Getaway CLE, Ltd.

Advanced Ohio Workers' Compensation Seminar

October 9, 2021
Las Vegas

THE A.D.R. Process in Ohio Workers' Compensation

10:15 a.m. – 11:45 a.m.

I. Introduction: In this presentation we hope to provide a review and critical examination of the Ohio Bureau of worker's Compensation's Alternative Dispute Resolution process ("ADR") from the various points of view of the parties involved. The driving concerns of the BWC with reference to a physician's medical treatment(s), prescription overview, diagnostic testing, physical therapy care, including chiropractic treatment involvement and oversight of same. In addition, a discussion of the BWC Formulary with an emphasis on which medications will and will not be paid for. An explanation of why generic drugs are a key component of this.

II. So Why do we have this System in Place?

A. Prior: BWC payment of Bills by Claims Examiners. Remember this? Anybody remember all the problems with this? (Me neither)

B. Farming it out

C. Constitutional Questions & Conflict Questions

D. We're going to see QHP and HPP notations all over the place, what do these mean?

III. Governing Law

A. Medical Treatment:

1. Formerly Ohio Administrative Code Rule 4123-7-02 et seq.

2. Currently: QHP/HPP Process O.A.C. Rule 4123.6-01 et seq.

3. Some highlighted sections:

    a. O.A.C. 4123-6-10 Payment to Providers

    b. O.A.C. 4123-6-06.2 Employee Choice of Provider

    c. O.A.C. 4123-6-20 Obligation of Providers to Submit medical documentation and reports
       -what constitutes "documentation" and "reports"

    d. O.A.C. 4123-6-20: Copying Charges

    e. O.A.C. 4123-6-02.8 Obligation of Providers to Report a work Injury

B. Medications:

1. O.A.C. 4123-6-21 (State Fund Employers)

2. O.A.C. 4123-6-21.1 (Self-Insured Employers)

C. The Billing and Reimbursement Manual (The BWC's Bible for Doctors, Available for viewing on-line under the "Providers" Tab)

D. The Miller Criteria: from ***State ex rel Miller v. Indus. Comm.*** 71 Ohio St. 3d 229 (1994) and O.A.C. 4123-6-16.2

1. The 3-prong test outlined by the Ohio Supreme Court

    a. Are the medical services reasonably related to the industrial injury (allowed conditions)?

    b. Are the services reasonably necessary for the treatment of the industrial injury (allowed conditions)?

    c. Is the cost of these services medically reasonable?

IV. The Process (Medical Treatment)

A. Time Limitations: Everything must be submitted within <u>one year</u> (1 YEAR !) from the date of service. It is NOW no longer 2 years, everybody knows this, right ?!?

-Exceptions: Anyone want to share their thoughts?

*Initial claim allowance

*Claim amendment (C-86 Additional Conditions)

B. Causation Requirements (O.A.C. 4123-6-25)

1. Claim must be allowed

   a. by BWC Order

   b. by Industrial Commission Order

   c. Recognized by the Self-Insured Employer

2. Medical Services must be rendered as a direct result of an injury sustained or occupational disease contracted by a claimant in the course of and arising out of employment.

3. Medical services must be medically Necessary for the diagnosis and treatment of conditions allowed in the clam are causally related to the conditions allowed in the claim and are rendered by a health care provider.

C. Format/Request itself

1. Must use the C-9 form (remember the old C-161?)

   a. Proper Completion of C-9 Form

   b. Provider Number and Signature

   c. Supportive Medical Documentation

   d. Is a HCFA From ever acceptable?

2. The MCO reviews the Request for Treatment on State Funded Claims

3. The Self-Insured Employer reviews it on Self-Insured Claims

Issues letter or notification (on the C-9 form itself?) of approval or denial of payment for requested services

4. Disputes (denied services):

a. State-Funded:

-C-11 Form/Appeal (letter, stamp)
(Timeliness of the C-11 Appeal. THOUGHTS??)
See ***Haylett bv. BWC*** 87 Ohio St.3d.325 (1999).

-BWC Review (wanna know a secret? The MCO issues the BWC Order, not the BWC !)

-I-12 Appeal of BWC/MCO Order

-The Process:

*District Hearing Officer

*Staff Hearing Officer

*Full Commission (the refusal order-anybody ever gotten a 3rd hearing on this issue???)

*Recon ??????-anybody ver gotten a 3rd hearing on this issue???)

*Court of Appeals (Mandamus)

**Sounds like a nice stream-lined process to take care of medical treatment & bills, eh ?

**Kinda defeats the purpose, doesn't it?

**And what exactly WAS the purpose again?

b. Self-Insured:
  -C86 Motion for Treatment
  -DHO/SHO/IC - *-mandamus?*

5. Some other considerations

  a. Obligation to submit reports

    -Provider charges
    *The famous "Dude ! We're getting YOUR Treatment approved so YOU can get PAID. Why are you charging ANYTHING for this?"

    -APQ's:
      *Are these even worth it?
      *Are they even helpful at all?
      *Framing the issue

    -Office Notes: Sometime these are better than reports but you have to make sure they're signed, etc.

  b. Diagnostic testing:

    -Ohio Administrative Code:

    *IT <u>WAS</u> O.A.C. Rule 4123-6-32, payment for x-rays, CT and MRI and Discograms). Now it is under O.A.C. 4123.31(F). The language sounds pretty compelling. Ever cite it in aa hearing?

