As Introduced

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H. B. No. 517

Representatives Sears, Newbold

Cosponsors: Representatives Henne, Hackett, Buchy, Amstutz, Beck, Grossman, Adams, J., Rosenberger, Wachtmann, Sprague, McGregor

A BILL

To amend sections 4121.44, 4121.441, 4121.63, 4123.511, 4123.53, 4123.651, 4123.66, and 4123.93 of the Revised Code to allow the Administrator of Workers' Compensation to pay for specified medical benefits during an earlier time frame, to require a workers' compensation claimant that refuses or unreasonably delays treatment without good cause to forfeit compensation and benefits during the time period of refusal or delay, to make changes to the health partnership program, and to make other changes to the Workers' Compensation Law. 1 2 3 4 5 6 7 8 9 10 11

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 4121.44, 4121.441, 4121.63, 4123.511, 4123.53, 4123.651, 4123.66, and 4123.93 of the Revised Code be amended to read as follows: 12 13 14

Sec. 4121.44. (A) The administrator of workers' compensation shall oversee the implementation of the Ohio workers' compensation qualified health plan system as established under section 4121.442 of the Revised Code. 15 16 17 18

(B) The administrator shall direct the implementation of the health partnership program administered by the bureau as set forth in section 4121.441 of the Revised Code. To implement the health partnership program, the bureau:

(1) Shall certify one or more external vendors, which shall be known as "managed care organizations," to provide medical management and cost containment services in the health partnership program for a period of two years beginning on the date of certification, consistent with the standards established under this section;

(2) May recertify external vendors for additional periods of two years; and

(3) May integrate the certified vendors with bureau staff and existing bureau services for purposes of operation and training to allow the bureau to assume operation of the health partnership program at the conclusion of the certification periods set forth in division (B)(1) or (2) of this section.

(C) Any vendor selected shall demonstrate all of the following:

(1) Arrangements and reimbursement agreements with a provider panel including a substantial number of ~~the~~ medical, professional, and pharmacy providers ~~currently being utilized by claimants~~ participating in the health partnership program, selected on the basis of access, quality, and cost.

(2) Ability to accept a common format of medical bill data in an electronic fashion from any provider who wishes to submit medical bill data in that form.

(3) A computer system able to handle the volume of medical bills and willingness to customize that system to the bureau's needs and to be operated by the vendor's staff, bureau staff, or some combination of both staffs.

(4) A prescription drug system where pharmacies on a 50
statewide basis have access to the eligibility and pricing, at a 51
discounted rate, of all prescription drugs. 52

(5) A tracking system to record all telephone calls from 53
claimants and providers regarding the status of submitted medical 54
bills so as to be able to track each inquiry. 55

(6) Data processing capacity to absorb all of the bureau's 56
medical bill processing or at least that part of the processing 57
which the bureau arranges to delegate. 58

(7) Capacity to store, retrieve, array, simulate, and model 59
in a relational mode all of the detailed medical bill data so that 60
analysis can be performed in a variety of ways and so that the 61
bureau and its governing authority can make informed decisions. 62

(8) Wide variety of software programs which translate medical 63
terminology into standard codes, and which reveal if a provider is 64
manipulating the procedures codes, commonly called "unbundling." 65

(9) Necessary professional staff to conduct, at a minimum, 66
authorizations for treatment, medical necessity, utilization 67
review, concurrent review, post-utilization review, and have the 68
attendant computer system which supports such activity and 69
measures the outcomes and the savings. 70

(10) Management experience and flexibility to be able to 71
react quickly to the needs of the bureau in the case of required 72
change in federal or state requirements. 73

(D) For purposes of division (C)(1) of this section, any 74
provider panel used by a vendor shall provide reasonable access to 75
providers, deliver cost-effective treatment, and achieve quality 76
benchmarks established by the administrator. 77

(E)(1) Information contained in a vendor's application for 78
certification in the health partnership program, and other 79

information furnished to the bureau by a vendor for purposes of obtaining certification or to comply with performance and financial auditing requirements established by the administrator, is for the exclusive use and information of the bureau in the discharge of its official duties, and shall not be open to the public or be used in any court in any proceeding pending therein, unless the bureau is a party to the action or proceeding, but the information may be tabulated and published by the bureau in statistical form for the use and information of other state departments and the public. No employee of the bureau, except as otherwise authorized by the administrator, shall divulge any information secured by the employee while in the employ of the bureau in respect to a vendor's application for certification or in respect to the business or other trade processes of any vendor to any person other than the administrator or to the employee's superior.

(2) Notwithstanding the restrictions imposed by division ~~(D)~~<u>(E)</u>(1) of this section, the governor, members of select or standing committees of the senate or house of representatives, the auditor of state, the attorney general, or their designees, pursuant to the authority granted in this chapter and Chapter 4123. of the Revised Code, may examine any vendor application or other information furnished to the bureau by the vendor. None of those individuals shall divulge any information secured in the exercise of that authority in respect to a vendor's application for certification or in respect to the business or other trade processes of any vendor to any person.

