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I. GENERAL

- A. Provider Number - A provider, who meets the qualifications to enroll as a Ohio Bureau of Worker's Compensation (BWC) provider, must enroll to receive an individual provider number. The provider must submit the individual provider number as the servicing provider number for billing purposes, unless otherwise noted below.
- B. ~~Provider Services~~ - See provider enrollment policy.
- C. ~~Therapy Visits~~ - See prior authorization policy.
- D. ~~Maximum Approval Period~~ - See prior authorization policy.

II. PRACTITIONER SERVICES -

- A. Covered Medical Service Provider
 - 1. Physician of Record
 - a. The physician of record is the primary attending physician chosen by the injured worker to direct treatment. The physician of record must be an eligible provider who is a BWC certified provider. The physician of record may or may not be a managed care organization (MCO) panel provider.
 - b. An injured worker with a date of injury prior to October 20, 1993, may retain a non-certified provider as a physician of record, if such relationship already exists.
 - c. Any request to change a physician of record must be changed to a BWC-certified provider. *(Section II.P.b.)*
 - 2. An injured worker may have only one (1) physician of record at any given time, even in claims where more than one (1) physician treats the injured worker.
 - 3. The MCO may not dispute an injured worker's selection of a physician of record.
 - 4. A physician of record must be a:
 - a. Medical Doctor;
 - b. Doctor of Osteopathic Medicine;
 - c. Doctor of Mechanotherapy;
 - d. Doctor of Chiropractic;
 - e. Doctor of Podiatry;
 - f. Doctor of Dental Surgery; or
 - g. Licensed Psychologist (e.g., PhD or PsyD).
- B. Physician Assistant
 - 1. The Physician Assistant provides services within the scope of the approved supervision agreement with the Physician Assistant collaborating or supervising physician(s).
 - 2. BWC reimburses the Physician Assistant at eighty-five percent (85%) of the [BWC Fee Schedule](https://www.bwc.ohio.gov/provider/services/FeeSchedules.asp) (<https://www.bwc.ohio.gov/provider/services/FeeSchedules.asp>). The reduction does not apply to supplies provided by the practitioner. BWC does

not reimburse incident to. OAC 4123-6-08.

3. The Physician Assistant may function as an assistant in surgery, in which case, reimbursement depends on both the assistant surgery modifier and the provider type. For example, if the fee for a procedure were \$1,000.00, then that procedure billed with assistant surgery modifier -80 would pay twenty percent (20%) of \$1,000.00 or \$200.00. Since the Physician Assistant receives reimbursement at eighty-five percent (85%) of the [BWC Fee Schedule](#), the fee in this case would be eighty-five percent (85%) of \$200.00 or \$170.00.
4. BWC cannot directly reimburse a Physician Assistant, but BWC can reimburse the supervising physician with whom the Physician Assistant has an approved supervision agreement. All services provided by a Physician Assistant shall be billed using the Physician Assistant's BWC issued provider number typed into block 25 of the *Health Insurance Claim Form* (CMS-1500), as the Physician Assistant is the servicing provider. The BWC provider number issued to the supervising physician or physician group must be typed into block 33 of the CMS-1500 to reflect the pay-to- provider.

C. Advanced Practice Nurse

1. An Advanced Practice Nurse includes Certified Nurse Practitioners and Clinical Nurse Specialists, acting within the scope of the standard care arrangement with their collaborating or supervising physician(s).
2. BWC reimburses the Advance Practice Nurse at eighty-five percent (85%) of the [BWC Fee Schedule](#). The reduction does not apply to supplies provided by the practitioner. BWC does not reimburse incident to. OAC 4123-6-08.
3. An Advanced Practice Nurse enrolled with BWC may provide and be reimbursed for assistance in surgery services, in which case reimbursement is based on both the assistant surgery modifier and the provider type. For example, if the fee for a procedure were \$1,000.00, then that procedure billed with assistant surgery modifier -80 would pay twenty percent (20%) of \$1,000.00 or \$200.00. Since the Advanced Practice Nurse receives reimbursement at eighty-five percent (85%) of the [BWC Fee Schedule](#), the fee in this case would be eighty-five percent (85%) of \$200.00 or \$170.00.
4. A Registered Nurse (CNOR) who is the first assistant in surgery, whom is not an Advanced Practice Nurse, may not enroll as a BWC provider and may not receive reimbursement for assistant surgery services.

