Managed Workers’ Compensation Program

In 1993, the Ohio General Assembly passed House Bill 107. This reform legislation initiated many changes in the Ohio Bureau of Workers’ Compensation (BWC) Program and mandated that the BWC develop a managed care system. The Health Partnership Program (HPP) was developed and required that all state-funded employers utilize a Managed Care Organization (MCO) for the medical management of their workers’ compensation claims.

The Health Plan Managed Workers’ Compensation Program, an Ohio BWC-certified MCO and URAC Accredited Care Management Organization medically manages workers’ compensation claims for state-funded employer groups and six self-insured employers. MCO ensure that the claimant receives appropriate and timely medical treatment focusing on a safe return to work. We are responsible for assisting claimants in obtaining quality medical care, while assisting the employers in controlling workers’ compensation costs.

The Health Plan employs full-time registered nurse (RN) case managers, who work in conjunction with support staff, to provide quality medical management services to claimants, employers, and provider offices.

Compensability (allowance) determination rests solely with the Ohio BWC.

Reporting Requirements
The provider is responsible for reporting all injuries to the MCO, utilizing the Ohio BWC First Report of Injury (FROI) 1, accompanied by supporting medical documentation within 24 hours of treatment.

Methods of reporting:

- Faxing: 1.877.847.6927
- Mailing: The Health Plan Managed Workers’ Compensation Program PO Box 97 St. Clairsville, OH 43950-0097
- Online: ohiobwc.com
- Online: healthplan.org

The Ohio BWC will assign a claim number. The Ohio BWC will notify the provider of the claim number. The Health Plan has distributed ID cards identifying The Health Plan as the MCO for the employer group.
Medical Management and Treatment

60-Day Presumptive Authorization Guidelines
Effective January 1, 2001, BWC implemented a pilot program giving providers presumptive authorization to provide specific medical services without waiting for prior authorization from the MCO. For dates of injury on or after November 1, 2002, presumptive approval to provide services were extended from 45 days from the date of injury to 60 days. The MCO shall adhere to the presumptive approval guidelines.

For a period not to exceed 60 days following the date of injury, physicians have presumptive approval to provide certain services when treating soft tissue and musculoskeletal injuries that are allowed conditions in a claim. Following are the services you can provide:

- Up to 12 physical medicine visits, including osteopathic, chiropractic, physical therapy, and occupational therapy performed by a provider, licensed to provide such services.
- 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 AC joint, elbow, wrist, finger, hip, knee, ankle, and foot, including toes) and up to three trigger point injections. Injections of the paraspinal region including ESI facet and SI are not included.
- E/M services and consultation services.

You must complete the following before you initiate any or all of the aforementioned services:

- File the FROI with the MCO.
- MCO may use disclaimer language when the claim is not yet in allowed status.
- Complete and file the Physician’s Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9) form with the MCO.
- Notify the MCO within 24 hours of treatment, if the injured worker will be off work for more than two calendar days.

You will still report injuries and provide written medical treatment plans to the MCO for medical management. In addition, you agree to notify the MCO within 24 hours if the injured worker will be off work for more than two calendar days. Except for emergency services, the services listed in the MCO Standardized Prior Authorization Table that do not fall within the presumptive approval parameters still require prior authorization. You must submit a C-9 to request formal authorization.

Why has the BWC adopted the presumptive authorization policy?

This change allows you to aggressively treat injured workers who suffer the most common work-related injuries — soft tissue and musculoskeletal injuries. This new policy supports BWC Health Partnership Program goals of early and safe return to work with new emphasis on remain at work and transitional work initiatives.
What are soft tissue and musculoskeletal injuries?

They are injuries, such as sprains, strains, superficial injuries, and contusions, per the International Classification of Diseases (ICD-9-CM) book.

Are there any limitations or noncovered procedures for diagnostic studies under presumptive authorization?

Medical necessity for the allowed conditions is always the driver for services. Surgical diagnostics, such as arthroscopic procedures, are not included, unless it is an emergency.

What are the benefits of the presumptive authorization program?

By eliminating wait time for authorizations, you can immediately schedule diagnostic testing and other procedures covered under the presumptive authorization policy at the time of the office visit. Quicker treatment means faster recovery, lower disability costs, and injured workers returning to gainful employment.

Will MCO case managers advise providers when they identify procedures that do not appear to be medically necessary?

Yes, but as long as providers follow commonly accepted treatment guidelines when treating the allowed conditions in a claim, the bill will be paid.

Does presumptive authorization apply to treatments provided within the first 60 days or requested within the first 60 days and provided later?

The presumptive approval guidelines apply to services provided within 60 days from the date of injury.

Where can I get more information on presumptive authorization?

For more information on presumptive authorization, call 1.800.OHIOBWC or the local customer service office.

Standardized Prior Authorization Table

The MCO and Ohio BWC collaborated in the development and implementation of a Standardized Prior Authorization Table. The procedures included in the Standardized Prior Authorization Table require prior authorization that can be obtained by submitting a BWC form C-9, “Physician’s Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease” to the assigned MCO. Please refer to the attached updated Standardized Prior Authorization Table.

The claimant may only have one physician of record (POR). The POR must be Ohio BWC certified if providing ongoing treatment to claimants with dates of injury 03.01.97 and beyond. A non-BWC certified provider can provide initial treatment to any claimant; however, an Ohio BWC certified provider must provide subsequent treatment. If the claimant chooses to receive treatment from a non-certified provider, the Ohio BWC will not reimburse for the services.

Treatment Guidelines

Chiropractic Quality Assurance and Practice Guidelines” to determine medical appropriateness of services and/or testing and return to work guidelines.

**Official Disability Guidelines**
Effective April 1, 2004, MCO staff began using the Official Disability Guidelines (ODG) in making their treatment authorization decisions. BWC staff will have access to ODG at the same time, but will not begin using them in the Alternative Dispute Resolution (ADR) process until this year when the guidelines have been added to our ADR rule.

The ODG are evidence-based treatment guidelines that BWC and the MCO will be using extensively 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 every day issues in claims and medical case management. Ohio providers can take advantage of the BWC negotiated price if they order on the web [worklossdata.com](http://worklossdata.com) or call the toll-free number at **1.800.488.5548**.