MCO Policy Reference Guide Chapter 9 Updated and New Policies

Policy Name:	**Miller Case Criteria**
Policy #:	MP-13-01
Code/Rule Reference:	Ohio Administrative Code (OAC) 4123-6-16.2, and 4123-6-06.2; *State, ex rel. Miller v. Indus. Comm*., 71 Ohio St.3d 229 (1994)
Effective Date:	06/25/13
Approved:	Freddie Johnson, Chief of Medical Services (Signature on file)
Origin:	Medical Policy
Supersedes:	All policies and procedures, directives or memos regarding *Miller* case criteria that predate the effective date of this policy.
History:	New 08/31/12 Rev. 2/15/13; 6/25/13
Review date:	06/25/18

I. POLICY PURPOSE

The purpose of this policy is to ensure that the Bureau of Workers Compensation (BWC) complies with the criteria set forth in the case of *State, ex rel. Miller v. Indus. Comm*., hereafter *Miller*, and uses the criteria to evaluate and make determinations for authorization and reimbursement of medical services and supplies.

II. APPLICABILITY

This policy applies to staff of the BWC and Managed Care Organizations (MCOs) who approve purchases of medical services and supplies.

III. DEFINITIONS

Miller criteria**:** mandatory evaluative three-prong test outlined by the Supreme Court of Ohio in the *Miller* case establishing that each prong must be met in order to allow reimbursement for any request for medical services/supplies. The three-part test was subsequently enacted as paragraphs (B)(1) through (B)(3) of 4123-6-16.2 of the Ohio Administrative Code.

IV. POLICY

A. It is the policy of BWC to authorize and reimburse for the service or supply that meets all three of the criteria outlined in *Miller*. The three criteria are:

1. Are the medical services reasonably related to the industrial injury (allowed conditions)?
2. Are the services reasonably necessary for the treatment of the industrial injury (allowed conditions)?
3. Is the cost of these services medically reasonable?

B. In determining whether the cost of services is medically reasonable under the third prong of the *Miller* criteria, BWC may consider whether a lesser cost service or supply meets the injured worker's needs. In such instances, BWC may authorize reimbursement for the lesser cost service or supply. However, BWC may not interfere with an injured worker's free choice of provider on the grounds that a different provider type or specialty could meet the injured worker's needs at lesser cost.

C. *Miller* clarifications/exceptions based on case law:
   1. Weight Loss Programs - BWC authorizes weight loss programs in claims in which obesity is not an allowed condition when it is documented that the weight loss will improve the allowed condition(s) in the claim.
      a. This improvement must be curative (therapeutic/healing, tending to overcome disease and promote recovery); and
      b. Not merely palliative (pain relieving).
   2. Treatment directed specifically to a body part or specific condition of a body part - Treatment shall be considered only after the additional specific body part or specific condition of a body part has been allowed in the claim.
   3. Psychiatric treatment - Treatment shall only be approved when psychiatric conditions are allowed in the claim, unless otherwise permissible under BWC law or policy, as in catastrophic claims and as part of a vocational rehabilitation plan.
   4. Contributing Non-allowed Condition – Treatment that is independently required for the allowed condition(s) in the claim may be approved even though a contributing non-allowed condition exists and/or may also be addressed in the course of the treatment.

D. For Non-allowed generalized conditions or diseases (e.g., obesity, diabetes, hypertension, etc.)
   1. Reimbursement may be considered for non-allowed generalized conditions or diseases when the *Miller* test is met, and one of the following is likely to occur:
      a. Treatment of the non-allowed generalized condition(s) has a positive impact on the treatment outcome of the allowed condition(s) in the claim; or
      b. The non-allowed generalized condition(s) becomes uncontrolled or temporarily exacerbated and the uncontrolled or temporarily exacerbated state is likely to delay, impede, or prevent treatment of the allowed condition(s) in the claim.
         In such instances, staff shall authorize medical services:
         i. Until the symptoms or condition returns to baseline; or
         ii. The temporary exacerbation has ended.

2. If a pre-existing non-allowed generalized condition is not brought under control or never returns to baseline, consideration should be given to an additional allowance in the claim.

Below are case scenarios on how *Miller* case criteria should be applied to non-allowed generalized conditions.

A diabetic injured worker sustains a laceration to the hand. The claim is allowed for the hand laceration and appropriate medical treatment is provided for the allowed condition, but not the non-allowed generalized condition of diabetes. If, however, the hand becomes infected and the diabetes is out of control, it is reasonable under *Miller* to authorize payment for the treatment of the diabetes until it is stabilized. The rationale for this decision is that treatment of the diabetes may promote resolution of the infection in the hand laceration, thereby improving the allowed condition. Note that the diabetes is not an additional allowance in the claim and should only be treated until the non-allowed generalized condition is stabilized.

An injured worker with controlled high blood pressure is undergoing an outpatient surgical procedure for their allowed condition. In the recovery room the injured worker experiences a hypertensive emergency, is given an IV antihypertensive medication, and then admitted to the hospital for observation. Authorization for this IV medication, hospitalization and services until the high blood pressure is under control are reasonable. However, once the blood pressure is controlled and the patient is released from the hospital, treatment for the high blood pressure is the responsibility of the injured worker and is not reimbursable by BWC. The rationale for this decision is that it was the treatment of the allowed condition that temporarily exacerbated the pre-existing non-allowed generalized condition.

Below is a case scenario on how *Miller* case criteria should be applied to contributing non-allowed conditions.

An injured worker sustains an industrial injury to the left knee. Two conditions have been formally allowed in the IW's claim: "contusion, left knee" and "internal derangement/tear medial meniscus left knee." The IW's physician requests approval for arthroscopic knee surgery on the grounds that the allowed conditions require the arthroscopy, advising that while early arthritic changes appear to be present in the IW's knee, the IW was having enough trouble from the allowed conditions to require the arthroscopic procedure. The physician's preoperative and postoperative diagnoses include non-allowed "degenerative arthritis, left knee" as well as "contusion, left knee" and "internal derangement/tear medial meniscus, left knee". The arthroscopic knee

surgery may be approved, even though the IW has a contributing non-allowed condition of "degenerative arthritis," because the surgery was independently required for the allowed conditions.

Below is a case scenario on how medically reasonable cost should be considered in determining reimbursement for medical supplies and/or services.

It has been determined that an injured worker weighing 450 lbs. needs a bedside commode, and that the bedside commode is both reasonably related to and reasonably necessary for the treatment of the allowed conditions. In determining reimbursement for the bedside commode, two models are available, both of which would meet the IW's needs and are comparable in all practical aspects (see comparison chart below).
BWC and the MCO may determine that the cost of the Brand A bedside commode is the medically reasonable choice as compared with the cost of Brand B. Padded seating, armrests, and backrest are not medically necessary to serve the IW's needs, and by adding these amenities, it increases the cost by $278.77.

Brand	**A**	**B**
Weight capacity	1000 lbs	850 lbs
Construction	Heavy duty steel	Heavy duty steel
Arms	Drop arms	Drop arms
Seat width	23.5"	24"
Warranty	3 year warranty	Limited lifetime warranty
Height	Adjustable	Adjustable
Ameneties	None	Padded seat, arm rests and backrest
Price	$247.55	$526.32

Policy Name:	**Fifteen Thousand Dollar Medical Only Program ($15,000 MEDICAL ONLY PROGRAM)**
Policy #:	CP-06-04
Code/Rule Reference:	R.C. 4123.29 (A) (6) O.A.C. 4123-17-59
Effective Date:	03/30/17
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance (Signature on file)
Origin:	Claims Policy (CP)
Supersedes:	08/12/13; 08/24/12; All policies and procedures regarding the $15,000 medical only program that predate the effective date of this policy.
History:	New 08/24/12; Rev. 08/12/13; 03/30/17
Review date:	03/30/20

I. POLICY PURPOSE

The purpose of this policy is to ensure the BWC administers the fifteen thousand dollar medical only program in accordance with the laws and rules.

II. APPLICABILITY

This policy applies to BWC field operations, BWC employer program unit, and managed care organizations (MCO).

III. DEFINITIONS

Fifteen thousand dollar medical only program ($15,000 Medical Only Program): An employer program which allows state fund employers the opportunity to pay up to the first $15,000 in medical and pharmacy bills for medical only claims with a date of injury on or after September 10, 2007.

Five thousand dollar medical only program ($5,000 Medical Only Program): An employer program which allows state fund employers the opportunity to pay up to the first $5,000 in

medical and pharmacy bills for medical only claims with a date of injury on June 30, 2006 to September 9, 2007.

Medical benefits: For purposes of this policy, medical benefits include: treatment, and when appropriate, travel to that treatment; services; supplies; pharmacy benefits.

One thousand dollar medical only program ($1,000 Medical Only Program): An employer program which allows state fund employers the opportunity to pay up to the first $1,000 in medical and pharmacy bills for medical only claims with a date of injury on July 1, 1995 to June 29, 2006.

IV. POLICY

A. It is the policy of BWC to ensure that state-fund employers may participate in the medical only program that allows the covered state fund employers to choose to pay the first $15,000 of medical benefits of a medical only claim, including reimbursement for a BWC physician file review and/or independent medical examination (IME) and travel reimbursement requests related to the IME. The medical only program shall not apply to claims in which an employer with knowledge of a claimed compensable injury or occupational disease has paid salary continuation (wages in lieu of temporary total compensation).

B. BWC shall follow the standard process for making a medical only claim determination when an employer is enrolled in the medical only program. BWC shall also ensure that medical benefits are not reimbursed while a particular claim is enrolled in the medical only program. Once the employer is enrolled, all medical only claims with a date of injury on or after the enrollment date will be automatically included in the appropriate medical only program. A claim that is changed to lost time is automatically removed from the medical only program.

C. It is the policy of BWC that medical only claims that are enrolled in the medical only program shall not be medically managed by the managed care organizations (MCO).

D. It is the policy of BWC that when a claim is removed from the medical only program for any reason, the MCO shall process the claim under standard protocols for claims management.

E. It is the policy of BWC that the MCO shall not reconcile duplicative payments (i.e., employer paid bills and BWC paid bills), and that the MCO shall refer the employer to the provider for reconciliation of duplicate payments.

F. An employer electing to participate in the medical only program must keep a record of the injury and shall keep a copy of all bills with proof and date of payment under the medical only program for six years from the last date a bill has been paid by the employer. This information must be made available to BWC, the injured worker and/or his/her representative upon request. BWC may request this information from the employer not more than twice a year. When an employer is enrolled in the medical only program payment of medical benefit bills in the claim extends the statute of limitations based on the last medical paid date by the employer.

BWC staff may refer to the corresponding procedure for this policy entitled "Procedure for $15,000 Medical Only Program" for further guidance.

Procedure Name:	**PROCEDURE FOR $15,000 MEDICAL-ONLY PROGRAM**
Procedure #:	CP-06-04.PR1
Policy # Reference:	CP-06-04
Effective Date:	03/30/17
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance (Signature on file)
Supersedes:	11/14/16; 03/14/14; CP-06-04.PR1 effective 08/12/13; New 08/24/12
History:	New 8/24/12; Rev. 08/12/13; 03/14/14; 11/14/16; 03/30/17
Review date:	03/30/20

I. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.

II. Determining if a Claim is Enrolled in the $15,000 Medical Only Program (15K Program)

A. To determine if a claim is enrolled in the 15K Program, field staff shall go to the Insured Policy Page in the Employer Profile statement and click on the Questions tab.

B. If the 15K group has checked the box stating that the employer is enrolled in the 15K Program, the system will automatically designate an appropriate claim as enrolled.

C. When an employer is enrolled in the 15K Program, the assigned field staff can enroll or terminate a claim from the program so long as the date of injury (DOI) is after the policy enrollment date and medical benefits have not yet been paid in the claim.

D. If the 15K Program checkbox is blank, the claim was never enrolled in the 15K Program.

E. If field staff has questions about a claim in the 15K Program, staff may send an email to the BWC Claims Policy Field Techs mailbox.

F. If field staff has questions about an employer in the 15K Program, staff may send an email to the BWC Employer Programs Unit mailbox.

III. Enrolling a claim into the 15K Program

A. When a claim is not systematically put into the 15K Program, staff may put a claim that is eligible for the program into the 15K Program when:
   1. The claim is changed from Lost Time (LT) to Medical Only (MO);
   2. There is a change in the policy number;
   3. Two or more claims are combined and the surviving object claim is not systematically placed into the 15K Program.

B. Field staff shall investigate and ensure that the employer is enrolled in the 15K Program, and if so, appropriately place the particular claim(s) into the 15K Program by:
   1. Ensuring the claim type is correct (e.g., LT changed to MO);
   2. Ensuring no medical benefits have yet been paid in the claim
      a. If no medical benefits were yet paid, staff shall enroll the claim in the 15K Program;
      b. If medical benefits have been paid, staff shall:
         i. Refer to the Medical Only Program workflow, and
         ii. Send the "Medical Only Program Employer" letter to recover payments and remove charges from the employer's experience.

C. Field Staff shall update the claims management system by updating Claim Maintenance, Profile tab to reflect that the claim is in the 15K Program.

IV. Un-enrolling a claim in the 15K Program

A. A claim can be un-enrolled when:
   1. It changes from MO to LT the claims management system will automatically enter a termination date.
   2. The employer elects to have the claim removed and field staff shall enter the termination date in the claim management screen under the Profile tab.

B. Staff shall un-enroll a claim by:
   1. Update the claim management screen under the Profile tab;
   2. Checking one of the following reasons in the drop-down box:
      a. Employer pays bills through the end date. This is selected when the employer has provided BWC with an end date because they no longer wish to be responsible for the bills in a specific claim.
      b. Employer withdraws effective DOI. This is selected when the employer does not wish to make any medical benefits payments in the claim at all and wants the claim excluded from date of injury.
      c. Reached Limit. This is selected when the employer has notified BWC that they have paid the medical only program maximum allowable.

V. Employer reimbursement to remove claim costs due to file reviews and independent medical examinations (IME) in the 15K Program claims

A. All medical benefit bills should be sent to the employer for payment, except when BWC is processing the claim, or when a file review and/or independent medical examination (IME) and travel reimbursement requests related to the IME are necessary.

B. Physician file reviews and/or IMEs and travel reimbursement requests related to the IME shall be paid by BWC as claim costs and will be charged to the claim. This charge will appear as a charge to the employer's experience regardless if the claim is enrolled in the 15K Program. Field staff shall remove these charges only at the request of an employer if the employer reimburses BWC for the claim costs.

C. Field staff shall follow the Medical Only Program Workflow for File Reviews & IMEs and use the "Medical Only Program Employer" Letter for File Reviews and IMEs.

VI. Application for Determination of Percentage of Permanent Partial Disability (%PP) or Increase of Permanent Partial Disability(C-92) in 15K Program claims.

A. C-92 applications may be filed in a claim that is enrolled in the medical only program.

B. Field staff shall process the C-92 application in its normal manner. If the determination of the C-92 application results in:
   1. A 1% or greater award – this will change the claim to LT and the claims management system will systematically remove the claim from the medical only program.
   2. A 0% award - the claim shall remain in the 15K Program.

VII. Treatment and claim reactivation requests in 15K Program claims.

A. When an MCO receives a Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9), and the claim is enrolled in the 15K Program, the MCO staff shall:
   1. Dismiss the C-9 request;
   2. Not include appeal language on the dismissal; and
   3. Notify the employer and provider.

B. When a claim is removed from the 15K Program for any reason, the MCO shall be responsible for the:
   1. Medical management of the claim; and
   2. Processing of all bills, regardless of the date of service.

C. When field staff receives a request for claim reactivation, staff shall verify whether the claim is enrolled in the 15K Program.

1. If the claim is enrolled, field staff shall notify the MCO that the claim is enrolled in the medical only program and the claim reactivation request will not be processed.
2. If the claim is not enrolled, field staff shall process the claim reactivation request.

VIII. Travel Reimbursement in 15K Program claims

A. When field staff receives a travel reimbursement request, staff shall verify if the claim is enrolled in the program or not.
   1. If the claim is enrolled and:
      a. If travel reimbursement is related to medical treatment, notify the injured worker that the claim is enrolled in the 15K program and the travel reimbursement request must be sent to the employer for processing. BWC shall not process the request.
      b. If travel reimbursement is related to an IME, BWC shall process the request for travel reimbursement, and, if appropriate, pay.
   2. If the claim is not enrolled, field staff shall process the travel reimbursement request, and if appropriate, pay in accordance with the *Travel Reimbursement* policy.

B. An employer may request to have claim costs due to a file review and/or IME and travel reimbursement requests related to the IME removed, for claims in the 15K Program claims, pursuant to section V. of this procedure, above.

IX. Statute of limitations in 15K Program claims

A. If there is a question as to whether the statute of limitations has expired in a claim, field staff shall request written documentation of the last medical benefit paid date from the employer. Once the employer submits the information, field staff shall calculate the new statute expiration date based upon the last medical benefit paid date and enters a new statute of limitations override date in other claims dates in the claims management system.

B. If a conflict exists in determining the date last medical paid date or the employer fails to submit written documentation of the last medical paid date, field staff shall refer the issue to the Industrial Commission on a Notice of Referral.

C. Staff may refer to the *Jurisdiction* policy and procedure for more information.

X. Complaints in the 15K Program claims

A. BWC may receive complaints from an injured worker, the IW representative, and/or providers regarding non-payment of medical benefit bills by the employer.

B. Field staff shall create a task and refer all complaints regarding the 15K Program to the employer program unit.

C. The employer program unit shall investigate the complaint with the employer and notify the assigned field staff of the outcome via email.
    1. If the employer is to be removed entirely from the 15K Program, the employer program unit will remove the employer and notify the assigned field staff. When the employer is removed from the program, all claims for the employer are removed.
    2. If the claim is to be removed from the 15K Program, the employer program unit shall notify the assigned field staff, and the field staff shall remove the particular claim from the 15K Program.
    3. If the claim is to remain in the 15K Program, the employer program unit shall notify the assigned field staff.

Policy Name:	**Artificial Appliance Requests**
Policy #:	MP-01-01
Code/Rule Reference:	R.C. 4123.57(B), (C); 4779.01(I); OAC 4123-6-39; 4123-6-25
Effective Date:	07/22/2013
Approved:	Freddie Johnson, Chief of Medical Services (signature on file)
Origin:	Medical Policy
Supersedes:	All policies and procedures regarding artificial appliance and self insured prosthesis requests that predate the effective date of this policy
History:	New
Review date:	07/22/2018

I. POLICY PURPOSE

The purpose of this policy is to ensure, in compliance with R.C. 4123.57 and OAC 4123-6-39, appropriate payment of artificial appliance and repair requests and appropriate processing of self insured artificial appliance and repair requests.

II. APPLICABILITY

This policy applies to all Managed Care Organizations (MCOs), field staff, BWC nurses and the Medical Billing and Adjustment Unit.

III. DEFINITIONS

Amputee Clinic: an interdisciplinary group of professional providers led by a physician with a specialty in physical medicine and rehabilitation, orthopedic surgery or vascular surgery knowledgeable in the field of prosthetics and physical disabilities, comprised of members that may include a podiatrist, physical therapist, occupational therapist, kinesiotherapist, prosthetist and other medical specialists that serves individuals requiring prosthetic devices.

Artificial appliance: Any item that replaces a body part or function of a body part of an injured worker who has received a scheduled loss or facial disfigurement award for that body part under R.C. 4123.57(B), and that The Ohio State University hospital amputee clinic, the

Rehabilitation Services Commission, an amputee clinic approved by the administrator or the administrator's designee, or a prescribing physician approved by the administrator or the administrator's designee determines is needed by the injured worker. Examples of artificial appliances include, but are not limited to, prosthetics, artificial eyes, wheelchairs, canes, crutches, walkers, braces, etc.

Multidisciplinary Evaluation (MDE): An independent examination that, depending on the needs of the injured worker, is conducted by a specialty physician, licensed physical or occupational therapist, and an independent prosthetist, who will consider and assess the injured worker's current condition regarding the amputation site and prosthetic needs. A prosthetist is considered to be independent if s/he has not provided services to the injured worker within the past two years.

Prosthesis: A custom fabricated or fitted medical device that is a type of artificial appliance used to replace a missing appendage or other external body part. It includes an artificial limb, hand, or foot, but does not include devices implanted into the body by a physician, artificial eyes, intraocular lenses, dental appliances, ostomy products, cosmetic devices such as breast prostheses, eyelashes, wigs, or other devices that do not have a significant impact on the musculoskeletal functions of the body.

IV. POLICY

General Policy Statements

A. It is the policy of BWC to pay for approved artificial appliance purchases or repairs:
   1. Out of the surplus fund;
   2. When the request for the artificial appliance purchase or repair meets the criteria established in *State, ex. Rel. Miller v. Industrial Commission, 71 Ohio St. 3d 229* (*1994*)(See *Miller* Policy); and
   3. When the injured worker has received an award under R.C. 4123.57(B) and the injured worker's need for the artificial appliance arises out of that award.

B. State Fund Claim Requests
   1. MCOs shall process state fund claim requests for artificial appliances.
   2. MCO-approved artificial appliance requests shall be paid from the surplus fund if the injured worker has received an award under R.C. 4123.57(B) and the injured worker's need for the artificial appliance arises out of that award.
   3. MCOs may utilize BWC's self insured policy and procedure in developing artificial appliance evaluation criteria.
   4. MCOs may staff the following artificial appliance issues with BWC:
      a. Medical appropriateness of requested artificial appliance;

b. Medical examination scheduling;
c. Billing reimbursement codes.

5. MCOs shall schedule medical examinations as set forth in paragraph IV.G.
6. BWC shall pay travel expenses associated with an artificial appliance in accordance with the *Travel Reimbursement* Policy.

C. Self-Insured Claim Requests
1. BWC shall process eligible self-insured claim requests for artificial appliances if the injured worker has received an award under R.C. 4123.57(B) and the injured worker's need for the artificial appliance arises out of that award.
2. BWC shall reimburse prior authorized travel expenses associated with an artificial appliance processed under IV.C.1 out of the surplus fund. See *Travel Reimbursement* Policy.
3. Artificial appliance requests that BWC determines do not arise under the provisions of R.C. 4123.57(B) shall not be processed by BWC and shall be returned to the self-insured employer for processing.

D. Self-insured employers requesting BWC processing of artificial appliance requests shall submit all of the following to BWC:
1. Written evidence of payment to the injured worker of a scheduled loss or facial disfigurement award under R.C. 4123.57(B) for the body part for which an artificial appliance is being requested.
2. Sufficient medical and claim information for BWC to process a request for an artificial appliance.

E. BWC shall ensure that the following information is available for processing an artificial appliance request and may contact the provider(s) and/or prosthetist to obtain the information if necessary:
1. Written evidence that an artificial appliance has been determined to be medically necessary for the injured worker from one of the following:
a. The Ohio State University hospital amputee clinic;
b. The Rehabilitation Services Commission;
c. An amputee clinic approved by the administrator or the administrator's designee;
d. A prescribing physician approved by the administrator or the administrator's designee.
2. Dated and signed prescription of the item being requested including the manufacturer, brand name and model number;
3. 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;

4. Clinical rationale for requested artificial appliance, replacement part(s) or repair(s) and a description of any labor involved;
5. Coding description for the artificial appliance or repair utilizing the healthcare common procedure coding system (HCPCS). 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;
6. Copy of the manufacturer's price list for items requested under a miscellaneous HCPCS code; and
7. Copy of any warranties related to the requested artificial appliance.

F. It is the prosthetist's responsibility to assure that any prosthetic device fits properly for three months from the date of dispensing. Any modifications, adjustments or replacements within the three months are the responsibility of the prosthetist who supplied the item and BWC will not reimburse for those services. The provision of these services by another provider will not be separately reimbursed.

G. Medical Examinations
   1. BWC (for self-insuring employer requests) shall, and the MCO (for state fund requests) may, schedule a multidisciplinary examination (MDE) for prosthetics or an independent medical examination (IME) for all other requests if:
      a. A requested artificial appliance has not been available on the United States market for at least two years; or
      b. In all cases that a physician review recommends an MDE or IME.
   2. BWC (for self-insuring employer requests) shall, and the MCO (for state fund requests) may, schedule a MDE for the following prosthesis claim requests:
      a. All initial multi-articulating hands or finger component prostheses;
      b. All initial microprocessor knees and feet;
      c. Requests for replacement knees and feet microprocessor components when any of the following apply:
         i. Microprocessor components are still under warranty;
         ii. Documentation evidences non-use of the prosthesis by the injured worker;
         iii. Documentation evidences that replacement is inappropriate due to a change in medical condition;
      d. All initial custom silicone restorative passive devices;
      e. Requests for replacement of custom silicone passive devices when either of the following apply:
         i. Documentation evidences non-use of the prosthesis by the injured worker;
         ii. Documentation establishes that replacement is inappropriate due to a change in medical condition;
      f. Cases with a history of five or more repairs and/or modifications of the prosthesis within the past twelve months;

g. Cases involving requests for authorization for specialized surgical intervention relating to external/augmented prosthetic control (e.g., targeted muscle reinnervations), skeletal attachment (e.g., osteo-integration) or similar new or advanced technology.

3. BWC (for self-insuring employer requests) and the MCO (for state fund requests) may schedule an MDE or an IME for individuals requesting an artificial appliance or artificial appliance repair that are not subject to the provisions of IV.G.1. or IV.G.2., above.

BWC staff may refer to the corresponding procedure for this policy entitled "Procedure for Artificial Appliance Requests " for further guidance.

Procedure Name:	**Procedures for Artificial Appliance Requests**
Procedure #:	MP-16-01.PR1
Policy # Reference:	MP-01-01
Effective Date:	07/22/2013
Approved:	Freddie Johnson, Chief of Medical Services (signature on file)
Supersedes:	All policies and procedures regarding artificial appliance and self insured prosthesis requests that predate the effective date of this procedure
History:	New
Review date:	07/22/2018

I. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.

II. State Fund Claim Requests

A. Managed Care Organizations (MCOs) process state fund requests for artificial appliances, replacement part(s) or repair thereof if the injured worker has received an award under R.C. 4123.57(B) and the injured worker's need for the artificial appliance arises out of that award, and may request BWC staffing of the following issues relating to artificial appliance requests:
   1. Medical appropriateness of requested artificial appliance;
   2. Medical examination scheduling;
   3. Billing reimbursement codes.

B. MCOs shall direct staffing requests, noting the injured worker's (IW) name and claim number, to:
   1. BWC staff assigned to the claim; or
   2. BWC catastrophic (CAT) nurse via email to: BWC.catnurse@bwc.state.oh.us.

C. BWC staff shall respond to the staffing request or forward it to the appropriate CAT nurse for response.

D. MCOs are responsible for processing payment requests for MCO-approved artificial appliances in accordance with Medical Billing and Adjustment Unit processing requirements.

E. MCOs shall forward travel reimbursement requests to BWC for processing.

III. Self-Insured (SI) Claim Requests

A. Field staff reviewing a request for an artificial appliance, replacement part or repair thereof, shall process the request if the injured worker has received an award under R.C. 4123.57(B) and the injured worker's need for the artificial appliance arises out of that award.
   1. Field staff shall request additional documentation from the employer if insufficient documentation has been received to make a determination.
   2. Field staff may consult with their local BWC attorney for assistance if necessary in determining whether the injured worker's need arises out of the award under R.C. 4123.57(B).
   3. Field staff shall return the request to the self insured employer for processing if the requirements of this paragraph are not met and shall note in the claim file the decision rationale.

B. Once a decision is made to process the request, field staff shall:
   1. Send an email to the CAT nurse (BWC.catnurse@bwc.state.oh.us) with the IW's name and claim number. Field staff process the request and shall work with the CAT nurse as noted.
   2. Document that the following are met prior to approving the artificial appliance, replacement part or repair:
      a. The necessity for the artificial appliance was identified in writing by one of the following:
         i. The Ohio State University hospital amputee clinic;
         ii. The Rehabilitation Services Commission;
         iii. An amputee clinic approved by the administrator or the administrator's designee;
         iv. A prescribing physician approved by the administrator or the administrator's designee.
      b. The *Miller* criteria are satisfied. (Refer to the *Miller* Policy). The following information will assist in determining whether *Miller* criteria are satisfied:
         i. From the physician of record:
            a) A detailed written order that is signed and dated and includes:
               i) The individual's name and claim number;
               ii) Narrative condition/description;

iii) Dated prescription;
iv) Description of the item being requested including the manufacturer, brand name, model number;

b) Medical documentation supporting the necessity of the requested item reflecting:
i) Amputation history (if relevant), therapeutic intervention, clinical course and treatment plan;
ii) Recent physical examination that includes a functional assessment and impact upon activities of daily living (if relevant), assistive devices utilized and co-morbidities that impact the use of prescribed artificial appliance;

ii. From the prosthetist (if a prosthesis is requested):
a) Medical documentation supporting the necessity of the requested item;
b) If relevant, dated and signed records documenting current and expected functional ability with an explanation of any difference. Lower limb prosthesis may utilize Medicare Functional Classification Levels (K-levels) to express functional ability;
c) Dated and signed medical records reflecting office visits and clinical rationale for the requested prosthesis, replacement part(s) or repair(s) and description of any labor involved;

iii. A coding description for the artificial appliance, replacement part(s) or repairs(s) utilizing the healthcare common procedure coding system (HCPCS). If a miscellaneous code or by report (BR) code is requested, all component items bundled in the miscellaneous or BR code listed along with a complete description and itemization of charges;

iv. Manufacturer's price list for items requested under a miscellaneous or BR code;

v. Warranties related to the requested artificial appliance.

3. If information set forth in III.B.2. is not in the provided medical records, field staff shall contact the provider and/or prosthetist to obtain the necessary information.

C. Artificial appliance requests meeting the criteria set forth in paragraph III.B. may be approved. Field staff shall complete the following when approving:
1. Staff the billing reimbursement codes with the CAT nurse. If there are questions relating to requested codes or pricing, the CAT nurse or field staff shall contact the provider to discuss the requested codes or discrepancies between the usual and customary rate (UCR) and the amount billed.
2. Update the claim management system with the approval, including a notation of the specific allowed codes and allowed miscellaneous or BR prices in the prior authorization screen with the allowed date range (window).
3. Send an approval letter (C-47) to the parties noting all allowed codes and the UCR

or the allowed pricing for the miscellaneous or BR codes.

a. Upon receipt of the C-19 Service Invoice from the provider, field staff shall:
    i. Compare the allowed codes and allowed prices in the claim management system and the C-47 to the billed codes on the C-19 Service Invoice to ensure a match.
    ii. If the allowed codes and pricing and the billed codes and pricing match, field staff shall approve the invoice.
    iii. If there is a discrepancy between any of the allowed codes and pricing and the billed codes and pricing on the C-19, field staff shall additionally note in the "Remarks" block on the C-19, the following:
        a) Any code(s) that were not authorized in the C-47 letter;
        b) Any pricing discrepancies between the C-19 and the C-47.
b. Compare the date of service on the C-19 (date of delivery of the service) to the allowed date range in the claim management system. The service date must fall within the allowed date range. If within the date range, field staff shall change the date range in the claim management system to the date of service on the C-19. If the date of service is out of the allowed date range, field staff shall contact the CAT nurse.
c. Send the C-19 to Medical Billing and Adjustments (MBA) so the bill can be paid via the surplus fund.

D. Field staff may consult with the CAT nurse for assistance in reviewing an artificial appliance request. Staffing will result in one of the following:
    1. The request will be pended: field staff shall send an additional request for documentation.
    2. The request will be denied: field staff shall update the claim management system and issue a denial letter (C-48) to all parties.
    3. The request will be referred for physician file review or the injured worker will be scheduled for an independent medical examination (IME) or a multidisciplinary evaluation (MDE): field staff shall notify the injured worker in writing of the scheduling of an IME or MDE.
        a. If the physician file review or multidisciplinary evaluation recommends denial of the request, field staff shall deny the request, update the claim management system, generate a C-48 and send it to all parties.
        b. If the physician file review or multidisciplinary evaluation recommends approval of the request, field staff shall approve the request and follow the provisions set forth in paragraph III.C.

E. The CAT nurse may contact the physician and/or prosthetist to discuss recommended amendments to the requested artificial appliance and/or repair request. Recommended amendments may arise from the CAT nurse, physician review

recommendations and/or IME or MDE recommendations.

1. If amendments are recommended, the CAT nurse shall request withdrawal of the original C-9 and request a revised C-9 reflecting the recommended amendments.
2. If a revised C-9 is submitted, the CAT nurse will review it to ensure that recommended amendments were incorporated and shall forward the request to field staff to complete the approval process as set forth in III.C.2. and III.C.3.
3. If agreement cannot be reached with the physician and/or prosthetist to withdraw and submit a revised C-9, field staff shall deny the C-9 request, update the claim management system and send a C-48 to all parties.

IV. BWC staff (for SI employer requests) shall schedule Multidisciplinary Evaluations and/or Independent Medical Examinations as follows:

A. The BWC CAT nurse shall schedule an:
   1. MDE for prosthetics if:
      a. A requested prosthetic has not been available on the United States market for at least two years;
      b. A physician review recommends an MDE; or
      c. One of the following is requested:
         i. All initial multi-articulating hands or finger component prostheses;
         ii. All initial microprocessor knees and feet;
         iii. Requests for replacement knees and feet microprocessor components when any of the following apply:
            a) Microprocessor components are still under warranty;
            b) Documentation evidences non-use of the prosthesis by the injured worker;
            c) Documentation evidences that replacement is inappropriate due to a change in medical condition;
         iv. All initial custom silicone restorative passive devices;
         v. Requests for replacement of custom silicone passive devices when either of the following apply:
            a) Documentation evidences non-use of the prosthesis by the injured worker;
            b) Documentation establishes that replacement is inappropriate due to a change in medical condition;
         vi. Cases with a history of five or more repairs and/or modifications of the prosthesis within the past twelve months;
         vii. Cases involving requests for authorization for specialized surgical intervention relating to external/augmented prosthetic control (e.g., targeted muscle reinnervations), skeletal attachment (e.g., osteo-integration) or similar new or advanced technology.

2. IME for any artificial appliance if:
    a. A requested artificial appliance has not been available on the United States market for at least two years; or
    b. A physician review recommends an IME.

B. The BWC CAT nurse may schedule an MDE or an IME for individuals requesting an artificial appliance or artificial appliance repair that are not subject to the provisions of IV.A.

V. The Multidisciplinary Evaluation

A. MDEs shall be scheduled at an amputee clinic and, depending on the needs of the injured worker, shall be conducted by a specialty physician, licensed physical or occupational therapist, and an independent prosthetist, who will consider and assess the injured worker's current condition regarding the amputation site and prosthetic needs. A prosthetist is considered to be independent if he or she has not provided services to the injured worker within the past two years.

B. The MDE shall include the following:
    1. A physician report including:
        a. Medical history;
        b. History and physical;
        c. Diagnostics that were reviewed;
        d. Discussion of contributory medical conditions that could be a barrier to use of the requested prosthetic device;
        e. Discussion of current condition of the amputation site and residual limb; and
        f. Current functional status and expected potential.
    2. A physical or occupational therapist report including:
        a. Current functional status; and
        b. Expected functional outcome.
    3. A prosthetist report including:
        a. Prior prosthetic use, if applicable;
        b. Current functional status;
        c. Expected functional outcome;
        d. HCPCS coding of the recommended device or repair; and
        e. Manufacturer list pricing of the recommended device.

C. Staff shall provide relevant information available in the claim file to the clinic performing the MDE, shall inform the clinic of the information set forth in paragraph V.B. to be addressed through the MDE and provide any additional questions to be addressed relevant to the requested artificial appliance, replacement part(s) or repair(s).

