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The Ohio Bureau of Workers' Compensation: An Analysis of the Status Quo and a Proposal for Improvement (A Medical Perspective)

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THE OHIO BUREAU OF WORKERS' COMPENSATION: AN
ANALYSIS OF THE STATUS QUO AND A PROPOSAL FOR
IMPROVEMENT (A MEDICAL PERSPECTIVE)

WILLIAM H. SEITZ, JR.*

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I. OVERVIEW AND HISTORY OF THE OHIO BUREAU OF WORKERS’ COMPENSATION

Ohio, one of the nation’s centers of manufacturing and commerce around which the Industrial Revolution was built, provided little protection for workers who sustained injuries in the work place, at the turn of the twentieth century. Due to limited medical resources and access to care, injured workers frequently lost their ability to earn a living and became a burden rather than a source of productivity for the community. By the early 1900s, the groundswell of response to this situation and the social injustice that it represented increased.

In 1911, the Ohio General Assembly passed the state’s first Workers’ Compensation law.¹ Participation by employers in the Workers’ Compensation program was voluntary.² The law created a state fund to compensate workers injured

¹Senate Bill No. 127 (approved Jun. 15, 1911); codified as Section 1465-37. “There is hereby created a state liability board of awards. . . .” *Id.*; see also Preamble of Senate Bill No. 127 (stating that it was an act “[t]o create a state insurance fund for the benefit of injured, and the dependents of killed employees, and to provide for the administration of such fund by a state liability board of awards”).

²Senate Bill No. 127 (approved Jun. 15, 1911); codified as Section 1465-57. Any employer who employs five or more workmen or operatives regularly in the same business, or in or about the same establishment who shall pay into the state insurance fund the premiums provided by this act, shall not be liable to respond in damages at common law or by statute, save as hereinafter provided, for injuries or death of any such employe (sic). . . .

Id.; Senate Bill No. 127 (approved Jun. 15, 1911); codified as Section 1465-60. All employers who employ five or more workmen or operatives regularly in the same business, or in or about the same establishment who shall not pay into the state insurance fund the premiums provided by this act, shall be liable to their employes (sic) for damages suffered by reason of personal injuries sustained in the course of employment. . . .

on the job.³ Through this process, the employer paid ninety percent and the employee paid ten percent of the proposed premium.⁴ However, because participation in the program was totally voluntary many employers declined to participate. Consequently, a 1913 amendment made the program compulsory for all employers.⁵ Provisions in the law mandated the use of the state insurance fund for claims by an injured worker.⁶ Alternatively, employers could be self-insured if they created their own fund that was deemed qualified to provide care for the number of workers they employed.⁷

Id.

³Senate Bill No. 127 (approved Jun. 15, 1911); codified as Section 1465-59.

The state liability board of awards shall disburse the state insurance fund to such employes (sic) of employers as have paid into said fund the premiums applicable to the classes to which they belong, that have been injured in the course of their employment, wheresoever such injury has occurred, and which have not been purposely self inflicted, or to their dependents in case death has ensued.

Id.

⁴Senate Bill No. 127 (approved Jun. 15, 1911); codified as Section 1465-58. "The premiums provided for in this act shall be paid by the employer and employes (sic) in the following proportions, to-wit: Ninety per cent. (sic) of the premium shall be paid by the employer and ten per cent. (sic) by the employes (sic)." *Id.*

⁵Amended Senate Bill No. 48 (approved Mar. 14, 1913); codified as Section 1465-60 (stating that "[t]he following shall constitute employers subject to the provisions of this act: 1. The state and each county, city, township, incorporated village and school district therein. 2. Every person, firm, and private corporation including any public service corporation that has in service five or more workmen or operatives regularly in the same business, or in or about the same establishment under any contract of hire, express, or implied, oral or written"). *Id.*; *but see* OHIO ADMIN. CODE 4123:19-03(A) (2007).

All employers granted the privilege to pay compensation directly shall demonstrate sufficient financial strength and administrative ability to assure that all obligations under section 4123.35 of the Revised Code will be met promptly. The administrator of workers' compensation shall deny the privilege to pay compensation, etc., directly, where the employer is unable to demonstrate its ability to promptly meet all the obligations under the rules of the commission and bureau. . . .

Id.

⁶Amended Senate Bill No. 48 (approved Mar. 14, 1913); codified as Section 1465-68.

Every employe (sic) . . . who is injured, and the dependents of such as are killed in the course of employment, wheresoever such injury has occurred, provided the same was not purposely self-inflicted . . . shall be paid such compensation out of the state insurance fund for loss sustained on account of such injury or death . . . and shall be entitled to receive such medical, nurse and hospital services and medicine, and such amount of funeral expenses as are payable in the case of other injured or killed employes (sic).

Id.

⁷Amended Senate Bill No. 48 (approved Mar. 14, 1913); codified as Section 1465-69.

