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Workers' Compensation Update

Presented by the Workers' Compensation Practice Group

Thursday, November 29, 2018

Workers' Compensation Law Update
November 29, 2018

8:30 a.m.	**Case Law Update** Jeffrey W. Harris, Esq., *Harris Law Firm*	**TAB A**
9 a.m.	**Medical Marijuana: What Employer's Need to Know** Andy M. Kaplan, Esq., *Vorys Sater Seymour & Pease LLP*	**TAB B**
10 a.m.	**Break**	
10:10 a.m.	**MCO Issues** Peter H. Mihaly, Esq., *Ohio BWC Legal Division*	**TAB C**
11:10 a.m.	**Break**	
11:20 a.m.	**ADA Concerns, Reasonable Accommodations, and Retaliatory Discharge Issues** Cori R. Besse, Esq., *The Law Firm of Sadlowski & Besse LLC*	**TAB D**
12:20 p.m.	**Break**	
12:30 p.m.	**Group Luncheon Presentation: Long-Term Strategies for Pain Management** Dr. Stephen Feagins, *Mercy Health*	**TAB E**
1:30 p.m.	**Break**	
1:40 p.m.	**Attorney Conduct: Hearing Room Decorum** Elizabeth Fox, Esq.,and Joseph W. Meyer, Esq., *Ohio Industrial Commission*	**TAB F**
2:40 p.m.	**Insights on Medical Reports and Tests** Dr. Stephen Feagins, *Mercy Health*	**TAB G**
3:15 p.m.	**Adjourn**	

TAB
A

SUPREME COURT

Voluntary Abandonment: Voluntary Abandonment may apply even when claimant is not capable of performing the duties of his former position of employment.

State ex rel. Klein v. Precision Excavating & Grading Company
2018-Ohio-3890

John Klein sustained a work related injury while working for Precision Excavating & Grading Company on November 5, 2014. Klein's claim was allowed for fractured ribs and traumatic hemopneumothorax and his physician found him temporarily and totally disabled from work through January 5, 2015. On November 13, 2014, Klein told the Bureau of Workers Compensation (BWC) that he was moving to Florida as of November 20, 2014. The issue of compensation went to hearing, where testimony was presented that Klein had been planning to move to Florida prior to his injury for better weather and more job opportunities. The employer testified that Klein informed them on October 31, 2014 that he would be moving to Florida and asked about the procedure for quitting his job, although nothing was provided to the employer in writing. Other evidence demonstrated that Klein had told others of his planned move to Florida prior to his injury. Based on the evidence, the Commission granted temporary total disability only for the dates of November 6, 2014 through, November 19, 2014, and found that Klein voluntarily abandoned his job for reasons unrelated to his injury when he moved on November 20, 2014. Klein appealed in mandamus, where the appellate court granted a writ based on *State ex rel. Reitter Stucco*, *Inc. v. Industrial Commission*, 2008-Ohio-499, and *State ex rel. OmniSource Corporation v. Industrial Commission*, 2007-Ohio-1951, which established that a claimant who voluntarily abandons his employment is entitled to temporary total disability compensation if he is medically incapable of returning to work at the time of abandonment. The Commission appealed that decision. Despite the previous precedent established by Supreme Court, this Court overruled *Reitter Stucco* and *OmniSource* and determined that Klein was not entitled to compensation from the date that he was found to have abandoned his job even though he was not medically capable of performing the job at the date abandonment was determined. In its decision, the Court abandoned the long standing principle that the most important question is whether a claimant is capable of performing his/her former position of employment due to work related injuries and determined that even if such work is not possible, voluntary abandonment will preclude compensation. The Court found that Klein voluntarily abandoned his position with the employer following his accident and for this Court that was enough to deny compensation.

Jurisdiction: Jurisdiction for case regarding improper debit card fees was with court of claims.

Cirino v. Ohio Bureau of Workers Compensation
2018-Ohio-2665

The question before the court in the *Cirino* case is whether the court of common pleas or the court of claims was the proper jurisdiction for a lawsuit against the Bureau of Workers' Compensation for