    ". . . approved for diagnostic purposes only. . . " WTF?? "Oh yeah, I am getting this MRI to help fight my athlete's foot."

  c. Physical therapy

    *Total Number of sessions, versus if at all

    *P.T. vs. D.C. care

d. Chiropractic treatment

*Is the BWC still hostile to chiropractors?
HECK YES ! The actually call them by name !

e. Consultations (“no prior authorization needed”)

V. The Process: Medication

A. Prescription Medication v. Over-the-Counter (OTC)

B. The BWC’s “Formulary”

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

C. Requesting Medication by the Physician of Record

1. Form Used: MEDCO-31

2. Formulary Request: MEDCO-35

D. The BWC Drug Review

1. At the request of the Employer/TPA/MCO

a. Form (MEDCO-34)

2. By the BWC (on its own, *sua sponte* for your Latin fans)

E. Generics vs. Name Brands:

1. The BWC’s Perspective: Generics all the way. No Exceptions. No more “D.A.W” (Dispense as Written)

2. Practice Tip: Watch out for this as the BWC is highly prejudicial in favor of the generic with few exceptions (almost none). Good luck getting something OTHER than generic, and be prepared to cite studies on side effects,

efficacy, and other concepts.

F. Provider Insistence on Brand-name medication:

1. "Dispense as Written"

2. Medical Justification

G. Some specific BWC policies on Medication and the Formulary

1. Examples and horror stories

2. What do you do? What do you tell your client?

a. Health Insurance is just easier, heck with BWC.

b. Provider prescriptions vs. PCP

VI. Final Thoughts and Trends

A. The TRUE obligation of doctors to submit reports/information

B. Trending: Employers appealing C-9 determinations and triggering the ADR/hearing process.

C. Freedom of Information/Public Records Requests and Treatment requests (if we have time HERE) What does this have to do with anything??

D. Comparative Analysis: State of Pennsylvania

E. Fee Agreement Issue (after you've done all this legal work, you've got the claim allowed, and perhaps even gotten PTD. Now you're going hearings every month. . . .for free . . . ??

F. So what do we walk away with on this??

<u>About the Presenter</u>: Joseph Gibson. Joe is an attorney with a private practice focusing on Workers' Compensation law representing both employers and injured workers. He is the owner of Gibson Law Offices, a law firm with locations in Fairborn and Tipp City Middletown. He was born in Dayton and raised in Middletown where he graduated in 1983 from Madison High School. In 1987 he graduated from the University of Dayton with Bachelor of Arts in Political Science. He went on to attend the University of Dayton School of Law, and where he earned his Juris Doctor degree in 1990. In the late 1980's and early 1990's, he worked for the Department of Defense at Wright-Patterson Air Force Base Air Force Logistics Command. His time there was mainly in the Air Force Contract Law Center where he reviewed Contracting Officer's Decisions for legal sufficiency. He also worked for the Legal Department at DAP, Inc. focusing of corporate matters, EPA and consumer products law. He was then appointed by the Ohio Bureau of Workers Compensation to be the local district attorney for Dayton and Springfield service offices where he represented the BWC at all levels of administrative hearing. He advised claim and risk staff on claim questions, premium issues, and agency policy. He has instructed at Sinclair Community College and Edison State Community College in the Political Science and Business Law Fields. In 2009 he was elected to City Council in his home town of Tipp City, Ohio earning the highest number of votes a candidate has ever won it the City's history. He was re-elected 4 years later and again in 2019. In 2014 he was selected to be Council President serving two terms. In 2018 he was elected Mayor of Tipp City. He also serves on the Tipp City-Monroe Township Cable Access Commission and the Miami County Council.

In his law practice he has attended thousands of workers' compensation hearings, and has tried many cases before judges and juries. He has argued before the Court of Appeals, the Supreme Court of Ohio and the Federal District Court. He was a member of the Dayton Bar Association Certified Grievance (Ethics) Committee and past Chairman the Dayton Bar Association Workers' Compensation/Social Security Committee. He is a member of the Dayton Bar Association, the Miami County Bar Association, the Phi Delta Phi Legal Fraternity, and the Sons of the American Legion. He is licensed to practice law in the State of Ohio and in the Federal District Court for the Southern District of Ohio.

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The ADR Process

Appendix

Ohio Administrative Code Rule 4123-6-10
Payments to Providers

Ohio Admin., Code Rule 4123-6-16
ADR Process

Ohio Administrative Code Rule 4123-6-20
Obligation to submit medical documentation and reports

Ohio Administrative Code Rule 4123-6-20.1
Charges for copies of medical reports.

Ohio Administrative Code Rule 4123-6-21

4123-6-21 Payment for outpatient medication.

Ohio Administrative Code Rule 4123-6.21.1
Payment for outpatient medication by self-insuring employer

Ohio Administrative Code Rule 4123-6-21.3
Outpatient Medication Formulary

Ohio Administrative Code Rule 4123-6-25
Payment for medical supplies and services

Ohio Administrative Code Rule 4123-6-37

Payment of hospital bills.

Ohio Administrative Code Rule 4123-6-02.8

Provider requirement to notify of injury.

BWC Policy Manual Chapter 5: The ADR Process

Rule 4123-6-10 | Payment to providers.

(A) HPP.

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

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

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

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

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

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

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

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

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

(a) As permitted under rule 4123-6-08 of the Administrative Code (including the appendix to the rule);
(b) As permitted under rule 4123-6-37.1, 4123-6-37.2 or 4123-6-37.3 of the Administrative Code;
(c) As permitted under rule 4123-18-09 of the Administrative Code;
(d) With non-bureau certified providers outside the state, where the treatment provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider;

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

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

(B) QHP.