~~(E)~~<u>(F)</u> On and after January 1, 2001, a vendor shall not be any insurance company holding a certificate of authority issued pursuant to Title XXXIX of the Revised Code or any health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code.

~~(F)~~(G) The administrator may limit freedom of choice of 112
health care provider or supplier by requiring, beginning ~~with the~~ 113
~~period set forth in division (B)(1) or (2) of this section~~ the 114
forty-sixth day after the date of the injury or the forty-sixth 115
day after the beginning date for treatment for the occupational 116
disease, that claimants ~~shall~~ pay an appropriate out-of-plan 117
copayment for selecting a medical provider not within the provider 118
panel of a health partnership program vendor as provided for in 119
this section. 120

~~(G)~~(H) The administrator, six months prior to the expiration 121
of the bureau's certification or recertification of the vendor or 122
vendors as set forth in division (B)(1) or (2) of this section, 123
may certify and provide evidence to the governor, the speaker of 124
the house of representatives, and the president of the senate that 125
the existing bureau staff is able to match or exceed the 126
performance and outcomes of the external vendor or vendors and 127
that the bureau should be permitted to internally administer the 128
health partnership program upon the expiration of the 129
certification or recertification as set forth in division (B)(1) 130
or (2) of this section. 131

~~(H)~~(I) The administrator shall establish and operate a bureau 132
of workers' compensation health care data program. The 133
administrator shall develop reporting requirements from all 134
employees, employers and medical providers, medical vendors, and 135
plans that participate in the workers' compensation system. The 136
administrator shall do all of the following: 137

(1) Utilize the collected data to measure and perform 138
comparison analyses of costs, quality, appropriateness of medical 139
care, and effectiveness of medical care delivered by all 140
components of the workers' compensation system~~.~~; 141

(2) Compile data ~~to support activities of the selected vendor~~ 142
~~or vendors and~~ annually to measure the outcomes and savings of 143

managed care organizations and providers in the health partnership program~~.~~; 144–145

(3) ~~Publish and report~~ Report the compiled data on the measures of outcomes and savings of the health partnership program ~~and submit the report~~ to the president of the senate, the speaker of the house of representatives, and the governor with the annual report prepared under division (F)(3) of section 4121.12 of the Revised Code~~. The administrator shall protect~~; 146–151

(4) Make the data compiled pursuant to division (I)(2) of this section available to employers and the public; 152–153

(5) Protect the confidentiality of all proprietary pricing data. 154–155

~~(I)~~(J) Any rehabilitation facility the bureau operates is eligible for inclusion in the Ohio workers' compensation qualified health plan system or the health partnership program under the same terms as other providers within health care plans or the program. 156–160

~~(J) In~~ (K) Notwithstanding division (G) of this section, in areas outside the state or within the state where no qualified health plan or an inadequate number of providers within the health partnership program exist, the administrator shall permit employees to use a provider not within the provider panel of a qualified health plan or health partnership program vendor, including, if necessary, a nonplan or nonprogram health care provider and shall pay the provider for the services or supplies provided to or on behalf of an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code on a fee schedule the administrator adopts. 161–172

~~(K)~~(L) No health care provider, whether certified or not, shall charge, assess, or otherwise attempt to collect from an 173–174

employee, employer, a managed care organization, or the bureau any amount for covered services or supplies that is in excess of the allowed amount paid by a managed care organization, the bureau, or a qualified health plan.

~~(L)~~(M) The administrator shall permit any employer or group of employers who agree to abide by the rules adopted under this section and sections 4121.441 and 4121.442 of the Revised Code to provide services or supplies to or on behalf of an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code through qualified health plans of the Ohio workers' compensation qualified health plan system pursuant to section 4121.442 of the Revised Code or through the health partnership program pursuant to section 4121.441 of the Revised Code. No amount paid under the qualified health plan system pursuant to section 4121.442 of the Revised Code by an employer who is a state fund employer shall be charged to the employer's experience or otherwise be used in merit-rating or determining the risk of that employer for the purpose of the payment of premiums under this chapter, and if the employer is a self-insuring employer, the employer shall not include that amount in the paid compensation the employer reports under section 4123.35 of the Revised Code.

Sec. 4121.441. (A) The administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall adopt rules under Chapter 119. of the Revised Code for the health care partnership program administered by the bureau of workers' compensation to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code.