D. The provider(s) performing the MDE shall bill for services rendered in the MDE on a C-19 Service Invoice.

VI. Travel Reimbursement

A. Field staff (or the CAT nurse when scheduling an MDE) shall process travel reimbursement requests as set forth in the *Travel Reimbursement* Policy.

B. Field staff shall notify the IW of the location of the travel reimbursement form (Form C-60) on ohiobwc.com and mail a form to the IW if requested.

Policy Name:	**Due Process**
Policy #:	CP-04-06
Code/Rule Reference:	The Fifth Amendment to the U.S. Constitution; the Ohio Constitution, Article I, Section 16.
Effective Date:	08/08/16
Approved:	Rick Percy, Chief of Operational Policy, Analytics, and Compliance (Signature on file)
Origin:	Claims Policy
Supersedes:	Policy #CP-04-06, effective 08/06/2013
History:	New 08/06/2013
Review date:	08/08/19

I. POLICY PURPOSE

The purpose of this policy is to ensure BWC staff are aware of the legal principle and expectations of due process in workers' compensation claims.

II. APPLICABILITY

This policy applies to BWC staff and managed care organization (MCO) staff.

III. DEFINITIONS

Due Process: The legal principle that government may not deprive an individual of life, liberty or protected property rights without providing:

- Notice; and
- An opportunity to be heard.

Notice: A legal concept describing the requirement that government makes a party aware of a legal process affecting their rights, obligations or duties.

Opportunity to Be Heard: A legal concept describing the requirement that government affords a party the chance to present the party's views or objections.

Parties to the Claim: For purposes of this policy, the injured worker and employer. BWC is also a party to the claim if the claim is appealed to the Industrial Commission or court.

IV. POLICY

A. It is the policy of BWC to ensure that a party is afforded appropriate due process when BWC (or a managed care organization, on behalf of BWC) is taking action in a claim that affects the rights, obligations or duties of the party.

B. The type of due process afforded to a party depends on the impact to the party's protected rights. Providing due process may include:
   1. BWC calling or sending a letter to the parties advising the parties of a request for action in a claim;
   2. BWC advising the parties of the opportunity to provide additional information or evidence to be considered when BWC is taking action in a claim; or
   3. BWC issuing an order to the parties, advising the parties of the right to appeal.

C. The type of due process BWC provides is addressed in the specific subject-matter policies and procedures. These steps may not be expressly identified as "due process" but are provided to achieve the "notice" and "opportunity to be heard" requirements.

D. Miscellaneous issues related to due process:
   1. If the last day for response to a notice falls on a weekend, a legal holiday, a day in which BWC is closed or a day in which BWC closes before its usual closing time, the last day for response shall be the next business day.
   2. Due process is not required and will not be provided for employers that are out of business or no longer doing business in Ohio. However, the employer may specifically request continued notice or may retain an authorized representative to oversee the employer's claims.

Policy Name:	**Travel Reimbursement**
Policy #:	CP-20-01
Code/Rule Reference:	O.A.C 4123-6-40
Effective Date:	03/30/17
Approved:	Rick Percy, Chief of Operational Policy, Analytics & Compliance
Origin:	Claims Policy
Supersedes:	Policy CP-20-01, effective 05/09/2014
History:	Rev. 12/01/15; 05/09/14, 01/01/14, 08/01/13, 07/08/13; New 11/21/12
Review date:	12/01/20

I. POLICY PURPOSE

The purpose of this policy is to ensure consistent and efficient reimbursement to the injured worker (IW) for allowable travel expenses.

II. APPLICABILITY

This policy applies to managed care organization (MCO) staff and BWC Field Operations staff.

III. DEFINITIONS

None

IV. POLICY

A. BWC shall reimburse an IW for reasonable and necessary travel expenses, upon the filing of a proper request, (excepting sections IV.B and C) when:
   1. The IW has been ordered or authorized by BWC or the IC to undergo a medical examination outside the community where he or she lives and the travel distance exceeds the mileage distance determined by BWC in the *Injured Worker Reimbursement Rates for Travel Expense* (C-60A).
   2. When medical treatment, including a service contained in an approved vocational rehabilitation plan, is necessary for the allowed condition, cannot be obtained

within the IW's community, the treatment has been pre-authorized and approved by the MCO, and the travel distance exceeds the mileage distance determined by BWC in the C-60A.

3. The IW's allowed conditions require the use of taxi or other special transportation for treatment or examination on account of an allowed injury or occupational disease.

B. The employer is responsible for the reimbursement of travel expenses when the travel is related to a request for a medical examination by a physician of the employer's choice. Reimbursement of travel expenses under this provision shall not require an order of BWC or the IC, unless there is a dispute. Reimbursement by the employer under this provision is not subject to the minimum mileage requirement applicable to BWC reimbursed travel.

C. The self-insuring employer is responsible for reimbursement of travel expenses if related to a self-insured claim, unless the travel is for:
   1. an exam prior to a determination for percentage permanent partial disability; or
   2. the provision of a prosthetic device pursuant to the *Artificial Appliance Requests* policy.

D. If a claim is enrolled in the *Fifteen Thousand Dollar Medical Only* program, refer to the *Fifteen Thousand Dollar Medical Only Program* policy.

E. To obtain reimbursement, the IW must, as soon as possible, complete and submit an *Injured Worker Statement for Reimbursement of Travel Expense* (C-60), or an equivalent documented travel reimbursement request to the responsible party reflected in sections IV.A-D.

F. BWC will deny travel expenses submitted more than two years after the IW's date of travel.

G. It is the policy of BWC that the following types of travel expenses must be pre-authorized by BWC to be reimbursable:
   1. Lodging;
   2. Travel in excess of 400 miles round trip;
   3. Companion travel;
   4. Travel by taxicabs, bus, train, air, or other special transportation; and
   5. Any other expenses identified on the C-60A as requiring pre-authorization.

H. Rates of Reimbursement:

1. BWC shall publish the C-60A that details the criteria and rates used to compute reimbursement of travel expenses.
2. Travel by automobile shall be reimbursed on a per mile basis, portal to portal, using the most direct and practical route.
3. Meals shall be reimbursed at the rate reflected on the C-60A only when an overnight stay is required and pre-authorized by BWC, or when the travel day exceeds twelve (12) hours. .
4. Travel by airplane, railroad, bus, taxi, or other special transportation shall be reimbursed at the actual and necessary cost of such fare; receipts are required.
5. Lodging shall be reimbursed at reasonable actual cost, up to the maximum amount reflected on the C-60A; receipts are required.
6. Miscellaneous expenses, such as tolls and parking, shall be reimbursed at actual and necessary cost; receipts are required.

I. BWC Pre-Pay Travel Program
   1. BWC may, in its sole discretion, assist an IW by pre-paying allowable lodging and/or transportation expenses, such as airplane or railroad fares. Such assistance is not mandated by statute or rule.
   2. Travel by automobile or taxi, meals, or other miscellaneous travel expenses are not eligible for pre-payment.
   3. An IW seeking to have travel expenses pre-paid shall submit the request to field staff as soon as possible prior to travel. Field staff shall advise the IW on the requirements and process for approval and arrangements.

J. Overpayment of Travel Expenses: If there is an overpayment of travel expenses, BWC shall issue an order indicating the overpayment and that the overpayment will be collected at 100% from any future approved travel expense reimbursement to the IW. The IW may also repay the overpayment amount at any time.

BWC staff may refer to the corresponding procedure for this policy entitled "Travel Reimbursement" for further guidance.

Procedure Name:	**Procedures for Travel Reimbursement**
Procedure #:	CP-20-01.PR1
Policy # Reference:	CP-20-01
Effective Date:	03/30/17
Approved:	Rick Percy, Chief of Operational Policy, Analytics & Compliance
Supersedes:	Procedure CP-20-01.PR1, effective 12/01/15
History:	Rev. 12/01/15; 05/09/14; 01/01/14, 08/01/13, 07/08/13; New 11/21/12
Review date:	12/01/20

I. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.

II. General Provisions and Pre-Authorization

A. Field staff may reimburse travel expenses when one of the following occur:
   1. When the Injured worker (IW) is ordered or authorized to appear for a medical examination occurring forty-five (45) miles or more, round trip from the IW's residence, by:
      a. BWC;
      b. The Industrial Commission (IC);
      c. The managed care organization (MCO);
   2. When the MCO has determined that treatment necessary for the IW's allowed condition(s), including a service contained in an approved vocational rehabilitation plan, is required and cannot be obtained within 45 miles round trip from the IW's residence;
   3. When the IW's allowed condition(s) requires the use of taxi or other special transportation for treatment or examination for the allowed injury or occupational disease.

B. The following travel expenses must be pre-authorized by field staff prior to travel required pursuant to section II.A:
   1. Lodging;

2. Travel in excess of 400 miles round trip;
3. Companion travel;
4. Travel by taxicab, bus, train, air, or other special transportation; and
5. Any other expenses identified on the *Injured Worker Reimbursement Rates for Travel Expenses* (C-60A) as requiring pre-authorization.

C. In cases arising under section II.A.2, the MCO shall identify the closest provider of the service, utilizing the hierarchy of distance (i.e., a provider in the following order of preference: within the local community, regional community, statewide community, or contiguous states where services can be obtained).
   1. The MCO shall staff its provider recommendations and the need for any pre-authorizations with field staff before authorizing treatment.
   2. The MCO and field staff shall document the rationale for the choice of provider(s) in the claim notes and what travel expenses are pre-authorized, if any.
   3. The MCO shall advise the IW to contact BWC for more information regarding requirements and procedures for obtaining reimbursement of travel expenses.

D. Field staff shall staff any questions and/or unusual situations regarding travel pre-authorization and/or reimbursement with the supervisor, and Claims Policy as needed.

III. Submission of a Travel Reimbursement Request

A. The IW must submit a request for travel reimbursement on a current *Injured Worker Statement for Reimbursement of Travel Expense* (C-60) form or an equivalent document (e.g., email, letter, or outdated C-60).

B. If field staff receives a travel reimbursement request and the reason for travel was for a medical examination scheduled by the IW's employer, field staff shall return the request to the IW, advising him or her that the request must be submitted to his or her employer for reimbursement.

C. If field staff receives a travel reimbursement request and the IW is employed by a self-insuring employer, field staff shall return the request to the IW, advising him or her that the request must be submitted to his or her employer for reimbursement unless the travel is for:
   3. An exam prior to a determination for percentage permanent partial disability; or
   4. The provision of a prosthetic device pursuant to the *Artificial Appliance Requests* policy.

D. If field staff receives a travel reimbursement request and the IW's claim is enrolled in the Fifteen Thousand Dollar Medical Only Program, field staff shall refer to the *Fifteen Thousand Dollar Medical Only Program* policy and procedure for further information.

E. If field staff receives a travel reimbursement request and the reason for the travel was for a medical examination scheduled by the IC, field staff shall forward the request to the IC office that scheduled the exam or fax the request to the IC for the IC's approval and processing.

IV. Review and Approval of Travel Expenses

A. Field staff shall review the C-60 or other equivalent documented travel reimbursement request by the IW, and verify that the expenses submitted meet the criteria for reimbursement, including necessary pre-authorizations. Field staff shall contact the IW to obtain any necessary clarification and/or missing documentation (e.g., receipts).

B. If the travel reimbursement request is for treatment that was not approved by the MCO, field staff shall deny the request. If the treatment is subsequently approved by the MCO, the travel reimbursement request will be approved, consistent with the requirements of this policy.

C. If field staff identifies that the need for treatment was approved, but the need for travel was not staffed or documented in notes, field staff shall approve the travel reimbursement request to the extent it is in compliance with the Travel Reimbursement policy.

V. Calculating Reimbursement

A. After field staff determines that all reimbursable costs are reasonable and necessary, field staff shall calculate reimbursement for travel expenses in the following manner:
   1. Reimbursement for travel by a personal vehicle shall be at the rate indicated on the C-60A, per mile, for the date(s) of travel.
      a. The total reimbursement is determined by multiplying the number of miles traveled by the per mile rate;
      b. Internet resources may be used as a tool to help determine reasonable and necessary mileage.
   2. Field staff shall reimburse for meals at the rates indicated on the C-60A when the travel:
      a. Includes an overnight stay; or
      b. Totals more than twelve (12) hours in one day.

3. Pre-authorized lodging for the IW shall be reimbursed at reasonable actual cost (receipts required), up to the maximum amount indicated on the C-60A, plus applicable taxes.
4. Travel by taxi, train, airplane, bus or other special transportation shall be reimbursed at reasonable actual cost (receipts required).
5. Miscellaneous travel expenses, such as tolls and parking, shall be reimbursed at the actual amount (receipts required).
6. Approved travel expenses related to pre-authorized companions shall be reimbursed at the same rates permitted for the IW, except
    a. Field staff shall not reimburse for lodging for the companion unless special circumstances require the companion to have a separate room.
    b. Field staff shall only reimburse mileage to the IW.

B. To process and document the C-60 form, field staff shall:
1. Enter the calculations in the appropriate section of the "Official Use Only" section of the form;
2. Indicate the appropriate procedure code(s) to be charged;
3. Check the "Surplus Fund" box if the travel expenses are related to:
    a. a percentage permanent partial exam;
    b. services in an approved vocational rehabilitation plan;
    c. a prosthetic provided to the IW pursuant to the *Artificial Appliances Requests* policy; or
    d. a medical exam for a denied statutory occupational disease. (See the *Occupational Disease Claims* policy for further information).
4. Sign, date, enter his or her phone number and "A" number where indicated, image a copy of the C-60 into the claim and send a copy to the IW with a copy of the C-60A;
5. Fax a copy of the completed C-60 to Benefits Payable. Benefits Payable will notify field staff if a C-60 is not completed properly. Field staff shall be responsible for correcting the C-60 and resubmitting.

C. If the request for travel reimbursement has not been submitted on a C-60, field staff shall process and document the request noting on the request or any attached document:
1. Calculations of reimbursable travel expenses;
2. The related procedure codes, as designated on the C-60; and
3. Whether any charges are to be made to the Surplus Fund.

D. If any of the IW's travel reimbursement request appears unreasonable or unnecessary, or is otherwise questionable, field staff shall contact the IW in an attempt to resolve.

Example: Mileage submitted by IW is thirty miles more than an online resource indicates the trip would be using the most direct route. Contact with the IW reveals that there was an accident causing a detour, resulting in the additional miles.

VI. Denial of Travel Reimbursement

A. If, after reviewing the C-60 or other submitted documentation, field staff determines that all or some of the submitted travel expenses do not meet the criteria for reimbursement per the *Travel Reimbursement* policy and procedures, field staff shall publish a miscellaneous order which states:
   1. "After a thorough review of your request for travel reimbursement filed on [date] BWC has determined that [a portion of] your request does not meet the criteria listed below:"
   2. The appropriate travel denial reason; and
   3. Any additional explanation needed to explain the basis for the denial and the statement: Therefore, we have denied [a portion of] your request for travel reimbursement.

B. In addition to a miscellaneous order, if only a portion of a travel reimbursement request is denied, field staff shall:
   1. Strike out the denied expenses on the C-60;
   2. Calculate the totals for the allowed expenses and indicate the amount of reimbursement;
   3. Image a copy of the C-60 into the claim and send a copy to the IW with a copy of the C-60A; and
   4. Fax the amended C-60A to Benefits Payable.

VII. IW Pre-pay Travel Program (Restricted Use)

A. If an IW requests assistance from BWC to prepay allowable and authorized lodging and or transportation expenses (e.g., hotel, airfare, bus fare) field staff shall advise the IW to submit the request to BWC management (i.e., team leader, supervisor or service office manager) as soon as possible prior to travel. The Pre-Pay Travel (PPT) unit shall be available for consultation via the "BWC Pre-Pay Travel" email box. Field staff shall also advise the IW that approval must be granted before any travel arrangements are made.

B. Field staff and BWC management shall staff the request.
   1. If approved by BWC management, field staff, in consultation with the IW shall complete the *Injured Worker Travel Card Authorization Log* (A-53) and submit it to the PPT unit for final approval or disapproval. The following information shall be submitted to the PPT:

a. Date(s) of travel;
b. Preferred travel time;
c. Travel destination (city and state);
d. Mode of travel (automobile travel excluded);
e. Appointment date and time;
f. Name, address and phone number of facility or physician;
g. Companion expenses, if any;
h. Hotel accommodations, including any special needs (e.g., handicap accessible, non-smoking/smoking, double beds). Incidental room expenses, such as room service, will not be pre-paid, though they may be reimbursable via a C-60, if appropriate;

2. Within two business days of receipt of the A-53 the PPT unit will approve or disapprove the request and notify field staff by email.
   a. If approved, the PPT unit will proceed with making travel arrangements.
   b. If disapproved, the A-53 will be cancelled and returned to field staff.
   c. Field staff shall document the approval or disapproval in the claim notes.

C. To process the approved A-53:
   1. The PPT unit will:
      a. Document the travel arrangements on the A-53 with the confirmed vendor, dates of travel, the total cost of travel and the confirmation numbers;
      b. Attach any itineraries received from the appropriate vendors and fax this information along with the approved A-53 to field staff;
      c. Maintain the completed and confirmed copy of the A-53 and fax a copy to Benefits Payable to be processed.
   2. Field staff shall image the A-53 and document the travel approval in the claim notes.

D. Once the A-53 is received by field staff:
   1. Field staff shall prepare a letter of confirmation to send to the IW, which includes the arrangements made by the PPT unit, any itineraries, and a C-60 for any expenses incurred by the IW that are not prepaid but approved, or otherwise meet the requirements of the *Travel Reimbursement* policy and procedures.
   2. Field staff shall set a diary for the next business day after the expected return date of the IW's travel;
   3. Field staff shall verify the IW traveled and kept the appointment per the arrangements confirmed on the A-53 and document the verification in claim notes;
   4. Field staff shall assure that any travel reimbursement request submitted by the IW does not include the pre-paid travel arrangements.

5. If field staff determines that the prearranged travel was not utilized, the IW shall be contacted to determine if there are justifiable reasons or circumstances that prevented the travel. This information shall be documented in the claim notes.

E. If, for any reason, the IW cancels the arrangements and does not make alternative arrangements, field staff shall notify the PPT unit immediately via the BWC Pre-Pay Travel email box. The PPT unit will contact the vendors and cancel the arrangements to avoid fees or penalties.
   1. Upon receipt of the cancellation notice, the PPT unit shall send a copy of the A-53 with the required cancellation notations, including any fee or penalties to Benefits Payable;
   2. Field staff shall document the travel cancellation in the claim notes;
   3. If new travel arrangements are made, a new A-53 shall be prepared and processed consistent with the Travel Reimbursement policy and procedures.

VIII. Overpayment of Travel Expenses

If there is an overpayment of travel expenses, field staff shall issue an order indicating the overpayment and that the overpayment will be collected at 100% from any future approved travel expense reimbursement to the IW. The IW may also repay the overpayment amount at any time.

Policy and Procedure Name:	**Drug Testing**
Policy #:	MP-21-01
Code/Rule Reference:	R.C. 4121.441, 4123.66; O.A.C. 4123-6-08, 4123-6-16.2, 4123-6-25
Effective Date:	09/23/16
Approved:	Freddie L. Johnson, Chief of Medical Services (signature on file)
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding urine drug testing that predate the effective date of this policy.
History:	Rev. 08/11/15, 05/09/14 and 12/11/13
Review date:	09/23/21

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for the utilization of drug testing (DT) for injured workers (IW), especially those who are receiving or being considered for chronic opioid therapy in the management of chronic non-cancer pain.

II. APPLICABILITY

This policy applies to MCOs and providers of drug tests.

III. DEFINITIONS

Alternative drug testing (ADT): a chemical analysis of bodily specimens, with the exception of urine, that are obtained to identify presence or absence of parent drugs or their metabolites. For the purpose of this policy, it is inclusive of both the immunoassay and a confirmation test such as gas chromatography, mass spectrometry or high-performance liquid chromatography.

Chronic opioid therapy: the consistent use of opioids for more than ninety (90) days.

Chronic pain: discomfort (i.e., pain) that extends beyond the expected period of healing.

Point-of-care testing: done at or near the site of patient care using commercial devices (e.g., in-office urine drug testing).

Urine drug testing (UDT): a chemical analysis of the urine to identify presence or absence of parent drugs or their metabolites. For the purpose of this policy, it is inclusive of both the immunoassay and a confirmation test such as gas chromatography, mass spectrometry or high-performance liquid chromatography.

IV. POLICY

A. It is the policy of BWC to:
   1. Ensure appropriate use of opioids in the treatment of chronic pain management by allowing DTs;
   2. Require provider submission of the IW's level of risk to the MCO prior to determining the appropriate number of DTs to authorize for the IW;
   3. Allow up to four DTs yearly as determined by the injured worker's (IW) individual risk assessment, which shall be submitted no less than once a year; and
   4. Allow up to two additional DTs yearly when a provider documents the demonstration of aberrant behavior by an IW.

B. Drug testing methods:
   1. It is the policy of BWC that UDTs are the preferred method of drug testing.
   2. It is the policy of BWC to allow Alternative Drug Testing (ADT) (e.g., blood, saliva and hair follicle):
      a. **Only** when a urine specimen is unobtainable due to medically documented reasons; and
      b. **Only** when testing facilities/labs use FDA approved test kits/devices to obtain ADTs.

C. It is the policy of BWC to reimburse for:
   1. DT performed in a laboratory that is CLIA (Clinical Laboratory Improvement Amendments) certified;
   2. DTs performed following the process outlined in the procedure section of this document;
   3. DT billed under codes reflected in this link (DT codes).
   4. Quantitative testing for an individual drug that the IW is prescribed which is not included in the standard drug panel listed in C.5;
   5. A standard drug panel immunoassay test that includes the following drugs:
      a. Amphetamines;
      b. Opiates;
      c. Cocaine;
      d. Benzodiazepines;
      e. Barbiturates;
      f. Oxycodone;
      g. Methadone;
      h. Fentanyl;
      i. Marijuana; and
      j. Hydrocodone.
   6. DT that includes the standard drug panel listed above in Section IV.C.5. a-j, when the IW is taking a prescription drug that is not paid for by BWC.

7. Additional tests for drugs not included in the standard drug panel listed above in Section IV.C.5. a-j when:
    a. The IW is prescribed the drug; and/or
    b. The physician deems the testing medically necessary.
8. Point-of-care DTs when medical documentation identifies an immediate need.
9. Drug confirmation by gas chromatography, mass spectrometry or high-performance liquid chromatography solely for the drug in question when the immunoassay results are positive or when:
    a. An unexpected drug or its metabolites are identified;
    b. The prescribed drug or its metabolites are not identified in the DT.
10. DTs immediately prior to the initiation of opioid therapy for chronic non-cancer pain or for the extension of opioid therapy beyond the acute phase (e.g., a patient has been on opioids for the treatment of an acute injury for six weeks or more and the practitioner is considering opioids for chronic pain).
11. DTs while a patient is on opioid therapy for chronic non-cancer pain to:
    a. Verify compliance with the treatment regimen; and/or
    b. Identify undisclosed drug use and/or abuse.

V. PROCEDURE FOR UDT AND ADT COLLECTION

A. UDT
    1. Providers of urine drug tests shall ensure a collection protocol that protects the security and integrity of the urine collection by:
        a. Testing the IW as soon as possible after the physician order is given;
        b. Verifying the IW's identification via a photo identification or other confirming ID;
        c. Collecting only one specimen at a time;
        d. Having the IW remove any garments which might conceal substances or items to adulterate the urine specimen;
        e. Instructing the IW to wash and dry his/her hands prior to urination;
        f. Securing all water sources;
        g. Ensuring the water in the toilet tank and bowl are blue;
        h. Inspecting the testing site to ensure no unauthorized substances are present;
        i. Removing all soaps, disinfectants, cleaning agents or other possible adulterants from the testing area;
        j. Providing individual privacy for the IW during specimen collection;
        k. Measuring the specimen temperature within four (4) minutes of its collection to ensure the temperature is between 90-100 Fahrenheit;
        l. Visually inspecting the urine for color and contaminants;
        m. Sealing and labeling the specimen with seals containing the date and specimen number in the presence of the IW;
        n. Having the IW initial the seals, certifying that it is his/her specimen.

2. A chain of custody form (appendix A) or equivalent form containing a minimum of the following elements shall be used in the collection and processing of the urine specimen:
    a. IW's name, address, date of birth, signature, date of signature and claim number;
    b. Collection site's name, address, phone and fax number;
    c. Reason for the test;
    d. Drugs to test for;
    e. Specimen temperature within four (4) minutes of collection;
    f. Additional comments;
    g. Collection time, date and printed name and signature of collector;
    h. Date and name of courier to whom the specimen was released;
    i. Printed name and signature of lab employee receiving the specimen and the date of specimen receipt;
    j. Documentation that the specimen bottle seals were intact upon the labs receipt of the specimen;
    k. Results and result date.

B. ADT shall be collected pursuant to the FDA approved drug kit.

C. Specimens failing to meet the above listed criteria shall be rejected for testing.

Appendix A Chain of Custody Form

Injured worker (donor) demographics		
Name:	Contact number:	Claim number:
Address, City, State and Zip Code:		Date of birth:
I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.		
Injured worker's signature:		Date (mm/dd/yy):

Collection site demographics		
Name:		Address, City, State and Zip Code:
Phone number:	Fax number:	

To be completed by the collector	
Reason for testing: ☐ Random ☐ Reasonable Suspicion/cause ☐ Follow-up ☐ Other (specify) _____	
Drug test to be preformed: ☐ Amphetamines ☐ Opiates ☐ Cocaine ☐ Benzodiazepines ☐ Barbiturates ☐ Oxycodone ☐ Methadone ☐ Fentanyl ☐ Marijuana metabolite ☐ Hydrocodone ☐ Other (specify)_____	
Temperature within 90 and 100 F within 4 minutes of collection: ☐ Yes ☐ No	
Specimen collection: ☐ Split ☐ Single ☐ None provided (explain) _____	
Additional observations:	
Time of collection:	Date of collection (mm/dd/yy):
I certify that the specimen given to me by the donor was collected, labeled, sealed and released to the courier service noted in accordance with applicable Federal requirements.	
Collector's name (please print):	Signature of collector:
Time of specimen release:	Date of specimen release (mm/dd/yy):
Name of courier the specimen bottles were released to: _____	

To be completed by the lab upon receipt of the specimen	
Accessioner's name (please print):	Signature of accessioner:
Specimen receipt date:	Specimen bottle seal intact? ☐ Yes ☐ No

Name of person specimen bottles released to:		
☐ Negative ☐ Positive ☐ Dilute ☐ Test cancelled ☐ Refusal to test ☐ Adultered ☐ Substituted Remarks: _____		
Positive for: ☐ Amphetamines ☐ Opiates ☐ Cocaine ☐ Benzodiazepines ☐ Barbiturates ☐ Oxycodone ☐ Methadone ☐ Fentanyl ☐ Marijuana metabolite ☐ Hydrocodone		
Other (list):		
Remarks:		
Lab technician's name (please print):	Signature of Lab technician:	Date (mm/dd/yy):

Policy and Procedure Name:	**Return to Work Data**
Policy #:	CP-18-01
Code/Rule Reference:	None
Effective Date:	March 1, 2018
Approved:	Kevin R. Abrams, Chief Operating Officer
Origin:	Claims Policy
Supersedes:	Policy # CP-18-01, effective 11/14/16
History:	New 12/23/13; Rev.11/14/16

I. POLICY PURPOSE

The purpose of this policy is to ensure that MCO and BWC staff appropriately verify, update and/or maintain return to work (RTW) data in the claims management system.

II. APPLICABILITY

This policy applies to MCO and Field Operations staff.

III. DEFINITIONS

Actual Return to Work (ARTW): The confirmed date the injured worker (IW) returns to employment, with or without work restriction(s). This may include an IW that has returned to the workplace with restrictions, but is participating in a vocational rehabilitation plan such as:

- Employer Incentive;
- On-the Job Training;
- Transitional Work; or
- Gradual Return to Work.

Estimated Return to Work (ERTW): The anticipated date the IW may be able to return to employment.

Last Date Worked (LDW): The last date the IW reported to work prior to taking time off, regardless of the length of time the IW worked on that date.

Return to Work Data: Data that includes any combination of the dates related to return to work, last date worked, estimated return to work, released to return to work or actual return to work.

Released to Return to Work (RRTW): The date the physician of record releases the IW to return to employment (with or without restrictions). This may include an IW that is released to return to work with restrictions, and is participating in a vocational rehabilitation service or program such as:

- Job Search/Job Seeking Skills Training;
- Job Retraining; or
- Work Trial.

Start and Stop Dates: The beginning and end dates of a working period or a period of disability/off work.

Wage Replacement Compensation: Compensation intended to replace an IW's earnings. This includes temporary total, living maintenance, living maintenance wage loss, wage loss (working and non-working), permanent total disability and salary continuation.

IV. POLICY

A. It is the policy of BWC to rely primarily on the managed care organizations (MCO) to provide accurate return to work data.

B. It is the policy of BWC to ensure that return to work data is identified, verified, properly updated and maintained in the claims management system.

VI. PROCEDURE

A. BWC staff shall refer to the *Standard Claim File Documentation and Altered Documents* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.

B. Medical Only Claims: The MCO shall provide RTW data on medical only claims, which will systematically update in the claims management system.
   1. The MCO shall determine the LDW, RRTW, ERTW, and ARTW dates based on documentation received and contained in the claim file or as provided by the employer, injured worker, provider or other reliable source.
      a. The MCO shall exercise due diligence in obtaining the ARTW date for all medical only claims.

b. Before submitting an ERTW that results in seven (7) or fewer missed days for a particular disability period in a medical only claim, the MCO shall contact the provider to verify the provider intended the RTW to be an ERTW and not an RRTW, and shall document the contact in notes.
c. The MCO shall not submit an RRTW date as an ERTW. RRTW dates will be captured on the Claims Maintenance>Claim Dates page in the claims management system.

C. The MCO shall enter detailed claim notes reflecting all actions taken to gather RTW data. Every claim note shall include the following:
1. If RTW data was obtained, what those dates are;
2. The name and position of the person the MCO spoke to or the name and date of the document being relied on to determine the reported dates;
3. The date the MCO spoke to the person who provided the RTW information, if applicable;
4. Clarifying details, including when "other" is noted as a reason the IW has not returned to work, if needed; and
5. Any other information relevant to and supporting the RTW data.

D. Lost Time Claims: For lost time claims, the MCO shall provide the RTW data to claims services staff via the Electronic Data Interchange (EDI) 148. Claims services staff shall presume the reliability of the data when accompanied by a detailed MCO note and enter the data into the claims management system.

E. If the MCO has not entered a note containing adequate information, or if for any other reason further verification is needed, claims services staff shall first contact the MCO, and then, only if necessary, the employer or employer representative, IW or IW representative, medical provider, vocational rehabilitation provider or other reliable resource. Claims services staff may also use documentation in the claim file for verification, as appropriate.

F. ERTW and End of Period Stop Dates
1. Claims services staff shall enter the initial ERTW date in order to:
a. Calculate days of work missed and determine if a claim is a medical only or lost time; and
b. Pay any form of compensation.
2. Claims services staff shall reflect a subsequent ERTW date (even if there is a RRTW date, or a no RTW reason) by entering a stop date (the day before an ERTW) on a period of disability. This occurs when:
c. A future date is received on a MEDCO-14;

d. When wage continuation information is received from the employer and there is no estimated date provided on the MEDCO-14 or other medical documentation.

G. ARTW

1. Claims services staff shall enter an ARTW date when:
   a. MCO staff has verified the IW has actually returned to employment; or
   b. BWC staff has verified the IW has actually returned to employment.
2. When entering ARTW data, claims services staff shall ensure the following is documented in the claims management system:
   c. Whether the RTW was:
      i. Light/modified duty (i.e., with restrictions); or
      ii. Full duty (i.e. with no restrictions); and
   d. The RTW job being returned to was:
      i. Same job, same employer; or,
      ii. Different job, same employer; or
      iii. Same job, different employer; or
      iv. Different job, different employer.

H. No RTW Information Provided

1. Once the IW is no longer receiving wage replacement compensation and claims services staff obtains a specific reason why the IW will not be returning to work, claims services staff shall update the claims management system to reflect one of the following reasons:
   a. Termination;
   b. Resignation;
   c. Layoff;
   d. Social Security retirement;
   e. Voluntary workforce abandonment;
   f. Incarceration;
   g. School enrollment;
   h. Retirement;
   i. Social Security disability;
   j. Other.
2. Claims services staff shall use the "Other" option as a reason for an IW not returning to work only when no other listed reason is accurate for the situation.
3. If more than one reason applies, claims services staff shall provide the additional reasons in comments.
4. Claims services staff shall not delete the ERTW date even when one of the reasons listed above apply.

I. RRTW

1. Claims services staff shall enter the RRTW date on the Claims Maintenance>Claims Dates screen in the claims management system when provided.
2. Claims services staff shall recognize that a release to return to work does not necessarily indicate that the IW will be immediately returning to work or otherwise that the ERTW date must be altered.
3. Claims services staff shall not assume the RRTW date and the ERTW date are the same.

J. Claims services staff shall ensure that all periods of lost time related to the allowed condition(s) are reflected in the claims management system with appropriately identified last date(s) worked and return to work date(s), including periods of lost time when the IW does not receive compensation.

1. Claims services staff shall ensure that compensation is not paid over periods of ineligibility.
2. Claims services staff shall not delete periods of lost time from the claims management system unless the periods are incorrect.
3. Example 1: The IC has issued an order which states that temporary total disability (TT) is denied because the IW violated a written work rule and was fired, and thus the IW voluntarily abandoned the job. In this case, in the disability management window in the claims management system, the disability type selected is “off work-ineligible for compensation”, medical status is “not released”, work status is “no RTW” and the “reason” is “voluntary workforce abandonment.”
4. Example 2: The IC has issued an order which states that TT is not payable because the IW lost time from work because of some reason other than the allowed conditions in the claim. In this case, in the disability management window in the claims management system, the disability type selected is “off work-ineligible for compensation”, medical status is “not released”, work status is “no RTW” and the “reason” is “no supporting medical documentation.” In addition, if an end date was entered into the previous working period, the end date should be removed.
5. Example 3: The MCO approves surgery for an allowed condition, but the IW does not request compensation for that period of lost time. In this case, on the disability management window in the claims management system, the disability type selected is “off work-ineligible for compensation”, medical status is “not released”, work status is “no RTW” and the “reason” is “Other” and then enter a comment indicating compensation not requested, to prevent payment of compensation. A second row is created and is sent electronically to the MCO to reflect the correct status. The new row is largely identical, except the disability type is “off work”, medical status is “not released”, work status is “no RTW”, and the “reason” is “other.”

K. Permanent Total Disability (PTD)

1. If the IW is receiving non-statutory PTD, claims services staff shall remove any ARTW or ERTW date which is after the most recent last date worked.
2. If an IW is receiving statutory PTD compensation claims services staff may enter RTW data without affecting compensation related to the statutory PTD.

Policy Name:	**Transitional Work Developer; Transitional Work Grant & Transitional Work Bonus**
Policy #:	MP- 20-1
Code/Rule Reference:	OAC 4123-17-55, 4123-6-01, 4123-6-02.2. Employer Policies EP-20-01 (*Transitional Work Grants*) and EP-20-02 (*Transitional Work Performance Bonus*)
Effective Date:	06/01/15
Approved:	John Annarino, Chief Medical and Health Officer (Signature on file)
Origin:	Medical Policy
Supersedes:	All Medical policies, directives or memos regarding Transitional Work Grant & Bonus Program that predate the effective date of this policy.
History:	Rev 06/01/15; New 05/30/14
Review date:	06/01/20

I. POLICY PURPOSE

The purpose of this policy is to ensure appropriate evaluation and approval of transitional work plans, ensure appropriate reimbursement for services provided by transitional work developers, and monitor participating employer utilization of transitional work plans for bonus payment calculation.

