Ohio Legislative Service Commission

Bill Analysis

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H.B. 517*

129th General Assembly
(As Introduced)

Reps. Sears and Newbold, Henne, Hackett, Buchy, Amstutz, Beck, Grossman, J. Adams, Rosenberger, Wachtmann, Sprague, McGregor

BILL SUMMARY

- Allows the Administrator of Workers' Compensation to pay for medical services identified by the Administrator and for the first fill of prescriptions occurring during an earlier timeframe than under current law.

- Allows for the medical services or first fill of prescriptions to be charged to the Surplus Fund Account if the claim is ultimately denied if the employer is a state fund employer who pays assessments into that account.

- Requires, if without good cause an employee refuses to undertake or unreasonably delays in engaging in specified activities, the employee to forfeit (rather than suspend under current law) the employee's right to have the employee's claim considered or to receive any payment for compensation or benefits (pertaining to the period of refusal).

- Allows the Administrator to dismiss without prejudice, rather than deny, a claim that has insufficient medical information to allow the Administrator to determine whether the claim is compensable.

- Allows a claimant to refile the dismissed claim.

- Requires, for a managed care organization (MCO) to be certified to participate in the Health Partnership Program (HPP), the MCO to have a provider panel that includes providers currently participating in the HPP and who satisfy the bill's requirements.

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* This analysis was prepared before the bill was introduced in the House Journal. Note that the list of sponsors and co-sponsors and the legislative history may be incomplete.

- Allows the Administrator to limit freedom of choice of provider to HPP certified providers beginning the 46th day after the date of the injury or the 46th day after the beginning date for treatment for the occupational disease, instead of the time period of MCO certification as under current law.

- Requires the Administrator, in the rules the Administrator adopts for the HPP, to include bonus payments to providers who substantially exceed quality benchmarks established by the Administrator in addition to other financial incentives as under current law.

- Allows the Administrator to request reimbursement for payments made in a workers' compensation claim that is ultimately denied from the claimant's third party payer.

CONTENT AND OPERATION

Timing of medical benefit payments

The bill allows the Administrator of Workers' Compensation to pay certain medical benefits earlier than when those benefits are paid under continuing law. Currently, the payment of medical benefits commence upon the earlier of either the date of the issuance of the staff hearing officer's order under the statutory appeals process or the date of the final administrative or judicial determination.[1]

Under the bill, the Administrator, in the rules the Administrator adopts pursuant to continuing law concerning medical benefits, 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 bill requires the Administrator, in the rules the Administrator adopts, to 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 under continuing law allowing a claim or allowing an additional condition to which the services relate and ending 45 days after the date the order was issued.

Similarly, the bill allows the Administrator, in the rules the Administrator adopts regarding medical benefits under continuing law, may adopt rules specifying the circumstances under which the Bureau of Workers' Compensation (BWC) may make immediate payment for the first fill of prescription drugs for medical conditions identified in an application for compensation or benefits under the Workers'

[1] R.C. 4123.511(I).

Compensation Law that occurs prior to the date the Administrator issues an initial determination order granting or denying compensation, benefits, or both (see **COMMENT**).

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 in the State Insurance Fund, the payments for medical services described above or for the first fill of prescription drugs for that claim or condition must 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.[2]

Forfeiture of compensation and benefits

Under the bill if without good cause, an employee refuses to undertake or unreasonably delays in engaging in any of the following activities, 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 (including living maintenance benefits with respect to rehabilitation services) pertaining to the period of refusal:

- Rehabilitation services, counseling, or training in accordance with an approved rehabilitation plan;
- A medical examination or vocational evaluation required by the Administrator or the Industrial Commission (the claimant must complete and submit a vocational questionnaire within 30 days after the Administrator or Industrial Commission mails the request for the forfeiture to apply);
- A medical examination requested by the employee's employer or executing a release for any medical information, record, or report relative to the issues necessary for the administration of a claim;
- Medical, nursing, and hospital services and medicine that are ordered by the employee's treating physician and that are payable under the Workers' Compensation Law.

[2] R.C. 4123.66(B) and (C).

Under the bill, the period of refusal or obstruction does not toll any time frame for the exercise of continuing jurisdiction by the Administrator or the Industrial Commission under continuing law.[3]

With respect to medical examinations and vocational evaluations required by the Administrator or Industrial Commission, medical examinations requested by an employer, or releases for information described above, current law requires consideration of a claim or the payment of compensation and benefits, as applicable to be suspended during the time period of refusal, rather than forfeited as required under the bill.[4]

Dismissal of an incomplete workers' compensation claim

Under the bill, if the Administrator, after conducting an investigation determines that insufficient medical information exists to grant or deny the payment of compensation, benefits, or both to a claimant, the Administrator, with notice to both parties, may dismiss the claim without prejudice. Thus, the claimant may refile the claim. Currently, if insufficient medical information exists to make that determination, the Administrator must deny the claim and the claimant may appeal that denial through the Industrial Commission.[5]