The rules shall include, but are not limited to, the following: 206 207

(1) Procedures for the resolution of medical disputes between an employer and an employee, an employee and a provider, or an employer and a provider, prior to an appeal under section 4123.511 of the Revised Code. Rules the administrator adopts pursuant to division (A)(1) of this section may specify that the resolution procedures shall not be used to resolve disputes concerning medical services rendered that have been approved through standard treatment guidelines, pathways, or presumptive authorization guidelines. 208 209 210 211 212 213 214 215 216

(2) Prohibitions against discrimination against any category of health care providers; 217 218

(3) Procedures for reporting injuries to employers and the bureau by providers; 219 220

(4) Appropriate <u>administrative and</u> financial incentives to reduce service cost and insure proper system utilization without sacrificing the quality of service<u>, including bonus payments to providers who substantially exceed quality benchmarks established by the administrator</u>; 221 222 223 224 225

(5) Adequate methods of peer review, utilization review, quality assurance, and dispute resolution to prevent, and provide sanctions for, inappropriate, excessive or not medically necessary treatment; 226 227 228 229

(6) A timely and accurate method of collection of necessary information regarding medical and health care service and supply costs, quality, and utilization to enable the administrator to determine the effectiveness of the program; 230 231 232 233

(7) Provisions for necessary emergency medical treatment for an injury or occupational disease provided by a health care provider who is not part of the program; 234 235 236

(8) Discounted pricing for all in-patient and out-patient medical services, all professional services, and all pharmaceutical services; 237 238 239

(9) Provisions for provider referrals, pre-admission and post-admission approvals, second surgical opinions, and other cost management techniques; 240 241 242

(10) Antifraud mechanisms; 243

(11) Standards and criteria for the bureau to utilize in certifying or recertifying a health care provider or a vendor for participation in the health partnership program; 244 245 246

(12) Standards and criteria for the bureau to utilize in penalizing or decertifying a health care provider or a vendor from participation in the health partnership program. 247 248 249

(B) The administrator shall implement the health partnership program according to the rules the administrator adopts under this section for the provision and payment of medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code. 250 251 252 253 254 255 256

Sec. 4121.63. Claimants who the administrator of workers' compensation determines could probably be rehabilitated to achieve the goals established by section 4121.61 of the Revised Code and who agree to undergo rehabilitation shall be paid living maintenance payments for a period or periods which do not exceed six months in the aggregate, unless review by the administrator or the administrator's designee reveals that the claimant will be benefited by an extension of such payments. 257 258 259 260 261 262 263 264

Living maintenance payments shall be paid in weekly amounts, not to exceed the amount the claimant would receive if the 265 266

claimant were being compensated for temporary total disability, but not less than fifty per cent of the current state average weekly wage. Living maintenance payments shall commence at the time the claimant begins to participate in an approved rehabilitation program. 267 268 269 270 271

A claimant receiving living maintenance payments shall be deemed to be temporarily totally disabled and shall receive no payment of any type of compensation except as provided by division (B) of section 4123.57 of the Revised Code for the periods during which the claimant is receiving living maintenance payments. 272 273 274 275 276

If, without good cause, a claimant refuses to undertake or unreasonably delays undertaking rehabilitation services, counseling, or training in accordance with an approved rehabilitation plan, the claimant forfeits the claimant's right to have the claimant's claim for compensation or benefits considered, if the claim is pending before the administrator or the industrial commission, or to receive living maintenance payments or any other payment for compensation or benefits pertaining to the period of refusal. The period of refusal or obstruction shall not toll any time frame for the exercise of continuing jurisdiction by the administrator or commission under section 4123.52 of the Revised Code. 277 278 279 280 281 282 283 284 285 286 287 288

Sec. 4123.511. (A) Within seven days after receipt of any claim under this chapter, the bureau of workers' compensation shall notify the claimant and the employer of the claimant of the receipt of the claim and of the facts alleged therein. If the bureau receives from a person other than the claimant written or facsimile information or information communicated verbally over the telephone indicating that an injury or occupational disease has occurred or been contracted which may be compensable under this chapter, the bureau shall notify the employee and the 289 290 291 292 293 294 295 296 297

employer of the information. If the information is provided verbally over the telephone, the person providing the information shall provide written verification of the information to the bureau according to division (E) of section 4123.84 of the Revised Code. The receipt of the information in writing or facsimile, or if initially by telephone, the subsequent written verification, and the notice by the bureau shall be considered an application for compensation under section 4123.84 or 4123.85 of the Revised Code, provided that the conditions of division (E) of section 4123.84 of the Revised Code apply to information provided verbally over the telephone. Upon receipt of a claim, the bureau shall advise the claimant of the claim number assigned and the claimant's right to representation in the processing of a claim or to elect no representation. If the bureau determines that a claim is determined to be a compensable lost-time claim, the bureau shall notify the claimant and the employer of the availability of rehabilitation services. No bureau or industrial commission employee shall directly or indirectly convey any information in derogation of this right. This section shall in no way abrogate the bureau's responsibility to aid and assist a claimant in the filing of a claim and to advise the claimant of the claimant's rights under the law. 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319

The administrator of workers' compensation shall assign all claims and investigations to the bureau service office from which investigation and determination may be made most expeditiously. 320 321 322

The bureau shall investigate the facts concerning an injury or occupational disease and ascertain such facts in whatever manner is most appropriate and may obtain statements of the employee, employer, attending physician, and witnesses in whatever manner is most appropriate. 323 324 325 326 327