[S]uch employers who will abide by the rules of the state liability board of awards and as may be of sufficient financial ability or credit to render certain the payment of compensation to injured employes or to the dependents of killed employes, and the furnishing of medical, surgical, nursing and hospital attention and services and medicines, and funeral expenses equal to or greater than is provided for in this act, or such employers as maintain benefit funds or departments or jointly with other

As the program grew over time, the Bureau of Workers' Compensation (BWC) developed into two divisions, an administrative arm and an insurance arm.⁸ The existing legislation provides that the Chief of the BWC, who is appointed by the Governor, oversees the system's administrative and insurance arm.⁹ On the other hand, the Industrial Commission has been the system's arm for claims adjudication.¹⁰ The three members of the Industrial Commission are appointees of the Governor and confirmed by the Ohio Senate, one member each representing labor, employers, and the public.¹¹

This system grew to become one of the largest monopolistic insurance companies in the world.¹² In 1995 due to the size of the fund, an oversight commission was developed to review investments as well as the investment policy of the BWC.¹³ A

employers maintain mutual associations of such said financial ability or credit, to which their employes (sic) are not required or permitted directly or indirectly to contribute . . . may, upon a finding of such facts by the state liability board of awards elect to pay individually or from such benefit fund department or association such compensation. . . .

Id.

⁸Ohio Bureau of Workers' Compensation, BWC Profile, <http://www.ohiobwc.com/basics/guidedtour/generalinfo/BWCProfile.asp> (last visited Apr. 7, 2007).

⁹OHIO REV. CODE ANN. § 4121.121(A) (LexisNexis 2006). "There is hereby created the bureau of workers' compensation, which shall be administered by the administrator of workers' compensation. . . . The governor shall appoint the administrator . . . , and the administrator shall serve at the pleasure of the governor." *Id.*

¹⁰OHIO ADMIN. CODE 4121:3-18(A)(b) (2007). "The claimant and the employer may appeal to the industrial commission from a decision of a staff hearing officer . . . , provided that such a decision was rendered by the staff hearing officer in its own name." *Id.* "[T]he administrator [may appeal] to the commission from orders of staff hearing officers on handicap reimbursement. The employer may also appeal to the industrial commission from such orders of staff hearing officers. . . ." OHIO ADMIN. CODE 4121:3-18(A),(C) (2007).

¹¹OHIO REV. CODE ANN. § 4121.02(A) (LexisNexis 2007).

There is hereby created the industrial commission. The commission shall consist of three members appointed by the governor, with the advice and consent of the senate. One member shall be an individual who, on account of the individual's previous vocation, employment, or affiliations, can be classed as a representative of employers; one shall be an individual who, on account of the individual's previous vocation, employment, or affiliations, can be classed as a representative of employees; and one shall be an individual who, on account of the individual's previous vocation, employment, or affiliations, can be classed as a representative of the public. Each member shall have six or more years of recognized expertise in the field of workers' compensation, and at least one member shall be an attorney registered to practice law in this state. No more than two members of the industrial commission shall belong to or be affiliated with the same political party.

Id.

¹²*Cf.* Ohio Bureau of Workers' Compensation, BWC Profile, <http://www.ohiobwc.com/basics/guidedtour/generalinfo/BWCProfile.asp> (last visited Apr. 7, 2007).

¹³OHIO REV. CODE ANN. § 4121.12(A) (LexisNexis 2006). "There is hereby created the workers' compensation oversight commission consisting of eleven members. . . ." *Id.*

The commission shall: (1) Review progress of the bureau in meeting its cost and quality objectives and . . . ; (2) Issue an annual report on the cost and quality

second five-member committee was charged with maintaining a viable fund to serve as the reservoir for providing medical care and appropriate wage reimbursement to workers who sustained work place injuries. Based on the size of the fund (\$19 billion by the end of the 2006 fiscal year), it would appear the reserves available for coverage of injured workers' medical care and wages should be more than adequate.¹⁴ However, due to poor financial oversight and expanding costs for administration, cuts in benefits, such as the elimination of non-generic prescription drugs and processes designed to deny coverage, have evolved.

Just as the work place has increased in complexity since the inception of the BWC, so has the practice of medicine and the delivery of health care. Expanding the understanding of disease and the response of human physiology to disease has improved diagnostic skills. Technology and early intervention have reduced suffering and shortened disability. Streamlined, minimally invasive, and innovative treatment modalities have provided the source for successful treatment of many diseases and injuries with significant reduction of morbidity and rapid return to function. Unfortunately, the BWC "system" has become so mired in red tape through its rules and regulations and dozens of complex forms that it is often difficult for injured workers to take advantage of the improvements in medical care in a timely fashion, and the "system" itself has frequently proven to be an obstacle to providing care.¹⁵

Moreover, the system has established an adversarial situation under which workers are pitted against their employers, and physicians frequently find themselves restricted in their ability to provide the needed care for their patients.¹⁶ This

objectives of the bureau to the president of the senate, the speaker of the house of representatives, and the governor; (3) Review all independent financial audits of the bureau. The administrator shall provide access to records of the bureau to facilitate the review required under this division. . . . (4) Study issues as requested by the administrator or the governor; (5) Contract with an independent actuarial firm to assist the commission in making recommendations to the administrator regarding premium rates; (6) Establish objectives, policies, and criteria for the administration of the investment program that include asset allocation targets and ranges, risk factors, asset class benchmarks, time horizons, total return objectives, and performance evaluation guidelines, and monitor the administrator's progress in implementing the objectives, policies, and criteria on a quarterly basis. . . . (7) Specify in the objectives, policies, and criteria for the investment program that the administrator is permitted to invest in an investment class only if the commission, by a majority vote, opens that class. . . . OHIO REV. CODE ANN. § 4121.12(G) (LexisNexis 2006).