(1) Within each QHP, all payments shall be in accordance with consistent billing and payment policies and practices established by the QHP and consistent with the provisions contained in paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.
(2) With the exception that no financial arrangement between an employer or QHP and a provider shall incentivize a reduction in the quality of medical care received by an injured worker, an employer or QHP may pay a QHP panel provider a rate that is the same, is above or, if negotiated with the provider in accordance with rule 4123-6-46 of the Administrative Code, is below the rates set forth in the applicable provider fee schedule rules developed by the bureau. Nothing in the rules pertaining to the QHP system shall be construed to inhibit employers or QHPs and providers in their efforts to privately negotiate a payment rate.
(3) An employer or QHP shall pay a bureau certified non-QHP panel provider other than a hospital the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.
(4) An employer or QHP shall pay a bureau certified non-QHP panel hospital the applicable amount under rule 4123-6-37.1 (inpatient) or 4123-6-37.2 (outpatient) of the Administrative Code, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.
(5) Employers' financial arrangements with company-based providers remain intact and services provided by company based providers need not be billed separately through QHP arrangements.

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

(a) The employer shall pay a non-bureau certified provider only for initial or emergency treatment of an injured worker for a workers' compensation injury, unless the QHP specifically

authorizes further treatment. A non-bureau certified provider shall inform the injured worker that the provider is not a participant in the QHP and that the injured worker may be responsible for the cost of further treatment after the initial or emergency treatment, unless payment for further treatment is specifically authorized by the QHP. The injured worker may continue to obtain treatment from the non-bureau certified provider, but the payment for the treatment shall be the injured worker's sole responsibility, except as provided in this paragraph.

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

(7) An employer or QHP shall pay a non-bureau certified hospital that provides initial or emergency medical treatment or further medical treatment that has been specifically authorized by the QHP the applicable amount under rule 4123-6-37.1 (inpatient) or 4123-6-37.2 (outpatient) of the Administrative Code, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.
(8) The employer or QHP shall not pay for missed appointments or procedures. If the provider customarily charges for missed appointments or procedures, the provider shall inform the injured worker upon the initial or emergency treatment that the provider charges for missed appointments or procedures and that such charges are the responsibility of the injured worker. Bills must only contain descriptions of services that have been actually delivered, rendered, or directly supervised by the provider for the actual conditions treated. A provider shall not transmit to the employer or QHP any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

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

(1) Payment for medical services and supplies by self-insuring employers shall be equal to or greater than the fee schedule established by the bureau in state fund claims, unless otherwise negotiated with the provider in accordance with rule 4123-6-46 of the Administrative Code. All payments by the self-insuring employer shall be consistent with the provisions contained in paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.
(2) The self-insuring employer shall not pay for missed appointments or procedures. If the provider customarily charges for missed appointments or procedures, the provider shall inform the injured worker upon the initial or emergency treatment that the provider charges for missed appointments or procedures and that such charges are the responsibility of the injured worker. Bills must only contain descriptions of services that have been actually delivered, rendered, or directly supervised by the provider for the actual conditions treated. A provider shall not transmit to the self-insuring employer any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

(D) Provider duty to report overpayment. A provider that has identified an overpayment must report and return the overpayment to the bureau, QHP or self-insuring employer within sixty days of identifying the overpayment. Providers must exercise reasonable diligence to identify and quantify overpayments.

Last updated June 4, 2021 at 10:25 AM

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

(A) Pursuant to division (A)(1) of section 4121.441 of the Revised Code, this rule shall provide procedures for an alternative dispute resolution (ADR) process for medical disputes between an employer, an injured worker, or a provider and an MCO arising from the MCO's decision regarding a medical treatment reimbursement request (on form C-9 or equivalent). An injured worker or employer must exhaust the ADR procedures of this rule prior to filing an appeal under section 4123.511 of the Revised Code on an MCO's decision regarding a medical treatment reimbursement request.
(B) Within fourteen days of receipt of an MCO decision, an injured worker, employer, or provider may dispute the decision in writing (on form C-11 or equivalent) to the MCO. The written medical dispute must contain, at a minimum, the following elements:

(1) Injured worker name.

(2) Injured worker claim number.

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

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

(5) Name of party making written appeal request.

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

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

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

(1) If an individual health care provider eligible to be physician of record would be providing the services requested in the dispute, the independent level of professional review shall consist of a peer review conducted by an individual or individuals licensed pursuant to the same section of the Revised Code as the health care provider who would be providing the services requested.

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) Either the MCO or the bureau may schedule an independent medical examination (IME) of the claimant to assist in the ADR process under this rule.

(1) An ADR IME will be limited to issues relating to medical treatment disputes, and will not include extent of disability issues. An ADR IME will not be conducted at the request of an employer and does not substitute for an examination permitted under section 4123.651 of the Revised Code.
(2) If an ADR IME is scheduled under this rule, the parties, and their representatives, if any, will be promptly notified as to the time and place of the examination, and the questions and information provided to the doctor. An electronic copy of the ADR IME report will be submitted to the claim file. The injured worker will be reimbursed for travel expenses in accordance with rule 4123-6-40 of the Administrative Code.
(3) If an injured worker refuses to attend an IME to assist in the ADR process, the MCO will refer the issue to the bureau, and the injured workers right to benefits may be suspended during the period of refusal.

Last updated April 8, 2021 at 12:17 PM

4123-6-20 Obligation to Submit medical documentation and reports

(A) A provider is responsible for the accuracy and legibility of all reports, information, and documentation submitted by the provider, the provider's employees, or the provider's agents to the bureau, industrial commission, injured worker, 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, injured worker, employer, or their representatives, MCO, QHP, or self-insuring employer any report, information, and documentation containing false, fraudulent, deceptive, or misleading information.

(B) Physician's medical reports of work ability.