This policy complements the Transitional Work Grants Policy and the Transitional Work Performance Bonus Policy developed by BWC Employer Services.

II. APPLICABILITY

This policy applies to BWC staff, Transitional Work Developers, Managed Care Organizations (MCOs) and Employers taking part in the Transitional Work Grant Program or the Transitional Work Performance Bonus Program.

III. DEFINITIONS

Eligible Employer – an employer that has met the BWC Employer Management eligibility criteria for participation in the Grant Program or Bonus Program.

Implementation Funds – funds remaining in the employer's Grant Program account after initial reimbursement for transitional work plan development. Implementation funds may be used to assist utilizing the transitional work plan with the first claim under the plan, provide transitional work plan program improvements, update a job analysis or add additional job analyses, or provide employer training relating to the transitional work plan.

Transitional Work (TW) – a work-site program that provides an individualized interim step in the recovery of an injured worker with job restrictions resulting from the allowed conditions in a claim. Developed in conjunction with the employer and the injured worker, or with others as needed, including, but not limited to the collective bargaining agent (where applicable), the physician of record, rehabilitation professionals, and the managed care organization, a transitional work program assists the injured worker in progressively performing the duties of a targeted job. OAC 4123-17-55(A)(5)

Transitional Work Developer (Developer) – the provider who develops the employer's transitional work grant plan. OAC 4123-17-55(A)(5)

Transitional Work Plan (TW Plan) – a plan with the following components: corporate analysis, employer-employee relations, policies and procedures, job analysis and program evaluation.

Transitional Work Bonus Program (**Bonus Program**) – Employers with a transitional work plan may receive a back-end discount for using their TW plan to return injured workers back to work. A BWC incentive is provided to qualified employers who return an injured worker to work quickly and safely after an injury through utilization of the employer's transitional work plan.

Transitional Work Grant Program (**Grant Program**) – BWC funds provided to qualified employers used to reimburse a percentage of the cost of development of a customized transitional work plan in the workplace.

IV. POLICY

A. Grant Program
   1. It is the policy of BWC that:
      a. Once BWC has approved an employer to participate in the Grant Program, the employer has 2 years from the date of application to complete development of a TW Plan and to complete reimbursement.
      b. Only developers meeting BWC eligibility requirements set forth in this policy shall develop TW Plans for the Grant Program. Employers may request

assistance locating a developer by checking the appropriate box on the Transitional Work Grant (TWG-1) application.

c. BWC's TW Unit shall review TW Plans submitted by employers and shall notify employers of Grant Program approval or denial following review of the TW Plan.
   i. Per the Employer Services Policy, BWC may approve an associated policy number for grant monies based on corporate organization if the associated policy number submits an application and meets all Grant Program eligibility requirements under its own policy number.
   ii. If multiple policy numbers are involved, BWC will work with the employer and developer to develop a TW Plan at the corporate level.

d. BWC will reimburse employers for TW Plan development costs based on reimbursement guidelines set forth in this policy.

e. Grievances:
   i. An employer may file a grievance with the TW Unit if:
      a) The TW Unit denied the Grant Program application based on the TW Plan submitted; or
      b) The employer disputes the TW Unit reimbursement for TW Plan development costs.
   ii. The TW Unit grievance decision shall be final.

f. Employer requests, documentation and grievances shall be submitted via:
   i. Email to TWSupport@bwc.state.oh.us (the preferred method of submission);
   ii. Facsimile to: 614-621-5758; or
   iii. Mail to: Transition Work Unit, BWC, 30 West Spring Street, L-20, Columbus, Ohio 43215.

2. BWC may assist employers in developing and/or updating a TW Plan if requested. Employers are not eligible for reimbursement relating to BWC assistance to the employer.

a. BWC may assist in the following circumstances:
   i. Employer is eligible to participate in the Bonus Program and does not have a TW Plan or needs assistance updating an existing TW Plan;
   ii. Employer has multiple policy numbers approved to participate in the Grant Program and needs assistance developing a corporate level TW Plan;
   iii. Employer was denied participation in the Grant Program because the employer reported fewer than 11 employees on its last payroll report to BWC; or
   iv. Employer previously received a grant from BWC for development of a TW Plan and needs assistance updating the TW Plan.

b. BWC assistance in developing and/or updating a TW Plan may include but is not limited to:
   i. Providing templates for the TW Plan development;

ii. Conducting workshops to train employers;
iii. Phone and/or on-site consultation at BWC's discretion;
iv. Generic job analysis; and/or
v. Assistance implementing existing grant plans or programs.

3. Transitional Work Developer Eligibility. Eligible developers shall be added to the Transitional Work Developer list on bwc.ohio.gov. The list includes the transitional work developer's name, service areas, business address, email and phone number.
   a. Developers shall meet all of the following requirements to be eligible:
      i. Be certified to participate in the Health Partnership Program as a vocational rehabilitation case manager, a licensed occupational therapist or a licensed physical therapist.
      ii. Complete a Transitional Work Developer Application (TWD-115 Form), available on bwc.ohio.gov, and meet the criteria set forth in the application. Applicants unable to meet the experience criteria set forth in the application may still be eligible to participate if they:
         a) Provide evidence of verified experience in developing transitional work programs or verified mentoring experience with a developer of transitional work services; or
         b) Request via email to TWSupport@bwc.state.oh.us that the Transitional Work Unit (TW Unit) provide names of developers that may be willing to provide guidance and/or mentoring. The TW Unit does not guarantee that the developer will provide mentoring experience.
      iii. Complete a BWC sponsored transitional work training program prior to delivering a TW Plan (if accredited between 2001 and 2006, the developer shall submit a TWD-116 Form and take a BWC sponsored refresher webinar course for the current Grant and Bonus Program).
   b. Failure to complete the training shall result in denial of the TW plan submitted by the employer.
   c. Developers that BWC determines do not meet requirements, except the provider certification requirement that shall be addressed by the Provider Credentialing Unit, may file a grievance with the TW Unit. The TW Unit shall investigate and its decision shall be final.
   d. Developer applications and grievances shall be submitted via:
      i. Email to: TWSupport@bwc.state.oh.us (the preferred method of submission);
      ii. Facsimile to: 614-621-5758; or
      iii. Mailed to: Transition Work Unit, BWC, 30 West Spring Street, L-20, Columbus, Ohio 43215.
4. Transitional Work Plan Review. TW Plans shall be reviewed based on criteria set forth in Appendix A to this policy. Review criteria include corporate description,

management and employee relations, policies and procedures, job analysis and evaluation and auditing process.

5. Employer Reimbursement.
    a. Reimbursement is a 3:1 match up to the amount of the grant award. Grant Program caps are based on the number of employees reported on the employer's last payroll report to BWC. If the employer did not report a number on the last payroll report, the number may be updated in the BWC web when completing the online application. Grant Caps are:
        i. 11-49 employees – up to $2900;
        ii. 50-199 employees - $5200;
        iii. 200+ employees - $6300.
    b. BWC will reimburse employers seventy-five percent (75%) of the final, total out-of-pocket cost the employer paid to the developer for covered services, after any discounts, rebates, or other cost or price adjustments offered by the developer are applied, subject to the following limitations:
        i. The maximum rate per service is:
            a) $200 per hour for TW developer labor;
            b) $200 per job analysis;
        ii. Developer hours or number of job analyses per employer are not limited;
        iii. Ineligible or unnecessary costs are not reimbursable and include but are not limited to:
            a) Costs associated with a developer's preparing and submitting a proposal to an employer;
            b) Travel and lodging expenses;
            c) Costs associated with development of a TW Plan by a non-BWC approved developer;
        iv. Reimbursement shall not exceed the amount of the employer's grant award.
    c. Employers may obtain reimbursement for TW Plan development costs after all of the following occur:
        i. The employer submits the developer's TW Plan to BWC;
        ii. BWC approves the TW Plan;
        iii. The employer pays the developer; and
        iv. The employer submits the following forms (available at bwc.ohio.gov) and documentation to BWC:
            a) Transitional Work Grant Reimbursement Request Form (Form TWG-2);
            b) BWC Service Invoice;
            c) BWC Transitional Work Agreement (Form TWG-3);
            d) Developer invoice to employer; and
            e) Employer proof of payment to the developer. Acceptable proof of payment includes:

i) Cancelled check that has been redacted of all confidential employer information;
ii) Credit card statement that has been redacted of all confidential employer information; or
iii) PayPal verification.

d. Implementation fund reimbursement is subject to the 3-to-1 match until the balance remaining is $200. At $200, the remaining balance may be paid for services. To obtain implementation fund reimbursement (if available), an employer shall submit to BWC the following documentation:
   i. Description of the service provided;
   ii. Invoice from the developer for services provided; and
   iii. Verification of payment for service provided.

e. BWC shall cancel checks disbursed and not cashed within 90 days or checks returned undelivered.

B. Bonus Program

1. Per the Employer Services *Transitional Work Performance Bonus* policy, EP-20-02, in addition to meeting Employer Services eligibility criteria, employers are required to submit documentation evidencing a developed and implemented TW Plan.
   a. Bonus Program employer applicants not utilizing the current Grant Program shall submit written documentation to the TW Unit that includes but is not limited to:
      i. Executive summary describing the TW Plan signed by a corporate officer;
      ii. Copy of the employer's TW Plan.
   b. An employer approved to participate in the Bonus Program is not required to submit TW Plan documentation with subsequent bonus period applications if there has been no lapse in Bonus Program participation, and the employer continues to meet Employer Services eligibility criteria.
2. Documentation shall be submitted prior to the bonus period cutoff date set forth in Employer Services *Transitional Work Performance Bonus* policy, EP-20-02, for inclusion in the current bonus period.
   a. Employers failing to timely submit documentation shall be denied and not be considered for the current bonus payment period.
   b. Documentation shall be submitted via:
      i. Email to: TWSupport@bwc.state.oh.us (the preferred method of submission);
      ii. Facsimile to: 614-621-5758; or
      iii. Mail to: Transition Work Unit, BWC, 30 West Spring Street, L-20, Columbus, Ohio 43215.
   c. BWC shall review submitted documentation and may contact the employer by phone or email to offer assistance, including, but not limited to:

i. Recommendations for improving or enhancing the TW Plan;
ii. Strategies and suggestions for implementing transitional work and light duty successfully;
iii. Informational assistance including:
    a) BWC job templates;
    b) BWC services to support transitional work such as job modifications, job analyses and vocational rehabilitation; and/or
    c) Process for submitting Transitional Work Offer and Acceptance Forms (TWB-2).

d. An employer that has its application for the transitional work bonus denied, or that disagrees with BWC's performance bonus determination, may file an appeal to BWC's Adjudicating Committee pursuant to Ohio Revised Code 4123.291 and OAC 4123-14-06. Employer appeals filed due to transitional work plan issues (e.g., employer believes it did not get appropriate credit for a return to work) will be addressed by the TW Unit.

C. MCO Responsibilities for the Bonus Program

1. Gathering and transmitting return to work information;
2. Reviewing and updating return to work information; and
3. Assisting employers in the collection of required forms.

Appendix A- Transitional Work Grant & Transitional Work Bonus Policy

Review of transitional work plans shall be based on the following criteria:

1. **Corporate Description Criteria:** In reviewing the corporate description developed by the developer, BWC shall consider whether the developer reviewed/addressed the following areas:
   a. Corporate description with analysis of the following:
      i. Current organizational status;
      ii. Corporate demographic information relating to:
         a) Number of employees;
         b) Industry type;
         c) Job classifications;
         d) Union positions, if applicable;
         e) Multiple business locations, if any;
         f) Related companies and associated policy numbers, if any;
         g) Managed Care Organization (MCO);
         h) Third Party Administrator (TPA), if applicable;
      iii. On-site interviews with employer-owners, supervisors, team leaders, union representatives, if applicable, and employees;
   b. Review of current corporate policies with recommendations for improvement in the following areas:
      i. Accident reporting;
      ii. Modified duty program;
      iii. Dispute procedures;
      iv. Return to work policies;
      v. Americans with Disabilities Act policies;
      vi. Training policies;
      vii. Safety policies;
   c. Transitional work grant plan objectives;
   d. Barriers to transitional work plan implementation.

2. **Management and Employee Relations Criteria:** Formation of a Transitional Work/Safety Committee with participation by:
   a. Management;
   b. Union, if applicable; and
   c. Labor.

3. **Policies and Procedures Criteria:** A developer may use BWC's policy and procedure templates or customize them to meet the needs of the employer but is

not permitted to charge for the use of BWC templates or forms. BWC shall consider whether the developer identified:

a. A company transitional work coordinator;
b. Employer mission statement;
c. Eligibility, entry, extension and exit guidelines;
d. Timeframes for implementation;
e. Dispute resolution policy;
f. Americans with Disabilities Act compliance and accommodation at alternate work sites, if applicable;
g. Multilingual and multicultural needs;
h. Interpreter Services offered or required;
i. Training plan including training for the company transitional work coordinator, management, supervisors and employees. At a minimum, the following educational requirements must be met:
    i. Written policies that are discussed with employees prior to program initiation;
    ii. Written course materials relating to the program provided to employees with the opportunity to review and comment or ask questions regarding the program and policies;
    iii. A method to document employee knowledge and understanding of the program;
    iv. Provision for employee education within six (6) weeks of employment; and
    v. Provision for refresher courses with educational materials on a yearly basis to all employees. The refresher course may be incorporated with annual safety training.
j. Community resources and contact list provided by the developer including formal agreements with preferred community providers to provide services to the employees, a community resource list with contact names, phone and fax numbers. A different community resource directory shall be developed for different locations and for workers in remote locations, if applicable. Community resources include:
    i. Physicians and physician groups in the area;
    ii. Urgent care centers and emergency departments;
    iii. Occupational medicine and physical medicine specialists;
    iv. Rehabilitation providers on-site and at clinics;
    v. Case managers and vocational rehabilitation managers.
k. Roles and responsibilities of the following:
    i. Managed care organization and third party administrator, if applicable;
    ii. Physician;
    iii. On-site providers;
    iv. Injured worker;

v. BWC;
vi. Employer-transitional work coordinator; and
vii. Vocational rehabilitation professionals.

4. **Job Analysis Criteria:** A job analysis examining different jobs and collecting measurements while the job is being performed. A job analysis may utilize the BWC's job analysis templates but the job analysis must be customized to meet the needs of the employer. In reviewing the job analysis developed by the developer, BWC shall consider if the following criteria are met:
   a. A job analysis may only be performed by a BWC certified:
      i. Occupational Therapist;
      ii. Physical Therapist;
      iii. Certified Professional Ergonomist (CPE);
      iv. Certified Human Factors Professional (CHFP);
      v. Associate Ergonomics Professional (AEP);
      vi. Associate Human Factors Professional (AHFP);
      vii. Certified Ergonomics Associate (CEA);
      viii. Certified Safety professional (CSP) with "Ergonomics Specialist" designation;
      ix. Certified Industrial Ergonomist (CIE);
      x. Assistive Technology Practitioner (ATP); or
      xi. Rehabilitation Engineering Technologist (RET).
   b. At a minimum, the job analysis shall include the following:
      i. The job title and summary description;
      ii. Essential functions of the job divided into work tasks with a description of the physical demands of required tasks analyzed at the job site with the worker's input including frequency, duration, and postures and the use of devices to measure force;
      iii. Equipment or tools used in the job performance of each work task;
      iv. Working environment and conditions of the job including knowledge, skill and experience generally required to perform the job.
   c. Repeat job analysis are prohibited unless a component of the job analysis is customized for a particular part of the job.
   d. All job analysis must be signed and dated by the actual servicing provider and must specify his/her credentials.
   e. All job analysis shall be submitted to BWC for use by claims and rehabilitation staff.

5. **Evaluation and Auditing Process Criteria:** Evaluation and auditing measures the effectiveness of the Grant Program and/or Bonus Program from both the employer

and employee perspective. Any of the following outcome-measures may be addressed:

a. Bonus Program calculations indicating successful utilization of the TW plan in returning injured workers to work;
b. Workers' Compensation savings analysis supplied by BWC Employer Services;
c. Reports supplied to the company by the MCO or TPA;
d. Productivity measurements;
e. Worker and management satisfaction.

Procedure Name:	**Procedure for Transitional Work Developer; Transitional Work Grant & Transitional Work Bonus**
Procedure #:	MP- 20-01.PR1
Policy # Reference:	MP-20-01
Effective Date:	06/01/15
Approved:	John Annarino, Chief Medical and Health Officer (Signature on file)
Supersedes:	All Medical procedures, directives or memos regarding Transitional Work Grant & Bonus Program that predate the effective date of this procedure.
History:	Rev 06/01/15; New 05/30/14
Review date:	06/01/20

I. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.

II. Transitional Work Developer Review

A. The Transitional Work Unit (TW Unit) shall review Transitional Work Developer (Developer) applications (Form TWD-115). Upon receipt of Form TWD-115, the TW Unit shall determine if the applicant:

1. Is certified in the Health Partnership Program (HPP) as one of the following provider types designated in O.A.C. 4123-6-02.2:
   a. Vocational rehabilitation case manager;
   b. Occupational therapist;
   c. Physical therapist.
2. Has sufficient experience in transitional work development.

B. TW Unit staff shall notify applicants meeting developer requirements of required training via email.

C. TW Unit staff shall add the developer's name, service areas, business address, email and phone number to the BWC Accredited Transitional Work Developer list on bwc.ohio.gov following completion of a BWC-sponsored training program noted in II.B.

D. TW Unit staff shall refer, via email, applicants not currently enrolled in HPP to the Provider Enrollment and Certification (Medco-13) form on bwc.ohio.gov.

E. TW Unit staff shall consult with the TW Unit manager if a determination is made that the applicant does not meet the experience criteria. If after consultation, the decision is to deny the applicant, staff shall send an email to the applicant with a list of developers that the applicant may contact to request mentoring to develop transitional work plans.

F. If an applicant files a grievance for the denial, the TW Unit shall investigate and respond to the grievance.
   1. The TW Unit shall:
      a. Send a written response via email within 10 business days of receipt of the grievance.
      b. If additional time is required to investigate the grievance, the TW Unit shall notify the grievant via email of the date by which it will issue a decision.
   2. The TW Unit grievance decision shall be final.

III. Grant and Bonus Program Evaluation Tools; TW Unit Roles and Responsibilities

A. Employers submit Transitional Work Grant Program (Grant Program) and Transitional Work Bonus Program (Bonus Program) applications online, via fax or by mail. The TW Unit is responsible for ensuring the paper applications are entered online into bwc.ohio.gov.

B. If Employer Services (ES) underwriting criteria are met, the system automatically creates a "TW Plan Look-Up" shell on BWCWeb. *See* Appendix A for detailed Plan Look-Up categories.
   1. The created TW Plan Look-Up notes the following:
      a. Type of application: Grant Program or Bonus Program;
      b. Application Date;
      c. Application status:
         i. If the application is for the Grant Program, the application status is "Approved" (because the application passed ES underwriting criteria).
         ii. If the application is for the Bonus Program, the application status is "Received" (the application cannot be "Approved" until the TW Unit completes verification and ES runs a final eligibility screening for the assigned bonus period).
      d. TW Plan Status. Plan Status will note "Expected." Expected means:
         i. BWC is expecting a TW plan from the Grant Program applicant; or

ii. BWC is expecting documentation confirming a TW plan from the Bonus Program applicant.

2. The system automatically assigns applications to the TW Unit staff
   a. TW Unit staff are authorized to re-assign applications based on workload/vacation schedules.
   b. Employers with multiple policy numbers have a separate TW Plan Look-Up shell for each policy number. The TW Unit shall assign employers with multiple TW Plan Look-Up shells to one reviewer.

C. TW Unit staff:
   1. Work together to:
      a. Review and approve Grant Program TW plans;
      b. Verify Bonus Program TW plan documentation.
   2. Utilize the following programs during the review process:
      a. BWCWeb – location of TW Plan Look-Up for the Grant Program and Bonus Program.
      b. SharePoint – location of Grant Program transitional work checklist created by TW Unit.
      c. Universal Document System (UDS)- depository for TW plan documents, emails and correspondence received.

IV. Grant Program TW Plan Review

A. The TW Unit shall:
   1. Process all TW plan documentation received via email, fax or mail and send out all correspondence relating to TW plan review and reimbursement decisions.
   2. Review the TWSupport@bwc.state.oh.us email box at least twice daily**.**
   3. Verify that submitted TW plans were developed by an approved transitional developer listed on bwc.ohio.gov.
   4. Scan documents received and sent out to UDS indexed by employer risk/policy number with a document type selected. Following are available document types:
      a. "TWSuppInfo"- Bonus Program documents;
      b. "TWGrant"- existing and new Grant Program documents; developer reimbursement documents;
      c. "TWB-1"- Bonus Program applications;
      d. "TWG-1" – Grant Program applications;
      e. "Correspond"- letters and correspondence to employers.
   5. Make sure a "TWG Checklist" (Checklist) exists in SharePoint for the employer risk/policy number noted on the submitted document(s). If no Checklist exists, TW Unit staff shall create the Checklist so that the reviewer will have a "shell" in which to input their TW plan reviews.
   6. Access BWCWeb TW Plan Look-up Grant Program to:

a. Insert the TW plan receipt date;
b. Within five business days following document receipt the TW plan documentation (located in the UDS system) is reviewed utilizing the Checklist to determine if plan criteria are met;
c. Update the TW Plan Status from "Expected" to "In Process." Changing the plan status to "In Process" gives notice the TW plan review is in process by the reviewer.

7. If TW plan information is missing or incomplete or does not meet required plan criteria, the reviewer shall:
   a. Update BWCWeb Grant Program Plan Status to "Pended" and take the following actions:
      i. Determine what is needed;
      ii. Prepare questions (using SharePoint template) addressed to the employer's TW coordinator;
      iii. Call employer's TW coordinator to discuss what is needed;
      iv. Email the questions to employer's TW coordinator confirming the conversation (if applicable) or requesting information (if unable to contact TW coordinator). The email shall include the following information:
         a) Timeframe for receipt of information if the reviewer is confirming information provided by employer's TW coordinator over the phone;
         b) Timeframe for response to the reviewer's request if no conversation with employer's TW coordinator occurred.
      v. Save the email to UDS.
      vi. If there is no response from the employer following the first phone call or no response to the email within three business days of sending, the reviewer shall:
         a) Place another call to employer's TW coordinator;
         b) Send a second email letter, save the email to UDS; and
         c) Place written notes in comments section of Checklist reflecting attempts to contact employer.
   b. Staff with TW Unit Manager if, after following the steps set forth in 7 a. i-vi. the TW plan information continues to be missing or incomplete or the TW plan does not meet required plan criteria. The TW Unit shall contact the developer to assist in obtaining information.
   c. If the decision is to deny the TW plan, the reviewer shall note the denial reason in the Checklist and update the BWCWeb Grant Program Plan Status to "Denied." The TW Unit shall then send an email "denial" letter to the employer's TW coordinator and save the letter to UDS.
   d. Upon successful completion of the TW Plan review the reviewer will update the BWCWeb Grant Plan Status to "Approved". The "Approved" plan status alerts the TW Unit management analysis to transfer the Checklist

information into the Transitional WorkGRANTS Reimbursement database used to determine employer reimbursement.

8. Create Correspondence:
    a. Timely mailing of Grant Program correspondence following TW plan review. The TW Unit shall email an approval or denial letter (as appropriate) to the employer within five business days of updating BWCWeb Plan Status to "Approved" or "Denied."
    b. Approval letters shall inform employers of required reimbursement documentation.
9. Investigate and respond to grievances relating to TW plan decisions.
    a. A written response shall be sent via email within 10 business days of receipt of grievance.
    b. If the grievance relates to actions taken by ES, the TW Unit shall forward the grievance to ES and notify the grievant via email letter of such action.
    c. If additional time is required to investigate the grievance, the TW Unit shall notify the grievant via email of the date by which a decision will be made.
    d. The TW Unit's grievance decision shall be final.
10. Upload report of the policy numbers of employers approved/denied for the Grant Program to the appropriate MCO Portal along with denial rationale.
11. TW Bonus Program participation: The TW unit staff shall then review the BWCWeb to determine if the employer submitted a Bonus Program application.
    a. If a Bonus Program application has not been received for the present bonus period, the TW Unit shall:
        i. Contact the employer's TW coordinator via email or telephone and request submission of an online Bonus Program application;
        ii. Monitor BWCWeb for the submission of a Bonus Program application by the employer; and
        iii. If/when the BWCWeb notes a BWC ES approved Bonus Program application; the TW Unit shall update the Bonus Program Plan Status to "Approved."
    b. If a Bonus Program application has been received for the present bonus period, the TW Unit shall update the BWCWeb Bonus Program Plan Status to "Approved" in addition to updating the BWCWeb Grant Program Plan Status.

V. Grant Program TW Plan Reimbursement/Implementation Funds

A. Employers submit reimbursement requests to the TW Unit for Grant Program TW plan development costs and implementation funds.

B. Upon receipt of documentation, the TW Unit shall:

1. Scan the documents into UDS. If an employer submits a check or credit card statement that does not have confidential information redacted, TW Unit staff shall redact confidential employer information prior to scanning the document.
2. Utilize the Transitional WorkGRANTS Reimbursement database checklist to ensure all required documentation was received and input invoice information.
3. Review submitted documentation and take one of the following actions:
    a. If all required documentation is submitted and payment is for allowed expenses, the TW Unit shall process the payment;
    b. If all required documentation is not submitted, pend payment authorization and contact employer via email noting additional documentation required for processing; or
    c. If request is for a non-allowed expense(s), deny the non-allowed reimbursement request and contact employer via email noting the non-allowed expense(s).

C. TW Unit staff shall utilize the Rates & Payments TW Grant Reimbursement System (R&P Program) for payment processing as follows:
    1. Two individuals shall be responsible for processing reimbursement requests (a "Creator" and a payment "Approver"). The creator and approver cannot be the same person. *See* Appendix B for specific payment processing steps.
    2. The creator shall:
        a. Create an invoice in the R&P Program for employer; and
        b. Enter invoice information into the system.
    3. The approver shall:
        a. Review payment request input by creator for accuracy and appropriateness of payment; and
        b. Approve payment of invoice. Approval authorizes BWC Benefits Payable to create a check and reimburse the employer. The approver shall staff all payment concerns with creator.
    4. Following approval, the TW Unit shall send a payment letter to the employer noting amount to be reimbursed and amount of funds remaining in grant award.
        a. Checks disbursed but not cashed after 90 days shall be cancelled by commission. If contacted by the employer, the TW Unit and BWC Benefits Payable staff shall work together to issue a replacement check.
        b. Checks returned undelivered shall be cancelled by BWC Benefits Payable. The TW Unit and BWC Benefits Payable shall work together to determine the appropriate address so that a replacement check can be issued.

D. The TW Unit shall monitor for employers eligible for reimbursement that have not submitted a reimbursement request. If a reimbursement request has not been submitted, the TW Unit may send an email reminder to the employer.

E. The TW Unit shall investigate and respond to employer-submitted grievances relating to TW plan development and implementation cost reimbursement.
   1. A written response shall be sent via email within 10 business days of receipt of a grievance.
   2. If additional time is required to investigate a grievance, the TW Unit shall notify grievant via email of the date by which a decision will be made.
   3. The TW Unit's grievance decision shall be final.

VI. Bonus Program TW Plan Verification

A. The TW Unit shall:
   1. Review the TWSupport@bwc.state.oh.us email box at least twice daily.
   2. Process all TW Plan documentation received via email, fax or mail.
   3. Scan to UDS all emails and documents received.
   4. Access BWCWeb TW Plan Look-Up Bonus Program to:
      a. Update plan documentation receipt date;
      b. Update Plan Status from "Expected" to "In Process." Changing plan status to "In Process" gives notice the submitted plan documents are scanned to UDS.
   5. Review and verify TW plan documentation (located in the UDS system) within five business days. TW plan verification may be demonstrated through submission of:
      a. Executive summary describing the TW Plan signed by a corporate officer;
      b. Copy of the employer's TW Plan.
   6. Following review and verification, update the BWCWeb Bonus Program TW Plan Status to "Approved." If the employer risk/policy number has an "Approved" Grant Program application and a Grant Program Plan_Status that is not in "Approved" status, the TW unit shall update the Bonus Program TW Plan Status to "Remeditin" [sic].
      a. Updating the Bonus Program grant status to "Remeditin" [sic] causes the system to change the Grant Program TW Plan Status to "Remeditin" [sic] which the system recognizes as "Expected."
      b. The TW UNIT may contact the employer to determine if the employer wants to continue with the Grant Program application.
      c. The system recognizes a Bonus Program TW plan in "Remeditin" [sic] status as "Approved" when Employer Services runs a final eligibility screening for the assigned bonus period.
      d. If an assigned employer's Bonus application is in "Received" status and the TW Unit has not received the employer's documentation, the TW Unit shall contact the employer and request documentation submission prior to the Employer Service cutoff date for inclusion in the current the bonus period (*See* Employer Services policy EP-20-02).

e. If the employer does not timely submit documentation, the TW Unit shall update BWCWeb Bonus Program TW Plan Status to "Denied." (The Bonus application will be denied at the time Employer Services runs a final eligibility screening for the assigned bonus period and the employer will be notified of the denial by Employer Services).

7. Upload the following TW plan reports to the appropriate MCO Portal for use by MCOs:
   a. At the close of the bonus application period (as set forth in the ES policy), a report noting policy numbers of employers approved to participate in the Bonus Program;
   b. A weekly Transitional Work Bonus Claims Participation report with an update of all claims for employers approved to participate in the Bonus Program.
8. Investigate and respond to appeals to BWC's Adjudicating Committee pursuant to Ohio Revised Code 4123.291 and OAC 4123-14-06 relating to transitional work plan documentation timeliness, review decisions and employer appeals relating to return to work credit.

B. TW Unit may contact the employer by email letter and/or phone following review of submitted documentation to offer BWC consultation services including but not limited to:
   1. Recommendations for improving or enhancing the TW plan;
   2. Strategies and suggestions for implementing transitional work and light duty successfully;
   3. Informational assistance including:
      a. BWC job templates;
      b. BWC services to support transitional work such as job modifications, job analyses and vocational rehabilitation; and/or
      c. Process for submitting Transitional Work Offer and Acceptance forms (TWB-2).

VII. Managed Care Organization (MCO) Responsibilities

A. MCOs shall:
   1. Indentify and refer employers to BWC needing a transitional work grant plan.
   2. Work with employers participating in the Bonus Program to obtain a completed BWC Offer and Acceptance Form (TWB-2) if not received;
   3. Submit on the 148 accurately the "Actual Return to Work" date and work status.
   4. Verify data entry accuracy of RTW dates and released type information on the Transitional Work Bonus Claims Participation weekly report posted on the MCO portal by the TW Unit.
      5. Work with employers with claimants released to work with restrictions to return to work using transitional work/modified duty.

Appendix A

BWC Web TW Plan Look-up contains the following categories:

- Policy Number – employer's risk/policy number
- Plan Status – status of transitional work plan. Plan status categories include:
  - Expected – BWC is expecting a transitional work plan;
  - In Process – a plan has been received and review initiated;
  - Pended – TW Unit has reviewed transitional work plan, items are missing, and the plan is on **h**old awaiting additional information;
  - Approved – TW Unit has approved transitional work plan;
  - Denied – transitional work plan has been denied;
  - Not Needed – Employer notified BWC that Grant or Bonus application no longer being requested or Employer Services denied Grant application because of an Attorney General balance;
  - Remedintin [sic] – "placeholder" category created because Grant and Bonus shells are "linked." Utilized when an employer submits both a Grant Program and Bonus Program application that pass Employer Service initial screening criteria and the Grant Program TW plan review has not yet been completed.
- Plan Status Effective Date – date transitional work plan was approved;
- Plan Receipt Date – date transitional work plan was received by BWC;
- Program Type - Grant or Bonus;
- Application Status – status of Bonus or Grant Application from Employer Services perspective.
- Application Date – receipt date of Bonus or Grant application from employer;
- Program Year Begin Date – only applies to Bonus applications. Notes what year to begin calculation for Bonus Program;
- TW Unit Assigned;
- Action – tool to input actions into BWCWeb.

Appendix B

1. The creator opens the Rates and Payments program and chooses Payment Menu on TW Grant Reimbursement screen. The Employer Reimbursement menu will open. Choose "Special Payments" on the menu bar and on the drop-down menu, select "Employer Payment" then select "Employer Reimbursement" from the subsequent drop down menu.
2. An "Employer Reimbursement – Window" will open. Enter employer's policy number in appropriate box. If employer policy number is not noted on documentation, choose "Lookup" in top right corner of screen to find employer's risk/policy number.
    a. If employer's TW Grant application and TW Grant plan are in "Approved" status, the "Employer Reimbursement" window will be displayed.
    b. If employer's TW Grant Plan Status is not in "Approved" status, a message will be displayed stating that the employer does not have an approved plan. No further action may be taken until TW Plan Look-up Grant Program plan status is in "Approved" Plan Status. Staff shall review why the plan is not in "Approved" status.
3. At the "Employer Reimbursement" screen, the creator will click on the "create" button to create the invoice in the system on the "Payment Entry" screen. (The "Payment Entry" screen provides information relating to the maximum grant allowable amount, the total grant amount paid and the remaining eligible amount). On the "Payment Entry" screen, the creator shall:
    a. Enter "Invoice From" and "Invoice To" information;
    b. Enter Invoice Amount. The allowed amount will be calculated by the system.
    c. Click the "ok" button on the screen.
4. Once the "ok" button is clicked, the approver is able to open the "Employer Reimbursement" screen. The approver shall:
    a. Review payment request for accuracy and appropriateness of payment;,
    b. Highlight invoice information noted; and
    c. Click the "Details" button on the screen.
    d. The "Payment Entry" screen will appear and the approver clicks the "Approve Invoice" button on the screen. At this point, the payment is authorized and will go through Benefits Payable batching to be paid that evening.

Policy and Procedure Name:	**Durable Medical Equipment (DME)**
Policy #:	MP-4-01
Code/Rule Reference:	R.C. 4123.66; O.A.C. 4123-6-02.2, 4123-3-15, 4123-6-07, 4123-6-16.2, and 4123-6-25
Effective Date:	06/06/14
Approved:	Freddie Johnson, Esq., Chief of Medical Services (signature on file)
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives or memos regarding durable medical equipment that predate the effective date of this policy.
History:	Rev. 07/16/13; New 09/21/12
Review date:	06/06/19

I. POLICY PURPOSE

The purpose of this policy is to ensure that the Bureau of Workers Compensation (BWC) reimburses for equipment meeting the criteria of Durable Medical Equipment (DME) when the equipment is reasonably related to and medically necessary for the treatment of an authorized condition(s) in a claim.

II. APPLICABILITY

This policy applies to all BWC and Managed Care Organization (MCO) staff having the responsibility of authorizing DME rental/purchase.

III. DEFINITIONS

Durable Medical Equipment: Equipment which is suitable for use outside of a medical facility and that:

- can withstand repeated use;
- can primarily and customarily serve a medical purpose;
- generally is not useful to a person in the absence of illness or injury;
- is appropriate for use in the home; and

- does not include disposable items.

Examples of DME include walkers, canes, crutches, hospital beds, bedside commodes, breathing machines, wheelchairs, power operated vehicles, etc.

IV. POLICY

A. It is the policy of BWC to reimburse providers for:
   1. DME purchases or rentals up to the purchase price, when deemed necessary and reasonable using the criteria outlined in *State, ex rel. Miller v. Indus. Comm.,* 71 Ohio St.3d 229 (1994,);
   2. DME purchased through a BWC certified supplier or in the absence of a certified provider, a supplier meeting the minimum credentialing standards for DME suppliers set forth in OAC 4123-6-02.2; and
   3. A single DME item of specified use, unless medical documentation substantiates the need for multiple items of the same use. This shall be evaluated on a case-by-case basis.