The Health Partnership Program

Provider panels

The Health Partnership Program (HPP) is the managed care portion of Ohio's Workers' Compensation system used by employers who pay premiums into the State Insurance Fund. The Administrator certifies a managed care organization (MCO) for a period of two years to provide medical management and cost containment services for the HPP. Under the bill, in addition to satisfying other continuing law requirements, to be certified an MCO must demonstrate arrangements and reimbursement agreements with a provider panel including a substantial number of the medical, professional, and pharmacy providers participating in the HPP, selected on the basis of access, quality, and cost, instead of providers currently being utilized by claimants as under current law. The bill requires any provider panel used by an MCO to provide reasonable access

[3] R.C. 4121.63, 4123.53, 4123.651, and 4123.66(D).

[4] R.C. 4123.53 and 4123.651.

[5] R.C. 4123.511(B).

to providers, deliver cost-effective treatment, and achieve quality benchmarks established by the Administrator.[6]

Access to providers

Similar to current law, the bill permits the Administrator to limit freedom of choice of health care provider or supplier by requiring, beginning the 46th day after the date of the injury or the 46th day after the beginning date for treatment for the occupational disease (instead of the time period of MCO certification as under current law), that claimants pay an appropriate out-of-plan copayment for selecting a medical provider not within the MCO provider panel.[7]

Under continuing law the Administrator must permit, in areas outside or within Ohio where no qualified health plan (a program similar to the HPP used mostly by self-insuring employers) or an inadequate number of providers within the HPP exist, employees to use a nonplan or nonprogram health care provider. In such circumstances, the Administrator must 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 the Workers' Compensation Law on a fee schedule the Administrator adopts. The bill expands this provision to permit employees to use a provider not within the MCO provider panel.[8]

Provider performance

Continuing law requires the Administrator to adopt rules for the HPP with the advice and consent of the BWC Board of Directors. In addition to other topics those rules must address, the rules must include appropriate administrative (as added by the bill) and financial incentives to reduce service cost and insure proper system utilization without sacrificing the quality of service, including, under the bill, bonus payments to providers who substantially exceed quality benchmarks established by the Administrator.[9]

Health Care Data Program

Continuing law requires the Administrator to establish and operate a BWC health care data program and to develop reporting requirements from all employees,

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[6] R.C. 4121.44(C)(1) and (D).

[7] R.C. 4121.44(F), renumbered (G) under the bill.

[8] R.C. 4121.44(J), renumbered (K) under the bill.

[9] R.C. 4121.441(A)(4).

employers and medical providers, medical vendors, and plans that participate in the workers' compensation system. As part of the program, the bill requires the Administrator to compile data annually to measure the outcomes and savings of MCOs and providers in the HPP and to make that data available to employers and the public. Currently, the data compiled must be to support activities of the selected MCO or MCOs. Additionally, the bill eliminates the requirement to publish the compiled data but maintains the requirement that the Administrator must report the compiled data to the President of the Senate, the Speaker of the House of Representatives, and the Governor with the annual report prepared under continuing law.[10]

Recoupment from third party payers

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 the Workers' Compensation Law, the bill permits the Administrator to 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 those services or medicine. The bill requires the employee and the employee's third party payer to cooperate with the Administrator regarding requests for reimbursements under the bill, and the third party payer and the Administrator may share information as needed to facilitate those requests. The third party payer must reimburse the Administrator in the amount that the Administrator disbursed and paid to or on behalf of the employee under the Workers' Compensation Law. The Administrator must credit any such amounts received to the Surplus Fund Account within the State Insurance Fund. The bill requires the Administrator to adopt rules, in accordance with the Administrative Procedure Act, to implement these requirements.

The bill defines "third party payer" to mean any of the following entities that provides coverage to an employee for medical, nurse, and hospital services or medicine:

- A person authorized to engage in the business of sickness and accident insurance under Ohio's insurance laws;
- A person or governmental entity responsible for providing coverage for medical services or items to an employee on a self-insurance basis;
- A health insuring corporation holding a certificate of authority under the Health Insuring Corporation Law;

[10] R.C. 4121.44(H), renumbered (I) under the bill.

- A group health plan as defined in the federal Employee Retirement Income Security Act (ERISA);[11]
- A service benefit plan as referenced in the Social Security Act;[12]
- A welfare plan as defined in continuing law;
- 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.[13]

COMMENT

In what appears to be a drafting error, the bill contains a cross-reference for an initial order issued under R.C. 4123.66(B), which, under the bill, is the provision for the early payment of medical benefits. This likely should refer to R.C. 4123.511(B), which is the requirements regarding issuing orders concerning the compensability of claims under the Workers' Compensation Law.

HISTORY

ACTION	DATE
Introduced	---

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[11] 29 United States Code (U.S.C.) 1167.

[12] 42 U.S.C. 1396a(a)(25).

[13] R.C. 4123.66(F).