allegedly improperly allowing fees to be charged to individuals trying to access their benefits through debit cards issued by the bureau. Cirino was charged fees for withdrawing money using his debit card and filed suit in the court of common pleas alleging that the Bureau improperly charged him administrative costs that the statute indicates must be borne by the Bureau and/or employers. The Bureau moved to have the case dismissed arguing that, because Cirino was askin soely for monetary damages, exclusive jurisdiction lay with the Court of Claims. The trial court denied the BWC's motion finding that Cirino was seeking equitable relief and not simple money damages. On appeal, the eight district appellate court agreed. However, the Supreme Court disagreed with the lower courts and vacated their decisions, finding that the Court of Claims has sole jurisdiction over this claim. The court found that restitution is a legal and not an equitable restitution because Cirino was not asking for specific funds in control of the BWC but was seeking funds which had been assessed by the third party bank involved. The Court found that the money here was not unjust enrichment for the bureau, but payments of compensation paid to Chase. Because the Bureau cannot order Chase to return the fees to the recipients, the Court found Cirino was not seeking specific funds under the control of the BWC. As such, the Court found that Cirino was seeking money to compensate for a loss he suffered when the fees were charged, that those charges were for money damages, and, as such that proper jurisdiction lay with the Court of Claims.

PTD Allocation: Commission must explain the basis for its PTD allocation

State ex rel. Penske Truck Leasing Company v. Industrial Commission
2018-Ohio-2153

Deborah Fizer filed for permanent total disability based on three workers compensation claims she had suffered while working as a driver for two separate employers. Fizer had a 2001 claim arising from her work at Penske which was allowed for cervical strain. A 2004 claim, also from Penske, was allowed for lumbar sprain, left rotator cuff sprain, and left shoulder adhesive capsulitis. A 2007 claim from her work at TQ Logistics was allowed for a neck sprain, left shoulder sprain, disc bulge with compression at C5 through C7, and recurrent depressive psychosis – severe. Permanent total disability was granted and apportioned as follows: 9 percent to the 2001 claim, 13 percent to the 2004 claim, and 78 percent to the 2007 claim. Penske appealed in mandamus challenging the allocation and arguing that there was no evidence supporting any apportionment to the 2001 claim and no support for the specific 13 percent allotted to the 2004 claim. The Magistrate and the court of appeals agreed with Penske's position that the allocation to the 2001 claim was not supported and the allocation to the 2004 claim was not explained. The Commission appealed arguing it is not required to provide mathematical explanations for its allocations. The Court said while the Commission is not required to explain allocation with mathematical precision it must still provide an explanation for the basis of its findings. In this case, the Court found that the Commission did not do so and as such mandamus relief was granted.

Vocational Evidence: The Commission improperly rejected vocational evidence where report was provided for injured worker by vocational specialist who previous conducted services for BWC

State ex rel. Gulley v. Industrial Commission
2017-Ohio-9131

Lloyd Gulley slipped off a piece of equipment at work in November 2009, and subsequently had a workers compensation claim allowed for left shoulder, back, hand, arm, and psychological conditions. He did not return to work following the injury. In 2010 and 2012, the Bureau of Workers Compensation approached Gulley about vocational rehabilitation and on both occasions he indicated he was not interested. In 2014 a referral was made to vocational rehabilitation and gulley was found not to be a feasible candidate. Gulley then filed for permanent total disability. Attached to his application was a full report from the vocational evaluator who found him not feasible for vocational rehabilitation indicating that Gulley was not employable. Permanent total disability was denied by the Commission. In its order, the Commission found that Gulley was capable of sedentary work, and that his negative nonmedical factors – age 64, 6th grade education, heavy only work experience – were outweighed by his lack of interest in vocational rehabilitation in 2010 and 2012. The Commission rejected the 2014 vocational evidence based on an alleged conflict of interest because the evaluator was first hired by the BWC and then retained by the injured worker. Gulley appealed in mandamus. The court of appeals agreed with the appeal and ordered a limited writ which required the Commission to issue an order without relying on the earlier refusals for rehabilitation services as he later attempted to participate in 2014. The Supreme Court began its discussion by noting that the issue in this case is one focusing on nonmedical analysis as there is no dispute about sedentary capacity for work. The Court found that the Commission did not abuse its discretion in considering the refusal to participate in vocational rehab in 2010 and 2012. However, the Court also found that Commission improperly found a conflict of interest based on the vocational evaluator doing work for the BWC before being retained by the injured worker. The Court noted that the assessment was neither incompatible or irreconcilable with the BWC's intersts and, therefore, the Commissions' rejection based on conflict of interest was in error. The Court noted that while the Commission is not bound to accept vocational evidence in the record, "it is required to review the evidence to determine whether the claimant is foreclosed from sustained remunerative employment." The court said the Commission failed to do that here and thus ordered the Commission to issue a decision in consideration of all evidence.