The administrator, with the advice and consent of the bureau of workers' compensation board of directors, may adopt rules that 328 329

identify specified medical conditions that have a historical record of being allowed whenever included in a claim. The administrator may grant immediate allowance of any medical condition identified in those rules upon the filing of a claim involving that medical condition and may make immediate payment of medical bills for any medical condition identified in those rules that is included in a claim. If an employer contests the allowance of a claim involving any medical condition identified in those rules, and the claim is disallowed, payment for the medical condition included in that claim shall be charged to and paid from the surplus fund created under section 4123.34 of the Revised Code. 330 331 332 333 334 335 336 337 338 339 340 341

(B)(1) Except as provided in division (B)(2) of this section, in claims other than those in which the employer is a self-insuring employer, if the administrator determines under division (A) of this section that a claimant is or is not entitled to an award of compensation or benefits, the administrator shall issue an order no later than twenty-eight days after the sending of the notice under division (A) of this section, granting or denying the payment of the compensation or benefits, or both as is appropriate to the claimant. After conducting an investigation, if the administrator determines that insufficient medical information exists to grant or deny the payment of compensation, benefits, or both to the claimant, the administrator may, with notice to both parties, dismiss the claim without prejudice. Notwithstanding the time limitation specified in this division for the issuance of an order, if a medical examination of the claimant is required by statute, the administrator promptly shall schedule the claimant for that examination and shall issue an order no later than twenty-eight days after receipt of the report of the examination. The administrator shall notify the claimant and the employer of the claimant and their respective representatives in writing of the nature of the order and the amounts of compensation and 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362

benefit payments involved. The employer or claimant may appeal the order pursuant to division (C) of this section within fourteen days after the date of the receipt of the order. The employer and claimant may waive, in writing, their rights to an appeal under this division. 363 364 365 366 367

(2) Notwithstanding the time limitation specified in division (B)(1) of this section for the issuance of an order, if the employer certifies a claim for payment of compensation or benefits, or both, to a claimant, and the administrator has completed the investigation of the claim, the payment of benefits or compensation, or both, as is appropriate, shall commence upon the later of the date of the certification or completion of the investigation and issuance of the order by the administrator, provided that the administrator shall issue the order no later than the time limitation specified in division (B)(1) of this section. 368 369 370 371 372 373 374 375 376 377 378

(3) If an appeal is made under division (B)(1) or (2) of this section, the administrator shall forward the claim file to the appropriate district hearing officer within seven days of the appeal. In contested claims other than state fund claims, the administrator shall forward the claim within seven days of the administrator's receipt of the claim to the industrial commission, which shall refer the claim to an appropriate district hearing officer for a hearing in accordance with division (C) of this section. 379 380 381 382 383 384 385 386 387

(C) If an employer or claimant timely appeals the order of the administrator issued under division (B) of this section or in the case of other contested claims other than state fund claims, the commission shall refer the claim to an appropriate district hearing officer according to rules the commission adopts under section 4121.36 of the Revised Code. The district hearing officer shall notify the parties and their respective representatives of 388 389 390 391 392 393 394

the time and place of the hearing. 395

The district hearing officer shall hold a hearing on a disputed issue or claim within forty-five days after the filing of the appeal under this division and issue a decision within seven days after holding the hearing. The district hearing officer shall notify the parties and their respective representatives in writing of the order. Any party may appeal an order issued under this division pursuant to division (D) of this section within fourteen days after receipt of the order under this division. 396 397 398 399 400 401 402 403

(D) Upon the timely filing of an appeal of the order of the district hearing officer issued under division (C) of this section, the commission shall refer the claim file to an appropriate staff hearing officer according to its rules adopted under section 4121.36 of the Revised Code. The staff hearing officer shall hold a hearing within forty-five days after the filing of an appeal under this division and issue a decision within seven days after holding the hearing under this division. The staff hearing officer shall notify the parties and their respective representatives in writing of the staff hearing officer's order. Any party may appeal an order issued under this division pursuant to division (E) of this section within fourteen days after receipt of the order under this division. 404 405 406 407 408 409 410 411 412 413 414 415 416

(E) Upon the filing of a timely appeal of the order of the staff hearing officer issued under division (D) of this section, the commission or a designated staff hearing officer, on behalf of the commission, shall determine whether the commission will hear the appeal. If the commission or the designated staff hearing officer decides to hear the appeal, the commission or the designated staff hearing officer shall notify the parties and their respective representatives in writing of the time and place of the hearing. The commission shall hold the hearing within forty-five days after the filing of the notice of appeal and, 417 418 419 420 421 422 423 424 425 426

within seven days after the conclusion of the hearing, the commission shall issue its order affirming, modifying, or reversing the order issued under division (D) of this section. The commission shall notify the parties and their respective representatives in writing of the order. If the commission or the designated staff hearing officer determines not to hear the appeal, within fourteen days after the expiration of the period in which an appeal of the order of the staff hearing officer may be filed as provided in division (D) of this section, the commission or the designated staff hearing officer shall issue an order to that effect and notify the parties and their respective representatives in writing of that order. 427 428 429 430 431 432 433 434 435 436 437 438