D. Independent Social Worker – BWC reimburses an Independent Social Worker at eighty- five percent (85%) of the [BWC Fee Schedule](#).

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- E. Professional Clinical Counselor - BWC reimburses a Professional Clinical Counselor at eighty-five percent (85%) of the [BWC Fee Schedule](#).
- F. Social Worker - BWC reimburses a Social Worker at seventy-five percent (75 %) of the [BWC Fee Schedule](#).
- G. Professional Counselor - BWC reimburses a Professional Counselor at seventy-five (75%) of the [BWC Fee Schedule](#).
- H. Physical Therapist, Occupational Therapist, Speech Pathologist and Massage Therapist
 1. Physical Therapist, Occupational Therapist, Speech Pathologist and Massage Therapist **must** individually enroll with BWC if employed by mixed group practices (i.e., Medical Doctor, Doctor of Osteopathic Medicine, Doctor of Chiropractic, Advanced Practice Nurse, Physician Assistant, Physical Therapist, etc.).
 2. Physical Therapist, Occupational Therapist, Speech Pathologist and Massage Therapist are not required to individually, enroll if employed by therapy groups, home health agencies, skilled nursing facilities or hospitals.
- I. Licensed Athletic Trainer
 1. A Licensed Athletic Trainer is eligible for enrollment by BWC.
 2. A Licensed Athletic Trainer **must** individually enroll with BWC if employed by mixed group practices (i.e., Medical Doctor, Doctor of Osteopathic Medicine, Doctor of Chiropractic, Advanced Practice Nurse, Physician Assistant, Physical Therapist, etc.).
 3. It is not a requirement for a Licensed Athletic Trainer to individually enroll when employed by therapy groups, home health agencies, skilled nursing facilities or hospitals.
- J. Non-Physician Acupuncturist
 1. A Non-Physician Acupuncturist **must** have a state medical board certificate of registration.
 2. A Non-Physician Acupuncturist is a practitioner BWC reimburses for acupuncture services only.
 3. BWC does not reimburse evaluation and management codes to acupuncturists.
- K. Urgent Care Facility
 1. Free-Standing
 - a. A freestanding urgent care facility **must** enroll as provider type 96.
 - b. A freestanding urgent care facility may bill only for physician services.
 - c. For reimbursement purposes, BWC shall treat freestanding urgent care centers as any other physician clinic.

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- d. BWC shall not reimburse freestanding urgent care centers a facility fee.
2. Hospital Based
 - a. A hospital based urgent care facility **must** enroll as a hospital provider type and be assigned a separate provider number. See [Application for Provider Enrollment and Certification \(MEDCO-13\)](#) form at BWC Website: <https://www.bwc.ohio.gov/downloads/blankpdf/MEDCO-13.pdf>.
 - b. A hospital based urgent care facility must be a part of the hospital cost report in order to receive reimbursement of a facility fee.
- L. Ergonomist
 1. To be BWC certified, an ergonomist **must** have one of the following certifications:
 - a. Certified professional ergonomist;
 - b. Certified human factors professional;
 - c. Associate ergonomics professional;
 - d. Associate human factors professional;
 - e. Certified ergonomics associate;
 - f. Certified safety professional with ergonomics specialist designation;
 - g. Certified industrial ergonomist;
 - h. Certified industrial hygienist;
 - i. Assistive technology practitioner; or
 - j. Rehabilitation engineering technologist.
 2. Ergonomic services must be signed and dated by the actual servicing provider specifying the servicing provider's credentials.
 3. An employer signature is required on the action plan.
 4. An Ergonomist may receive reimbursement for travel and mileage. See the [BWC Fee Schedule](#) for current reimbursement rates.
- M. Covered Vocational Rehabilitation Case Management Provider
 1. To provide and receive payment for vocational rehabilitation case management, including the services provided by an intern, the service provider must be BWC certified and enrolled.
 2. [Ohio Administrative Code \(OAC\) 4123-6-02.2\(C\)\(48\)](#) identifies the type of credentials a vocational/medical case manager must maintain. A nationally recognized accreditation committee must have credentialed the provider in one of the following:
 - a. Certified Rehabilitation Counselor;
 - b. Certified Disability Management Specialist;
 - c. Certified Rehabilitation Registered Nurse;
 - d. Certified Vocational Evaluator;
 - e. Certified Occupational Health Nurse;
 - f. Certified Case Manager; or
 - g. [The American Board of Vocational Experts](#).

