

4123-6-20 Obligation for submitting medical documentation and reports.

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

(B) Interim medical reports and medical documentation.

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

- (1) The date of the report;
- (2) The date of the last examination;
- (3) The "International Classification of Disease" diagnosis code(s) recognized in the claim for all conditions and all parts of the body being treated that are affecting the length of disability, including a primary diagnosis code, with a narrative description identifying the condition(s) and specific area(s) of the body being treated;
- (4) Any reason(s) why recovery has been delayed;
- (5) The date temporary total disability began;
- (6) The current physical capabilities of the claimant;
- (7) An estimated or actual return to work date;
- (8) An indication of need for vocational rehabilitation;
- (9) Objective findings; and
- (10) Clinical findings supporting the above information.

(C) Treatment plan.

- (1) Upon allowance of a claim by the bureau, industrial commission, or self-insuring employer, the physician of record and other providers treating the claimant shall provide and continue to update a treatment plan to the MCO, QHP, or self-insuring employer according to the format or information requirements designated by the bureau. A treatment plan should include at least the following:
 - (a) Details of the frequency, duration, and expected outcomes of medical interventions, treatments, and procedures;
 - (b) The projected or anticipated return to work date; and
 - (c) Factors that are unrelated to the work related condition, but are impacting recovery.
 - (2) Modifications should be made to the initial treatment plan as treatment is extended, changed, completed, added, deleted or canceled. The modification should describe the current prognosis for the injured worker, progress to date, and expected treatment outcomes.
 - (3) Treatment plans should be updated when significant changes occur in the claim which impact claims management. Changes include:
 - (a) Additional allowance;
 - (b) Re-activation;
 - (c) Authorization of expenditures from the surplus fund;
 - (d) Return to modified or alternative work;
 - (e) Maximum medical improvement;
 - (f) Rehabilitation;
 - (g) A new injury while receiving treatment in the claim.
 - (4) Supplemental reports from the attending physician and other providers may be requested by the bureau, industrial commission, employer, MCO, QHP, or by the claimant or representative. These reports shall be used to determine the appropriateness of a benefit or bill payment.
- (D) In accepting a workers' compensation case, a medical provider assumes the obligation to provide to the bureau, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer, upon written request or facsimile thereof and within five business days, all medical, psychological, or psychiatric documentation

relating causally or historically to physical or mental injuries relevant to the claim required by the bureau, MCO, QHP, or self-insuring employer, and necessary for the claimant to obtain medical services, benefits or compensation.

(E) Independent medical examinations.

- (1) A provider performing an independent medical examination of a claimant shall create, maintain, and retain sufficient records, papers, books, and documents in such form to fully substantiate the accuracy of the resulting report submitted to the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer in connection with a workers' compensation claim. The provider, the provider's employees, and the provider's agents shall keep such records in accordance with rule 4123-6-45.1 of the Administrative Code, and such records shall be subject to audit pursuant to rule 4123-6-45 of the Administrative Code.
- (2) A provider performing an independent medical examination of a claimant shall keep confidential all information obtained in the performance of the independent medical examination, including but not limited to knowledge of the contents of confidential records of the bureau, industrial commission, claimant, employer, or their representatives, MCO, QHP, or self-insuring employer. The provider, the provider's employees, and the provider's agents shall maintain the confidentiality of such records in accordance with all applicable state and federal statutes and rules, including but not limited to rules 4123-6-15 and 4123-6-72 of the Administrative Code.

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