Except as otherwise provided in this chapter and Chapters 4121., 4127., and 4131. of the Revised Code, any party may appeal an order issued under this division to the court pursuant to section 4123.512 of the Revised Code within sixty days after receipt of the order, subject to the limitations contained in that section. 439 440 441 442 443 444

(F) Every notice of an appeal from an order issued under divisions (B), (C), (D), and (E) of this section shall state the names of the claimant and employer, the number of the claim, the date of the decision appealed from, and the fact that the appellant appeals therefrom. 445 446 447 448 449

(G) All of the following apply to the proceedings under divisions (C), (D), and (E) of this section: 450 451

(1) The parties shall proceed promptly and without continuances except for good cause; 452 453

(2) The parties, in good faith, shall engage in the free exchange of information relevant to the claim prior to the conduct of a hearing according to the rules the commission adopts under section 4121.36 of the Revised Code; 454 455 456 457

(3) The administrator is a party and may appear and 458
participate at all administrative proceedings on behalf of the 459
state insurance fund. However, in cases in which the employer is 460
represented, the administrator shall neither present arguments nor 461
introduce testimony that is cumulative to that presented or 462
introduced by the employer or the employer's representative. The 463
administrator may file an appeal under this section on behalf of 464
the state insurance fund; however, except in cases arising under 465
section 4123.343 of the Revised Code, the administrator only may 466
appeal questions of law or issues of fraud when the employer 467
appears in person or by representative. 468

(H) Except as provided in section 4121.63 of the Revised Code 469
and division (K) of this section, payments of compensation to a 470
claimant or on behalf of a claimant as a result of any order 471
issued under this chapter shall commence upon the earlier of the 472
following: 473

(1) Fourteen days after the date the administrator issues an 474
order under division (B) of this section, unless that order is 475
appealed; 476

(2) The date when the employer has waived the right to appeal 477
a decision issued under division (B) of this section; 478

(3) If no appeal of an order has been filed under this 479
section or to a court under section 4123.512 of the Revised Code, 480
the expiration of the time limitations for the filing of an appeal 481
of an order; 482

(4) The date of receipt by the employer of an order of a 483
district hearing officer, a staff hearing officer, or the 484
industrial commission issued under division (C), (D), or (E) of 485
this section. 486

(I) ~~Payments~~ Except as otherwise provided in divisions (B) 487
and (C) of section 4123.66 of the Revised Code, payments of 488

medical benefits payable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code shall commence upon the earlier of the following: 489 490 491

(1) The date of the issuance of the staff hearing officer's order under division (D) of this section; 492 493

(2) The date of the final administrative or judicial determination. 494 495

(J) The administrator shall charge the compensation payments made in accordance with division (H) of this section or medical benefits payments made in accordance with division (I) of this section to an employer's experience immediately after the employer has exhausted the employer's administrative appeals as provided in this section or has waived the employer's right to an administrative appeal under division (B) of this section, subject to the adjustment specified in division (H) of section 4123.512 of the Revised Code. 496 497 498 499 500 501 502 503 504

(K) Upon the final administrative or judicial determination under this section or section 4123.512 of the Revised Code of an appeal of an order to pay compensation, if a claimant is found to have received compensation pursuant to a prior order which is reversed upon subsequent appeal, the claimant's employer, if a self-insuring employer, or the bureau, shall withhold from any amount to which the claimant becomes entitled pursuant to any claim, past, present, or future, under Chapter 4121., 4123., 4127., or 4131. of the Revised Code, the amount of previously paid compensation to the claimant which, due to reversal upon appeal, the claimant is not entitled, pursuant to the following criteria: 505 506 507 508 509 510 511 512 513 514 515

(1) No withholding for the first twelve weeks of temporary total disability compensation pursuant to section 4123.56 of the Revised Code shall be made; 516 517 518

(2) Forty per cent of all awards of compensation paid 519

pursuant to sections 4123.56 and 4123.57 of the Revised Code, until the amount overpaid is refunded; 520 521

(3) Twenty-five per cent of any compensation paid pursuant to section 4123.58 of the Revised Code until the amount overpaid is refunded; 522 523 524

(4) If, pursuant to an appeal under section 4123.512 of the Revised Code, the court of appeals or the supreme court reverses the allowance of the claim, then no amount of any compensation will be withheld. 525 526 527 528

The administrator and self-insuring employers, as appropriate, are subject to the repayment schedule of this division only with respect to an order to pay compensation that was properly paid under a previous order, but which is subsequently reversed upon an administrative or judicial appeal. The administrator and self-insuring employers are not subject to, but may utilize, the repayment schedule of this division, or any other lawful means, to collect payment of compensation made to a person who was not entitled to the compensation due to fraud as determined by the administrator or the industrial commission. 529 530 531 532 533 534 535 536 537 538