VSSR: Safety Violation Upheld for Trench Collapse

State ex rel. Sunesis Construction v. Industrial Commission
2018-Ohio-3

Timothy Roark was killed in a trench collapse in July 2005. Death benefits were awarded to his dependent children. The dependent also filed for a number of violations of specific safety requirements that apply to trenches and excavations. The Commission found that Roark's death was due to the employer's failure to properly support the trench excavation. Sunesis appealed that decision and a writ of mandamus was granted ordering the Commission to comply with *Noll* and indicate what evidence it relied upon. The Commission issued a new order in 2011, again granting the VSSR application, this time citing the evidence it relied upon. Sunesis appealed. The court of appeals upheld the decision rejecting

Sunesis's argument that the Commission abused its discretion by failing to determine the actual degree of the slope. The Supreme Court further upheld the decision. It rejected the arguments by Sunesis, finding that the cited sections did apply, that the VSSRs were the proximate cause of death, and that unilateral negligence was not a defense as the question is whether the employer complied with the safety requirements.

VSSR: Code Section covering Calendars excepts those machines from coverage under 4123:1-5-11 regarding nip points.

State ex rel. 31, Inc. v. Industrial Commission
2017-Ohio-9112

Duane Ashworth was employed by 31 as a calendar operator. Under O.A.C. 4123:1-13-01(B)(3) "A calendar is defined as 'a machine equipped with two or more metal rolls revolving in opposite directions and used for continuously sheeting or plying up rubber or plastic compounds and for fractioning or coating fabric with rubber or plastic compounds.'" Ashworth's job was to grab rubber coming out of the calendar with both hands and peel it off the bottom roll into a cooling tank. Ashworth was injured when the machine caught his right hand and pulled it into a three inch space between the rolls. Ashworth filed for a violation of a specific safety requirement under O.A.C. 4123:1-5-11(D)(10) which states that employees should be protected from nip points on machines with rollers. That same section however, includes an exception for machines covered by other sections of the code. 31 argued that the section in question did not apply based on this exception. The Commission ultimately rejected this argument and granted the safety violation claim based on a failure to protect nip points. 31 appealed. The court of appeals upheld the Commission's decision. On appeal the Supreme Court agreed with 31's arguments. It found that the Ohio Administrative Code has a specific section for calendar machines and, as such, O.A.C. 4123:1-5-11(D)(10) does not apply.

VSSR: No Safety Violation Where Employee Engages Machine and Removes Machine During Maintenance contrary to employer policy

State ex rel. Ohio Paperboard v. Industrial Commission
2017-Ohio-9233

John Ruckman suffered injuries in the course of his employment with Ohio Paperboard when – Ruckman's arm was caught in a conveyer while he performed maintenance on a machine. Ruckman filed for violations of specific safety requirements related to the incident. The Commission determined that Ohio Paperboard violated 4123:1-5-06(C)(2), (C)(4), and (D)(1) which require guards and emergency shut off buttons on power driven conveyers and that the violations caused Ruckman's injuries. Specifically, those code sections require 1) a means to disengage conveyers from the power supply at the point of contact; 2) guarding of pinch points; and 3) means to disengage each machine within easy reach of the operator. The Commission concluded that Ruckman was an "operator" of the machine as he was assigned to work that machine, that he was exposed to the machine and that his injury occurred

at a pinch point. Ohio Paperboard appealed. The court of appeals upheld the decision. Ultimately, the Supreme Court overruled the lower court and overturned the Commission's determination. The reasons given by the Court was that the machine was not in normal operation during the time of the accident, but was under maintenance, and during that maintenance work, Ruckman unlocked the machine and removed a guard to access and remove the trapped wires which were the cause of the problems for which the maintenance was needed. The Court did reject Ohio Paperboard's assertion that Ruckman was not an operator of the machine, noting that the section on operators was broad and the Commission used its discretion to find that Ruckman was an operator, but then overturned the Commission's decision based on arguments related to the fact that the conveyer was shut down for maintenance at the time of the injury. The Court reasoned that a means to disengage the conveyer from power and provide guards did not apply during the maintenance process. The Court stated that the stop button was accessible during normal operations and that guards were also present at this time. The court further found that Ohio Paper required that the machine be shut down during maintenance such that the cited provisions would not be required. The Court concluded that Ohio Paper fulfilled its obligations and that Ruckman was the one who removed the guard and engaged the power supply against his employer's policy and that, as such, no safety violation occurred.

Violation of Specific Safety Requirement: Impossibility standard established by Court and met by employer despite the fact that the evidence used to meet the standard was submitted after the initial hearing.