(1) Physicians treating injured workers shall complete, sign, and submit to the MCO a physician's report of work ability on form MEDCO-14 or equivalent upon every injured worker encounter, unless:

(a) The injured worker has been awarded compensation for permanent total disability;

(b) The injured worker returns to work without restrictions within seven days of the injury; or

(c) The injured worker is seeing the treating physician after the treating physician has submitted a MEDCO-14 or equivalent releasing the injured worker to return to the former position of employment without restrictions.

(2) The physician's report of work ability must include at a minimum the following:

(a) The date of the report;

(b) The date of the last examination;

(c) 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;

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

(e) The date temporary total disability began;

(f) The current physical capabilities of the injured worker;

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

(h) An indication of need for vocational rehabilitation;

(i) Objective findings; and

(j) Clinical findings supporting the information in this rule.

(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 injured worker 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 estimated 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 that impact claims management. Changes include:

(a) Additional allowance;

(b) Re-activation;

(c) Authorization of expenditures from the surplus fund;

(d) Return to modified or alternative work;

(e) Maximum medical improvement;

(f) Rehabilitation;

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

(D) Supplemental reports or other bureau forms from the attending physician and other providers may be requested by the bureau, industrial commission, employer, MCO, QHP, or by the injured worker or

representative. These reports shall be used to determine the appropriateness of a benefit, bill payment, or allowance.

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

(F) Independent medical examinations.

(1) A provider performing an independent medical examination of a injured worker 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, injured worker, 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 injured worker 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, injured worker, 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.

Last updated April 8, 2021 at 12:18 PM

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

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

(B) Except as provided in this rule, a medical provider shall not assess a fee or charge the bureau, industrial commission, MCO, QHP, self-insuring employer, claimant, employer, or their representatives for the costs of completing any bureau form or providing any documentation requested pursuant to rule 4123-6-20 of the Administrative Code.

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

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

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

(C) As provided in division (B) of section 4123.651 of the Revised Code, a claimant shall promptly provide a current signed release of medical information, records, and reports relative to the issues necessary for the administration of the claim when requested by the employer. The employer shall immediately provide copies of all medical information, records, and reports to the bureau and to the claimant or the claimant's representative upon request.

Last updated April 8, 2021 at 12:18 PM

Rule 4123-6-21 | Payment for outpatient medication.

(A) Except as otherwise provided in rule 4123-6-21.6 of the Administrative Code, medication must be for the treatment of a work related injury or occupational disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer. The bureau may deny a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of the allowed conditions in a claim.
(B) Medication may be prescribed by any treating provider authorized by law to prescribe such medication; however, reimbursement for medication shall be denied under the following circumstances:

(1) Reimbursement for prescriptions written by providers who are not enrolled with the bureau and who refuse to become enrolled shall be denied.

(2) Reimbursement for prescriptions written by providers who are enrolled but non-certified shall be denied except in the following situations:

(a) The prescription is written by a non-bureau certified provider during initial or emergency treatment of the injured worker if the injured worker's claim and treated conditions are subsequently allowed.

(b) The prescription is written by a non-bureau certified provider who is outside the state or within the state where no or an inadequate number of bureau certified providers exist and the MCO has determined that the treatment to be provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider and has authorized the non-bureau certified provider to continue to provide the treatment.

(c) The prescription is written by a non-bureau certified provider for an injured worker with a date of injury prior to October 20, 1993, the provider was the injured worker's physician of record prior to October 20, 1993, and the injured worker has continued treatment with that non-bureau-certified provider.

(C) Drugs covered are limited to those that are approved for human use in the United States by the food and drug administration (FDA) and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) The bureau may require prior authorization of certain drugs or therapeutic classes of drugs, drugs above a certain cost threshold, drugs submitted outside a certain time frame from the date of injury or the last prescription submitted. or drugs being prescribed for a condition or in a manner not approved by the FDA. The bureau will publish a list of all such drugs or therapeutic classes of drugs, cost thresholds, or time frames for which prior authorization is required.

(E) Prescriptions for compounded drug products:

(1) Prior authorization may be required for compounded sterile drug products.

(2) Compounded non-sterile prescriptions.

(a) Reimbursement for non-sterile compounded prescriptions will be denied, except when a commercially available formulary product becomes unavailable (listed on the "Food & Drug Administration Drug Shortages List," or "American Society of Health-System Pharmacists Drug Shortages List").

(b) Reimbursement for non-sterile compounded prescriptions shall only be considered upon the submission of both:

(i) A prior authorization request, and

(ii) A copy of the signed prescription that lists all active pharmaceutical ingredients. The prescription must comply with the Ohio state board of pharmacy requirements for a valid prescription set forth in rules 4729-5-13 and 4729-5-30 of the Administrative Code.

(c) Approval for reimbursement of non-sterile compounded prescriptions will be for an initial period of thirty days with subsequent approvals contingent upon commercial product availability. Not more than one prescription for a non-sterile compounded prescription will be approved for reimbursement in any thirty day period.

(F) Drugs which fall into one of the following categories may be approved and reimbursed by an MCO as part of a comprehensive treatment plan submitted by the physician of record or treating physician:

(1) Drugs for the treatment of obesity;

(2) Drugs for the treatment of infertility;

(3) Non-compounded parenteral drugs not intended for self-administration;

(4) Drugs used to aid in smoking cessation;

(5) Drugs dispensed to a injured worker while the injured worker is admitted to a hospital during an approved inpatient admission or during the course of an outpatient visit in a hospital.

(G) Payment for medications to pharmacy providers shall include both a product cost component and a dispensing fee component.

(1) Except as provided in this paragraph, product cost component shall be the lesser of the following: maximum allowable cost, if applicable, or the average wholesale price (AWP) of the commonly stocked package size minus fifteen per cent.