(L) If a staff hearing officer or the commission fails to issue a decision or the commission fails to refuse to hear an appeal within the time periods required by this section, payments to a claimant shall cease until the staff hearing officer or commission issues a decision or hears the appeal, unless the failure was due to the fault or neglect of the employer or the employer agrees that the payments should continue for a longer period of time. 539 540 541 542 543 544 545 546

(M) Except as otherwise provided in this section or section 4123.522 of the Revised Code, no appeal is timely filed under this section unless the appeal is filed with the time limits set forth in this section. 547 548 549 550

(N) No person who is not an employee of the bureau or commission or who is not by law given access to the contents of a claims file shall have a file in the person's possession. 551 552 553

(O) Upon application of a party who resides in an area in which an emergency or disaster is declared, the industrial commission and hearing officers of the commission may waive the time frame within which claims and appeals of claims set forth in this section must be filed upon a finding that the applicant was unable to comply with a filing deadline due to an emergency or a disaster. 554 555 556 557 558 559 560

As used in this division: 561

(1) "Emergency" means any occasion or instance for which the governor of Ohio or the president of the United States publicly declares an emergency and orders state or federal assistance to save lives and protect property, the public health and safety, or to lessen or avert the threat of a catastrophe. 562 563 564 565 566

(2) "Disaster" means any natural catastrophe or fire, flood, or explosion, regardless of the cause, that causes damage of sufficient magnitude that the governor of Ohio or the president of the United States, through a public declaration, orders state or federal assistance to alleviate damage, loss, hardship, or suffering that results from the occurrence. 567 568 569 570 571 572

Sec. 4123.53. (A) The administrator of workers' compensation or the industrial commission may require any employee claiming the right to receive compensation to submit to a medical examination, vocational evaluation, or vocational questionnaire at any time, and from time to time, at a place reasonably convenient for the employee, and as provided by the rules of the commission or the administrator of workers' compensation. A claimant required by the commission or administrator to submit to a medical examination or vocational evaluation, at a point outside of the place of 573 574 575 576 577 578 579 580 581

permanent or temporary residence of the claimant, as provided in this section, is entitled to have paid to the claimant by the bureau of workers' compensation the necessary and actual expenses on account of the attendance for the medical examination or vocational evaluation after approval of the expense statement by the bureau. Under extraordinary circumstances and with the unanimous approval of the commission, if the commission requires the medical examination or vocational evaluation, or with the approval of the administrator, if the administrator requires the medical examination or vocational evaluation, the bureau shall pay an injured or diseased employee the necessary, actual, and authorized expenses of treatment at a point outside the place of permanent or temporary residence of the claimant. 582 583 584 585 586 587 588 589 590 591 592 593 594

(B) When an employee initially receives temporary total disability compensation pursuant to section 4123.56 of the Revised Code for a consecutive ninety-day period, the administrator shall refer the employee to the bureau medical section for a medical examination to determine the employee's continued entitlement to such compensation, the employee's rehabilitation potential, and the appropriateness of the medical treatment the employee is receiving. The bureau medical section shall conduct the examination not later than thirty days following the end of the initial ninety-day period. If the medical examiner, upon an initial or any subsequent examination recommended by the medical examiner under this division, determines that the employee is temporarily and totally impaired, the medical examiner shall recommend a date when the employee should be reexamined. Upon the issuance of the medical examination report containing a recommendation for reexamination, the administrator shall schedule an examination and, if at the date of reexamination the employee is receiving temporary total disability compensation, the employee shall be examined. The administrator shall adopt a rule, pursuant to Chapter 119. of the Revised Code, permitting employers to waive 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614

the administrator's scheduling of any such examinations. 615

(C) If, without good cause, an employee refuses to submit to 616
any medical examination or vocational evaluation scheduled 617
pursuant to this section or obstructs the same, or refuses to 618
complete and submit to the bureau or commission a vocational 619
questionnaire within thirty days after the bureau or commission 620
mails the request to complete and submit the questionnaire the 621
employee forfeits the employee's right to have his or her the 622
employee's claim for compensation considered, if the claim is 623
pending before the bureau or commission, or to receive any payment 624
for compensation theretofore granted, is suspended during or 625
benefits pertaining to the period of the refusal or obstruction. 626
The period of refusal or obstruction shall not toll any time frame 627
for the exercise of continuing jurisdiction by the administrator 628
or commission under section 4123.52 of the Revised Code. 629
Notwithstanding this section, an employee's failure to submit to a 630
medical examination or vocational evaluation, or to complete and 631
submit a vocational questionnaire, shall not result in the 632
dismissal of the employee's claim. 633

(D) Medical examinations scheduled under this section do not 634
limit medical examinations provided for in other provisions of 635
this chapter or Chapter 4121. of the Revised Code. 636