¹⁴Ohio Bureau of Workers' Compensation and Industrial Commission of Ohio (A Department of the State of Ohio), Financial Statements and Supplementary Financial Information For the Years Ended June 30, 2006 and 2005 and Independent Auditors' Report Thereon 12, *available at* http://www.auditor.state.oh.us/Public/AuditSearch/Reports/2007/Ohio_Bureau_of_Workers_Comp_06_05-Franklin.pdf

¹⁵*See infra* Part V, Appendices.

¹⁶OHIO ADMIN. CODE 4123:3-09 (2007).

Contested or disputed claims as well as claims requiring investigation shall be referred, immediately after the initial review, to the appropriate office of the bureau from which investigation and determination of issues may be made most expeditiously. Formal hearings before a district hearing officer with notices to the interested parties shall be scheduled at the earliest date.

adversarial situation is not unique to Ohio. In fact, it is prevalent in most states.¹⁷ In reports published in peer-reviewed medical journals and presented at national scientific meetings considering outcomes of various medical treatment modalities, BWC patients are frequently factored out of the general pool of patients and considered a separate sub-group, because typically their outcomes are less successful than those of the general population.¹⁸

Why should this be? The answer lies in the system's inherent adversarial environment under which a worker injured on the job frequently has to fight to prove the injury was in fact job-related.¹⁹ In the current process, the employer, in an attempt to keep premium costs down, contests the worker's claim.²⁰ The worker develops a sense of anger at the employer while attempting to prove her point. In the lengthy, expensive ensuing debate the worker feels that the employer and the "system" have wronged her, has further caused injury by delay, and as a result feels that she is owed compensation not only for the injury but for the aggravation, anxiety, and frustration involved. Once the worker begins to obtain benefits, the injured worker has lost a significant amount of loyalty to the employer and, therefore, has also lost incentive to return to the work place in a timely fashion.

The system also fosters incomplete diagnosis and treatment by accepting only the initial diagnosis at the patient's "point of entry," which is usually a corporate clinic or an emergency room.²¹ From this point forward, amending the diagnosis requires a

Id.

¹⁷*See, e.g.*, N.Y. WORKERS' COMP. LAW § 20(1) (Consol. 2007).

The board shall have full power and authority to determine all questions in relation to the payment of claims presented to it for compensation under the provisions of this chapter. The . . . chair or board shall make or cause to be made such investigation as it deems necessary, and upon application of either party, shall order a hearing, and within thirty days after a claim for compensation is submitted under this section, or such hearing closed, shall make or deny an award, determining such claim for compensation, and file the same in the office of the . . . chair. Immediately after such filing the . . . chair shall send to the parties a copy of the decision. Upon a hearing pursuant to this section either party may present evidence and be represented by counsel. The decision of the board shall be final as to all questions of fact, and, except as provided in section twenty-three of this article, as to all questions of law.

Id.

¹⁸*Cf. see, e.g.*, Rudolf Bertagnoli et al., *The Treatment of Disabling Multilevel Lumbar Discogenic Low Back Pain with Total Disc Arthroplasty Utilizing the ProDisc Prosthesis: A Prospective Study with 2-Year Minimum Follow-Up*, 30 SPINE 2192 (2005) (noting that workers compensation factors in their patient selection and research analysis).

¹⁹STATE OF OHIO INDUS. COMM'N, POLICY STATEMENTS AND GUIDELINES, BURDEN OF PROOF, MEMO S5.

²⁰Employers may contest any claim made by their employees. OHIO ADMIN. CODE 4123:3-09(B) (2007). "The employer retains the right to contest the immediate allowance and payment of a medical condition in a claim under this rule." *Id.*

²¹OHIO ADMIN. CODE 4123:6-04.3 (2007).

(A) The bureau shall determine the compensability of all claims as provided in rule 4123-6-04.5 of the Administrative Code. Upon referral from an MCO, the bureau will determine both the causal relationship between the original injury and the current incident precipitating a medical treatment reimbursement request and the necessity

special hearing.²² As a result, the insurance fund created to provide a resource and refuge for injured workers has substantially changed and no longer meets the goals and ideals for which it was created. Rather, the system fosters misdiagnosis, impedes ability to amend to include accurate diagnoses and delays prompt and appropriate care. From a physician's standpoint the system appears to be designed to delay treatment, escalate cost, and defer resources away from the injured worker and the health delivery system whose goal is to restore health. The result is a legal and bureaucratic entanglement in which it seems that a large percentage of the insurance dollar is spent on the system itself rather than on the injured worker.

