CHAPTER 3

MEDICAL AND RETURN TO WORK MANAGEMENT

BWC defines medical management and cost containment services as those services provided by an MCO pursuant to its contract with BWC, including return to work management services that promote the rendering of high quality, cost-effective medical care that focuses on minimizing the physical, emotional, and financial impact of a work-related injury or illness and promotes a safe return to work.

Through the use of managed care and return to work management strategies, an MCO shall provide medical management and cost containment services that promote the rendering of high-quality, cost-effective medical care that focuses on minimizing the physical, emotional, and financial impact of a work-related injury or illness and promotes a safe return to work. The MCO shall provide medical management and return to work/remain at work management services for the life of a claim**,** as long as the employer remains in contract with the MCO. The MCO is responsible for the medical management component of workers' compensation claim management and shall:

- Adhere to the most current version of the MCO Policy Reference Guide and provide medical management and return to work/remain at work services for all workers' compensation cases to which it is assigned.
- Support BWC initiatives such as but not limited to the return to work (RTW) goals of the agency.
- Educate employers on the value of transitional /return to work services
- Provide medical management and return to work services under the leadership of the MCO Medical Director who assumes responsibility for all MCO medical management outcomes as outlined in the MCO policy guide. The MCO Medical Director shall be involved in the development, monitoring and quality assurance of policies and procedures for medical management and return to work/remain at work services. The MCO Medical Director shall maintain a current, unrestricted license to practice, and shall have either (a) a minimum of ten (10) years clinical practice experience or (b) Board Certification if a Medical Doctor or Doctor of Osteopathy.

A. MCO MEDICAL MANAGEMENT RESPONSIBILITIES

SERVICE	DESCRIPTION
1. Claim Intake	MCO responsible for data collection and validation (other than wage information) necessary to support BWC claim determination. Data collection and validation include contacting the employer to verify facts and obtain employer certification of the claim, and obtaining necessary medical information from providers.
2. Alternative Dispute Resolution (medical issues)	MCO completes timely dispute resolution processes regarding medical and treatment issues.
3. Professional Nursing Services Authorizations	MCO performs authorization and ongoing monitoring of professional nursing services.

SERVICE	DESCRIPTION
4. Caregiver Services Re-Authorization	BWC will review caregiver services for re-authorization. The MCO determines the type of Home Health Agency Nursing care in cases where a caregiver is no longer able, or no longer chooses to provide caregiver services. Replacement "family or friend" is not an option. Coordination of cases is to occur between MCO and BWC when Caregiver services and Home Health agency services are both approved in a claim to prevent service overlap.
5. Home and Van Modification Authorizations	MCO is responsible for identifying the need for home or vehicle modifications and referring to the BWC Catastrophic Nurse Advocate (CNA). The CNA will then develop a plan for home or vehicle modifications necessary as the result of a catastrophic injury. The CNA will work closely with the MCO case manager and the necessary vendors to ensure coordination of the services. MCO is not responsible for authorizing home and van modifications.
6. Utilization Review • in-patient services • outpatient services including surgery • high cost diagnostic services • physical medicine	MCO performs utilization review for all claims for employers selecting the MCO.
7. Bill Review • clinical editing • integration of medical management and bill payment systems	MCO reviews all bills using nationally accepted clinical editing guidelines, clinical editing guidelines identified in chapter 8, and integrating medical management documentation.
8. Independent Medical Exams	MCO makes appropriate referrals for specialist care and obtain second opinions as indicated, and documents follow up of all IME recommendations for medical treatment if notified. Agreed medical examinations may be completed for medical management at the MCO's expense. The exceptions noted for ADR/IME.
9. Provider Relations	MCO is responsible for maintaining arrangements with providers or provider panel, for assisting provider with BWC enrollment and certification and insuring providers' eligibility to participate in HPP. MCO must also maintain Provider Relations contact for BWC and for the public.
10. Out-of-State, Out-of-Country Medical Management and Provider Management	MCO performs medical management, provider payment and provider management services for all claims for employers selecting the MCO.

SERVICE	DESCRIPTION
11. Medical-Claim Management	MCO provides medical claim management services including obtaining medical information, reviewing treatment plan with BWC approved treatment guidelines and authorizing medical services/supplies.
12. Additional Allowance	MCO is responsible for collecting medical documentation to clarify requests for additional allowances submitted on a C9. MCO collects and evaluates medical information and makes a recommendation to BWC regarding whether medical information in the claim supports the existence of the additional allowance requested. MCO shall assist the employer in understanding claim medical information when necessary.
13. Peer review	MCO performs peer review process for network and non-network providers on utilization review and treatment issues. MCO has peer review processes for educating and disciplining providers who are identified as outliers of normal treatment patterns based on profiling and utilization trends. MCO has a credentialing committee and decertification processes for network providers. The MCO is responsible for payment of peer reviews.
14. Permanent Partial Disability (C-92) Review and Exams	In cooperation with BWC, MCO educates treating physicians on necessary medical documentation for request for increase in permanent partial disability.
15. Claim File Review	All file review requests are at the MCO's expense.
16. Quality Assurance	MCO maintains credentialing committee for panel providers and a quality assurance committee for panel and non-panel providers. MCO must maintain quality assurance standards and practices within their operations including a tracking system and feedback mechanisms. The MCO shall have a medical management quality assurance program that includes the use of quality assurance policies and procedures manual that is updated at least quarterly, and that is in compliance with URAC accreditation standards.
17. Sub-Acute, Long-Term Facility and Alternative Care Management	MCO performs authorization, coordination of care at appropriate level of setting and provides on-going monitoring and quality assurance for long-term care.

SERVICE	DESCRIPTION
18. Vocational Management	MCO educates providers about return-to-work goals, workers' compensation issues, etc. The MCO identifies the need for vocational services, as necessary, for return-to-work goals. Note: BWC will only reimburse Comprehensive Occupational Rehab Programs (Work Hardening) that are CARF accredited.
19. Remain at Work (RAW)	MCO is responsible for identifying injured workers and employers to participate in the Remain at Work program. The MCO is charged with coordinating between the employer, IW and provider, as well as developing a case management plan, as appropriate.
20. Return to Work (RTW)	MCO is responsible for documenting and implementing a case management plan that addresses RTW planning on all lost-time claims where the IW has not returned to work regardless of DOI.
21. 30-Day Assessment	MCO is responsible for working with the customer service team Disability Management Coordinator (DMC) in all claims in which the injured worker has not returned to work 30 days beyond the 50th percentile of the MoD Days Absent benchmarks. Public employers' claims will be reviewed at 45 days. In conjunction with the MCO and others, BWC will identify return to work barriers and come to agreement with the MCO regarding appropriate next steps. If the agreed upon course of action is not carried out by the MCO or no resolution can be attained, the MCO will be asked to implement 30-Day Assessment Recommendations developed by the DMC. The MCO may appeal these recommendations within 5 working days. There are two levels of appeal. If the second appeal supports the implementation of the Assessment Recommendations, BWC will reclaim the vocational portion of the claim and assess a penalty.

SERVICE	DESCRIPTION
22. Treatment Standards/Guidelines	MCO maintains national standards for utilization review functions and maintains BWC approved treatment guidelines. BWC distributed the following treatment guidelines to BWC certified providers designated by BWC. MCO staff began using Official Disability Guidelines (ODG) in making their treatment authorization decisions effective April 1, 2004. The MCO shall follow up on treatment reimbursement approvals for all inpatient services and outpatient surgical services, all diagnostic studies (excluding x-rays) and all therapies in all claims subject to initial assessment/triage and/or Medical Case Management within fourteen (14 days) of the treatment reimbursement approval, in order to ensure that necessary care and/or treatment is delivered in a timely fashion. The MCO shall review the results of all approved diagnostic studies (except x-rays) in all claims subject to initial assessment/triage and/or Medical Case Management within fourteen (14) calendar days of completion to determine the necessity of medical management services or notification to the Bureau Customer Service Team of medical support for payment or non-payment of temporary total compensation or other circumstances materially impacting Bureau claims management.
23. Medical Case Management	Medical case management is an essential component in effecting a successful claim outcome. Because the MCO's share claim operations duties with BWC, it is essential that the role, responsibilities and activities of the MCO's be clearly defined so that each will be able to interact effectively to reach optimal results
24. Case Management Plan	The case management plan is formed by a compilation of all information that the case manager has gathered from the injured worker, the physician and the employer as well as any other pertinent sources that impact the progress and successful outcome of the claim resolution.

SERVICE	DESCRIPTION
25. Catastrophic Claim Program Coordinator	The MCO shall have a designated catastrophic claim program coordinator, who shall be responsible for directing the MCO's management of catastrophic claims assigned to the MCO. The catastrophic claim program coordinator shall be a registered nurse, shall meet the Standard CM 4 qualifications for case manager supervisors as required by URAC accreditation standards, and shall meet all other qualifications set forth in the MCO Policy Reference Guide. In addition, this coordinator is required to have 2 years of Ohio BWC MCO case management experience. Past clinical experience in critical care is recommended, but not required. Must be proficient in the MCO Policy Reference Guide, and will attend all training designated by BWC for the catastrophic claim program coordinator.
26. Vocational Rehabilitation Program Coordinator	The MCO shall have a designated vocational rehabilitation program coordinator, who shall be responsible for directing the MCO's management of vocational rehabilitation services in claims assigned to the MCO. The vocational rehabilitation program coordinator shall meet the Standard CM 4 qualifications for vocational rehabilitation as set forth in Rule 4123-6-02.2 of the Ohio Administrative Code, shall meet the qualifications for case manager supervisors as required by URAC accreditation standards, and shall meet all other qualifications set forth in the MCO Policy Reference Guide. In addition, this coordinator is required to have 1 year of field vocational rehabilitation case management experience, be proficient in the MCO Policy Reference Guide, especially Chapter 4, and will attend all training designated by BWC for the vocational program coordinator. **Note:** It is not necessary for MCOs to make changes to meet the 1 year experience requirement. However, if this position becomes vacant at the MCO, this position should be filled with an individual who meets the requirement.

B. AUTHORIZATION AND DENIAL OF MEDICAL TREATMENT

A Clinician (as defined in Appendix G of the contract) shall make all treatment reimbursement denial on behalf of the MCO.

1. Adherence to BWC approved Treatment Guidelines

The MCO services shall include implementation of the Official Disability Guidelines and utilization review to evaluate the necessity and/or effectiveness of medical care.

All MCO medical case management staff members shall complete annual training on the Official Disability Guidelines, utilization review and protocols.

a. Official Disability Guidelines

MCO staff shall use the **Official Disability Guidelines** (ODG) in making their treatment authorization decisions.

The ODG are evidence based treatment guidelines that BWC and the MCOs will be using to assist in medical and claims case management. ODG is a web-based tool available to BWC and MCO staff on their desktops. BWC and MCO staff will be able to easily search and find pertinent information necessary to everyday issues in claims and medical case management.

Ohio providers can take advantage of the BWC negotiated price if they order on the web www.WorkLossData.com or call the toll free number (800-488-5548).

2. *Miller vs. IC* – see Chapter 9

3. Emergency Department Reimbursement

It is common for injured workers to seek treatment in an emergency room after their accident has occurred. Often, the specific conditions to be included in the claim are not known at the time treatment was received. Therefore, a bill for emergency room services may contain conditions that have not been allowed, which results in denial of the bill. To address this circumstance, as long as the condition being billed is medically related to the allowed injury, non-allowed diagnoses (including codes on BWC's invalid ICD code list) on bills for services rendered within 72 hours of date of injury, including services received in an emergency room, will pass through BWC's payment system.

Treatment in the emergency department of a hospital must be of an immediate nature to constitute an emergency. **Prior authorization of such treatment is not required**. However, in situations where the emergency department is being utilized to deliver non-emergency care, notification will be provided to the injured worker, the hospital, and the provider of record that continued use of the emergency department for non-emergent services will not be reimbursed by BWC/MCOs.

4. Therapy Visits

The maximum time allowable per visit for therapy services with timed procedure codes, i.e., physical medicine and rehabilitation modalities and therapeutic procedures should be no longer than one hour without prior authorization. If therapy services with timed codes

are billed over one hour/day, further medical review and approval must occur if services were not authorized prior to payment being made.

5. Request for Medical Services

Requests for medical services that require prior authorization must be submitted by the physician of record (POR) or treating physician to the appropriate MCO prior to initiating any non-emergency treatment. The preferred method of submission is the BWC Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9) form; however, any other physician generated document may be used, provided that the substitute document contains, at a minimum, the data elements on the C-9 form. The POR or treating physician should identify additional conditions to be allowed in the claims on item six of the C-9 form and should spell out additional conditions with supporting documentation.

a. Authorization Guidelines

The following guidelines were implemented to help the MCO consider authorization, promote safe and early return to work, and expedite the payment of medical bills:

1) The MCO must respond to the physician within three business days with a decision regarding the proposed treatment request.
2) The MCO must return fax of the authorized, denied or pended medical services request back to the physician within the required three business days. If faxing is not feasible, the MCO is required to call the physician in order to communicate the decision and follow-up in writing via mail.
3) If the MCO is unable to make a decision within three business days due to the need for additional information, the MCO will send a request for Additional Medical Documentation C-9 form (C-9-A) to the provider.
4) The MCO may request CPT codes but may not pend or deny the request for treatment if the CPT codes are not provided. CPT codes are used to report procedures or services that were delivered. CPT codes are not additional medical documentation that an MCO may require to make a decision on a request for treatment.
5) The provider must return the form C-9-A and any additional supporting documentation to the MCO within ten business days. The MCO will contact the provider via letter each time medical documentation, including the *Physician's Report of WORK ABILITY* (MEDCO-14), *Request for Additional Medical Documentation for C-9* (C-9-A) or other documentation necessary to manage an injured worker's claim is requested but not received in the designated time period for the medical documentation.
6) The MCO has five business days from the date additional information is received to make a subsequent decision. The MCO must render a decision to allow or deny the medical services request if the physician does not provide the MCO with any requested documentation within ten business days for all active claims. The physician must be notified by fax or phone of the subsequent decision. Note:

for inactive claims, the MCO may dismiss the C-9 (with no ADR appeal rights) after the ten days if the medical requested on the C-9-A is not returned. If the MCO chooses to dismiss the C-9 without prejudice after using the C-9-A to request for medical documentation within the last 60 days, the MCO shall fax both the dismissed C-9 and C-9-A to the service office to be imaged into the claim file.

7) If the MCO is unable to make a decision within three business days due to the need for a physician review and the requesting provider is notified, the medical review must take place and a decision rendered by the MCO within five business days. All MCO physician reviews shall be imaged into the BWC claim file with the C9/ C9 determination letter. Again, the requesting provider must be notified by fax or phone of the subsequent decision.

8) The MCO may pend a C-9 requesting a prosthetic if a Multi-Disciplinary Clinic Evaluation (MDE) is being obtained. The MCO shall render a decision within five business days of receipt of the MDE.

9) The MCO must respond to the physician within sixteen business days with a decision regarding the proposed treatment request on an inactive claim (see Reactivation in chapter 2).

10) The MCO must consider and communicate with POR possible alternative treatments that may be eligible for reimbursement if requested by the provider, based on the Official Disability Guidelines. Such alternative treatment proposals/suggestions must be communicated in the decision letter to the provider.

11) The MCO shall obtain beginning and estimated ending dates for inpatient services if not provided on the request for medical services. Allowing the injured worker to choose the health care provider does not limit the MCO's authority and responsibility to promote a safe and early return to work by assisting in determining the earliest possible date for inpatient and/or outpatient services.

12) The MCO shall include a treatment authorization number for services approved on the request for medical services.

13) Treatment reimbursement request denials and approvals outside of treatment guidelines, pathways, or presumptive authorization must be made by a clinician. Clinicians and non-clinicians may issue treatment request approvals within treatment guidelines, pathways or presumptive authorization.

14) To expedite service delivery, timelines for approvals of routine diagnostics (x-rays, CAT scans, MRI scans and EMG/NCV) should be no longer than two weeks. Timelines for approvals of other medical treatments or services with no specified timeframe on the request should be no longer than 30 days. Services not able to be or not rendered in this time must have an update in IW claim notes as to the rationale for the delayed service delivery. Services that run continuously over a longer timeframe (such as facility placement) should not be approved for more than six months maximum.

15) Approval of C-9s submitted by a PT or OT shall be valid for no longer than 30 days unless the approval specifies a longer period and such longer period is supported by the prescription accompanying the C-9.

16) The MCO must check the enrollment status and provider type of the servicing provider before services are rendered (unless the C-9 is retro) to confirm the provider's eligibility for payment for the services to be rendered. If the provider is not eligible to render or receive payment for the services, the MCO must assist the IW to find an eligible servicing provider. Failure to confirm servicing provider eligibility for payment may subject the MCO to recovery for any inappropriately approved services.

A medical service request will be considered approved and the provider may initiate treatments when all of these criteria are met:

- The MCO fails to communicate a decision to the physician within three business days of receipt of an original medical services request or five business days if the request was pended;
- The physician has documented the medical services request completely and correctly on a C-9 or other acceptable document;
- The physician has proof of submission to the appropriate MCO;
- Medical services are for the allowed conditions;
- The claim is in a payable status.

In instances when a C-9 is not responded to within three business days and the provider initiates treatment, the MCO will provide concurrent and retrospective review of that treatment.

If it is found before, after or during delivery, that any approved medical treatment reimbursement request is not medically indicated or necessary, is not producing the desired outcomes, or the injured worker is not responding, the MCO will notify the parties of its decision to discontinue payment of approved treatment that has not already been rendered. Only charges for treatments already rendered will be paid. If the provider, IW, or employer wish to dispute the decision, they may do so via the ADR process.

The MCOs may dismiss without prejudice a C-9 when:

1) there is no evidence that the provider has seen and examined the injured worker within the previous 30 days from the date of the C-9 submission, unless there is proof that the injured worker requested a visit with the provider;
2) the C-9 is submitted from a provider in state and out of state who is not enrolled with BWC and who refuses to become enrolled, or who is enrolled but not BWC-certified and is not eligible under any of the exceptions for payment as a non-certified provider (emergency care, "grandfathered" pre-HPP physicians of record, inadequate number of BWC-certified providers available);

3) there is no supporting medical evidence for inactive claims or the medical evidence is dated more than sixty days prior to the date of the request (refer to Requesting a Claim Reactivation in chapter 2);
4) the C-9 is a duplicate and is not accompanied by evidence of new or changed circumstances impacting treatment, and such evidence is not provided to the MCO upon request via C-9A or equivalent;
5) the C-9 is on a claim for an employer participating in the $15,000 Medical-only Program;
6) Claim is settled medical or medical and indemnity, and the dates of service requested are on or after the effective date of the settlement;
7) The underlying claim has been disallowed or dismissed in its entirety, or the only allowances in the underlying claim are for substantial aggravation of a pre-existing condition, and the conditions have been determined in a final administrative or judicial determination to be in a non-payable status;
8) The services or supplies being requested are never covered by the bureau pursuant to other bureau statutes or rules;
9) The MCO has requested supporting medical documentation from the provider necessary to the MCO's evaluation and determination, via C-9A or equivalent, and such documentation is not provided to the MCO.

The injured worker, injured worker representative, BWC, and the provider shall be notified when a C-9 is dismissed without prejudice for the aforementioned reasons (only the provider and employer need to be notified for a dismissed C-9 in the $15K program), however, the MCO shall not include appeal language in this notification as the C-9 will not be appealable through the ADR process.

MCOs shall fax signed C-9s, along with all supporting medical evidence that was not attached to the C-9 (i.e. IMEs, peer review), to the designated numbers for each service office. Since medical documentation will be rolling from the MCO's provider fax line into the Medical Repository, MCOs are not required to re-fax the medical attached to a C-9 to the service offices. The medical documentation will already be indexed waiting for the arrival of the MCO's C-9.

If the MCO receives a C-9 requesting treatment by a provider with a lapsed certification, the MCO shall process the C-9 based on the Miller criteria. The MCO shall contact the provider and the injured worker to educate them on the situation and may use the following disclaimer language on the C-9 **"Provider certification status has lapsed. Approval of this treatment does not guarantee bill payment. For information regarding becoming recertified contact 1-800-OHIO-BWC option 0-3-0."**

b. Medical service request for a condition not allowed in the claim

If an MCO receives a request for consideration of an issue relating to the delivery of medical services for a condition or part of the body that is not allowed in the claim, the MCO may use a disclaimer (see 7c. Standardized Prior Authorization – Disclaimers) if the condition is being adjudicated and the requested treatment is

medically necessary and appropriate for the requested condition(s), or the MCO may deny the request for the reason that the condition or part of the body is not allowed in the claim. The MCO may not ask the provider to withdraw the C9. The MCO must check V3 on the date of the C9 decision and base its decision to approve/deny on what is allowed in V3.

The provider may recommend an additional allowance on the C-9 with supporting medical evidence, or the injured worker may file a motion (C-86) requesting an additional allowance. The MCO is responsible for reviewing the medical information in the claim, obtaining additional medical information as needed and documenting whether the medical information available in the claim supports the existence of the additional condition requested on the C-9. The bureau will review the recommendation or motion and will consider the additional allowance. Once the condition(s)/ICD-9 code(s) are updated to an "allowed" status (see chapter 2 - Proactive Allowance), the Notification of Injury/Claim Status Changes letter is systematically sent to the provider of record/treating physicians and the parties in the claim. The CST will notify the MCO of the final decision by telephone or e-mail. This will provide immediate feedback to MCO, so it can move forward with issuing decisions on the treatment plan request. The MCO shall assist the employer in understanding available medical information as necessary.

c. Retroactive medical service request

The MCO shall authorize, deny, or pend a provider's proposed ***retroactive*** medical service request (submitted on a C-9 or other appropriate form) within **thirty (30) calendar days** from the MCO's medical service request receipt date. However, when processing a C-9, or other appropriate form, that includes **retroactive** and **future treatment request(s)** the MCO shall follow the standard **3 business** day time frame authorization requirements for each treatment request. This would include the ability to pend for additional medical documentation/review if necessary.

d. Provider compliance for BWC's prior authorization policy

On April 1, 2005, MCOs began notifying physicians who failed to comply with prior authorization policies and procedures. Per Rule 4123-6-02.3 (D)(8), BWC-certified providers have agreed to "*practice in a managed care environment and adhere to MCO and bureau administrative procedures and requirements concerning provider compliance, outcome measurement data, peer review, quality assurance, utilization review, bill submission, and dispute resolution."* Failure to do so can negate the MCO's ability to work with the physician to effectively manage the injured worker's claim.

Providers received a standardized provider non-compliance education letter from the MCO each time a *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) or physician generated document is received after the treatment or service has been

provided. This notice was revised in May 2007 and was required to be utilized in June 2007. The standardized letter (distributed to all MCOs) must:

- Be personalized to the specific physician requesting the C9;
- Have a copy of the retro C-9 or written request for medical;
- Provide a specific MCO provider relations representative as the main contact for information;
- Include rationale explaining validation and why provider did not meet 'just cause';
- Image into provider claim via service office fax numbers

MCOs are no longer required to send educational letters to providers who have submitted retro C-9s after the treatment or service has been provided without "just cause"; however, the MCOs are still to keep track of such providers as set forth below. "Just cause" reasons may include, but are not limited to:

- Emergency treatment;
- Provider not aware that services were for a workers' compensation claim;
- Provider non BWC certified and no established relationship with the IW;
- Provider recently became BWC certified (within last 6 months);
- Pending additional allowances with BWC or Industrial Commission;
- Pending claim allowance with the BWC or Industrial Commission;
- Treatment provided was within the presumptive authorization guidelines;
- Treatment provided does not require prior authorization;
- Other (provider provided other documented justification for just cause)

Each MCO will maintain information on each provider that is non-compliant with BWC's prior authorization policy. The MCO must submit the information monthly on the BWC portal via the Compliance Referral list.

Complete directions for reporting non-compliance are available to all MCOs on the Portal, MCO Home Page, under Shared documents , Provider Non-compliance monitoring . All medical documentation non- compliance should be reported utilizing the process in Chapter 6, of the MPRG.

e. Guidelines to address withdrawn medical service request

To address those situations when a requesting physician indicates that the C-9 request is no longer valid and would like it to be withdrawn or disregarded, the MCO shall:

- Respond to the C-9 request by noting at the bottom of the C-9 that the request has been withdrawn and noting reason,
- Contact the requesting physician's office and indicate date;
- Sign and date the C-9;
- Document all discussion in notes;

- Fax the C-9 to the provider and BWC.
- Send notification letter to the injured worker as well explaining that the requested treatment has been withdrawn and document in notes.

An example of a C-9 withdrawal may be when the MCO receives a C-9 for a surgery request and then the IW notifies the MCO that either they do not want to proceed with the surgery or they want to get a second opinion. The MCO then calls the POR to discuss, indicates the IW's concerns and the POR states to disregard the request and will request again if needed later.