Sec. 4123.651. (A) The employer of a claimant who is injured 637
or disabled in the course of his the claimant's employment may 638
require, without the approval of the administrator or the 639
industrial commission, that the claimant be examined by a 640
physician of the employer's choice one time upon any issue 641
asserted by the employee or a physician of the employee's choice 642
or which is to be considered by the commission. Any further 643
requests for medical examinations shall be made to the commission 644
which shall consider and rule on the request. The employer shall 645

pay the cost of any examinations initiated by the employer. 646

(B) The bureau of workers' compensation shall prepare a form 647
for the release of medical information, records, and reports 648
relative to the issues necessary for the administration of a claim 649
under this chapter. The claimant promptly shall provide a current 650
signed release of the information, records, and reports when 651
requested by the employer. The employer promptly shall provide 652
copies of all medical information, records, and reports to the 653
bureau and to the claimant or ~~his~~ the claimant's representative 654
upon request. 655

(C) If, without good cause, an employee refuses to submit to 656
any examination scheduled under this section or refuses to release 657
or execute a release for any medical information, record, or 658
report that is required to be released under this section and 659
involves an issue pertinent to the condition alleged in the claim, 660
~~his~~ the employee forfeits the employee's right to have ~~his~~ the 661
employee's claim for compensation or benefits considered, if ~~his~~ 662
the employee's claim is pending before the administrator~~,~~ or 663
commission~~, or a district or staff hearing officer,~~ or to receive 664
any payment for compensation or benefits ~~previously granted, is~~ 665
~~suspended during~~ pertaining to the period of refusal. The period 666
of refusal or obstruction shall not toll any time frame for the 667
exercise of continuing jurisdiction by the administrator or 668
commission under section 4123.52 of the Revised Code. 669

(D) No bureau or commission employee shall alter any medical 670
report obtained from a health care provider the bureau or 671
commission has selected or cause or request the health care 672
provider to alter or change a report. The bureau and commission 673
shall make any request for clarification of a health care 674
provider's report in writing and shall provide a copy of the 675
request to the affected parties and their representatives at the 676
time of making the request. 677

Sec. 4123.66. (A) In addition to the compensation provided for in this chapter, the administrator of workers' compensation shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper and, in case death ensues from the injury or occupational disease, the administrator shall disburse and pay from the fund reasonable funeral expenses in an amount not to exceed fifty-five hundred dollars. The bureau of workers' compensation shall reimburse anyone, whether dependent, volunteer, or otherwise, who pays the funeral expenses of any employee whose death ensues from any injury or occupational disease as provided in this section. The administrator may adopt rules, with the advice and consent of the bureau of workers' compensation board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefor. In case an injury or industrial accident that injures an employee also causes damage to the employee's eyeglasses, artificial teeth or other denture, or hearing aid, or in the event an injury or occupational disease makes it necessary or advisable to replace, repair, or adjust the same, the bureau shall disburse and pay a reasonable amount to repair or replace the same. 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699

(B) The administrator, in the rules the administrator adopts pursuant to division (A) of this section, may identify specified medical services that are presumptively authorized and payable to a provider who provides any of the services identified in, and complies with the requirements set forth in, the rules the administrator adopts for the services rendered. The administrator, in the rules the administrator adopts under this division, shall limit the payment for these services to only those services rendered to a claimant during the time period beginning the date the administrator issues an order pursuant to division (B) of 700 701 702 703 704 705 706 707 708 709

section 4123.511 of the Revised Code allowing a claim or allowing an additional condition to which the services relate and ending forty-five days after the date the order was issued. 710 711 712

If the claim or additional condition is ultimately disallowed in a final administrative or judicial order, and if the employer is a state fund employer who pays assessments into the surplus fund account created under section 4123.34 of the Revised Code, the payments for medical services made pursuant to this division for that claim or condition shall be charged to and paid from the surplus fund account and not charged through the state insurance fund to the employer against whom the claim or additional condition was filed. 713 714 715 716 717 718 719 720 721

(C) The administrator, in the rules the administrator adopts pursuant to division (A) of this section, may adopt rules specifying the circumstances under which the bureau may make immediate payment for the first fill of prescription drugs for medical conditions identified in an application for compensation or benefits under section 4123.84 or 4123.85 of the Revised Code that occurs prior to the date the administrator issues an initial determination order under division (B) of this section. If the claim is ultimately disallowed in a final administrative or judicial order, and if the employer is a state fund employer who pays assessments into the surplus fund account created under section 4123.34 of the Revised Code, the payments for medical services made pursuant to this division for the first fill of prescription drugs shall be charged to and paid from the surplus fund account and not charged through the state insurance fund to the employer against whom the claim was filed. 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737

(D) If, without good cause, an employee refuses to undertake or unreasonably delays undertaking medical, nursing, and hospital services and medicine that are ordered by the employee's treating physician and that are payable under division (I) of section 738 739 740 741

4123.511 of the Revised Code, the employee forfeits the employee's right to have the employee's claim for compensation or benefits considered, if the claim is pending before the administrator or the industrial commission, or to receive any payment for compensation or benefits pertaining to the period of refusal. The period of refusal or obstruction shall not toll any time frame for the exercise of continuing jurisdiction by the administrator or commission under section 4123.52 of the Revised Code. 742–749