State ex rel. Jackson Tube Service v. Industrial Commission
2018-Ohio-3892

Chad Thompson was an industrial electrician who had both legs broken when a flywheel suspended from a claim fell on him during the course of his employment. Thompson pursued a safety violation against his employer related to the injury. Thompson testified that he understood that there was a fixture offered by the manufacturer that could have prevented the accident. Jackson Tube had testimony that it was not aware of any alternative way to perform the task while keeping an individual from being under the flywheel while it was being placed into a machine. The Commission rejected Jackson Tube's impossibility argument and found a violation of O.A.C. 4123:1-5-15(D) for requiring Thompson to work under a suspended load. Jackson Tube filed a motion for rehearing arguing that a mistake of fact occurred as the manufacturer does not provide a device to assist in replacing the flywheel, and attached to that motion an affidavit which referenced a discussion with the manufacturer. Jackson Tube's motion for rehearing was denied and an appeal in mandamus was filed. That appeal was initially rejected, as the Commission's reliance on Thompson's testimony that alternative means could have been provided and Jackson Tube's failure to demonstrate that an alternative was impossible. Jackson Tube appealed to the Supreme Court who overturned the lower court decisions and issued a writ of mandamus. The Court first established a standard for the impossibility defense, stating that the employer must show "(1) that it would have been impossible to comply with the specific safety requirement or that compliance would have precluded performance of the work and (2) that no

alternative means of employee protection existed or were available." In this case, the Court found that the employer did provide such evidence while the claimant merely provided conjecture. As such, the Court found that the Commission's reliance on what the claimant "believed" regarding alternative methods was in error and ordered a decision which denied the safety violation claim. Interestingly, three of the Court's justices dissented from the opinion. The dissenters noted that the evidence which the Court relied upon was not presented at the initial hearing even though it could have been available, that at the hearing itself, Jackson Tube also testified that it "believed" that no other means were available, and that Jackson Tube had considered other means to prevent working under the load such as using a hook. The dissent notes that the majority is letting Jackson Tube have a second bite by providing evidence that was not presented until after the initial decision was made and that it ignores the Commission's discretion. Finally, the dissenters criticized the majority for creating its standard based on a federal law – not any Ohio law – which was not suggested by any of the parties in the claim.

TAB
B

PRACTICE AREAS

Labor and Employment

Litigation

INDUSTRIES

Manufacturing

EDUCATION

Georgetown University Law Center, J.D., 1983, *magna cum laude*
Georgetown Law Journal, Editor, 1983

Amherst College, B.A., 1979, Phi Beta Kappa

BAR AND COURT ADMISSIONS

Ohio

U.S. Court of Appeals for the Sixth Circuit

U.S. District Court for the Southern District of Ohio

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ANDREW M. KAPLAN

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Andy is a partner in the Vorys Cincinnati office and a member of the labor and employment group. He represents employers in state and federal court employment litigation and in agency proceedings. He also counsels employers on issues pertaining to the ADA, the FMLA, employment discrimination, reductions-in-force, terminations, severance agreements and other aspects of the employer-employee relationship.

Andy also represents self-insured and state-funded employers in workers' compensation matters before the Industrial Commission of Ohio and the trial and appellate courts of Ohio. His work in the area of workers' compensation also includes defense of safety violation claims and intentional tort claims.

Career highlights include:

- 33 years of litigation experience in state and federal court and before administrative agencies
- 30 years of experience representing employers before the Industrial Commission of Ohio and in the courts on a broad range of workers' compensation issues

Andy is a member of the American Bar Association, the Ohio State Bar Association, and the Cincinnati Bar Association.

Andy has given presentations on multiple employment-related topics and on workers' compensation issues including claims management and defense, violations of specific safety requirements, and intentional torts.

Andy received his J.D. *magna cum laude* from Georgetown University Law Center, where he was an editor of the *Georgetown Law Journal*. He received his B.A. from Amherst College, where he was a member of Phi Beta Kappa.