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- N. Covered Vocational Rehabilitation Employment Specialist Provider [OAC 4123-6-02.2\(C\)\(17\)](#)
1. A covered vocational rehabilitation employment specialist provider provides job placement, job development, job seeking skills training, job club and job coach services.
 2. A covered vocational rehabilitation employment specialist provider **must** be BWC certified as a type 86 Employment Specialist to provide these services on or after 10/1/15.
 3. The criteria for a covered vocational rehabilitation employment specialist provider to be BWC certified as a type 86 include:
 - a. Attainment of certification in one of the following:
 - i. Certification for American Board of Vocational Experts;
 - ii. Certified Rehabilitation Counselor;
 - iii. Certified Case Manager;
 - iv. Global Career Development Facilitator;
 - v. Associate Certified Coach;
 - vi. Professional Certified Coach;
 - vii. Master Certified Coach;
 - viii. Certified Disability Management Specialist;
 - ix. Commission on Accreditation of Rehabilitation Facilities accreditation for employment and community services in job development or employment supports; or
 - b. Evidence of the completion of three (3) or more courses, seminars or workshops prior to submitting an application for certification, totaling a minimum of eighty (80) hours and approved by BWC or by an entity offering a certification referenced above, in at least two (2) of the following domain areas:
 - x. Job development;
 - xi. Job placement;
 - xii. Career and lifestyle development;
 - xiii. Vocational consultation and services for employers;
 - xiv. Professional roles and practices; and/or
 - xv. Ethic and utilization of community resources.
- O. Non-Covered Provider
1. An individual provider is a provider who is **not** directly reimbursable by BWC and who **cannot** directly enroll with BWC. Examples of these providers include, but are not limited to:
 - a. Physician Intern;
 - b. Psychology Intern;
 - c. Psychology Assistant; or
 - d. An out-of-state provider, who provides services in a state that, does not have

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an Ohio equivalent licensure requirement.

- e. The provider is permitted to give services under the direct supervision (i.e., in the presence of the supervisor) of a provider who is licensed and enrolled by BWC to deliver such services. The licensed provider must bill for the services.
- 2. A network acting as a service coordinating entity only and not meeting qualifications for a provider type recognized by BWC that directly provides goods or medical services to the injured worker is a non-covered provider.
- 3. Direct manufacturer, supplier of surgical equipment or surgical supplies, is a non-covered provider.

P. Guidelines

- 1. Provider Signature on Medical Evidence - The following grid identifies provider types whose signature is acceptable on medical evidence.

PROVIDER TYPE				
Physician of Record (POR) or treating physician which includes the following: <ul style="list-style-type: none"> • Medical doctor (M.D.), • Osteopath (D.O.), • Chiropractor (D.C.), • Dentist (D.D.S.), • Mechanotherapist (D.M.T.), • Podiatrist (D.P.M.) , • Psychologist, • Ophthalmologist. 	Advanced Practice Nurse (A.P.N.) which includes the following: <ul style="list-style-type: none"> • Certified Nurse Practitioner (C.N.P.), • Certified Nurse Specialist (C.N.S.), Physician Assistant (P.A.)	Licensed Independent Social Worker (L.I.S.W.) Licensed Professional Clinical Counselor (L.P.C.C.)	Audiologist (A.U.D.) Optometrist (O.D.) Physical Therapist (P.T.) Occupational Therapist (O.T.)	Licensed Social Worker (L.S.W.) Licensed Professional Counselor (L.P.C.) All other non-physician providers

