Ohio Administrative Code

Rule 4123-6-20 Obligation to submit medical documentation and reports.

Effective: April 1, 2021

(A) A provider is responsible for the accuracy and legibility of all reports, information, and documentation submitted by the provider, the provider's employees, or the provider's agents to the bureau, industrial commission, injured worker, employer, or their representatives, MCO, QHP, or self-insuring employer in connection with a workers' compensation claim. The provider, the provider's employees, and the provider's agents shall not submit or cause or allow to be submitted to the bureau, industrial commission, injured worker, employer, or their representatives, MCO, QHP, or self-insuring employer any report, information, anddocumentation containing false, fraudulent, deceptive, or misleading information.

(B) Physician's medical reports of work ability.

(1) Physicians treating injured workers shall complete, sign, and submit to the MCO a physician's report of work ability on form MEDCO-14 or equivalent upon every injured worker encounter, unless:

(a) The injured worker has been awarded compensation for permanent total disability;

(b) The injured worker returns to work without restrictions within seven days of the injury; or

(c) The injured worker is seeing the treating physician after the treating physician has submitted a MEDCO-14 or equivalent releasing the injured worker to return to the former position of employment without restrictions.

(2) The physician's report of work ability must include at a minimum the following:

(a) The date of the report;

(b) The date of the last examination;

(c) The "International Classification of Disease" diagnosis code(s) recognized in the claim for all conditions and all parts of the body being treated that are affecting the length of disability, including a primary diagnosis code, with a narrative description identifying the condition(s) and specific area(s) of the body being treated;

(d) Any reason(s) why recovery has been delayed;

(e) The date temporary total disability began;

(f) The current physical capabilities of the injured worker;

(g) An estimated or actual return to work date;

(h) An indication of need for vocational rehabilitation;

(i) Objective findings; and

(j) Clinical findings supporting the information in this rule.

(C) Treatment plan.

(1) Upon allowance of a claim by the bureau, industrial commission, or self-insuring employer, the physician of record and other providers treating the injured worker shall provide and continue to update a treatment plan to the MCO, QHP, or self-insuring employer according to the format or information requirements designated by the bureau. A treatment plan should include at least the following:

(a) Details of the frequency, duration, and expected outcomes of medical interventions, treatments, and procedures;

(b) The estimated return to work date; and

(c) Factors that are unrelated to the work-related condition, but are impacting recovery.

(2) Modifications should be made to the initial treatment plan as treatment is extended, changed, completed, added, deleted or canceled. The modification should describe the current prognosis for the injured worker, progress to date, and expected treatment outcomes.

(3) Treatment plans should be updated when significant changes occur in the claim that impact claims management. Changes include:

(a) Additional allowance;

(b) Re-activation;

(c) Authorization of expenditures from the surplus fund;

(d) Return to modified or alternative work;

(e) Maximum medical improvement;

(f) Rehabilitation;

(g) A new injury while receiving treatment in the claim.

(D) Supplemental reports or other bureau forms from the attending physician and other providers may be requested by the bureau, industrial commission, employer, MCO, QHP, or by the injured worker or representative. These reports shall be used to determine the appropriateness of a benefit, bill payment, or allowance.

(E) In accepting a workers' compensation case, a provider assumes the obligation to provide to the bureau, injured worker, employer, or their representatives, MCO, QHP, or self-insuring employer, upon written request or facsimile thereof and within five business days, all medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to the claim required by the bureau, MCO, QHP, or self-insuring employer, and

necessary for the injured worker to obtain medical services, benefits or compensation.

(F) Independent medical examinations.

(1) A provider performing an independent medical examination of a injured worker shall create, maintain, and retain sufficient records, papers, books, and documents in such form to fully substantiate the accuracy of the resulting report submitted to the bureau, industrial commission, injured worker, employer, or their representatives, MCO, QHP, or self-insuring employer in connection with a workers' compensation claim. The provider, the provider's employees, and the provider's agents shall keep such records in accordance with rule 4123-6-45.1 of the Administrative Code, and such records shall be subject to audit pursuant to rule 4123-6-45 of the Administrative Code.

(2) A provider performing an independent medical examination of a injured worker shall keep confidential all information obtained in the performance of the independent medical examination, including but not limited to knowledge of the contents of confidential records of the bureau, industrial commission, injured worker, employer, or their representatives, MCO, QHP, or self-insuring employer. The provider, the provider's employees, and the provider's agents shall maintain the confidentiality of such records in accordance with all applicable state and federal statutes and rules, including but not limited to rules 4123-6-15 and 4123-6-72 of the Administrative Code.