Insights

"*Labor and Employment Alert*: Kentucky Supreme Court Prohibits Mandatory Arbitration Agreements," October 10, 2018

"*Labor and Employment Alert*: Oklahoma Becomes the 30th State to Legalize Medical Marijuana," July 2, 2018

"*Labor and Employment Alert*: Massachusetts Enacts the Pregnant Workers Fairness Act," August 4, 2017

"*Labor and Employment Alert*: Massachusetts High Court Requires Reasonable Accommodation for Medical Marijuana Users," July 27, 2017

ANDREW M. KAPLAN

(Continued)

"Political Speech in the Workplace," *Cincinnati Business Courier*, October 14, 2016

"*Labor and Employment Alert*: New Massachusetts Pay Equity Law: Equal Pay for Comparable Work (But Not Until 2018)," August 19, 2016

"*Labor and Employment Alert*: Workers' Compensation Retaliation Does Not Require a Workplace Injury Under Ohio Law," August 2, 2016

"*Labor and Employment Alert:* Bi-Partisan Medical Marijuana Legislation Introduced in Ohio," May 2, 2016

"*Labor and Employment Alert*: Ohio City Enacts Wage Theft Ordinance," February 16, 2016

Honors and Awards

The Best Lawyers in America, Cincinnati Workers Compensation Law - Employers "Lawyer of the Year," 2018

The Best Lawyers in America, Workers' Compensation Law - Employers, 2013-2019

Super Lawyers, Corporate Counsel Edition, Employment and Labor, November 2010

Ohio Super Lawyers, Employment and Labor, 2008-2009

Volunteer Lawyer of the Year Award, Volunteer Lawyers for the Poor Foundation, 2006

Outstanding Service Award for Pro Bono Service, United States District Court for the Southern District of Ohio, 1996

Martindale-Hubbell AV Peer Review Rated

Events

Workers' Compensation Annual Client Briefing

2018 International Association of Official Human Rights Agencies Annual Conference

2018 Cincinnati Labor and Employment Update

Cincinnati Labor and Employment Law Update

Workers' Compensation Annual Client Briefing

HR Academy: Cincinnati Labor & Employment Law Update

Home Builders Association of Greater Cincinnati Legal Update

2015 Labor & Employment Update

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ANDREW M. KAPLAN

(Continued)

2014 Cincinnati Labor and Employment Law Update

2013 Cincinnati Labor and Employment Law Update

2012 Cincinnati Labor and Employment Law Update

CityScape Cincinnati: A View Towards Development & Growth Opportunities

Employee Documentation, Discipline and Discharge

2011 Cincinnati Labor and Employment Law Update

2009 Cincinnati Labor and Employment Law Update

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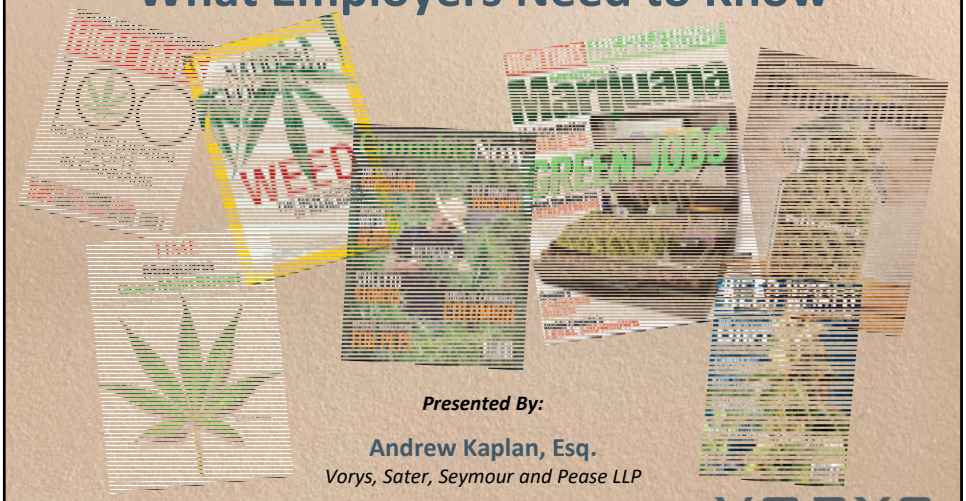
Medical Marijuana: What Employers Need to Know



Presented By:

Andrew Kaplan, Esq.
Vorys, Sater, Seymour and Pease LLP

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Good to the Last Drop

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The power of the lawyer is in the uncertainty of the law.

~ Jeremy Bentham

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Hippies to Hipsters: Marijuana Ain't What it Used to Be

- Changes in the way marijuana is grown and processed have dramatically increased marijuana's potency.
- **Users can now get the same amount of THC from a single puff that people in the 1970's got from an entire joint.**
- Marijuana-infused products like baked goods, candy, and sodas are often stronger than smoked marijuana. Concentrates such as hash oil have the highest amount of THC.
- The Washington State Liquor and Cannabis Board collaborated with "industry partners" to produce *Marijuana Use in Washington State, An Adult Consumer's Guide* to help consumers understand the differences in the types of marijuana available in retail stores and the relevant laws.

