Time	Prefix is 1 or 2	2-012345
Public Employee Medical-Only	Prefix is “PEM”	PEM12345
Public Employee Lost-Time	Prefix is “PEL”	PEL12345
Old Public Employee	Prefix is “PE”, prior to 1/1/81	PE234567
Public Work Relief Employment	Prefix is “PWRE”	PWRE1234
Occupational Disease	Prefix is “OD”	OD123456
Occupational Disease Public Employee	Prefix is “ODPE”	ODPE1234
Non-Complying Employer Medical-Only	Prefix is “M”, Suffix is “-27”	M1234-27
Non-Complying Employer Lost-Time	Prefix is “L”, Suffix is “-27”	L1234-27
Old Non-Complying Employer	Suffix is “-27”	12345-27
Self-Insuring Employer Medical-Only	Prefix is “M”, Suffix is “-22”	M12345-22
Self-Insuring Employer Lost-Time	Prefix is “L”, Suffix is “-22”	L12345-22
Self-Insuring Occupational Disease	Prefix is “OD”, Suffix is “-22”	OD1234-22
Old Self-Insuring Employer	Suffix is “-22”	12345-22
Rehabilitation Medical-Only	Prefix is “RM”	RM12345
Rehabilitation Lost-Time	Prefix is “RL”	RL12345
Prefixes ONG - Ohio National Guard	APP - Apprenticeship	
YC - Youth Commission	CD - Civil Defense	

Due to heightened security awareness and state law, BWC has incorporated a new Sensitive Data Policy. To prevent unauthorized disclosure of BWC sensitive information this policy prohibits the electronic transmission of Sensitive Data without encryption (password protection). All claims information, including injured worker claim number and name are considered sensitive and must be masked if used in email format (John Smith, claim 09-123456 would be acceptably emailed as John S., 09-xxx456.)

If you receive an electronic document from BWC or the Managed Care Organization (MCO) it will be password protected if sensitive data is included. BWC and/or the MCO will provide you with the password that will generally be used. Once you open a document and respond to the message, the document will remain password protected when the changes are saved.

Please note that a faxed transmission to a phone number is considered secure and is an accepted means of communication of sensitive data. Please have identifying injured worker information (name and claim number/SSN) that assures to BWC or the MCO that you are involved in this injured workers care, or a signed consent may be needed before the case can be discussed.

R. FRAUD

Workers' compensation fraud is defined by BWC, to a large extent, as an intentional act or series of acts resulting in payments (or could have resulted in payments) to a person who is not entitled to receive those payments. Examples of workers' compensation fraud include (but, are not limited to);

- Injured workers who go back to work, but still collect lost time benefits.
- Injured workers who claim to have been injured in the course of their employment when in fact they were injured elsewhere.
- Injured workers who fake an injury at work
- Providers who bill for services not rendered.
- Providers who bill for a more expensive level of service than provided. This process is sometimes referred to as "upcoding". (Note: BWC utilizes AMA CPT® Assistant Guidelines, which are based on accepted industry standards, when reviewing medical reports and documentation.)
- Providers who attempt to bill uncovered expenses to the workers' compensation claim.

- Employers who under report their premiums.
- Employers who misrepresent the manual classification of their employees to secure a lower premium rate.

Senate Bill 7 (SB7), effective June 30, 2006, expands the definition of workers' compensation fraud to include altering, forging or creating workers' compensation certificates to falsely show correct coverage, providing false information when that information is needed to determine an employer's actual premium or assessment, and failing to secure or maintain workers' compensation coverage with the intent to defraud the bureau. It also:

- Prohibits persons, health-care providers, managed care organizations (MCOs) from obtaining or attempting to obtain by deception payments under the workers' compensation law to which they are not entitled.
- Authorizes monetary penalties and decertification for persons, health-care providers and MCOs for obtaining or attempting to obtain by deception payments under the workers' compensation law to which they are not entitled and specifies procedures for enforcing these provisions.