(a) For repackaged brand name medications, the product cost component shall be calculated using the AWP of the original labeler.

(b) For compounded prescriptions, the product cost component shall be limited to the lesser of the maximum allowable cost, if applicable, for each ingredient, or the AWP of the commonly stocked package size minus fifteen per cent for each ingredient.

(c) The maximum reimbursement for any one non-sterile compounded prescription will be one hundred dollars.

(2) The dispensing fee component for non-compounded prescriptions shall be three dollars and fifty cents. Only pharmacy providers are eligible to receive a dispensing fee.

(3) The dispensing fee component for non-sterile compounded prescriptions shall be eighteen dollars and seventy-five cents.

(4) The dispensing fee component for sterile compounded prescriptions shall be thirty-seven dollars and fifty cents.

(H) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined by the bureau under paragraph (G) of this rule. The bureau shall not reimburse any third-party pharmacy biller that submits pharmacy bills on behalf of a pharmacy provider or that has purchased pharmacy bills from a pharmacy provider for subsequent submission to the bureau for payment. Pharmacy providers are required to submit for billing the NDC number of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or the bureau's pharmacy benefit manager's payment system must be used for billing purposes. The pharmacy provider shall:

(1) Include prescriber information within bills submitted electronically to the bureau or the bureau's pharmacy benefits manager for payment. The prescriber information must include the national provider identifier (NPI) or the drug enforcement administration (DEA) number;

(2) Not pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker, or to any other person, firm, or corporation (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services for which payment may be made by the bureau, the bureau's pharmacy benefits manager, or MCO under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;

(3) Comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service.

(I) The bureau may establish a maximum allowable cost for single source or multi-source medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the FDA and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations" in effect on the billed date(s) of service. The methodology used to determine a maximum allowable cost for a qualified drug product shall be determined by the bureau. The bureau may choose to utilize the maximum allowable cost list of a vendor or develop its own maximum allowable cost list.

(J) Injured workers who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication for which pharmaceutically and therapeutically equivalent medication exist, as defined in paragraph (I) of this rule, shall be liable for the product cost difference between the AWP of the dispensed brand name drug minus fifteen percent and the established maximum allowable cost price of the drug product. However, the bureau may approve reimbursement of the dispensed brand name drug at the AWP of the drug minus fifteen per cent if the following circumstances are met:

(1) The injured worker has a documented, systemic allergic reaction as a result of taking the generic equivalent which is consistent with known symptoms or clinical findings of a medication allergy; or

(2) The injured worker has been prescribed, and has tried, another generic equivalent and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.

(K) The following dispensing limitations may be adopted by the bureau:

(1) The bureau may publish supply limitations for drugs which represent the maximum number of days supply that may be dispensed at any one time for a single prescription.

(2) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

(3) Requests submitted that exceed any published days supply limit or maximum quantity limit shall be denied. Denials may be overridden by the bureau in cases where medical necessity and appropriateness have been determined.

(4) Refills of drugs not scheduled by the DEA requested before eighty per cent of any published days supply limit has been utilized will be denied.

(5) Refills of drugs scheduled by the DEA requested before ninety per cent of any published days supply limit has been utilized will be denied.

(6) Denials may be overridden by the bureau for the following reasons with supporting documentation:

(a) The injured workers pharmacy is submitting an early refill for a shortened days supply to support synchronizing the filling or refilling of the prescription in a manner that allows the dispensed drug to be obtained on the same date each month;

(b) The injured worker is traveling out of the country and will be unable to refill medications during that time;

(c) The injured worker's pharmacy will be closed for more than two days.

(d) An emergency or disaster, as defined in division (O) of section 4123.511 of the Revised Code, is declared by the governor of Ohio or the president of the United States.

(L) Except as otherwise provided in paragraph (F) of this rule, outpatient medications shall be billed to and reimbursed through the bureau's pharmacy benefits manager. Pharmacy providers must submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the bureau's pharmacy benefits manager's established bill processing system as a condition of provider enrollment or reimbursement. Submission by paper or by tape-to-tape will not be accepted by the bureau or the bureau's pharmacy benefits manager.

(M) A claimant may request outpatient medication reimbursement in accordance with rule 4123-6-26 of the Administrative Code using form C-17 or equivalent. Claimant reimbursement may be limited to the following situations:

(1) Claimants whose medication is not payable under division (I) of section 4123.511 of the Revised Code on the date of service, but later becomes payable;

(2) Emergency situations where an enrolled pharmacy provider is not available;

(3) Claimants who reside out of the country.

(N) A "pharmacy provider" designation and provider number can be obtained by a provider who meets all the following criteria:

(1) Has a valid "terminal distributor of dangerous drugs" as defined in section 4729.01 of the Revised Code if located within Ohio; or an equivalent state license if located outside of Ohio; and,
(2) Has a valid DEA number; and,

(3) Has a licensed registered pharmacist in full and actual charge of a pharmacy; and,

(4) Has the ability and agrees to submit bills at the point of service.

All state and federal laws and regulations relating to the practice of pharmacy and the dispensing of medication by a duly licensed pharmacist must be observed.

(O) The bureau may contract with a pharmacy benefit manager to perform drug utilization review and on-line bill processing, maintain a pharmacy provider network and prior authorization program for medications, and provide management reports. The bureau or its vendor may also contract rebate agreements with drug manufacturers. The bureau may utilize other services or established procedures of the pharmacy benefits manager which may enable the bureau to control costs and utilization and detect fraud.