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Navigating Through the Haze

- **Pot:** A brief history and the current state of marijuana "legalization"
- **Politics:** Pot makes strange bedfellows
- **Preemption**: The increasingly hazy "conflict" between state and federal law
- **Prophecy**: Employment law issues facing employers

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Ancient History

- 2900 BCE – Chinese Emperor Fu Hsi referenced marijuana as a popular medicine.
- Cannabis has been referenced for medicinal properties and used to treat a broad range of conditions (e.g., muscle spasms, menstrual cramps, depression, epilepsy, and rheumatism).
- Jamestown settlers brought marijuana plants to North America in 1611, and hemp fiber was an important export – it's reported that George Washington grew it and Queen Victoria used it.

Source: www.medicalmarijuana.procon.org

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The 1930's

- Demand for marijuana-based "medications" grew.
- Parke-Davis and Eli Lily sold standardized extracts for use as analgesics, antispasmodics, and sedatives.
- One company marketed marijuana cigarettes as an asthma remedy.

Source: www.medicalmarijuana.procon.org

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The 1930's (cont'd)

- Growing opposition to marijuana.
  - William Randolph Hearst denounced marijuana in his newspapers.
  - The Bureau of Narcotics urged federal action to control marijuana.
- 1937 – AMA opposed the marijuana tax and supported research on medical cannabis. But tax law passed, and "sin tax" led to decline in use.
- 1942 – marijuana removed from U.S. Pharmacopeia, detracting from its therapeutic legitimacy.

Source: www.medicalmarijuana.procon.org

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The 1950's & 1960's

- 1950's – Congress established mandatory minimum prison sentences for possession. Included in the Narcotic Control Act of 1956.
- 1961 – United Nations established rule that "for other than medical and scientific purposes, the use of cannabis must be discontinued as soon as possible."
- 1968 – University of Mississippi became an official (and only) grower of marijuana for federal government's research purposes.

Source: www.medicalmarijuana.procon.org

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The 1970's

"Users are Losers" Campaign

"America's public enemy #1 is drug abuse." ~ President Nixon

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Controlled Substances Act

- Federal law establishing requirements for manufacture, importation, possession, use, and distribution of certain regulated substances.
- Places drugs into one of five schedules based on medical use, potential for abuse, safety, and other factors.
- Schedule I drugs have no currently accepted medical use and a high potential for abuse:
  - Marijuana, heroin, LSD, ecstasy, methaqualone, peyote.
- Various health care laws, state criminal laws, and other laws are tied to these schedules.

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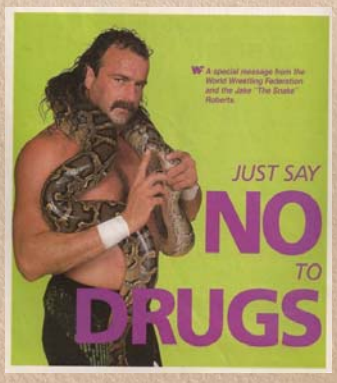
The 1980's

1986 – President Reagan signed the Anti-Drug Abuse Act, instituting mandatory sentences for drug-related crimes.



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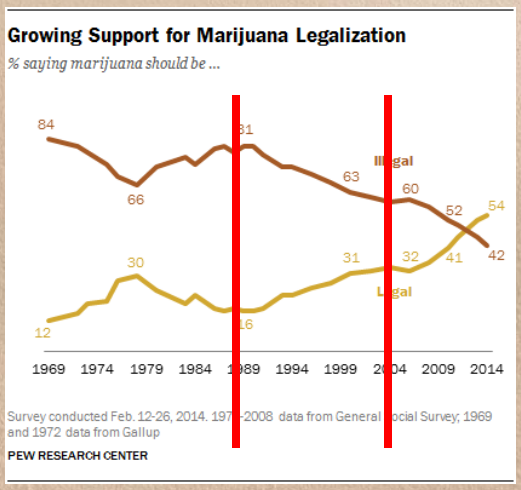
The 1990's



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The New Millennium

- 2016: $5.9 billion spent on "legal" marijuana.
- 2017: Colorado's total marijuana sales = **$1.5 billion (plus $250 million in taxes, fees, etc.)**.
- 2021: nationwide marijuana sales expected to be $19 billion.

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June 25, 2018

FDA approves first drug comprised of an active ingredient derived from marijuana to treat rare, severe forms of epilepsy.