A worker's compensation claim is frequently a nightmare for the patient (injured worker), the employer (insurance payor), and the physician (health care provider). Because of the wastefulness inherent in the system, the overall cost of providing workers' compensation care in the State of Ohio has increased dramatically and as a result has seen significant reductions in hospital reimbursement levels and patient benefits, such as prescription drug availability.²³

II. EXAMPLES OF PROBLEMS WITH THE OHIO BUREAU OF WORKERS' COMPENSATION

To understand the problems with the workers compensation system, consider the following two clinical examples.²⁴

A. Case Example 1

The first case example demonstrates what happens when the patient's initial diagnosis upon entering the system is incorrect but later corrected and treated by a

and appropriateness of the requested treatment in a claim which has not had activity or a request for further action within a period of time in excess of thirteen months. . . .

(C) After the claim has been filed, the bureau shall assign a claim number and shall notify the employee, employer and MCO of that claim number.

Id.

²²Any time an employee files a claim or a claim is amended, the employer retains the right to challenge the claim. OHIO ADMIN. CODE 4123:3-09(B) (2007).

²³Bureau of Workers' Compensation, BWC Year End Statistics, *available at* <http://www.ohiobwc.com/downloads/blankpdf/BWCstatsheet.pdf> (last visited Apr. 7, 2007); OHIO ADMIN. CODE 4123:6-21(I) (2007). Although medical claims and medical benefits paid decreased from 2004 to 2006, the average per medical claim cost of those medical benefits paid has increased. Bureau of Workers' Compensation, BWC Year End Statistics, *available at* <http://www.ohio-bwc.com/downloads/blankpdf/BWCstatsheet.pdf> (last visited Apr. 7, 2007). In 2004, that average was \$5369 (\$848,717,070 medical benefits paid / 162,105 medical claims filed); in 2005, that average was \$5817 (\$898,350,192 medical benefits paid / 154,419 medical claims filed); and in 2006, that average was \$5860 (\$848,717,070 medical benefits paid / 144,828 medical claims filed). *Id.*

Claimants who request a brand name drug or whose physician specifies a brand name drug . . . for a medication which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug. OHIO ADMIN. CODE 4123:6-21(I) (2007).

²⁴These examples are based on the author's actual clinical experiences. The author, however, has made some inconsequential changes to protect patient privacy and confidentiality.

physician capable of making a more accurate diagnosis, but the physician does not follow proper protocol in changing the initial diagnosis.

1. Case Example: The Physician who Treats the Patient Without Getting the Initial Diagnosis Changed

A middle-aged man who has run a jackhammer over an extended period of years progressively developed pain, numbness, and tingling in his wrist radiating down to his thumb, index, and middle finger. He reached a point where the degree of pain, numbness, and weakness in his hand no longer allowed him to do his normal job activities. His supervisor sent him to an emergency room where he was erroneously diagnosed as having a “wrist sprain.” He was given a tight brace and instructed to do some exercises, but his symptoms did not resolve over a period of two months during which he was unable to work. That man was finally referred to a hand and upper extremity specialist who examined him and found all of the cardinal signs of “carpal tunnel syndrome.” Based on the findings at the initial office consultation, the proper diagnosis of “carpal tunnel syndrome” was made, and he was started on a course of conservative therapy including medications, appropriate splinting, and rehabilitation. Within six weeks, his symptoms resolved, and he was gradually transitioned back into the work place.

2. The Result: The Bureau of Workers’ Compensation Does Not Reimburse the Physician

The result of this treatment was that the physician and the health care providers did not get paid, the patient’s benefits were stopped from the time of the initial consultation, and the worker’s diagnostic and pharmacy bills did not get paid. The question is why? The answer lies in the fact that the specialist who correctly diagnosed and treated the problem as carpal tunnel syndrome did so without obtaining a BWC mandated electromyographic study (EMG) costing over \$1000. Because the original claim was for a “wrist sprain” and the patient was successfully treated when the diagnosis was changed to carpal tunnel syndrome, additional diagnostic and treatment codes did not match. As a result, the diagnosis was disallowed, and the system came to a halt. Over six months passed before the bureaucratic problem was corrected.

B. Case Example 2

The second case example demonstrates what happens when the physician who makes an accurate diagnosis uses the workers’ compensation system to correct the diagnosis so that he or she can proceed without fear of not being reimbursed for the procedures performed.

1. Case Example: The Physician who Follows the Proper Protocol in Getting the Initial Diagnosis Changed

A laborer with a job requiring strenuous repetitive overhead activities was lifting a heavy object with a co-worker when the co-worker lost hold of the other end, and a wrenching injury occurred to the laborer’s right shoulder. From that moment forward, the injured worker was unable to elevate his arm and experienced pain with any degree of movement, even at night while attempting to sleep. After a week of no improvement, the worker visited the local emergency room, where a physician diagnosed the problem as a “shoulder strain.” The emergency room physician gave