B. It is the policy of BWC to require that:
   1. MCOs ensure, in accordance with the Provider Reimbursement Manual, that providers have obtained prior authorization for the purchase of DME costing $250 or more.
   2. MCOs obtain prior authorization from BWC for the rental of DME when the total cost of the rental is anticipated, or has the probability, to exceed eighty percent (80%) of the purchase price of the DME.

C. Special considerations for specific equipment
   1. Manual Wheelchairs
      a. A wheelchair is covered when the injured worker's (IW) condition is such that without a wheelchair she/he would be bed or chair bound.
      b. Upgrades beneficial solely in allowing the IW to perform leisure or recreational activities are generally not covered.
      c. Specially sized wheelchairs are reimbursable when documentation supports the need, such as for IW's with slender or obese builds, or narrow doorways.
      d. Information submitted by the DME supplier must be corroborated by documentation in the IW's medical records and available upon request.
   2. Power Operated Vehicles (POV)/Motorized Wheelchairs
      a. Medical Requirements:
         i. Requests must be from a physician in one of the following specialties:
            a) Physical Medicine;
            b) Orthopedic Surgery;
            c) Neurology; or
            d) Rheumatology.

ii. If an above listed specialist is more than one day's round trip from the IW's home, the physician of record may make the request.
iii. Requests with insufficient medical evidence to support the need for a POV requires a Justification of Medical Necessity for Seating/Wheeled Mobility form / C-190 or equivalent from a physician listed above, or an Occupational Therapist (O.T) or Physical Therapist.
iv. Require an occupational therapy (O.T) evaluation by a BWC certified Occupational Therapist not employed by the DME vendor documenting type of POV/wheelchair needed, medical indications, necessary options/accessories, and appropriate vehicle size to accommodate mobility throughout IW's living quarters.

b. Physical/mobility requirements:
i. The IW's movement throughout the home must not be possible without the POV
ii. The IW must have adequate trunk stability to ride in a POV and safely transfer in and out of a POV.
iii. The IW must be unable to operate a manual wheelchair, but be capable of safely operating the controls of a POV.

V. PROCEDURE

A. Requirements for the purchase or rental of DME
1. The MCO shall process DME that is reimbursable via the fee schedule in accordance with:
a. The C-*9 Processing* policy and procedure; or
b. The *Claim Reactivation* policy and procedure.
2. If the MCO cannot process the DME pursuant to procedure A. 1. a-b, then they shall process DME provided by a BWC-certified provider according to the *Override Process* policy and procedure.

B. Procedural requirements for a POV
3. Prior to authorizing the purchase of a POV, the MCO shall discuss with the BWC catastrophic nurse if home modifications will be necessary to accommodate the POV/motorized wheelchair.
4. The MCO shall ensure that it receives a signed itemized quote from the DME vendor including all features, accessories and the inclusion of a rental at no charge for repairs occurring during the warranty period of the POV/wheelchair is required.
5. The MCO shall call the IW after the delivery of the POV/wheelchair to ensure the POV/wheelchair comfortably accommodates the IW, fits inside the home and has the options medically necessary for the IW to perform activities of daily living. If there are issues, the MCO may schedule a post delivery O.T. follow-up evaluation.

Policy Name:	**Medical Evidence for Diagnosis Determinations (MEDD)**
Policy #:	CP-13-02
Code/Rule Reference:	RC 4123.53; O.A.C. 4123-3-09
Effective Date:	05/26/2015
Approved:	Rick Percy, Chief of Operational Policy, Analytics & Compliance (Signature on File)
Origin:	Operational Claims Policy
Supersedes:	All Injury Management policies, directives and memos regarding MEDD that predate the effective date of this policy.
History:	New
Review date:	05/26/2020

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC considers and makes determinations based on the sufficiency of medical evidence required to support allowances in the claim, and that staff use the Disability Determination Guidelines (DDG) to improve the quality of referrals to the Medical Service Specialist or the physician reviewer/examiner.

II. APPLICABILITY

This policy applies to field staff and Managed Care Organizations (MCO).

III. DEFINITIONS

Causal relationship: For purposes of this policy and related procedure, a reasoned medical determination with legal implications that determines if the condition the injured worker (IW) is requesting is compatible with or could result from the mechanism or mode of injury, or could be the result (e.g., flow-through) of a previously allowed condition in the claim.

Contrary medical evidence: For purposes of this policy and related procedure, medical evidence that does not support the allowance of a claim or condition, and may derive from the medical opinion of a BWC physician review/exam or from medical documentation that

conflicts with the medical documentation submitted to support the allowance of the condition.

Disability Determination Guidelines (DDG): Tool used by BWC to identify the appropriate medical information needed to support field staff's processing a requested condition in the claim without needing to seek additional medical input; also used to improve the quality of referrals to the Medical Service Specialist and the physician reviewer/examiner.

Medical Evidence: Relevant information that may prove or disprove whether a requested condition is medically supported in a claim; one criterion that BWC must consider when determining compensability of a claim or allowance of a condition.

Minor Injury: Injury type, as specifically identified by BWC, that requires no medical evidence for staff to allow the condition in the claim and permits staff to make a claim allowance or condition allowance decision based on the description of the accident.

Preponderance of the evidence: A standard of proof which is met when a party's evidence on a fact indicates that it is "more likely than not" that the fact is as the party alleges it to be.

IV. POLICY

C. It is the policy of BWC to:
   1. Use the DDG as a tool to assess the sufficiency of medical evidence;
   2. Weigh the medical evidence as one criterion with other required legal factors such as jurisdiction, coverage, compensability and causality;
   3. Make claim and condition determinations based on the totality of the evidence.

D. BWC shall not use the DDG as the exclusive criteria to either allow or deny a claim or new condition.

E. BWC staff will consider the causal relationship between the requested condition and the mode or method of injury.
   1. Causality shall be established in one of the following ways:
      a. Direct causation (i.e., proximately caused);
      b. Substantial aggravation/exacerbation of a pre-existing condition (i.e., a worsening);
      c. Acceleration (i.e., hastened progression); or,
      d. Flow-through (i.e., new condition that develops as a result of an allowed condition).
   2. MCOs must make and document at least two efforts to contact the provider. The MCO must try to obtain causality information. The MCOs must submit causality

indicators, as indicated below, to BWC and identify the documentation the MCO is relying upon to support the indicator. The MCOs must submit one of three values:

a. "Y" – indicates yes; the provider indicates the injury is causally related to the IW's employment;
b. "N" – indicates no; the provider does not indicate that the injury is causally related to the IW's employment;
c. "U" – indicates that the causality is undetermined and that BWC must seek additional information. Examples include:
    i. Provider failed to respond to whether a causal connection existed.
    ii. The injured worker did not seek medical treatment and the injury is not a minor injury.

F. Medical documentation, except as noted in Section IV.E, below, is required and must establish that the condition probably occurred as a result of the injury or as a flow-through to already allowed conditions.

G. It is the policy of BWC to permit field staff to allow, without the submission of medical evidence, a claim or condition classified as a minor injury.
    1. Minor injuries include only the following:
        a. First degree burns to less than 10% of the body
        b. Superficial lacerations (e.g., cut, open wound)
        c. Superficial contusions (e.g., bruise, hematoma)
        d. Insect stings
        e. Minor animal or human bites
        f. Superficial foreign body in the eye
        g. Corneal abrasions
        h. Conjunctivitis (also known as pink eye)
        i. Dermatitis
        j. Blisters
        k. Superficial injury/abrasion
    2. Staff shall not delay the investigation and processing of a minor-injury claim because BWC has not received medical evidence
    3. Field staff shall consider whether a causal relationship between the minor injury and the mode or mechanism of injury is established by a preponderance of the evidence (i.e., more likely than not).
    4. Field staff will consider the description of the accident to determine if the circumstances of the accident could produce the injury the IW is requesting.
    5. Staff may identify and code the diagnosis consistent with the mechanism of injury for these types of injures if there is no medical evidence on file.

H. For non-minor injuries, if field staff obtain the appropriate medical evidence in accordance with the DDG and determine that all other legal factors are met:
    1. Field staff will either:
        a. Code the condition using the ICD code provided by the treating physician; or,
        b. Code the diagnosis using the narrative diagnosis the treating physician has provided, whether or not the treating physician has provided an ICD code; or,
        c. If the physician has provided both an ICD code and a narrative diagnosis and the two do not match, field staff will seek clarification from the BWC ICD Modification Unit.
    2. Field staff will verify the site/location of injury:
        a. If field staff cannot verify the site or location:
            i. Field staff will select a site/location.
            ii. If it is discovered, even after expiration of the appeal period, that the site/location is different, BWC will consider such a clerical error and will issue a corrected order.
        b. Field staff shall refer to the *ICD Modification* policy and procedure, if needed.

I. If field staff cannot obtain appropriate or sufficient medical evidence in accordance with the DDG <u>for initial allowance of the claim</u>, staff may make a referral to the local nurse and/or request a physician review for an opinion.
    1. Field staff may allow the claim or condition for the diagnosis(es) the physician reviewer provides.
    2. If a physician reviewer recommends allowance of a diagnosis different than what the IW requested, BWC will notify the parties via an order that the requested condition will be considered when the IW submits supporting medical evidence for that particular condition.
    3. Example:
        a. Treating physician diagnoses rotator cuff syndrome but no MRI was performed.
        b. Per the DDG, staff cannot allow the condition without a physician review.
        c. The physician reviewer recommends allowance of sprain/strain of the shoulder based on the medical evidence in the file.
        d. Staff will issue an order allowing the sprain/strain of the shoulder and noting that the rotator cuff syndrome will be considered when the IW submits supporting medical evidence.

J. <u>For subsequent allowance</u> requests, if field staff cannot obtain:
    1. Any medical evidence, the subsequent allowance request will be dismissed;
    2. Appropriate or sufficient medical evidence in accordance with the DDG, field staff shall seek a physician review and refer the issue to the IC.

K. Signatures

1. It is the policy of BWC to accept original or stamped signatures on physician reports.
2. It is the policy of BWC to accept electronic data interface (EDI) transmissions of medical evidence to make medical determinations. However, if a claim is contested, BWC must obtain the hard copy medical report with a provider's signature from the MCO.
3. It is the policy of BWC to accept a healthcare provider's authorized representative's signature on medical reports. The physician of record (POR) or treating physician's authorized representative/designee will sign for the POR or treating physician and initial.
4. It is the policy of BWC to accept the signature of a nurse practitioner or a physician assistant to diagnose conditions for claim allowance decisions, additional conditions, and medical treatment decisions within the scope of their practice.
5. Please refer to the "Physician Signature on Medical Evidence" Chart, located on COR for BWC staff.

BWC staff may refer to the corresponding procedure for this policy entitled "Medical Evidence for Diagnosis Determinations* (MEDD)*" for further guidance.

Procedure Name:	**MEDICAL EVIDENCE FOR DIAGNOSIS DETERMINATIONS (MEDD)**
Procedure #:	CP-13-02.PR1
Policy # Reference:	CP-13-02
Effective Date:	05/26/15
Approved:	Rick Percy, Chief of Operational Policy, Analytics & Compliance (Signature on File)
Supersedes:	All Injury Management procedures, directives and memos regarding MEDD that predate the effective date of this procedure.
History:	New
Review date:	05/26/2020

I. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements, and BWC staff and Managed Care Organization (MCO) staff shall follow any other specific instructions included in this procedure.

II. Staff shall ensure a claim is compensable for initial determination

A. Staff shall refer to the following policies and procedures to evaluate a claim, in addition to using the Disability Determination Guidelines (DDG) detailed in this procedure and corresponding policy:
   1. *Interstate Jurisdiction*
   2. *Jurisdiction*
   3. *Compensability and Coverage.*

B. Causality
   1. BWC shall consider the relationship between the requested condition and the mode or method of injury to determine the specific theory of causation, which is one of the following:
      i. Direct causation (i.e., the injury or employment proximately caused the condition);
      ii. Substantial aggravation/exacerbation of a pre-existing condition (i.e., the injury or employment worsened a condition the injured worker [IW] already

had);
iii. Acceleration (i.e., the injury or employment hastened the progression of a condition);
iv. Flow-through (i.e., a new condition that develops as a result of an allowed condition);
v. A non-work related injury or illness.

2. Staff shall rely on medical documentation, except as noted in Section IV, below, to establish the condition probably resulted from the injury or employment.

C. The MCO is primarily responsible for gathering the documentation that establishes causality and shall submit the causality indicators to BWC via the Electronic Data Interchange (EDI) 148 for initial determinations (for subsequent decision requests, the MCO shall include this information in a detailed note).
1. The MCOs shall choose one of the following indicator values:
i. "Y" – Yes, the provider has indicated that the injury is causally related to the IW's injury or employment;
ii. "N" – No, the provider has indicated that the injury is not causally related to the IW's injury or employment;
iii. "U" – Undetermined. Reasons the MCO submits a "U" causality factor include, but are not limited to, the following reasons:
i) The provider would not provide an opinion as to whether or not the injury was causally related to the IW's employment. The MCO shall enter a note indicating the provider declined to establish a causal connection.
ii) The provider did not provide an opinion as to whether or not the injury was causally related to the IW's employment and the MCO has documented at least two attempts to obtain the information.
iii) The injured worker did not seek medical treatment.
2. The MCO shall identify the documentation that supports the causality indicator.
3. The MCOs shall not submit the initial EDI 148 until the MCO has:
a. Obtained and provided the causality indicator; or,
b. Documented a failure to obtain the information after at least two attempts to contact the provider and secure the causality information.

D. Field staff shall determine if the medical evidence the MCO gathered, including consideration of the causality factor, supports the subjective/objective exam findings for the diagnosis(es) being requested.

III. Staff Shall Use the DDG

A. Field staff shall refer to the DDG to ensure that the appropriate medical evidence

required for the requested diagnosis(es) is submitted, and if all required evidence is in the claim, field staff may issue a decision without sending the claim for Medical Service Specialist (MSS) or physician review.

B. If supporting evidence is submitted and field staff determines the requested condition(s) is related to the employment/injury, field staff shall follow the process in the *ICD Modification* policy and procedure.

C. If the supporting evidence is submitted but field staff is not sure the diagnosis is related to the employment/injury, field staff shall:
   1. Refer the claim to the MSS to clarify and verify the medical documentation and assist in determining if the information in the submitted medical evidence meets the requirements of the DDG.
   2. Then, the MSS may request a physician review to opine on a diagnosis.

D. If the IW's request for a condition is not supported by the medical evidence, field staff shall send for a physician review, and:
   a. If the decision is an initial determination and the physician reviewer recommends allowance of a diagnosis different from the requested condition(s), field staff shall allow the claim for the physician reviewer's recommended allowed conditions and include in the order the following statement: "The specific condition requested will be considered upon submission of appropriate medical evidence."
   b. If the decision is subsequent to the initial determination period, field staff shall:
      i. Seek clarification of the request;
      ii. Ask the IW to modify the request;
         i) If the IW agrees to modify, process the request; or
         ii) If the IW will not agree to modify, refer the claim to the Industrial Commission (IC).

E. If the supporting evidence is not submitted after attempts to secure it have been made (except for a minor injury, covered in Section IV below), field staff shall:
   a. Check to verify if a diagnostic test is planned, and if field staff does not yet have results, field staff may set a task in the claim to follow-up with the MCO to obtain the test results prior to sending the claim for physician review.
      i. For an initial determination:
         i. If the evidence is not obtained before the determination date arrives and the IW is requesting only one condition, field staff shall deny the claim;
         ii. If the IW is requesting more than one condition and evidence is obtained on some but not all of the conditions, field staff shall indicate that the condition for which no evidence was obtained is neither allowed nor disallowed.
      ii. For a subsequent determination, if the evidence is not obtained before the

determination date arrives, field staff shall process the claim with the evidence on file.

b. If no diagnostics are received or planned, send the issue to the Virtual Medical group so that an MSS may request a physician review to opine on the appropriate diagnosis, if any, for the claim allowance; and,
c. Code and process the claim based on the physician reviewer's diagnosis, if one is supplied.

IV. Minor Injuries

A. Field staff shall rely on the description of the accident to determine if the mode or mechanism of injury could produce the requested condition.

B. Staff shall not require medical evidence to determine the compensability of minor injuries. Minor injuries only include:
   1. First degree burns to less than 10% of the body
   2. Superficial lacerations (e.g., cut, open wound)
   3. Superficial contusions (e.g., bruise, hematoma)
   4. Insect stings
   5. Minor animal or human bites
   6. Superficial foreign body in the eye
   7. Corneal abrasions
   8. Conjunctivitis (also known as pink eye)
   9. Dermatitis
   10. Blisters
   11. Superficial injury/abrasion.

C. Field staff shall, if determining the claim is compensable, identify a diagnosis code consistent with the mode/mechanism of injury.

D. Field staff shall not allow a minor injury if there is contrary evidence on file, but shall:
   1. If it is an initial determination, issue an order based on the evidence; or,
   2. If it is a subsequent decision, refer the claim to the IC for hearing. Field staff may refer to the *Notice of Referral* policy and procedure.

V. How to Gather Medical Evidence or Additional Medical Evidence

A. Field Staff shall work and coordinate with the MCO, who is primarily responsible, to gather medical evidence, as needed.

B. Field staff shall follow up with the MCO if the MCO does not send medical evidence

within three (3) days of BWC's receipt of the initial EDI 148. If the MCO does not submit the medical evidence within four (4) days of the BWC's receipt of the initial EDI 148, field staff shall coordinate efforts with the MCO and may contact the treating physician directly for information.

C. Lost-time field staff shall call the MCO or provider to obtain information, and if that is unsuccessful, may send the "Request for Additional Information" letter to the treating provider, as needed, to obtain additional or sufficient medical evidence.

D. Medical Claims staff may call the MCO or provider to obtain information, and shall send the "Request for Additional Information" letter to the treating provider, as needed, to obtain additional or sufficient medical evidence.

VI. Physician Signature

A. Field staff shall ensure that physician reports are signed.

B. Staff may accept electronic data interface (EDI) transmissions as medical evidence in making claim determinations. However, if a claim is contested, BWC must obtain the hard copy medical report with a provider's signature from the MCO.

C. Staff shall ensure that the person signing the report has authority to do so. Staff shall refer to chart entitled "Physician Signature on Medical Evidence" for details on signatory authorization.

D. Staff shall accept a healthcare provider's authorized representative's signature, pursuant to IC Resolution R97-1-06. The POR or treating physician's authorized representative (designee) will sign for the POR or treating physician and initial.

E. Staff shall accept the signature of a nurse practitioner and/or physician assistant as valid medical evidence for claim allowance decisions and medical treatment decisions with the scope of practice, but not for disability certification.

Policy Name:	**ICD Modification**
Policy #:	CP-09-02
Code/Rule Reference:	R.C. 4121.32, 4121.39
Effective Date:	05/06/16
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance (signature on file)
Origin:	Claims Policy
Supersedes:	All Injury Management policies, directives or memos regarding ICD Modification that predate the effective date of this policy.
History:	Rev. 01/07/2016; New 08/11/2015
Review date:	05/06/19

I. POLICY PURPOSE

The purpose of this policy is to ensure that claims are assigned the correct numeric ICD code(s) and/or injury description (narrative condition) based on the supporting medical evidence, and that the code is accurately reflected in the claims management system.

II. APPLICABILITY

This policy applies to BWC Field Operations staff, Medical Services staff and managed care organizations (MCOs).

III. DEFINITIONS

Encoder: Web-based software that converts a narrative medical description into a numeric ICD description, or vice versa.

ICD: International Classification of Diseases. ICDs are standardized classifications of diseases, injuries, and causes of death, by etiology and anatomic localization and codified into a multi-digit number, which allows clinicians, statisticians, health planners and others to speak a common language, both in the US and internationally.

IV. POLICY

A. It is the policy of BWC to assign the most accurate and specific ICD code and narrative description for each condition allowed and/or disallowed in a claim to ensure that the correct allowed conditions are captured in the claims management system and that all future correspondence, including requests for independent medical exams (IMEs), will contain the correct allowed conditions.

B. It is the policy of BWC to update or modify condition(s) that have been coded incorrectly when:
   1. The description does not exactly match the condition allowed by order in the claim; or
   2. ICD codes and descriptions in the claims management system encoder are not an exact match with the conditions that need to be allowed or which have been allowed in the claim; or
   3. ICD codes have expired or been revised due to changes in the diagnosis code set.

C. It is the policy of BWC that the narrative condition/description requested on a First Report of Injury (FROI), Request for Authorization and/or Recommendation of Additional Conditions (C-9), a Motion (C-86), or allowed by BWC or Industrial Commission (IC) Order takes precedence over the actual numeric International Classification of Diseases (ICD) code(s).

D. It is the policy of BWC that a BWC or IC Order is required for conditions to be recognized as allowed or denied.

E. BWC shall provide notice of correction, modification, or deletion to the parties in the claim via BWC order or letter unless:
   1. The ICD code is being changed but the narrative description remains the same; or
   2. The narrative description is being modified to reflect an earlier BWC or IC order.

BWC staff may refer to the corresponding procedure for this policy entitled "Procedure for ICD Modification" for further guidance.

Procedure Name:	**PROCEDURES FOR ICD MODIFICATION**
Procedure #:	CP-09-02.PR1
Policy # Reference:	CP-09-02
Effective Date:	05/06/16
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance
Supersedes:	All Injury Management procedures, directives and memos regarding ICD Modification that predate the effective date of this procedure.
History:	Rev. 01/07/2016; New 08/11/2015
Review date:	05/06/2019

I. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure.

II. General Guidelines for ICD Modifications

A. Field staff shall obtain allowed conditions from the order which originally granted the condition(s). Field staff shall not obtain the conditions from the "previously allowed" section of an Industrial Commission (IC) order.

B. Field staff shall not delete or modify narrative descriptions for conditions allowed outside BWC's jurisdiction and shall staff all requests for modifications to conditions allowed by the IC with a BWC Field Attorney.

C. Field staff shall update the claims management system with all conditions allowed by BWC or IC Order.

D. Field staff shall use the encoder, the ICD coding manual, Medical Evidence for Diagnosis Determination (MEDD) policy and procedure and/or the correct coding tool found on Claims On-Line Resources (COR) to:
   1. Ensure conditions are assigned the correct ICD code;
   2. Ensure any requested condition has not already been addressed by another ICD code; and

3. Map an ICD-9 to an ICD-10.

E. Field staff shall:
   1. Ensure all ICD-9 codes in claims with a Health Insurance Claim Number (HICN) have been converted to ICD-10 codes.
   2. Convert all ICD-9 codes to ICD-10 codes when in a claim for any reason.
   3. Convert all ICD-9 to ICD-10 codes when Alternative Dispute Resolution (ADR) issues are being processed.

F. Field staff shall identify the correct site and location of all conditions when required.

G. Field staff shall utilize the site drop-down box on the diagnosis/injury status maintenance window to clarify a condition, when necessary. For example, a C-86 Motion is submitted requesting the condition Disc Displacement. Field staff shall choose the correct disc level(s) from the site drop-down box.

H. Field staff shall not request a modification on a condition when the condition is complete as coded. For example, a First Report of Injury (FROI) is submitted with the condition "lumbar strain" and the accompanying ICD code is S39.012A. The code S39.012A comes up "Strain of Muscle, Fascia and Tendon Thoracic thru Sacral Reg"; this code/narrative includes the "lumbar" site; therefore field staff shall not send the condition for modification.

I. Field staff shall seek agreement from all parties in the claim when a need for an ICD code modification is identified on a condition previously allowed by BWC order.
   1. When all parties are in agreement:
      a. Field staff shall vacate the original BWC order and issue a new corrected order with the corrected narrative/condition when modifying or adding a new condition;
      b. Field staff may staff modifications that require vacating an order and issuing a new order with a supervisor or BWC attorney.
   2. When all parties are not in agreement, or where the condition was previously allowed by IC order, field staff shall staff with a BWC attorney to consider referral to the IC for continuing jurisdiction.

J. Field staff shall request a description be modified prior to issuing a BWC order or referring to the Industrial Commission (IC) via the "Notice of Referral" (NOR) if a description cannot be accurately coded.

K. Field staff may correct or modify ICD codes without notice to the parties in the claim when the narrative description does not change.

L. Field staff shall complete the electronic referral form located on the "BWC ICD Modification Request" SharePoint site when modifications, clarification or ICD coding assistance is needed, following the requirements below.

M. General guidelines for requesting ICD modifications from the "BWC ICD Modification Request" SharePoint site:
   1. Staff shall follow these procedures for all claims requiring modification, including Self Insured (SI) claims.
   2. Field staff shall send requests for clarifications/modifications to the "BWC ICD Modification Request" SharePoint site:
      a. Whenever staff cannot, using the available tools, assign a code with the correct description for an allowed condition in the claim,
      b. As a resource for coding assistance and clarification, or
      c. For assistance in validating a code the staff selected or requesting the appropriate code that best reflects the diagnosis description.
   3. Field staff shall review all medical documentation in the claim prior to sending the request to the ICD modification SharePoint site to ensure the requested modifications are appropriate. When appropriate, the requests for clarification/modification shall be sent through the SharePoint site:
      a. Before a BWC order is issued;
      b. Before a NOR to the IC is sent; or,
      c. When an allowance made by IC Order is unclear.
   4. Field staff shall:
      a. Have the following information available in order to complete the electronic referral form on the "BWC ICD Modification Request" SharePoint site:
         i. IW's name and claim number;
         ii. The reason for the request, which will systematically assign the priority:
            a) Additional Allowance (C86);
            b) Additional Allowance (C9);
            c) Death;
            d) FROI;
            e) IC Order;
            f) MCO Request;
            g) Modification;
            h) New Claim (0-7 day);
            i) New Claim (28 day);
            j) New Claim (Surgery Pending);
            k) New Claim (CAT Claim);
            l) Question;
            m) Sprain/Strain; or

n) Surgery pending (after claim determination).

iii. Whether the claim is Self Insured (SI), and if the condition/ICD code was allowed by the SI employer, the date of the correspondence and/or claims management note documenting this information;

iv. Whether the request is for a BWC order or IC order, and if it is for an IC order, the date of the order and the exact description of the condition as stated in the IC Order;

v. Dates of medical documentation, applications or orders (e.g., MRI report dated, C-86 Motion (C-86), IC Order, etc.) that impact or support the request;

vi. If supporting medical documentation was not provided, the date and type of documentation that was requested;

b. Any request that fails to provide the required elements listed above shall be returned specifying the missing elements that need to be included.

5. Field staff shall receive a confirmation via the SharePoint site "BWC ICD Modification Request" SharePoint site coordinator. The returned SharePoint electronic referral form shall contain the correct ICD code to use or indicate that the ICD description has been corrected in the claims management system.
6. The BWC ICD Modification Request SharePoint site coordinator shall return urgent or rush requests made by field staff the same day when requests are made prior to 1 p.m. Requests made by field staff after 1 p.m. will be returned the next business day.
7. Field staff shall enter notes in the claims management system explaining the need for any diagnosis modification and shall identify the documentation used to support the decision.
8. If the field and the "BWC ICD Modification Request" SharePoint site coordinator disagree with the recommended modifications, the issue shall be staffed with the BWC Nursing Director or designee for determination.
9. Field staff shall send any questions regarding manual conversions (mapping ICD-9 to ICD-10) for existing claims to the ICD-9 to ICD-10 Conversion Referrals SharePoint site.
10. Field staff shall use the BWC ICD-10 Project Inquiry mailbox to:
    a. Send questions regarding system-mapped ICD codes;
    b. Request specific training topics (with 'training topic' or 'training request' in the subject line); and
    c. Ask general ICD-10 project-related questions.

III. Correcting/Modifying ICD Code/Description Before Issuing a BWC Decision

A. Field staff shall ensure ICD codes and narrative descriptions correspond and are valid workers' compensation conditions on all requests/recommendations for allowances [i.e., First Report of Injury (FROI), C-86 and C-9 Request for Medical Service

Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupation Disease (C-9)], as well as ensure conditions identified on the documentation, are correct and valid workers' compensation conditions.

B. Reviewing and Investigating the Request
   1. Field staff shall issue the BWC order or NOR to the IC, as appropriate, when the description provided can be accurately coded or the ICD and supporting documentation match exactly.
   2. Field staff shall review the FROI and/or medical documentation to obtain the correct location and/or site when that information is not identified on the request. For example: the FROI gives the condition "crushing injury of hand"; field staff shall review the available documentation to determine if the injury was to the right or left hand.
   3. Field staff shall not review medical documentation and diagnose a condition; all conditions other than minor injuries must be diagnosed by a physician. For example: If an MRI report is submitted but the POR has not formally accepted the findings, field staff cannot use those findings to support adding a condition to a claim.
   4. Field staff shall request the narrative description be modified/corrected if the requested/recommended description is correct based on the medical documentation in file but that description cannot be accurately coded in the claims management system. Field staff shall only do this when:
      a. Issuing an initial order; or
      b. Allowing a subsequent condition; or
      c. Referring to the IC with a NOR (if a subsequent condition should be denied). Field staff shall clearly state BWC's position on the request and outline the supporting evidence following the Notice of Referral policy.
   5. Field staff shall contact the requesting party, MCO or physician of record/treating physician to clarify the code and/or condition description when:
      a. The ICD code is provided without description;
      b. The condition does not match a valid ICD code;
      c. ICD code is correct but spinal levels are required but not documented.
   6. Field staff shall request medical documentation if clarification is not given and the documentation on file is insufficient to determine the appropriate ICD code/condition. Prior to sending to medical review, field staff shall request medical documentation from:
      a. The MCO;
      b. The physician of record/treating physician, when the MCO is unable to obtain the documentation.
   7. Field staff shall send the request to physician review if the condition has not been clarified to request what, if any, condition is supported by the medical evidence.

8. Based on the result of the physician review, field staff shall adhere to the following policies to address the requested condition(s):
    a. *Additional Allowance*; and/or
    b. *Order, Waivers, Appeals and Hearings*; and/or
    c. Notice of Referral.
9. Field staff shall use the ICD code A00.00 on claims for which there was no injury.
10. If requests or recommendations are made for symptoms and/or generic conditions, field staff shall:
    a. Determine if the symptom requested is addressed by a condition already allowed in the claim.
    b. If the request is addressed by a condition already allowed in the claim, telephone the requesting party and ask the filing party to withdraw the request/recommendation.
    c. If the request is not addressed by a condition already allowed in the claim, telephone the requesting party and/or physician of record/treating physician to clarify the request (i.e., determine what condition is causing this symptom).
    d. Send the request to physician review asking what, if any, condition does the medical documentation support.
    e. Based on the result of the physician review, follow the:
        i. Additional Allowance; and/or
        ii. Orders, Waivers, Appeals and Hearings; and/or
        iii. Notice of Referral.

IV. Correcting/Modifying ICD Descriptions after Allowance

A. Field staff shall not address ICD codes/conditions in claims that fall outside an employer's experience or were allowed more than five years ago for employers who are experience-rated, except in the following circumstances:
    1. The condition in question is one that is currently driving the claim cost (indemnity and/or medical).
    2. Anticipated future medical or indemnity costs may be incurred due to the condition in question (i.e., request for treatment or compensation may be filed).

B. Field staff shall review retro-rated or Public Employer State Agency (PES) employer claims for modifications at any time when there are potential medical and/or indemnity impacts identified that adversely affect the claim cost.

C. The field may staff with an Employer Service Specialist (ESS) or the BWC attorney to determine if the incorrect diagnosis is one that impacts claim costs.

V. Correcting/Modifying ICD Codes Never Formally Allowed by BWC or IC Order

A. Field staff shall not address conditions which were never formally allowed by BWC or IC Order that fall outside an employer's experience or have been allowed more than five years ago unless potential medical and/or indemnity impacts are identified that adversely affect the claim cost.

B. When the claims management system has an ICD code(s)/description listed that was never formally allowed by BWC or IC Order, field staff shall determine if the condition should be allowed, denied, or deleted, and staff shall follow the procedures in Section V. E-G below.

C. Field staff shall include medical bill review in the investigation to determine if the condition(s) is supported by medical evidence and a causal relationship can be established, but a BWC or IC order recognizing the condition is still required.

D. The condition(s) remains in an allowed status in the claims management system until the determination process is complete.

E. Field staff shall follow the Additional Allowance policy to allow the condition or to refer the condition to the IC.

F. If the condition was not previously allowed by BWC or IC Order and should be denied, the issue of denial of the condition cannot be sent to the IC unless there is a C-86 currently on file requesting the condition.
   1. If the condition should be denied, and there is a C-86 on file, the C-86 is referred to the IC for hearing via a NOR.
   2. If there is no C-86 on file, field staff shall follow the procedures to delete the condition.

G. If field staff determines a condition should be deleted from the claim:
   1. Field staff shall review all conditions not formally addressed by a BWC or IC Order when there is no supporting medical evidence to allow the condition, or the condition does not appear to be related to the claim.
   2. Field staff shall address the conditions by issuing the "BWC ICD Deletion" letter found in COR. The ICD code shall not be deleted in the claims management system without issuing a "BWC ICD Deletion" letter to notify the parties in the claim.
   3. If there are multiple ICD codes on the claims management system that were never formally addressed by BWC or IC Order:
      a. Field staff shall include all the conditions to be deleted in the "BWC ICD Deletion" letter.
      b. Field staff shall issue both a BWC order and the "BWC ICD Deletion" letter when

some conditions can be allowed through the Additional Allowance policy, and some conditions have no supporting medical evidence and should be removed.

4. Field staff shall not remove the ICD codes addressed by the "BWC ICD Deletion" letter from the claims management system until 14 days after the "BWC ICD Deletion" letter has been sent, allowing parties the time to request/recommend allowance of the conditions by filing a C-86 or C-9 with supporting evidence.
    a. Field staff shall delete the condition(s) after 14 days if no C-86 or C-9 is filed.
    b. Field staff shall follow the Additional Allowance policy if a C-86 or C-9 is filed.
    c. Field staff shall not delete the ICD Code(s) until the additional allowance process is complete.

VI. Correcting/Modifying ICD Description Allowed by Industrial Commission (IC) Order

A. If field staff discovers a condition allowed by IC Order is not available through the encoder in the claims management system, field staff shall follow the general guidelines in Section II of this procedure to obtain the correct ICD code.

B. Field staff shall request modification if the ICD code is correct but the condition description is not available through the claims management system encoder.

C. Field staff shall manually generate the "Notice of Injury Claim Status" letter through the claims management system to notify the parties/provider of the corrected description once the correction is made.

D. Field staff shall update the claims management system notes explaining that the ICD description has been modified to reflect the diagnosis description stated in the IC Order.

VII. Correcting/Modifying Miscoded ICD description

A. When conditions were formally allowed by BWC or IC Order, but were miscoded in the claims management system:
    1. Field staff shall follow the general guidelines in Section II of this procedure to obtain the correct ICD code.
    2. Field staff shall determine if the ICD description needs to be modified to match the allowance in the order.
    3. Field staff shall request modification if the ICD code is correct, but the ICD description is not available through the claims management system.
    4. Field staff shall update notes in the claims management system explaining that the ICD code and/or description has been modified to reflect the diagnosis description stated in the BWC or IC Order.
    5. Field staff shall manually generate the "Notice of Injury Claim Status" letter in the

claims management system to notify the parties/provider of the corrected code and/or description once the correction is made.

B. When conditions were formally allowed by BWC or IC Order, but modification was never requested, field staff shall:
   1. Follow the general guidelines in Section II of this procedure to obtain the correct ICD code;
   2. Request the description be modified when the ICD code is correct, but the ICD description does not reflect the narrative description in the IC/BWC Order.
      a. **Example**: BWC Order was issued using the description modification functionality in the claims management system and the ICD description on the diagnosis/injury screen was never updated to reflect the narrative description published on the BWC Order.
      b. **Example**: Field staff discovers discrepancy between the ICD narrative description that was allowed by IC Order and the ICD narrative description that is contained in the claims management system. The ICD modification was never requested.