"This approval serves as a reminder that advancing sound development programs that properly evaluate active ingredients contained in marijuana can lead to important medical therapies."

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June 25, 2018

"But, at the same time, we are prepared to take action when we see the illegal marketing of CBD-containing products with serious, unproven medical claims. Marketing unapproved products, with uncertain dosages and formulations can keep patients from accessing appropriate, recognized therapies to treat serious and even fatal diseases."

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All politics is local.

~ Former House Speaker Tip O'Neill

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We have watched where the politicians have consistently failed to be able to fashion rational policy and show a little back bone. This issue has been driven by the people.

~ Rep. Earl Blumenauer (D-Oregon)

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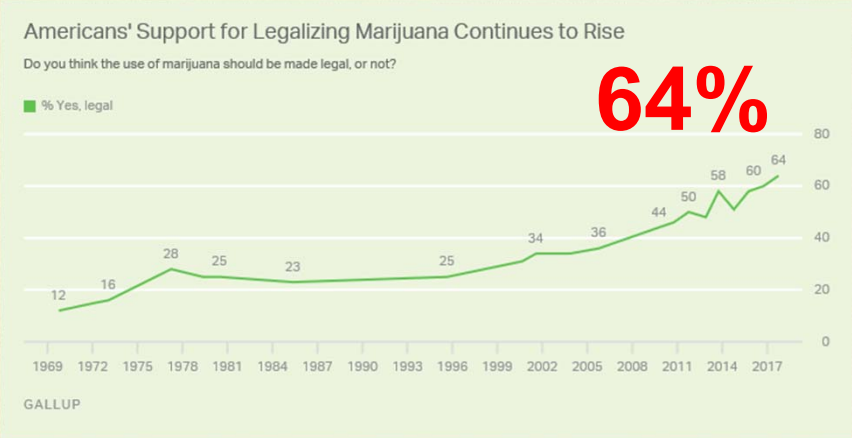
Latest Gallup Poll on Legalization
(October 25, 2017)



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Pot Makes Strange Bedfellows in Ohio

- **2015:** Proposed constitutional amendment to legalize recreational and medical marijuana. Defeated at ballot: 65% vs. 35%.
- **January 2016:** Ohio House of Representatives created a bipartisan medical marijuana task force.
- **Early 2016:** Two new ballot proposals circulated to amend the Constitution to authorize medical marijuana.
- **April 2016:** Republicans and Democrats introduce HB 523 to legalize medical marijuana.
- **May 2016:** HB 523 passes the House and Senate in just two weeks.
- **June 8, 2016:** Governor John Kasich signed HB 523.

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Ohio Medical Marijuana Law

- Effective September 6, 2016.
- Entire medical marijuana program must be operational by September 8, 2018. Didn't happen.
- Ohio Medical Marijuana Control Commission.
  - Pharmacy Board, Medical Board, and Department of Commerce.
  - Rules have been adopted for cultivators, processors, testing laboratories, dispensaries, patients/caregivers, and physicians.
  - www.medicalmarijuana.ohio.gov

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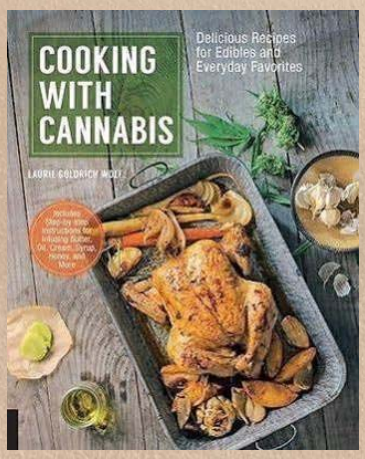
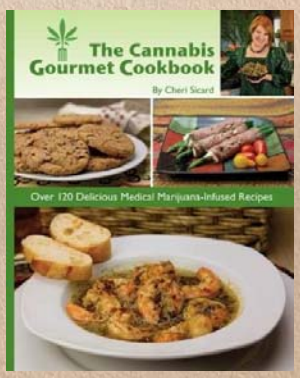
Pot in 2018 – Potpourri or Pandora's Box?





