Ohio Administrative Code

Rule 4123-17-59 Fifteen thousand dollar medical-only program.

Effective: July 1, 2014

(A) Any employer who is paying premiums to the state insurance fund and whose coverage is in force may elect to participate in the fifteen thousand dollar medical-only program as provided in section 4123.29 of the Revised Code. No formal application is required; however, an employer must elect to participate by telephoning the bureau. Once an employer has elected to participate in the program, the employer will be responsible for all bills in all medical-only claims with a date of injury the same or later than the election date and the employer agrees to pay bills within thirty days of receipt of the bill, unless the employer notifies the bureau within fourteen days of receipt of the notification of a claim being filed that it does not wish to pay the bills in that claim, or the employer notifies the bureau that the fifteen thousand dollar maximum has been paid, or the employer notifies the bureau of the last day of service on which it will be responsible for the bills in a particular medical-only claim.

(B) Employers may pay bills only on any alleged medical-only injury. The provisions of this program and rule shall not apply to claims in which an employer with knowledge of a claimed compensable injury or occupational disease, has paid wages in lieu of compensation or total disability. Payment of a bill by an employer does not waive the bureau's right to adjudicate the claim, nor does it waive the employer's right to contest the claim should a claim be filed.

(C) This program in no way supersedes the right of any injured worker to file a workers' compensation claim with the bureau.

(D) An employer or its agent may elect to pay to the injured worker or the provider on behalf of the injured worker the first fifteen thousand dollars of a medical-only claim. Employers may elect which medical-only claims they do not wish to cover under this program.

(1) An employer electing to pay bills in its employees' medical-only claims is responsible for all bills in a claim until the fifteen thousand dollar maximum is reached and the employer provides notice to the bureau that the employer has paid the first fifteen thousand dollars of the bills in the claim by

providing the bureau the date of service of the bill which reached the fifteen thousand dollar maximum, or the employer provides notice to the bureau that it no longer wishes to be responsible for the bills in a particular claim by providing the bureau the last date of service that it will pay. The bureau will process all related bills received after the withdrawal notification date.

(2) If the fifteen thousand dollar maximum has not been reached and the payment of a bill will exceed the fifteen thousand dollar maximum, the employer should pay that portion of the bill that will bring the payment to the fifteen thousand dollar maximum and inform the provider to bill the bureau for the remainder of the bill. The employer should then notify the bureau that the first fifteen thousand dollars has been paid, and provide proof of such payment and copies of all bills paid, in the proper billing format, to the bureau. The bureau will then be responsible for processing all future bills.

(3) The employer cannot elect to pay only certain bills for a claim and submit other bills in that claim to the bureau for payment.

(4) Once an employer has elected to pay bills in medical-only claims under this program, the employer must pay all bills under this program within thirty days of receipt of the bill. The employer shall provide copies of the bills paid in the claim, in the proper billing format, to the bureau and the injured worker or the injured worker's representative upon request. Upon written request from the bureau, the employer shall provide documentation to the bureau of all medical-only bills that they are paying directly. Such requests from the bureau may not be made more frequently than on a semiannual basis. Failure to provide such documentation to the bureau within thirty days of receipt of the request may result in the employer's forfeiture of participation in the program for such injury.

(E) An employer electing this program must keep a record of the injury to include: name, address, and social security number of the injured worker; date and time of injury; type of injury; part of body injured; and a brief description of the accident. The employer also shall keep a copy of all bills with proof and date of payment under this program. This information will be made available to the bureau and the injured worker or their representative upon request. The information must be kept on file for five years from the last date a bill has been paid by the employer or the information has been received by the bureau.

(1) An employer in the program must notify the bureau within fourteen days of a claim being filed of the employer's intention not to cover the first fifteen thousand dollars of the medical costs of the claim. This notification may be by telephone or in writing.

(2) The bureau will process all related bills in a filed medical-only claim in the normal manner unless the employer has previously notified the bureau that it has elected to participate in the fifteen thousand dollar program.

(3) In those cases in which the bureau has been properly notified by the employer of the employer's intention to directly pay the bills, the bureau shall not pay any bills submitted to the bureau directly from the provider but will notify the provider that the bill should be submitted to the employer until the provider is notified by the employer that the bureau is responsible for the bills in the claim. No interest shall be paid by the bureau on account of bills not paid within thirty days if such bills are the responsibility of the employer.

(4) All bills submitted to the bureau or the employer for payment must be in the proper billing format and must be received by the bureau or the employer within one year of the date of service on the bill.

(F) An employer electing this program has the responsibility to notify the injured worker and medical provider, in writing, of the acknowledgment of the alleged medical-only injury, that it has elected under section 4123.29 of the Revised Code to pay the first fifteen thousand dollars, that all bills should be submitted to the employer, and that the injured worker and the bureau should not be billed.

(1) Once an employer in this program pays a bill on a work-related injury the bureau will not reimburse that employer.

(2) In the event that a duplicate payment is made, it will be the employer's responsibility to seek reimbursement from the provider. The employer may request reimbursement of such bills from the provider, and the provider shall reimburse the employer where the bureau has paid the bill.

(3) In the event that a medical-only claim changes to a lost time claim, the bureau will not reimburse the employer for bills that have been paid by the employer under this program.

(G) The employer shall pay all bills as billed or agree upon an appropriate reimbursement level with the provider for claims with a date of injury prior to June 30, 2009. Providers must accept the bureau fee schedule as payment in full for claims with a date of injury on or after June 30, 2009. A certified health care provider shall extend to an employer who participates in this program the same rates for services rendered to an employee of that employer as the provider bills the administrator for the same type of medical claim processed by the bureau and shall not charge, assess, or otherwise attempt to collect from an employee any amount for covered services or supplies that is in excess of that rate. Providers may only balance bill the bureau on the occasion of a bill that would require an employer to exceed the fifteen thousand dollar maximum. The bureau will not mediate fee disputes between the employer and the provider. If an employer elects to enter the program and the employer fails to pay a bill for a medical-only claim included in the program, the employer shall be liable for that bill and the employee for whom the employer failed to pay the bill shall not be liable for that bill.

(H) Payments made by the employer in this program will not be charged to that employer's experience modification; however, if a claim has been filed with the bureau and bills paid by the bureau, these payments will be included in the employer's experience modification. The bureau will not adjust the employer's experience modification to remove such payments unless the employer has complied with this rule and the bureau has made such payments in contravention of this rule. Failure by an employer to make timely payments on all bills will not affect the coverage of that employer and will not obligate the bureau to pay interest to the medical provider; however, the bureau may exclude employers who do not make timely payment on all bills in this program from participation in this program. An employer may appeal a decision of the bureau excluding the employer from this program to the adjudicating committee under rule 4123-14-06 of the Administrative Code.

(I) An employer who elects to participate in this program may cancel its participation in the program at any time by telephoning the bureau. The bureau will process all related bills in all medical-only claims against that employer's account after the date of the telephone call.