him a sling and instructed him to follow up with his primary care physician in two weeks. During that period of time, the patient became worse, and the shoulder became stiffer; the patient remained unable to work. His primary care physician tried to treat the problem with pain medication and aggressive rehabilitation, which only made the problem worse. Finally, he was referred to an orthopaedic specialist who diagnosed a tear of the rotator cuff and arthritis at the acromioclavicular joint. The extended period of inactivity had also resulted in a condition of adhesive capsulitis (frozen shoulder). The specialist determined this by physical examination and x-rays; however, the extent of rotator cuff pathology required an imaging study (either MRI or ultrasound). Before further management, including appropriate rehabilitation for the correct diagnosis, the patient needed to get his attorney to amend the diagnosis to include all the appropriate diagnostic codes. In addition, the patient had been unable to take the anti-inflammatory medicine given to him by his primary care physician to treat the problem because of a gastro-intestinal (GI) condition. The physician prescribed a more specific GI toxic anti-inflammatory, but the BWC disallowed it because it was not available in a generic prescription.²⁵

Eight weeks later the case was amended and the patient was allowed to get an imaging study, which confirmed the rotator cuff disruption as well as some spurs, labral detachment, and partial biceps rupture (all part of the syndrome of impingement). The physician recommended surgery to correct the problem. The employer, however, recommended a second opinion. So, the patient was referred to another physician (a non-orthopedic surgeon) chosen by the employer who stated that despite a specific injury and despite strenuous long standing occupational use of his hands above his head all of the symptoms from which the patient was suffering were chronic and degenerative in nature and unrelated to his work injury. A hearing was then held, and surgery was denied. The patient's attorney wrote a letter to the treating specialist requesting a review of the independent medical examination. The treating physician prepared a report refuting the independent medical examiner's finding. This process took another six weeks. A new hearing was held, the appropriate diagnosis was finally allowed, and surgery was approved.

2. The Result: Patients Must Wait Months Before They Can Receive the Proper Treatment

The patient did not have surgery until almost eight months after his injury. Post-operatively, he was guided through a rehabilitation process with anticipation of gradually getting back to light duty in about three months. However, six weeks after surgery the employer requested an independent medical examination to determine the patient's functional capacity. The patient was sent to an industrial center for independent medical examination and tested on resistive exercise equipment that was inappropriate at this early stage after surgery. During this examination, he suddenly experienced pain and could not lift the arm. Upon returning to his treating physician, it was clear he had torn the not-yet-healed rotator cuff, and the injured worker was essentially back at the first stage.

This unnecessary period of denials, appeals, second opinions, report writing, and further hearings took a condition which could well have been corrected initially with three-to-six month total disability and turned it into an extended multi-year disability

²⁵Cf. OHIO ADMIN. CODE 4123:6-21(I) (2007).

with an angry patient, an angry employer, a frustrated treating physician, and a huge expenditure of financial resources.

C. Conclusion: Ohio Must Streamline Its Workers' Compensation System

These are just two examples of thousands of cases that exemplify the problem with the BWC system. Physicians and attorneys must be advocates for their patients and clients. The current system is not addressing the needs of patients and clients; as a result, the system prolongs their suffering, effects their family's well being, and ultimately provides a disincentive for them not to return to the work place. The morass of paperwork, inability to obtain timely authorization to treat, and the cost of personnel needed to address these issues disincentives physicians to treat these patients. Therefore, the State of Ohio must take steps to streamline its workers' compensation system.

III. RECOMMENDATIONS FOR REMEDYING THE WORKERS' COMPENSATION SYSTEM

Relatively straightforward revisions could be made to the rules that govern the BWC so that patients receive treatment sooner and employers have their employees returning to work more quickly. This section outlines some of those needed revisions.

A. Recommendation 1: Physicians Should Only Identify the Body Region of the Injury at the Initial Intake Point

When a patient is injured, there should be acknowledgement at the point of initial care by the plant physician, the emergency room physician, or the primary care physician that the patient has suffered an injury. The physician should identify the injury's body region, but at the initial generic intake point, the physician should not make a definitive final diagnosis. Then, that physician should initiate appropriate initial triage care and refer the injured worker to the most appropriate treating physician.

Implementing this recommendation would help remedy the situation faced by the laborer, in Case Example 2, who had to wait eight weeks to have his initial diagnosis amended, as the time-consuming hearings to change the initial diagnosis that caused the delay would no longer be required.²⁶

B. Recommendation 2: A Certification Process that Allows Amended Diagnoses Without Extensive Mandates

There should be a certification process across medical specialties under which recognized experts are deemed capable and proficient to make appropriate diagnoses, and amend those diagnoses as clinical information evolves and becomes clear, without a mandate to perform expensive tests or require independent medical examinations or hold hearings. Precedent for this exists on every hospital medical staff when physicians apply for specific privileges in that their education and training are documented, and the appropriate credentialing is granted based on specific

²⁶See *supra* Part II.B.

credentialing criteria.²⁷ Such credentialing could easily be applied to physicians in various specialties caring for injured workers. The BWC or some other entity could periodically audit physician performance by case review.