(E)(1) If an employer or a welfare plan has provided to or on behalf of an employee any benefits or compensation for an injury or occupational disease and that injury or occupational disease is determined compensable under this chapter, the employer or a welfare plan may request that the administrator reimburse the employer or welfare plan for the amount the employer or welfare plan paid to or on behalf of the employee in compensation or benefits. The administrator shall reimburse the employer or welfare plan for the compensation and benefits paid if, at the time the employer or welfare plan provides the benefits or compensation to or on behalf of employee, the injury or occupational disease had not been determined to be compensable under this chapter and if the employee was not receiving compensation or benefits under this chapter for that injury or occupational disease. The administrator shall reimburse the employer or welfare plan in the amount that the administrator would have paid to or on behalf of the employee under this chapter if the injury or occupational disease originally would have been determined compensable under this chapter. If the employer is a merit-rated employer, the administrator shall adjust the amount of premium next due from the employer according to the amount the administrator pays the employer. The administrator shall adopt rules, in accordance with Chapter 119. of the Revised Code, to implement this division. 750–773

(2) As used in this division, "welfare plan" has the same meaning as in division (1) of 29 U.S.C.A. 1002. 774 775

(F)(1) As used in this division, "third party payer" means any of the following entities that provides coverage to an employee for medical, nurse, and hospital services or medicine: 776 777 778

(a) A person authorized to engage in the business of sickness and accident insurance under Title XXXIX of the Revised Code; 779 780

(b) A person or governmental entity responsible for providing coverage for medical services or items to an employee on a self-insurance basis; 781 782 783

(c) A health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code; 784 785

(d) A group health plan as defined in 29 U.S.C. 1167; 786

(e) A service benefit plan as referenced in 42 U.S.C. 1396a(a)(25); 787 788

(f) A welfare plan as defined in division (E)(2) of this section; 789 790

(g) Any other person or governmental entity that, by law, contract, or agreement, is responsible for the payment or processing of a claim for a medical item or service for an employee. 791 792 793 794

(2) If the administrator has properly disbursed and paid any amounts to or on behalf of an employee for medical, nurse, and hospital services or medicine for an injury or occupational disease and that injury or occupational disease is subsequently determined to be noncompensable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code, the administrator may request that the employee's third party payer reimburse the administrator for the amount the administrator paid to or on behalf of the employee for medical, nurse, and hospital services 795 796 797 798 799 800 801 802 803

or medicine. The employee and the employee's third party payer 804
shall cooperate with the administrator regarding requests for 805
reimbursements under this division, and the third party payer and 806
the administrator may share information as needed to facilitate 807
those requests. The third party payer shall reimburse the 808
administrator in the amount that the administrator disbursed and 809
paid to or on behalf of the employee under this chapter or Chapter 810
4121., 4127., or 4131. of the Revised Code. The administrator 811
shall credit any such amounts received to the surplus fund account 812
created in section 4123.34 of the Revised Code. The administrator 813
shall adopt rules, in accordance with Chapter 119. of the Revised 814
Code, to implement this division. 815

Sec. 4123.93. As used in sections 4123.93 and 4123.931 of the 816
Revised Code: 817

(A) "Claimant" means a person who is eligible to receive 818
compensation, medical benefits, or death benefits under this 819
chapter or Chapter 4121., 4127., or 4131. of the Revised Code. 820

(B) "Statutory subrogee" means the administrator of workers' 821
compensation, a self-insuring employer, or an employer that 822
contracts for the direct payment of medical services pursuant to 823
division ~~(L)~~(M) of section 4121.44 of the Revised Code. 824

(C) "Third party" means an individual, private insurer, 825
public or private entity, or public or private program that is or 826
may be liable to make payments to a person without regard to any 827
statutory duty contained in this chapter or Chapter 4121., 4127., 828
or 4131. of the Revised Code. 829

(D) "Subrogation interest" includes past, present, and 830
estimated future payments of compensation, medical benefits, 831
rehabilitation costs, or death benefits, and any other costs or 832
expenses paid to or on behalf of the claimant by the statutory 833
subrogee pursuant to this chapter or Chapter 4121., 4127., or 834

4131. of the Revised Code. 835

(E) "Net amount recovered" means the amount of any award, settlement, compromise, or recovery by a claimant against a third party, minus the attorney's fees, costs, or other expenses incurred by the claimant in securing the award, settlement, compromise, or recovery. "Net amount recovered" does not include any punitive damages that may be awarded by a judge or jury. 836 837 838 839 840 841

(F) "Uncompensated damages" means the claimant's demonstrated or proven damages minus the statutory subrogee's subrogation interest. 842 843 844

Section 2. That existing sections 4121.44, 4121.441, 4121.63, 4123.511, 4123.53, 4123.651, 4123.66, and 4123.93 of the Revised Code are hereby repealed. 845 846 847

Section 3. This act applies to all claims pursuant to Chapters 4121., 4123., 4127., and 4131. of the Revised Code arising on and after the effective date of this act. 848 849 850