Another example might be if a POR requested a tens unit and/or supplies based on a request from an ancillary provider and later learns, after follow up from the MCO to obtain supporting medical documentation to determine that validity of the request, that the request was unwarranted because the IW has an older claim and is not currently receiving supplies for the tens unit.

f. C-9s for Specialists Consultations

Although most consults do not require authorization, many specialists are not comfortable scheduling and performing consultations without an authorized C9. While PORs, BWC and the MCOs have attempted to educate the specialists, many will not accept the IW if the "approved" box is not checked the on the C-9.

Therefore, MCOs should check the appropriate box (approve or deny) on the C-9 for these consultations to ensure appropriate services are rendered to the injured worker.

This will not change the way the MCO will use the disclaimer when the claim/**condition** is not yet allowed (see standardized prior authorization - section C). It is only checking the approved box for the consultation with the disclaimer as appropriate.

g. Approval of direct service provider only:

Rule 4123-6-02(B) **Provider Access to the HPP – generally** notes the following: A provider shall be certified or recertified by the bureau to treat injured workers **if the provider is a direct service provider** and maintains basic credentialing criteria under Rule 4123-6-02.2 of the Administrative Code; meets and maintains all other applicable criteria under the workers' compensation statutes and rules; and completes and signs a provider application and agreement or recertification application and agreement.

Therefore, the MCO shall authorize services to be rendered by a BWC certified provider type eligible for reimbursement of that service requested. Service Coordinators are not eligible to enroll or provide services to BWC's injured workers.

6. Requests and Authorizations for Mental Health Services

a. Authorization

Information used to support requests and authorization for mental health services can be submitted on the C-9 form.

Important: Ohio law protects the confidentiality of the mental health providers' progress notes; therefore, MCOs cannot request copies of this document. Requests for copies of the progress notes with the deletion of any non-claim related information is also prohibited. However, a detailed summary of the notes can be requested, which can be used to support the C-9. Authorizations are to be granted for either a specific number of sessions or period of time. **MCOs are prohibited from authorizing "continuous" or "indefinite" mental health treatment.** Once the authorized limits have been reached, a new C-9, accompanied by a detailed summary, must be resubmitted to the MCO for re-evaluation of the treatment.

b. Psychiatric/Psychological Evaluation

If the psychiatric condition is allowed in the claim, an IW may be reimbursed for the cost of the psychiatric/psychological exam if it was needed to obtain medical evidence to support the allowance. Payment for psychiatric/psychological evaluation and/or treatment may be considered, on a case by case basis, if one or more of the following applies:

- A psychiatric/psychological condition is allowed in the claim;
- A psychiatric/psychological exam is scheduled by BWC;
- A psychiatric/psychological condition is subsequently added to the claim when the injured worker or provider absorbed the cost of an examination performed to provide evidence to support the motion.
- An injured worker is participating in an approved vocational rehabilitation or catastrophic treatment plan;
- The evaluation is either part of an authorized pre-admission evaluation for an approved chronic pain program or the injured worker is participating in an authorized chronic pain program;
- The evaluation/treatment is either part of an authorized detoxification or substance abuse program.

7. Standardized Prior Authorization

a. Presumptive Approval

For dates of injury on or after Nov. 1, 2002 presumptive approval to provide services will be extended from the first 45 days following an injury to the first 60 days following an injury. The MCO shall adhere to the following standardized prior authorization and presumptive approval guidelines.

For a period not to exceed 60 days following the date of injury, physicians of record, or other approved providers licensed to practice medicine, osteopathy, chiropractic, mechanotherapy, dentistry, or nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife or certified nurse practitioner as applicable have presumptive approval for providing the following services when treating soft tissue and musculoskeletal injuries for allowed conditions in allowed claims:

- A maximum of 12 physical medicine visits per injured worker claim which may include any combination of osteopathic manipulative treatment, chiropractic manipulative treatment, and physical medicine and rehabilitation services performed by a provider whose scope of practice includes these procedures, including, but not limited to, doctor of chiropractic, doctor of osteopathic medicine, doctor of allopathic medicine (MD), physical therapist, occupational therapist, athletic trainer, or massage therapist. NOTE: BWC's position is the maximum time allowable per visit for therapy services should be no more than one hour without prior authorization. If services are over one hour per day, further medical review and approval must occur unless such services received prior authorization.
- A maximum of 12 physical therapy treatments within sixty days following the date of injury may be reimbursed without prior authorization. The treatments must be for allowed soft tissue and musculoskeletal conditions in allowed claims, and even though prior authorization is not required, the criteria set forth in paragraphs (B)(1) to (B)(3) of Rule 4123-6-16.2 of the Administrative Code (the *Miller* criteria) must still be met for the treatments to be reimbursed.
- Diagnostic studies, including x-rays, CAT scans, MRI scans and EMG/NCV
- Up to three soft tissue or joint injections involving the joints of the extremities (shoulder including acromioclavicular, elbow, wrist, finger, hip, knee, ankle and foot including toes) and up to three trigger point injections. Injections of the paraspinal region, including epidural injections, facet injections, and sacroiliac injections are not included in the presumptive approval guidelines.
- E/M services and consultation services.

The following criteria must be met prior to initiating any or all of the aforementioned services:

- The provider shall file the First Report of Injury (FROI) with the MCO.
- The provider shall complete and file the C-9, with documentation, to the MCO.
- The MCO will notify the provider within three business days acknowledging receipt of the C-9 and that a review was completed to ensure that services being rendered are medically necessary for the claim allowance. **NOTE: The MCO shall not deny reimbursement for presumptive approval services solely on the grounds that the provider did not file the C-9 prior to delivering the services. The MCO will contact the provider and explain that the C-9 is necessary in order that a review can be completed to ensure that services rendered were medically necessary for the claim allowance.**
- When the claim or condition for which treatment is being requested is not yet in an allowed status, the MCO-may use the disclaimer language when notifying the provider (within three business days) that the MCO received the C-9 and a review was completed to ensure that services being rendered are medically necessary for the claim allowance.
- The provider shall notify the MCO within 24 hours of treatment if the injured worker will be off work for more than 2 calendar days

b. Standardized Prior Authorization Table

Important: Services listed in the standardized prior authorization table in Chapter 1 of the BWC Provider Billing and Reimbursement Manual and not indicated as exceptions will still require prior authorization. Providers must submit a C-9 to indicate services to be provided through formal authorization. Requests for medical services that require prior authorization must be submitted by the physician of record or treating physician. Provider types whose signature must appear on the C-9 treatment request include all POR provider types (MD, DO, DC, DDS, DMT, DPM, and Psychologist), optometrist, advanced practice nurse, physician assistant, independent social worker, and professional clinical counselor. Treatment requests from any other provider type should not be processed.

Whether or not prior authorization is required, BWC will only reimburse for services that meet all Miller Criteria.

Chapter 1 of the BWC Provider Billing and Reimbursement Manual may be accessed on BWC's website via the following link:

http://www.ohiobwc.com/provider/services/agreement.asp

The following EOBs were developed to provide an explanation to providers for bills for services rendered under Presumptive and Standardized Prior Authorization guidelines and were denied:

560 Payment is denied as documentation has not been received by MCO for presumptive authorization to apply.

561 Payment is denied as prior authorization is required for epidural injections.

562 Payment is denied as these physical medicine/OMT/CMT services/visits exceed 12 in the initial 60 days and have not been authorized.

563 Payment for this procedure is denied as prior authorization is required for more than three injections in the claim's initial 60 days.

564 Payment is denied as these physical medicine/OMT/CMT services exceed the initial 60 day time frame.

565 Payment is denied as prior authorization is required for psychiatric &/or chronic pain programs.

566 Payment is denied as prior authorization is required as the diagnostic test exceeds the claims initial 60 day time frame.

c. Disclaimers

Disclaimers may only be used on a C-9, or any other physician generated treatment request, when the claim or the condition for which the treatment is being requested is not yet in an allowed status. Disclaimer boxes shall not be checked when authorizing treatment for allowed claims and conditions that are within the statute of limitations. The following disclaimer language is part of the C-9 form:

"This medical payment authorization is based upon a claim or additional condition that is currently being adjudicated by BWC/IC as of the date of the

MCO's signature. If the claim or additional condition is ultimately disallowed, the services /supplies to which this medical payment authorization applies may not be covered by BWC and may be the responsibility of the injured worker."

Note: For services that fall under the Presumptive Authorization guidelines, MCO's may use the disclaimer language when notifying the provider (within three business days) that the MCO received the C-9 and a review was completed to ensure that services being rendered are medically necessary for the claim allowance.

The following grid was designed to assist MCOs with appropriate treatment request disclaimer application:

EDI Claim/Condition Status	**Definition**	**Disclaimer**		
		Yes	**No**	**Comment**
NC = NEW CLAIM	Claims are automatically placed in this status immediately after the claim number is assigned	Yes		
AG = ALLEGED	Claim is pending a decision during the investigation process	Yes		
AA = ALLOW/APPEAL	The claim has been allowed by BWC Order and is being held for the appeal period	Yes		
AL = ALLOW	The claim is allowed. The appeal period is expired and no appeals were filed		NO	
DP = DISALLOWED/APPEAL	The claim has been disallowed by BWC Order and is being held for the appeal period	Yes		
DA = DISALLOWED	The claim is disallowed. The appeal period is expired and no appeals were filed.			Not applicable
HR = HEARING	The claim is being set for hearing due to the filing of an appeal. This is only applicable to the initial decision	Yes		
HD = HEARING - DHO	District Hearing Officer has allowed the claim and is being held for the expiration of the appeal period.	Yes		
DS = DISMISSED	Claim application has been dismissed at the request of the injured worker.			Not applicable

PM = PENDING SETTLE MEDICAL ONLY	Claim is pending settlement for medical only portion.			Treatment cannot be authorized when a claim is in a pending settled status
PI = PENDING SETTLE INDEMNITY	Claim is pending settlement for indemnity only portion.			Treatment cannot be authorized when a claim is in a pending settled status
PB = PENDING SETTLE MEDICAL & INDEMNITY	Entire claim is pending settlement.			Treatment cannot be authorized when a claim is in a pending settled status
SM = SETTLED MEDICAL ONLY	Only the medical portion of the claim has been settled. Indemnity can continue to pay.			Not applicable
SI = SETTLED INDEMNITY ONLY	Only the compensation portion of the claim has been settled. Medical bills can continue to pay.		NO	
ST = SETTLED MEDICAL & INDEMNITY	The entire claim has been settled. Neither medical bills nor compensation can be paid.			Not applicable

8. Due Process

Treatment reimbursement decisions shall be communicated in writing, with an appropriate explanation (including appropriate references to treatment guidelines in all treatment reimbursement denials) and due process appeal language, within three (3) business days from the MCO's treatment reimbursement request receipt date as follows:

- All treatment reimbursement decisions shall be sent to the Bureau and the provider;
- Treatment reimbursement denials shall also be provided to the injured worker and his or her representative, if any;

Treatment reimbursement approvals, including those approved via the alternative dispute resolution (ADR) process, shall also be provided to the injured worker and his or her representative, if any, and to the employer and its representative, if any, unless the employer or representative has waived, in writing, its right to receive notice or the employer is in a status other than Active, Reinstate, or Debtor in Possession. The notification to the injured work and his or her representative shall include a clear explanation of what treatment was approved for reimbursement, as well as any time frame allotted for completion for the treatment.

In cases where an injured worker or employer representative has been identified to the MCO, the MCO must confirm such representation in the claim via EDA or with the CCT,

and copy the representative(s). Additionally, in all instances where an MCO decision is to deny authorization for services, such denial must be accompanied by clearly documented rationale and supporting medical evidence (physician review) justifying such denial.

For BWC auditing purposes, a note in the IW electronic file is not acceptable as proof that a treatment reimbursement decision was faxed to all parties. A fax verification sheet that includes at a minimum: the recipients fax number, date transmitted and quantity of pages successfully transmitted is acceptable. Electronic signatures are acceptable, however, typing someone's name and using a specific font type to provide an appearance of being a handwritten signature is not acceptable. Handwritten signatures on paper are always acceptable.

a. Provider Numbers on a C-9

BWC sometimes assigns a servicing provider number to an individual provider based on his/her social security number with a two digit (-00) suffix. The MCO shall validate the certification status and provider type of a provider prior to approving care based upon the servicing provider number on the C-9. While the requesting provider must be clearly identified on the C-9 form, the individual servicing provider number is not required on the C-9The MCO shall work with the provider or injured worker to identify and validate the certification status and provider type of the servicing provider. The MCO may pend the C9 if necessary to obtain any additional necessary information.

Although the provider file data is public information, the individual provider's social security number is not public information. All provider numbers should never be sent to injured workers, employers, and/or their authorized representatives. In response to the concern generated by the provider community that injured workers, employers, and their representatives are being given access to their social security number on the C-9, the MCO is required to black out all the provider numbers on copies of the C-9 sent to those parties.

In addition, because a C-9 responded to by the MCOs and sent to BWC is captured in the claim document repository and parties to the claim can view this document, the MCOs are required to black out all provider numbers on the C-9 **prior** to submitting it to BWC.

9. Physician's Report of Work Ability (MEDCO-14)

The Physician's Report of Work Ability (MEDCO-14) is a combination of return to work information and recommendation for compensation. The Request for Temporary Total Compensation (C-84) is most often used to report that an injured worker is still temporarily totally disabled from work due to the injury. However, the Physician's Report of Work Ability (MEDCO-14) may also be used to extend compensation

The physician of record (POR) or treating physician must complete this standard form at every visit when the injured worker has been placed under work restrictions or when the injured worker is temporarily totally disabled. It is similar to forms used by MCO or

physician offices and will provide a permanent record for the physician's file. The two-part form allows injured workers to receive a copy for their records. By faxing a copy to the MCO, employers will be able to be informed of work restrictions and explore work site adaptations/modifications.

By obtaining the MEDCO-14 form, the MCO will reduce the need for phone calls requesting information from several parties regarding the IW's RTW progress along with providing important information to the injured worker regarding their recovery and work limitations. Injured workers will have immediate information that can be shared with their direct supervisor when returning to the job. In addition, employers will be informed and see the progress of all injured workers from the beginning of treatment until they are back on the job and will be able to assist in successful return to work practices.

As is the case with the C-9, any physician-generated document may be used instead of the MEDCO-14, if the substitute document contains, at a minimum, the data elements on the MEDCO-14.

C. CHANGE OF PHYSICIAN

The MCO is responsible for notifying all parties to the claim of any physician of record (POR) changes. The POR is the attending or authorized physician chosen by the injured worker to direct treatment.

1. Eligible Providers

Providers eligible to be a POR include:
- Doctor of Medicine;
- Doctor of Osteopathic Medicine or Surgery;
- Doctor of Podiatric Medicine;
- Doctor of Chiropractic;
- Doctor of Mechanotherapy;
- Doctor of Psychology;
- Doctor of Dental Medicine or Surgery

2. Selection of a POR

The injured worker may select as physician of record (POR) an eligible provider who is a:
- BWC-certified provider
- MCO panel provider
- Non-bureau certified provider, subject to the injured worker's payment responsibilities. **NOTE: Injured workers with dates of injury prior to Oct. 20, 1993, may retain, without assuming payment responsibilities, a non-certified provider as a POR if such a relationship already exists. If the IW decides to change physicians, a BWC-certified provider must be selected or the IW will be responsible for payment.**

At the time of an injury, the injured worker may seek medical care directly from a provider or may seek assistance from the MCO. If the injured worker has not already

sought medical care or selected a provider, the MCO may refer the injured worker to a provider. The MCO shall inform the injured worker that he/she may select any specialty of provider. The MCO shall ask if the injured worker has any preference as to the specialty of provider and shall make any referrals accordingly. The MCO shall not discriminate against any category of health care provider when referring the injured worker to a provider. The injured worker may, however is not required to, seek medical care from the referring provider.

The MCO may not dispute an injured worker's selection of a POR nor shall the MCO deny an IW's request for change of POR to a non-BWC certified provider. However, if an IW requests a change of POR to a non-BWC certified provider, the MCO must clearly communicate to the IW at the time of the request that the IW will be responsible for payment and will have no recourse against the MCO, BWC, or the employer.

The MCO may not dispute an injured worker's selection of a specific facility or provider as indicated by their signature along with the POR referral. This instruction is based upon **Rule 4123-6-062 Employee access to the HPP; employee choice of provider**, which allows an injured worker to select a BWC certified provider.

An injured worker may only have one POR at any given time. In claims where more than one physician treats the injured worker, there still can only be one recognized POR. To change the POR, an injured worker must notify the MCO in writing. The notification must include the name and address of new physician and the reason for requested change. The injured worker also must sign the document.

For claims initially filed with the MCO and belonging to employers assigned to the MCO, the MCO shall submit the POR to BWC via 148 within seven (7) Business Days of the MCO's receipt of notification of the injury or within three (3) Business Days of the MCO's receipt of information identifying the POR, whichever is later.

For claims initially filed with BWC or with another MCO, the MCO shall submit the POR to BWC via subsequent 148 submissions within seven (7) Business Days of the MCO's receipt of the claim from BWC or within three (3) Business Days of the MCO's receipt of information identifying the POR, whichever is later.

The MCO shall notify BWC via subsequent 148 of any change in POR within three (3) Business Days of the MCO's receipt of notification of the change.

The POR must be an individual and not a group practice. When the MCO authorizes a POR and transmits the data to BWC, the POR should be indicated by her/his individual Provider ID number and not the group practice number. The CSS can update change of POR on V3 however he/she will not process the request. This must be done by the MCO.

Note: The POR is the attending or authorized physician chosen by the injured worker to direct treatment. The POR is an individual BWC certified provider who is a Doctor of Medicine (provider type 67); Doctor of Osteopathic Medicine or Surgery (provider type

66); Doctor of Podiatric Medicine (provider type 70); Doctor of Chiropractic (provider type 9); Doctor of Mechanotherapy (provider type 38); Doctor of Psychology (provider type 72); or Doctor of Dental Medicine or Surgery (provider type 15). The individual provider, who meets the criteria for one of these provider types, with an individual BWC provider number, may be considered the POR. Hospitals and groups do not meet this definition. If an injured worker presents for emergency treatment and does not designate the individual physician provider who treated him or her as a POR, then that provider is not the POR. The MCO will include that provider's information in the treating physician section of the FROI and leave the POR field blank. The POR field is an expected field on the FROI; however, it is not mandatory. Hospitals or facilities should never be entered in the POR field.

D. MCO MEDICAL CASE MANAGEMENT PROGRAM, PROCESS AND PERFORMANCE REQUIREMENTS

Medical case management is an essential component in effecting a successful claim outcome. Because the MCO's share claim operations duties with BWC, it is essential that the role, responsibilities and activities of the MCO's be clearly defined so that each will be able to interact effectively to reach optimal results.

1. Requirements for MCO URAC Accreditation and Reaccreditation

The MCO's are responsible for maintaining full unqualified accreditation status for their case management programs throughout the term of their contract with BWC. It is the decision of the MCO as to whether the 2 year or 3 year accreditation option is elected. However, the 2 year option should not be selected for the sole purpose of avoiding the random audit pool. BWC reserves the right to require an additional audit at the MCO's expense if there are concerns with the MCO's case management accreditation status or its case management processes.

Unless otherwise specified, references to URAC CM Standards below are to the URAC Version 3.0 standards. BWC recognizes that some MCOs may be accredited under the URAC Version 3.1 or 4.0 CM standards, which may differ slightly. Each MCO must comply with the version of the URAC CM standards the MCO's accreditation is based on.

a. Costs

The MCO is responsible for all costs associated with maintaining full accreditation and reaccreditation. The MCO is required to submit URAC documentation or correspondence regarding any accreditation change to the MCO Business Unit, Managed Care Operations of the BWC within two (2) days of receipt. The MCO must also submit copies of all reaccreditation status letters to BWC. In some instances, the BWC has defined specific service criteria in certain categories of case management program components which are also addressed in the URAC program. These categories are identified in the service specifications that follow. They are intended to define the Ohio BWC service expectations in relation to the URAC provisions.

b. Subcontracted Case Management Programs
MCO's who subcontract their case management programs must do so only to an MCO with an accredited case management program. In addition, the MCO must be accredited by URAC in their Core Standards.

c. BWC /URAC Interface
BWC and URAC reserve the right to exchange information that is pertinent to the MCO's accreditation or to BWC's regulatory authority.

2. Definition of Medical Case Management
URAC (Version 3.0) defines Case Management as: "A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a consumer's health needs through communication and available resources to promote quality cost-effective outcomes."

URAC (Version 4.0) defines Case Management as: "A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes."

Within the Ohio workers' compensation program, this process 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.

By definition, then, it requires multidisciplinary skill sets that enable the practitioner to assess the impact of injuries, the psychosocial implications of threat to the income stream, the features of the health service delivery system, medical treatment regimens, disease management protocols, and realities of the workplace. Its core requirements are assessment, planning and communication. Its target objectives are the right treatment at the right time at the right cost in the right delivery method all aimed at the ultimate goal of safe and timely return to work if at all possible.

3. Case Management Criteria (URAC Standard CM 14)
URAC addresses this topic with the question, "What prompts the case management process to begin?" Their standard recognizes the contractual basis for customer specification of case management activity. To that end, the BWC criteria for MCO medical case management have been designed as follows.

Because the need for medical case management is a function of the relative risk of the individual, the assignment of active, ongoing medical case management by a professional nurse case manager is often a decision making process dependent on such case elements as severity, complexity, or opportunity as well as duration of disability. In order to promote consistency throughout the system, selection criteria have been established to provide a minimum standard of service for both triage as well as mandatory follow-up.

Guiding principles:
►*Referral for medical case management consideration will be initiated for those cases in which:*

- *the duration of disability is equal to or greater than 14 days*
- *the injured worker remains out of work*
- *the injured worker is at increased risk for delayed or incomplete recovery or compromised return to work.*
- *the medical expenses or utilization patterns are in excess of normal expected values*

►*All cases in which the duration of disability is equal to or greater than 21 days will be managed by a medical case manager unless criteria established for exclusion are met (See Chapter 3 Section D- 8)*
►*All catastrophic cases will be managed by a MCO catastrophic nurse case manager in collaboration with the BWC CAT nurse.*

a. Medical Triage Requirements

All the following claims or diagnostic categories *must* be referred to a nurse or clinician as defined in Appendix G *no* later than the close of the next Business Day following the date on which the claim meets such criteria for initial assessment/triage and consideration of Medical Case Manager assignment.

- All lost time claims with a disability period of 14 calendar days with lost time continuing unless this initial assessment has already been performed by a nurse or clinician
- All surgical cases
- This clinical assessment must be based on the information developed through completion of the 3-point contact by a nurse or non-clinician within five (5) business days of receipt of the case through initial intake or referral from the claim processing area. In accordance with URAC requirements, some basic data collection elements gathered by non-clinical support staff may be utilized. However, this does not eliminate the need for completion of the 3-point contact review by the nurse or clinician as addressed in URAC Standard CM18 (Version 3.0).
- The decision to assign the case to the medical case manager or not must be based on risk factors (e.g., RTW estimated date >50th percentile of MoD Days Absent, age, occupation/job requirements, co-morbidities, medical treatment plan, psychosocial factors, etc.)
- If the case is assigned to a Medical Case Manager following the case management referral assessment, the Medical Case Manager may use the services of non-clinical support staff for certain monitoring functions in accordance with URAC standards. (For example non-clinical support staff can document verification of appointment attendance, return to work on the date expected. The non-clinical support staff will provide the information to the medical case manager without any independent assessment of clinical status or response to treatment.) However, the initial care plan with targeted RTW date and summary of approved plan of

care must be completed by the nurse case manager and documented in the case management system and BWC V-3 system. Updates to the care plan must be made by the nurse case manager.

- If the claim is not assigned to the medical case manager for management, the rationale for making the assignment to other than the medical case manager must be documented in the medical case management notes.
- Utilization management services shall be provided for any cases which are not assigned to a medical case manager. (This includes any cases which meet case management discharge criteria, are closed to case management, but eligible for workers' compensation benefit consideration.)
- Case assignment and contact person must be sent to the BWC CSS in the Case Management Plan

b. Mandatory Medical Case Management Assignment

The following diagnostic categories *must* be assigned to and case managed by a medical case manager no later than the close of the next Business Day following the date on which the claim meets such criteria for referral excluding those claims which satisfy the discharge criteria presented in chapter 3, section D-8 of this manual:

► All lost time claims with a disability period of 21 calendar days or greater with lost time continuing

►All Catastrophic claims* ►Amputations

►Brain Injuries (Traumatic or Anoxic) ►Spinal Cord Injuries

►Eye injuries requiring hospitalization

►All claims with request for inpatient hospitalization

► All claims with psychiatric disorders allowed requiring hospitalization

►Claims with pre-existing or non-related significant co-morbidities (such as diabetes, heart disease, mental health disorders, etc.) which negatively impact the disability duration

***See Section G1 of this Chapter "Catastrophic claims" for the definition of catastrophic claims.**

4. The Case Management Coalition

Because the work process of the medical case manager is essentially that of coordinator, communication is central to effective practice. The three parties that have the most power to determine the outcome of every claim are the injured worker, the employer and the medical provider. These are the central contacts for the medical case management process, and, therefore, the mandatory contacts for the initial assessment. Attempts to contact the parties must be documented on the assessment form and/or MCO notes.