These changes would remedy the problem faced by the physician, in Case Example 1, who treated the patient without running expensive test when he changed the patient without running expensive test when he changed the initial diagnosis and, thus, the BWC did not pay him, as this amendment would have allowed him, the specialist, to change the initial diagnosis without additional tests and hearing.²⁸

C. Recommendation 3: Test Guidelines that Establish Specific Diagnoses

A set of clinical as well as diagnostic test guidelines should be set up to establish specific diagnoses based on accepted medical practice. These guidelines should be flexible enough so that unnecessary medical test requirements, which cause extensive delays and expenditure of financial resources, are not necessary in all cases but may be obtained when necessary. Evidence based proactive principles and peer-review would then guide diagnosis and management.

D. Recommendation 4: Eliminate Reviews of the Bureau of Workers' Compensation's Certified Physicians' Diagnosis and Treatment Strategies

When diagnoses and treatment strategies are recommended by a physician certified in the management of BWC claims within a specific area of specialty that physician should be allowed to manage the injured worker's case without costly reviews by panels or physicians (frequently less expert in the field).

Had this amendment been in place, the patient in Case Example 2, would not have suffered the six-month delay, because the patient would not have been required to have undergone a second opinion by a non-specialist physician chosen by the employer and would not have been required to refute that physician's findings.²⁹

E. Recommendation 5: Notation on a Prescription Should Be Adequate to Obtain that Prescription

A notation on a prescription demonstrating a need for a specific drug or piece of equipment related to a patient's special needs should be adequate to obtain that prescription. Furthermore, fully reimbursed medication should not be limited to only "generic" prescriptions.³⁰

This recommendation would help solve the problem, in Case Example 2, in which the physician could not prescribe the appropriate GI toxic anti-inflammatory medication because it was unavailable in generic form and, thus, disallowed by the BWC.³¹

²⁷OHIO REV. CODE ANN. § 3705.351(A) (LexisNexis 2006). "The governing body of every hospital shall set standards and procedures to be applied by the hospital and its staff in considering and acting upon applications for staff membership or professional privileges." *Id.*

²⁸*See supra* Part II.A.

²⁹*See supra* Part II.B.

³⁰OHIO ADMIN. CODE 4123:6-21(I) (2007).

³¹*See supra* Part II.B.

IV. CONCLUSION: OHIO MUST STREAMLINE ITS WORKERS' COMPENSATION SYSTEM
SO THAT PATIENTS RECEIVE TREATMENT AND RETURN TO WORK AS QUICKLY AS
POSSIBLE

These changes would reduce the layers of bureaucracy that currently require hearing after hearing, review of voluminous documentation by multiple providers, and excessive financial expenditure. The resultant savings should reduce the overall cost and allow the health care dollars to be invested in an appropriate way enhancing the care of the patient by facilities and experts delivering medical care and rehabilitation. The system would then promote returning the injured worker to the work place more expeditiously, and ultimately save employers the excessive expense they now incur through their premiums. Most importantly, however, these changes would help the injured worker recover from his injury as quickly as possible.

Such a process would require a major overhaul of the BWC system and would also require legislative and executive support at the state level. It would require careful and combined oversight by the medical and legal professions whose charge is to protect, care for, and advocate for the people they serve. Nevertheless, Ohio has the opportunity to once again be on the cutting edge of reform. The "overhaul" of the BWC would not require major structural changes, but rather a thoughtful reorganization of policies.³²

³²OHIO REV. CODE ANN. § 4121.121(B)(13) (LexisNexis 2007).