To ensure only legitimate claims are paid, BWC is aggressively attacking fraud through its Special Investigations Department. The Special Investigations Department has investigative personnel located in each service office, its own automated detection team as well as a team that specializes in health care fraud investigations. Individuals and corporations convicted of workers' compensation fraud can expect to receive penalties that range from a misdemeanor (\$1,000 fine and up to six months incarceration) to a felony (fines ranging from \$2,500 - \$15,000 and from 6 months to 5 years incarceration), restitution and an order to reimburse BWC for its investigative costs.

If you suspect fraud, call the Special Investigations Department at 1-800-OHIOBWC (1-800-644-6292) or complete the online fraud report in the Medical Providers section of our website www.ohiobwc.com.

1. Unethical Marketing

BWC has received an increasing number of complaints from injured workers, MCOs, and providers that suggests that a small number of telemarketing companies who represent BWC-certified providers have attempted to obtain significant profit opportunities by use of false, misleading, or deceptive marketing to injured workers. Examples of false, misleading, or deceptive marketing practices that violate guidelines listed in the BWC Provider Billing and Reimbursement Manual, include, but are not limited to:

- Attempting to influence injured workers to be examined by a specific physician or to select a certain physician either as a physician of record (POR) or as a treating physician.
Ohio Administrative Code 4123-6-062 states that an injured worker may choose as the primary attending physician, or POR, an eligible provider who is a:
 - BWC-certified provider that is an MCO panel provider;
 - BWC-certified provider that is not an MCO panel provider;
 Note: Injured workers with dates of injury prior to October 20, 1993 may retain a non-certified provider as a POR if such relationship already exists.
- Telling injured workers that they will not have to pay one penny out of pocket.
Per BWC policy as stated in the Provider Billing & Reimbursement Manual: Injured workers are not required to contribute a co-payment and do not have to meet any deductibles. BWC-certified providers are required to bill the appropriate MCO for reimbursable covered services and shall not, in accordance with their provider agreement, request payment from the injured worker;
- Telling injured worker that they will be charged if they miss an appointment.
Per BWC policy as stated in the Provider Billing & Reimbursement Manual: Reimbursement will not be made for failed appointments. Only medical services provided will be reimbursed.
- Telling injured workers that reimbursement of compensation will be suspended if they choose not to see a specific physician.
ORC 4123.53 states that benefits may be suspended should an injured worker fail to attend a second BWC scheduled exam.

Telemarketing companies representing BWC-certified providers shall maintain the highest level of ethical standards and shall not use, or promote the use of, advertising matter, promotional materials, or other representation; however, disseminated or published, that is false, misleading, or deceptive to an injured worker being treated for an injury or an occupational disease.

S. REQUEST FOR TEMPORARY TOTAL COMPENSATION (C-84) FORM

Physicians of record or treating physicians use treatment plans and the C-84/equivalent form to provide BWC or a self-insuring employer with medical information regarding the injured worker's extent of disability so that an extension of temporary total compensation benefits may be considered. The attending physician must provide the following information:

- Primary condition being treated necessitating lost-time;
- Date of the injured worker's last exam and the date of his or her next appointment;
- Disability dates and return-to-work date of injured worker;
- Causal relationship of the disability period to the work injury/illness;
- Injured worker's maximum medical improvement (MMI);
- Injured worker's rehabilitation and employment potential;
- Narrative medical report submitted every 90 days identifying subjective/objective findings, diagnostic test results and the treatment plan. 4123-6-20 states that interim reports are submitted every 30 days.

The C-84/equivalent form requires the provider of record's signature. . A stamped signature, as well as an electronic signature from the POR/treating physician, is acceptable. Other authorized staff may sign for the POR/treating physician (POR's designee, a Provider Assistant (PA), or a physician in the same group practice, etc). The POR/treating physician designee will sign for the POR/treating physician and include his/her own initials on the form. However, while the PA can sign as a POR designee, he/she cannot sign a physician C-84/equivalent form or certify compensation in his/her own name. If the physician C-84 is submitted online, the electronic signature must be that of the POR/treating physician.