In addition, since the BWC shares responsibility for successful management of the claim, the Agency presents important communication linkages. These include: the Claim Service Specialist (CSS), Medical Service Specialists (MSS), CAT nurses, Medical Claim Specialist (MCS/Med only claims) and Disability Management Coordinator (DMC).

Other sources, such as family members, specialty providers, community agencies, etc. should be included as they emerge and are identified in the case.

5. Early Injury Assistance (EIA) Support Materials

As part of the data gathering process and as soon as practical, the MCO shall collect and supply to BWC relevant information to assist the BWC in determining whether to send EIA support materials to the IW. For all Lost Time claims, the MCO shall send a note titled EIA Support Materials (or equivalent) with one of the below numeric values indicating how the IW appears to feel about their injury. If the MCO determines, when a claim changes over from Medical Only to Lost Time or at any time in the life cycle of the claim, that the IW's situation has changed and that receipt of the support materials would improve the outcome for the IW, the MCO shall also send the EIA Support Material note. BWC will send out support materials as appropriate based on the numeric value in the note.

- Number 1. My injury has caused such a major upset, I'm worried it may take a long time to get back on my feet – if ever.
- Number 2. This is a really hard time for me; but I am trying to hang on.
- Number 3. This is a challenge but I'm actually coping pretty well with it.
- Number 4. I'm pretty much OK now, but still dealing with minor inconveniences.
- Number 5. I'm back to normal, working, and everything's fine.

If the numeric value is 1, 2, or 3, the MCO shall determine how the IW feels about the (workers' compensation) insurance process (forms, letters, mailings, claim allowance, medical treatment approval process, etc.) and include one of the following designations in the same note:

- VS – very satisfied
- S – satisfied
- OK – okay
- DS – dissatisfied
- VD – very dissatisfied

Below is the recommended script for determining this information; however, the MCO is not required to use the script.

"[IW NAME] I'd like to know how you are doing overall. I'm going to read you a list of 5 different descriptions of how you might be feeling these days. Pick the one that fits your situation the best. I'll read them all first, and then you choose one.

Number 1. My injury has caused such a major upset, I'm worried it may take a long time to get back on my feet – if ever.
Number 2. This is a really hard time for me; but I am trying to hang on.
Number 3. This is a challenge but I'm actually coping pretty well with it.
Number 4. I'm pretty much OK now, but still dealing with minor inconveniences.
Number 5. I'm back to normal, working, and everything's fine.

Which one describes your situation the best?" *{Wait for response and repeat list of answers as needed}*

Follow-up question if the IW answered 1, 2, or 3 to the initial question:

"Now let's talk about your satisfaction with how things have been going since you were injured. The next question is about the workers' compensation insurance claims process you have experienced so far and is also a multiple choice question. But for this question, I'd like you to tell me how you feel by picking one of the following choices: very satisfied (VS), satisfied (S), OK, dissatisfied (DS), or very dissatisfied (VD). I can repeat the choices whenever you want me to. Just let me know."

"How satisfied have you been with the workers' comp insurance claims process so far – that means the forms you filled out, the letters, mailings, or other information you may have received, and the claim allowance and medical treatment authorization process?" *{Wait for response and repeat list of answers as needed}*

{If injured worker gives a different answer ask for clarification} "You said {*their words}* ……. So does that mean you are VS, S, OK, DS, VD?"

{If the injured worker answers OK, dissatisfied or very dissatisfied request this additional information} "I see. You said [*OK, DS, VDS]*. What happened that made you say that – instead of being "satisfied"? *{Wait for response}* Can you tell me briefly -- what would have made you feel better about it?"

6. Case Management Assessment *(*URAC Standard CM18)

Thorough assessment initially and continually throughout the course of the claim life is essential to the case management process and is the foundation of the case management plan.

a. Initial Assessment

Comprehensive information gathering is the foundation of the initial assessment. Requirements are as follows:

- At minimum, sources include the injured worker, the employer and the treating physician
- It must address:
  - ►Age
  - ►Work requirements
  - ►Injury history
  - ►Co morbidities
  - ►Claim history
  - ►Job environment (Supportive of RTW?)
  - ►Current or proposed treatment regimen description
  - ►Appropriateness of treatment
  - ►IW compliance (If non-compliant, why?)
  - ►Prognosis and expected duration of disability given age, occupation, medical history, and any other pertinent factors – Reference Ohio Specific Disability Duration Guidelines (OSDD) or ODG if OSDD does not include diagnosis

►Injured worker's understanding and expectations of injury, treatment and return to work
►Possible obstacles to return to work
► Safety needs
►Attending physician's understanding of the IW's job requirements and worksite situation

- The initial assessment must be completed within five (5) business days of receipt of the claim by the medical case manager.
- The medical case management file must document contact with the injured worker, employer of record and the physician.

Any circumstances which precluded contact with any of the primary individuals must be documented in the file

b. Return to Work Letter

In order to ensure that return to work expectations are clear to the injured worker, the employer and the physician, the medical case manager will conclude the initial assessment process by estimating a realistic return to work date. The MCO may communicate this target date by correspondence to all parties according to the following selection criteria:

- Claim is in allowed status (regardless of expiration of appeal period)
- Injured worker has lost ≥ 14 calendar days
- Injured worker remains out of work
- Letter will be sent to injured workers of private employers
- Claims assigned to Public Employers can be included at the discretion of the MCO or requested by the PE employer only
- The letter should not be sent to IWs with catastrophic claims

Methodology

- The Primary/Controlling ICD-9 code will drive the determination of expected duration of disability
- The MoD Days Absent benchmarks will be the first order of reference
- If the ICD-9 diagnosis is not present in MoD, then the ODG reference will be used
- The 30th percentile will serve as the reference target date for return to work calculation
- Additional injured worker specific data obtained in the medical assessment will be considered in determining whether the 30th percentile date is reasonable for the specific worker's situation
- These elements include but are not limited to:
- Multiple conditions or co-morbidities
- Age
- Type of employment
- Prognosis for recovery and ability to resume prior duties
- If prognosis is limited, availability of modified or transitional work
- The return to work reference date in a lost time claim should be applied from the date of disability

- If the injured worker has remained at work in advance of a scheduled surgery, after which lost time can be expected, the post-surgical date should be considered
- Letter is addressed to the IW with copies to all parties
    - Employer
    - Physician of Record
    - Legal Representatives (for IW and Employer)
    - BWC
- MCO faxes copy of the letter to BWC Service Office imaging number and enters V-3 note that includes the ICD-9 diagnosis of reference
- Medical Case Management continues to work toward the targeted return to work date

7. Case Management Plan

The case management plan is formed by a compilation of all information that the case manager has gathered from the injured worker, the physician and the employer as well as any other pertinent sources that impact the progress and successful outcome of the claim resolution.

The initial plan must be completed within three (3) business days of completion of initial assessment. (It is noted that there may be occasions wherein the medical case manager is unable to make contact with all three principles to the discussion. In such an instance, a preliminary plan should be established with action steps to reach the missing party included as an element of the plan.)

Goals are the first step in the case management process. These goals should be understood by all members of the team (i.e., case manager, injured worker, Physician, employer, claim staff) and guide development of the interventions selected to achieve them.

The **case management plan** is action oriented and time bound and identifies the intervention(s) and resources to be used in order to assist the injured worker to achieve the goals specified within each phase of the plan. Accountabilities are established within the case management plan so that all participants are aware of their respective responsibilities in meeting the goals

a. Initial Case Management Plan

The following items of information must be provided to the BWC Claim Service Specialist (CSS) on the initial case management plan:

- Name of injured worker
- Claim number
- Name of case manager
- Allowed/alleged diagnosis(es)
- Last date worked
- RTW objective according to hierarchy (including estimated date for RTW)
- Availability of workplace accommodation

- Barriers to treatment
- Barriers to full recovery
- Barriers to return to work
- Documentation of attempts to complete 3-point contact and reason for inability to contact if not completed
- Need for vocational services
- Treatment plan (services and schedules)
- Short term goal including targeted time for achievement (should correlate with case management follow-up contact and reevaluation planned)
- Long term goal including targeted time for achievement
- Action steps planned with specific completion dates, and specific assignment for completion (e.g., case manager will contact employer of record to discuss work restrictions and worksite accommodations by xx/xx/xxxx, employer will review transitional work plan of company by xx/xx/xxxx, etc.)
- Next planned contact

b. Update to the Case Management Plans

The case management plan is a dynamic tool and, as such, it is formed and changed as a result of the progress of the case and the associated ongoing assessment of the case manager. Since the case management plan is injured worker specific, the frequency of the updates is a function of the case management action plan itself and the update intervals determined by planned follow-ups as well as spontaneous events in the life of the claim. The following items of information must be provided to the BWC Claim Service Specialist (CSS) on the updates to the initial case management plan as they occur:

- Changes in medical status
- Prior goals achieved?
- Changes in short term goals
- Changes in long term goals
- Change in estimated RTW and reason
- Changes in treatment plan
- Action steps planned with specific completion dates, and specific assignment for completion

c. Interface with BWC claim operations

The MCO must share the case management plan with the CSS assigned to the claim by faxing a copy of the plan to the imaging fax number of the service office within two (2) business days of completion or revision of the plan. (Note: Addition of the option of entering case management notes into V-3 will be offered when the formatting and case note title requirements have been finalized and fully tested.). Since the case management plan is the foundation for return to work planning, the case manager is encouraged to discuss any case that presents special circumstances or considerations, or, particularly, need interventions from BWC for either the injured worker or the employer.

The plan must be labeled: "[MCO name] Case Management Plan" with Claim number attached so that it will be appropriately indexed into the BWC's system.
NOTE: This document will be available in BWC's website for access by parties to the claim. Therefore, content should reflect respect for sensitive information.

Some MCO's have requested that a standardized plan format be developed and utilized by all MCO's. BWC will support this initiative and will actively participate in the development with the MCO Business Council Quality of Care Subcommittee.

Staffings between the MCO and the BWC presents the ideal situation for collaboration. These staffings may be formal or informal. BWC is encouraged to involve the MCO case manager in formal staffing of claims with higher levels of complexity or risk for extended disability. The MCO is encouraged to initiate formal or informal staffing with the CCT when progress in the claim is compromised or the expected progress is not realized.

d. Thirty (30) Day Assessment
The Disability Management Coordinator will review **all claims** in which the injured worker has not returned to work thirty (30) days beyond the 50th percentile of MoD Days Absent benchmarks.

Return to work barriers will be identified in these claims and, if the barriers appear to be valid, BWC and the MCO will come to mutual agreement about a future course of action.

If the MCO does not follow through with these steps, the BWC Service Office Manager will submit "Thirty (30) Day Assessment Recommendations" to the MCO via e-mail. If BWC and the MCO still cannot arrive at a mutual solution, the MCO may appeal the thirty (30) Day Assessment Recommendations within five (5) working days to the Rehab Administrative Designee e-mail box.

Note: The case management plan may be used to meet the requirements of the MCO's RTW plan which is used to communicate the MCO's plan with respect to the 30 day assessment.

8. Ongoing Evaluation and Management
Timeframes for successive contacts and case updates vary with the circumstances (goals and treatment milestones) of each case. It is the responsibility of the case manager to redate cases for follow-up according to each subsequent assessment of goal achievement or lack thereof. Contacts must match the continuum of care which, in turn must match a reassessment of progress.

Some elements of the ongoing evaluation(s) include:

- Is the IW progressing as expected?
- If progress is not consistent with expectations, why not?
- Are there indications for a change in treatment plan or medical service (e.g., IME, second-opinion, specialist referral)?

At the conclusion of this re-evaluation, the case manager repeats the case management plan process (see **Section 6.2)** and communicates updated information to the BWC CSS. The action plan is updated and the case re dated for the next contact as reflected in the action plan. This process continues until claim resolution.

9. Case Management Discharge Criteria

The criteria for case closure include but are not limited to the following:

- When the goals of successful claim resolution have been achieved
- When the opportunity for further progress is negligible.
- Return to full duty or modified duty (Note: The case should remain open for 30 days following return to work at which time the MCO will contact the IW to assure that he/she is able to maintain this status.)
- Settlement of the medical benefits components of the claim
- Full settlement of the claim
- Death of the injured worker
- The IW has reached MMI status as deemed by the IC or BWC (Ongoing medical management, however, continues under the UM/UR service of the MCO)
- Rehabilitation services are being rendered and the goals of the medical service plan have been achieved. (Ongoing medical management, however, continues under the UM/UR service of the MCO.)
- The claim is disallowed by BWC
- Order of Permanent Total Disability. (Ongoing medical management, however, continues under the UM/UR service of the MCO. Case should be referred back to medical case management if referral criteria are met due to questionable utilization patterns.
- The IW is not longer working due to retirement or disability separation. MMI has been achieved, no compensation is being paid. (Ongoing medical management continues under the UM/UR service of the MCO.)
- Job abandonment; the IW has been released to return to work, compensation has been terminated, and/or the employer or MCO is unable to locate the IW.
- The injured worker refuses participation in the case management process including telephonic contact. However, the claim will remain assigned to the case manager for employer collaboration and medical monitoring services due to a level of acuity or risk factors of the claim. Circumstances must be documented accordingly consistent with URAC requirements for case management definition and interface with BWC claim operations
- Employer and claim is transferred to another MCO
- When the treatment status and return to work status does not require case management services based on the professional judgment of the medical case manager or clinician and the IW's acute overall medical condition is stable and is documented accordingly

The rationale for case management closure must be documented in case management notes and the claim file. Documentation must include any recommendations for continuing claim management by BWC claim operations or MCO UM/UR staff. Case management closure requires that notification be given to the assigned BWC Catastrophic Nurse Advocate on all

catastrophic claims via e-mail, telephonic notice and/or staffing. If the BWC Catastrophic Nurse Advocate does not agree with the decision to close case management, case management closure will be deferred until a time mutually agreed upon by the MCO and the BWC Catastrophic Nurse Advocate. In the unlikely event a mutually agreed time cannot be determined; BWC catastrophic supervisory staffing may be requested to determine CM closure.

E. REMAIN AT WORK PROGRAM

According to Rule 4123-6-19 BWC shall take measures and make expenditures, as it deems necessary, to aid injured workers who have sustained compensable injuries or contracted occupational diseases to remain at work.

1. Remain at Work (RAW) Services

Remain at work is the process of assisting injured workers in maintaining employment and avoiding lost time following an industrial injury. An injured worker's participation in RAW services is voluntary.

2. Eligibility

An injured worker is eligible to participate in a remain-at-work program when:

- The injury results in 7 or less days off work due to the allowed conditions in the claim which is certified by the employer or is allowed pursuant to a bureau or industrial commission order; and,
- It is documented by the employer, the injured worker or physician of record that the injured worker is experiencing problems that are work-related and result from the allowed conditions in the claim. A C9 from the POR or notes in claim file by Managed Care Organization (MCO) documenting contact with the employer, injured worker or POR would fulfill this requirement.

3. Referrals

Anyone can refer an injured worker for RAW services; however, the MCO shall determine the need for services and document those needs in the notes they enter into the claim file and BWC's Web site.

The MCO will gather and assess claim information to determine the type of RAW services appropriate for the claim.

4. Services Provided in a Remain at Work Program and Billing Codes

RAW services include one or any combination of (but not limited to) the following:

- Transitional Work with PT/OT if focused on job progressions and offered on-site (WO637);
- Ergonomic study (W0664);
- Ergonomic implementation (W0513)

- Functional Capacity (CPT code);
- Job analysis (W0645);
- Physical therapy, on-site (CPT Code);
- Occupational therapy, on-site (CPT code);
- Physical reconditioning (W0648);
- Gradual Return to Work (no billing code);
- On the Job Training (OJT) (billing codes for the specific services provided in OJT may be used);
- Job Modification (W0663 when reimbursing provider but not when employer provides the Job Modification);
- Tools and Equipment (W0665); and
- Remain-at-Work Vocational Rehabilitation Case Management (VRCM) (Z codes as listed in Chapter 4, Reimbursable Services, "Vocational Rehabilitation Case Management"). Remain at Work case management services are available but are not required to give it a Remain at Work "status".
- Effective 2-15-10 Providers of the following services: ergonomic study, ergonomic implementation, job analysis and transitional work may be reimbursed for travel and mileage using codes Z3050 RAW service – Other Provider Travel and Z3052 RAW Service – Other Provider Mileage.

Note: Job Club, Job Search/Development and Job Seeking Skills Training Services are not RAW services

5. Billing and RAW services

Although the above services are traditionally associated with Surplus Fund (i.e. "W"codes), if offered as a RAW service, they will be charged to the employer's risk.

The bureau will not reimburse an employer for remain at work services that are provided "out of pocket" by the employer. The MCO is required to advise the employer in writing if resources are available to the organization at no charge such as via the BWC (i.e. ergonomic assessments) or via Opportunities for Ohioans with Disabilities (i.e. job modifications, tools and equipment) prior to "encumbering fees". Written information regarding those services will allow the employer to make informed decisions prior to encumbering fees. The bureau will not reimburse an employer for remain at work services that are provided "out of pocket" by the employer.

If the claim is subsequently disallowed, BWC will not be responsible for the cost of RAW services that were provided.

Note: By Report codes—For vocational rehabilitation services reimbursed by report, the MCO must request a V3 note approving payment from Rehab Policy as there is not a DMC for medical only claims. The request must be sent via password protected email

and include information from the "Vocational Rehabilitation By Report Request " template, found as an appendix of Chapter 4.

6. **RAW and Established Transitional Work Programs**
RAW programs are sometimes easier to provide in an established Transitional Work Program, but a Transitional Work Program does not have to be in place to offer RAW services.

7. **Initiation of Services**
To ensure payment for the services they provide, PT/OT providers should staff all RAW referrals with the MCO before the initiation of services. It cannot be assumed that Presumptive Approval is still available for the particular claim. (See section on Presumptive Approval in Chapter 3). A C-9 must be submitted prior to the implementation of PT/OT services.

Vocational Rehabilitation Case Management (VRCM) services do not require C-9's; however, the MCO must give prior approval before these services are implemented. VRCM should staff the referral with the MCO and at the initiation of the services and periodically to track injured worker's progress.

8. **Remain at Work Services terminate when:**
- A bureau, IC or court order subsequently disallows the claim, or
- Injured worker declines to participate, or
- The claim changes to a lost time claim because the injured worker has missed 8 or more days due to the allowed conditions in the claim. However, in this situation, the injured worker may be referred, if eligible, for surplus funded services under vocational rehabilitation. [Note: if the claim changes to lost time solely due to a % PP award granted pursuant to Ohio Revised Code 4123.57(A), the injured worker may complete those RAW services previously authorized; however, no new services may be authorized]. the lump sum settlement date becomes effective, or
- injured worker successfully maintains employment and no further services are needed.

9. **Initial and Final RAW Report**
Initial RAW Report: The MCO shall enter a note into the claim file that includes the problems the injured worker is experiencing on the job and the RAW services being provided. The MCO shall provide continuous claim monitoring until closure at which time they shall submit a final RAW report.

Final RAW Report: Is due within 5 business days of notification of the completion of RAW services, the MCO must enter a note in the claim file. This note should indicate injured worker's work status, (i.e. released for full duty original job or full duty different job) and the date RAW services were completed.

F. PRIMARY ICD-9-CM (PRIMARY DIAGNOSIS)

Establishment of a primary diagnosis code is necessary for improving the management of claims through the identification of the condition that is driving them.

1. Why are Primary ICD-9 codes required?

Primary ICD-9 codes are required for:

- Effective medical management;
- Reliable management reporting;
- Establishment of accurate reserves.

2. Additional Information

The Primary ICD-9 is:

- Identified for allowed conditions only;
- The cost driver of the claim for medical services/treatment and compensability;
- Injury/condition that is the cause of the injured worker's inability to work;
- The diagnosis that determines medical services/treatment and compensability;
- The most severe injury/condition;
- Dynamic in nature as medical conditions arise.

Only one primary ICD-9 can be identified for all lost-time or medical-only claims. The physician of record and the MCO establish and identify the primary ICD-9. The MCO must identify the initial primary ICD-9 via 148 transmission and notify BWC whenever the primary ICD-9 changes within 2 business days from receipt of changed information.

G. CATASTROPHIC CLAIMS

The Health Partnership Program (HPP) places emphasis on a consistent, cooperative approach to catastrophic case management by MCOs and BWC. Each catastrophic claim is different, which necessitates highly individualized management.

Beginning January 1, 2003, the MCO's designated a catastrophic claim program coordinator, who shall be responsible for directing the MCO's management of catastrophic claims to the MCO.

Qualifications: The catastrophic claim program coordinator shall be a registered nurse and shall meet the qualifications for case manager supervisors as required by URAC standards.

Experience: In addition, the catastrophic claim program coordinator is required to have at least 2 years of previous Ohio MCO case management. Experience in critical care: It is recommended, but not required, that coordinators have experience in critical care, and knowledge of home care, social services and rehab services.

Training: Coordinator must be proficient in the MCO Policy Reference Guide, and will attend all training sessions designated by BWC for the catastrophic claim program coordinator.

MCOs are responsible for notifying the MCO Business & Reporting Unit within 2 business days of any changes to this information and updating the MCO portal.

The MCOs are unique in their strategies for managing catastrophic claims. For example, adjustment counseling services, normally available in a vocational rehab plan, may well be provided in catastrophic claims to assist an injured worker in overcoming disability related life situations or depression. Regardless, BWC mandates that a seamless, customer-oriented case management process is in place that assures effective and efficient care and services are delivered to injured workers.

In order to obtain this goal, MCOs shall designate a core group of Catastrophic Case Managers. The number of Catastrophic Case Managers designated will be at each MCO's discretion based upon the number of catastrophic claims the MCO has. Catastrophic Case Managers are not excluded from managing non-catastrophic claims; however, all catastrophic claims that are in case management must be managed by a Catastrophic Case Manager. MCOs shall keep a current list of their CAT CM's with contact information on the BWC portal and update any changes to that list within 2 business days.

Qualifications: The Catastrophic Case Manager shall be a registered nurse and have at least 1 year of previous Ohio MCO case management experience. The catastrophic case manager must be proficient in the MCO Policy Reference Guide.

The Catastrophic Claim Program Coordinator will have direct oversight of the management of the MCO's CAT cases and the MCO's Catastrophic Claim Program. That is not to say, however, that the Catastrophic Coordinator cannot also be a Catastrophic Case Manager. Catastrophic Coordinators should be aware of what is happening in the MCO's catastrophic claims and be a resource for the MCO Catastrophic Case Managers or BWC CNA on catastrophic related questions and issues.

1. Definition

Catastrophic claims result from sudden, traumatic occupational injuries that are severe in nature, occupational diseases incurred over time, or medical complications that are secondary to conditions originally allowed in a claim. Catastrophic claims require CAT services due to severely limited mobility and/or cognition that affects the ability to perform activities of daily living care such as eating, dressing, personal hygiene, maintaining bodily functions and ambulation. Catastrophic injuries may include but are not limited to:

- Severe brain or brain stem injuries or brain damage resulting from surgery or secondary to compensable injury of disease
- Multiple major extremity amputations/fractures/crush injuries/loss of use of 2 or more limbs
- Paraplegia/quadriplegia/hemiplegia/diplegia
- Total industrial blindness
- $2^{nd}/3^{rd}$ degree burns of more that 25% of body
- Actual anticipated hospitalization in excess of four weeks, i.e., ventilators, ICU, psychiatric hospitalization

- Severe occupational diseases and bloodborne pathogens (not end stage); toxic exposure with long term complications
- Any other medical diagnoses identified by the MCO and CNA

2. Expected Outcomes

Managing a catastrophic case requires that all services be coordinated in a timely manner, as required by the needs of injured workers and their families. Expected outcomes of catastrophic case management include:

- Expediting claim allowance for prompt payment of medical and indemnity benefits;
- Providing a BWC on-site advocate for the injured worker;
- Insuring the delivery of appropriate, quality medical services;
- Preventing any further disabilities or impacts to injured workers and their families.

3. BWC Catastrophic Nurse Advocate (CNA)

A CNA with specialized experience in the management of catastrophic injuries will be assigned to a BWC Customer Service Office that covers a specific region. (A list of the CNAs can be found on the MCO portal) This nurse will facilitate the establishment of key claim services, thus fulfilling a vital role as an injured worker advocate. As such, the CNA will interact with any person involved with an injured worker's claim. Duties encompassed by the advocate include, but are not limited to:

- Partner with MCOs to:
- Identify problems.
- Staff case dispositions with CCT/Providers.
- Assist with completing BWC forms.
- Coordinate discharge planning.
- Advise IW of local resources.
- Identify necessary services and interventions.
- Recommend vocational services if appropriate after staffing with CCT.
- Forward provider concerns to the BWC Credentialing unit
- Determine appropriateness of Adjustment Counseling (CNA authorizes adjustment counseling in certain cases in conjunction with the MCO. Usually includes up to 10 sessions, but up to 20 sessions maximum in rare instances)

4. Requirements

a) MCOs will provide case management for all catastrophic claims.