(P) The bureau may identify circumstances under which it may consider reimbursement for pharmacist professional services (also known as cognitive services) when payment for such services results in a measurable, positive outcome. The bureau shall be responsible for developing the criteria which will be used to assess the compensability of billed pharmacist professional services. The bureau shall be responsible for developing the structure of the reporting of the measurable outcomes used to justify the payment of pharmacist professional services, which may include reimbursement for the dispensing fee component. The amount that could be reimbursed for pharmacist professional services shall be determined by the bureau.

(Q) The bureau shall retain a registered pharmacist licensed in the state of Ohio to act as the full-time pharmacy program director to assist the bureau in the review of drug bills. The pharmacy program director may assist the bureau in determining the appropriateness, eligibility, and reasonableness of compensation payments for drug services. The bureau may adopt a drug formulary with the recommendation of the bureau's pharmacy and therapeutics committee established by rule 4123-6-21.2 of the Administrative Code, and may consult with the committee on the development and ongoing annual review of the drug formulary and other issues regarding medications.
Last updated August 2, 2021 at 9:36 AM

Rule 4123-6-21.1 Payment for outpatient medication by self-insuring employer.

(A) Medication must be for treatment of a work related injury or occupational disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer.

(B) Medication may be prescribed by any treating provider authorized by law to prescribe such medication.

(C) Drugs covered in self-insuring employer claims are limited to those that are approved for human use in the United States by the food and drug administration (FDA) and that are dispensed by a registered pharmacist.

(D) A self-insuring employer may approve and reimburse for various drugs as a part of a comprehensive treatment plan submitted by the physician of record or a treating physician when reasonably related to and medically necessary for treatment of the allowed conditions in the claim, provided that such approval and reimbursement shall not constitute the recognition of any additional conditions in the claim even if such drugs are used to treat conditions that have not been allowed in the claim.

(E) Payment for medications to pharmacy providers shall include both a product cost component and a dispensing fee component.

(1) Except as provided in this paragraph, product cost component shall be the lesser of the following: maximum allowable cost established under paragraph (N) of this rule, if applicable, or the average wholesale price (AWP) of the commonly stocked package size minus fifteen per cent.

(a) For repackaged brand name medications, the product cost component shall be calculated using the AWP of the original labeler.

(b) For compounded prescriptions, the product cost component shall be limited to the lesser of the the maximum allowable cost, if applicable, for each ingredient or the AWP of the commonly stocked package size minus fifteen per cent for each ingredient.

(c) The maximum product cost component reimbursement for any one non-sterile compounded prescription will be four hundred dollars.

(2) The dispensing fee component for non-compounded prescriptions shall be three dollars and fifty cents, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider pursuant to rule 4123-6-46 of the Administrative Code. Only pharmacy providers are eligible to receive a dispensing fee.

(3) The dispensing fee component for non-sterile compounded prescriptions shall be eighteen dollars and seventy-five cents.

(4) The dispensing fee component for sterile compounded prescriptions shall be thirty-seven dollars and fifty cents.

(F) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined in paragraph (E) of this rule, unless the self-insuring employer has negotiated a payment rate with the provider pursuant to rule 4123-6-46 of the Administrative Code. Pharmacy providers are required to submit for billing the national drug code (NDC) number of the stock bottle from

which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(G) The pharmacy provider shall:

(1) Include prescriber information within bills submitted electronically to the self-insuring employer or its vendor for payment. The prescriber information must include the national provider identifier (NPI) or the drug enforcement administration (DEA) number;

(2) Not pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker, of to any other person, firm, or corporation (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services for which payment may be made by the self-insuring employer or its vendor or QHP under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;

(3) Comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service.

(H) Claimant reimbursement for medications shall be in accordance with rule 4123-6-26 of the Administrative Code and shall at least be equal to the bureau's established rate for the medication, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider utilized by the claimant pursuant to rule 4123-6-46 of the Administrative Code, in which case the claimant reimbursement shall be at least the rate negotiated with the provider. Requests for reimbursement must be paid within thirty days of receipt of the request.

(I) Self-insuring employers must obtain a drug utilization review from a physician before terminating payment for current medications, as follows:

(1) Except as otherwise provided in paragraph (I)(7) of this rule, before terminating payment for current medications, the self-insuring employer shall notify all parties to the claim (including authorized representatives) and the prescribing physician, in writing, that a physician drug review is being performed, or has been performed, regarding the necessity and appropriateness of the continued use of current medications (by therapeutic drug class).

(2) The written notice shall inform all parties to the claim (including authorized representatives) and the prescribing physician that they have twenty-one days from receipt of the notice to provide additional information and/or medical documentation to justify the need for continued use of the medications (by therapeutic drug class).

(3) The self-insuring employer shall provide all medically related information regarding the medications to an independent physician reviewer for review and opinion as to the necessity or appropriateness of the medications. If the self-insuring employer has obtained an independent physician reviewer's report prior to sending the notice required by paragraph (I)(1) of this rule and subsequently receives additional information and/or medical documentation pursuant to paragraph (I)(2) of this rule, the self-insuring employer shall provide the additional information and/or medical documentation to the independent physician reviewer and obtain an addendum. The independent physician reviewer's report (and addendum, if applicable) shall address the medical rationale, necessity and appropriateness of the drug treatment in the control of symptoms associated with the allowed conditions in the claim.