Injured Worker signature and completion of C-84/equivalent form required

Effective 11/5/2009, the injured worker is required to sign and complete the C-84/equivalent form to provide information regarding work status, disability dates, his or her employer's name, light-duty work availability and receipt of other benefits. The physician is encouraged to remind the injured worker to complete and sign the front page of the C-84/equivalent form before he or she sends it to the BWC. Temporary Total compensation will not be paid without the completed and signed form from the injured worker.

Obtain C-84 forms by contacting your local customer service office or BWC forms and publications at 1-800-OHIOBWC (800-644-6292) or fax (614) 644-1999. The C-84 can also be ordered via the Internet at <http://www.ohiobwc.com>.

T. CLAIM REACTIVATION

The time frame for inactive claims changed from thirteen (13) months to twenty-four (24) months; the revised rule 4123-3-15 was effective on October 12, 2010. The claim reactivation policy ensures timely and appropriate benefit payments on inactive claims - which are claims that have had a lapse of activity in which no medical or compensation has been paid for more than 24 months. We want to make sure inactive claims are reactivated appropriately. In addition, we want to offer the same level of BWC/MCO communication on inactive claims that we have on new claims.

Effective October 24, 2010, bills with dates of service on or after the claim's inactive date are denied with **EOB 265: Payment is denied because the claim is inactive.** Providers should always verify the active/inactive status of an injured worker's claim before scheduling or delivering services. The claim status and diagnosis information can be found on ohiobwc.com or by contacting the assigned MCO. If the claim is inactive, prior to delivering services, the provider must notify the injured worker that, unless the claim is reactivated, the services will not be payable by workers' compensation and the injured worker will be responsible for payment.

To trigger a reactivation review, the provider must submit to the MCO either a request for medical service and/or medical bill payment for services rendered. The provider must submit medical documentation, which has been completed within the previous 60 days, to the MCO that supports a causal relationship between the condition(s) allowed in the claim and the condition treated or the request for treatment.

The MCOs will have a maximum of 16 business days to respond to the treatment request and refer the claim reactivation issue to BWC. BWC will have up to 28 days from receipt of the MCOs request to provide due

process, conduct an investigation, and determine if the requested action is causally related to the original claim allowance. BWC will issue an Order either allowing or denying the claim reactivation and treatment issue based on the information available once the investigation is completed. This order is appealable to the Industrial Commission of Ohio (IC).

BWC's goal is to more thoroughly investigate reactivation decisions so we can make the best decision regarding injured workers' benefits.

How are physicians and other health-care providers affected?

- Health-care providers who treat an injured worker whose claim is inactive should use the C-9 to thoroughly document the need for treatment and how the care relates to the workplace injury.
- The MCO will dismiss the C-9 request on an inactive claim when there is no supporting medical evidence, or the medical evidence is dated more than 60 days prior to the date of the request. A C-9 dismissed in this manner will not be appealable through the alternative dispute resolution (ADR) process. However, reconsideration of the treatment issue will occur upon submission of the requested documentation. The provider will have up to ten business days to submit the requested information.
- If prescription medications are denied due to an inactive claim, contact BWC to request a claim reactivation review.

If you have questions about claim reactivation, log on to www.ohiobwc.com, or call 1-800-OHIOBWC.

U. SUBSTANTIAL AGGRAVATION OF PRE-EXISTING CONDITION

Claims with date of injury (DOI) on or after 8/25/06 may be allowed for substantial aggravation of a preexisting condition.

The substantial aggravation must be documented by objective diagnostics findings, objective clinical findings, or objective test results. Subjective complaints may be evidence of a substantial aggravation, but they are insufficient to support allowance of a substantial aggravation without objective diagnostic findings, objective clinical findings, or objective test results.

Once the substantially aggravated pre-existing condition has returned to a level that would have existed without the injury, no compensation or benefits are payable for the condition. Therefore, a claim will always be *allowed* for aggravation of a pre-existing condition once the condition has become a claim allowance; however, compensation and benefits are not be payable once this condition is returned to the pre-injury state.

