Ohio Administrative Code

Rule 4123-6-10 Payment to providers.

Effective: April 1, 2021

(A) HPP.

(1) The MCO shall accumulate medical records and bills for services rendered to injured workers for provider services and submit the bills electronically to the bureau for payment in a bureau approved format, utilizing billing policies, including but not limited to clinical editing, as set forth in the MCO contract. The MCO shall submit a bill to the bureau within seven business days of its receipt of a valid, complete bill from the provider.

(2) For a provider in the MCO's panel or with whom the MCO has entered into an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider, in accordance with rule 4123-6-14 of the Administrative Code, either the lesser of the bureau fee schedule, the MCO contracted fee, or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

(3) For a bureau certified provider who is not in the MCOs panel or with whom the MCO does not have an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider, in accordance with rule 4123-6-14 of the Administrative Code, either the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

(4) For a non-bureau certified provider who is not in the MCO's panel or with whom the MCO does not have an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider for initial or emergency treatment, in accordance with rule 4123-6-14 of the Administrative Code, either the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

(5) For a non-bureau certified provider who is not in the MCO's panel or with whom the MCO does

not have an arrangement, other than a hospital, the bureau shall electronically transfer to the MCO for payment to the provider for subsequent treatment after the initial or emergency treatment, in accordance with rule 4123-6-14 of the Administrative Code, either the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee, only under the following circumstances:

(a) Where the treatment provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider and the MCO has authorized the treatment pursuant to rule 4123-6-06.2 of the Administrative Code, or

(b) Where the treatment provided by the non bureau certified provider is reasonably available through a like bureau certified provider, the non-bureau certified provider may only be reimbursed for the treatment if the provider becomes bureau certified. If the provider refuses or fails to become bureau certified, the treatment shall not be reimbursed.

(6) For hospital services, the bureau shall electronically transfer to the MCO for payment to the hospital, in accordance with rule 4123-6-14 of the Administrative Code, either the lesser of the applicable amount pursuant to rule 4123-6-37.1 (inpatient) or 4123-6-37.2 (outpatient) of the Administrative Code or the MCO contracted fee, or, if applicable under paragraph (A)(7) of this rule, the MCO negotiated fee.

(7) The MCO shall have authority to negotiate fees with providers, either by contract or on a case-by-case basis, in the following circumstances:

(a) As permitted under rule 4123-6-08 of the Administrative Code (including the appendix to the rule);

(b) As permitted under rule 4123-6-37.1, 4123-6-37.2 or 4123-6-37.3 of the Administrative Code;

(c) As permitted under rule 4123-18-09 of the Administrative Code;

(d) With non-bureau certified providers outside the state, where the treatment provided by the non-

bureau certified provider is not reasonably available through a like bureau certified provider;

(e) With bureau certified providers and non-bureau certified providers within the state, where unusual circumstances justify payment above BWC's maximum allowable rate for the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) level II and level III coded services/supplies, and such circumstances are documented and approved by the bureau.

(8) The bureau shall not pay for missed appointments or procedures. If the provider customarily charges for missed appointments or procedures, the provider shall inform the injured worker upon the initial or emergency treatment that the provider charges for missed appointments or procedures and that such charges are the responsibility of the injured worker. Bills must only contain descriptions of services that have been actually delivered, rendered, or directly supervised by the provider for the actual conditions treated. A provider shall not transmit to the MCO or bureau any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

(B) QHP.

(1) Within each QHP, all payments shall be in accordance with consistent billing and payment policies and practices established by the QHP and consistent with the provisions contained in paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.

(2) With the exception that no financial arrangement between an employer or QHP and a provider shall incentivize a reduction in the quality of medical care received by an injured worker, an employer or QHP may pay a QHP panel provider a rate that is the same, is above or, if negotiated with the provider in accordance with rule 4123-6-46 of the Administrative Code, is below the rates set forth in the applicable provider fee schedule rules developed by the bureau. Nothing in the rules pertaining to the QHP system shall be construed to inhibit employers or QHPs and providers in their efforts to privately negotiate a payment rate.

(3) An employer or QHP shall pay a bureau certified non-QHP panel provider other than a hospital the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, unless an alternate payment arrangement is negotiated between an employer or QHP and

the provider in accordance with rule 4123-6-46 of the Administrative Code.

(4) An employer or QHP shall pay a bureau certified non-QHP panel hospital the applicable amount under rule 4123-6-37.1 (inpatient) or 4123-6-37.2 (outpatient) of the Administrative Code, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.

(5) Employers' financial arrangements with company-based providers remain intact and services provided by company based providers need not be billed separately through QHP arrangements.

(6) An employer in the QHP system shall authorize and pay for initial or emergency medical treatment for an injury or occupational disease that is an allowed claim or condition provided by a non-bureau certified provider as follows:

(a) The employer shall pay a non-bureau certified provider only for initial or emergency treatment of an injured worker for a workers' compensation injury, unless the QHP specifically authorizes further treatment. A non-bureau certified provider shall inform the injured worker that the provider is not a participant in the QHP and that the injured worker may be responsible for the cost of further treatment after the initial or emergency treatment, unless payment for further treatment is specifically authorized by the QHP. The injured worker may continue to obtain treatment from the non-bureau certified provider, but the payment for the treatment shall be the injured worker's sole responsibility, except as provided in this paragraph.

(b) An employer or QHP shall pay a non-bureau certified provider that provides initial or emergency medical treatment or further medical treatment that has been specifically authorized by the QHP, other than a hospital, the lesser of the bureau fee schedule or the charges billed by the provider for the allowed services rendered, unless an alternate payment arrangement is negotiated between an employer or QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.

(7) An employer or QHP shall pay a non-bureau certified hospital that provides initial or emergency medical treatment or further medical treatment that has been specifically authorized by the QHP the applicable amount under rule 4123-6-37.1 (inpatient) or 4123-6-37.2 (outpatient) of the Administrative Code, unless an alternate payment arrangement is negotiated between an employer or

QHP and the provider in accordance with rule 4123-6-46 of the Administrative Code.

(8) The employer or QHP shall not pay for missed appointments or procedures. If the provider customarily charges for missed appointments or procedures, the provider shall inform the injured worker upon the initial or emergency treatment that the provider charges for missed appointments or procedures and that such charges are the responsibility of the injured worker. Bills must only contain descriptions of services that have been actually delivered, rendered, or directly supervised by the provider for the actual conditions treated. A provider shall not transmit to the employer or QHP any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

(C) Self-insuring employer (non-QHP).

(1) Payment for medical services and supplies by self-insuring employers shall be equal to or greater than the fee schedule established by the bureau in state fund claims, unless otherwise negotiated with the provider in accordance with rule 4123-6-46 of the Administrative Code. All payments by the self-insuring employer shall be consistent with the provisions contained in paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.

(2) The self-insuring employer shall not pay for missed appointments or procedures. If the provider customarily charges for missed appointments or procedures, the provider shall inform the injured worker upon the initial or emergency treatment that the provider charges for missed appointments or procedures and that such charges are the responsibility of the injured worker. Bills must only contain descriptions of services that have been actually delivered, rendered, or directly supervised by the provider for the actual conditions treated. A provider shall not transmit to the self-insuring employer any bill containing false or misleading information that would cause a provider to receive payment for services that the provider is not entitled to receive.

(D) Provider duty to report overpayment. A provider that has identified an overpayment must report and return the overpayment to the bureau, QHP or self-insuring employer within sixty days of identifying the overpayment. Providers must exercise reasonable diligence to identify and quantify overpayments.