VIII. Adding Specific Levels for Back Injury Claims

A. When the IC has allowed a back condition (e.g., degenerative disc disease) without indicating a specific level:
   1. Field staff shall staff with the BWC field attorney to determine if the claim should be returned to the IC for clarification if the IC Order is still within the appeal period.
   2. Field staff shall not update the condition to add specific levels without a formal order.

B. If treatment is requested in a claim where the level is not indicated and the MCO contacts field staff to clarify the allowed condition, field staff shall:
   1. Review the medical documentation supporting the allowance that is referenced in the "based on" section of the IC Order;
   2. Determine what level(s) was supported by the medical documentation if indicated;
   3. Staff with the MCO to determine what level the requested treatment addresses.
      a. If the requested treatment is for the level that is found in the medical evidence, document this in notes in the claims management system for future reference and share the information with the MCO. No updates shall be made to the allowed conditions;
      b. If the requested treatment is for levels that appear to be unrelated to the level as indicated in the medical documentation cited in the IC Order; or, the level is supported by medical documentation received after the IC Order, field staff shall staff with the BWC attorney to consider filing a C-86 for continuing jurisdiction

to clarify the allowance in the claim.

IX. How to Replace Expired ICD Codes

A. Field staff shall request modification through the "BWC ICD Modification Request" SharePoint site when expired codes are identified.

B. Field staff shall add current codes when expired codes are identified by the ICD Modification SharePoint site coordinator.

C. BWC ICD Modification Request SharePoint site coordinator will modify the narrative to reflect the previously allowed condition(s).

D. Field staff shall delete the expired code from the claims management system.

Policy Name:	**Applicability of Medical Documentation Submitted by Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants**
Policy #:	MP-03-03
Code/Rule Reference:	R.C. 4123.56, 4723.42, 4723.43, 4730.08, 4730.20, O.A.C 4123-5-18, 4123-6-20
Effective Date:	06/01/17
Approved:	Freddie L. Johnson, Chief of Medical Services
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding the Certification of Periods of Disability by Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants.
History:	Rev. 06/01/17; New 02/26/16
Review date:	02/26/20

I. POLICY PURPOSE

The purpose of this policy is to provide direction to medical providers, BWC staff and Managed Care Organizations (MCOs) on the applicability of medical documentation submitted by different provider types that is used as supporting evidence in certifying periods of temporary total disability.

II. APPLICABILITY

This policy applies to BWC staff, MCOs, and providers.

III. DEFINITIONS

Certified nurse practitioner (CNP): A registered nurse holding a license to practice as a CNP from the Ohio Board of Nursing or equivalent, authorized to practice in collaboration with one or more physicians. A CNP may provide preventative and primary care services, provide services for acute illnesses, and evaluate and promote patient wellness within the nurse's nursing specialty, consistent with the nurse's education and certification, and in accordance

with rules adopted by the nursing board. A CNP who holds a certificate to prescribe may, in collaboration with one or more physicians, prescribe drugs and therapeutic devices.

Clinical nurse specialist (CNS): A registered nurse holding a license to practice as a CNS from the Ohio Board of Nursing or equivalent, authorized to practice in collaboration with one or more physicians. A CNS may provide and manage the care of individuals and groups with complex health problems and provide health care services that promote, improve, and manage health care within the nurse's nursing specialty, consistent with the nurse's education and in accordance with rules adopted by the nursing board. A CNS who holds a certificate to prescribe may, in collaboration with one or more physicians, prescribe drugs and therapeutic devices.

Physician assistant (PA): A skilled person holding a license to practice as a PA from the State Medical Board of Ohio or equivalent, qualified by academic and clinical training to provide services to patients under the supervision, control and direction of one or more physicians with whom the physician assistant has entered into a supervision agreement approved by the state medical board and who are responsible for the PA's performance.

Physician extender (PE): For purposes of this policy, a physician extender is a certified nurse practitioner, clinical nurse specialist or physician assistant.

IV. POLICY

A. It is BWC's policy to recognize, the following as authorized to take action as outlined in section IV.B., below:
   1. Physicians, or
   2. PEs, only:
      a. During the first six weeks after the date of an injury, for no more than six weeks of disability, or
      b. With the co-signature of a physician.

B. The authorized individuals as noted in section IV.A., above, may do any of the following:
   1. Examine the injured worker (IW);
   2. Submit medical documentation BWC may use to support an IW's temporary total disability due to an allowed work-related injury or disease;
   3. Complete and submit a MEDCO-14 form or its equivalent; and
   4. Submit a detailed return to work (RTW) plan.

C. BWC does not authorize PEs to:
   1. Submit medical documentation which may be utilized to support any type of compensation other than temporary total disability;
   2. Work outside the scope of their collaborative or supervisory agreement;

3. Be granted Physician of Record (POR) status; or
4. Be granted the status of a Disability Evaluators Panel (DEP) physician.

V. PROCEDURE

A. Before awarding the initial period of temporary total disability, BWC shall ensure that the physician or PE has:
   1. Examined the IW;
   2. Completed, signed and submitted the MEDCO-14 or equivalent;
      a. The PE may sign and submit a MEDCO-14 or equivalent, which may be utilized to support temporary total disability without a physician signature during the first six weeks after the date of injury, and for no more than six weeks of disability;
      b. Following the period specified in V.A.2.a. above, the PE may sign and submit a MEDCO-14 or equivalent, which may be utilized to support temporary total disability only with the co-signature of a physician;
      c. At any point in the life of the claim, a MEDCO-14 or equivalent signed only by a physician may be utilized in support of temporary total disability
   3. Completed a detailed treatment and RTW plan.

B. If an initial period of TT is granted based upon a MEDCO-14 or equivalent signed only by a PE, prior to the conclusion of that initial period BWC shall inform the IW that ongoing requests for TT must be supported with medical documentation signed or co-signed by a physician (not a PE only).

C. If a PE renders treatment for periods of TT beyond the initial six weeks following the date of injury, BWC shall ensure that the supporting medical documentation indicates that:
   1. The PE and/or physician has examined the IW; and
   2. A physician co-signature is on the MEDCO-14 or equivalent if such medical documentation is being used to extend an injured worker's periods of disability.

D. BWC shall ensure that medical documentation supporting an IW's RTW is signed by:
   1. A physician; or
   2. A PE:
      a. Independently, when the RTW occurs within the initial six-week period immediately following the date of injury; or
      b. With a physician co-signature, when the RTW occurs after the initial six-week period immediately following the date of injury.

E. Please refer to *Temporary Total Compensation* policy and procedure for further guidance on the payment of this type of compensation.

Policy/Procedure Name:	**On-site Case Management**
Policy #:	MP-15-01
Code/Rule Reference:	N/A
Effective Date:	03/07/16
Approved:	Freddie L. Johnson, Chief of Medical Services (Signature on file)
Origin:	Medical Policy
Supersedes:	All medical policies, procedures, directives and memos regarding on-site case management claims that predate the effective date of this policy/procedure.
History:	New
Review date:	03/07/21

POLICY PURPOSE

The purpose of this policy is to ensure that the Bureau of Workers' Compensation (BWC) provides direction to the managed care organizations (MCO) for completing an on-site case management visit(s) and for developing and/or managing an individualized care plan for the injured worker (IW).

APPLICABILITY

This policy applies to BWC catastrophic nurse advocates (CNAs) and MCO staff.

DEFINITIONS

Case Management Plan: Compilation of all information that the medical case manager has gathered from the IW, the physician and the employer as well as any other pertinent sources that impact the progress and successful outcome of the claim resolution; action-oriented, time-bound and specific to the intervention(s) and resources to be used to assist the injured worker in achieving the specified goals specified within each phase of the plan; ensures that accountabilities are established so that all participants are aware of respective responsibilities in meeting the goals.

Catastrophic Claim: A claim in which there is a serious injury or occupational disease resulting in limited mobility and/or cognition related to the allowed conditions in the claim that severely limits the ability of the IW to perform activities of daily living and has a high probability of resulting in permanent disability.

Medical Case Management: Collaboration to assess, plan, implement, coordinate, monitor and evaluate options and services to meet an IW's health needs using communication and available resources to promote quality cost-effective outcomes; within the Ohio workers' compensation program, includes identifying and minimizing potential barriers to recovery, identifying and assessing future treatment needs, evaluating appropriateness and necessity of medical services, authorizing reimbursement for medical services, resolving medical disputes and facilitating successful return to work or claim resolution for injured workers; can be telephonic and/or on-site depending on the need of the IW.

Non-catastrophic Claim: A claim that does not involve a catastrophic injury or occupational disease, but requires an on-site visit to remove barriers that undermine a case manager's effective management of the claim.

On-site Case Management: Oversight of a claim that requires a case manager to travel to various settings (e.g., hospital, home, rehabilitation center) when assessing, planning, implementing, coordinating, monitoring and evaluating the options and services required to meet the IW's health and human service needs; characterized by face-to-face advocacy, communication and resource management that promotes quality and cost-effective interventions and outcomes.

Task-based Visit: A one-time case management activity with a specific purpose or objective.

POLICY

A. It is the policy of BWC that on-site case management visit(s) may be conducted for catastrophic and non-catastrophic injuries for injured workers who reside in Ohio. Examples of claim issues or conditions that may require an on-site case management visit(s) include, but are not limited to, the following:
    1. For catastrophic injuries or occupational diseases:
        a. Brain injuries, moderate to severe;
        b. All major extremity amputations, multiple complex fractures, crush injuries, loss of use of one or more limbs;
        c. Spinal cord injuries such as paraplegia, quadriplegia, hemiplegia or diplegia;

d. Total occupational blindness (blindness that occurs as a result of work or occupational activity);
e. Severe burns, such as second or third degree burns on more than 25 percent of the body;
f. Anticipated hospitalization in excess of four weeks, i.e., ventilators, ICU, psychiatric hospitalization;
g. Severe occupational diseases (not end stage); bloodborne pathogens; and toxic exposure with long term complications; and
h. Any other medical diagnosis identified by the MCO and CNA.

2. For non-catastrophic injuries or occupational diseases where the case manager has clearly documented the barriers in the claim:
   a. Inability to obtain medical records precipitating the need for on-site record review and/or retrieval;
   b. Documented unsuccessful telephonic case management;
   c. The transfer of an injured worker from the hospital to another facility for rehabilitation or other care;
   d. An extended hospital stay, recurrent admissions and failed or repeated surgeries;
   e. Non-compliance with physician and/or rehabilitation appointments;
   f. Delayed healing process;
   g. Lack of an acceptable support system for the IW;
   h. Delayed return to work;
   i. Request by an employer, physician, injured worker, and/or the injured worker's family and/or representative request on-site case management;
   j. BWC recommendation for an on-site case management visit; and/or
   k. BWC and /or the MCO's medical director determine that on-site case management would remove barriers that may impede the injured worker's return to work.

B. It is the policy of BWC that on-site case management visit(s) shall be executed as follows:
   1. For catastrophic claims:
      a. A minimum of one, unless waived by BWC's CNA; and
      b. More than one visit at the discretion of the MCO.
   2. For non-catastrophic claims:
      a. No minimum number of visit(s) required; and
      b. One or more visit(s) as determined by the MCO.

C. It is the policy of BWC that on-site visit(s) shall be integrated into an individualized case management plan for cases that are in active case management in accordance with chapter three of the MPRG. The case management plan shall clearly outline how such visit(s) can support or address care of the IW.

D. It is the policy of BWC that cases not in active case management but requiring the case manager to execute a task-based visit shall be documented in the claims management notes or integrated into a case management plan.

E. It is the policy of BWC that only one task-based on-site visit shall be permitted on claims that are not in active case management and it shall be documented in claims management notes. If more than one on-site visit is necessary to address the IW's care or to remove barriers, a case management plan shall be developed or reactivated to reflect the current condition of the IW.

F. MCO responsibilities:
   1. The MCO shall ensure that on-site case management visit(s) are executed for catastrophic and non-catastrophic claims, as appropriate.
   2. The case manager develops an individualized case management plan for catastrophic claims that:
      a. Incorporates any planned on-site case management visit(s), clearly outlining how such visit(s) will support or address care of the IW; and
      b. Identifies and evaluates options and services needed to meet the IW's needs.
   3. The case manager shall develop the case management plan and share it with appropriate individuals, as needed, when on-site case management is deemed appropriate.
   4. The MCO shall ensure that a summary of the on-site case management visit(s) is documented in the claims management system using a standard note title "MCO On-site Case Management Visit."
   5. The on-site case management note shall include, but is not limited to, the following components:
      a. The date of visit;
      b. The care setting/location;
      c. The name of participants and their roles;
      d. The clinical justification or purpose for visit;
      e. The summary of the visit including accomplishments and objectives met during visit; and
      f. The follow-up steps from visit.
   6. The MCO shall send a request for waiver of an on-site case management visit to the BWC CNA mailbox at **bwc.catnurse@bwc.state.oh.us** with the subject line "Request for a Waiver." The email shall include the following information:
      a. Claim number;

b. Name of the injured worker;
c. Date of injury; and
d. Explanation for waiver.

7. The BWC CNA shall ensure that any case management visit(s) that he or she waives is documented in notes.
8. The CNA may waive on-site case management visit(s) for catastrophic claims when:
   a. The CNA makes a clinical determination that an on-site case management visit is not indicated; or
   b. The claim is managed by Paradigm.
9. When waiving an on-site case management visit, the CNA shall:
   a. Conduct a careful assessment of the catastrophic claim to determine if it is appropriate to waive the on-site case management visit; and
   b. Document the rationale in notes.

Policy Name:	**Claim Reactivation**
Policy #:	CP-03-13
Code/Rule Reference:	O.A.C. 4123-3-15
Effective Date:	02/13/17
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance (Signature on file)
Origin:	Claims Policy (CP)
Supersedes:	Claim Reactivation policy CP-03-13 dated 12/14/16.
History:	New 12/14/16; 02/13/17
Review date:	02/13/2020

I. POLICY PURPOSE

The purpose of this policy is to ensure that when BWC receives a request for compensation or medical benefits in a state-fund claim that has had no activity or request for further action for more than a 24 month period, BWC appropriately reactivates the claim if the request is causally related to the allowed condition(s) in the claim and payment is appropriate.

II. APPLICABILITY

This policy applies to Field Operations staff and Managed Care Organization (MCO) staff.

III. DEFINITIONS

Active claim: A claim that has had payment of compensation, a paid date of service or a reactivation within a 24-month period.

Inactive claim: A claim that has had no payment of compensation, no paid date of service and no reactivation for more than a 24-month period.

Last Indemnity Paid Date: The most recent date a compensation payment was made in a claim and the date BWC will use for the active/inactive calculation if the last paid date of service is prior to this date.

Last Paid Date of Service (LPDOS): The most recent date of service for which BWC paid medical benefits in a claim, and the date BWC will use for the active/inactive calculation if the last indemnity paid date is prior to this date.

Medical benefits: For purposes of this policy, including but not limited to office visits, emergency room visits, diagnostics (e.g., x-rays, MRI or CT scan), prosthetics, durable medical equipment, vocational rehabilitation and prescription medication.

Reactivation: The process used to update a claim from inactive to active status.

Retro C-9: A medical treatment request for reimbursement of service(s) that the provider has already provided to the injured worker.

IV. POLICY

A. General information
   1. It is the policy of BWC to pay compensation or medical benefits in a state-fund claim that has had no activity or request for further action in it for more than a 24-month period when it receives a request for compensation or medical benefits that is causally related to the allowed condition(s) in the claim and payment is appropriate.
   2. The claims management system uses the following dates to establish whether a claim is active or inactive:
      a. If payment of compensation has been made, the date payment was made in the claim;
      b. If no payment of compensation has been made, he system chooses the date based on the latest of the following dates:
         i. Date of filing;
         ii. Date of service;
         iii. Date of payment of invoice.
      c. If payment of compensation and medical benefits has been made, the later of the two, subject to the criteria in section IV.A.2.b.
      d. For reactivation, the system uses the date the claims management system is updated by BWC.
   3. It is the policy of BWC that when the request for medical treatment /medical bill payment is not requested within one year and seven days from the date of first denial of the medical bill payment, the request will be denied, except when it is the result of an error by the BWC or the MCO.
   4. A party to the claim may appeal a claim reactivation and medical treatment decision to the Industrial Commission.

B. Request for action in an inactive claim
    1. It is the policy of BWC that any request for action in an inactive claim is a request that requires authorization, the MCO, not BWC, will take action when medical treatment is for a:
        a. Date of service(s) prior to the inactive date; or
        b. Prosthetic, orthotic, vision, hearing or dental device, medical supplies or durable medical equipment (DME) categories as outlined below when such request is the only issue presented:
            i. Canes
            ii. Crutches
            iii. Walkers
            iv. Decubitis care equipment (e.g., heel or elbow protector)
            v. Heat/cold application (e.g., electric heat pad)
            vi. Safety equipment
            vii. Restraints
            viii. Other orthopedic devices.
    2. The MCO shall refer a medical treatment request in an inactive claim to BWC for BWC to take action:
        a. When the medical treatment request is accompanied by supporting medical evidence dated not more than 60 days prior to the date of the request, or
        b. When such medical evidence is subsequently provided to the MCO upon request.
    3. The MCO may dismiss without prejudice and without a referral to BWC a request for medical treatment in an inactive claim:
        a. When the request is not accompanied by supporting medical evidence dated not more than 60 days prior to the date of the request; or
        b. When such medical evidence is not subsequently provided to the MCO upon request.
    4. Responsibilities
        a. The MCO will address a request when the claim is inactive as outlined in section IV.B.1.a.-b.
        b. BWC will address:
            i. Medical Benefits, except in IV.B.1.a.-b.
                a) Causal relationship between the original injury and the current incident that is triggering the medical treatment; and
                b) Necessity and appropriateness of the medical treatment request.
            ii. Compensation benefits
                a) Causal relationship between the original injury and the current incident that is triggering the request for compensation; and/or
                b) Causal relationship between the original injury and the current incident that is triggering the request for an additional allowance.
        c. The MCO shall forward to BWC, and shall work together, to address:

i. Multiple issues filed concurrently with dates of service both before and after the inactive date on the request; and
ii. Eligibility and feasibility requests for vocational rehabilitation.

5. It is the policy of BWC that when prescription medication is prescribed in an inactive claim, the MCO and BWC will evaluate the medical treatment that is triggering the prescription medication.
6. BWC will not process, and the MCO will dismiss, similar or duplicate medical treatment requests in an inactive claim when new and changed circumstances are not present to re-evaluate the request.

C. Independent medical examinations (IME) and physician file reviews (PFR)
1. BWC does not have to obtain an IME or PFR when the:
   a. Evidence supports the request; or
   b. Request is untimely, including:
      i. Outside the statute of limitations; or
      ii. Medical bill payment request is outside the one year and seven days of the adjudication of the initial medical bill.
2. BWC will, if the evidence does not support the request, require a PFR or an IME prior to issuing a BWC order or a notice of referral (NOR) to the IC. BWC must have a PFR or an IME if issuing a denial order.

D. Processing timeframe for claim reactivation requests
1. The MCO may take up to 16 business days to respond to the treatment request and forward the claim reactivation issue to BWC. This consists of:
   a. Three business days to:
      i. Review the medical treatment request and respond to the provider if medical documentation is not needed; or,
      ii. Pend the request to obtain medical documentation from the provider;
   b. 10 business days for the provider to submit additional medical documentation to the MCO, if needed; and
   c. Three business days from receipt of requested additional medical documentation to review and forward the claim reactivation to BWC.
2. The BWC has 28 calendar days to address the following:
   a. The causal relationship between the original injury and the current incident that is triggering the medical treatment request; and
   b. The necessity and appropriateness of the medical treatment request.
3. BWC shall address the issue of claim reactivation by:
   a. Issuing a BWC Order; or
   b. Making a recommendation on a NOR to the IC when BWC does not have jurisdiction to issue an order.

4. Once the decision is final, it is BWC's policy to notify the MCO of the decision, and the MCO shall notify the provider:
    a. By letter within three business days from receipt of the BWC notification when medical treatment services have not yet been rendered;
    b. By letter within 30 calendar days from receipt of the BWC notification when medical treatment services have been rendered already;
    c. Via bill payment when the MCO pays or adjusts the bill that was originally denied. In this instance, the MCO does not need to send a letter as the payment of the bill shall serve as the notice to the provider.

E. BWC's claims management system runs a program that systematically updates a claim to inactive when it is 24 months after the last paid date in a claim.

BWC staff may refer to the corresponding procedure for this policy entitled "Procedure for Claim Reactivation" for further guidance.

Procedure Name:	**PROCEDURE FOR CLAIM REACTIVATION**
Procedure #:	CP-03-13.PR1
Policy # Reference:	CP-03-13
Effective Date:	02/13/17
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance (Signature on file)
Supersedes:	Claim Reactivation procedure CP-03-13.PR1 dated 12/14/16.
History:	New 12/14/16; 02/13/17
Review date:	02/13/20

I. BWC staff shall:

A. Refer to the *Standard Claim File Documentation and Altered Documents* policy and procedure for claim-note requirements and shall follow any other specific instructions included in this procedure; and

B. Refer to the *Jurisdiction* policy and procedure to determine if a claim is statutorily open.

II. Request for action in an inactive claim

A. The MCO or BWC field staff may receive a request in an inactive claim in one of the following ways:
   1. The treating physician submits the *Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) form;
   2. A party to the claim files a *Motion* (C-86);
   3. A party to the claim files a specific application for compensation; or
   4. A provider or a party to the claim makes a verbal request.

B. Upon receipt of a medical treatment request, the MCO shall:
   1. Process in accordance with this procedure if the date(s) of service is after the inactive date.
   2. Process in accordance with this procedure if the dates of service are both prior to and after the inactive date.

3. Process the request in accordance with the standard processing protocol if the date(s) of service is prior to the inactive date or it is a request specified in section III.G.2.

C. The MCO and BWC field staff shall address the medical treatment triggering the request for prescription medication in an inactive claim and will not address the appropriateness of the prescription medication(s).

D. The MCO and Disability Management Coordinator (DMC) shall consider a referral for vocational rehabilitation in an inactive claim as a request for claim reactivation and shall refer to Chapter 4 of the MCO Policy Reference Guide (MPRG) for additional information. The MCO and the DMC shall work together with the BWC field staff to publish a BWC Subsequent Allowance order in accordance with section VI.

III. MCO process for medical treatment requests in an inactive claim

A. The MCO may view the current inactive date on the bwc.ohio.gov website, and if necessary, may contact BWC field staff to obtain the active/inactive claim history located on the status window under Milestone dates.

B. MCO referral to BWC for claim reactivation
   1. The MCO shall refer a medical treatment request to BWC on an inactive claim when the request is supported by:
      a. Medical evidence dated not more than 60 days prior to the date of the request; or
      b. Such evidence is subsequently provided to the MCO upon request (via a C-9-A form or equivalent).
         i. When current medical documentation is not on file, the MCO shall request such documentation from the provider via the *Request for Additional Medical Documentation for C-9 (C-9-A)* form or equivalent; and
         ii. Document the request in the MCO notes.
   2. When documentation requested from a provider is not received, the MCO shall dismiss the request in accordance with section III.F.
   3. The MCO, prior to making a recommendation to allow or deny the medical treatment request, may indicate an independent medical examination (IME) or physician file review (PFR) is necessary. The MCO and BWC shall collaborate to have the IME/PFR completed. Once the report/review is on file, the MCO shall provide the clinical findings note.
   4. When referring to BWC for a reactivation review, the MCO shall:
      a. Review and make a recommendation to BWC field staff;
      b. Send the recommendation to BWC field staff copying the supervisor in a secure email that includes:

i. Standard subject title: "Request for Claim Reactivation Review"; and
ii. A message that consists of, at a minimum, the following:
a) Claim number;
b) Injured worker name;
c) Name of provider requesting the medical treatment;
d) The date(s) of the C-9, C-86 or verbal request;
e) A detailed description of the medical treatment request;
f) The frequency and duration of the medical treatment request;
g) The beginning and ending dates of the medical treatment requested (to determine duplicate requests);
h) The body part being treated, including ICD code(s);
i) An indication if the medical treatment has been previously rendered or not;
j) The MCO recommendation to allow or deny the request;
k) The medical evidence relied upon to support the MCO recommendation;
l) An indication of which prong(s) of *Miller* the treatment does not meet, if the recommendation is to deny request;
m) The MCO Medical Director's opinion and recommendation (when applicable); and
n) Any other information the MCO would like to relay to BWC.

5. The MCO shall create, at the same time it sends the secure email to BWC, a clinical findings note with a title that reflects its content (e.g., "Claim Reactivation Clinical Findings"). The note should include, at a minimum:
a. The date(s) of the C-9, C-86 or verbal request;
b. A detailed description of the medical treatment request;
c. The frequency and duration of the medical treatment request;
d. The beginning and ending dates of the medical treatment requested (to determine duplicate requests);
e. The body part being treated, including ICD code(s);
f. An indication if the medical treatment has been previously rendered or not;
g. The MCO recommendation to allow or deny the request;
h. The medical evidence relied upon to support the MCO recommendation;
i. An indication of which prong(s) of *Miller* the treatment does not meet, if the recommendation is to deny request;
j. The MCO Medical Director's opinion and recommendation (when applicable); and
k. Any other information the MCO would like to relay to BWC.

C. Multiple medical treatment request(s) when claim reactivation is in process:
1. When the MCO receives a similar or duplicative medical treatment request(s) and a previous request sent to BWC is pending, the MCO shall:

a. Send the request to BWC if the prior request is at a point in time where all the requests can be handled together on one BWC order.
    i. The MCO shall immediately contact BWC field staff to make BWC field staff aware there is an additional request(s) that must be addressed.
    ii. BWC field staff shall address all medical treatment requests at the same time, which may include obtaining an addendum to an IME/PFR.
        a) BWC field staff may not address the medical treatment request if the BWC order is already issued; and
        b) BWC field staff shall immediately notify the MCO if an order has already been issued.
b. Not send it to BWC when a BWC order has already been issued. The MCO shall:
    i. Notify the provider the medical treatment request is deferred for consideration and will not be addressed until the current claim reactivation/medical treatment request is resolved and all appeals are exhausted.
    ii. Include the following statement on medical treatment requests in a letter to the provider, "C-9 is pended as claim reactivation review is currently in process based on a prior medical treatment request dated <Enter Date of Request>."

2. When the MCO receives a new medical treatment request that is not a similar or duplicate request of a previous request pending before the BWC or the IC, the MCO shall staff with BWC field staff to determine if the new request for medical treatment is to be included or not with the current medical treatment request for claim reactivation.
    a. If the new medical treatment request will be addressed with the prior request, the MCO shall:
        i. Prepare clinical findings note that contains each of the elements listed in section III.B.5; and
        ii. Send a secure email that contains each of the elements listed in section III.B.4.
    b. If the new medical treatment request will not be included with the prior request, the MCO shall:
        i. Defer consideration of the medical treatment request until the previous request pending is resolved and decision is final; and
        ii. Notify the provider that the request is deferred for consideration as indicated in section III.C.1.b.i.-ii.

D. Similar or duplicate medical treatment request when the claim reactivation decision is final
    1. For a final decision denying the prior request, the MCO shall review the documentation in the claim to determine if there are new and changed

circumstances that would impact the previous claim reactivation denial.

a. If there is documentation of new and changed circumstances that may impact the previous claim reactivation denial, the MCO shall perform the claim reactivation review pursuant to section III.B.
b. If there is no documentation of new and changed circumstances that would impact the previous claim reactivation denial, the MCO shall dismiss subsequent medical treatment requests that are similar or duplicate pursuant to section III.F.
c. For example, when an additional condition(s) in the claim has recently been allowed, this could be considered a new and changed circumstance that justifies consideration of an apparent duplicate treatment request. In this situation, it is appropriate to address the request for treatment through the claim reactivation process.

2. For a final decision allowing the prior request, the MCO shall address and process deferred or subsequent C-9/medical treatment requests utilizing the standard processing protocol.

E. The MCO shall refer a request to BWC for BWC to issue a denial when the request is not submitted within one year and seven days from the adjudication date of the previously submitted and denied medical bill, except in cases of an error by BWC or the MCO.

1. Example: a medical bill for treatment rendered on 12/21/2014 is denied on 1/5/2015; the MCO receives a request on 1/6/2016 for payment for medical treatment rendered on 12/21/2014. MCO/BWC will process request.
2. Example: a medical bill for treatment rendered on 12/21/2014 is denied on 1/5/2015; the MCO receives a request on 1/20/2016 for payment for medical treatment on 12/21/2014. BWC will deny the request for reactivation.
3. Example of MCO error: MCO receives and approves a C-9 request for medical treatment on 11/1/2014; a medical bill (for approved C-9 on 11/1/2014) for medical treatment rendered on 12/21/2014 is denied on 1/5/2015; the MCO receives a request on 2/29/16 in an inactive claim for payment of medical treatment on 12/21/2014. MCO denied the bill in error since treatment was prior approved. MCO/BWC will process request.
4. Example of BWC error: On 12/23/2014, the provider files an additional allowance (AA) request on a C-9 with a medical bill for treatment rendered on 12/21/2014. On 1/5/2015, the MCO denies the medical bill for treatment rendered on 12/21/2014 and forwards the C-9 to BWC to address the AA request. BWC processes the AA request and allows the condition; however, BWC fails to notify the MCO of the final decision as required. On 5/12/2016, the MCO receives a request to adjudicate the previously denied medical bill for payment of treatment rendered on 12/21/2014. Since BWC failed to provide notification to the MCO of the final decision on the AA request, the MCO/BWC will process the request.

F. MCO Dismissal
    1. When the MCO dismisses a request, the MCO shall:
        a. Notify all parties to the claim;
        b. Notify the provider;
        c. Fax to BWC:
            i. A copy of the request and the dismissal to the provider;
            ii. Include the C-9-A or equivalent used to communicate with the provider to request additional medical documentation.
    2. For a dismissal of a similar or duplicate medical treatment request that was previously denied, the MCO shall ensure that the dismissal also includes:
        a. Date of the final BWC/Industrial Commission (IC) order that denied claim reactivation;
        b. Date of the C-9/medical service request; and
        c. Specific medical treatment requested.
    3. The MCO shall ensure there is no appeal language in the dismissal.
    4. The MCO shall ensure there are no new and changed circumstances prior to issuing a dismissal.
    5. The MCO shall dismiss without prejudice, and without referral to BWC, a medical treatment request that:
        a. Is not accompanied by supporting medical evidence dated not more than 60 days prior to the date of the request; and
        b. Such evidence is requested by, but not subsequently provided to, the MCO.

G. The MCO shall refer all medical treatment requests to BWC staff in an inactive claim, except in the following situations:
    1. The medical treatment request is for a date of service(s) prior to the inactive date;
    2. The medical treatment request is only requesting the following:
        a. Prosthetics;
        b. Orthotics;
        c. Durable medical equipment (DME) categories as outlined in the Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS), Level II codes:
            i. Canes
            ii. Crutches
            iii. Walkers
            iv. Decubitis Care Equipment (e.g., heel or elbow protector)
            v. Heat/Cold Application (e.g., electric heat pad)
            vi. Safety equipment
            vii. Restraints
            viii. Other orthopedic devices, (e.g., adjustable elbow extension)
        d. Vision, hearing and dental devices (e.g., eye glasses, hearing aids, dentures);

e. Medical supplies (e.g., hearing aid battery).

3. The MCO may request BWC update the claim to active status when the medical treatment request does not need a referral to BWC and the MCO allows the request. The MCO shall send a secure email to BWC staff that:
   a. Requests BWC staff to update the claim to active in the claims management system; and
   b. Provides the rationale to support making the claim active.

IV. BWC process when in receipt of a claim reactivation and medical treatment request

A. BWC field staff shall identify when a claim is inactive by looking in the claims management system on the status window and the status reason would be "Inactive Claim." Field staff may also see under milestone dates, the active/inactive history.

B. BWC field staff shall update the status in the claims management system by opening a claim and selecting:
   1. "Status";
   2. "Claim Status";
   3. "Update claim status to "Reactivation Requested" to process request;
   4. Create a Legal Case Management Case.

C. Upon request for medical services on an active claim, BWC shall notify the MCO to process the request in accordance with the MCO standard processing protocol.

D. BWC may receive a request for action in an inactive claim for issues other than requested medical treatment (e.g., compensation, additional allowance, lump sum settlement). Field staff shall process the request as directed in the policy and procedure specific to the request. If an application for compensation is approved, field staff shall refer to section VII.A.-B. to make the claim active prior to issuing payment. Requests that will impact the active/inactive status include, but are not limited to:
   1. When the BWC or IC modifies or alters an award of compensation or benefits that has been previously granted;
   2. When the BWC or IC grants a new award of compensation or settles the claim;
   3. When the injured worker files for an allowance of an additional condition or compensation benefits that have not been previously considered; or
   4. When an injured worker dies and there is potential entitlement for accrued benefits or payment of medical bills, or the decedent's dependent(s) is requesting death benefits due to relatedness between the allowed conditions in the claim and the death.

E. Upon request for medical treatment (and/or a combination request of multiple issues)

on an inactive claim, BWC shall:

1. Immediately begin processing the request when it is a request for claim reactivation and medical treatment received from the MCO; or
2. Forward the request to the MCO if field staff determines that the MCO has not seen the request.
3. When the request to reactivate the claim is vague and non-specific, and there is no other request for specific benefits and/or medical treatment, field staff shall:
    a. Contact the filing party to determine the specific benefits and/or medical treatment requested;
    b. Send the request to the MCO to begin processing if specific benefits and/or medical treatment is identified;
    c. Dismiss the request to reactivate the claim by using the "Dismissal Letter" if specific benefits and/or medical treatment cannot be identified;
    d. Note the request and outcome in claim notes.

F. When field staff receives a secure email from the MCO for a claim reactivation and medical treatment request, field staff shall respond to the MCO in a secure email within three business days notifying the MCO that the claim reactivation request was received and that BWC has started processing the request.

G. BWC investigation

1. If the medical treatment request is made more than five years from the date of injury and the claim is inactive, field staff shall ensure the claim is statutorily active, as referred to in section I.B. of this procedure.
2. If the claim is an inactive self-insured bankrupt claim, field staff shall audit the claim to determine the following prior to beginning the investigation:
    a. All allowed conditions are documented in the claims management system;
    b. The claim is appropriately labeled as inactive;
    c. Validation the claim is statutorily open.
3. BWC field staff shall provide due process by attempting to call the parties to the claim at least once; however, when phone contact is unsuccessful, field staff shall send:
    a. The "Claim Reactivation IW Due Process" letter; and
    b. The "Claim Reactivation Employer Due Process" letter.
4. Field staff shall investigate issues prompting the medical treatment request to determine if the requested medical treatment is causally related to the original claim allowance. Field staff may staff with the appropriate discipline (e.g., BWC attorney on the timeliness of filing a medical treatment request) as the situation warrants.
5. Field staff may, as part of the investigation, send the Claim Reactivation Investigation Questions to the:

a. Employer;
b. Injured worker; and
c. Provider.

V. IME and PFR

A. Field staff may refer the claim for an IME or PFR as the situation warrants. Field staff shall create the appropriate medical exam scheduling case or medical file review case in the claims management system.

B. Field staff shall have a PFR completed in the claim prior to issuing a BWC Subsequent Allowance Order when BWC is recommending denial of request.

C. Field staff shall document in notes and notify the supervisor when the IME or PFR will cause the processing of the request to exceed 28 days.

D. Field staff shall add the appropriate set of questions for all issues being addressed (e.g., additional allowance and/or temporary total compensation), to the questions that address the medical treatment and claim reactivation request.