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FORM					
Physician's Report of Work Ability (MEDCO-14)	YES	*YES (see below)	NO	NO	NO
	<p>*For the first six weeks immediately following the date of injury, an A.P.N. and /or P.A. may independently complete and sign a MEDCO-14 to support payment or non-payment of temporary total disability.</p> <p>Subsequent MEDCO-14s must be co-signed by a physician who has examined the injured worker (IW) or has reviewed medical documentation of an A.P.N.'s and /or P.A.'s examination of the IW.</p>				
Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9)	YES	YES	YES	Medical Services Reimbursement YES (see exception below)	NO
				Recommendation for Additional Condition – NO	
<p>Exception: C-9s signed by a P.T. or O.T. for therapy services must be accompanied by a prescription from the POR or treating physician, an A.P.N. or P.A.</p>					
ADR Appeal to the MCO Medical Treatment/Service Decision (C-11)	YES	YES	YES	YES	YES

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	YES	YES	YES	NO	NO
Indicate causality designation and provide signature on (in the “Treatment info.” section of the) First Report of an Injury, Occupational Disease or Death (FROI-1)	<p>NOTE: FROI-1 applications may be filed by anyone, but the causality designation and provider signature in the “Treatment info.” section as noted can only to be completed by those providers designated above.</p>				

- a. General Information Regarding Signatures on Medical Evidence:
 - i. An original or stamped signature on an application or medical evidence is acceptable.
 - ii. A form with a scanned signature is acceptable, but an electronic signature is not acceptable.
 - iii. Medical reports signed by a POR or treating physician’s authorized “scribe/designee” are acceptable. The scribe/designee will:
 - a) Sign the POR or treating physician’s name.
 - b) Enters his/her initials next to the POR or treating physician’s name.
- ~~b. Change of Physicians: See policy of the same name.~~
- ~~2. Two (2) Physicians Treating At The Same Time (OAC 4123-6-27) – See policy of the same name.~~
- ~~3. Treatment Of Family Members (OAC 4123-6-06.2) - See policy of the same name.~~
- ~~4. Multiple Visits – See policy of the same name.~~
- ~~5. Reimbursement For In-Home Physician Visits and Physician Mobile Office Visits – See policy of the same name.~~
- ~~6. Office Based Surgery - See policy of the same name.~~
- ~~7. Unsupervised Physical Reconditioning Program (OAC 4123-6-07(B)(5)) – See policy of the same name.~~
- ~~8. Billing Codes- See general reimbursement policy.~~
- ~~9. Telephone Call Codes (99371-99373) – See telephone services and virtual check in services policy.~~

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10. ~~Consultation Codes (CPT® codes 99241-99245 and 99251-99255)~~ – See policy of the same name.
11. ~~By-Report codes for Professional Services~~ For both vocational and professional by-report code policy information, first refer to BWC's General Provider Reimbursement policy and then refer to *Chapter 3 for Vocational Rehabilitation*.
12. ~~Reimbursement for Interpretation of Emergency Room X-rays~~: See policy of the same name.
13. Provider Reimbursement in Multiple Claims
 - a. Evaluation and Management Services
 - i. General Rule
 - a) A provider may receive reimbursement for only one (1) Evaluation and Management service per injured worker per day. Exceptions shall be reviewed on a case-by-case basis.
 - b) Example: Evaluation and Management service was provided in the morning, but due to an unforeseen problem, the injured worker had to return later in the day for a reason that would require another complete Evaluation and Management service.
 - ii. Injured Worker with Multiple Claims - If a provider is treating an injured worker with multiple claims, the Evaluation and Management services may be billed in one (1) claim only for each visit. The service shall be billed to the claim representing the chief complaint or reason for the visit.
 - iii. Multiple Physicians - If multiple physicians of different specialties provide Evaluation and Management services to an injured worker on a single day for conditions allowed in a claim, upon review of documentation, the MCO may make a determination to reimburse each provider for the evaluation and management service, if appropriate.
 - iv. Injured Worker with More than Two (2) Claims – BWC shall not routinely reimburse for chiropractic manipulative treatment in more than two (2) claims and if rendered on the same date of service, BWC shall deny it.
 - b. Physical Medicine Procedures
 - i. Reimbursement for physical medicine procedures shall be at the BWC fee.
 - ii. CPT® codes 97012 – 97028 are reimbursable in only one claim per date of service as these codes describe treatments to **one or more areas** without time specifications
 - iii. CPT® codes 97032 – 97530:
 - a) BWC may reimburse in only one (1) claim if a total of fifteen (15) minutes or less are provided; and
 - b) BWC may reimburse in more than one (1) claim if the total time units for each service exceed one (1) unit or fifteen (15) minutes.
 - i) For each fifteen (15) minutes, one (1) unit may be billed in each