Case management for all catastrophic claims is essential and required for all active CAT claims. . The CNA staffs with the MCO to facilitate medical management. The CNA staffs with the CCT for claims determination.

b) A CNA will provide guidance to MCOs and Customer Service Teams (CCTs).

The CNA facilitates resolution of issues affecting catastrophic case management through CCT and MCO staffing. Additionally, the CNA serves as a liaison to the Brain Injury Advisory Committee (BIAC) to assist in resolving legislative inquiries, provides direction to the CCT, monitors trends and facilitates communication among

all customer groups. The CNA does not negotiate rates or approve medical services as these are medical case management issues handled by the MCO.

c) MCOs must identify potential catastrophic claims.
This requirement, fundamental to the claims management process, has been in place since the implementation of HPP. MCOs are unable to populate the field in V3 when they identify potential catastrophic claims. When an MCO is notified or identifies a catastrophic claim, these steps must be completed:

- The MCO will contact the assigned CNA by telephone or email within one business day of identifying a potentially catastrophic claim. (Refer to Catastrophic Nurse Advocate Roster on the BWC Portal for CAT Nurse assignment and their back up for staffing coverage.);

d) MCOs and CSTs must notify the CNA no later than one business day after a catastrophic claim has been identified.

To assure that the advocacy program begins as soon as possible, the CNA must be notified of the catastrophic injury within one business day of a catastrophic claim's identification.

e) MCOs will submit a treatment plan to BWC as outlined in the MCO Case Management Plans in chapter 3 of this document. Subsequent plans will be submitted as required by Rule 4123-6-20.
The MCO case manager develops the plan in collaboration with the injured worker, members of the health care team and employer. This requirement also applies to catastrophic claims.

- Claim number
- Treatment plan begin and end dates
- Treating ICD-9 codes
- frequency, duration, and expected outcomes of medical
* interventions, treatments, and procedures
- Maximum Medical Improvement , as applicable
- Estimated date of last treatment
- MCO contact name
- MCO contact telephone number
- MCO number
* Factors unrelated to the work injury but impacting recovery
* Any Projected anticipated or actual RTW date
* Vocational Rehabilitation updates
- Claim reactivation, as applicable
- File notes containing any additional information impacting the injured worker.

f) MCOs, CSTs and CNAs shall conduct an informal staffing within one to three business days of notification. Subsequent staffing to be held based upon the severity level of the claim.

It is imperative that the MCO, CCT and CNA share information regarding the circumstances of the claim. In particular, the severity of the claim must be discussed so an appropriate course of action can be determined.

g) BWC will complete the initial determination on claims identified as catastrophic within 48 hours of notification if possible.
Due to the severity of catastrophic claims, the determination of the claim must be expedited so medical benefits and indemnity payments can be initiated. Speedy determination will help minimize the impact of the claim to injured workers and their families. It is important to remember, however, that only the injured worker is eligible to receive care. Treatment for family members, whether medical or psychological, is not part of the claim. The MCO and/or CNA will staff family member concerns with the employer to see if crisis intervention can be paid for by the company.

h) The CNA will staff all catastrophic claims that are in case management on a quarterly basis, and will review all claims flagged with the catastrophic indicator annually and staff with the MCO as needed.
Due to the severity of **catastrophic** claims, communication between the MCO and the CNA must occur regularly until the injured worker stabilizes and case management is closed. Additionally, the MCOs should routinely submit plans of care that will assist the CCT with disability determinations. If communications do not occur, the CNA must initiate telephone contact with the MCO as needed. Furthermore, a V3 diary will keep the claim file active and afford a method by which the CNA can identify and address subsequent issues.

i) The CNA is responsible for notifying the CST when the claim is no longer considered catastrophic.
Fundamentally, the goal of medical case management is to minimize the impact of the claim on the injured worker. In instances when this is successfully achieved and a claim no longer meets catastrophic criteria, the CNA will place a note to this effect in V-3 which will generate a diary to the CSS.

j) The CNA is responsible for removing the V3 catastrophic indicator when the claim is no longer considered catastrophic.
Removing the catastrophic indicator is imperative to maintaining data integrity for not only the claim, but also for tracking all catastrophic claims. Removing the indicator will trigger an outbound EDI 148 transmission to the MCO. The Team Leader/MSS can remove the catastrophic indicator upon notification from the CNA.

k) The CNA provides the Customer Service Office and the MCOs with information pertaining to local community resources.
This information is used to assist injured workers and MCOs with identifying local resources that can assist in the recovery process (i.e., a TBI network, Ohio Rehabilitation Services Commission).

l) BWC will use management reports to track catastrophic claims.

Management reporting is essential to evaluating BWC's and the MCOs' catastrophic case management. Measures that are necessary to effectively analyze these entities' performance may include but not limited to:

* Time lines (i.e., initial determination within 48 hours of notification); time between date of filing and notification to the Catastrophic Nurse Advocate);
- Claim costs in relation to the primary diagnosis;
- Claims submitted to Alternative Dispute Resolution (ADR), including the dispute type and the outcome;
- Number of claim identified, including those that have had the catastrophic indicator removed;
- Claim costs in relation to the assigned MCO.

Catastrophic Case Management Plan (CCMP)

A Catastrophic Case Management Plan (CCMP) –may be considered and reviewed with the BWC catastrophic nurse advocate (CNA) for appropriateness on catastrophic claims that are chronic and result in a disabling condition. A CCMP is not appropriate for IWs residing in assisted living facilities, nursing homes or TBI facilities as there is usually a plan of care developed by the facility. CCMPs are to be used as tools to assist in the ongoing medical management of a catastrophic injury and are normally used in instances of extenuating circumstances (i.e. IW is out of state).

A Catastrophic Case Management Plan (which is distinct from the legally required plan of care) is used to address the long-term needs of severely disabled injured workers. It is necessary to consider the concerns of the injured workers' family members; however, **family members are not part of the workers compensation claim**. The MCO Catastrophic Case Manager and/or the CNA should staff family members' concerns and discuss them with the employer to see if the employer is willing to pay for crisis intervention.

The MCO's Catastrophic Case Manager and the assigned BWC CNA determine the necessity for a CCMP. The MCO shall research if a prior Life Care Plan exists for litigation purposes and adapt such a plan for BWC purposes. **All conditions allowed in the claim shall be addressed on the CCMP and must contain the current status of the allowed condition or must indicate that the allowed condition has completely resolved as of a certain date.**

The Catastrophic Case Management Plan (CCMP) shall include, but it is not limited to, the following critical elements:

a) Medical services:

Physician of record, specialist's evaluations. List all appropriate specialists deemed necessary based on claim allowances and literature review.

No recommendations for psychological intervention shall be placed on a CCMP without an allowed condition in the claim, with the exception of adjustment counseling as determined per Section G3 of this Chapter. A

psychological/psychiatric evaluation may only be recommended in the CCMP if the claim is specifically allowed for a psychiatric condition, or adjustment counseling is determined to be appropriate per staffing with the CNA under Section G3 of this Chapter "BWC Catastrophic Nurse Advocate (CNA)". If there is no psychological condition specifically allowed in the claim and issues are identified, the person preparing the CCMP must contact the BWC CNA to staff the issues.

All medications must be listed with dosage, frequency, route and indications and side effects that may require additional medical evaluation or laboratory testing, if it is necessary due to specific drugs.

Recommendations for dental services shall not be placed on a CCMP without an allowed dental condition in the claim. Dental evaluation and/or treatment can be considered only if the claim is specifically allowed for a dental condition secondary to medication use or actual physical damage at time of injury. If a problem is identified, the person preparing the CCMP must contact the BWC-CNA.

b) Home/Vehicle Modifications:
The BWC Catastrophic Nurse Advocate (CNA) is the primary authorization source for home and vehicle evaluations and modifications.

In situations where the MCO receives a request for authorization of home or vehicle modifications, the MCO should immediately notify the BWC CNA. Home/vehicle modifications should not be placed on a CCMP plan without prior approval by the BWC catastrophic nurse. Home/vehicle modifications should be based on BWC policy and the date the modifications were completed should be listed on the CCMP. Recommendations regarding home/vehicle modifications identified by the life care planner should be referred to the CNA for a decision and not placed on the plan.

- If approved by the CNA, the estimated cost of each additional modification and how it will benefit the injured worker must be included on the CCMP. All dates of home/vehicle modifications should be listed on the CCMP.

c) Therapies
All therapies should include date of initial evaluation and therapies completed to date, including the servicing provider and his/her phone number.

d) Durable Medical Equipment
All DME that is being used by the injured worker must be listed along with the cost for each item and anticipated replacement date and cost. Wheelchair evaluation(s) and all DME must be based on BWC/MCO policy. The CCMP must include the last date of purchase, cost and the normal anticipated time for

replacement and/or repair. The MCO must update the plan with date of purchase and cost whenever new equipment is necessary.

e) Rehabilitation
The CCMP must address if the injured worker is currently in a vocational rehabilitation plan, has completed vocational rehabilitation. All beginning and ending dates and name of person providing the service and the cost must be included in the CCMP.

f) Activities of Daily Living
Items including, but not limited to, cell phone, memberships, adaptive clothing, and computers are not normally considered medical equipment or medically necessary items and are not reimbursed by BWC. These items shall not be mentioned in the CCMP.

g) Educational and recreational programs:
The CCMP should include all educational opportunities in which the IW is participating.

h) Supportive Care

- Home maintenance services which include home repair, house cleaning, laundry service, meal preparation, snow removal, lawn care , pet care, and garden care, are **not reimbursable** per BWC/MCO policy and should not be included in a CCMP.
- Transportation needs of the IW should be included and based on BWC/MCO policy.
- Monthly charges for services and/or equipment should not be placed in a CCMP. The service can be addressed but should not include a monthly allowance.

i) Return to Work: Return to work goals should be included on the CCMP.

The BWC CNA must approve the need for a CCMP and will document the need in V3. Once the need for a CCMP has been approved, the MCO will be notified by E-mail. The MCO must contract with a BWC certified provider within 60 days. It is important that the MCO's Catastrophic Case Manager selects and instructs the provider and works closely with him/her to insure that a quality, timely CCMP is provided. The MCO also must inform the provider of the name of the BWC CNA that is assigned to the claim.

The CCMP must be completed within 60 days of referral from the MCO to the provider.

The CCMP shall include at the beginning of the report that all services in the plan are subject to BWC/MCO policy and based upon medical necessity in relation to the allowed conditions of the claim. The provider writing the CCMP shall work with the BWC CNA and the MCO and be familiar with the unique differences required for providing a

CCMP. All CCMPs must be reviewed with the CNA before they are discussed with the IW or the IW's family and before implementation.

A CCMP is a rarely used tool for managing a catastrophic claim and requires an annual MCO review based upon an assessment of the injured workers condition. Although plans can and do change, their integrity must be maintained by both current and future MCOs involved with the claim. A plan can neither be arbitrarily revised nor abandoned if the MCO assigned to the claim changes (e.g., due to open enrollment or mergers). The MCO shall review the completed CCMP at a minimum of once a year and provide updates to the BWC Catastrophic Nurse, and denote this review in claim notes. Only treatments and supplies related to the current allowances in the claim are included in the CCMP. The current MCO must follow BWC/MCO policy for consideration of equipment, supplies, treatment, etc. In all cases, the substantive goals in the plan must remain intact for the life of the injured worker. Inclusion in the CCMP does not automatically guarantee approval of requested items. The MCO is responsible for authorization of services/supplies and notifying parties to the claim.

To write a CCMP, the provider must possess at least one of the following credentials and will be enrolled as a provider type 76:

- Certified Occupational Health Nurse (COHN);
- Certified Rehabilitation Counselor (CRC);
- Certified Insurance Rehabilitation Specialist (CIRC);
- Certified Vocational Evaluator (CVE);
- Certified Rehabilitation Nurse (CRRN);
- Certified Case Manager (CCM); and/or
- Certified Disability Management Specialist (CDMS)
- American Board of Vocational Experts Certification (ABVE)

These credentials alone do not automatically qualify a provider to complete a CCMP. The MCO shall be responsible for choosing a BWC certified provider that is also certified as a Life Care Planner by the International Commission on Health Care Certification (ICHCC) or has experience developing quality Life Care Plans.

The CCMP is part of the cost of the claim and is charged to the employer's risk (i.e., the employer's experience), not to the Surplus Fund. Reimbursement for the CCMP must be billed using Level III HCPCS code Z1000 at current BWC fee schedule rates. The CCMP shall be billed one time only, using the completion date as the date of service.

The MCO will work with the provider throughout the development of the plan and shall obtain a copy of the completed CCMP no more than 60 days after the date the MCO requested the CCMP. If the CCMP is not complete, the provider shall send the incomplete plan along with a request for a specific number of days and the reason they are requesting an extension of the completion date. No additional reimbursement will be made for the extended time unless it is determined by the MCO and the BWC CNA that payment above the fee schedule is warranted.

6. **Emergency Response Systems**
A catastrophic injured worker choosing to live at home rather than in a nursing home may require home health nursing care assistance/supervision up to 24 hours a day due to work-related injuries. An injured worker (IW) may be so severely physically impaired that he/she is not able to call for emergency assistance. There are occasional situations where an IW could use an emergency alert system for a limited period of time each day (minimum of 8 hours per day), thus providing autonomy for the IW and eliminating the necessity of home health care for one shift of nursing care each day.

Eligible criteria for an emergency response system include:
- Claim for IW has previously been designated as a BWC catastrophic claim.
- IW is not capable, due to injuries allowed in the claim, to summon help independently in an emergency situation.
- IW is home alone for a minimum of an 8 hour period (no agency or caregiver services or anyone else with the IW),
- IW is capable of using the service.

An emergency response system requires prior authorization and the request must be submitted by the POR or treating physician on a C-9 form or another physician generated document that contains the data elements on the C-9 form. MCO is required to staff the need for an emergency response system with the assigned BWC catastrophic nurse and obtain approval from the catastrophic nurse prior to authorization of service.

The MCO is required to enroll the provider of emergency medical response system as type 79 after approval has been given by BWC catastrophic nurse.

Initial authorization is limited to a maximum of three months. Continued evaluation and authorization required each 3 months based on medical necessity. MCO will notify the catastrophic nurse when the monitoring has been discontinued.

BWC's responsibility for reimbursement is limited to the initial activation fees and the monthly monitoring fee. BWC is not responsible for any other costs or services for subsequent installation/de-installation, additional pendants/equipment for family members, or damages incurred to the injured worker's residence caused by forced-entry in an emergency situation. The provider will be required to bill for the system each three months on CMS-1500 or C-19 Service Invoice using the following Z codes:

- Z5601 Emergency Response System Initial/Installation Fee
- Z5602 Emergency Response System Monthly Maintenance Fee

There are different types and brands of emergency response systems. A vendor who is in close proximity to the IW may be an appropriate choice.

7. **Residential Care/Assisted Living**
MCOs shall perform a thorough assessment of level of care needs and develop a plan of care that focuses on the individual needs of the injured worker (IW). This assessment

must include an evaluation of the cost effectiveness of Residential/Assisted Living care required for the IW as well as the ability of the facility to meet the medical treatment, safety, supervision and activity of daily living needs of the injured worker. **Note: An Assisted-Living Assessment Screening Tool is available on BWC portal – shared documents – Policy alerts folder.**

- The Residential/Assisted Living Care Facility must be a BWC certified provider or meet the criteria for same before recommendation for placement of the IW in a Residential/Assisted Living Facility.
- If necessary, the MCO shall assist the facility in becoming BWC Certified.
- An evaluation of the injured worker must be completed to determine his/her needs. **The screening tool found on the portal** must be used to assess the level of care needs of the injured worker. The rationale for the placement decision must be included on the assessment form. This assessment documentation must be imaged into the claim. In addition to assessing the injured worker (IW) the Assisted Living facility should also be assessed in relation to quality of care and service as well as the ability to meet the particular needs of the individual IW before placement into the facility. The following criteria are suggested for the facility consideration :
  1. What is the staff to resident ratio?
  2. What health and wellness services are available?
  3. Is the location convenient to friends and family?
  4. Are activities planned for residents?
  5. Is 24 hour Nursing Care available?
  6. Do services and quality of living meet your standards?
  7. Is the value comparable to cost?
  8. What are the residency criteria?
  9. Will assisted living improve the quality of life for the IW?

  - The MCO shall staff the claim with the BWC CAT nurse after completing the assessment of the injured worker and the facility. The staffing summary must include a cost comparison of the Residential/Assisted Living arrangements recommended for the IW as well as the determination of appropriateness of placement. NOTE: Although the placement approval is the responsibility of the MCO, collaboration with the BWC CAT nurse is encouraged.

- As with any high cost claim, services or Residential/Assisted Living care shall not be authorized for indefinite periods of time. The Residential/Assisted Living placement shall be reviewed, including the bills, at least every three (3) months for the first six months of placement or when new services are requested. If continuing placement is requested and approved beyond the initial six (6) month period, subsequent level of care reviews shall be reviewed at least every six (6) months or when new services are requested.

  - Any changes in living arrangements shall be staffed with the CAT Nurse before they are authorized. The care plan and services provided must be for the allowed conditions in the claim.

The per diem, all inclusive fee for residential care/assisted living, must be billed with code Z0180 not to exceed the current BWC fee schedule amount. The MCO will request a written copy of the services included in the daily/monthly charge and it must be copied into the IW's claim.

H. EXPOSURE OR CONTACT WITH BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS WITH OR WITHOUT PHYSICAL INJURY

The current Exposure or Contact with Blood or Other Potentially Infectious Materials (OPIM) **With or Without Physical** Injury Policy has been clarified regarding the specifically assigned ICD-9 codes that are to be used and the billing and reimbursement issues surrounding the current policy.

Federal Occupational Safety and Health Administration (OSHA) in many cases mandates employers to pay for all costs associated with exposure to blood or Other Potentially Infectious Materials (OPIM), regardless of the presence or absence of a physical injury. OSHA does not mandate how the employer pays for all costs associated with the exposure. BWC will handle exposure claims in the same manner as all other claims. Employers may be cited if they are found to be non-compliant.

If the claim is allowed for a physical injury (e.g. needlestick, cut or open wound etc.), the provider will submit the bills for testing, counseling, prophylactic treatment and any required ongoing testing, counseling and treatment to the MCO/BWC. The MCO will accept the CDC/OSHA standards for treatment and will not require prior authorization or deny payment for any/all preventative treatment that is required for possible exposure to blood/OPIM, according to CDC protocols.

BWC makes the claim determination:

If a First Report of Injury (FROI) is received by the MCO for an incident of exposure to blood or other potentially infectious materials (OPIM) **with or without** a **physical injury**, the FROI must be filed with BWC, in accordance with the Ohio Revised Code. The FROI meets OSHA's requirements for filing exposure incidents. This will assist the employer by eliminating the need to file two (2) forms.

Pursuant to Ohio Revised Code, a worker must have "contracted" a disease from a workplace exposure or there must be a physical injury. Claims for exposure to blood or other potentially infectious materials (OPIM) only are non-compensable in Ohio; therefore, claims that show no evidence of a physical injury will be disallowed.

1. **Claims filed for exposure to blood/OPIM without a physical injury:**
   - If a claim shows exposure to blood or OPIM, but **no** evidence of a **physical injury**, such as spit in the eye, urine splash on the body surface, blood on the skin, or an air borne material, the claim will be disallowed according to Ohio law.
   - **ICD-9 code 994.9 "Effects of other external causes" will be the specifically assigned code** for all claims filed for exposure to blood or other potentially infectious

materials (OPIM**) without a physical injury**. In addition the ICD-9 code will be defined as exposure to blood/OPIM.

- The BWC order will inform the employee that the claim was disallowed according to Ohio law **due to no physical injury**. The BWC order will also state that in some cases, the employer may be required under Federal OSHA standards to pay for the cost of treatment.
- **If the claim is disallowed due to no physical injury,** and the MCO receives a bill from the provider, the MCO shall not send the bill to BWC, but shall send the rejected bill, as usual, following the procedure defined in the MCO Policy Reference Guide, back to the provider. The MCO must keep a copy of the rejected bill.

2. Claims filed for exposure to blood/OPIM with a physical injury:

- If the claim shows exposure to blood or OPIM and there is evidence of a **physical injury,** such as needlestick, cut or open wound, the claim will be allowed for the injury, but not the exposure. BWC assigns open wound codes 870 through 893, according to the specific body part that was injured.

If the claim is allowed for a physical condition, reimbursement will be made for all office visits, Emergency Department visits, treatment such as suturing, cleaning of the area and prophylactic treatment required according to current Centers for Disease Control (CDC) protocol. This may include, but is not limited to, office visit(s), tetanus, HIV or hepatitis testing, suturing, dressing, counseling, preventive medication and follow-up testing/treatment. Providers may use Preventative Medicine Individual Counseling CPT codes only when billing for these services as required per CDC/OSHA guidelines for these claims only. Providers will be reimbursed according to the current fees in effect on the date of service.

Note: Periodic audits will be conducted to ensure correct use of these codes.

- The MCO will accept the CDC/OSHA standards for treatment and will not require prior authorization or deny payment for any/all preventative treatment that is required for possible exposure to blood or OPIM, according to CDC protocols.

3. Employee contracts a disease after exposure:

- In the event a worker actually contracts a disease following exposure to blood or other OPIM, the claim will be handled as an occupational disease claim.

Exposure to Blood or Other Potentially Infectious Materials
With or Without Physical Injury Grid

Exposure Without Physical Injury	Exposure With Physical Injury
MCO files FROI	MCO files FROI
BWC **disallows** the claim. Examples of exposure without physical injury include spit or splash of blood or Other Potentially Infectious Materials (OPIM). BWC will specifically assign ICD-9 code 994.9 and identify the exposure as	BWC **allows** the claim for the physical injury. Examples of exposure with a physical injury include needlestick or open wound. The exposure to blood or OPIM is never allowed.

blood/OPIM. The BWC order will state that the claim is disallowed, due to no physical injury and that the employer may be responsible for payment of bills according to Federal Occupational Safety and Health Administration (OSHA) guidelines. For more information regarding OSHA guidelines and compliance, visit their web site at www.OSHA.gov. or the Ohio Bureau of Occupational Safety & Health, Division of Labor & Worker Safety.	The MCO will accept the CDC/OSHA standards for treatment and will not require prior authorization or deny payment for any/all preventative treatment that is required for possible exposure to blood/OPIM, according to CDC protocols.
If the claim is disallowed due to no physical injury, and the MCO receives a bill from the provider, the MCO shall not send the bill to BWC, but shall send the rejected bill, as usual, following the procedure defined in the MCO Policy Reference Guide, back to the provider. The MCO must keep a copy of the rejected bill.	If the provider sends the bill to the MCO, the MCO will send all bills for the entire service to BWC. This includes the office visit(s), HIV or hepatitis testing/treatment, tetanus injection, suturing, dressing, counseling, preventative medication and follow-up testing/treatment. Providers may use Preventative Medicine Individual Counseling CPT codes only when billing for these services as required per CDC/OSHA guidelines for these claims only. Payment will be made to the provider at the current fees in effect on the date of service.
If the employee contracts a disease after being exposed, at work, **without a physical injury** and the claim filed was not allowed**,** the employee may file a new claim. The claim may become allowed for the disease, as an occupational disease claim.	**If the employee contracts a disease** after being exposed, at work, **with a physical injury** and the claim filed was allowed, the employee may file a new claim or file to have the claim amended for the disease. The claim may become allowed for the disease, as an occupational disease claim.

4. **Exposure to Blood and Other Body Fluids Under SB 223**
   As stated in the current Exposure or Contact With Blood or Other Potentially Infectious Materials With or Without Physical Injury Policy; Federal Occupational Safety and Health Administration (OSHA) mandates employers, that are obligated by OSHA, to pay for all costs associated with exposure to blood or other potentially infectious materials (OPIM), regardless of the presence or absence of a physical injury. Private employers are mandated to follow OSHA. However, public employers are not mandated to follow OSHA.

Senate Bill 223, effective March 14, 2003, insures that a peace officer, firefighter, or emergency medical worker when coming into contact with the blood or other body fluid of another person in the course of and arising out of the peace officer's firefighter's or emergency medical workers employment shall have the costs paid for post-exposure ` medical services consistent with current standards of medical care existing at the time of the exposure. This applies to State Fund (private and public) and Self Insured public employers for of peace officers, firefighters and emergency medical workers employed or volunteering for self-insured public employers.

Per the statute (Ohio Revised Code 4123.026), BWC: *". . .shall pay the costs of conducting post-exposure medical diagnostic services . . . to investigate whether an injury or occupational disease was sustained by a peace officer, firefighter, or emergency medical worker when coming into* ***contact*** *with the blood or other body fluid of another person . . . through any of the following means:*

(1) Splash or spatter in the eye or mouth, including when received in the course of conducting mouth-to-mouth resuscitation;

(2) A puncture in the skin;

(3) A cut in the skin or another opening in the skin such as an open sore, wound, lesion, abrasion, or ulcer."

BWC or a self-insuring public employer, will pay for post-exposure medical care for peace officers, firefighters, or emergency medical workers who, in the course of and arising out of their employment, if the worker has a cut in the skin or other open sore, wound abrasion or ulcer that comes into physical contact with another person's blood or body fluid and does not sustain a physical injury. If the worker is splashed with another persons blood or body fluid on shin that is intact (does not have an open wound) will not be paid for medical care by BWC or the Self Insuring Employer.