VI. Issuing the decision on claim reactivation and medical treatment

A. Field staff shall:
   1. Issue a BWC Subsequent Allowance Order when:
      a. Allowing the request in its entirety;
      b. Denying the request in its entirety;
      c. Allowing the request in part and denying in part (e.g., the request may be causally related to the original injury and current incident; however, the requested medical treatment may not be appropriate to allow in its entirety as a portion of the medical treatment requested is for experimental treatment); and
      d. The issue is for eligibility and feasibility of vocational rehabilitation. Field staff shall work with the DMC and MCO for the appropriate order insert.
   2. Issue a BWC Subsequent Allowance Order when:
      a. The decision includes multiple issues including the request for medical treatment (e.g., additional allowance and/or temporary total compensation); and
      b. BWC has jurisdiction to address all the issues in the request. Field staff shall select the appropriate order inserts.
   3. Send a Notice of Referral (NOR) to the IC when BWC does not have jurisdiction to issue a decision on all of the requests (e.g., we have requests for medical treatment, an additional allowance and temporary total compensation, and the evidence does

not support the additional allowance or the temporary total requests). The NOR shall include all of the requests because field staff shall not address some issues via an order and send the remaining issues to the IC.

B. Field staff shall include in the BWC Subseqeunt order the following information:
   1. The date(s) of the C-9, C-86 or request;
   2. A detailed description of the requested medical treatment, without CPT codes;
   3. The frequency and duration of requested treatment, if appropriate;
   4. The beginning and ending dates of the requested treatment, if appropriate;
   5. The supporting justification used for the determination;

C. BWC field staff shall notify the MCO when:
   1. The BWC order or NOR is issued;
   2. An appeal is filed to the BWC or IC order; and
   3. The appeal period has expired for a final decision of a BWC or IC order.

D. After all appeals have been adjudicated, BWC field staff shall:
   1. If the decision is to grant the claim reactivation, update the claim status to "reactivation approved" the claim in the claims management system.
   2. If the decision is to deny the claim reactivation, notify the MCO of the final decision, update claim notes and once the final decision is to deny claim reactivation, the claim status is changed to "inactive claim."

E. The MCO shall, upon notification from BWC of a final decision, notify the provider in the following manner:
   1. If the medical treatment request is denied, the MCO shall:
      a. Provide written notification to the provider within three business days from receipt of the BWC notification; or
      b. If the medical treatment has previously been rendered, communicate the bill payment decision to the provider within 30 calendar days from receipt of the BWC notification.
   2. If the medical treatment request is allowed, the MCO shall:
      a. Approve the medical treatment request; or
      b. Pay/adjust the bill originally denied, which serves as notice to the provider.

VII. Process to change the claim from inactive status to active status or active to inactive in the claim management system

A. Field staff shall activate a claim in the claims management system when:
   1. The MCO requests, with support, that the claim be made active;
   2. Field staff is processing a Tentative Order granting a 1% or more for percentage of permanent partial disability or increase of permanent partial disability award;

3. Field staff is paying compensation in a claim;
4. BWC issues a "Approval of Settlement Agreement" letter; or
5. Field staff finds that the situation warrants the claim be made active. For example:
    a. BWC receives a request from the MCO for claim reactivation for an IW with an approved prosthetic for new bolts and screws;
    b. IW has received new bolts and screws for the approved prosthetic every other year for the last 16 years. The request was later than usual this year as the provider was unavailable and IW could not get in to see the provider until after the claim became inactive.
    c. BWC/MCO shall staff the claim and grant the request without an order to avoid further delay for the necessary bolts and screws.
6. Field staff shall activate a claim in the claims management system by:
    a. Opening a Claim;
    b. Selecting Status;
    c. Change Status Reason to: Reactivation Requested;
    d. If approved, Change Status Reason to: Reactivation approved.
    e. Clicking Save.

B. Field staff may make a claim inactive in the claims management system as follows:
    1. If a claim is activated, field staff may reset the claim to inactive status if the claim was:
        a. Placed in active status inappropriately;
        b. Placed in active status to update data that will not result in a payment.
    2. When payment is made for medical benefits or compensation, the claim cannot be reset to an inactive status unless, after review, field staff determines it was not appropriate to make payment for medical benefits and/or compensation.
        a. For payment of compensation, field staff shall make an adjustment(s) to the Indemnity Benefit plan and the claims management system will adjust the last indemnity paid date in the claim and evaluate for closure.
        b. For payment of medical, field staff shall make the claim inactive as indicated in section VII.B.3. and ensure the medical treatment bill is adjusted and a new medical paid date will be sent and the claims management system will evaluate for closure.
        c. Field staff shall ensure that a note is entered in the claims management system documenting the action completed.
    3. Field staff shall make a claim inactive in the claims management system by:
        a. Opening a Claim;
        b. Ensure all compensation and/or medical recovery steps are complete;
        c. Any open cases are closed;
        d. Selecting Status;
        e. Change Status to "Close Claim";

f. Change Status Reason to: “Inactive Claim”;
g. Clicking Save.

4. Field staff shall not set the claims management system to an inactive status when an appropriate medical treatment or indemnity payment is made in the claim.

Policy Name:	**Exposure to Blood or Other Potentially Infectious Materials**
Policy #:	CP-05-02
Code/Rule Reference:	R.C. 4123.01; R.C. 4123.026
Effective Date:	08/07/15
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance. (Signature on file)
Origin:	Claims Policy
Supersedes:	All Injury Management policies, directives and memos regarding claims for exposure to a potentially infectious disease that predate the effective date of this policy.
History:	New
Review date:	08/07/20

I. POLICY PURPOSE

The purpose of this policy is to ensure that field staff and MCO staff handle claims filed for exposure to blood or other potentially infectious materials properly, including claims covered by R.C. 4123.026 (also referred to as Senate Bill (SB) 223 claims).

II. APPLICABILITY

This policy applies to field staff and MCO staff.

III. DEFINITIONS

Emergency Medical Worker: As defined by R.C. 4123.026**,** a first responder, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, certified under R.C. Chapter 4765, whether paid or volunteer.

Exposure: The condition of being subjected to a potentially infectious agent, which may have a harmful effect.

Airborne exposure: Transmission of potentially infectious agents through the air, typically by sneezing, coughing, raising dust, spraying of liquids or similar activities likely to generate aerosol particles or droplets.

Blood borne exposure: When potentially infectious blood or another body fluid that may contain blood, comes in contact with the eye, mouth, other mucous membrane, non-intact skin or through parenteral contact (injected, infused, or implanted). Note: The exposure required by R.C. 4123.026/SB 223 falls within this definition.

Firefighter: As defined by R.C. 4123.026, a firefighter, whether paid or volunteer, of a lawfully constituted fire department.

Other potentially infectious materials (OPIM): A term used by the Occupational Safety and Health Administration (OSHA) which refers to human body fluids other than blood, but which may contain blood, such as saliva or semen.

Peace Officer: As defined by R.C. 2935.01, an individual legally vested with law enforcement rights who generally works for a city, county or state public employer and can be either "traditional" (e.g., police officer) or "non-traditional" (e.g., certain park rangers, tax agents or liquor agents).

IV. POLICY

A. It is the policy of BWC that a claim for an exposure without an accompanying physical injury will be disallowed. See section IV.D below for provisions made for claims filed pursuant to R.C. 4123.026/SB 223.

B. If a claim for exposure includes evidence of a physical injury, the claim shall be allowed for the physical injury if all other required factors relating to jurisdiction and initial allowance are met.
   1. In an allowed claim, BWC will pay for the costs of conducting post-exposure medical diagnostic services to investigate whether the injured worker (IW) contracted an occupational disease from the exposure.
   2. BWC will also pay for the costs of related preventive treatment in accordance with Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC) exposure treatment protocols.

C. If an IW contracts a disease after being exposed, the IW may:
   1. Make a request for an additional allowance of an occupational disease in the related existing allowed claim; or
   2. If there is not a related existing allowed claim, file a new claim for an occupational disease.

D. Exposure by a Firefighter, Peace Officer or Emergency Medical Worker Under R.C. 4123.026/SB 223

1. It is the policy of BWC that BWC or the self-insuring public employer will pay the costs of conducting post-exposure medical diagnostic services, consistent with the standards of medical care existing at the time of the exposure, when the following criteria are met:
    a. The IW is a:
        i. Firefighter of a lawfully constituted fire department;
        ii. Peace officer; or
        iii. Emergency medical worker; and
    b. The IW has come into contact with the blood or other body fluid of another person, in the course of and arising out of the IW's employment or when responding to an inherently dangerous situation, through:
        i. A splash or spatter in the eye or mouth, including when received in the course of conducting mouth-to-mouth resuscitation;
        ii. A puncture in the skin; or
        iii. A cut in the skin or another opening in the skin, such as an open sore, wound, lesion, abrasion or ulcer.
2. Airborne exposure is not included under R.C. 4123.026/SB 223; the exposure must be of the nature described in IV.D.1.b.
3. An accompanying physical injury is not required for coverage of post-exposure medical diagnostic services and preventive treatment under R.C. 4123.026/SB 223.

BWC staff may refer to the corresponding procedure for this policy entitled "*Exposure to Blood or Other Potentially Infectious Materials*" for further guidance.

Procedure Name:	**Procedure for Exposure to Blood or Other Potentially Infectious Materials**
Procedure #:	CP-05-02.PR.1
Policy # Reference:	CP-05-02
Effective Date:	11/14/16
Approved:	Rick Percy, Chief of Operational Policy, Analytics & Compliance (Signature on file)
Supersedes:	Procedure CP-05-02.PR.1, effective 08/07/15.
History:	New 08/07/15
Review date:	08/07/20

I. BWC staff shall refer to the *Standard Claim File Documentation* policy and procedure for claim-note requirements and shall follow any other documentation-specific instructions included in this procedure.

II. Unless otherwise noted, the procedures listed below apply to all claims of exposure, including those that meet the criteria of R.C. 4123.026/Senate Bill (SB) 223.

III. Investigating the Claim

A. When the managed care organization (MCO) receives a claim that includes an exposure which may meet the criteria of R.C. 4123.026/SB 223, the MCO shall:
   1. Indicate "Alleged exposure to blood or body fluid" in the "Description of Accident" section on the *First Report of Injury, Occupational Disease or Death* (FROI); and
   2. File the FROI with BWC in the usual manner.

B. When a claim is received by BWC alleging an exposure, field staff shall determine if the injured worker (IW):
   1. Was exposed through:
      a. An airborne exposure (e.g., being in a room where an infectious person sneezes or coughs); or
      b. A bloodborne exposure (e.g., blood splashed on an open cut, spit in the eye). Field staff shall recognize that physical contact with blood or another body fluid does not automatically equate to a blood borne exposure; and
   2. Suffered a physical injury in addition to the alleged exposure (e.g., a needle stick from a bloody needle may be an exposure to blood or other potentially infectious

materials (OPIM) and the punctured skin from the needle stick would be a physical injury).

C. When there is any question regarding whether the incident is an exposure-only claim or whether there is a physical injury, field staff shall:
   1. Refer to the *Compensability* policy; and
   2. Staff the claim with the supervisor, medical service specialist and/or BWC attorney, as necessary.

D. Field staff shall also determine if the claim meets the criteria of R.C. 4123.026/SB 223. The criteria are:
   1. The IW is a:
      a. Firefighter of a lawfully constituted fire department;
      b. Peace officer, such as a:
         i. Sheriff;
         ii. Deputy sheriff;
         iii. Marshal;
         iv. Deputy marshal;
         v. Member of an organized police department; or
         vi. Non-traditional peace officer such as some park rangers, tax and liquor agents, officers of metropolitan housing authorities, and transit authorities; or an
         vii. Emergency medical worker; and
   2. The IW has come into contact with the blood or other body fluid of another person in the course of and arising out of the IW's employment, or when responding to an inherently dangerous situation through:
      a. A splash or spatter in the eye or mouth, including when received in the course of conducting mouth-to mouth resuscitation;
      c. A puncture in the skin; or
      d. A cut in the skin or another opening in the skin, such as an open sore, wound, lesion, abrasion, or ulcer.
   3. Field staff shall staff with the BWC attorney if it is unclear if the IW meets the criteria of R.C. 4123.026/SB 223.

IV. Processing the Claim

A. <u>Exposure to a contaminant</u>: If field staff determines the IW was not exposed to blood or OPIM but was exposed to another contaminant (e.g., chemicals), field staff shall determine if there was a physical injury and process the claim consistent with the *Initial Claim Determination* policy and/or any other applicable policy.

B. No exposure/no physical injury: When field staff determines the IW was not exposed to blood or OPIM and the claim does not include a physical injury, field staff shall:
   1. Disallow the claim due to no physical injury or disease; and
   2. If the claim meets the criteria of R.C. 4123.026/SB 223, include in the order the "Exposure" insert "SB223 Exposure Claims (no contact w/blood or body fluid)".
   3. See "Exposure-Denial order inserts (including SB223)" under "Correspondence" on COR.

C. Exposure without a physical injury
   1. When field staff determines the IW has been exposed to blood or OPIM, but there is no accompanying physical injury, field staff shall:
      a. Enter ICD-10 code T75.89xA;
      b. Ensure the narrative description of the code is modified to reflect an exposure to blood or other body fluid. (See the *ICD Modification* policy for further information); and
      c. Disallow the claim due to no physical injury.
   2. If the claim does not meet the criteria of R.C. 4123.026/SB 223, field staff shall issue the appropriate denial order using the applicable "Exposure" insert.
      a. The order shall include language advising the IW that the employer may be required to pay for the cost of testing and/or preventive treatment.
      b. See "Exposure-Denial order Inserts (including SB223)" under "Correspondence" on COR.
   3. If the claim does meet the criteria of SB 223:
      a. Field staff shall:
         i. Update information in the claims handling statement to reflect "falls under 223";
         ii. Enter a note in the claims management system that indicates the following: *SB223 applies-claim is disallowed due to no physical injury but the worker did have a qualifying blood or body fluid exposure; HPP notified and packet sent to IW*.
         iii. Prepare and print locally the appropriate denial order using the applicable "Exposure" insert. (See "Exposure-Denial Order inserts (including SB223)" under "Correspondence" on COR). The order shall include language advising the IW that BWC will reimburse the IW the cost of:
            a) Conducting post-exposure medical diagnostic service to investigate whether the IW contracted an occupational disease from the exposure, consistent with the standards of medical care existing at the time of the exposure; and
            b) Any related preventive treatment in accordance with OSHA's exposure treatment protocol.
         iv. Send the IW a packet that includes:

a) An "SB223-Exposure-No injury with contact" letter;
b) The denial order; and
c) An SB 223 Fact Sheet.

d. The MCO shall:
   i. Accept the Centers for Disease Control and Prevention (CDC) and OSHA standards for diagnostic and preventive treatment related to exposure to blood or OPIM;
   ii. Not require prior authorization and shall not deny services that are consistent with OSHA and CDC standards;
   iii. Price bills submitted for these services at $0.00; and
   iv. Submit the bill to BWC's Medical Billing and Adjustments (MB&A) unit.
e. Services that may be required due to exposure to blood or OPIM include:
   i. Office visits;
   ii. Emergency Department visits;
   iii. Treatment, such as cleaning, suturing, and dressing of the area;
   iv. Tetanus, HIV or hepatitis testing;
   v. Counseling;
   vi. Prophylactic treatment/medication; and
   vii. Follow-up testing and treatment.

D. <u>Exposure With a Physical Injury</u>

1. When field staff determines the IW was exposed to blood or OPIM and also suffered a physical injury, field staff shall:
   a. Allow the claim for the physical injury, if all other required factors relating to jurisdiction and initial allowance are met;
   b. Enter the ICD code applicable to the physical injury;
      i. No code shall be entered for the exposure to blood or OPIM.
      ii. An ICD code is only entered for exposure to blood or OPIM when there is no physical injury and the claim is being disallowed.
      iii. Exposure to blood or OPIM is never an allowed condition.
   c. If the claim meets the criteria of R.C. 4123.026/SB 223:
      i. Enter a note in the claims management system that indicates the following: *SB223 applies-claim is allowed for the physical injury but not for the exposure. Letter and fact sheet sent to the IW;* and
      ii. Send the IW a packet that includes:
         a) "SB223 – Exposure – Injury with contact" letter (available on COR);
         b) BWC initial allowance order; and
         c) "Exposure to Blood and Other Bodily Fluids under SB223 – BWC Fact Sheet" (available on COR).
2. The MCO shall:

a. Accept the CDC and OSHA standards for diagnostic and preventive treatment related to exposure; and
d. Not require prior authorization and shall not deny services that are consistent with OSHA and CDC standards.

V. Contraction of Occupational Disease after Exposure

A. Field staff shall consider an application for the contraction of an occupational disease after exposure either as:
   1. An additional allowance to an allowed existing related claim; or
   2. A new claim, if there is not an allowed existing related claim.

B. Examples:
   1. Additional Allowance
      a. The IW files a claim for exposure to blood and a needle stick.
      b. The claim is allowed due to the physical injury of the needle stick.
      c. Medical treatment is approved for the needle stick and for diagnostic testing and preventive treatment for the exposure.
      d. The IW later contracts an occupational disease related to the exposure.
      e. The IW files for an additional allowance in the existing allowed claim for the occupational disease contracted from the exposure.
   2. New Claim
      a. The IW files a claim for exposure to blood or OPIM, but there is no physical injury.
      f. The claim is disallowed for the exposure, and the IW does not qualify under R.C. 4123.026/SB 223.
      g. The IW later is found to have contracted an occupational disease related to the exposure.
      h. The IW files a new claim for occupational disease.

Policy Name:	**Brain Injury Residential Rehabilitation Services**
Policy #:	MP-02-01
Code/Rule Reference:	R.C. 4123.05; O.A.C. 4123-6-02.2
Effective Date:	06/01/17
Approved:	Freddie Johnson, Chief of Medical Services (signature on file)
Origin:	Medical Policy
Supersedes:	All medical policies, procedures, directives and memos regarding brain injury claims that predate the effective date of this policy.
History:	New
Review date:	07/01/20

I. POLICY PURPOSE

The purpose of this policy is to ensure that the Bureau of Workers' Compensation (BWC) provides direction for the identification and provision of appropriate brain injury residential rehabilitation services based on the injured worker's (IW) level of cognitive and physical function when he or she has experienced a work-related brain injury.

II. APPLICABILITY

This policy applies to MCO staff, BWC's catastrophic nurse advocates (CNA) and BWC's medical administrative staff.

III. DEFINITIONS

Acquired Brain Injury: An injury to the brain, occurring after birth, which is not hereditary, congenital, degenerative or caused by birth trauma.

Lifelong Living Brain Injury Facility: A facility that provides post-acute residential living services for the duration of the IW's life, if needed.

Neurobehavioral Brain Injury Rehabilitation: A program that provides intensive physical and cognitive services for the individual with a brain injury who is exhibiting maladaptive behavior.

Post-Acute Brain Injury Facility: A facility that provides non-hospital based post-acute care for an individual who no longer requires a comprehensive inpatient rehabilitation program but demonstrates the need for continued rehabilitation and specialized services.

Transitional Living Placement Facility: A facility that provides short-term reintegration services for an individual to transition into the community or a more appropriate setting.

Traumatic Brain Injury (TBI): An injury to the head arising from an external force (i.e., blunt or penetrating trauma or acceleration or deceleration forces).

4. **Mild TBI (MTBI)**: Manifested by at least one of the following:
    a. Any period of loss of consciousness (LOC) up to 30 minutes;
    b. Any dysfunction of memory for events immediately before the trauma or post-traumatic amnesia (PTA), which occurs up to 24 hours after the trauma;
    c. Any alteration in mental state at the time of the accident (e.g., transient confusion, disorientation, impaired consciousness); and/or
    d. Focal neurological deficit(s) that may be transient and show no evidence of traumatically induced intracranial lesion on neuroimaging studies.
5. **Moderate/Severe TBI:** Manifested by at least one of the following:
    a. LOC greater than 30 minutes;
    b. PTA greater than 24 hours; and/or
    c. Evidence of traumatically induced intracranial lesion on neuroimaging studies.

IV. Policy

It is the policy of BWC:

A. To authorize brain injury residential rehabilitation services when the request:
    1. Meets the Miller criteria (refer to the *Miller* policy); and
    2. Is made after:
        a. The stabilization of life threatening conditions; and
        b. The IW is physically, emotionally, cognitively and psychologically able to participate at least three hours per day in active therapy.

B. To require that Brain Injury Residential Rehabilitation facilities are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) for brain injury services and are BWC-certified as a type 82 provider:
    1. Treatment at a facility that is enrolled, but not certified, as a type 82 provider may be approved if no BWC-certified facilities are available within a 45-mile radius of the IW's home.

2. A facility may also be approved, if after the MCO staffs with BWC catastrophic nurse, BWC approves the placement.

C. That claims for an IW receiving brain injury residential rehabilitation services, other than lifelong living services, are designated as catastrophic claims in the claims management system.

D. That the IW remains in case management with a nurse case manager while participating in any brain injury residential rehabilitation program, other than lifelong living services.

E. That the MCO shall process a request for brain injury residential rehabilitation services provided through a facility in accordance with the *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) in the MCO Policy Reference Guide (MPRG).

F. That an IW receiving services from a brain injury residential rehabilitation facility requires comprehensive rehabilitative services that may include, but are not limited to, the following services:
   1. Physical therapy (PT);
   2. Occupational therapy (OT);
   3. Speech therapy;
   4. Recreational therapy; and/or
   5. Neuropsychological treatments.

G. The following are requirements the MCO must follow to authorize the following services:
   1. Post-acute and/or neurobehavioral brain injury rehabilitation services shall be authorized for no more than 18 months, unless medically necessary.
      a. If it is medically necessary to extend post-acute or neurobehavioral brain injury rehabilitation services beyond 18 months, the claim shall be reviewed with a BWC CNA prior to authorizing an extension.
      b. Post-acute brain injury rehabilitation and/or neurobehavioral rehabilitation services shall be authorized for no more than 90 days at a time, with a review of placement occurring every 90 days to ensure continued appropriateness of placement.
   2. Transitional residential services may be authorized for no more than 90 days, with a review of placement occurring every 90 days to ensure continued appropriateness of placement.
   3. Lifelong living TBI services provided at a residential TBI facility shall be authorized for no more than one year at a time, with a review of placement occurring every year to ensure continued appropriateness of placement.

V. Billing and Reimbursement

It is the policy of BWC that:

A. Reimbursement shall be made in accordance with the level of service(s) provided and shall be reevaluated when service(s) are reauthorized.

B. Facilities shall use the correct billing code for all TBI and residential rehabilitation services.

C. Brain injury residential rehabilitation services are billed as an all-inclusive code that shall include the following:
   1. Psychotherapy;
   2. Group therapy;
   3. Recreational therapy (including group outings);
   4. Behavioral counseling;
   5. Vocational counseling;
   6. Team conferences;
   7. Report preparation;
   8. Room and board;
   9. Medical management;
   10. Pharmacology management;
   11. Nutritional and dietary monitoring;
   12. Nursing and case management services;
   13. Structured schedule for activities of daily living (ADLs);
   14. Restorative services such as PT, OT, and speech therapy; and
   15. Family involvement, which may include home visits and phone contacts.

D. The daily per diem rate for residential post-acute TBI rehabilitation services shall not cover:
   1. Physician fees;
   2. Prescription medications;
   3. Durable medical equipment (DME); and
   4. Medical services such as labs or radiology, or driver's evaluations.

E. Payment for request(s) that were preauthorized and meet the Miller criteria may be reimbursed (e.g., One-on-one sitter services).

F. Lifelong living long-term TBI residential programs are billed as an all-inclusive code that shall include:
   1. Group therapy;
   2. Room and board;
   3. Assistance with ADLs;

4. Nursing and staff oversight;
5. Pharmacology management;
6. Nutritional and dietary monitoring;
7. Recreational activities, including group activities;
8. Case management, team conferences and report preparation; and
9. Family involvement, which may include home visits and phone contracts.

G. The daily per diem rate for lifelong living long-term residential programs shall not cover:
   1. Physician fees;
   2. Prescription medications;
   3. Durable medical equipment (DME);
   4. Speech therapy and behavioral therapy;
   5. Medical services such as labs or radiology; and
   6. Physical and occupational therapy not provided in a group setting.

H. Lifelong living residential services, other than services performed by TBI facilities, shall be billed using the appropriate residential fee code. This includes residential care, assisted living and skilled nursing facilities.

I. All requests for reimbursement that are above the BWC fee schedule shall be negotiated by the MCO and approved by BWC as outlined in the *Pricing Override Process* policy and procedure.

Staff may refer to the corresponding procedure for this policy entitled "*Brain Injury Residential Rehabilitation Services*" for further guidance.

Procedure Name:	**Procedure for Brain Injury Residential Rehabilitation Services**
Procedure #:	MP-02-01.PR1
Policy # Reference:	MP-02-01
Effective Date:	06/01/17
Approved:	Freddie Johnson, Chief of Medical Services (signature on file)
Supersedes:	All medical procedures, directives and memos regarding Brain Injury Residential Rehabilitation Services claims that predate the effective date of this procedure.
History:	New
Review date:	07/01/20

I. General Requirements for all Brain Injury Residential Rehabilitation Services

A. The Managed Care Organization (MCO) shall ensure that facilities are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) for brain injury services and BWC-certified as a type 82 provider. However, the MCO may approve treatment at a facility that is enrolled, but not certified as a type 82 provider, if it determines no BWC-certified facility is available.

B. The MCO shall obtain documentation to justify the IW's admission and/or transfer to a brain injury residential rehabilitation facility that shall include, but is not limited to, the following:
   1. Complete medical history from the date of injury;
   2. The appropriate multi-disciplinary evaluations and/or a comprehensive summary that indicates that the IW is physically, emotionally, cognitively and psychologically capable of participation in the recommended rehabilitation program;
   3. Level of cognitive function determined by an evaluation tool (e.g., Ranchos Los Amigos Scale or equivalent cognitive function rating scale);
   4. Screening evaluation that addresses the IW's rehabilitation potential and specific treatment goals to help the IW improve function or accommodate for lost function.

C. The MCO shall ensure that all requests for brain injury residential rehabilitation services meet the Miller criteria (refer to the *Miller* policy).

II. Post-Acute Brain Injury Residential Rehabilitation Services

A. The MCO shall ensure that:
   1. The IW's cognitive and physical condition reflects the need for post-acute brain injury residential rehabilitation services.
   2. The IW does not require a neurobehavioral comprehensive residential rehabilitation program.
   3. The IW is medically stable and physically able to participate in active and/or cognitive therapy for three hours or more per day.
   4. The claim contains medical documentation that justifies the transfer of the IW to a post-acute brain injury residential rehabilitation program.
   5. An initial assessment is scheduled with the facility chosen to provide services for an IW receiving post-acute rehabilitation services.

B. The MCO shall obtain, at a minimum, monthly documentation of care provided for the IW in post-acute brain injury rehabilitation facilities. The documentation shall include, but is not limited to, the following:
   1. Treatment history and expected discharge outcomes, to include projected discharge date and the anticipated discharge placement;
   2. Treatment team members and the number of hours the IW spends with the treatment team members;
   3. Treatment progress summary and comparison of progress from previous reports.
   4. Test results and cognitive function assessment/scale, medical problems and how these relate to treatment;
   5. Status of treatment goals; and
   6. Family involvement and support.

C. The MCO shall ensure that post-acute brain injury residential rehabilitation services are authorized for a maximum of 18 months.
   1. If post-acute residential brain injury services are needed for longer than 18 months, the MCO shall base its decision on the IW's progress and anticipated additional functional gain.
   2. If the MCO determines that no additional functional gain is demonstrated or anticipated, then the MCO shall have the IW assessed for a more appropriate setting.
   3. The MCO shall review all authorizations extending beyond 18 months for brain injury rehabilitation with a BWC catastrophic nurse.

D. The MCO shall approve post-acute brain injury services for up to a maximum of 90 days at a time.
   1. The MCO shall review placement every 90 days to ensure continued appropriateness of placement.
   2. The MCO may authorize additional days of treatment beyond the initial 90 days if it has supporting medical documentation provided by the physician of record (POR),

treating physician, and/or the facility providing post-acute brain injury residential rehabilitation services. The documentation shall include, but is not limited to:

a. Medical summary;
b. Status of treatment goals;
c. Treatment summary and progress report;
d. Family interaction and support in treatment;
e. Current treatment plan, history and expected discharge outcomes;
f. Treatment team members and contact hours with the treatment team; and
g. Justification for continuation of residential brain injury rehabilitation services.

3. If the assessment indicates that post-acute rehabilitation is not needed, the MCO shall investigate a more appropriate placement for the IW.

lll. Neurobehavioral Brain Injury Residential Rehabilitation Services

A. The MCO shall ensure that:
   1. An IW that requires a neurobehavioral program is enrolled in a comprehensive neurobehavioral rehabilitation program that includes intensive cognitive restorative services and a comprehensive rehabilitation plan.
   2. The IW's cognitive and physical condition reflects the need for neurobehavioral brain injury residential rehabilitation services.
   3. The IW is medically stable and physically able to participate in active and/or cognitive therapy for three hours or more per day.
   4. The claim contains medical documentation that justifies the admission and/or transfer of the IW to a neurobehavioral brain injury rehabilitation program.
   5. An initial assessment is scheduled with the facility chosen to provide neurobehavioral rehabilitation services.
      a. The assessment shall provide additional justification for the neurobehavioral brain injury program.
      b. If the assessment indicates that neurobehavioral rehabilitation is not needed or if the facility is unable to provide the level of services required for an IW, the MCO shall investigate a more appropriate placement for the IW.

B. The MCO shall obtain, at a minimum, monthly documentation of care provided for the IW in neurobehavioral rehabilitation facilities. The documentation shall include, but is not limited to, the following:
   1. Treatment history and expected discharge outcomes, to include projected discharge date and the anticipated discharge placement;
   2. Treatment team members and the number of hours the IW spends with the treatment team members;
   3. Status of treatment goals;
   4. Treatment progress summary and comparison of progress from previous reports;

5. Test results, medical issues, or assessments completed during the month;
6. Family involvement and support.

C. The MCO shall ensure that neurobehavioral brain injury residential rehabilitation services are authorized for a maximum of 18 months.
   1. If neurobehavioral brain injury services are needed for longer than 18 months, the MCO shall base the decision to continue the services on the documented IW progress and anticipated additional functional gain.
   2. If no additional functional gain is demonstrated or anticipated, the MCO shall asses the IW for a more appropriate setting.
   3. The MCO shall review all authorizations extending beyond 18 months for neurobehavioral brain injury residential rehabilitation with a BWC catastrophic nurse.

D. The MCO shall approve neurobehavioral brain injury residential rehabilitative services for up to a maximum of 90 days at a time.
   1. The MCO shall review placement every 90 days to ensure continued appropriateness of placement.
   2. The MCO may authorize additional days of treatment beyond the initial 90 days if it has supporting medical documentation provided by the physician of record (POR), treating physician and/or the facility providing neurobehavioral brain injury rehabilitation services. The documentation shall include, but is not limited to:
      a. Medical summary;
      b. Status of treatment goals;
      c. Treatment summary and progress;
      d. Family interaction and support in treatment;
      e. Current treatment plan, history and expected discharge outcomes;
      f. Treatment team members and contact hours with the treatment team; and
      g. Justification for continuation of neurobehavioral brain injury rehabilitation service.
   3. If the assessment indicates that neurobehavioral rehabilitation is not needed, the MCO shall investigate a more appropriate alternative placement for the IW.

IV. Transitional Living Placement

A. The MCO shall only approve transitional living programs when the goal is to reintegrate the IW back into the community.

B. The MCO shall ensure that the claim contains medical documentation that justifies the movement of the IW to a transitional living program. The MCO shall ensure the documentation includes, at a minimum, the following elements:

1. Medical necessity;
2. Post accident history;
3. Goals and anticipated length of treatment; and
4. A statement from the POR, treating physician or residential neurobehavioral or post-acute traumatic brain injury (TBI) rehabilitation facility regarding the IW's rehabilitation potential.

C. The MCO shall obtain, at a minimum, monthly documentation of the IW's progress in a transitional living program.

C. The MCO shall approve transitional living programs for up to a maximum of 90 days at a time.
   1. The MCO shall review placement every 90 days, and review placement every 30 days for requests for services that extend beyond the initial 90 days to ensure the request includes:
      a. IW progress in the program;
      b. Goals for additional time in the program; and
      c. Justification of medical necessity.
   2. The MCO shall determine a more appropriate placement if the request does not justify transitional living services extending beyond 90 days or beyond 30 days after the initial 90 days.

V. Lifelong Living TBI Services

A. The MCO shall approve lifelong living services when the IW:
   1. Has reached a plateau in his or her physical, cognitive and behavioral functioning; and
   2. Is not expected to return independently to the community or home.

B. When evaluating residential lifelong services provided by a residential TBI facility, the MCO shall:
   1. Ensure that an authorization of lifelong services provided at a residential TBI facility is not approved for more than one year at a time.
   2. Review placement every year to determine if the placement remains appropriate.
      a. If the placement remains appropriate, the MCO shall authorize no more than one additional year.
      b. If the placement is not appropriate, the MCO shall investigate alternative placement for the IW.

VI. Billing and Reimbursement

A. The MCO shall ensure that reimbursement(s) are made in accordance with the level of service(s) provided and shall be evaluated when service(s) are reauthorized.

B. The MCO shall ensure that the facility use the correct billing code for all TBI and residential rehabilitation services.

C. The MCO shall ensure that brain injury residential rehabilitations services are billed as all-inclusive codes and the following services shall not be billed separately:
   1. Psychotherapy;
   2. Group therapy;
   3. Recreational therapy (including group outings);
   4. Behavioral counseling;
   5. Vocational counseling;
   6. Team conferences;
   7. Report preparation;
   8. Room and board;
   9. Medical management;
   10. Pharmacology management;
   11. Nutritional and dietary monitoring;
   12. Nursing and case management services;
   13. Structured schedule for activities of daily living (ADLs);
   14. Restorative services such as PT, OT, and speech therapy; and
   15. Family involvement, which may include home visits and phone contacts.

D. The MCO may authorize, if appropriate, payment for other services not included in the daily per diem rate, such as:
   1. Physician fees;
   2. Prescription medications;
   3. Durable medical equipment (DME);and
   4. Medical services such as labs, radiology, or driver's evaluations.

E. The MCO shall authorize payment for requests that meet the Miller criteria and that were pre-authorized (e.g., one-on-one sitter services).

F. The MCO shall ensure that lifelong living long-term TBI residential programs are billed using an all-inclusive code that includes:
   1. Group therapy;
   2. Room and board;
   3. Assistance with ADLs;
   4. Nursing and staff oversight;

5. Pharmacology management;
6. Nutritional and dietary monitoring;
7. Recreational activities, including group activities;
8. Case management; team conferences and report preparation; and
9. Family involvement, which may include home visits and phone contracts.

G. The MCO may authorize, if appropriate, other services not included in the daily per diem rate for lifelong living long-term residential programs, such as:
   1. Physician fees;
   2. Prescription medications;
   3. Durable medical equipment (DME);
   4. Speech therapy and behavioral therapy;
   5. Medical services such as labs or radiology; and
   6. Physical and occupational therapy not provided in a group setting.

H. The MCO shall ensure that lifelong living residential services, other than services performed by TBI facilities, use the appropriate residential fee code. This includes residential care, assisted living and skilled nursing facilities.

I. The MCO shall negotiate all requests for reimbursement above the fee schedule and seek BWC approval as outlined in the *Pricing Override Process* policy and procedure.

Staff may refer to the corresponding policy for this procedure entitled "*Brain Injury Residential Rehabilitation Services*" for further guidance.