When a request to allow a claim for substantial aggravation of a pre-existing condition is filed, an independent medical exam (IME) **may** be necessary to assist BWC in making an appropriate determination; however, an exam is not required, especially when the request is supported by the evidence mandated by law. Claims Service Specialists (CSSs) should staff the claim with the nurse and/or other members of their team to determine if an exam or file review is appropriate.

The following types of medical evidence/documentation may be submitted and/or gathered for decisions involving a substantially aggravated pre-existing condition(s):

- Lab reports, X-rays, MRI, CT reports or any other diagnostic tests that may document the current status of the substantially aggravated pre-existing condition;
- Lab reports, X-rays, MRI, CT reports other diagnostic tests pertaining to the condition prior to the injury;
- Documentation of current medication including dosage and frequency for substantially aggravated pre-existing condition (i.e. insulin or pain medication);
- Documentation of medication including dosage and frequency for substantially aggravated pre-existing condition that IW was receiving prior to the date of injury;
- Any objective physician examination findings of substantially aggravated pre-existing condition prior to injury and subsequent to injury;
- PT, OT records prior to and subsequent to injury;
- Emergency Room reports;
- Accident reports

The managed care organization (MCO) must consider requests for medical treatment when a final BWC/IC decision has determined that the substantially aggravated pre-existing condition has returned to a level that would have existed without the injury and other conditions are allowed in the claim. If the request is denied and an appeal is filed, the issue will go through the Alternative Dispute Resolution (ADR) process.

If the substantially aggravated pre-existing condition is the only condition allowed in the claim, treatment requests will be dismissed without prejudice once a final BWC/IC decision has determined that the condition has returned to a level that would have existed without the injury.

V. PSYCHIATRIC CONDITION AS A RESULT OF FORCED SEXUAL CONDUCT

Effective 8/25/06, pursuant to Senate Bill 7, a compensable injury includes a psychiatric condition sustained by the employee where the psychiatric condition has arisen from sexual conduct in which the individual was forced by threat of physical harm to engage or participate.

This provision of the law (ORC 4123.01(C)(1)) opened the door for the allowance of emotional or stress claims absent a physical injury. Under current Ohio workers' compensation law, this is the **only** situation that permits an individual to have a claim allowed for a psychiatric condition with no physical injury.

When BWC receives an initial application requesting allowance of a psychiatric condition only as a result of forced sexual conduct, the investigation and other succeeding processes should be treated the same as any other claim requesting a psych condition as an initial allowance. The only difference is that most other claims will request allowance of a physical condition as well as the psychiatric condition.

According to Joint Resolution R03-1-01, all motions or applications filed on or after March 1, 2003 requesting the allowance of a psychiatric condition shall be accompanied by supporting evidence consisting of a medical report by a licensed psychiatric specialist, a clinical psychologist, a licensed professional clinical counselor, or a licensed independent social worker.

W. THIRD-PARTY PAYERS

When an injured worker is eligible for public or private insurance and workers' compensation benefits, the MCO, BWC or the self-insuring employer is the primary payer. Bill services related to compensable conditions to workers' compensation before attempting to collect from another payer.

X. \$15,000 MEDICAL-ONLY PROGRAM

Ohio employers can participate in BWC's \$15,000 Medical-Only Program, designed to offer employers the opportunity to pay the first \$15,000 of medical payments for their employees' work-related injuries. Participating employers will notify providers that they are responsible for the first \$15,000 of their employee's alleged work-related injuries. The \$15,000 maximum applies only to claims with a date of injury (DOI) on or after September 10, 2007. For DOI prior to September 10, employers in the program still have the opportunity to pay up to:

- \$1,000 Medical Only Program: Claim is Medical-Only with DOI 7-1-95 through 6-29-06;
- \$5,000 Medical-Only Program: Claim is Medical-Only with DOI 6-30-06 through 9-9-07;
- \$15,000 Medical-Only Program: Claim is Medical-Only with DOI 9-10-07 and after.