SB 223 claims do not include exposure to air-borne diseases. It specifically states that a worker (as specified in the bill) must come into contact with the blood or other body fluid of another person from a splash or spatter in the eye or mouth, including when received in the course of conducting mouth-to-mouth resuscitation; a puncture in the skin; or a cut in the skin or another opening in the skin such as an open sore, wound, lesion, abrasion, or ulcer.

Examples:
The claim is not compensable under SB223 if:
The worker (as specified in the bill) is only in the presence of someone (air borne exposure) that has TB or other infectious disease but there is no physical contact with blood or other body fluid contact via a splash or spatter in the eye or mouth or in the course of mouth-to-mouth resuscitation, skin puncture or cut in skin or another opening such as open sore, wound, lesion, abrasion or ulcer.

The claim is compensable under SB223 if:

The worker (as specified in the bill) comes into physical contact with the blood or other body fluid of another person who has TB or other infectious disease via a splash or spatter in the eye or mouth or in the course of mouth-to-mouth resuscitation, skin puncture or cut in skin or another opening such as open sore, wound, lesion, abrasion or ulcer.

SB 223 applies to State Fund (private and public) and Self Insured public employers for peace officers, firefighters, and emergency medical workers employed by or volunteering for the self- insured public employer."

As used in SB 223, a "Peace Officer" generally will be a sheriff, deputy sheriff, marshal, deputy marshal or member of an organized police department. Peace Officers will generally work for city, county or state public employers and they are not limited to "traditional" law enforcement officers. Certain park rangers, tax and liquor agents, officers of metropolitan housing authorities or transit authorities, and others are also considered peace officers. For more detail, refer to Section 2935.01 of the Revised Code or contact the Legal Operations department if there is a question.

A "Firefighter" generally means a firefighter, whether paid or volunteer, of a lawfully constituted fire department.

An "Emergency medical worker'" generally means a first responder, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, certified under chapter 4765. of the Revised Code, whether paid or volunteer.

SB 223 changes the definition of what is paid in claims involving a peace officer, firefighter, or emergency medical worker; however, it does not change what is allowed or the definition of injury in Ohio. In accordance with Ohio law, BWC will disallow the claim for exposure and place it in a disallowed/inactive status. The MCO will not be able to update the claim via the 148. All updates must be made by the BWC CSS.

Providers will report exposure incidents on the FROI to the assigned MCO or online at www.ohiobwc.com as they would any other workplace incident for a state fund claim. ***The MCO must be aware of the employers and occupations that will be impacted by this policy***. To assist BWC with identifying these claims for "special processing" providers or MCOs should indicate "ALLEGED EXPOSURE to BLOOD or BODY FLUID" in the Description of Accident section when completing the FROI. In addition, the MCO shall file the claim with BWC in the same way as all other claims, (i.e., medical only or lost time). Once the claim is identified as an exposure claim, the MCO will be notified by BWC via e-mail of the claims assigned to that MCO that have been disallowed for Exposure without physical injury to Blood /OPIM (ICD-9 diagnosis code 994.9)

The MCO shall accept the Centers for Disease Control /OSHA standards for treatment and shall not require prior authorization or deny payment for post-exposure medical care

or preventative medicine services that may be required as a result of possible exposure to blood/OPIM, according to CDC/OSHA protocols.

Reimbursement will be made for all office visits, Emergency Department visits, tetanus, HIV or hepatitis testing, suturing, dressing, physician evaluation/management (including counseling), prophylactic medication and follow-up testing/treatment required according to current Centers for Disease Control (CDC) protocol. Providers will be reimbursed according to the current fees in effect on the date of service.

Bills will be sent to the assigned MCO as usual. Reimbursement will be made if the claim is allowed for the physical injury. Claims that do not have a physical injury allowed but do have physical contact documented will be paid under the SB223 payment for claims that are disallowed Though the claim will be in a disallowed status, the MCO shall not inappropriately reject these bills upfront. The MCO shall price the bill at $0.00, attach EOB 256 (claim is disallowed), and submit to BWC. Claims that have no physical injury and no physical contact documented will not be paid. The MCO must follow standard billing protocols.

BWC will flag these claims in Cambridge for manual bill processing to permit payment even though the claims have been disallowed. BWC will review each bill and apply the necessary EOBs, including ***EOB 879: Payment Being Made in a Disallowed Claim for Testing or Other Services due to Alleged Exposure (SB223).***

If the claim is allowed for a physical injury (e.g. needlestick, cut or open wound etc) the provider will submit the bills for testing, physician evaluation and management (including counseling), preventative treatment and any required ongoing testing and treatment to the MCO. The MCO will accept the CDC/OSHA standards for treatment and will not require prior authorization or deny payment for any/all preventative treatment that is required for possible exposure to blood/OPIM, according to CDC protocols.

If the claim is allowed due to a physical injury or the claim is disallowed due to no physical injury and physical contact with blood or body fluids, reimbursement will be made for all office visits, Emergency Department visits, tetanus, HIV or hepatitis testing, suturing, dressing, physician evaluation/management (including counseling), prophylactic medication and follow-up testing/treatment required according to current Centers for Disease Control (CDC) protocol (i.e. 6 months or a year after the exposure). Providers will be reimbursed according to the current fees in effect on the date of service.

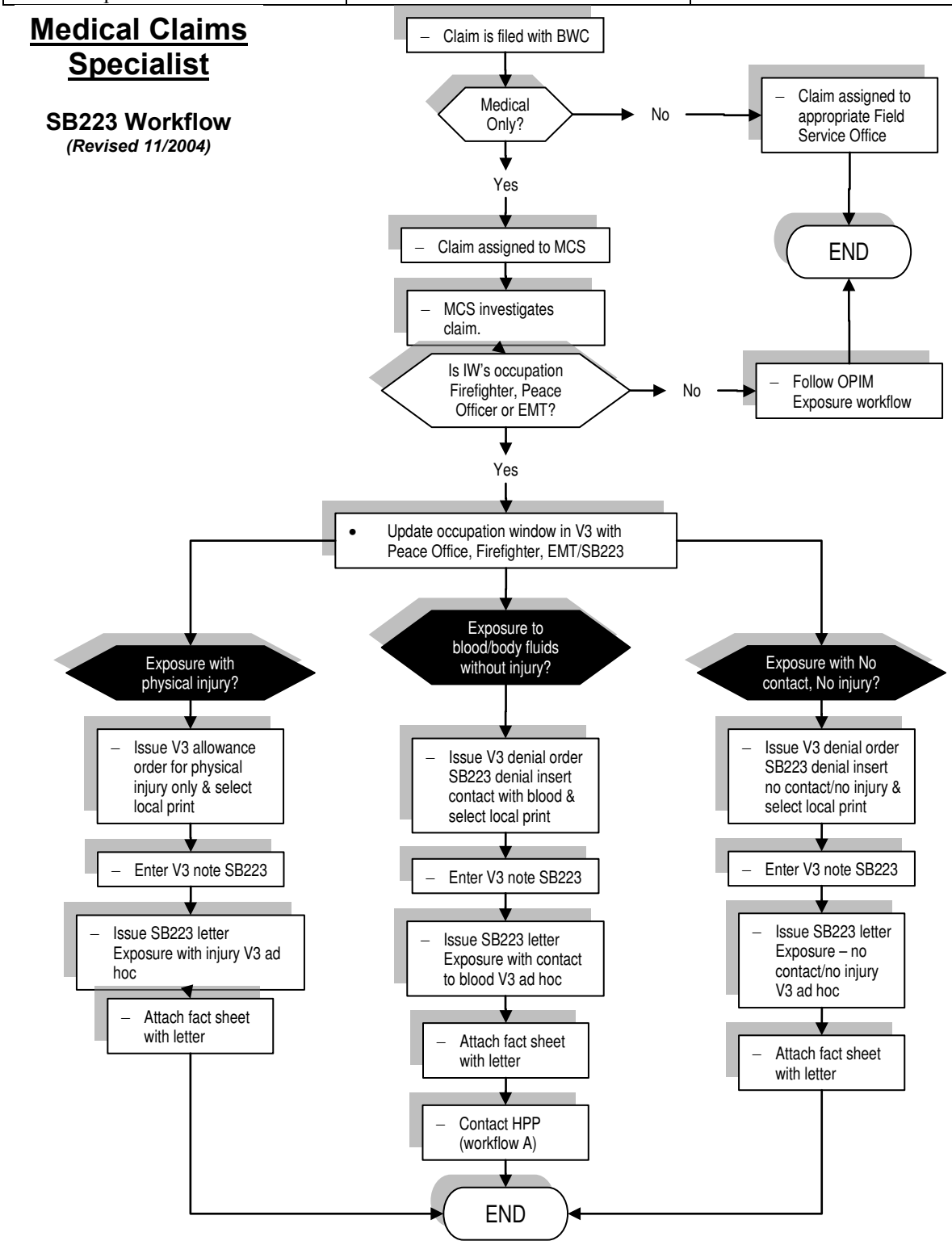
In the event a peace officer, firefighter, or emergency medical worker, actually contracts a disease following exposure to blood or body fluid a new claim must be filed and the claim will be handled as an occupational disease claim.

SB223-Exposure Claims

Effective for dates of occurrence on or after March 14, 2003

Exposure and Physical Contact with Physical Injury	Exposure and Physical Contact without Physical Injury	Exposure and No Physical Contact and without Physical Injury
A Peace Officer, Firefighter or EMT has been exposed to blood or body fluids and has sustained a physical injury	A Peace officer, fire fighter or EMT has been exposed to blood or body fluids but did not sustain a physical injury.	A Peace officer, fire fighter or EMT had an air born exposure, but did not sustain a physical injury.
Checklist	**Checklist**	**Checklist**
The Worker: • Was physically injured; • Had other person's blood or body fluid splashed on: o His/her eyes or mouth. o Puncture of the skin. o Cut or opening in his/her skin (sore, etc.)	The Worker: • Was NOT physically injured; • Had other person's blood or body fluid splashed on: o His/her eyes or mouth. o Puncture of the skin. o Cut or opening in his/her skin (sore, etc.)	The Worker: • Was NOT physically injured; • Did NOT have **physical contact** with another person's blood or body fluid; • Was exposed to an air borne condition such as Tuberculosis (TB) Whooping Cough and /or Meningitis or other infectious disease **without physical contact with blood or body fluid.**
MCO Processing	**MCO Processing**	**MCO Processing**
If the provider sends the bill to the MCO, the MCO will send all bills for the entire service to BWC. This includes the office visit(s), HIV or hepatitis testing/treatment, tetanus injection, suturing, dressing, counseling, preventative medication and follow-up testing/treatment. Providers may use Preventative Medicine Individual Counseling CPT codes only when billing for these services as required per CDC/OSHA guidelines for these claims only. Payment will be made to the provider at the current fees in effect on the date of service.	BWC or a self-insuring public employer will pay for post-exposure medical care for peace officers, firefighters, or emergency medical workers who, in the course of and arising out of their employment, are exposed to blood or other body fluids of another person and do not sustain a physical injury. If the provider sends the bill to the MCO, the MCO will send all bills for the entire service to BWC. This includes the office visit(s), HIV or hepatitis testing/treatment, tetanus injection, suturing, dressing, counseling, preventative medication and follow-up testing/treatment. Providers may use Preventative Medicine Individual Counseling CPT codes only when billing for these services as required per CDC/OSHA guidelines for these claims only. Payment will be made to the provider at the current fees in effect on the date of service.	This claim is disallowed and the worker did not have physical contact with blood or body fluids. In accordance with OH Laws medical bills will not be paid
If the employee contracts a disease after being exposed, at work, **with a physical injury** and the claim filed was allowed, the employee may file a new claim or file to have the claim amended for the disease. The claim may become allowed for the disease,	**If the employee contracts a disease** after being exposed, at work, **without a physical injury** and the claim filed was not allowed**,** the employee may file a new claim. The claim may become allowed for the disease, as an occupational disease	

as an occupational disease claim.	claim.	



I. BIOTERRORISM EXPOSURE POLICY

All state fund claims alleging potential non-accidental exposure to anthrax or other biological agent will be automatically referred to BWC's medical advisor for an occupational disease medical review. Where the worker tests negative for anthrax, BWC will disallow the claim in accordance with Ohio law. In the event a worker actually contracts anthrax, the claim will be handled as an occupational disease claim.

Emergency medical diagnostic services necessary to investigate the claim and confirm or rule out an anthrax diagnosis will be paid by BWC as occupational disease claim investigative costs. Prophylactic antibiotic therapy, initiated in accordance with Ohio Department of Health and the Centers' for Disease Control protocol, will also be reimbursed by BWC. Reimbursement for prophylactic antibiotic therapy initiated prior to substance testing will be considered on a case by case basis and BWC may limit reimbursement in these cases.

Each case involving non-accidental alleged or real exposure to anthrax or other biological agent will be handled by a centralized claims team, led by BWC's physician medical advisor and specially trained claims staff to ensure BWC resources are deployed prudently. Only workers who come into direct contact with the potential anthrax or other biological agents in the course of their employment and are instructed by emergency response personnel to seek emergency treatment will be covered by this policy.

Each MCO will be notified by BWC via e-mail of the claims assigned to that MCO that have been disallowed for Alleged Exposure to Anthrax (ICD-9 diagnosis code 989.89). Injured workers will be notified of the special procedures for their claims by way of a letter. Providers are told to send bills to MCOs. BWC will flag these claims in Cambridge for manual bill processing to permit payment even though the claims have been disallowed. If your billing system is unable to cut checks for disallowed claims, please contact the BWC MCO Business Unit immediately**.**

Please take the following steps for any bills received for these claims:

1. **Do not inappropriately reject bills at MCO level** - rejections are allowed only for missing or invalid mandatory elements such as claim number, diagnosis code, procedure code and place of service codes. Non-allowed or non-covered procedure codes and diagnosis codes are valid codes, although they are not usually payable. These bills need to be in the BWC's bill payment system.

2. MCO should submit the bills priced at $0.00 with EOB 256 (claim is disallowed).
   - Attach EOB 270 (ICD-9 is disallowed) , if provider billed with 989.89
   - Attach EOB 276 (ICD-9 is not allowed), if provider billed with something other than 989.89.

3. Do not attach informational or override EOBs. Once BWC receives the bills, we will review each bill and apply additional EOBs if needed.

4. Send an email to **HPPSSU@bwc.state.oh.us.** advising that bills have been submitted to BWC; be sure that the e-mails are not misdirected to HPP adjustments or to other BWC addresses. Failure to send email notification to **HPPSSU@bwc.state.oh.us** may delay the processing of the bills.

5. Please contact BWC immediately if you are unable to determine how to handle a specific bill.

J. HOME AND VEHICLE MODIFICATION

The BWC Catastrophic Nurse Advocate (CNA) will develop a plan for home or vehicle modification. The CNA will address all home and vehicle modification requests for all claims regardless if the equipment being requested is for a catastrophic claim and will issue a determination. The CNA will work closely with the MCO case manager and the necessary vendors to insure coordination of the services.

If the MCO receives a request for home and/or vehicle modification(s), the MCO shall respond to the provider and injured worker in writing, according to C-9 processing timeframes, that the request is being forwarded to the specific CNA assigned to the service office where the claim is located. If the MCO receives a request for other services/supplies on the same C-9, the MCO shall review and respond to the non-home and vehicle modification services request within the C-9 processing timeframes.

The BWC Catastrophic Nurse Advocate is the primary authorization source for home and vehicle evaluations and modifications.

- In situations where the MCO receives a request for authorization of home or vehicle modifications, the MCO should immediately notify the BWC CNA.
- Reimbursement of home and vehicle modification services is made by either BWC or the MCO depending upon specific service and provider type.
- Actual home and vehicle modifications are performed by a vendor, billed with a specific W code and paid by BWC.
- Other services provided by a vendor require W codes for billing. These services are paid by BWC. **Exception:** Scooter/wheelchair lift and installation (W4000) including anchoring the lift to the vehicle or attachment of a hitch is authorized and paid by the MCO. An installation that requires additional vehicle modification requires review/authorization by BWC
- Services billed by out-patient hospital require the use of revenue codes with appropriate CPT codes and are paid by the MCO.
- Services billed by in-patient hospital require revenue codes only and are paid by the MCO.

The following list outlines specific billing, coding, and reimbursement information:

Description of	Provider	HCPCS/CPT®	Revenue	Fee	Billing	Bill To

Service	Type	Code	Code		form	
Driving evaluation PT, OT or certified driving instructor	Non-facility	W0500	NA	By report (BR)	C-19 or HCFA 1500	BWC
Driving evaluation OT	Facility Outpatient	97003	OT	Hospital's outpatient reimbursement rate*	UB-92	MCO
Driving evaluation PT	Facility Outpatient	97001	PT	Hospital's outpatient reimbursement rate*	UB-92	MCO
Driving instruction for modified vehicle- PT, OT or certified driving instructor	Non-facility	W0549	NA	By Report (BR)	C-19 or HCFA-1500	BWC
Driving instruction for modified vehicle PT	Facility Outpatient	97535	PT	Hospital's outpatient reimbursement rate*	UB-92	MCO
Driving instruction for modified vehicle OT	Facility Outpatient	97535	OT	Hospital's outpatient reimbursement rate*	UB-92	MCO
PT/OT evaluation for home/vehicle modification	Non-facility	W0678	NA	By Report (BR)	C-19 or HCPCS 1500	BWC
PT evaluation for home/vehicle modification	Facility Inpatient	NA	PT	Hospital's inpatient reimbursement rate*	UB-92	MCO
OT evaluation for home/vehicle modification	Facility Inpatient	NA	OT	Hospital's inpatient reimbursement rate*	UB-92	MCO
Home Modification (includes permanent ramp)	Vendor	W0675	NA	By Report (BR)	C-19 or HCPCS 1500	BWC
Vehicle Modifications	Vendor	W0679	NA	By Report	C-19 or HCPC	BWC

				(BR)	S 1500	
Home and Vehicle Modification Repairs	Vendor	W0677	NA	By Report (BR)	C-19 or HCPC S 1500	BWC
Portable Ramp Rental or Purchase	Vendor	W0676	NA	Current Fee Schedule	C-19 or HCPC S 1500	BWC
Lift, vehicle, 3-4 wheeled chair with manual swing	Vendor	W4000	NA	Current Fee Schedule	C-19 or HCPC S 1500	MCO
Lift, vehicle, 3-4 wheeled chair with motorized swing	Vendor	W4001	NA	Current Fee Schedule	C-19 or HCPC S 1500	MCO

* Please refer to Hospital Reimbursement methodology in chapter 3 of BWC's Billing and Reimbursement Manual for past and current payment methodology information.

K. HOME INFUSION

MCOs shall negotiate a per diem rate for all home infusion therapy services. This rate includes nursing services, medical supplies, medication, and pharmacy services. All-inclusive per diem rates may be negotiated with the following BWC certified providers:

a) A Medicare certified Joint Commission accredited, community health accreditation program (CHAP) accreditation , or an accreditation through an organization that has been granted deeming authority by the Centers for Medicare or Medicaid Services home health agency which has its own state pharmacy board licensed fluid therapy pharmacy; or

b) A state pharmacy board licensed fluid therapy pharmacy which holds ~~JCAHO~~ Joint Commission accreditation as a certified home infusion therapy provider with nurses either employed by the pharmacy or contracted by the pharmacy through a Medicare certified or Joint Commission accredited home health agency.

The negotiated per diem rate is expected to be equal to or lower than the BWC fees for the individual components. Billing for home infusion therapy, either by a home health agency or by a pharmacy, must be submitted to the MCO on a CMS-1500 or a BWC C-19 Service Invoice. Bills may not be submitted to the Pharmacy Benefit Manager. The following Level III HCPCS codes are to be used when billing for home infusion therapy:

- W9010 All-inclusive per diem rate, parenteral nutrition;
- W9020 All-inclusive per diem rate, enteral nutrition;
- W9030 All-inclusive per diem rate, antibiotic home infusion therapy;
- W9040 All-inclusive per diem rate, pain management home infusion therapy;
- W9050 All-inclusive per diem rate, fluid replacement home infusion therapy;
- W9060 All-inclusive per diem rate, chemotherapy home infusion therapy;
- W9070 All-inclusive per diem rate, multiple home infusion therapies.

When a bill is submitted for home infusion services using an all-inclusive negotiated rate, the negotiated rate code includes all charges for nursing services, medication, medical supplies, and pharmacy services, unless the code is for a service unrelated to the infusion therapy.

Example: Services and supplies for which the fee maximum might be considered when negotiating a rate for home infusion therapy for an injured worker with an indwelling heparin well, and who has an order for ampicillin sodium 500 mg q6h x 10 days, are:

- W0105 Skilled Nursing Visits - initial daily assessment
- W0100 Home Health Agency Registered Nurse, per 15 minutes
- J0290 Ampicillin Sodium 500 mg, 4 x day
- A4245 Alcohol wipes, per wipe, 8 x day
- A4215 Sterile needle, 4 x day
- W9006 Sharps container needle disposal
- E0776 IV pole (generally rental for one month is equivalent to one-tenth purchase price)

L. HOME HEALTH AGENCY SERVICES

1. Eligible Providers

To be enrolled and certified by BWC, home health agencies must be certified by Medicare, accredited by the Joint Commission, accredited by the Community Health Accreditation Program (CHAP), or accredited through an organization that has been granted deeming authority by the Centers for Medicare and Medicaid Services.

2. Services

a. Skilled Nursing, Hourly Nursing, Home Health Aide, and Social Worker

Billing for home health services must be submitted to the MCO on a CMS 1500 or C-19 Service Invoice using the appropriate Level I (CPT®) codes for physical, occupational or speech therapy and Level II or Level III HCPCS codes, listed in Chapter 2 of the Billing and Reimbursement Manual, for other services including skilled nursing, hourly nursing, home health aide, and social worker visits.

b. Home Health Codes

The following codes specific to services provided by home health agencies **were** implemented for dates of service beginning 1/1/2006:

- **W2704** Home health agency worker providing direct care, mileage per mile, beginning with 51st mile round trip.
- **W2705** Travel time, home health agency professional worker each 6 minutes
- **W2706** Travel time, home health agency non-professional worker each 6 minutes

The MCO should select the BWC certified Home Health Agency that is closest to the injured worker's residence.

Mileage

- Payment of mileage is limited to those home health agency workers who are providing direct care to the injured worker.
- Mileage will be reimbursed beginning with the 51st mile for a round trip for an injured worker. No mileage will be reimbursed for the first 50 miles of a round trip
- Mileage is calculated as follows:
  - mileage calculation begins from home health worker's home base to IW home, and ends with return trip from IW home to home health worker's home base or next client whichever comes first **or**
  - Mileage begins from home health workers previous point of service to IW home and ends with return trip from IW home to home health worker's home base or next client whichever comes first.

Travel Time

- Payment of travel time is limited to those home health agency workers who are providing direct care to the injured worker.
- Travel time is calculated as followed:
  - Time begins from home health worker's home base to IW home, and ends with return trip from IW home to home health worker's home base or next client whichever comes first **or**
  - Time begins from home health workers previous point of service to IW home and ends with return trip from IW home to home health worker's home base or next client whichever comes first.

Note: The mileage and travel time codes may not be billed in conjunction with the all-inclusive per diem home infusion therapy codes or hospice codes.

M. INTERPRETER SERVICES

As part of a joint resolution of the Industrial Commission of Ohio (IC) and Bureau of Worker's Compensation (BWC), interpreter services are available throughout Ohio for hearings, medical examinations, rehabilitation, and consultations for individuals who are deaf or hearing impaired and communicate using American Sign Language or for individuals with a foreign language barrier. Approval of interpreter services is a claims function and not medical management of the claim. Interpreter services are provided and paid for as part of the cost of administering the claim to ensure that an IW is afforded Due Process of Law. This policy revision is intended to provide guidelines for approving interpreter services for foreign language speaking and hearing impaired injured workers for BWC services that are reasonable to assist the IW in the recovery of his/her injury. This policy revision will identify separate guidelines for approving interpreter services for injured workers with a foreign language barrier and for services for deaf or hearing impaired IWs as deafness is a disability under ADA.

General Guidelines for approval of Interpreter Services
It is difficult to determine or define every instance and the length of time that should be allowed for IWs to receive interpreter services in situations that do not involve Due Process. Injury management of the claim, including discussion with the IW's employer, will assist the Customer Care Team in determining the IW's available resources; therefore, providing only those interpreter services that are "reasonable, necessary and appropriate". The local CCT is familiar with community resources and is encouraged to approve services with providers within the community or location of the IW. This will reduce the costs associated with interpreter's travel time.

All requests for interpreter services that are eligible for reimbursement by BWC must be made directly to the Claims Services Specialist (CCS) except in cases that involve vocational rehabilitation. If the IW is participating in a vocational rehabilitation plan, the Disability Management Coordinator (DMC) must approve and monitor the extent of the services.