(4) When the independent physician reviewer's report (and addendum, if applicable) indicates the drug treatment is not medically necessary or appropriate for treatment or in the control of symptoms associated with the allowed conditions in the claim, the self-insuring employer may terminate

reimbursement for the medications (by therapeutic drug class) effective as of the date of receipt of the independent physician reviewer's report, or addendum if one is obtained, or in the case that a drug is in a therapeutic class that requires a "weaning-off" period, in accordance with the tapering schedules set forth in the appendix to rule 4123-6-21.5 of the Administrative Code or such other date as agreed to by the prescribing physician and self-insuring employer.
(5) In the event the self-insuring employer terminates reimbursement for the medications as set forth in paragraph (I)(4) of this rule, the self-insuring employer or its authorized representative shall provide all parties to the claim (including authorized representatives) and the prescribing physician with a copy of the independent physician reviewer's report (and addendum, if applicable) and the self-insuring employer shall notify the injured worker and the injured worker's representative in writing of its decision to terminate. The employer's notification to the injured worker and injured worker's representative shall indicate that the injured worker has the right to request a hearing before the industrial commission.

(6) In the event there is a dispute as to whether the drug treatment is medically necessary or appropriate for treatment of the symptoms associated with the allowed conditions in the claim, the disputed matter shall be adjudicated in accordance with paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.
(7) The self-insuring employer may terminate current medications that have been removed from the bureaus outpatient medication formulary set forth in the appendix to rule 4123-6-21.3 of the Administrative Code without obtaining a physician drug review. However, the tapering schedules set forth in the appendix to rule 4123-6-21.5 of the Administrative Code would apply.
(J) Self-insuring employers may deny initial requests for a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for the treatment of the allowed conditions in a claim.

(K) Self-insuring employers may contract with a pharmacy benefits manager. A self-insuring employer utilizing a pharmacy benefits manager may require pharmacy providers to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the pharmacy benefits managers established bill processing system as a condition of reimbursement, and may refuse submission by paper or by tape-to-tape. Self-insuring employers utilizing a pharmacy benefits manager may refuse to reimburse any third-party pharmacy biller that submits pharmacy bills on behalf of a pharmacy provider or that has purchased pharmacy bills from a pharmacy provider for subsequent submission to the self-insuring employer for payment.

(L) Self-insuring employers utilizing a pharmacy benefits manager may require prior authorization of drugs or therapeutic classes of drugs which appear on the bureau's published list of drugs or therapeutic classes of drugs for which prior authorization is required. Notwithstanding rule 4123-19-03 of the Administrative Code, the self-insuring employer shall approve or deny a prior authorization request within three business days of the request.
(M) Self-insuring employers utilizing a pharmacy benefits manager may apply the following dispensing limitations, adopted by the bureau, to medications approved and reimbursed by the self-insuring employer:

(1) The bureau may publish supply limitations for drugs which represent the maximum number of days supply that may be dispensed at any one time for a single prescription.

(2) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

(3) Requests submitted that exceed either the days supply limit or maximum quantity limit shall be denied; provided, however, that the pharmacy provider may still fill the prescription up to the days supply limit or maximum quantity limit, as applicable. Denials may be overridden by the self-insured employer in cases where medical necessity and appropriateness have been determined.

(4) Refills of drugs not scheduled by the DEA requested before eighty per cent of any published days supply limit has been utilized will be denied.

(5) Refills of drugs scheduled by the DEA requested before ninety per cent of any published days supply limit has been utilized will be denied.

(6) Denials may be overridden by the self-insured employer for the following reasons with supporting documentation:

(a) The injured worker's pharmacy is submitting an early refill for a shortened days supply to support synchronizing the filling or refilling of the prescription in a manner that allows the dispensed drug to be obtained on the same date each month;

(b) The injured worker is traveling out of the country and will be unable to refill medications during that time;

(c) The injured worker's pharmacy will be closed for more than two days.

(d) An emergency or disaster, as defined in division (O) of section 4123.511 of the Revised Code, is declared by the governor of Ohio or the president of the United States.

(N) Self-insuring employers utilizing a pharmacy benefits manager may apply the maximum allowable cost list of the pharmacy benefits manager.

(O) Injured workers who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication for which pharmaceutically and therapeutically equivalent medications exist, as defined in paragraph (I) of rule 4123-6-21 of the Administrative Code, shall be liable for the product cost difference between the AWP of the dispensed brand name drug minus fifteen per cent and the established maximum allowable cost price of the drug product. However, the self-insuring employer or its vendor may approve reimbursement of the dispensed brand name drug at the AWP of the drug minus fifteen per cent if the following circumstances are met:

(1) The injured worker has a documented, systemic allergic reaction as a result of taking the generic equivalent which is consistent with known symptoms or clinical findings of a medication allergy; or

(2) The injured worker has been prescribed, and has tried, another generic equivalent and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.

(P) A self-insuring employer has sufficient grounds to refuse to pay for the dispensing of drugs and other medications when a pharmacy provider fails to observe any state or federal law relating to his or her professional licensure or to the dispensing of drugs and other medication.

Last updated July 1, 2021 at 1:29 PM

Rule 4123-6-21.3 | Outpatient medication formulary.

(A) The administrator hereby adopts the formulary indicated in the appendix to this rule, developed with the recommendation of the bureau's pharmacy and therapeutics committee, effective August 1, 2021.

(B) Except as otherwise provided in paragraph (F) of this rule, the formulary indicated in the appendix to this rule shall constitute the complete list of medications that are approved for reimbursement by the bureau for the treatment of a work related injury or disease in an allowed claim when dispensed to an injured worker by a registered pharmacist from an enrolled outpatient pharmacy provider.

(C) The formulary indicated in the appendix to this rule also contains specific reimbursement, prescribing or dispensing restrictions that have been placed on the use of listed drugs. The formulary will be reviewed and updated as necessary. The most current version will be electronically published by the bureau.

(D) The administrator will consider current medical literature and best practices and the recommendations of the bureaus pharmacy and therapeutics committee when making additions, deletions, or modifications of coverage of medications listed in the formulary.

(E) The bureau shall provide an expedited review process for clinically or therapeutically unique medications when necessary.