1. Provider Responsibilities

- Bill the employer directly for services related to injuries covered by the \$15,000 Medical-Only Program.
- An employer pays providers directly for the injured worker's medical care up to \$15,000.
 - For claims with a DOI on or after June 30, 2009 and enrolled in the Medical-Only Program, the employer will use the BWC Fee Schedule for medical payments. Employers may access the provider fee schedule on our website at www.ohiobwc.com. If an Employer has questions regarding BWC's Fee Schedule and/or has general billing questions, they should be directed to contact Provider Relations by calling 1-800-OHIOBWC option 0-option 3-option 0.
 - A certified health care provider shall accept from an employer who participates in the Medical-Only Program the BWC Fee Schedule as full payment. The provider shall not

charge, assess, or otherwise attempt to collect from an employee any amount for covered services or supplies that is in excess of the BWC Fee Schedule.

- For claims with a DOI prior to June 30, 2009, the employer is to pay as billed or according to any provider agreed upon amount.
- The MCO may not act as an agent of the employer and may not process the bills on behalf of the employer.
- If the MCO receives a C-9 form (Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease) for a claim in the Medical-Only Program, it may dismiss without prejudice and notify the provider and employer. An employer cannot deny or allow a C-9 form; however, the C-9 form does provide notice to the employer of the services that may be rendered in a claim by a treating provider. The employer may review the C-9 form for the treating diagnosis and requested services for the injured worker. The employer can also use the information to decide if the claim will remain in the Medical-Only Program, based on anticipated cost of requested services and treatment.
- Bill in the same manner and on forms that the provider uses to bill the MCO or BWC.
- A provider cannot bill a state-fund employer directly outside of the \$15,000 Medical-Only Program.

2. Exceeding the \$15,000 Maximum

- The employer will pay that portion of the bill that will bring their payment to the \$15,000 maximum.
- The employer will then inform the provider to bill the MCO or BWC for the remainder of the bill. Contact the assigned provider representative to make arrangements for special processing of this bill.

3. \$15,000 Maximum is Reached or claim is removed from Medical-Only Program

- The employer should notify BWC, the injured worker and the provider that MCO or BWC will be responsible for processing all bills after a specific date of service.
- The employer will forward proof of bill payment to BWC, including copies of bills paid, upon written request from BWC.
- After a claim has been removed from the Medical-Only Program for any reason, medical management and all bills received will be handled by the MCO. The MCO will be responsible for processing all bills regardless of date of service after the claim's termination from the program. **BWC will not** mediate fee disputes between employers and providers. If BWC and the employer both pay a bill, the employer is responsible for recovering the payment. BWC will not recover duplicate payments unless it is proven that the employer followed program requirements and the error was on the part of BWC. A BWC claim must be filed and allowed before the MCO or BWC can consider these medical bills for payment. The same process applies when a claim is removed from the program.
- The MCO will continue to process bills related to medical-only claims filed in the normal manner when an employer has not elected to participate in the \$15,000 Medical-Only Program.

If BWC has issued a claim number, BWC will process the bill and inform the provider that it cannot be paid while the claim is covered by the \$15,000 Medical-Only Program. In this case, providers will receive the following Explanation of Benefits (EOB) code on their BWC Remittance Advice:

210 BWC cannot reimburse these services, as this claim is part of the \$15,000 Medical-Only Program. Submit medical bills to the injured worker's employer.

Refund duplicate payments directly to the employer.

4. Injured Worker Loses More Than Seven Work Days

If over seven days of work are lost, the injury is no longer eligible for this program and the claim is filed with BWC. This process automatically changes the claim to lost-time and removes it from the \$15,000 Medical-Only Program.

Y. DISABILITY EVALUATORS PANEL (DEP)

The DEP is a statewide panel of physicians and medical professionals who perform medical examinations and medical file reviews for BWC to ensure that qualified medical specialists do quality, objective evaluations. Evaluations requested by BWC include medical examinations required by statute: 90 day; 200 week; occupational disease (allowance); and permanent partial disability. Other evaluations are done for clarification of disability issues in claims. The DEP is open to providers who meet BWC’s acceptance criteria as a qualified medical specialist and who sign a written agreement for performance of medical examinations and medical file reviews. Acceptance criteria include:

- Licensure without restrictions;
- Specialty board certification;
- Active clinical practice within specialty;
- Professional and general liability and workers’ compensation coverage;
- Agreement to BWC’s performance requirements, fees and peer reviews of evaluation reports.