The IC is only responsible for IC related interpreter services, such as hearings and reimbursement will only be made for interpreter services approved by the IC for IC related Services. The IC may be contacted by calling 1-800-521-2691or (614) 752-4036); TDD number: 1-800-686-1589.
BWC shall refer requests for IC hearings or other IC services to the IC.

MCOs shall refer all requests for interpreter services immediately to the IW's assigned CSS/DMC. This is especially important if the request is made on a C-9. It will be necessary for the MCO and the CSS/DMC to coordinate interpreter services approval in conjunction with the medical treatment, to prevent delays and facilitate communication with the IW and the provider. As previously noted, approval of interpreter services is a claims function and not medical management of the claim. Therefore, the CSS or DMC shall approve or deny interpreter services and shall place a note in V3, stating that interpreter services were discussed and it was determined to allow or deny the interpreter services were discussed and it was determined to allow or deny the request. The CCT/DMC will work with the MCO to facilitate communication of the IW's needs for interpreter services and what is "necessary and reasonable." "Necessary and reasonable" services are based on the individual situation of each IW as determined by the CSS/DMC. BWC's Claims, Medical and/or Rehab Policy units will help staff cases as needed upon request. Requests for interpreter services should be acted upon immediately to prevent delays in treatment.

Approval of interpreter services that <u>require Due Process</u>
Interpreter services will be provided to injured workers and employers who are unable to communicate because of a hearing impairment or foreign language barrier in the following situations:

- IC hearings;
- Independent Medical Exams.

When the injured worker needs an interpreter for an ADR IME that is required by the MCO, BWC will pay for both the IME and the interpreter services. It may be necessary for more than one ADR IME in the life of a claim. The MCO will contact the IW's assigned CSS/DMC, who will make arrangements for the interpreter services, in the same manner as all other interpreter services.

Approval of interpreter services for situations that <u>do not require Due Process</u>

In the course of managing an injury, it may be necessary to assist the IW with communication by approving interpreter services in situations that do not involve Due Process of Law for issues related to the allowed conditions in the claim:

- In the investigation or administrative needs of the claim;
- To explain workers compensation benefits;
- For a medical specialist consultation that has been requested by the Physician of Record (POR);
- To assist the IW who is participating in a vocational rehabilitation plan. In most cases interpreter services will not be necessary for the entire time span of the vocational rehabilitation plan. Interpreter services within the IW's home community should be used whenever possible. The DMC must approve and monitor the extent of the services.
- To expedite treatment in a catastrophic injury claim. The Catastrophic Nurse Advocate (CNA) will work with the CSS/DMC to explore all options and document their findings to explain why interpreter services are needed.

BWC <u>will typically not approve</u> Foreign Language Interpreter Services in the following situations:

- Communication with durable medical equipment (DME) suppliers;
- Physician of Record (POR) routine office visits; (The IW has a choice of selecting his/her POR and is responsible for communicating with his/her physician.)
- Physical or Occupational Therapy

BWC <u>Shall</u> approve Sign Language Interpreters for deaf or hearing impaired IWs who use sign language, when requested, in the following situations:

- Communication with durable medical equipment (DME) suppliers;
- Physician of record (POR) routine office visits;
- Physical or Occupational Therapy

BWC will not approve Foreign Language or Sign Language Interpreter Services for an injured worker receiving hospital based services as the hospital is responsible for providing these services. Hospitals may inform BWC that an injured worker may require interpreter services when discharged. This is especially true for planned hospitalizations. This will prevent delays in treatment. If the IW has been approved for hospital based services and requires an interpreter, the CSS/DMC should notify the hospital social services or other department designated for obtaining interpreters, concerning the IW's need for assistance to facilitate communication. The CSS/DMC should inform the hospital to call him/her if interpreter services will be needed soon after

the injured worker is discharged. Coordination of interpreter services for injured worker's that need the services, is a necessary part of eliminating time lost for the injured workers care and return to work.

Utilize BWC's Customer Contact Center to provide phone services such as calling a doctor**'**s office, completing a FROI, and explaining compensation. The Customer Contact Center provides Spanish voice communication for every call and is available to make phone arrangements with BWC Bilingual Employees throughout the state for people who need other foreign language interpretation. The Customer Contact Center can assist the CSS/DMC in contacting the IW by using a TTY or TDD, for the deaf or communicating between the CSS/DMC and an IW who speaks a foreign language. The Customer Contact Center may utilize the Ohio Relay Service to communicate with both deaf/hearing impaired and Spanish speaking individuals. It is important to note that Customer Contact Center Personnel are not available to accompany the IW; however, telephonic interpreter services are an accepted cost effective method to assist injured workers who speak a foreign language.

- The IW, employer, MCO, CSS or DMC may contact **BWC Customer Contact Center** in the following ways:
  - Telephone Number: 1-800-OHIOBWC (1-800-644-6292);
  - TTY Number: 1-800-BWC-4-TDD (1-800-292-4833);
  - Fax Number: 1-877-520-OHIO (6446);
  - Mailing Address: BWC Customer Service, 30 W. Spring Street, L- 10, Columbus, OH 43215-2233;
  - E-mail: Send a message (Contact Us) @ www.ohiobwc.com

Who may request Interpreter Services:
Requests for interpreter services may be made to a BWC CCT or DMC by the IW, IW's family or acquaintance, the provider, Physician of Record (POR), or MCO. Requests by a specific interpreter or by the IW for a specific interpreter to provide service for a specific IW must be evaluated and determined to be necessary by the CSS/DMC. The length of time and number of times should be approved.

The extent or length of time approved for interpreter services should be based on interpreter services that are necessary and reasonable. "Necessary and reasonable" services are based on the individual situation of each IW as determined by the CSS/DMC. Necessary and reasonable services are provided at critical junctures in the claim and to insure recovery. However, it is not always necessary and reasonable for an IW to have an interpreter present at each appointment or for the entire length of an appointment throughout the life of a claim. BWC must pre-approve all BWC related requests for interpreter services and payment will be made by BWC to the provider as outlined in this policy. Retro approval of interpreter services shall be made only for unusual circumstances.

Procedures for the CSS/DMC or Exam Schedulers

After the CSS/ DMC or exam scheduler approves or denies the interpreter services a letter must be sent to the IW and copies sent to all parties. If a party objects he/she may file a Motion.

The CSS or DMC or exam scheduler shall approve or deny interpreter services and shall place a note in V3, stating that interpreter services were discussed. The CSS or DMC or exam scheduler, that approved interpreter services, shall contact or call the appropriate interpreter provider to make arrangements for all interpreter services approved for BWC purposes.

It will be necessary for the CSS/DMC or exam scheduler to sign the C-19 with his/her (A) number before imaging the document and faxing a copy to MB&A. (This is the same workflow as the C-60 travel reimbursement procedure.) The original C-19 does not need to be sent to Medical Billing and Adjustments (MB&A).

The CSS/DMC or exam scheduler will need to instruct the provider of the Interpreter Services to send the bill to his/her attention instead of sending it to the address noted on the C-19.

Vocational Rehabilitation:
Vocational Rehabilitation plans requiring interpreter/translator services must be approved by the DMC prior to plan implementation. This requirement is in Chapter 4, Section M, of the MCO Policy Reference Guide "DMC Authorization of Special Voc Rehab Plan Types." MCOs will receive additional instructions regarding the need for DMC authorization of pre-plan services.

The DMC should provide oversight of vocational rehab services (both pre-plan and plan services) to assure that the IW receives necessary and reasonable services. "Necessary and reasonable" services are based on the individual situation of each IW as determined by the DMC. Sign language interpreter services for deaf or hearing impaired injured workers will be approved, when requested, for POR, Physical or Occupational Therapy appointments occurring during rehabilitation programming. BWC's Rehab Policy unit will help staff cases as needed upon request of the DMC. In general, necessary and reasonable services are provided at critical junctures in the rehabilitation process, such as the initial interview with the IW and when the IW signs the rehab agreement.

If a bi-lingual vocational rehab case manager is used, that case manager will not be reimbursed additionally for interpreter services.

MCO Scheduled Examinations and Responsibility:
The MCO is responsible for payment of both the examination and the interpreter services if the injured worker needs an interpreter for an examination that is scheduled by the MCO. The MCO may use its own interpreter services or may request assistance from BWC.

If an MCO approves interpreter services in error without BWC approval, the MCO shall be responsible for reimbursement to the provider. Payment will be transferred from the

MCO's administrative account into the provider account to cover the exact payment issued from the provider account to pay for the services provided. Supporting documentation for the transaction must be maintained for audit trail purposes.

Payment for Interpreter Services:
Family members, friends, medical, health care and vocational providers and/or community volunteers may provide interpretation for IWs but are not eligible for enrollment or to receive reimbursement.

BWC's Medical Billing and Adjustments:
BWC Medical Billing and Adjustments (MB&A) must verify approval of all interpreter services (BWC & IC) before processing the bill. Interpreter services that are **not** approved by BWC or the IC will be denied for reimbursement using EOB 353, "Payment is denied as prior authorization is required for this service."

Billing Instructions, Codes and Fees:
Current fees can be found on BWC's website **www.ohiobwc.com** by going to Medical Providers/Look-ups/Fee Schedule Look-up, then entering the listed codes. BWC providers are expected to bill their usual and customary rate. Reimbursement will be at the provider billed amount or at the BWC fee, whichever is lower. **Inquiries about unresolved billing issues** should be directed to BWC's provider Relations Department at 1(800) OHIOBWC, 1-800-644-6292, option 0-3-0.

Bills must be submitted on BWC's C-19 Service Invoice that can be found on BWC's website under Medical Providers, forms. Instructions for completing the form can also be found on BWC's website, under medical providers, services, billing and reimbursement manual, chapter 4.

All Interpreter Services (BWC or IC) must to be billed with the appropriate code(s) listed below on a C-19 Service Invoice (C-19).

- **W1930** Interpreter Services, per fifteen (15) minutes.
- **W1931** Interpreter Wait Time, per six (6) minutes, Maximum of 30 minutes per date of service (including waiting for an IW that does not show up for appointment).
- **W1932** Interpreter Travel Time, per six (6) minutes (including travel time for an IW that does not show up for appointment).
- **W1933** Interpreter Mileage, per mile.

Enrollment of Providers of Interpreter Services:
Providers delivering Interpreter Services for BWC/IC approved services will be enrolled as provider type 99 (other). When an MCO requests enrollment of the interpreter, the MCO must include the approved vocational rehabilitation plan and interpreter's qualifications with a non-certified enrollment form. Providers of Interpreter Services may enroll using the Medco-13A Form found on the web site, www.ohiobwc.com.

N. SMOKING CESSATION PROGRAMS WITH OR WITHOUT FDA APPROVED SMOKING DETERRENT DRUGS

1. **Smoking Deterrent Programs**
   An MCO may consider reimbursement of smoking cessation programs with or without FDA approved smoking deterrent drugs when the guidelines below are met. Reimbursement of smoking deterrent drugs used in conjunction with a smoking cessation program is included within the fee for the smoking deterrent program.

   BWC and the MCO responsible for medically managing the claim may consider reimbursement eligibility for smoking cessation programs in the following situations:
   - for injured workers whose allowed pulmonary condition impairs their ability to meet established treatment and return to work goals;

     or
   - for the maintenance of pulmonary function in injured workers who have an allowed pulmonary condition.

   Reimbursement of FDA approved smoking deterrent drugs will only be considered when used within an MCO approved/accredited smoking cessation program. This positive behavioral modification program would include education and counseling regarding nicotine addiction and the use of nicotine replacement products, relapse prevention strategies, stress management techniques and/or other appropriate services that would treat an allowed pulmonary condition or improve the allowed pulmonary condition to enable the injured worker to return to work.

2. **Reimbursement Guidelines:**
   BWC will not provide reimbursement for prescription smoking deterrent drugs outside an approved program. The drugs are included in the total program reimbursement. BWC's pharmacy benefits manager () will not reimburse smoking deterrent drugs.

   Providers of smoking cessation programs are required to enroll as a BWC certified provider and bill for services on either the HCFA1500 or the BWC Service Invoice (C-19). Bills must then be submitted to the managing MCO for reimbursement.
   Note: Smoking deterrent drugs that are not FDA approved will not be reimbursed and shall not be billed to BWC or the MCO.

3. **Reimbursement Codes**
   a. **Services for smoking cessation with prescription drugs**
      Services for smoking cessation with prescription drugs may be reimbursable, when the allowed lung condition presents a barrier to meeting established treatment and return to work goals and when the Miller Criteria have been met. These services must focus on behaviorally oriented education and counseling regarding nicotine addiction and the use of nicotine replacement products, relapse prevention strategies and behavioral modification techniques and/or other appropriate services that would improve the allowed condition and enable the injured worker to return to work. The HCPCS Level III code for reimbursement is W5000

   b. **Services for smoking cessation without prescription drugs**

Services for smoking cessation, without prescription drugs when the lung condition presents a barrier to meeting established treatment and return to work goals or when the Miller Criteria have been met. These services must focus on behaviorally oriented education and counseling regarding nicotine addiction, relapse prevention strategies and behavioral modification techniques and/or other appropriate services that would improve the allowed condition and enable the injured worker to return to work. The HCPCS Level III code for reimbursement is W5001.

O. NURSING HOME NEGOTIATED RATE GUIDELINES

1. Per Diem Rate

The following services and supplies are generally included in the nursing home per diem rate, either intermediate or skilled:

- Room and board, including oral diet and supplements;
- Basic personal hygiene items and services, including soap, shampoo, wash basins, tissues, underpads;
- Basic psychosocial services;
- Occasional non-prescription medications;
- Durable medical equipment, unless prescribed for the exclusive use of the injured worker;
- Disposable, non-reusable medical supplies;
- Wheelchairs and other ambulatory aids unless prescribed for the exclusive use of the injured worker;
- Laundry services;
- Maintenance therapy, including basic range of motion exercises and assistance with ambulation;
- Activity programs.

2. Basic Nursing Home Per Diem Billing Codes:

- HCPCS Code W0170 Skilled Nursing Care
- HCPCS Code W0180 Intermediate Level Care

3. Negotiated Nursing Home Per Diem Billing Code:

- HCPCS Code W0176 Negotiated Per Diem

4. Negotiated Rates

In extenuating circumstances when the injured worker's condition requires services and supplies over and above those reimbursed using the per diem codes W0170 or W0180, nursing homes may request a negotiated rate. The MCO is responsible for nursing home rate negotiations with both panel and non-panel providers. Use HCPCS Code W0176 to bill for negotiated nursing home per diem rates.

The services/supplies must be medically necessary for treatment of the work-related injury. The injured worker's physician must order the services/supplies.

Supplies that may be considered in a negotiated rate include:

- Wound-care products;

- Ostomy supplies;
- Urinary catheters and catheter supplies;
- Tube feeding supplies;
- Respiratory therapy supplies;
- Other medically necessary supplies.

Additional payment also may be approved if the injured worker requires services beyond those described as basic services, including:

- Respiratory therapy;
- Extensive wound care;
- Other medically necessary services.

Physical, occupational and speech therapy may be included in the negotiated per diem rate or may be billed separately, at the discretion of the MCO, using the appropriate HCPCS codes in addition to the basic per diem rate code.

Medications are not included in the negotiated per diem rate. The supplying pharmacist must bill for the medications.

Medical, dental, podiatry, optometry, transportation, radiology and laboratory services are not included in the negotiated rate. The servicing provider must bill for these services.

Nursing home service approvals should not be for more than 6 months at a time.

5. Legend Drugs

Legend drugs are not payable to nursing home providers. However, a pharmacy located within a nursing home may be eligible for reimbursement of legend drugs if the pharmacy meets the eligibility requirements for being a pharmacy provider, as stated in the Provider Billing and Reimbursement Manual. Nursing homes must bill over-the-counter medications and all medical supplies, including IV supplies, as part of the intermediate or skilled per diem rates.

Hospitals operating on-site nursing homes may dispense legend drugs to the nursing homes' residents from the hospital pharmacy. However, the hospital pharmacy must be able to meet the requirements for becoming a pharmacy provider, including the ability to electronically bill PBM, BWC's pharmacy benefits manager.

P. HOSPICE

BWC enrolls hospice providers as Provider Type 30 - Home Health Agency. Hospices must be licensed by the state and be Medicare/Medicaid certified to become providers. Criteria for hospice services eligibility includes:

- Request for hospice care must be at POR direction.
- The need for hospice care must be directly related to the claim allowance.
- The injured worker must be terminally ill with an estimated life expectancy of less than six months.

- Aggressive treatment has been stopped. All future treatment will be palliative (for the comfort of the patient).

Services should be authorized for no more than 90 days at a time. All services and supplies must be provided for patient comfort rather than for treatment.

- In home hospice care that includes all services and supplies necessary for the patient's comfort – may include nursing care, counseling services, massage, art, music, bereavement therapies, supplies.
- Respite hospice care that may be provided in hospice facilities or in nursing homes or hospitals with which the hospice provider has a contract to provide respite care.
- Acute hospice care **for pain management** in hospice facilities or in nursing homes or hospitals with which the hospice provider has a contract to provide acute pain management services.

All services and supplies are reimbursed to the hospice provider at an all inclusive per diem rate. The per diem rate is paid regardless of the number of services or the time spent providing those services. The hospice provider reimburses the facility (nursing home, hospital, etc.) with which it has a contract. The following billing codes are used to bill for hospice services:

- Z0500 – in home hospice care per diem
- Z0550 – respite hospice care per diem
- Z0560 – acute hospice hospital care for pain management per diem

R. WEIGHT CONTROL DRUGS.

BWC does not reimburse for weight control/loss drugs dispensed by a pharmacy provider. BWC and the MCO may consider reimbursement of weight control/loss drugs only when used as part of an approved/accredited weight control program.

S. CHRONIC PAIN PROGRAMS

All Chronic Pain Programs are required to be BWC certified. Chronic pain programs must include all of the following overall objectives:

- Improve general physical conditioning in order to achieve return to work readiness, if appropriate;
- Improve overall function for return to work readiness, if appropriate;
- Increase comfort/decrease pain rating by use of pain management skills;
- Decrease dependency on the health care system;
- Identify/clarify vocational goals; if appropriate;
- Reduce inappropriate use of narcotics and other medications that may cause dependence or addiction.

In order to be considered for a chronic pain management treatment program, the IW must receive authorization for and must undergo a comprehensive multidisciplinary evaluation that includes:

- medical history and physical/neuromuscular examination to include review of medications;
- review of past, pertinent medical records;
- psychological evaluation;
- physical therapy evaluation;
- occupational therapy evaluation
- cardiac stress test, if necessary;
- specialist consultation(s) as necessary.

Injured worker eligibility indicators include:

- Injured worker is symptomatic of excessive pain behaviors disproportionate to the compensable injury or condition.
- Injured worker has not responded to traditional medical treatment or to an extended course of individual therapy modalities. If an injured worker has not responded to traditional medical treatment or to an extended course of individual therapy modalities, it is recommended that the injured worker be referred to a BWC certified CARF accredited multidisciplinary pain management program for evaluation to determine appropriateness for entrance into the program. The ideal time frame for referral is six months to three years post injury, but referrals should not be limited to those time frames.
- Injured worker's use/abuse of alcohol or drugs is not so excessive that it is likely to interfere with full participation in the program.
- Injured worker is not currently experiencing any acute medical problems, is not anticipating any medical or surgical intervention and is considered medically stable to participate in a multidisciplinary, physically challenging program.
- Injured worker has previously completed no more than one BWC certified CARF/Joint Commission accredited multidisciplinary pain management program.
- Injured worker is demonstrating significant emotional distress as a result of the allowed injury, such as depression, anxiety or impaired interpersonal, familial, occupational or social functioning; however psychological dysfunction is not so severe as to interfere with full program participation.
- Injured worker has expressed interest and desire to participate in a chronic pain management program with a goal of returning to work, if appropriate. If no return to work goal exists, there must be an expectation of documentable cost savings through decreased reliance on health care resources as a result of participation in the program.
- Diagnosis allowed in the claim may be, but is not limited to ICD-9 chronic pain diagnoses listed:
  - 719.4 - pain in joint (fifth digit identifies body part)
  - 307.89 - other psychalgia or pain disorder associated with both psychological and general medical condition
  - 337.21 - RSD, upper limb
  - 337.22 - RSD, lower limb
  - 724.6 - chronic lumbosacral sprain/strain (already allowed for lumbar/lumbosacral sprain/strain)
  - 722.8* - postlaminectomy syndrome (fifth digit identifies back level)

– 729.1 - fibromyalgia

Inpatient programs are appropriate only when the injured worker's condition is such that a highly supervised and monitored program is essential for success. One or more of the following criteria must be met in order for an inpatient program to be approved.

- IW requires weaning from prescribed medication before any possible benefit of the pain management program could be realized.
- IW exhibits personality/behaviors such that effective participation would be unlikely in an unsupervised/unmonitored setting.
- IW needs a structured environment for psychological support and/or medical monitoring.
- IW's pain behaviors are reinforced in the home to the point that it is necessary for the IW to be removed from the home in order to effectively succeed in a pain program.

Outpatient programs are appropriate when the injured worker's condition does not warrant the highly supervised environment of an inpatient program. Outpatient with lodging may be warranted if the IW resides more than 25 miles from the chronic pain program facility, or the IW is involved in dysfunctional home, family or relationship that contributes to and exacerbates pain behaviors. Outpatient without lodging is appropriate if the IW resides within 25 miles or less of the pain program facility, has a supportive home/family structure, does not significantly rely on medication, and does not use illicit drugs or misuse alcohol.

Only BWC certified chronic pain programs may bill chronic pain program per diem codes. Certified chronic pain programs may be certified by BWC if they have CARF accreditation if they are free standing, or if hospital based, are CARF or Joint Commission accredited.
Chronic pain program per diem codes include:

- W1000 CARF/Joint Commission accredited BWC certified chronic pain program, per day -non-hospital based pain management program, per diem
- W1001 CARF/Joint Commission accredited BWC certified chronic pain program pre-admission evaluation- non-hospital based pain management program, per diem
- W1002 CARF /Joint Commission accredited BWC certified chronic pain program, per half day (four hours or less) non-hospital based pain management program, per diem
-

The following local Level III HCPCS procedure codes are used when the chronic pain program (billing facility) has a contractual agreement with other facilities to provide travel, meals, and or lodging to the injured worker:

- Z0600 Vocational rehabilitation or chronic pain program, not claimant reimbursement, travel
- Z0601 Vocational rehabilitation or chronic pain program, not claimant reimbursement, meals
- Z0602 Vocational rehabilitation or chronic pain program, not claimant reimbursement, lodging

For chronic pain program per diem billing and for billing the level III codes to provide travel, meals and or lodging in a chronic pain program**, the** 11-digit BWC provider number of the **group practice** to whom the payment is to be made must be included in box 25 and 33 of the CMS-1500.

Services provided by a chronic pain program must be billed with the appropriate per diem code with the exception of the following services that may be billed separately:

- physician services;
- psychologist services;
- physical therapy or occupational therapy services **not included in the scheduled pain management program**

For services billed separately from the chronic pain program, the 11-digit BWC provider number of the **individual treating** practitioner must be included in box 25 of the CMS-1500 and the 11-digit BWC provider number of the **group practice** to whom the payment is to be made must be entered in box 33.

The following drug screen codes will be reimbursed without MCO prior authorization when an injured worker is in an MCO approved, BWC certified pain management program or is being treated by a physician in the management of chronic non-malignant pain related to allowed claim conditions.

HCPCS code G0431-- Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), **per patient encounter**

HCPCS Code G0434--Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, **per patient encounter**

- **80102©** Drug confirmation, each procedure
- **83925©** Opiate(s) drug and metabolites, each procedure (e.g. morphine, meperdine)

The drug screens are covered with MCO discretion. The codes should be reviewed by the MCO for medical necessity and allowed condition relatedness prior to payment (allowed or denied).

Note: Reimbursement of drug screens performed by employers or drug screening of injured workers performed in the emergency room at the time of injury continue to be non-covered by BWC.

1. ICD-9-CM Codes for "Pain"

For BWC purposes, ongoing pain symptoms of at least 12 months duration post completion of conservative care or last definitive surgical procedure (laminectomy, fusion, etc.) provided there has been ongoing medical care and attempts to identify and treat the source of the pain by the injured worker will be considered as a major criteria for any of the BWC recognized chronic pain diagnoses.

“338 Pain, not elsewhere classified” instructs the user to “use additional code to identify: pain associated with psychological factors (307.89)”. This code excludes generalized pain (780.96) and “localized pain, unspecific type” which is coded to pain by site. It also excludes pain disorder extensively attributed to psychological factors (307.80). Since this code is nonspecific and requires an additional code, BWC does not recognize this code.

“338.0 Central Pain Syndrome” includes Dejerine-Roussy syndrome, myelopathic pain syndrome, and thalamic pain syndrome (hyperesthetic). These are not common pain syndromes seen in workers’ compensation and BWC does not recognize this code.

“338.1 Acute Pain” includes fifth digit designations for “338.11 acute pain due to trauma”, “338.12 acute post-thoracotomy pain”, “338.18 other acute postoperative pain”, and “338.19 other acute pain”. As noted all of these codes describe acute pain whose treatment should be reasonably covered by other diagnoses or the authorization of procedures to treat the diagnoses. Therefore, these codes are not recognized by BWC.