Policy and Procedure Name:	**Damage to Dentures, Eyeglasses and Hearing Aids**
Policy #:	CP-4-07
Code/Rule Reference:	R.C. 4123.66; O.A.C. 4123-6-31
Effective Date:	11/08/13
Approved:	Rick Percy, Chief of Operational Policy, Analytics & Compliance (Signature on file)
Origin:	Claims Policy
Supersedes:	All policies and procedures, directives or memos regarding damage to dentures, eyeglasses and hearing aids that predate the effective date of this policy.
History:	New
Review date:	11/08/18

I. POLICY PURPOSE

The purpose of this policy is to ensure that requests for the repair or replacement of dentures, eyeglasses and hearing aids damaged in the course of an allowed industrial injury are processed appropriately.

II. APPLICABILITY

This policy applies to BWC Field Operations and MCO staff.

III. DEFINITIONS

Denture: Artificial replacement of a tooth or teeth.

Eyeglasses: For the purpose of this policy, refers to any removable prescriptive corrective lenses (i.e., glasses and contacts).

Hearing Aid: **A** removable electronic device used to amplify sound that is worn in or behind the ear of a person with a hearing impairment.

IV. POLICY

A. General Policy Statements for both repair or replacement
   1. It is the policy of BWC to ensure that the repair or replacement of dentures, eyeglasses and hearing aids damaged in the course of an injury or industrial accident resulting in an allowed claim is covered regardless of:
      a. The allowed condition(s) in the claim; and,
      b. Whether or not the items were in use at the time of the injury. For example, an injured worker (IW) has a hearing aid in a pocket and not his/her ear at the time of the injury, but the device is damaged in the course of the industrial accident.

   2. BWC pays for repair or replacement of an item one time for each industrial accident resulting in injury.

B. Repair - The MCO shall approve only a repair when:
   1. The denture, eyeglasses or hearing aid is repairable; and,
   2. The cost of the repair would be less than the replacement cost.

C. Replacement
   1. BWC shall only pay for replacement dentures, eyeglasses or hearing aids when the IW submits documentation from the original supplier or a servicing provider (e.g., a bill or an itemized statement of the original item).
   2. The MCO shall only approve a deluxe feature (e.g., anti-reflective or scratch-resistant coating for glasses, bluetooth-capable hearing aids) on a replacement of dentures, eyeglasses or hearing aids when the IW submits documentation from the service provider attesting that a deluxe feature was on the damaged item.
   3. The MCO shall only approve a replacement of dentures, eyeglasses and hearing aids based on the BWC fee schedule.
   4. It is the responsibility of the IW to pay for any exams necessary to obtain replacement dentures, eyeglasses and hearing aids.

D. BWC shall not pay for any other personal use items damaged in an industrial accident (e.g., shoes, jewelry, clothes, wheelchairs).

E. Requests to reimburse an IW directly for services the IW paid out-of-pocket must be submitted within the later of:
   1. One year of the date of service; or,
   2. One year after the earlier of:
      a. The Staff Hearing Officer order; or,
      b. The final administrative or judicial order allowing payment.

V. PROCEDURE

A. The MCO shall process requests submitted via the *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) in accordance with the *C-9* procedures.

B. Field Staff shall refer all requests for repair or replacement submitted via a *Motion* (C-86) to the MCO on an "MCO Referral" letter, in accordance with the *Motions* policy and procedure.

C. When the MCO receives a reimbursement request for repair or replacement of denture, eyeglasses or hearing aid that the IW, employer or other third party has already paid, the MCO shall request:
    1. A receipt; and
    2. Proof of payment.

D. The MCO shall review the documentation provided to determine if it is payable.
    1. If it is determined that the service is payable, the MCO shall:
        a. Submit to BWC a *Service Invoice* (C-19) with the explanation of benefits code 771 referenced; and
        b. Reimburse the IW, employer or other third party.
    2. If it is determined the service is not payable, the MCO shall notify the party requesting reimbursement.

Policy Name:	**Opioid Use Disorder Treatment Coverage**
Policy #:	MPRG-01
Code/Rule Reference:	O.A.C. 4123-6-21.7, 4123-6-37.1, 4123-6-37.2, 4123-6-08; 4123-6-10; 4123-6-06.2; 4123-6-40; 4123-6-16
Effective Date:	08/15/2018
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding Opioid Use Disorder Treatment Coverage
History:	New
Review date:	08/15/2023

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction to MCOs for the authorization and payment of opioid use disorder treatment directly supporting coverage specified in Ohio Administrative Code 4123-6-21.7, complementing the Billing and Reimbursement Manual (BRM) Policy BRM-07, which MCOs must also adhere to.

II. APPLICABILITY

This policy applies to the action of authorizing and reimbursing for opioid use disorder treatment.

III. DEFINITIONS

Refer to Billing and Reimbursement Manual Policy BRM-07.

IV. POLICY

A. **Claim allowance**:
   1. Pursuant to OAC 4123-6-21.7, a claim allowance of Opioid Use Disorder (or an equivalent diagnosis such as opioid dependence) is not required for treatment approval, but the opioid use must be related to the industrial injury.
   2. MCOs will follow the 776 procedures for relatedness approvals.
   3. Treatment for injured workers (IWs) who have a claim allowance of Opioid Use Disorder (or an equivalent diagnosis such as opioid dependence) is subject to this policy, except the time limitation of 18 months length of total treatment does not apply.

B. **Confirming American Society of Addiction Medicine (ASAM) Placement for Opioid Use Disorder Treatment.**

Pursuant to OAC 4123-6-21.7 and BWC's *Opioid Use Disorder Treatment Coverage* Policy BRM-07, prior to approving a request for opioid use disorder treatment the MCO shall:

1. Identify the ASAM placement level documented in the assessment report;
2. Apply ASAM patient placement criteria to the assessment documentation to confirm that the placement noted in the assessment documentation matches the C-9 ASAM level of requested treatment and this is the most appropriate care setting for the IW, assessing for:
    a. Length of treatment;
    b. Location of treatment; and
    c. Complicating factors.

C. **Coordination with the Prescriber:** The MCO shall:

1. Ensure that, where weaning is recommended by the prescriber for outpatient individualized treatment (unbundled) using ASAM placement level 1, the treatment plan contains a weaning schedule consistent with the standard dose tapering schedules set forth in the appendix to rule 4123-6-21.5 of the Ohio Administrative Code; and
2. Ensure that there is documentation of a single prescriber (or treatment facility) that will prescribe/administer all medications and services necessary for opioid weaning and treatment of opioid use disorder.
3. When a facility is providing treatment, the facility must confirm that one clinical prescriber is managing the treatment at any given time.
4. Ensure that the prescriber is educated on and agrees to the parameters set forth in OAC 4123-6-21.7 (F) and the *Opioid Use Disorder Treatment* policy, including drug testing and reporting requirements.
5. When an IW is enrolled in treatment for opioid use disorder pursuant to O.A.C. 4123-6-21.7, the MCO may approve drug test frequency in excess of BWC's *Drug Testing* policy limitations.

D. **Events of IW non-compliance**. The MCO shall:

1. Discuss events of non-compliance during opioid use disorder treatment:
    a. Document all instances of IW non- compliance either by
        i. Submission of reports to the IW claim file, or
        ii. A summary of the instance(s) of non-compliance in the notes of the IW claim file if no hard copy report or documentation exists.
    b. Discuss non-compliance with the IW and prescriber.
    c. Receive a recommendation from the prescriber regarding justification for continued treatment.
2. If the MCO recommends to discontinue treatment based on the non-compliance as defined in OAC 4123-6-27 (F), the MCO must obtain BWC secondary approval.
3. Initiate discussion with BWC after a determination has been made to recommend treatment discontinuation. The MCO shall:

a. Receive approval/denial for the termination of treatment reimbursement from BWC's Medical Division through use of the email address MEDPOL@bwc.state.oh.us;
b. Document the BWC Medical Division decision in the claim file; and
c. Issue a decision with ADR appeal language denying further reimbursement for services.
d. Provide the service provider with a copy of the coverage termination decision and copy this decision to the claim file; and
e. Deny reimbursement for any care delivered beyond the date of the notice of coverage termination.

E. Upon approval of an opioid treatment plan for an IW, the MCO shall notify BWC's pharmacy department that they have approved the IW for an opioid treatment program.

F. **Reimbursement:**

1. Reimbursement is subject to the applicable BWC fee schedule corresponding to the ASAM level of placement.
2. MCOs must discuss reimbursement with the opioid use disorder treatment provider for inpatient and outpatient treatment at ASAM levels 2.1 or higher, prior to authorizing treatment.
    a. Inpatient treatment providers may opt to be reimbursed pursuant to the OAC 4123-6-37.1 alternative per diem rate. For this reimbursement, the MCO must:
        i. Facilitate separate facility enrollment as provider type 35
        ii. Instruct the facility to:
            a) Bill using that assigned provider number in order to be paid the per diem rate, and
            b) Use the specific revenue center codes identified in the inpatient hospital reimbursement rule to trigger the per diem payment.
        iii. Hospitals are not required to enroll in provider type 35, unless they opt for the alternative inpatient per diem reimbursement.
    b. Outpatient treatment providers shall bill a per diem rate for ASAM levels 2.1 and 2.5 only using BWC local level codes for this treatment.
        i. This treatment may not be
            a) Unbundled;
            b) Or billed with any other procedure code.
        ii. May be paid on either the UB04 or CMS-1500, depending on provider enrollment.
        iii. The reimbursement for the structured outpatient treatment will be the same per diem, regardless of the bill type.
        iv. May only be provided by a facility enrolled as provider type 10, 34, 35, or 36.
3. Travel must be prior authorized pursuant to BWC's *Travel Reimbursement* policy and procedure.

a. MCOs should not reimburse any travel related expenses unless they meet the requirements of the *Travel Reimbursement* policy and procedure and have been staffed and authorized through BWC field staff.
b. Travel authorization must be separately documented.

4. MCOs must enforce utilization and frequency limitations through the use of clinical edits. (Refer to Appendix).

APPENDIX: Opioid Use Disorder Treatment Coding and Reimbursement Table

NEW CODE	Description	Limits	Prof	OPPS	IPPS	Provider type
Z0430	Detox program assessment	1 prior to initiating treatment	Y	Y	N	Physician or other licensed Addiction specialist or facility
Billed with Revenue Code 0126	Acute medically monitored inpatient/residential detox; ASAM level 3.7 or 4; For provider type 35, all inclusive per diem triggered with this revenue code and provider type combination.	Without allowance, max 30 days (do not have to be consecutive, includes days billed with 0126 and 1002 on UB-04)	N	N	Y	Provider type 34, 35, or 36
Billed with revenue code 1002	Sub-acute clinically managed inpatient/residential detox; ASAM level 3.5; For provider type 35, all inclusive per diem triggered with this revenue code and provider type combination.	Without allowance, max 30 days (do not have to be consecutive, includes days billed with 0126 and 1002 on UB-04)	N	N	Y	Provider type 34, 35 or 36
Z0450	Partial Hospitalization detox; ASAM level 2.5; all inclusive per diem; must include at least 4-8 hours per day at least 5-7 days per week *(CAM Code Description change)*	Without allowance, no authorization after 18 months (incl any detox code)	Y	Y	N	10, 34, 36 or 35
Z0460	Intensive Outpatient detox; ASAM level 2.1; all inclusive per diem; at least 3 hours per day for 2-7 days each week	Without allowance, no authorization after 18 months	Y	Y	N	10, 34, 36 or 35

		(incl any detox code)				
Z0470	Case Management-coordination, consolidation, and organization of care; ASAM level 1 only. This code cannot be billed while the IW is in programs billed by Z0460, Z0450, or inpatient detox.	Without allowance, no authorization after 18 months (incl any detox code)	Y	N	N	Social worker

Policy Name:	**Override of Diagnosis-Related Denials with Application of EOB 776 and EOB 779**
Policy #:	MPRG-02
Code/Rule Reference:	Ohio Administrative Code (OAC) 4123-6-16.2; *State, ex rel. Miller v. Indus. Comm*., 71 Ohio St.3d 229 (1994)
Effective Date:	October 1, 2018
Origin:	Medical Policy
Supersedes:	All MCO policies and procedures, directives and memos regarding the use of EOB 776 and 779 that predate the effective date of this policy.
History:	REVISED
Review date:	10/1/2023

I. POLICY PURPOSE

The purpose of this policy is to define the appropriate use of explanation of benefits (EOB) codes 776 and 779 to override diagnosis-related denials on medical bills to ensure timely payment to providers.

II. APPLICABILITY

This policy applies to the approval, application, or override of diagnosis-related billing edits.

III. DEFINITIONS

Edit 387: An edit programmed in BWC's bill processing system which causes the line item or entire bill to deny when the primary billed ICD is not allowed in the claim or in the same ICD grouping.

EOB 776: An override EOB code in which payment is being made for treatment of a non-allowed, but related condition when an ICD code is not allowed in the claim and the service is for this non-allowed, but related condition.

EOB 779: An override EOB code in which payment is being made for treatment of an allowed condition:

- Billed with a health status (V or Z code); or
- Billed with an ICD code that has a digit expansion; or

- Where the treatment meets the criteria for presumptive authorization; or
- Where the diagnostic procedure is related and has been prior authorized.

***Miller* criteria:** Mandatory evaluative three-prong test outlined by the Supreme Court of Ohio in the *Miller* case establishing that each prong must be met in order to allow reimbursement for any request for medical services/supplies. The three-part test was subsequently enacted as paragraphs (B)(1) through (B)(3) of 4123-6-16.2 of the Ohio Administrative Code. The three-prong test is comprised of the following:

- The requested medical services are reasonably related to the industrial injury (allowed conditions);
- The requested services are reasonably necessary for treatment of the industrial injury (allowed conditions); and
- The costs of the services are medically reasonable.

IV. POLICY

A. Criteria for Using Diagnosis Override EOBs

1. After validating that medical services meet the *Miller* criteria, an MCO shall apply the appropriate EOB code to indicate the approval of bill payment for a diagnosis code not allowed in the claim or not in the same ICD grouping (edit 387).
2. The MCO shall determine the appropriate EOB to apply based on the billed diagnosis(es)
    a. The MCO shall apply EOB 776 for payment of non-allowed but related conditions.
    b. The MCO shall apply EOB 779 for payment for treatment of certain allowed conditions billed with a non-allowed diagnosis when:
        i. The principal diagnosis on the bill is a valid V (ICD-9-CM) or Z (ICD-10-CM) code; or
        ii. The principal diagnosis on the bill is an ICD code that has a digit expansion (e.g., a five-digit code is expanded to six digits, or a six-digit code is expanded to seven digits); or
        iii. Treatment of an allowed condition meets BWC's presumptive authorization criteria; or
        iv. Services are rendered when the IW has symptoms indicating that further diagnostic studies are necessary to determine if a more extensive work-related injury than previously identified has occurred. If the diagnostic study was related to an allowed claim condition and prior authorized by the MCO, the MCO shall pay the bill utilizing EOB 779 if:
            a) A new condition is not found and the ICD code billed is one that is not already allowed in the claim.
            b) A new condition is found. However, the MCO shall not approve payment for further treatment until the new condition is allowed in the claim.

3. The MCO shall not apply EOBs 776 or 779:
    a. When bills contain ICD codes that do not follow ICD Official Guidelines for Coding and Reporting (e.g. incomplete codes, codes that do not accurately reflect the medical documentation);
    b. When a condition is expressly disallowed in a claim; or
    c. Based solely on the request of the provider.

B. The MCO shall not ask or require providers to change ICD codes solely for bill payment purposes.

C. MCO Review, Approval and Documentation Requirements
    1. Application of EOB 776:
        a. The review shall be completed by a nurse or coder.
        b. The nurse or coder shall enter a claim note which:
            i. Analyzes how each of the three prongs of the *Miller* test were satisfied; and
            ii. Addresses the rationale for utilizing EOB 776, citing specific medical documentation used in decision-making
    2. Application of EOB 779:
        a. The review may be completed by a coder or biller, if a nurse or coder has:
            i. Completed an analysis of *Miller* at the time of service authorization; and
            ii. Determined that the services are related to an allowed condition; or
            iii. Prior authorized the treatment
        b. The coder or biller shall enter a note into the claim file. The note shall:
            i. Document the review of the bill;
            ii. Refer to the original *Miller* review note, which was created either by a nurse or coder

D. Follow Up Action – When a new condition is identified, MCOs shall discuss with the provider, as applicable, the possibility of submitting a recommendation for an additional allowance.

Policy Name:	**Evaluation and Authorization Decisions Based On Ohio Administrative Code Based Treatment Guidelines**
Policy #:	MPRG-03
Code/Rule Reference:	OAC 4123-6-16.1, OAC 4123-6-16.2
Effective Date:	October 1, 2018
Origin:	Medical Policy
Supersedes:	n/a
History:	New
Review date:	10/1/2023

I. POLICY PURPOSE

The purpose of this policy is to provide direction to MCOs for evaluating and issuing an approval decision for requested treatment services for which an Ohio Administrative Code (OAC) treatment guideline exists.

II. APPLICABILITY

This policy applies to *Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) authorizations for services with applicable OAC rule based treatment guidelines.

III. DEFINITIONS

Ohio Administrative Code (OAC) Rule Based Treatment Guideline: Clinical evidence based guidelines recommended by BWC and BWC medical advisory committees and adopted by Ohio Administrative Code rule, designed to facilitate quality care and limit inappropriate utilization of care services. The OAC Rule Based Treatment Guidelines are different from the HPP Medical Treatment Guidelines (currently ODG).

IV. POLICY

A. When OAC Rule Based Treatment Guidelines apply to requested treatment, an MCO shall evaluate a *Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) for authorization utilizing:

1. Applicable OAC Rule Based Treatment Guidelines; and

2. BWC policies directly supporting the applicable OAC Rule Based Treatment Guidelines.

B. An MCO shall deny a C-9 for services for which an OAC treatment guideline exists when:
   1. Applicable OAC Rule Based Treatment Guidelines are not met; or
   2. Provider documentation that demonstrates compliance with applicable OAC Rule Based Treatment Guidelines is not provided and an attempt to obtain the necessary provider documentation (through form C-9A or equivalent) is unsuccessful.

C. When a C-9 denial is based on lack of compliance with applicable OAC Rule Based Treatment Guidelines, the MCO shall document in the C-9 denial verbiage:
   1. All the reasons for the denial; and
   2. All the citation(s) of the applicable OAC Rule Based Treatment Guidelines rule sections and subsections which are not met, or for which documentation has not been provided.

Policy Name:	**Reimbursement for Telemedicine**
Policy #:	MPRG-04
Code/Rule Reference:	O.A.C. 4123-6-08
Effective Date:	October 1, 2018
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding Telemedicine.
History:	New
Review date:	10/1/2023

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction to MCOs for the authorization (when applicable) and payment of telemedicine visits, complementing the Billing and Reimbursement Medical Policy BRM-09, which MCOs must also adhere to.

II. APPLICABILITY

This policy applies to the action of authorizing (when applicable) and reimbursing for telemedicine visits.

III. DEFINITIONS

Refer to BRM Policy BRM-09.

IV. IV. POLICY

A. MCOs must ensure a telemedicine visit:
   1. Is scheduled at an appropriate originating and distant site, and
   2. Is provided by a health care provider who is properly licensed or certified in the jurisdiction where the IW is located.

B. When the provider and injured worker are in different states, MCOs must perform due diligence to validate the provider has the appropriate licensure or certification in the jurisdiction of the IW, when applicable, by:
   1. Requesting the provider to submit evidence of licensure or certification;
   2. Contacting State licensing boards to validate;

3. Image license or certificate documentation in the claim file;
4. Provide licensure or certificate updates to BWC Provider Enrollment.

C. MCOs shall enact procedures to ensure telemedicine services requiring prior authorization are appropriately authorized. Not all services eligible for telemedicine require prior authorization.

Policy Name:	**Nursing Home and Assisted Living Services**
Policy #:	MP-2020-03
Code/Rule Reference:	OAC 4123-6-08, 4123-6-02.2
Effective Date:	3/6/2020
Origin:	Medical Policy
Supersedes:	All medical policies, directives and memos regarding nursing home and assisted living services that predate the effective date of this policy.
History:	Rev. 4/1/2018; 07/01/2019
Review date:	3/6/2025

I. POLICY PURPOSE:

The purpose of this policy is to facilitate a more efficient process for managing IWs who need nursing home or assisted living services. Over the course of time BWC has identified variations that create challenges to the execution of a consistent approach in addressing the IW's needs in those environments. This policy clarifies the authorization, rate negotiation and billing and reimbursement requirements and further defines requirements specific to the use of a short term post-acute procedure code.

The name of this policy has been updated to remove the term "residential care" as the terms "residential care facility" and "assisted living facility" have the same meanings according to BWC's enrollment and certification rule.

II. APPLICABILITY

This policy complements the Provider Billing and Reimbursement Manual BRM-01 policy and applies when MCOs authorize and reimburse nursing home and residential care services within the Ohio workers' compensation system.

III. DEFINITIONS

See **BRM-01** for definitions related to this policy.

Short term post acute nursing home services: For purposes of this policy, short term nursing home services will refer to skilled nursing facility (SNF) services ordered for post acute services delivered to IWs upon discharge from a hospital admission for up to 30 days.

Facility: For purposes of this policy, facility will refer to any facility addressed by this policy, including nursing home, SNF and assisted living facilities.

IV. POLICY

A. Authorization Period

1. Facility care may be authorized for periods not to exceed six (6) months at a time.
2. Short term post-acute SNF services may be authorized for a maximum of one hundred (100) days with medical justification, and are subject to the following requirements:
    a. Initial MCO authorization:
        i. Is limited to up to thirty (30) days.
        ii. Can be extended an additional seven (7) days, for a total of thirty-seven (37) days without BWC approval.
    b. Any request for extension for more than thirty-seven (37) days up to the limit of one hundred (100) days:
        i. Must have secondary BWC medpol prior approval;
        ii. Including when the negotiated reimbursement rate is at or below the published fee schedule limit for this service.
3. If requested short term post-acute SNF services do not immediately follow an inpatient admission but follow a recent admission (e.g. 5 days), the MCO shall email medpol@bwc.ohio.gov to discuss the appropriate SNF services local level code.

B. Requirements for All Facility Care

1. MCOs must review periodic documentation prior to each renewal period to ensure the services, including medication, are related to the allowed condition(s).
2. The placement, including the bills shall be reviewed:
    a. At least every three (3) months for the first year of placement; or
    b. When new services are being requested; or
    c. At least once per month when the care is short term post acute; or
    d. At each prior authorization renewal period.
3. Any changes in care needs, including living arrangements must be:
    a. Evaluated by the MCO; and
    b. Reimbursement must be renegotiated, as applicable.
4. MCOs must ensure facilities understand the various system rules and policies governing facility services, including but not limited to:
    1. Expected medical documentation requirements and submission timeframes;
    2. Expectation for notification of changes in care needs of the IW;
    3. What is included in the per diem rate and what is separately billable including recent changes such as the following services always included in daily rate:
        i. Related medication (prescription and non-prescription);
        ii. All therapies;
        iii. Non-emergent transportation.
    4. Rate renegotiation when the IW's care needs change;
    5. Treatment (including medication) relatedness to the allowed condition;

6. Other payment arrangements when care or medication is unrelated to the allowed condition;
7. Certification requirements for enrollment; and
8. Billing requirements once treatment is authorized.

5. BWC is unable to accept a date span on the CMS-1500, however, the MCO shall not reject a facility bill that includes a date span.
   a. The MCO must transmit the "from" date as the line item date of service; and
   b. Transmit the "to" date in the NTE notes segment of the 837P.
   c. Units of service must reflect the total number of days included in the date span.
   d. MCOs must validate that facilities are not submitting bills with overlapping dates of service.

C. Rate Negotiations:

1. **Basis for reimbursement negotiations**
   a. Short term post acute SNF services must be negotiated based on the Patient Driven Payment Model (PDPM) Health Insurance Prospective Payment System (HIPPS) code and associated reimbursement rate;
   b. All other services will continue at least through October 2020, to be negotiated using the Resource Utilization Group IV (RUG) HIPPS code and associated reimbursement rate. Additional clarification will be provided to the MCOs prior to October 2020 regarding replacement of RUG.
2. **Short term post acute SNF services negotiation using PDPM HIPPS:**
   a. The SNF must provide a copy of their completed patient assessment identifying the IW's PDPM HIPPS code.
   b. When the SNF is unable to provide the actual PDPM HIPPS code prior to admission:
      i. MCOs may negotiate based on an estimated PDPM HIPPS code; and
      ii. The actual PDPM HIPPS code is required within six (6) business days after the admission date.
   c. When the PDPM HIPPS rate is different than what was estimated at admission, the MCO must:
      i. Immediately update the reimbursement to match the PDPM HIPPS rate; and
      ii. Always obtain BWC approval whenever the reimbursement is above the published fee schedule limit.
   d. The MCO must immediately renegotiate reimbursement when reviewing medical documentation, no less frequently than once per month and:
      i. The IW's actual PDPM HIPPS code differs from the last notated PDPM HIPPS code; or
      ii. The IW's care needs change.
   e. The MCO shall review the SNF's completed patient assessment to validate diagnoses and potential cost-drivers in the assessment against:

i. The MCO's knowledge of the IW's clinical status based on the MCO's medical case management activities; and
ii. Medical documentation from the SNF and other providers.
iii. The MCO must discuss any discrepancies with the facility (e.g. SNF documented a clinically complex condition or service which may affect reimbursement but there is no evidence of such documented elsewhere).

f. When completing the Pricing Override Policy template for payment above the fee schedule consideration, the MCO must include:
i. The SNF's six digit Medicare number; and
ii. The PDPM HIPPS code after validating clinical status; and
iii. The initial admission date; and
iv. The requested length of the extension (which may not exceed more than 100 total days).
v. There is no PDPM HIPPS rate for care beyond 100 days.
vi. When applicable, BWC will re-validate the requested negotiated rate against the Medicare PDPM HIPPS rates.
vii. Cost comparisons are not required on the template if the requested rate is less than or equal to the Medicare PDPM rate for the short term post-acute SNF service.
viii. The SNF patient assessment used to determine the PDPM rate.

3. For all other services not considered short term post-acute:
a. The MCO must negotiate using the applicable RUG IV HIPPS code and rate; and
b. The RUG rate must be documented on the Pricing Override Policy template.
4. Once the MCO negotiates a reimbursement rate, the MCO must, upon request, provide to BWC evidence of the communication to the facility of:
a. Billing rate;
b. Documentation requirements;
c. Billing requirements including medication, therapies and transportation; and
d. Stipulations, if any, of non-related services that are not payable by BWC.

D. Assisted Living Services

1. When a request for assisted living is received, the MCOs shall:
a. Perform an assessment of the IW's level of care needs and
b. Develop a plan of care that focuses on the individual needs of the IW.
2. The assessment must include:
a. An evaluation of the cost effectiveness of this level of care;
b. The ability of the facility to meet the following IW needs:
i. Medical treatment;
a) Staff to resident ratio; and
b) Availability of nursing staff.
ii. Safety;
iii. Supervision; and

iv. Activity of daily living needs.

c. The rationale for placement.

d. MCOs may use the Assisted Living Screening form on the MCO Portal – Shared documents – Policy Alerts folder.

e. The screening documentation must be imaged into the claim file.

3. Although placement approval is the responsibility of the MCO, collaboration with the BWC CAT nurse is encouraged.

Policy and Procedure Name:	**MCO Fee Schedule and Payment Override Policy**
Policy #:	MP-2022-05
Code/Rule Reference:	OAC 4123-6-01; OAC 4123-6-08; OAC 4123-6-10; OAC 4123-37; OAC 4123-37.1; OAC 4123-37.2; OAC 4123-6-37.3; OAC 4123-6-38;
Effective Date:	05/01/2022
Supersedes:	All policies, procedures, directives and memos regarding pricing overrides that predate the effective date of this policy.
History:	New 06/06/2014; Rev. 01/2016; Revised 05/01/2022
Review date:	05/01/2027

I. POLICY PURPOSE

Ohio BWC's provider reimbursement rates, service limitations and other pricing requirements are published in Ohio Administrative Code (OAC) rules. BWC annually adopts fee schedules and other service limitations, creating stability and transparency in the workers' compensation environment. These rates and limitations are established based on expected standards of cost and treatment.

Unique injured worker circumstances may include requests for reimbursement rates or service levels that exceed the established standards, which is sometimes necessary to ensure injured workers' access to quality medical care When an MCO receives such a request, the MCO must evaluate all requested services against the Miller criteria. This may require the MCO to obtain additional clarification from the providers; conduct independent research; and/or perform cost analyses. When an MCO makes the determination that the requested services meet all prongs of Miller and exceed the established benefit plan, the MCO is required to document the detailed justification to support these decisions. Under certain circumstances, OAC rules also require the MCO to submit their decision and justification to BWC to review and agree to exceptions to the published fees and other rule limitations.

The purpose of this policy is to provide direction to managed care organizations (MCOs) on the requirements for obtaining BWC approval for exceptions to the published reimbursement rates and service limitations. Specifically, the policy details when BWC prior approval for a pricing or other payment related override is required, and how and when approval must be obtained. It clarifies payment rules which must be followed, including when the injured worker's choice is more costly than other available alternatives. Additionally, because this process is used to justify exceptions in existing OAC rules, the policy details documentation requirements necessary to justify override requests submitted by MCOs.

II. APPLICABILITY

This policy applies to MCO staff responsible for processing provider authorization requests and approving medical bill payment. It also applies to BWC staff responsible for reviewing MCO medical and vocational reimbursement exception requests and facilitating BWC-approved payments.

III. DEFINITIONS

BWC fee schedule amount – for purposes of this policy, the "BWC fee schedule amount" refers to the amount payable under any of BWC's reimbursement rules for ambulatory surgery centers, hospitals, professional providers or vocational rehabilitation providers. This amount includes all discounting, bundling or other calculations applied under the applicable reimbursement methodology (e.g. multiple procedure reductions; reductions based on provider type, direct graduate medical education per diem, rule-based limitations, etc.).

Ohio region provider – an out of state provider that is located within 45 miles from the Ohio border.

Prior approval - BWC's approval on requests received, reviewed and approved by BWC prior to the initiation of the service delivery.

Retrospective approval - BWC's approval on requests received, reviewed and/or approved by BWC following the initiation of the service delivery.

Rule-based limitations – restrictions defined in Ohio Administrative Code on the reimbursement of services or products, where the rule language allows for exceptions. An example includes OAC 4123-6-38 which indicates that home health services are generally rendered for no more than eight hours per day.

IV. POLICY

D. **Services Requiring BWC Secondary Approval** - BWC **prior approval** for fee schedule and payment override is required for any of the following requests:
   1. Rule-based limits including but not limited to:
      a. Fee schedule limits
         i. Any service/supply that exceeds the BWC fee schedule amount for:
            a) Certified in-state providers;
            b) Certified out-of-state providers; or
            c) Non-certified in-state providers.
         ii. Any service/supply which is equal to or greater than twice the fee schedule amount for non-certified out-of-state providers.

b. Clinical or treatment-based rules permitting exceptions, including but not limited to:
    i. Home health services that exceed eight hours per calendar day pursuant to OAC 4123-6-38;
    ii. Short-term post-acute skilled nursing facility services that exceed 37 consecutive days pursuant to *Provider Billing and Reimbursement Manual Policy BRM-01, Nursing Home and Assisted Living Services*;

2. BWC-specific clinical editing/policy-based limits including but not limited to:
    a. Codes that may be negotiated by an MCO (i.e., NRC or BR with fee listed as $0.00 on the fee schedule) and the requested reimbursement is ten thousand dollars ($10,000) or greater;
    b. Use of a code designated as By Report when a more appropriate billing code exists and is listed on the BWC fee schedule with a designated fee;
    c. Use of a code designated as By Report when a more appropriate billing code exists that is not listed on the BWC fee schedule;
    d. Requests for personal exoskeletons (i.e., Rewalk®) including:
        i. Consultations for evaluation for the device;
        ii. Rental of the device; or
        iii. Purchase of the device.
    e. Requests for prosthetic artificial intelligence add-on devices;
    f. Requests for custom-painted iris implants for treatment of acquired aniridia;
    g. Requests for surgical procedures, to include both the professional and facility services, for purposes of implanting an osseointegration device.
3. When a service involves more than one provider (e.g., surgeon, hospital, post-acute skilled nursing facility), all provider service payment negotiations must be submitted on the same template.

B. **Timing of Fee Schedule or Payment Override Requests**- For requests requiring BWC approval per section IV.A. of this policy:
1. MCOs must complete the latest version of the Pricing Override Template for each request.
2. MCOs must submit the Pricing Override Template to BWC (medpol@bwc.state.oh.us):
    a. Prior to the delivery of service when prior approval is required;
    b. With as much notice as possible to avoid unintended delays in care;
    c. Understanding that if services are not emergent, the MCO may be at risk for penalties if the service initiates prior to receiving BWC prior approval.
3. Requests must include all required data elements identified in the template and/or per policy, including cost comparisons of care alternatives and the rationale as to how the request meets Miller.

4. Requests should not be delayed while the MCO is facilitating enrollment of the provider.
    a. Details of the enrollment should be identified in the template.
    b. MCOs must ensure that the provider is eligible to be reimbursed for services under BWC's rules.
5. Requests for retrospective consideration:
    a. The MCO may submit a request for retrospective review when the MCO:
        i. Did not reasonably foresee the need for override; or
        ii. Receive a request for override.
    b. The MCO must provide detailed explanation that the request is retrospective.
    c. After review of the MCO's documentation and rationale, a determination will be made regarding the responsibility for payment above the fee schedule.

C. **Cost Reasonability** – This section is applicable to MCO requests for fee schedule pricing overrides.
1. When requesting BWC approval for pricing overrides, the MCO must demonstrate cost reasonability as detailed in section IV.C.2. through IV.C.6. of this policy, except when:
    a. The injured worker has been previously approved by BWC for lifelong placement in a residential facility (e.g., nursing home, assisted living, brain injury facility); and
    b. The request does not include a change in care needs (e.g., care needs remain under the brain injury lifelong living placement); and
    c. The request does not include a change in reimbursement rate; or
    d. The request is for:
        i. A provider not in the Ohio region; and
        ii. For a rate less than or equal to the state's workers' compensation fee schedule.
2. The MCO must provide a new, updated cost analysis with each pricing override request, except those detailed in section IV.C.1 of this policy.
3. The MCO must provide an itemized list of all medically necessary components of the requested services or items/devices and related direct and indirect costs that are impacting the request for payment above the fee schedule.
    a. Examples of itemized service components may include but are not limited to:
        i. Room and board daily rate;
        ii. Medications included in the daily rate;
        iii. Home health aide services, including individual tasks (e.g., bathing, dressing, transfers, eating) and the associated time duration for each task;
        iv. Home health nursing (RN or LPN) services, including individual tasks and skill level required (e.g., intravenous medication administration, wound care). *Please note, when an MCO is requesting an RN, the MCO must*

provide scope of licensure details that prohibit an LPN from providing the care;

v. Behavior-related services (e.g., one-on-one supervision due to risk for self-harm);
vi. Specialty services that are atypical due to unique circumstances.

b. Examples of itemized components of items/devices may include but are not limited to:
    i. Individual product components (e.g., prosthetic hand artificial intelligence add-on component);
    ii. Labor costs;
    iii. Mark-up amount;
    iv. Warranties.