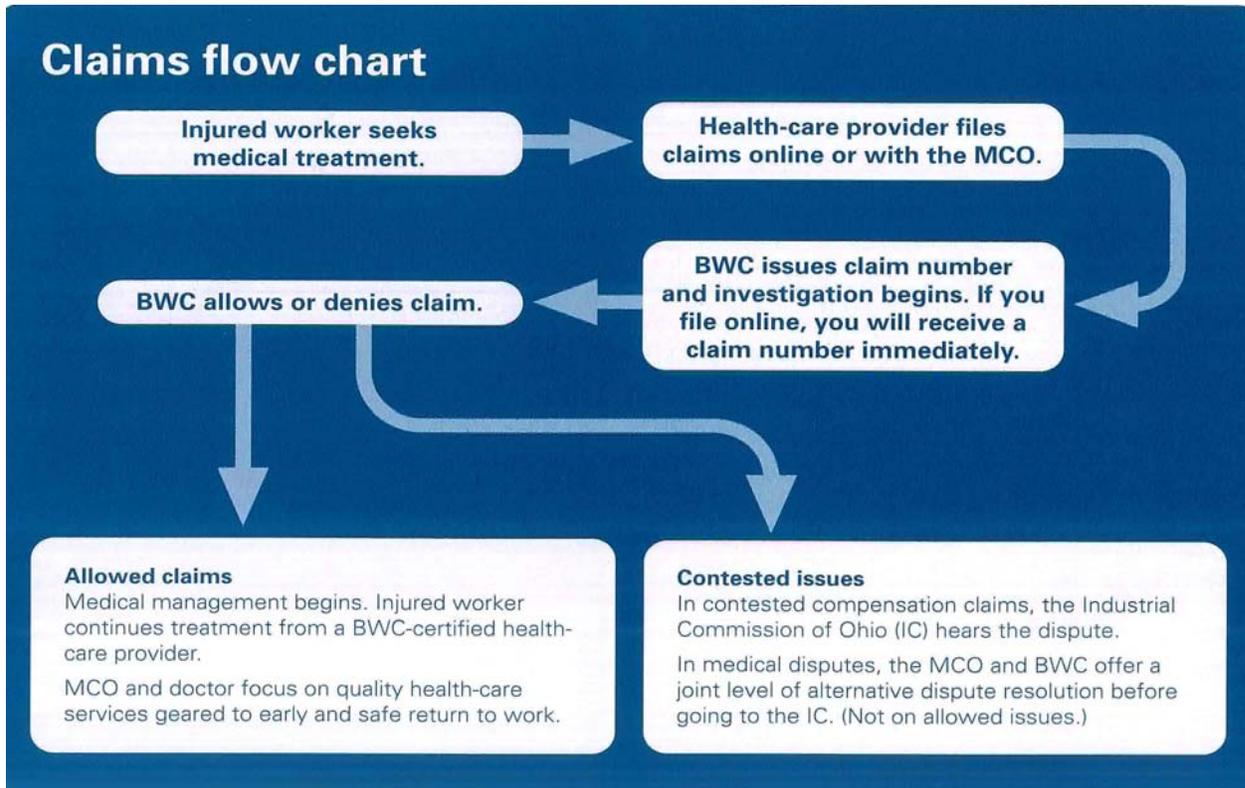
The administrator is responsible for the management of the bureau of workers' compensation and for the discharge of all administrative duties imposed upon the administrator in this chapter . . . and in the discharge thereof shall . . . [s]et standards for the reasonable and maximum handling time of claims payment functions, ensure, by rules, the impartial and prompt treatment of all claims and employer risk accounts, and establish a secure, accurate method of time stamping all incoming mail and documents hand delivered to bureau employees.

Id.

V. APPENDICES

A. Appendix A: Claims Flow Chart

The Claims Flow Chart³³ suggests a single solution. However, the frequent route of “contested issues” stops the process and frequently reverts to the first step in the chart.



³³Ohio Bureau of Workers' Compensation, Claims Flow Chart, http://www.ohiobwc.com/basics/guidedtour/providerno/report_injuries/ClaimsFlowchart.asp (last visited May 18, 2007).

B. Appendix B: Forms Used in a Bureau of Workers' Compensation Claim

These two charts³⁴ contain a list of forms used in BWC claims and a list of all reviews, which require prior authorization before the treatment or benefit process can continue.

| BWC forms indexed in the medical repository | | |
|--|---|---|
| Document type | Description | Rationale |
| C-1 | For payment of compensation | FROI replaced this form, but a few medical benefits still come in |
| C-140 | Wage loss application | Includes medical restrictions outlined by physician |
| C-1A | Attending physician's report | See C1 |
| C-2 | Application for death benefits | See C1 |
| C-23 | Change of physician notice | Includes physician information |
| C-3 | Application for medical benefits only | See C1 |
| C-5 | Death benefits | See C1 |
| C-50 | Self-insured claim application | See C1 |
| C-6 | Accrued compensation | See C1 |
| C-63 | Additional information request | A V3 letter asking for additional medical information |
| C-84 | Physician's supplemental report | This is a statement of medical disability |
| C-85A | Application to reactivate claim | Form has medical information attached |
| C-86 | Motion | Request for additional medical conditions |
| C-92 | Determination of % PP disability | Determination of percentage of medical disability – medical information is attached |
| C-92A | Increase in % of PP disability | Determination of percentage of medical disability – medical information is attached |
| C-92EXA | C92/C92A exams | Determination of percentage of medical disability – medical information is attached |
| DELETED | Deleted document | To be used by indexers for documents not included in this list |
| FROI | First report of injury | Main medical claim form |
| MED | Medical documents | Medical information that does not fit in the stated categories |
| MEDCO-14 | Physician's Return-to-Work Report | Form used by physicians for work restrictions |
| MEDCO-211 | Physician review | Forms used by physicians for medical assessment |
| OD-1 | Occupational disease application | See C1 |
| OD-122 | Self-Insured occupational disease application | See C1 |
| REHAB | Rehabilitation notes | Contains medical documents – supports rehabilitation plan |

³⁴Ohio Bureau of Workers' Compensation, Medical Management, http://www.ohiobwc.com/basics/guidedtour/providerno/med_manage/IndexedForms.asp (last visited May 18, 2007).