To apply for the DEP or for additional information, call BWC’s DEP Coordinator at (614) 995-0451 or write to: Ohio Bureau of Workers’ Compensation, Disability Evaluators Panel Coordinator, P.O. Box 15189, Columbus, OH 43215-0189. Providers authorized to perform these services may access the DEP handbook outlining billing codes, fees and instructions on BWC’s website under the Medical Providers page.

1. 90-Day Exams

An independent medical examination is required by statute after 90 consecutive days of temporary total compensation. This evaluation ensures that injured workers are receiving quality medical care and timely, appropriate claims management by MCOs and BWC. This exam determines:

- The ability for return to work and/or the attainment of MMI;
- Rehabilitation potential;
- Appropriateness of care.

Selection of the examining physician’s specialty from BWC’s DEP will be based on the specialty of the physician of record, the examiner’s ability to assess the injured worker’s rehabilitation potential, geographic proximity, and other factors. The examining physician may contact you to ensure that all pertinent medical information has been received and to discuss evaluation findings and recommendations.

Z. ASSISTANCE

To continuously improve service to our customers, BWC has 15 customer service offices.

BWC Service Offices

Cambridge

61501 Southgate Road, Suite 2
Cambridge, OH 43725-9114
(740) 435-4200
(866) 281-9351 Fax

Canton

400 Third Street SE, Suite 2
Canton, OH 44702-1102
(330) 438-0638
(866) 281-9352 Fax

Columbus

30 West Spring Street, L-11
Columbus, OH 43215-2256
(614) 728-5416
(866) 336-8352 Fax

Cleveland

615 West Superior Avenue, L-6
Cleveland, OH 44113-1889
(216) 787-3050
(866) 336-8345 Fax

Garfield Heights

4800 East 131st Street, Suite A
Garfield Heights, OH 44105-7132
(216) 584-0100
(866) 457-0590 Fax

Dayton

3401 Park Center Drive, Suite 100
Dayton, OH 45414-2577
(937) 264-5000
(866) 281-9356 Fax

Hamilton

Governor’s Hill

One Renaissance Center
345 High Street, L-6
Hamilton, OH 45011-6055
(513) 785-4500
(866) 336-8343 Fax

8500 Governor's Hill Drive, L-4
Cincinnati, OH 45249-1369
(513) 583-4400
(866) 281-9357 Fax

Logan

1225 West Hunter Street
Logan, OH 43138-1011
(740) 385-5607
(866) 336-8348 Fax

Lima

2025 East Fourth Street
Lima, OH 45804-4101
(419) 227-3127
(866) 336-8346 Fax

Portsmouth

1005 Fourth Street
Portsmouth, OH 45662-4315
(740) 353-2187
(866) 336-8353 Fax

Mansfield

The Tappan Building
240 Tappan Drive North, Suite A
Mansfield, OH 44906-1367
(419) 747-4090
(866) 336-8350 Fax

Toledo

One Government Center, Suite 1236
Toledo, OH 43604-0794
(419) 245-2700
(866) 457-0594 Fax

Youngstown

242 Federal Plaza West, Suite 200
Youngstown, OH 44503-1206
(330) 797-5500
(866) 457-0596 Fax

Central (Medical Claims, Special Claims)

30 West Spring Street, L-23
Columbus, OH 43215-2256
(800) 644-6292
(866) 336-8352 Fax

For HPP managed claims, direct all billing questions to the injured worker's MCO

Call 1-800-OHIOBWC (1-800-644-6292) to reach:

Injured worker relations, employer relations, forms and publications, fraud, rehabilitation and safety & hygiene.