(F) Notwithstanding paragraph (B) of this rule, in cases of medical necessity supported by medical documentation and evidence of need the bureau may reimburse for:

> (1) New drugs approved for use in the United States by the food and drug administration (FDA) on or after the effective date of the formulary, and for new indications approved by the FDA on or after the effective date of the formulary for existing drugs that are not on the formulary, with prior authorization, for a period not to exceed one hundred eighty days from the adjudication date of the first prescription for the requested drug.
>
> (2) Antineoplastic drugs prescribed for treatment of an allowed cancer condition in a claim.

(G) Notwithstanding the appendix to this rule, in cases of medical necessity supported by medical documentation and evidence of need the bureau may reimburse for new dosage forms or strengths approved by the FDA on or after the effective date of the formulary for existing drugs that are on the formulary, with prior authorization, for a period not to exceed one hundred eighty days from the adjudication date of the first prescription for the requested drug.

Last updated August 2, 2021 at 9:36 AM

4123-6-25 Payment for medical supplies and services.

(A) Medical or other services to be approved for payment must be rendered as a direct result of an injury sustained or occupational disease contracted by a claimant in the course of and arising out of employment. The claim must be allowed by an order of either the bureau of workers' compensation or the industrial commission, or have been recognized by a self-insuring employer.

Medical supplies and services will be considered for payment when they are medically necessary for the diagnosis and treatment of conditions allowed in the claim, are causally related to the conditions allowed in the claim, and are rendered by a health care provider. Payment for services rendered to a claimant shall be paid to a health care provider only when the provider has either delivered, rendered or supervised the examination, treatment, evaluation or any other medically necessary and related services . Provider supervision of services shall comply with the requirements of the provider's regulatory board and the centers for medicare and medicaid services (CMS), if applicable, for supervision of the service, as in effect on the billed date of service, unless otherwise specified in the bureau's provider billing and reimbursement manual in effect on the billed date of service. By submitting any fee bill to the bureau, in either hardcopy or electronic format, the health care provider affirms that medical supplies and services have been provided to the claimant as required by this rule.

Providers billing for services rendered shall follow the procedures set forth in the bureau's provider billing and reimbursement manual in effect on the billed date of service.

(B) Services rendered by health care providers are subject to review for coding requirements outlined in paragraph (C) of this rule. Payments to health care providers may be adjusted based upon these guidelines.

(C) Coding systems.

(1) Billing codes.

(a) Practitioners are required to use the edition of the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) in effect on the billed date of service to indicate the procedure or service rendered to injured workers.

(b) Inpatient and outpatient hospital services must be billed using the national uniform billing committee's revenue center codes in effect on the billed date of service (date of discharge for inpatient services).

(c) Outpatient medication services must be billed pursuant to the requirements described in the bureau's provider billing and reimbursement manual in effect on the billed date of service.

(d) To insure accurate data collection, the bureau shall adopt a standardized coding structure which shall be adopted by any MCO, QHP, or self-insuring employer.

(2) Diagnosis codes.

Providers must use the appropriate "International Classification of Diseases, clinical modification" codes for the condition(s) treated to indicate diagnoses.

(D) Prior to services being delivered, the provider must make reasonable effort to notify the claimant, bureau, MCO, QHP or self-insuring employer when the provider has knowledge that the services may not be related to the claimed or allowed condition(s) related to the industrial injury or illness, or that a service is non-covered. The provider may not knowingly bill or seek payment from the bureau, MCO, QHP or self-insured employer for services that are not related to the claimed or allowed condition(s) related to the industrial injury or illness. The provider may not knowingly mislead or direct providers of ancillary services to bill or seek payment for services that are not related to the claimed or allowed condition.

The provider may not bill or seek payment from the claimant for services determined as medically unnecessary through the use of bona fide peer review based on accepted treatment guidelines.

4123-6-37 Payment of hospital bills.

(A) Direct reimbursement will not be made to members of a hospital resident staff.

(B) Payment for personal comfort items, which include, but are not limited to, telephones, television, and private rooms provided at the patient's request, are not compensable.

(C) Bureau fees for hospital inpatient services.

(1) Bureau fees for hospital inpatient services will be based on usual and customary methods of payment, such as prospective payment systems, including diagnosis related groups (DRG), per diem rates, rates based on hospital cost to charge ratios or percent of allowed charges.

(2) Except in cases of emergency , prior authorization must be obtained in advance of all hospitalizations. The hospital must notify the bureau, the injured worker's MCO, QHP, or self-insuring employer of emergency inpatient admissions within one business day of the admission. Failure to comply with this rule shall be sufficient ground for denial of room and board charges by the bureau, MCO, QHP, or self-insuring employer from the date of admission up to the actual date of notification. Room and board charges denied pursuant to this rule may not be billed to the injured worker.

(D) Bureau fees for hospital outpatient services.

(1) Bureau fees for hospital outpatient services, including emergency services, will be reimbursed in accordance with usual and customary methods of payment which may include prospectively determined rates, allowable fee maximums, ambulatory payment categories (APC), hospital cost to charge ratios, or a percent of allowed charges, as determined by the bureau.

(2) Treatment in the emergency room of a hospital must be of an immediate nature to constitute an emergency as defined in this chapter. Prior authorization of such treatment is not required. However, in situations where the emergency room is being utilized to deliver non-emergency care, notification will be provided to the injured worker, the hospital, and the provider of record that continued use of the emergency room for non-emergent services will not be reimbursed.

(E) The bureau may establish the same or different fees for in-state and out-of-state hospitals based on the above reimbursement methodologies.

(F) Payment will be made for hospital services in accordance with rule 4123-6-10 of the Administrative Code.

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

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

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

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

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

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