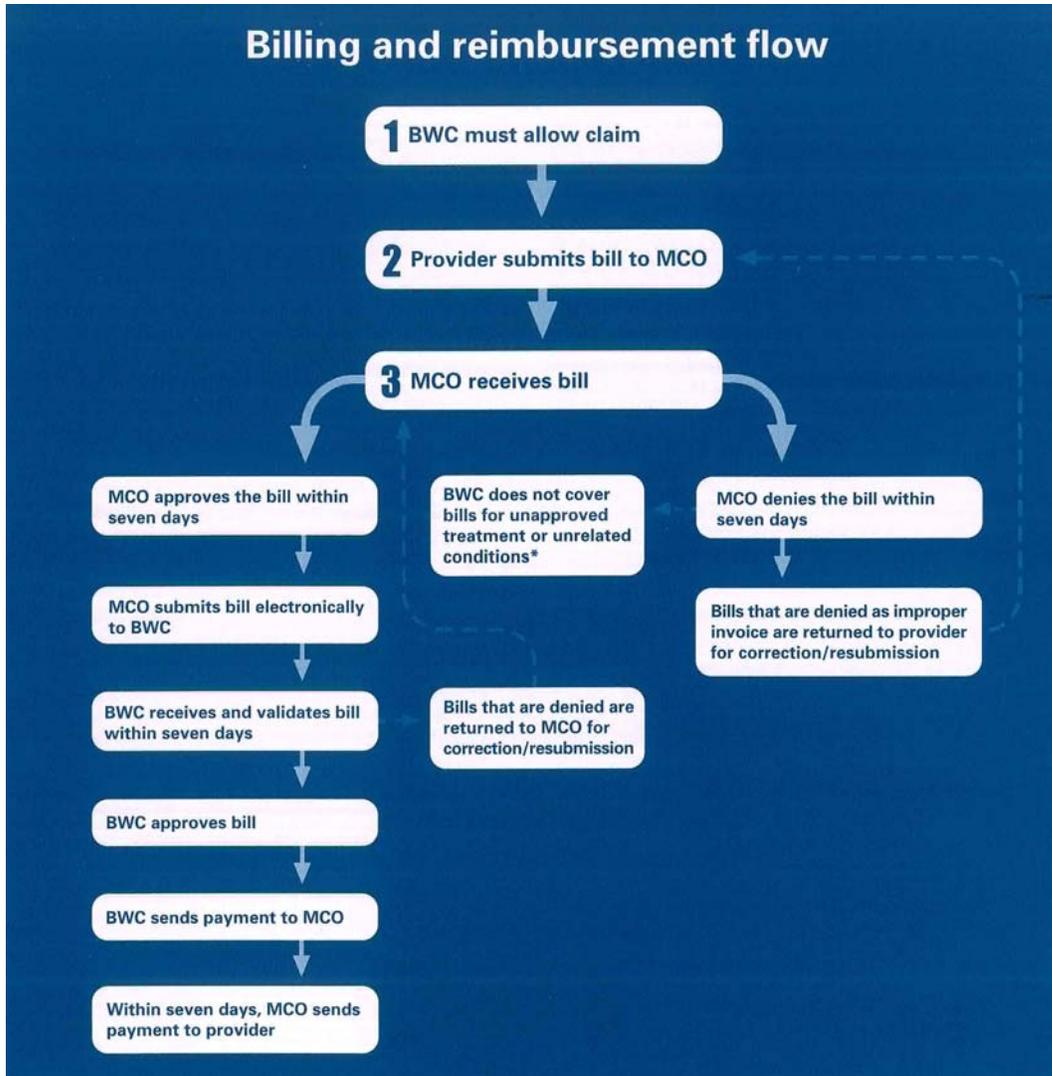
Standardized prior authorization table

| Service | Requirement |
|---|--|
| Physical medicine services, including chiropractic/osteopathic manipulative treatment and acupuncture | PA |
| Consultations - psychological/chronic pain program only | PA |
| Chronic pain program including pre-admission evaluation and treatment | PA |
| Dental | PA |
| Diagnostic testing | PA (except basic X-rays, which do not require PA) |
| DME | PA if the purchase price > \$250 PA for all DME rental |
| Home/auto/van modifications | PA required from BWC |
| Home health agency services | PA |
| Hospital inpatient treatment, including surgery and outpatient/ASC surgery | PA for surgery from date of injury, if not emergency |
| In-home physician services | PA after first visit |
| Injections | PA |
| Non-emergency ambulance services | PA |
| Orthotic and prosthetic devices and/or repair | PA > \$250 |
| Skilled nursing facility (SNF)/Extended care facility (ECF) | PA |
| TENS and NMEs units | PA, both rental and purchase |
| TENS and NMEs monthly supplies | PA for a maximum of six months per authorization |
| Vision /hearing services | PA > \$100 |
| Vocational rehabilitation - All vocational rehabilitation services, in or out of plan | PA |

Note: PA not required for transitional work on-site therapy services provided by an OT or PT that fall under the presumptive authorization guidelines. Occupational rehabilitation (work hardening) requires CARF accreditation

C. Appendix C: A Theoretical Flow Chart of Billing and Reimbursement

This theoretical flow chart illustrates the billing and reimbursement process.³⁵ Any bill which is initially denied must be reprocessed and resubmitted. Denials frequently parallel the injured worker's experience in obtaining benefits and compensation.



³⁵Ohio Bureau of Workers' Compensation, Billing and Reimbursement, <http://www.ohiobwc.com/basics/guidedtour/providerno/billreimb/BRFlowchart.asp> (last visited May 18, 2007).