AA. GLOSSARY

The following definitions pertain to medical coverage, and the billing and reimbursement of health-care services provided to injured workers. For other definitions, refer to the CPT® manual.

- 1. Allowed Condition** - Condition recognized as reimbursable in an active claim, which is a direct result of an industrial injury or occupational disease.
- 2. BWC Certified Provider** - A credentialed provider who signs a provider agreement with BWC and has agreed to be medically managed by any employer's MCO.
- 3. BWC Managed Claim** - A state-fund claim, which is not part of the HPP. In addition, Black Lung, Marine Fund and self-insuring claims are not part of HPP.
- 4. Consultation** - Services provided by a physician at the request of another physician regarding diagnosis, treatment and recommendations for continuing medical care in a particular claim. A consultant is expected to provide only an opinion.

5. **Covered Services** - Reimbursable medical services or supplies.
6. **Date of Injury (DOI)** - The date on which the injured worker sustained a work-related injury.
7. **Date of Service (DOS)** - The date on which treatment or services were provided to an injured worker.
8. **Due Process** - Parties must be given timely and appropriate notice of a decision, which allows an opportunity for the parties to submit additional evidence related to a particular issue for consideration.
9. **Health Partnership Program (HPP)** - The managed-care program for state-fund employers.
10. **HPP Managed Claim** - A claim, which is part of HPP. A BWC-certified MCO is responsible for medically managing the claim, paying all medical bills, and resolving disputes.
11. **Inactive Claim** - A claim where there has been no payment or other activity for twenty-four months.
12. **Independent Medical Evaluation (IME)** - An evaluation performed by a physician other than the treating physician. An IME usually includes a study of previous history and medical care information, and an examination and evaluation of the injured worker. This service may be necessary to make a judgment regarding the status of the injured worker or to determine the need for further medical services.
13. **Lost-Time Claim** - A claim filed when eight or more calendar days are lost from the job due to an industrial injury or occupational disease.
14. **Managed Care** - The coordinated delivery of health care through provider networks using utilization and payment/pricing strategies designed to provide appropriate, effective, and efficient health care.
15. **Managed Care Organization (MCO)** - A vendor who contracts with the bureau to provide medical management and cost-containment services.
16. **MCO Panel Provider** - A BWC-certified provider who is a panel provider within a BWC-certified MCO.
17. **Medical-Only Claim** - A claim filed when seven or fewer calendar days are lost from the job due to an industrial injury or occupational disease.
18. **Non-BWC Certified Provider** - A provider who is not approved by BWC for participation in HPP and has not signed a provider agreement with BWC or is not an eligible provider type for certification. For claims with dates of injury prior to Oct. 20, 1993, the injured worker may continue to be treated by the physician of record (POR) even if the POR is a non-BWC certified provider. However, if, for any reason, the injured worker decides to change physicians, a BWC certified-provider must be selected.
19. **Non-Covered Services** - Medical services or supplies that are not reimbursed.
20. **Occupational Disease** - An occupational disease is generally contracted in the course of and arising out of employment, usually occurring over a period of time.
21. **Physician of Record** - The primary care attending physician. BWC permits treatment by only one physician at a time for treatment of the allowed condition(s) in the claim. The injured worker must send a written request to change the physician of record. For a change of physician in a BWC-managed claim (i.e. Marine Fund or Black Lung claims), send a C-23 form to BWC and to the MCO for a change of physician in a MCO-managed claim.
22. **Prior Authorization Number** - The number given to providers for services requiring prior authorization.
23. **Provider Number** - An 11-digit number assigned to the provider by BWC to facilitate billing and reimbursement for services rendered under the workers' compensation program.

24. **Qualified Health Plan (QHP)** - The name of the managed-care program for self-insuring employers.
25. **Remittance Advice** - An itemized listing of bills paid or denied during the payment process.
26. **Self-Insuring Employer** - Employers who have been granted the privilege by BWC of administering their own workers' compensation programs and who pay compensation and benefits directly.
27. **State-Fund Employers** - Public and private employers who pay premiums for workers' compensation coverage.