Ohio Administrative Code

Rule 4123-6-16.2 Medical treatment reimbursement requests.

Effective: April 1, 2021

(A) Medical treatment reimbursement requests (on form C-9 or equivalent) must be submitted by a provider eligible to submit such requests to the MCO responsible for medical management of the claim prior to initiating any non-emergency treatment.

The following provider types are eligible to submit medical treatment reimbursement requests to the MCO:

(1) A physician as defined in rule 4123-6-01 of the Administrative Code;

(2) The following non-physician practitioner types:

(a) Advanced practice nurses;

(b) Physician assistants;

(c) Physical therapists;

(d) Occupational therapists;

(e) Optometrists;

(f) Audiologists;

(g) Licensed independent social workers;

(h) Licensed professional clinical counselors.

(B) Medical treatment reimbursement requests shall be evaluated by the MCO using the following

three-part test (all parts must be met to authorize treatment reimbursement):

(1) The requested services are reasonably related to the industrial injury (allowed conditions);

(2) The requested services are reasonably necessary for treatment of the industrial injury (allowed conditions);

(3) The costs of the services are medically reasonable.

(C) For informational purposes, the bureau may require the provider to include on the medical treatment reimbursement request the applicable codes, from the edition of the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) in effect on the date of the request, for the procedures or services being requested.

However, review of the request shall be directed to the treatment being requested, and shall not be construed as approving or denying payment for the specific codes listed by the provider.

(D) Medical treatment reimbursement requests in inactive claims shall be processed in accordance with the provisions of rule 4123-3-15 of the Administrative Code.

(E) Medical treatment reimbursement requests submitted by a physical therapist or occupational therapist must be accompanied by a prescription as required in paragraph (B) of rule 4123-6-30 of the Administrative Code, and approval of such requests shall be valid for no longer than thirty days unless the approval specifies a longer period and such longer period is supported by the prescription. Approval of all medical treatment reimbursement requests shall be valid for no longer than six months unless the approval specifies a longer period.

(F) The MCO may dismiss without prejudice medical treatment reimbursement requests under the following circumstances:

(1) The request has been submitted by a provider who is not enrolled with the bureau and who refuses to become enrolled, or who is enrolled but non-certified and is ineligible for payment as a non-certified provider under rule 4123-6-06.2 or 4123-6-10 of the Administrative Code or division

(N) of section 4121.44 of the Revised Code.

(2) The request is not accompanied by supporting medical documentation that the submitting provider has examined the injured worker within thirty days prior to the request, or that the injured worker requested a visit with the provider, and such evidence is not provided to the MCO upon request (through form C-9A or equivalent).

(3) The request duplicates a previous request that has been denied in a final administrative or judicial determination where the new request is not accompanied by supporting medical documentation of new and changed circumstances impacting treatment, and such evidence is not provided to the MCO upon request (through form C-9A or equivalent).

(4) The underlying claim has been settled, and the dates of service requested are on or after the effective date of the settlement. If the request includes both dates of service on or after the effective date of the settlement and dates of services prior to the effective date of the settlement, the MCO may dismiss without prejudice only that portion of the request relating to dates of service on or after the effective date of the settlement.

(5) 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.

(6) The services or supplies being requested are never covered by the bureau pursuant to other bureau statutes or rules.

(7) Unless otherwise provided in this chapter of the Administrative Code, the MCO has requested from the submitting provider (through form C-9A or equivalent) supporting medical documentation necessary to the MCO's evaluation and determination, and such documentation is not provided to the MCO.

(8) A fee bill for the service was not submitted to the bureau or commission within the applicable time frame as set forth in rule 4123-3-23 of the Administrative Code.

(G) If the MCO determines 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 may notify the parties of its decision to discontinue payment of approved treatment that has not already been rendered.

This decision shall be subject to alternative dispute resolution pursuant to rule 4123-6-16 of the Administrative Code.

(H) Notwithstanding any other provision of this rule, the bureau may reserve the authority to authorize or prior authorize reimbursement for services including, but not limited to, return to work management services pursuant to paragraph (D) of rule 4123-6-04.6 of the Administrative Code, caregiver services, and home and vehicle modifications.