claim using the modifier **PT** in the first claim and **ST** in the second claim.

- ii) An example of using CPT® code 97110 – Therapeutic exercises to develop strength and endurance take place for thirty (30) minutes. If the injured worker has two (2) claims, one (1) unit can be billed in each.

~~14. Valid Modifiers – See General Reimbursement policy~~

III. OTHER BWC CERTIFIED PROVIDER SERVICES

~~A. Billing From All Other BWC Certified Providers – See general reimbursement policy~~

~~B. Medical Services Request – See prior authorization policy and refer to Signature on Medical Evidence Grid, in section II.P.1.~~

~~C. Durable Medical Equipment See policy of the same name.~~

~~D. Equipment Used As Part Of A Surgical Procedure (see policy of same name.)~~

IV. SERVICES APPROVED AND REIMBURSED BY BWC RATHER THAN BY THE MCO

A. Prosthetics/Artificial Appliances

1. All eligible prosthetic/artificial appliance and repair thereof, whether for state fund claims or self-insured claims, are paid from the surplus fund.
 - a. **For MCO managed claims**, the MCO receives the [C-9](#) request for authorization and approves or denies the request. If the request is approved, the provider submits the bill to the MCO.
 - b. **In self-insured claims**, BWC is responsible for processing requests for artificial appliance and travel expenses associated with the artificial appliance in **all self-insured claims**. When an artificial appliance is needed in a self-insured claim, the physician/provider must send a request for the artificial appliance and/or request for repair, as well as the subsequent bills, to the appropriate BWC Customer Service Team. The BWC Customer Service Team must submit the bill from the provider to Medical Billing and Adjustments.
2. The provider must ensure that the following information is available for processing an artificial appliance request. Processing may be delayed if the following information is not included with the request:
 - a. Written evidence that an artificial appliance has been determined to be medically necessary for the injured worker from one (1) of the following:
 - i. The Ohio State University hospital amputee clinic;

- ii. The Opportunities for Ohioans with Disabilities agency;
 - iii. An amputee clinic approved by the administrator or the administrator's designee; and
 - iv. A prescribing physician approved by the administrator or the administrator's designee.
 - b. Dated and signed prescription for the item being requested including the manufacturer, brand name and model number;
 - c. Recent physical examination that includes a functional assessment with current and expected ability, impact upon activities of daily living, assistive devices utilized and co-morbidities that impact the use of the prescribed artificial appliance;
 - d. Clinical rationale for requested artificial appliance, replacement part(s) or repair(s) and a description of any labor involved;
 - e. Coding description for the artificial appliance or repair utilizing the HCPCS (i.e., If a miscellaneous code is requested, all component items bundled in the miscellaneous code shall be listed along with a complete description and itemization of charges;
 - f. As appropriately required by the appendix to [OAC 4123-6-08](#), a copy of the manufacturer's invoice for items requested under a miscellaneous HCPCS code; and
 - g. Copy of any warranties related to the requested artificial appliance.
3. It is the prosthetist's responsibility to assure that any prosthetic device/artificial appliance fits properly for three (3) months from the date of dispensing. Any modifications, adjustments or replacements within the three (3) months are the responsibility of the prosthetist who supplied the item and BWC shall not reimburse for those services. The provision of these services by another provider shall not be separately reimbursed.

~~V.—UTILIZING PRESCRIPTION MEDICATION FOR THE TREATMENT OF INTRACTABLE PAIN: Refer to BWC's Outpatient Medication rules.~~