“338.2 Chronic Pain” specifically excludes “355.9 causalgia”, “355.71 causalgia lower limb”, “354.4 causalgia upper limb”, “338.4 chronic pain syndrome”, “729.1 myofascial pain syndrome”, “338.3 neoplasm related chronic pain”, and “337.20-337.29 reflex sympathetic dystrophy”. 338.2 “Chronic pain” itself lacks specificity or infer a causal relationship to work injury or treatment to work injury. Therefore, code 338.2 is not recognized by BWC.

The other codes under 338.2 which have a fifth digit are recognized by BWC and include the following codes which can be allowed when the condition and medical document meet diagnostic criteria. These codes include “338.21 chronic pain due to trauma”, “338.22 chronic post-thoracotomy pain”, “338.28 other chronic postoperative pain” and “338.29 other chronic pain”. To enhance the specificity of the code “338.29 other chronic pain” and identification of the body part involved in the allowance, BWC will indicate the body part in the narrative for the code. For example, an allowance for chronic low back pain that meets claim allowance criteria may be designated by BWC as “338.29 other chronic pain – lumbar region”. For the most part, this code will be reserved for those claims meeting the criteria for chronic pain in which there have been no operative procedures or no other code for chronic pain is appropriate.

“338.3 Neoplasm related pain (acute) (chronic)” described as cancer associated pain, pain due to malignancy either primary or secondary, or tumor associated pain will be recognized by BWC when the claim has a specific neoplasm allowed in the claim and the condition meets other criteria for claim allowance.

“338.4 Chronic pain syndrome” is described as chronic pain associated with significant psychosocial dysfunction. Since this code is no more specific than “338.2 Chronic pain” and by description has “significant psychosocial dysfunction” which in most cases should require psychological/psychiatric treatment, BWC will not recognize this code. However, individuals with these findings should/may be considered appropriate for allowances of one of the other chronic pain codes combined with “307.89 Other psychalgia or pain disorder associated with both psychological and general medical condition” or a more specific psychiatric code such as “296.2 major depressive disorder, single episode”.

"307.80 Psychogenic pain, site unspecified" (described as "Pain Disorder Associated with Psychological Factors" in *DSM-IV-TR*[1]) is to be used when psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. General medical conditions play no role or a minimal role in the onset or maintenance of the pain. Since the role of the medical condition is minimal, it would be difficult to link the psychological factors to the work injury. Therefore, this condition will not be recognized by BWC as it relates to chronic pain conditions.

In addition to these ICD-9 Codes for 338, the 2007 version of *ICD-9-CM* has "780.96 Generalized pain" for pain Not Otherwise Specified. Since this code is primarily a symptom code that is nonspecific and since the codes described above are more specific, BWC does not recognize this code.

As a result of these newer codes being recognized by BWC, "724.6 chronic lumbosacral sprain/strain" when the claim already has an allowance for lumbar/lumbosacral sprain/strain will no longer be utilized since these claims will now be allowed for "338.29 other chronic pain" with BWC staff inserting the description of the body region affected.

In summary, the following codes will be recognized by BWC to represent allowances for conditions primarily manifest by chronic pain when allowance criteria are met:

Previously recognized:

- pain in joint (fifth digit of code identifies specific body part)
- other psychalgia or pain disorder associated with both psychological and general medical condition
- Reflex Sympathetic Dystrophy (RSD), upper limb
- Reflex Sympathetic Dystrophy (RSD), lower limb
- Postlaminectomy syndrome
- Fibromyalgia

Recognized as a result of *ICD-9-CM* (2007 Version):

- Chronic pain due to trauma
- Chronic post-thoracotomy pain
- Other chronic post-operative pain
- Other chronic pain
- Neoplasm related pain (acute) (chronic)

(Note: BWC Staff will indicate in the code descriptor the body part/region considered responsible/involved in the chronic pain.)
(Note: While BWC does not recognize "338.4 chronic pain syndrome" described as chronic pain associated with significant psychosocial dysfunction, any of the codes listed above may be additionally allowed for "307.89" or another psychiatric ICD-9 Code if the allowance criteria are met.)

No longer recognized by BWC in future claims:

- Chronic lumbosacral sprain/strain (claim already allowed for lumbar/lumbosacral sprain/strain)

a. Pain in Joint (Chronic) ICD-9 Code: 719.4 (fifth digit identifies body part)

[1]American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Definition:
Ongoing pain symptoms of at least 12 months duration post completion of conservative treatment or last definitive surgical procedure provided medical records indicate there has been ongoing medical care and attempts to identify and treat the source of pain. Such attempts should include appropriate diagnostic studies and consultations.

Note: This diagnosis is a secondary diagnosis of ongoing symptoms after completion of treatment in an individual who is significantly limited due to pain in a joint allowed in the claim. It requires a primary diagnosis recognized as allowed for the specific joint. It should not be used when a more specific and appropriate diagnosis is available to explain symptoms such as osteoarthritis, chondromalacia patellae, or adhesive capsulitis. Injured worker should be at maximum medical improvement in relation to the allowed condition of the joint.

Subjective:
- Symptoms of pain of varying nature, intensity, and character localized to joint with primary allowed condition.
- Treatment must be shown to have been present for at least 12 months following completion of conservative or last surgical treatment.
- May have other symptoms such as but not limited to joint swelling, buckling, decreased motion, or instability. Symptoms including pain should not involve multiple sites such as polyarthralgias, fibromyalgia, or systemic connective tissue diseases.

Objective:
- None

Diagnostic Tests**:**
- Diagnostic studies and medical records show absence of other appropriate diagnoses to account for painful condition including but not limited to osteoarthritis, recurrent injury such as torn meniscus, tendonitis, adhesive capsulitis, or degenerative condition of cartilage. Medical records should document diagnostic studies and/or consults to try to determine the source of pain.

b. Chronic lumbosacral sprain/strain ICD-9 Code: 724.6

This code is to be used for instability or ankylosis of lumbosacral or sacroiliac joint(s). For allowances of chronic pain in these areas (lumbosacral and/or sacroiliac joint(s), use diagnosis code 338.29.
Definition:
Ongoing pain symptoms of the lumbosacral region of at least 12 months duration post completion of conservative treatment provided medical records indicate there has been ongoing medical care and attempts to identify and treat the source of pain. Such attempts should include appropriate diagnostic studies and consultations.

Note: This diagnosis is a secondary diagnosis of ongoing symptoms after completion of treatment in an individual whose activity is significantly limited due to pain. It requires a primary diagnosis recognized as allowed such as lumbosacral sprain/strain and lack of invasive surgical intervention such as laminectomy, discectomy, or fusion. It should not

be used when a more specific and appropriate diagnosis is available to explain symptoms such as degenerative disc disease, spondylosis, or spondylolisthesis. Injured worker should be at maximum medical improvement in relation to the allowed condition of the lumbar spine.

Subjective:

- Symptoms of pain of varying nature, intensity, and character localized to low back with primary allowed condition having received conservative treatment and evaluation for more specific cause of pain such as herniated disc, etc.
- Treatment must be shown to have been present at least 12 months following completion of conservative treatment.
- May have other symptoms such as but not limited to leg pain, weakness, decreased spinal movement, etc.
- Symptoms including pain should not involve multiple sites such as polyarthralgias, fibromyalgia, or systemic connective tissue diseases.

Objective:

- None specific. Diagnosis is for chronic symptom of pain.

Diagnostic Tests:

- Diagnostic studies and medical records show absence of other appropriate diagnoses to account for painful condition including but not limited to disc pathology, spondylosis, spondylolisthesis, degenerative disc disease, and degenerative osteoarthritis.

c. Postlaminectomy Syndrome (fifth digit identifies back level) ICD-9 Code: 722.8*

Definition:
Ongoing pain symptoms of at least 12 months duration post completion of definitive surgical procedure such as discectomy, laminectomy, fusion, etc. (Surgical procedures does not include epiduroscopy, epidural steroid injection, myelogram, or discograms.) provided medical records indicate that pain is primary factor limiting performance of activities and focus of medical care is toward controlling/relieving pain. Medical records should document there has been ongoing medical care and attempts to identify and treat the source of pain. Such attempts should include appropriate diagnostic studies and consultations.

Note: This diagnosis is a secondary diagnosis of ongoing symptoms after completion of surgical treatment and rehabilitation in an individual who has undergone a surgical spinal procedure and is significantly limited due to pain. It requires a primary diagnosis recognized as allowed such as lumbosacral sprain/strain and usually a secondary diagnosis to allow for the surgical procedure and documentation of invasive surgical intervention such as laminectomy, discectomy, or fusion. Many of these injured workers may have completed or may be eligible for multidisciplinary pain treatment program. Injured worker should be at maximum medical improvement in relation to the allowed condition of the lumbar spine for which the individual underwent the procedure.

Subjective:

- Symptoms of pain of varying nature, intensity, and character localized to spine region with primary allowed condition having received surgical procedure, rehabilitation, and evaluation for more specific cause of pain such as recurrent herniated disc, etc. causing symptoms post-operatively.
- Treatment must be shown to have been present at least 12 months following completion of last surgical treatment.
- May have other symptoms such as but not limited to leg pain, weakness, decreased spinal movement, etc.
- Symptoms including pain should not involve multiple sites such as polyarthralgias, fibromyalgia, or systemic connective tissue diseases.

Objective:
- None specific. Diagnosis is for chronic symptom of pain.

Diagnostic Tests:
- Diagnostic studies and medical records show prior surgical procedure and absence of more specific diagnosis to explain painful condition such as recurrent herniated disc, etc. Medical records should document diagnostic procedures and/or consultations to try to determine and treat the source of pain in the individual.

d. Chronic pain due to trauma ICD-9 Code: 338.21 "chronic pain due to trauma"
(Note: BWC to indicate body part/region in narrative for code)

Definition:
Ongoing pain symptoms of at least 12 months duration post completion of conservative treatment or last definitive surgical procedure provided medical records indicate the mechanism of injury involved a significant traumatic event. Medical records must document that there has been ongoing medical care and attempts to identify and treat the source of pain. Such attempts should include appropriate diagnostic studies and consultations as appropriate.

Note: This diagnosis is a secondary diagnosis of ongoing symptoms after completion of treatment in an individual who sustained a significant traumatic injury and whose activity is significantly limited due to pain. It should not be used when a more specific and appropriate diagnosis is available to explain symptoms such as osteoarthritis, reflex sympathetic dystrophy, or neuropathic pain. Injured worker should be at maximum medical improvement in relation to the allowed condition(s) pertaining to the traumatic event.

Subjective:
- Symptoms of pain of varying nature, intensity, and character localized to body region of primary allowed condition that has received completion of planned treatment.
- Treatment must be shown to have been present at least 12 months following completion of conservative or last surgical treatment.
- May have other symptoms such as but not limited to joint swelling, buckling, decreased motion, or instability. Symptoms including pain should not involve multiple sites such as polyarthralgias, fibromyalgia, or systemic connective tissue diseases.

Objective:
- None

Diagnostic Tests:
- Diagnostic studies and medical records show absence of other appropriate diagnoses to account for painful condition such as osteoarthritis, reflex sympathetic dystrophy, etc.

e. Chronic post-thoracotomy pain ICD-9 Code: 338.22

Definition:
Ongoing pain symptoms of at least 12 months duration post completion of thoracotomy for a recognized allowed condition in the claim. Medical records must indicate that pain is primary factor limiting performance of activities and focus of medical care is toward controlling/relieving pain. Medical records should document there has been ongoing medical care and attempts to identify and treat the source of pain. Such attempts should include appropriate diagnostic studies and consultations.

Note: This diagnosis is a secondary diagnosis of ongoing symptoms after completion of a thoracotomy for an allowed condition in an individual who is significantly limited due to pain when the pain is believed to be the primary result of the thoracotomy.

Subjective:
- Symptoms of pain of varying nature, intensity, and character localized to the region of the thoracotomy despite the individual having received conservative treatment and evaluation for more specific cause of pain.
- Treatment must be shown to have been present for at least 12 months following completion of conservative or last surgical treatment.
- May have other symptoms.
- Symptoms including pain should not involve multiple sites such as polyarthralgias, fibromyalgia, or systemic connective tissue diseases.

Objective:
- None specific. Diagnosis is for chronic symptom of pain.

Diagnostic Tests:
- Diagnostic studies and medical records show absence of other appropriate diagnoses to account for painful condition such as primary pulmonary or cardiac etiology.

f. Other chronic post-operative pain ICD-9 Code: 338.28
(Note: BWC to indicate body part/region in narrative for code)

Definition:
Ongoing pain symptoms of at least 12 months duration post completion of a definitive surgical procedure other than thoracotomy (338.22) or lumbar discectomy, laminectomy or fusion (722.8) for a recognized allowed condition in the claim. Medical records must indicate that pain is primary factor limiting performance of activities and focus of medical care is toward controlling/relieving pain. Medical records should document

there has been ongoing medical care and attempts to identify and treat the source of pain. Such attempts should include appropriate diagnostic studies and consultations.

Note: This diagnosis is a secondary diagnosis of ongoing symptoms after completion of surgical treatment in an individual who has undergone a surgical procedure and is significantly limited due to pain believed to be the result of the procedure.

Subjective:

- Symptoms of pain of varying nature, intensity, and character localized to the body region of the primary allowed condition for which the surgical procedure was performed.
- Treatment must be shown to have been present at least 12 months following completion of the last surgical treatment.
- May have other symptoms such as but not limited to referred pain, weakness, decreased movement, etc.
- Symptoms including pain should not involve multiple sites such as polyarthralgias, fibromyalgia, or systemic connective tissue diseases.

Objective:

- None specific. Diagnosis is for chronic symptom of pain.

Diagnostic Tests:

- Diagnostic studies and medical records show prior surgical procedure and absence of more specific diagnosis to explain painful condition such as recurrent herniated disc, RSD, osteoarthritis, etc.

g. Other chronic pain ICD-9 Code: 338.29
(Note: BWC to indicate body part/region in narrative for code)
(Note: Use this code only if documentation does not meet 338.21, 338.22, and 338.28 which are more specific codes.)

Definition:
Pain in body part/region requiring medical care for at least 12 months (no reactivation) after completion of conservative treatment for the primary allowed condition. Medical records must indicate that pain is primary factor limiting performance of activities and focus of medical care is toward controlling/relieving pain. Medical records should document there has been ongoing medical care and attempts to identify and treat the source of pain. Such attempts should include appropriate diagnostic studies and consultations.

Note: This diagnosis is a secondary diagnosis of ongoing symptoms after completion of treatment in an individual who is significantly limited due to pain. It requires a primary diagnosis recognized as allowed for the specific body part/region. It should not be used when a more specific and appropriate diagnosis is available to explain symptoms such as osteoarthritis, reflex sympathetic dystrophy, etc. or a more specific chronic pain diagnosis such as chronic post-thoracotomy pain or postlaminectomy syndrome..

Subjective:
- Symptoms of pain of varying nature, intensity, and character localized to body part/region for the primary allowed condition that has received completion of conservative treatment.
- Treatment must be shown to have been present for at least 12 months following completion of conservative treatment directed at the allowed condition in the claim.
- Symptoms including pain should not involve multiple sites such as polyarthralgias, fibromyalgia, or systemic connective tissue diseases.

Objective:
- None

Diagnostic Tests:
- Diagnostic studies and medical records show absence of other appropriate diagnoses to account for painful condition including but not limited to osteoarthritis, reflex sympathetic dystrophy, etc.

h. Neoplasm related pain (acute) (chronic) ICD-9 Code: 338.3

Definition:
Pain in body part/region as a direct result of a neoplasm which is a recognized allowed condition in the claim. Pain must significantly impacts activity and requires ongoing medical treatment directed toward relief of pain. Individual may or may not have had surgery, chemotherapy, radiation therapy or other treatment of the neoplasm. No specific difference in the claim allowance regarding acute versus chronic duration of pain.

Note: This diagnosis is a secondary diagnosis of ongoing pain symptoms attributed directly to a recognized allowed condition of neoplasm of a body part/region/organ system.

Subjective:
- Symptoms of pain of varying nature, intensity, and character attributed to a neoplasm that is recognized as an allowed condition in the claim.
- Treatment does not have specific time duration but optimally individual should have received some treatment focused to the neoplasm.
- May have other symptoms such as but not limited to, weakness, fatigue, decreased appetite, etc.
- Symptoms including pain should not involve multiple sites such as polyarthralgias, fibromyalgia, or systemic connective tissue diseases.

Objective:
- None specific. Diagnosis is for chronic symptom of pain.

Diagnostic Tests:
- Diagnostic studies and medical records support the diagnosis of the neoplasm.

i. Pain Disorder Associated with Both Psychological Factors and a General Medical Condition
ICD-9 Code: 307.89

Definition:
Chronic pain condition in which both psychological factors and a general medical condition are considered to be significant contributors to the disorder whether the psychological contribution contributes to the onset, severity, exacerbation, or maintenance of the pain. Evaluation and treatment in most cases will require evaluation and treatment of the medical conditions believed to be causing pain and evaluation and treatment of the psychological factors.

Note: This diagnosis is a secondary diagnosis or second diagnosis of an individual who is already recognized as having a chronic pain condition recognized by BWC. This condition may be combined with an allowance of a chronic pain disorder to provide the equivalent of chronic pain syndrome. In lieu of this diagnostic code, more specific psychiatric diagnostic codes (most commonly those of depression) may be appropriate and more specific.

Note: BWC does not recognize ICD-9 Code "307.80 Psychogenic pain, site unspecified" since this code is a primary mental health code and a medical condition has no or very minimal role.

Subjective:
- Symptoms of pain of whose onset, severity, or maintenance are believed to be significantly affected by psychological factors and a chronic medical pain condition.
- Individual must have a chronic pain allowance describing a general medical condition.

Objective:
- None specific.

Diagnostic Tests:
- Since this condition is considered a mental disorder, a psychological/psychiatric independent medical evaluation must be performed as in any other request for a psychological/psychiatric allowance.

T. WHEELCHAIRS

In order to be covered by BWC, a wheelchair must be reasonable and necessary for the treatment of the allowed claim condition or improve the functioning of the injured or affected body part and meet all BWC regulatory requirements.
- A wheelchair is covered if the injured worker's condition is such that without the use of a wheelchair he would otherwise be bed or chair confined.
- An upgrade that is beneficial solely in allowing the injured worker to perform leisure or recreational activities is generally non-covered.
- Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair. Reimbursement also includes support services such as emergency services, delivery, set-up, education, and on-going assistance with the use of the wheelchair for 90 days.

- Payment is usually made for only one wheelchair at a time. Rental of a wheelchair is covered if an injured worker-owned wheelchair is being repaired.
- For an item to be considered for coverage and payment by BWC, the information submitted by the supplier must be corroborated by documentation in the injured worker's medical records. The injured worker's medical records supporting the medical necessity of the wheelchair must be made available by the MCO upon request.

The physician of record or treating physician is responsible for writing the prescription for the wheelchair and completing the C-9 requesting the wheelchair and submitting this request to the MCO. The physician's request should include the type of wheelchair requested, current medical status of the injured worker and documentation supporting medical necessity of the wheelchair.

The BWC medical service specialist is responsible for working with the MCO case manager or delegated MCO staff and the DME supplier to insure the wheelchair under consideration is the most appropriate to fit the injured worker's specific medical needs. This includes ordering the correct size wheelchair and necessary wheelchair modifications while considering medical necessity and cost containment. The medical service specialist will work with the MCO to be certain the injured worker can use this wheelchair in the home or facility where the injured worker resides and that access to enter/exit is accounted for.

The BWC Catastrophic Nurses are responsible for working with the MCO case manager or delegated MCO staff and the DME supplier to insure the wheelchair under consideration is the most appropriate to fit the catastrophically injured worker's specific medical needs. All ramp and/or home modification requests are referred to the CAT nurse.

1. **Power Operated Vehicles**
   For any power operated vehicle (POV) to be reimbursable by BWC/MCO, it must be reasonable and necessary for the treatment of an allowed claim condition, illness or injury. A power operated vehicle can be reimbursed when the following criteria are met:
   - The IW's condition is such that without the use of the wheelchair, the IW would not be able to move around in his/her residence; and
   - The IW is unable to operate a manual wheelchair; and
   - The injured worker is capable of safely operating the controls for the POV; and
   - The IW can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV; and
   - It is ordered by a physician who is one of the following specialties: Physical Medicine, Orthopedic Surgery, Neurology, or Rheumatology. Exception: When a specialist is not reasonably accessible (e.g. more than one day's round trip from the IW's home or the IW's condition precludes such travel), an order from the IW's physician of record may be acceptable.

   A POV will usually be denied as not medically necessary when it is needed only for use outside the home. If a POV is covered, an electric wheelchair provided at the same time or subsequently will generally be denied as not medically necessary.

2. **Specially sized wheelchairs**
Payment may be made for a specially sized wheelchair even though it is more expensive than a standard wheelchair. For example, a narrow wheelchair may be required because of the narrow doorways of an injured worker's home or because of the injured worker's slender build. Such difference in the size of the wheelchair from the standard model is not considered a deluxe feature. A physician's certification or prescription for a special size is not required when it can be determined from documentation in the file that a specially sized wheelchair (rather than a standard one) is needed.

U. WAGE LOSS COMPENSATION

1. Applicable Laws and Rules include:

R.C. 4123.56 Compensation for Wage Losses of Returning Employee
Rule 4125-1-01 Rule for Wage Loss Compensation

Wage loss is payable in claims with date of injury or diagnosis on or after August 22, 1986. Wage loss is available when an injured worker, as a direct result of the restrictions caused by allowed conditions in the claim, suffers a reduction in earnings.

a. Working Wage Loss (WWL) may be paid when the injured worker returns to employment other than his/her former position of employment.

b. Non-Working Wage Loss (NWWL) is payable when the injured worker is unable to find employment within the restrictions which are a direct result of the allowed conditions in the claim.

The injured worker applies for WL benefits by completing the Application for Wage Loss Compensation (C-140) and submitting a Wage Loss Statement (C-141) which documents job search activity. The C-140 application includes a medical report that identifies any restrictions that are a result of the allowed conditions in the claim and whether those restrictions are temporary or permanent. This information may be documented by the attending physician on the back of the C-140 or any other format that provides the necessary medical information.
The physician must identify:

- any restrictions which are a direct result of the allowed conditions in the claim;
- whether these restrictions are temporary or permanent;
- any other restrictions;
- physical capacities.

Subsequent medical reports are required ***every 90 days*** if the conditions are temporary and ***every 180 days*** if they are permanent. The Claims Service Specialist (CSS) will coordinate obtaining these subsequent medical reports with the MCO. The back of the C-140 may also be used as the subsequent medical report or any other format which provides the necessary medical information.

V. TENS and NMES

The intent of this policy is to implement minimum standards for all vendors supplying TENS/NMES units to Ohio's injured workers and to establish standardized criteria for the

medical indications for the use of TENS/NMES. Refer to Chapter 3 of the BRM for TENS/NMES directives to providers. Rule 4123-6-43 covers payment for transcutaneous electrical nerve stimulators and neuromuscular electrical stimulators. This rule can be accessed on BWC's Web site at:

https://www.ohiobwc.com/basics/guidedtour/generalinfo/ORCandOAC.asp.

TENS: A device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the patient's perception of pain by inhibiting the afferent pain nerve impulses and/or stimulating the release of endorphins.

NMES: A device which transmits an electrical stimulus to muscle groups and causes the muscle to contract.

1. Required Criteria for TENS/NMES Units

These criteria apply to all vendors supplying TENS/NMES units to Ohio's injured workers.

a. BWC Minimum Technical and Educational Criteria

1) TENS and NMES units

Requirement: Device must produce constant current.
Rationale: Constant current maintains waveform as it is driven through the skin. It allows the current to be delivered in a uniform pattern, increasing the comfort for the patient. Breakdown of the waveform may result in increased skin irritation and burning.

2) Electrodes

Requirements: a.) Impedance must be no greater than 75 ohms. Ideal impedance is 30-60 ohms. b) **Re-usable electrodes** must be able to be reused 10-15 times depending on skin condition.
Rationale: a.) Increased ohms cause the need for higher current levels for maximum functioning; b.) Re-use of electrodes provides for increased efficiency and decreased costs.

3) Instruction/Education

Requirement: TENS and NMES units must be personally fitted and face to face instruction given by a direct employee of the **billing provider** within 5 business days of the request for the unit, payable 1 time per Injured Worker.
Rationale: Injured workers are more apt to use the TENS or NMES unit correctly and to have fewer problems and increased relief if given face to face instruction rather than if given written or telephonic instruction.

4**) Supplies**

The MCO may authorize the use of a TENS unit and supplies according to the current process (e.g. 6 month period); however, the injured worker should not automatically receive supplies throughout the authorization period without MCO verification that supplies are needed. Also, the TENS provider must receive authorization from the injured worker's MCO prior to delivery of supplies and/or equipment. The TENS provider will then deliver the supplies and bill the MCO.