4. The MCO must provide the frequency and duration of each service requested, when applicable, such as with home health services.
5. The MCO must provide documentation of attempts to negotiate lower rates with the provider and associated outcomes.
6. The MCO must provide a cost analysis that compares substantially similar services or items/devices that may include but is not limited to:
    a. Cost comparisons for the same service or item/device provided by other providers or vendors (e.g., cost estimates for all-inclusive nursing home care);
    b. Identification of and cost comparisons for alternative services or items/devices that would provide the same medical treatment benefit for the injured worker (e.g., other brands or models of a prosthetic device or DME);
    c. Identification of cost differences between the alternative skilled nursing facility (using the appropriate service code and definition based on the IW's condition) and the total services necessary for treatment at home which would be reflected as part of the facility's daily rate such as therapies, DME and home modifications.
    d. Published prices/charges (e.g., hospital or vendor Web sites, average rates in region);
    e. Fee schedule comparisons from other payers (e.g., Medicare, Medicaid, worker's compensation rate for out of state services);
    f. Manufacturer's invoices or quotes;
    g. Additional details of the cost analysis must be made available upon request (Web sites used, telephone numbers, emails, contact names, conversation dates, etc.).
7. If the cost analysis identifies an alternative service, provider or item/device that meets the IW's care needs and is available at a lower cost than the requested reimbursement rate, the MCO must:
    a. Deny the request per the cost prong of Miller; or
    b. Negotiate reimbursement with the potential treating provider to the lowest cost estimate from other providers; or

c. Provide justification and supporting documentation why the alternative, lowest cost alternative cannot be utilized. Acceptable justification may include the following:
    i. Access to care issues
        a) No alternative providers are available within 45 miles of the injured worker's residence (e.g., lower cost nursing homes have no beds available; only one home health care provider exists in an out of state, rural area);
        b) Obtaining the lowest cost service, item or device would cause a significant and undetermined delay in care which would negatively impact the injured worker's medical condition (e.g., a lower cost item/device is on long term backorder; injured worker requires urgent surgery to prevent further nerve damage);
        c) Provider choices are limited due to coordination of care issues (e.g., out of state, BWC-certified surgeon has admitting privileges at only one hospital);
    ii. The injured worker received the service or item/device prior to the MCO being notified of the injured worker's claim;
    iii. The injured worker has specialized medical needs which require the higher cost service, item/device (e.g., injured worker who is visually impaired requires a device with larger displays or audio output; a computerized, microprocessor controlled prosthetic limb is required because a standard passive or body-powered prosthetic device cannot be used or is insufficient to meet the functional needs of the injured worker in performing activities of daily living).

D. **Medical or Vocational Necessity and Reasonability** - The MCO must document medical or vocational necessity and reasonability when requesting BWC approval.
    1. The MCO must document how the requested service, item or device is treating the allowed condition(s).
    2. The requested service, item or device cannot be solely for the IW's comfort or convenience.
    3. If the MCO cannot document medical necessity and reasonability, the MCO must deny the request for not meeting the requirements of Miller or vocational necessity.

E. **Additional Documentation Requirements**
    1. For requests requiring BWC approval per section IV.A. of this policy, the following documentation must be submitted in the email with the pricing override template:
        a. C-9 Request for Authorization;
        b. Medical documentation supporting the request;
        c. Required documentation to be submitted with requests for home health services to demonstrate compliance with OAC 4123-6-38:

i. The written treatment plan with specific frequency and duration by discipline (e.g., aide services three times per week for ten hours) signed by the treating physician (please note the treatment plan cannot be written by the MCO or the home health agency); and
ii. An office visit note demonstrating the IW has been seen by the treating physician within the past 12 months.

d. Upon BWC request, MCOs may be required to submit additional documentation to support requests for home health services and demonstrate compliance with OAC 4123.6.38 and the Home Health Services Policy (BRM-12) including but not limited to:
   i. Copies of recent home health agency notes when the request is retrospective or for a continuation of services;
   ii. A generally accepted daily agency schedule for the time requested, with frequency and duration identified for each service and discipline, including incidental services.
e. For residential TBI facility extensions submit a letter of medical necessity dated within the past 12 months, from the treating physician supporting the current level of care;
f. Industrial Commission order, if applicable;
g. Physician review, if applicable.

2. The MCO's demonstration of cost reasonability per section IV.C of this policy, if required.
3. Documentation must justify the pricing override request and specific documentation requirements may differ from case to case.
4. *The MCO must support and fully justify any request for payment overrides.*
5. BWC will review the requested information and determine if the request can be supported based solely on the documentation submitted with the request.
6. All documentation must be imaged into the IW's claim.

F. For BR and NRC fees negotiated by the MCO that do not require BWC prior approval per section IV.A of this policy, at the time services are authorized, MCOs shall:

1. Enter a claim note entitled "MCO code and fee approval" with the following information, at a minimum:
   a. Provider name;
   b. BWC provider number;
   c. Provider type;
   d. Date(s) of service;
   e. Approved code(s);
   f. Description of service/supply for any By-Report code;
   g. Approved reimbursement rate;

h. Approved units of service;
i. How Miller criteria or vocational necessity is met;
j. The MCO's cost analysis;
k. Documentation of negotiation attempts and results;
l. MCO justification for pricing override.

2. To facilitate bill processing, the MCO must:
   b. Apply EOB 752 to the bill; and
   c. Apply all applicable EOBs from the following list to indicate the services and circumstances related to the approval:
      a) 782 – Vocational rehabilitation local code
      b) 787 – Prosthetics
      c) 788 – J3490 Unclassified drugs
      d) 789 – Unlisted CPT codes
      e) 790 – Unlisted HCPCS codes
      f) 791 – Other coded services/procedure requiring EOB 752 override
      g) 792 – Out-of-state non-certified provider payment above fee schedule (used in addition to EOB 860 for BR/NC/NRC codes).

Policy Name:	**Outpatient Services Treated as Inpatient Services**
Policy #:	MP-2022-08
Code/Rule Reference:	OAC 4123-6-37.1
Effective Date:	08/01/2022
Origin:	Medical Policy
Supersedes:	All policies, directives and memos regarding reimbursement of hospital outpatient services provided within one or three days of an inpatient admission
History:	New 08/01/2022
Review date:	08/01/2027

I. POLICY PURPOSE:

A. Background

Effective June 25, 2010, the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010," was signed by President Obama. Section 102 of the law pertains to Medicare's policy for payment of outpatient services provided on either the date of a beneficiary's admission or during the three calendar days immediately preceding the date of a beneficiary's inpatient admission to a hospital inpatient prospective payment system, "IPPS" (or during the one calendar day immediately preceding the date of a beneficiary's inpatient admission to an IPPS exempt hospital or distinct part unit). This policy is known as the "3-day (or 1-day) payment window." Under the payment window policy, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services that are furnished to the beneficiary during the 3-day (or 1-day) payment window. The law makes the policy pertaining to admission-related outpatient non-diagnostic services more consistent with common hospital billing practices and makes no changes to the existing policy regarding billing of outpatient diagnostic services. Section 102 of Pub. L. 111-192 is effective for services furnished on or after the date of enactment, June 25, 2010.

CMS adopted conforming regulations in the IPPS final rule, which displayed at the Federal Register on July 30, 2010 *(see* CMS-1498*)*. The Medicare Claims Processing Manual, Chapter 3, Section 40.3-Outpatient Services Treated as Inpatient Services

details this policy. The policy details the applicability to various hospital types and distinct part hospital units; services included and excluded from the provision; and proper billing processes.

B. Purpose

The purpose of this policy is to define the role of the MCO in applying edits related to this provision of the inpatient prospective payment system. This includes clarifying how an MCO will process hospital outpatient services provided within one or three days of an inpatient admission for Ohio's injured workers.

II. APPLICABILITY

This policy applies to the MCOs' application clinical and reimbursement related edits to bills for hospital outpatient services provided within one or three days of a related inpatient admission for the Ohio workers' compensation system.

III. DEFINITIONS

There are no definitions for this policy.

IV. POLICY

A. Authorization

1. MCOs should apply disclaimer language to C-9s when authorizing pre-admission testing.
2. Disclaimer must notify providers that pre-admission testing reimbursement will be made in accordance with Medicare's Hospital Services Treated as Inpatient Services Policy.

B. Bill Applicability

1. Medicare's policy on Outpatient Services Treated as Inpatient Services is applicable to inpatient and outpatient hospital bills that contain the same Federal tax identification numbers.
2. Medicare's policy on Outpatient Services Treated as Inpatient Services is not applicable when inpatient and outpatient hospital bills do not contain the same Federal tax identification numbers.

C. Bill Processing

1. Except as otherwise noted in this policy, MCOs should implement bill editing to comply with Medicare's policy on Outpatient Services Treated as Inpatient Services.
2. In the case the Medicare policy is modified, MCOs should apply the Medicare policy in effect based on the date of service.
3. MCOs shall deny reimbursement for outpatient services that should be billed as inpatient services using EOB 082 - *Payment is denied. Outpatient services subject to Medicare's 1 day or 3 day payment window policy must be reported on the related inpatient bill.*
4. MCOs shall not deny otherwise payable inpatient services when if the inpatient bill does not include outpatient services.
5. As requested by the hospital, MCOs shall process adjustments to add appropriate outpatient services to the inpatient bill.

Policy and Procedure Name:	**Evaluation of Spinal Cord Stimulator Requests**
Policy #:	MP-2023-08
Code/Rule Reference:	O.A.C 4123-6-35
Effective Date:	8/21/2023
Supersedes:	All medical policies, directives, and memos regarding the authorization of spinal cord stimulators that predate the effective date of this policy
History:	New
Review Date:	8/21/2028

I. POLICY PURPOSE

The purpose of this policy is to clarify when O.A.C. 4123-6-35 – Payment for Spinal Cord Stimulator applies to requests related to spinal cord stimulators and the criteria to be used for these requests.

II. APPLICABILITY

This policy applies to the MCO's evaluation, approval or denial of requests related to spinal cord stimulators.

III. DEFINITIONS

Spinal Cord Stimulator - *an implanted device that sends low levels of electricity directly into the spinal cord to relieve pain*.

IV. POLICY

A. O.A.C. 4123-6-35 applies to requests for authorization of a spinal cord stimulator trial or implantation received on or after 09/01/2022.

B. O.A.C. 4123-6-35 does not apply to requests for battery replacements, correction of device malfunctions, or lead revisions, regardless of when the spinal cord stimulator was implanted.

1) Battery replacement or correction of device malfunctions for implanted spinal cord stimulators will be authorized when determined necessary and appropriate by a licensed, qualified technician.
2) Lead Revisions will be authorized for implanted devices when determined to be medically necessary and appropriate, consistent with O.A.C. 4123-6-16.2(B) (i.e., the *Miller* criteria).

C. For Replacement of a Functioning Spinal Cord Stimulator

1) O.A.C. 4123-6-35 applies when
   a. An injured worker currently has a functioning implanted spinal cord stimulator (including a cervical spinal cord stimulator authorized prior to 09/01/2022 or granted by the Industrial Commission), and
   b. There is a request for a newer version, upgrade, or otherwise a different spinal cord stimulator.
2) Conservative care, as described in O.A.C. 4123-6-35(A)(2), will be met if such care is provided within six months of the request for a replacement of a functioning spinal cord stimulator.
3) The surgeon's evaluation and all components of the evaluation (e.g., HBAI, education, etc.), as described in O.A.C. 4123-6-35(A)(3)(a) – (g) must have been done in contemplation of and relative to the current request for a new spinal cord stimulator.

Policy and Procedure Name:	**Home Health Nursing and/or Home Health Aide Service Requests for Exceptional Cases**
Policy #:	MP 2023-08
Code/Rule Reference:	O.A.C. 4123-6-38; O.A.C 4123-6-08; MP-2022-05
Effective Date:	August 1, 2023
Origin:	Medical Policy
Supersedes:	
History:	New
Review Date:	08/01/2028

I. POLICY PURPOSE

Home health nursing and home health aide services are offered with the focus of providing safe, effective, and cost-efficient care within an injured worker's home, or as appropriate service augmentation when an injured worker may be in a facility or other environment where nursing services and/or home health aide are not considered a part of the facility or environment service package.

In general, the approach to home health nursing and home health aide services is that the workers' compensation system does not reimburse for individual nurse or home health aide service providers whose sole purpose is to, on a fulltime equivalent basis, provide services to only one injured worker. The governing rule specifically states in part that: "…*only part-time or intermittent home health nursing services or home health aide services will be authorized, in accordance with the written treatment plan. Part-time or intermittent care means that total home health nursing services and home health aide services do not exceed eight hours per day."*

Notwithstanding the above rule excerpt, additional rule language states: "*In exceptional cases, the bureau may authorize more than eight hours of total home health nursing services or home health aide services when medically necessary and appropriate."* This policy provides guidance regarding the interpretation of "exceptional cases" and the consideration of the number of hours associated with an injured worker's related needs.

This policy complements and should be used in conjunction with MP-2022-05, *MCO Fee Schedule and Payment Override Policy.*

II. APPLICABILITY

This policy applies to the MCO's evaluation, approval, or denial of requests related to home health nursing services or home health aide services.

III. DEFINITIONS

Exceptional Cases – Those claims which involves the following allowed conditions: hemiplegia, paraplegia, quadriplegia, or amputation of two (2) or more limbs, or definite moderate-severe traumatic brain injury (TBI).

Definite Moderate-Severe TBI – TBI cases where an individual presents with one or more of the below listed clinical criteria:

- Loss of consciousness of 30 minutes or more;
- Post-traumatic amnesia (PTA) of 24 hours or more;
- Worst Glasgow Coma Scale score in the first 24 hours<13(unless invalidated by factors such as intoxication, sedation, systemic shock)
- One or more of the following present:
  - Intracerebral hematoma;
  - Subdural hematoma;
  - Epidural hematoma;
  - Cerebral contusion;
  - Hemorrhagic contusion;
  - Penetrating TBI (dura penetrated);
  - Subarachnoid hemorrhage;
  - Brain Stem Injury.

IV. POLICY

A. When a request for home health nursing and/or home health aide services is submitted to the MCO, the MCO will determine if the injured worker is deemed to meet the exceptional case definition.
B. If the exceptional case definition is met, it is presumed that the request for more than 8, but not more than 16, hours of home health nursing and/or home health aide services is medically necessary and appropriate.
C. The total number of hours up to the 16 to be approved for reimbursement will be determined by considering:
    1. Medical necessity as evaluated via *Miller* criteria.
    2. Existing or required home modifications or adjustments where the injured worker resides.
    3. Overlap of services by a home health nursing and home health aide where both are requested.

Policy and Procedure Name:	**MCO Submission of Provider or MCO Initiated Bill Adjustments or Voids**
Policy #:	MP-2024-01
Code/Rule Reference:	OAC 4123-6-08; 4123-6-37.1; 4123-6-37.2; 4123-6-37.3; 4123-3-23; 4123-6-04.4(B), MPRG Policy Alert 2021-02, BRM 2024-1
Effective Date:	1/1/2024
Supersedes:	All policies, procedures, directives, and memos regarding provider or MCO initiated adjustment or void requests that predate the effective date of this policy.
History:	New 1/1/2024
Review date:	1/1/2029

I. POLICY PURPOSE

The purpose of this policy is to clarify the existing requirements for submission to BWC of hard copy or electronic void requests or adjustments for provider bills (meeting bill timeliness guidelines) to a prior paid, partially paid or denied bill using the X12 837 institutional (I) or professional (P) billing format.

In this policy BWC clarifies specific expectations to perform due diligence reviews, including validation of the data used in adjustment or void requests. The policy also details the denial explanation of benefit codes (EOBs) or override EOBs that must be used.

It is important to note the BWC recovery policy will continue to provide guidance to MCOs when adjustments (or voids) result in overpayments.

II. APPLICABILITY

This policy is in direct support of BRM-XX and applies to all actions relevant to the request, approval and adjudication of an adjustment or void.

III. DEFINITIONS

See BRM 2024-1, *Adjustments and Voids,* for additional definitions.

Adjustment or void attestation: A required EOB used to attest to the MCO's intention and accuracy of the submitted electronic request to replace or void a bill.

Adjustment reject: A validation error that prevents BWC from processing the automated adjustment or void.

Adjustment EOB: EOB(s) added by an MCO to explain the reason(s) for the adjustment. Used with both institutional and professional bill types.

Adjustment trigger override: A required adjustment EOB on non-institutional bills that will cause the billing system to recognize the bill as an adjustment and will allow the replacement of the original bill to occur. This is used in conjunction with adjustment EOBs.

History only adjustment: An adjustment made to reflect a change in the bill that does not result in monies being paid or recovered.

MCO Error – see BRM-27.

Void reason code (VRC): A required EOB that will trigger and describe the best reason to execute the void.

IV. POLICY

A. Adjustment or Void submission: MCOs must submit adjustment (replacement bills) and void requests to BWC hard copy or electronically within 14 calendar days of receipt.

1. Manual adjustments are submitted using the BWC Request for Adjustment form by:
   a. Emailing to the Adjustment mailbox at hpp.adjustments@bwc.ohio.gov; or
   b. Faxing to the attention of HPP Adjustments at (614) 621-3135; or
   c. Mailing to BWC, 30 W. Spring St., L20, Columbus, OH 43213, Attn: MB&A.
2. MCOs must use the applicable EOBs included in the appendix to this policy to:
   a. Signify MCO attestation of the review and accuracy of the adjustment or void request;
   b. Execute the change and identify the reason for the adjustment or void, including MCO error, when applicable;
   c. Identify when an overpayment has been collected in full;
   d. Override specific edits, when appropriate; and
   e. Request BWC's review.
3. **Adjustment or Void Validity Rejects:**
   a. Rejects will be sent to MCOs via the 824 or 835 X12 EDI transaction sets.
   b. When an MCO receives an adjustment (or void) reject on the 835 X12 EDI transaction, the MCO will:
      i. Correct the reject reason, and
      ii. Resubmit the corrected adjustment or void request to BWC.
   c. MCOs shall not process adjustment reject EOBs through to a provider.
4. **When submitting a void regardless of bill type:**
   a. An override attestation EOB is required (EOB 906).
   b. Void Reason Code (VRC) –
      i. One VRC is billed with the override attestation to cause a void to execute in BWC's system; and
      ii. Will be returned to the MCO and provider on the 835 X12 EDI transaction.
   c. Except on an institutional bill, the NUBC industry standard reason (condition) code is also required but is not returned on the 835 X12 EDI transaction.
5. **When submitting an adjustment regardless of bill type**:
   a. An override attestation EOB is required (EOB 907).
   b. The override adjustment trigger code is billed with the override attestation to cause an adjustment to replace the original or most recently adjusted bill in BWC's system.

c. Adjustment reason EOB(s):
    i. At least one adjustment EOB is required to document the reason(s) for the requested adjustment and complete the requested system action, such as a line denial.
    ii. All adjustment reason EOBs added to the replacement bill by the MCO will be returned on the 835 EDI remittance advice transaction.
d. Except on an institutional bill, the NUBC industry standard reason (condition) code is also required but is not returned on the 835 EDI remittance advice transaction.

6. **MCO Merger/Acquisition**:
    a. MCOs may receive adjustments to invoices when an MCO merger/acquisition takes place and bills submitted by the original MCO are later adjusted.
    b. The financially responsible MCO may submit an adjustment or void, even if that is different from the original submitting MCO.
7. **MCO request for BWC review:** MCOs should append EOB 717 (MCO requests for BWC review) to the electronic submission of an adjustment or void only when:
    a. Requesting BWC's manual intervention; or
    b. Requesting to override bill timeliness due to
        i. MCO error when the provider otherwise appealed timely; or
        ii. Third party subrogation requests meeting bill timeliness criteria, or
    c. As otherwise required by policy.
    d. MCOs must verify correct coding, industry standard edits, and BWC reimbursement rules before requesting a 717 to override billing edits applied by BWC.
8. **Tracking:** MCOs track the status of all adjustments and voids at every stage of the process. Tracking documentation must include, but is not limited to the following:
    a. Adjustment log;
    b. Date the MCO was first notified of the adjustment or void;
    c. Method of notification (e.g., phone call, returned check, BWC report, etc.);
    d. Date of the adjustment or void submission to BWC;
    e. Date MCO received respective 835 remittance;
    f. Date underpayment was issued to a provider;
    g. Date contact was made with the provider notifying of recovery of an overpayment;
    h. Date provider submitted overpayment back to MCO.
9. **Documentation:** MCOs maintain and image documentation to support adjustment or void requests, including:
    a. Provider initiated correspondence;
    b. Original bill and subsequent bill submissions;
    c. Proof to support overrides of duplicate check, coding changes, clinical edits, bill timeliness, etc.;
    d. *Please note: When requesting an adjustment for a duplicate EOB edit, MCOs must provide justification (written explanation of the request) and appropriate duplicate EOB on the adjustment form, including why the adjustment is not a duplicate payment. The MCO must provide the CIN of the bill that caused the duplicate denial to demonstrate the research that was found to be invalid.*
    e. Note identifying the adjustment or void and applicable reason.

10. **MCO Error:** When citing error as a reason for the adjustment, the MCO shall submit documentation to support the error, including but not limited to:
    a. A copy of the revised bill from the provider when documenting a provider's billing error;
    b. A copy of the original bill when documenting an MCO's billing error, when the error is related to data entry;
    c. Copies of date stamped documentation;
    d. Note or phone logs, etc.;
    e. Requests to override the EOB 125 (bill timeliness) must include:
        i. A copy of the original bill submitted timely, with the proof of timely submission as evidenced by a date stamp; and
        ii. Evidence that the provider requested additional payment timely (within 1 year and 7 days from the date of the adjudication) using call logs and note logs; and
        iii. Written summary and associated documentation of the MCO error that resulted in the adjustment request not being submitted timely.
11. The MCO shall not require the provider to refund the original bill's paid amount to process a requested adjustment. MCOs shall recover only the exact overpayment amount when an adjustment will result in a lesser payment amount.
12. Since an adjustment will replace the original bill, MCOs must resubmit any applicable EOB from the original bill, including to unmodified lines.
13. Clinical and bill editing must be applied to all electronic adjustments before submitting to BWC.
14. MCOs must validate missing or invalid data elements, including but not limited to:
    a. Data elements required to match to the original invoice;
    b. Reason codes when applicable;
    c. Notes when applicable;
    d. When changes submitted do not match with reason codes.
15. BWC will not apply EOB 938 (Payment is denied as this MCO Bill Document number *already exists*) to reject the adjustment or void when
    a. The bill type is 0XX7 or 0XX8 on hospital bills; or
    b. The claim frequency code is 7 or 8 on professional bills.
16. **Original BWC Claim Identification Number** (CIN)
    a. To facilitate matching of the correct invoice to be adjusted or voided, MCOs must supply the BWC Original CIN on the adjustment or void, except if subsequent adjustments are necessary.
    b. When a subsequent adjustment is necessary (i.e., adjustment suffix -01, 02, etc.), then the BWC CIN referenced must be the most recently adjusted CIN, instead of the original bill's CIN.
    c. The MCO shall not deny an adjustment or void request that does not include the BWC CIN submitted from the provider. The MCO is responsible for the application of this identifier.
17. **MCO Bill Document Number**:
    a. To ensure BWC's identification of the correct invoice to be adjusted or voided, MCOs must also submit the Original MCO Bill Document Number matching the original BWC CIN, with the adjustment or void request.

b. For subsequent adjustment requests, MCOs will submit the most current MCO Bill Document Number, if different than the MCO Bill Document number for the original bill, to identify the correct bill being requested for adjustment or void.

18. MCOs must submit a bill adjustment when:
    a. An initial bill was submitted and processed timely, and
    b. An adjustment is being requested; and
    c. The adjustment request would be submitted within the timely window.
19. An exception to Paragraph IV.A.18 is a new bill can be submitted when:
    a. The initial bill was processed timely; and
    b. The amount paid was zero; and
    c. The resubmitted bill would be within the initial bill timeliness window.
20. An adjustment requires a change.
    a. An adjustment without a change will be rejected.
    b. History only adjustments cannot be systematically submitted but can be submitted manually to Medical Billing and Adjustments.

B. MCO Error in Entry of Servicing or Pay-to Provider Number: If a provider number chosen by the MCO is incorrect and a warrant is returned to the MCO uncashed, the MCO shall:

1. Void the returned, uncashed warrant;
2. Identify the appropriate provider number/suffix;
3. Submit a void of the initial bill paid incorrectly to account for the returned warrant; and
4. Submit a new 837 bill using the correct provider number.
5. The MCO will use the original receipt date and original interest date of the original bill paid in error for this submission.

C. Adjustments for Hospital Bills

1. Late charges must be added to the original or most recently adjusted bill as an adjustment, replacing the bill.
2. When requesting a manually submitted adjustment, the MCO must first submit a request for a test adjustment to determine the appropriate pricing and/or recovery amount.
3. MCOs cannot split a bill into multiple bills for one date of service.

D. Recoveries of voids or adjustments resulting in overpayments:

1. MCOs must follow BWC's recovery policy unless otherwise indicated.
2. <u>Submission of test adjustments.</u>
    a. When submitting electronic adjustments, MCOs do not submit a request for MB&A to run a test adjustment, however,
    b. When submitting manual adjustments, MCOs may submit a request to BWC to determine if an adjustment will result in an overpayment recovery.
3. When an **electronic adjustment results in an overpayment**, MCOs will be notified of the overpayment details through applicable EOBs identified in the appendix of this policy. BWC will issue the edit 424 report to each MCO with applicable adjustments resulting in a recovery.
    a. MCOs must maintain each day's recovery report as this recovery information will not be maintained by CAM.
    b. MCOs will utilize the bill information included on the nightly report to initiate recovery with the impacted provider.

c. MCOs will not receive the edit 424 report for manual adjustments that result in an overpayment situation. Communication is directly with the MCO through email notification.

4. MCOs must track and collect overpayments in full:
   a. Before submitting to BWC when the overpayment resulted from a VOID; or
   b. After being notified by BWC that the adjustment submitted resulted in an overpayment to avoid underfunding the provider account.
   c. BWC will not track partial payments made to the MCO.
   d. MCOs will notify BWC of the fully collected recovery using the applicable EOB identified in the appendix of this policy.

E. BWC review and compliance audits:

1. Certain reason codes or EOBs may result in BWC suspension and prospective review of MCO justification and supportive documentation.
2. BWC may also perform retrospective audits to determine MCO compliance.

Appendix 1: Applicable BWC EOBs for Adjustment or Void requests
KEY:

- ***Highlights refer to new codes (when the EOB is highlighted) or description changes (when the description is highlighted).***

EOB	EOB Description	837	824	835	Code Type
BWC Validation Reject EOBs to an MCO's request for ADJUSTMENT AND VOID. Note: MCOs must correct and resubmit.					
416	Invalid adjustment		X		Adjustment Reject
738	Provider must void the original bill and resubmit new billing to change pay-to provider, servicing provider or claim number or bill type		X		Adjustment Reject
740	Claim number does not match original billed claim number		X		Adjustment Reject
802	BWC CIN does not match original or last adjusted bill CIN.		X		Adjustment Reject
803	Adjustment received with a MCO bill document number that does not match the original MCO bill document number.		X		Adjustment Reject
804	There is an adjustment already in process for this bill.		X		Adjustment Reject
805	MCO number on adjustment request does not match MCO number on previous bill record.		X		Adjustment Reject
808	Request for adjustment was received without EOB 906 or 907 identifying the MCO attestation of the adjustment or void request. Please attach appropriate EOBs when requesting and adjustment or void to previously adjudicated invoice.		X		Adjustment Reject
Validation Reject specific to Institutional EOBs ADJUSTMENT AND VOIDs. Note: MCOs must correct and resubmit.					
413	Bill change reason code must be present and equal to D0-D2, D4 or D9. Bill type 0XX7		X		Adjustment Reject
414	Bill change reason code must be present and equal to D5 or D6 for a void request 0XX8		X		Adjustment Reject
417	Only one bill change reason code may be applied to a single adjustment request form a provider. Choose the single bill change reason code that best describes the reason for the provider's request and resubmit. Bill type 0XX7 or 0XX8		X		Adjustment Reject

EOB	EOB Description	837	824	835	Code Type
419	Dates of service must change for bill change reason code D0 0XX7		X		Adjustment Reject
420	Charges must be changed for claim change reason code D1 0XX7		X		Adjustment Reject
421	Revenue codes/HCPCS must change for bill change reason code D2 0XX7		X		Adjustment Reject
423	ICD diagnosis and/or ICD procedures must change for bill change reason code D4 0XX7		X		Adjustment Reject
425	Unable to determine reason for adjustment or void request. On institutional bills, missing a reason code.		X		Adjustment Reject
806	Institutional adjustment reason code D4 must be submitted with MCO override attestation EOB 730. Bill type 0XX7		X		Adjustment Reject
Override or Attestation EOBs					
728	An MCO or provider-initiated adjustment resulted in a recovery that has been collected.	X		X	Override attestation
730	MCO verifies review and approval of diagnosis or ICD procedure code changes and approves 0XX7 adjustment request (institutional adjustment only)	X		X	Override attestation
906	Electronic void - MCO reviewed and approved. Must be on the void to initiate processing of the void. This will not override clinical edits.	X		X	Override Attestation
907	Electronic adjustment - MCO reviewed and approved. Must be on the adjustment to initiate processing of the adjustment. This will not override clinical edits.	X		X	Override Attestation
164	ADJUSTMENT TRIGGER. Must be included on a non-institutional adjustment to execute the replacement.	X			Adjustment Trigger Code
VOID REASON CODE (VRC) Required to execute a void. Limited to 1 Void Reason Code (VRC) on the void. This reason will be returned on the 835.					
083	MCO paid bill in error. Reverse entire bill.	X		X	VOID (VRC)
084	Other reason for void as documented by the MCO. Contact MCO with questions.	X		X	VOID (VRC)
106	MCO paid the wrong provider in error. (Servicing or pay-to). Reverse entire bill.	X		X	VOID (VRC)
108	MCO paid services under the wrong claim number in error. Reverse entire bill.	X		X	VOID (VRC)
810	Provider billed in error. Reverse entire bill.	X		X	VOID (VRC)
812	Services not rendered. void entire bill.	X		X	VOID (VRC)
856	Reversed (entire) invoice due to duplicate payment.	X		X	VOID (VRC)

EOB	EOB Description	837	824	835	Code Type
870	Payment voided as check has not been cashed within 4 months of issuance and MCO has been unable to contact provider.	X		X	VOID (VRC)
General EOBs to describe reasons for ADJUSTMENT. Must add at least one of these applicable ADJUSTMENT EOBs to describe the reason(s) for the change.					
004	MCO priced amount changed due to provider error.	X		X	ADJUSTMENT
006	Date of service changed due to provider entry error.	X		X	ADJUSTMENT
538	Treatment reimbursement approved by MCO thru bill grievance or Alternative Dispute process (no appeal) - adjustment done to process previously disputed services.	X		X	ADJUSTMENT
540	Treatment reimbursement approved by BWC (final determination) - adjustment done to process previously disputed services.	X		X	ADJUSTMENT
542	Treatment reimbursement approved by DHO (final determination) - adjustment done to process previously disputed services.	X		X	ADJUSTMENT
544	Treatment reimbursement approved by SHO (final determination) - adjustment done to process previously disputed services.	X		X	ADJUSTMENT
785	MCO authorized payment of additional procedures.	X		X	ADJUSTMENT
811	Claim number for this IW changed. For use only when BWC changes the claim number, not when a mistake was made in keying. Required BWC manual intervention.	X		X	ADJUSTMENT
813	Services not industrially related.	X		X	ADJUSTMENT
815	Claim is now allowed. Submitting adjustment to pay previously denied services.	X		X	ADJUSTMENT
819	Changed the total billed provider amount due to line item changes.	X		X	ADJUSTMENT
820	Line item billed in error. Submitting replacement bill to remove line billed in error.	X		X	ADJUSTMENT
824	Provider error: Date of service changed on a professional bill.	X		X	ADJUSTMENT
825	The charges on this line item have been denied as this service occurred during the follow-up period and should be part of the global fee.	X		X	ADJUSTMENT

EOB	EOB Description	837	824	835	Code Type
827	Revenue or procedure code changed due to medical provider coding error on original line item.	X		X	ADJUSTMENT
828	Service code is part of a global fee.	X		X	ADJUSTMENT
829	Service code payment change resulting from a determination by IC or BWC.	X		X	ADJUSTMENT
830	Service code denied by IC or BWC.	X		X	ADJUSTMENT
831	Services rendered as a part of BWC authorized vocational rehabilitation program.	X		X	ADJUSTMENT
833	Modifier changed due to medical provider coding error.	X		X	ADJUSTMENT
836	Amount billed for line item changed due to medical provider coding error.	X		X	ADJUSTMENT
838	MCO line item priced amount changed due to provider/panel relationship.	X		X	ADJUSTMENT
842	Additional line items added from unbundling charges.	X		X	ADJUSTMENT
846	Changed invoice data due to medical provider coding error.	X		X	ADJUSTMENT
847	Changed the units billed due to medical provider coding error.	X		X	ADJUSTMENT
850	BWC error in processing.	X		X	ADJUSTMENT
851	Provider is adding Late charges on a facility bill. Replacing entire bill to add charges.	X		X	ADJUSTMENT
852	Changed header EOB.	X		X	ADJUSTMENT
853	Provider changed or added diagnosis code(s).	X		X	ADJUSTMENT
854	Provider is adding information omitted on a facility invoice. Header level info such as condition codes, etc.	X		X	ADJUSTMENT
855	Line(s) reversed due to duplicate payment.	X		X	ADJUSTMENT
857	Claim settled, but BWC is responsible for the bill. Needs BWC's manual intervention.	X		X	ADJUSTMENT
864	Adjusted to charge to correct risk number.	X		X	ADJUSTMENT
865	Charged to vocational rehabilitation in error. Adjusting to charge services to the risk.	X		X	ADJUSTMENT
868	MCO is decertified but adjustment request was received prior to decertification date.	X		X	ADJUSTMENT
873	Line item EOB changed at the MCO's request.	X		X	ADJUSTMENT

EOB	EOB Description	837	824	835	Code Type
876	Payment above fee schedule has been approved by BWC (PA number included on adjustment). This is NOT an override EOB and will not result in automatic payment at the higher rate unless the Medpol PA number is appended to the adjustment.	X			ADJUSTMENT
886	Payment made for different level of inpatient care in the same hospital room.	X		X	ADJUSTMENT
826	Revenue or procedure code changed due to MCO input error on the original line item.	X		X	ADJUSTMENT
832	Modifier changed due to MCO input error.	X		X	ADJUSTMENT
834	Changed the units billed due to MCO input error.	X		X	ADJUSTMENT
835	Amount billed for line item changed due to MCO input error.	X		X	ADJUSTMENT
837	MCO line-item priced amount changed due to MCO input error.	X		X	ADJUSTMENT
839	MCO number of units priced amount changed due to MCO input error.	X		X	ADJUSTMENT
840	MCO number of units priced amount changed due to provider/panel relationship. Not identified in advance.	X		X	ADJUSTMENT
841	Additional line items added; previously omitted due to MCO input error.	X		X	ADJUSTMENT
844	Changed the invoice data due to MCO input error.	X		X	ADJUSTMENT
845	Changed the MCO total priced amount due to line-item changes due to MCO input error.	X		X	ADJUSTMENT
863	Line item adjusted to recover amount paid over fee schedule in error.	X		X	ADJUSTMENT
884	Data element changed to comply with current BWC requirements. MCO error in initial submission.	X		X	ADJUSTMENT
897	Other MCO error in processing, MCO initiated adjustment.	X		X	ADJUSTMENT
Recovery EOBs					
426	This bill's payment amount was reduced by an adjustment of another bill. Contact the MCO with any questions.	X		X	Recovery adjustment
894	Partial recovery of overpaid medical. For use by the MCO when the MCO has not been able to collect the entire amount overpaid to the provider for more than 90 days after initial partial recovery. Only used for MCO tracking. BWC will not reconcile partial recovery.	X		X	Recovery Adjustment

BWC USE ONLY EOBs					
424	This adjustment resulted in an overpayment that the MCO must collect. Resubmit new adjustment with 728 override after collection is complete.				Bill Recovery Report