The rule requires the injured worker's MCO to regularly determine the specific TENS supplies needed by the injured worker throughout the period of time authorized for TENS use. The MCO shall implement a process to determine the specific type and quantity of medically necessary supplies required by the injured worker for use of the approved TENS unit. The MCO shall have contact with the injured worker at **regular intervals** as often as mutually established by the MCO and injured worker. However, where TENS supplies are authorized for a period exceeding 45 days, MCO contacts to injured worker must occur at least one time every 45 days.

The MCO shall maintain documentation of each contact and the type and quantity of each supply requested by the injured worker. The MCO shall verify and document the injured worker's choice of BWC-certified TENS supply provider. If the injured worker requests assistance in selecting a TENS supply provider, the MCO shall maintain documentation of the communication and the selected vendor.

For each contact with the injured worker, the MCO shall ensure the specific supplies requested are necessary for the effective use of the authorized TENS unit. The MCO shall issue an authorization communication (e.g. letter, email, phone call, etc.) to the TENS supply provider selected by the injured worker. Where TENS supplies are authorized for a period exceeding 45 days, authorization communication shall be issued to the provider at least one time every 45 days. The authorization communication shall include the type and quantity of supplies approved and the beginning and end dates of the approval. The MCO shall maintain a copy or documentation of each authorization communication.

The TENS supply provider shall only distribute and bill for authorized supplies. The MCO shall reimburse the TENS supply provider only for distributed and authorized supplies.

b. BWC Medical Necessity Criteria

1) TENS for Chronic Pain

Prior authorization by BWC, MCO, or self-insured employer or their agents is required for TENS rental or purchase. Payment for a transcutaneous electrical nerve stimulator (TENS) is covered for the treatment of patients with chronic, intractable pain who meet the following criteria:

- Documentation from the physician of chronic pain that has been present for three months;
- Documentation from the physician of the location of pain, duration of time patient has had pain, and the presumed cause of the pain;
- Documentation from the physician of other modalities that have been tried and failed;
- Trial rental period of only one month to determine the effectiveness of TENS unit.

For purchase of a TENS unit for chronic pain, the following documentation must be present in the physician's records at the conclusion of the 30 day trial:

- Frequency and duration of use of TENS;
- Results of TENS units modulating pain

2) TENS for Acute Post-operative Pain

TENS rental is generally limited to 30 days beyond surgery. For reimbursement beyond 30 days, the physician must provide medical documentation for justification.

3) Neuromuscular Stimulators (NMES)

A NMES device provides an electrical stimulus directly to the muscle or motor nerve of the muscle, causing the muscle to contract. The goal is to stimulate denervated muscle to prevent atrophy or degeneration and to strengthen/train healthy muscles that are at risk of atrophy from immobilization or disuse due to injury. Prior authorization by BWC, MCO, or self-insured employer is required prior to NMES rental or purchase.

The MCO Medical Director or an MCO physician consultant is required to review each request for home rental or purchase of NMES based on medical necessity and BWC NMES criteria.

Reimbursement of NMES devices for home use for the treatment/prevention of muscle atrophy requires the following conditions be met:

- The patient has suffered partial or complete loss of function in one or more muscles because of an injury to a peripheral nerve or nerve root, and
- Denervation is substantiated by EMG confirming the nerve injury. The EMG must demonstrate positive waves and/or fibrillation in the affected muscles.

BWC/MCOs will reimburse NMES and also Functional Electrical Stimulation (FES) to enhance walking of injured workers with spinal cord injuries (SCI) who meet all the following criteria:

- Diagnosis of paraplegia of both lower limbs (ICD-9 344.1);
- Willingness to use the device on a long-term basis;
- High motivation, commitment and cognitive ability to use the device for walking;
- Completion of a physical therapy training program of a minimum of 30 sessions with the NMES unit over a 3 month period;
- Intact lower motor units (L1 and below) both muscle and peripheral nerve;
- Demonstration of brisk muscle contraction to NMES and sensory perception of electrical stimulations sufficient for muscle contraction;
- Muscle and joint stability for weight bearing at upper and lower extremities with demonstration of balance and control to maintain an upright support posture independently;
- Ability to transfer independently and demonstration of standing independently for at least 3 minutes;
- Demonstration of hand and finger function to manipulate controls;
- Minimum of 6-month post recovery spinal cord injury and restorative surgery; and
- Absence of hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis

The appropriate Level I CPT® code to be billed to MCO/BWC for the required physical therapy with the NMES unit is 97116-gait training.

NMES/FES for walking is contraindicated for SCI injured workers with any of the following:

- Cardiac pacemakers or cardiac defibrillators;
- Severe scoliosis or severe osteoporosis;
- Irreversible contracture;
- Autonomic dysreflexia: or
- Skin disease or cancer at the area of stimulation

3. **Coding of TENS/NMES**
TENS/NMES coding information can be found in Chapter 8 of this manual.

W. UTILIZATION OF PRESCRIPTION MEDICATION FOR INTRACTABLE PAIN

The purpose of this policy is to provide to Ohio physicians treating Ohio Injured Workers, BWC personnel, MCOs, BWC's Disability Evaluators Panel (DEP) drug file reviewers and independent medical examiners, and injured workers, their employers and their respective representatives:

- the rules for prescribing narcotic medication in the treatment of intractable pain according to The State Medical Board of Ohio Administrative Code Chapter 4731-21;
- the expectations of the type of medical evaluation and documentation necessary to support and facilitate using prescription medication for the treatment of intractable pain in injured workers in the Ohio Workers' Compensation System;
- the key elements that may be necessary in the claim file to assist BWC personnel and physicians performing reviews to determine whether the use of prescription medications in the claim meet statutory requirements;
- the rationale and process for BWC claims management personnel to use to obtain when necessary the information needed to support or deny the use of prescription medications for the treatment of intractable pain and to facilitate the use of prescription medication when necessary and appropriate for treatment, obtain necessary information when insufficient information is lacking in the claim file, and to deter use of prescription medications when there is lack of proof of medical necessity and appropriateness.

Issues important to Ohio Workers' Compensation include:

- Lack of use of prescription medication, particularly opioids, by physicians who are treating chronic intractable (non-malignant, benign) pain in some of Ohio's injured workers has been identified.
- Variance in interpretation and application of The State Medical Board of Ohio Administrative Code Chapter 4731-21 by physicians performing claims management services for BWC and BWC personnel which ultimately impacts authorization/denial decisions regarding use of prescription medications.
- Lack of strict claims management guidelines regarding criteria to support use or to deny authorization of prescription medication in the treatment of intractable pain.
- Concern for overuse and excessive prescribing of prescription pain medication for some injured workers has been identified by BWC personnel, pharmacists, physicians, employers, and other parties as it impacts well being of the injured worker, potential for inappropriate use and distribution, social implications, and financial costs to the system.

Statutes regarding the use of prescription medication for the treatment of intractable pain have changed considerably in the past ten years both nationally and in Ohio.

In October 1997 the Ohio General Assembly passed Sub. H.B. 187 which required the State Medical Board of Ohio to establish standards and procedures for physicians regarding the diagnosis and treatment of intractable pain. The State Medical Board of Ohio's pain management rules became effective in November 11, 1998. These rules are contained in Chapter 4731-21 of the Ohio Administrative Code.

The State Medical Board of Ohio Rule 4731-21-02 pertains to "utilizing prescription drugs for the treatment of intractable pain".

Since these rules provide the legal authorization and criteria for use of the prescription drugs for treatment of intractable pain, they must also be followed by physicians providing opinions for authorization of payment of such medications in claims in either file reviews or independent medical evaluations for BWC.

According to Rule 4731-21-01 "Definitions" of The State Medical Board of Ohio Rules:

> *"Intractable pain" means a state of pain that is determined, after reasonable medical efforts have been made to relieve the pain or cure its cause, to have a cause for which no treatment or cure is possible or for which none has been found. "Intractable pain" does not include pain experienced by a patient with a terminal condition. "Intractable pain" does not include the treatment of pain associated with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition."*

To comply with this definition, reasonable medical efforts should have been made to relieve the pain or cure its cause and that the pain has a cause for which no treatment or cure is possible or at least none has been found. Therefore, intractable pain would be considered only after reasonable medical efforts have been made to diagnose the cause of the pain and adequate and appropriate medical treatment has been provided to treat the cause. Many medical conditions seen in workers' compensation patients could be considered "intractable pain" such as, but not limited to, complex regional pain syndrome I or the chronic pain frequently associated with lumbar procedures such as postlaminectomy syndrome. Due to wide variance of symptoms and treatment over the clinical course of a condition, not all patients with these allowed conditions in the claim meet the definition of "intractable pain".

Rule 4731-21-02 provides the guidelines or expectations of physicians managing intractable pain with prescription drugs. Paragraph (A) requires:

- an initial evaluation that includes complete medical, pain, alcohol and substance abuse histories;
- assessment of the impact of pain on physical and psychological functions;
- review of previous diagnostic studies and previously utilized therapies;
- an assessment of coexisting illnesses, diseases or conditions; and
- an appropriate physical examination

The medical diagnosis must be documented that indicates the intractable pain along with the signs, symptoms, and causes of the pain. An individual treatment plan is required to be documented specifying the medical justification of the treatment of intractable pain with prescription drugs on a protracted basis, the intended role of prescription drug therapy within the overall plan, and other medically reasonable treatment for relief of the intractable pain that have been offered or attempted without adequate or reasonable success. The response to the treatment must be documented along with modifications to the treatment plan. Section (4)(a) of Paragraph (A) states that the diagnosis of intractable pain can be made only after having the patient "evaluated by one or more other practitioners who specialize in the treatment of the anatomic area, system, or organ of the body perceived as the source of the pain." The prescribing physician is to maintain a copy of the report of the evaluation. The evaluation is not required if the patient has been evaluated and treated within a "reasonable period of time" by one or more other practitioners who specialize in the anatomic area, system, or organ perceived to be the source of pain and the treating practitioner is satisfied that he or she can rely on the evaluation to meet the requirements of the Rule. The practitioner is required to obtain and maintain a copy of the records or report on which he/she relied to meet the requirements of an evaluation by a specialist. Last, Paragraph (A) requires an informed consent be present retained in the medical record informing the patient of the risk and benefits of receiving prescription drug therapy and of available treatment alternatives.

Paragraph (B)(1) requires that the practitioner see the patients at "appropriate periodic intervals to assess the efficacy of treatment, assure that prescription drug therapy remains indicated, evaluate the patient's progress toward treatment objectives, and note any adverse drug effects". Paragraph (B)(2) also requires ongoing assessment of functional status, the pain intensity, and its interference with activities of daily living, quality of life, and social activities. If there is evidence or behavioral indications of drug abuse, the practitioner may obtain a drug screen. According to Paragraph (B)(3), "It is within the practitioner's discretion to decide the nature of the screen and which type of drug to be screened." Results of the screening should be documented in the patient's medical record.

Paragraph (C) requires immediate consultation with an addiction medicine or substance abuse specialists if the practitioner believes or has reason to believe the patient is suffering from addiction or drug abuse.

Based on the above statutory and regulatory documents described, the use of prescription medication for the treatment of chronic intractable pain is acceptable in Ohio on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions so long as the treating physician complies with The State Medical Board of Ohio Rules. Based on Ohio Supreme Court decision, it is also required that the authorization of payment for services be reasonably related, reasonably necessary for treatment of the allowed injury, and that the costs are medically reasonable. To support the reasonably necessary requirement, practitioners can be expected to provide medical documentation to support intractable pain and the need to use prescription medication for the treatment of intractable pain when present. Medical records should

also reflect or explain how the intractable pain and its treatment are reasonably related to the allowed injury in the claim.

Key elements expected to be present in the medical file include but are not limited to:

- Reasonable medical efforts (diagnostic study, consultation, and treatment) have been performed to relieve the pain, identify the source, and cure its cause.
- No other treatment or cure is possible or none has been found.
- The initial evaluation by the treating practitioner meets the requirements of Rule 4731-21-02. (Note: This is not intended to be point-by-point specific, but that the medical records do document sufficient history, pain description, relatedness of the pain to the allowed condition in the claim, alcohol and substance abuse history, assessment of physical and psychological function, diagnostic studies and treatment performed, and an appropriate physical examination.)
- Appropriate consultation has been performed either by consultation or previous treating specialist as defined by Rule 4731-21-02 within a reasonable period of time, not to exceed six months from the beginning of such treatment.
- Medical records provide appropriate documentation to support continued use of the medication and consistent with Rule 4731-21-02. This includes adequate monitoring of the patient on a periodic basis to determine the continued need for prescription medication.

BWC expects as part of the treatment guidelines that MCOs will provide authorization for the following services:

- Periodic office visitation to monitor treatment compliance, results, physiologic and psychological functioning.
- In certain claims, it may be necessary to obtain periodic urine drug testing to determine drug abuse based on evidence or behavioral indications of addiction as described in Rule 4731-21-02 Paragraph (B)(3). This most likely would be no more frequent than quarterly.
- Referral to an addiction medicine specialist or substance abuse specialist for consultation and evaluation (most likely each case would need to be evaluated for treatment) if the practitioner believes or has reason to believe the patient is suffering from addiction or drug abuse as described in Rule 4731-21-02 Paragraph (C).

Since there is no specific allowance of "chronic intractable pain", BWC personnel involved with claim management determinations and physicians performing file reviews or Independent Medical Evaluations for BWC should consider the following criteria in regard to the use of prescription medication to treat chronic intractable pain:

- that the medical records meet the definition of "intractable pain" as defined by the State Medical Board of Ohio particularly in relation to reasonable medical efforts to determine the source and treat the cause of the pain have been documented;
- that a second opinion from an appropriate specialist has been performed;
- that the medical records provide a reasonable relationship of the symptoms to the allowed conditions in the claim; and

- That the use of such medication is reasonably necessary to help manage the symptoms experienced by the injured worker.

Should the above criteria be met, even though there is no allowance for chronic intractable pain on the claim, then the BWC may authorize reimbursement for prescription medication used in the treatment of chronic intractable pain.

In claim management, many, if not most, cases would be a continuation of or "flow-through" of treatment of a condition that is presumed to be the cause of pain and for which the injured worker has received appropriate diagnostic testing, treatment, and evaluations. Many individuals considered to have "chronic intractable pain" will have obvious limitation of activity and difficulty controlling pain following treatment of the allowed condition. Other claims will be more difficult to assess. There may be issues of (1) need for additional diagnostic testing; (2) need for specialist consultation, (3) uncertainty of diagnosis or relationship to the allowed conditions in the claim, or (4) medical records do not support the apparent need for continued treatment. It can be anticipated that some employers may also request an independent medical evaluation of injured workers for the purpose of justification of ongoing treatment in many of these cases.

In questionable cases or those requested by the employer, independent medical evaluation performed by a specialist appropriate for the body part or system considered to be the source of "chronic intractable pain" would be appropriate to determine issues such as:

- Recommendations for any additional testing to identify source of pain
- Other treatment that should be considered
- Specialty consultation that may be beneficial
- Provide description of the pain and impact on daily living, functioning, etc.
- Clarify relationship of symptoms (pain) to the allowed conditions or work injury
- Determine the apparent need for continued treatment
- Other issues as deemed necessary.

In most workers' compensation cases, the presumed source of pain will be limited to the musculoskeletal system. Appropriate independent medical evaluating specialists would, in general, be limited to orthopedists, hand surgeons for the upper extremity, neurosurgeons, physical medicine and rehabilitation specialists, and possibly occupational medicine and pain specialists depending on the nature of the issue.

Treating physicians who consistently fail to provide appropriate medical records or follow The State Medical Board of Ohio rules should be referred to DEP Central or Provider Relations along with the specific claim numbers of injured workers being treated.

Note: For the complete BWC position paper including references, see the BWC website www.ohiobwc.com under Medical Providers/ Services/Medical Position Papers.

X. NEW MEDICAL TECHNOLOGIES and PROCEDURES POLICY

BWC has developed a process for evaluating requests for the review of new medical technology or procedures for coverage for the treatment of workers' compensation

conditions. This process does not apply to new products or methods for the treatment of conditions when a similar method or product for treatment is currently available. The review will include the following steps.

- BWC or MCO identifies the technology or procedure of concern in regard to authorization.
- BWC will gather information regarding the procedure, treatment or technology. Sources may include manufacturer's literature, submitted documentation from the provider requesting authorization of the service, and information from the MCO
- The BWC Medical Services Division will review the documentation and will research other sources such as MEDLINE or other databases; *The Cochrane Library,* established treatment guidelines and specialty organizations, such as the Centers for Disease Control.
- The BWC Medical Services Division will review the information and create a draft position document focusing on indications, outcomes, adverse effects, safety and cost.
- The draft position will be presented to the appropriate medical committee (i.e., MCO Medical Directors Committee or BWC Health Care Quality Assurance Advisory Committee).
- The final position paper will be posted on BWC's website.

Y. VERTEBRAL AXIAL DECOMPRESSION

The purpose of this policy is address the coverage and reimbursement of vertebral axial decompression therapy by BWC. This modality has also been called lumbar decompression or spinal decompression by some providers.

Decompression therapy is intended to create negative pressure on the spine, so that the vertebrae are elongated, pressure is taken off the roots of the nerve, and a disk herniation may be pulled back into place. Decompression therapy is generally performed using a specially designed computerized mechanical table that separates in the middle. Although the American Medical Association (AMA), FDA and Centers for Medicare and Medicaid Services (CMS) all consider decompression therapy to be a form of traction, the manufacturers of these devices consider them different from traction devices. (Sherry, 2001) (Gose, 1998) (Colorado, 2001) (Deen, 2003) (Humana, 2004)

While there are some limited promising studies, the evidence in support of vertebral axial decompression is insufficient to support its use in low back injuries. This policy includes, but is not limited to, mechanical traction provided by the following powered traction devices:

- VAX-D
- DRS System
- Spina System
- DRX 2000, DRX 3000m, DRX 5000
- Lordex Traction Unit

Per the CPT© Assistant November 2004/ Volume 14, Issue 11:
"CPT© code 97012, application of modality to one or more areas; traction, mechanical, is intended to identify a procedure that creates a force to allow for separation between joint

surfaces. The degree of traction is controlled through the amount of force allowed, duration (time), and angle of pull using mechanical means. Therefore, code 97012 would be the most appropriate code to report for various types of mechanical traction devices including vertebral axial decompression."

BWC requires vertebral axial decompression (spinal decompression, decompression therapy) to be billed with the CPT code for mechanical traction and will pay one unit of service per visit, regardless of the length of time the traction is applied. The decision regarding authorization of decompression therapy will remain with the individual MCO.

Z. INTERFERENTIAL THERAPY

Interferential or sympathetic therapy is a type of electrical stimulation of the peripheral nerves that is designed to alleviate pain by inducing a systemic effect on sympathetically induced pain. Interferential stimulation is customarily provided on an out-patient basis for about 20 treatment sessions followed by purchase of a home unit for the patient to self-administer the interferential therapy for an unlimited period of time. Following a review of the literature and coverage policies of other third party insurers, BWC has determined that insufficient evidence exists to determine the effectiveness of "**self-administered"** sympathetic therapy/ interferential therapy. BWC and the MCO will not reimburse the rental or purchase of a therapy unit used to self-administer interferential therapy.

AA. DURABLE MEDICAL EQUIPMENT

Durable medical equipment is defined as equipment which:

- Can withstand repeated use; i.e., could normally be rented and used by successive patients;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in a patient's home.

The following reusable items are examples of DME:

- hospital beds
- mattresses for hospital beds
- walkers
- wheelchairs
- breathing machines
- crutches
- bedside commodes
- seat lift mechanism

BWC considers a seat lift mechanism to be medically necessary for an injured worker who requires a mobility aid to stand from a seated position due to physical limitations that are reasonably related to the industrial injury (disease). BWC reimburses the seat-lift mechanism, (E0627, E0628 or E0629) when the MCO determines it is medically

necessary and appropriate to the industrial injury. BWC does not reimburse the chair (furniture).

Equipment which is primarily and customarily used for a non-medical purpose does not qualify as durable medical equipment and will not be reimbursed by BWC. Some examples include:

- Home furniture including, but not limited to: reclining chairs, non-hospital beds, water beds, lounge beds (such as Adjust-A-Sleep Adjustable Bed, Craftmatic Adjustable Bed, Electropedic Adjustable Bed, Simmons Beautyrest Adjustable Bed)
- Home exercise equipment, such as treadmills and exercise bikes, are not considered to be durable medical equipment and shall not be authorized or paid by for BWC/MCO, except when the criteria has been met for an IW who is participating in a vocational rehab program.
- Home whirlpools including built-in whirlpools and pumps, portable hydrotherapy pools, Jacuzzi tubs, portable saunas and spas, and TheraSaunas as considered to be not medically necessary. This includes non-portable hot tubs/whirlpools billed as E1310**.** When a request is received for a built in hot tub/whirlpool, the MCO must call the provider to advise that BWC covers the "over tub whirlpool" (E1300) if determined to be medically necessary and appropriate to the industrial injury

BWC/MCO must determine that DME is necessary and reasonable. The Miller Case addresses these criteria.

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

Specific features of durable medical equipment that have been determined by the MCO/BWC to be features that are not medically necessary or do not have a reasonable relationship to the allowed conditions in the claim will not be reimbursed by BWC/MCO. Examples include:

- BWC will not reimburse a heavy duty/bariatric piece of equipment unless the IW meets the weight requirements.
- BWC limits reimbursement of a hospital bed mattress to a single size mattress, or the size that is required by the injured worker determined by the IW**'**s weight, height, and medical condition. BWC does not reimburse for a double, queen, or king size mattress to accommodate two people.
- BWC will not reimburse a mattress for a non-hospital bed.
- BWC will not reimburse a "deluxe" model if the standard model provides the features that are medically necessary for the IW.

BWC considers Durable Medical Equipment (DME) to be purchased when rental has reached the BWC purchase fee. BWC does not accept a provider's percentage reduction from the rental fees already paid which result in BWC payment of additional monies for the purchase of the equipment beyond the BWC purchase fee.

Note: Equipment used as part of a surgical procedure (i.e. implantable devices, surgical hardware) must be billed by the facility where the procedure takes place (i.e. ASC, hospital) or by the physician if done in the physician's office. BWC or the MCO will not reimburse the manufacturer or supplier of the equipment when the equipment is used as part of a surgical procedure. Examples of equipment used as part of a surgical procedure include, but are not limited to: implantable neurostimulator pulse generator, implantable neurostimulator electrodes, implant hardware, implantable infusion pump and implantable intraspinal catheter.

BWC follows HCPCS Level II to report Durable Medical Equipment E0100-E9999.

BB. IN-HOME PHYSICIAN VISITS and PHYSICIAN MOBILE OFFICE VISITS

In-home physician visits (services) shall require prior authorization after the first visit; however, the first and following visits must meet the *Miller* Criteria.

In-home physician visits may be appropriate and should be approved only when the injured worker is homebound and is unable to access outpatient facilities because of sensory impairment, immobility or transportation problems due to physical limitations. Examples might include injured workers with catastrophic conditions or those requiring end of life care. Lack of transportation does not constitute a medical reason for approving in-home physician visits.

Prior approval shall be granted by the MCO according to the plan of care and health care needs for the specific injured worker. Reimbursement to physicians will be made using Current Procedural Terminology (CPT) codes for Home Visits and the level of code must reflect current coding documentation standards for the CPT level of service. Services rendered must only be those services indicated by the circumstances that are medically necessary.

Mobile van or trailer physician visits or services, when the injured worker walks to the van or trailer, will be reimbursed as a normal office visit according to CPT levels of service and **will not be eligible for billing as a home visit.** Mobile offices must bill using the appropriate office or other outpatient services CPT evaluation and management code, with place of service 15 (mobile unit) and will be reimbursed at BWC's Non-Facility Fee.

If a physician chooses to make a home visit to an injured worker who does not meet the criteria for a home visit or when determined by the MCO/BWC not to be medically necessary**,** the physician may not bill the services as a home visit. If the services are considered medically appropriate and necessary if delivered in a customary office setting, the physician must bill using the appropriate office or other outpatient services CPT evaluation and management code, with place of service 12 (home) and will be reimbursed at BWC's Facility Fee.

CC. OFFICE BASED SURGERY

BWC currently follows state licensure requirements for enrollment of providers, as outlined in BWC Rules. The following providers that would perform surgery in their offices are Doctors of Medicine (M.D.), Doctors of Osteopathic Medicine (D.O.) and Podiatrists (D.P.M.) and are licensed in Ohio by the Ohio State Medical Board. Physicians who perform surgery in their office must follow the State Medical Board rules (Ohio Administrative Code Chapter 4731-25 Office Based Surgery). BWC will not enroll physicians who perform surgery in their office any differently than is the current practice.

The Ohio State Medical Board is obligated to investigate complaints or allegations of possible violations that are received by the board and has the authority, by law, to act upon the allegations; therefore BWC/MCOs who have knowledge of a physician who may not be in compliance with his/her licensure requirements in regard to office based surgery or other issues, are encouraged to report this information to the Ohio State Medical Board. Providers of office surgery are reimbursed according to BWC's provider fee schedule as place of service code 11 (office) and are reimbursed at the Non-Facility Fee.