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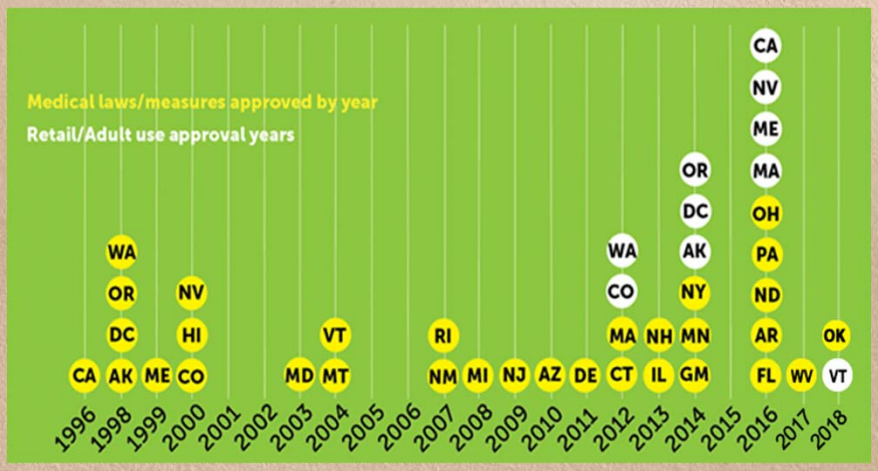
What Happened in 2016?



Source: National Conference of State Legislature

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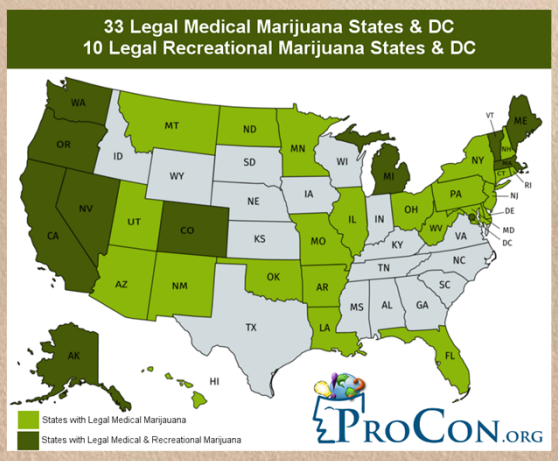
Red State, Blue State, Green State



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This Constitution, and the Laws of the United States which shall be made in Pursuance thereof … shall be the supreme Law of the Land … anything in the constitutions or laws of any State to the contrary notwithstanding.

~ U.S. Constitution Art. VI, cl.2

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Politics, Pot, and the Feds

"We must not capitulate, intellectually or morally, to drug use. We must create and foster a culture that's hostile to drug use."

- Former Attorney General Jeff Sessions (8/28/17)

"Prosecutorial discretion is everything given the current conflict between the federal law and the law of many states."

- Rep. Jared Huffman (D-California) (6/17)

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Politics, Pot, and the Feds (cont'd)

- **The Preemption Doctrine**
  - Supremacy Clause of the U.S. Constitution.
  - Federal law generally prevails over conflicting state law.

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Politics, Pot, and the Feds (cont'd)

- Counterarguments to preemption:
  - Federal government cannot mandate that states enforce the federal prohibition against marijuana.
    - Federal agents enforce CSA.
    - State agents/police officers enforce state laws, and if state law does not criminalize marijuana use/possession, then there is no conflict between federal and state law.
  - CSA does not regulate employment matters.

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Federal – State Law Quagmire

- **Drug Free Workplace Act**: Employers must maintain drug-free environment to be a federal contractor or receive federal funding. 41 U.S.C. 8102 *et seq.*
- **Americans with Disabilities Act**: Current users of illegal drugs are not protected. 42 U.S.C. 12101 *et seq.*
- **DOT Regulations:** Under the Motor Carrier Act, zero tolerance for the use of illegal drugs. 49 U.S.C. 10101 *et seq.*
- **OSHA General Duty Clause**: Work places must be free from hazards that "are causing or are likely to cause death or serious physical harm to his employees." 29 U.S.C. 654, *5*(a)1.
- **Gun Ownership:** Felons can't own firearms or ammo.

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Employment Issues

- Discrimination
- Reasonable accommodation for disabilities
- Unemployment compensation
- Workers' compensation
- Drug testing
- Interplay with federal laws (ADA, etc.)

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Use and Misuse of Medical Marijuana

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Use and Misuse

- Qualifying Condition
- Qualifying Use
- Qualifying Place

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Qualifying Conditions (cont'd)

- **Ohio**: AIDS, amyotrophic lateral sclerosis, Alzheimer's disease, cancer, chronic traumatic encephalopathy, Crohn's disease, epilepsy or another seizure disorder, fibromyalgia, glaucoma, hepatitis C, inflammatory bowel disease, multiple sclerosis, pain that is either chronic and severe or intractable, Parkinson's disease, positive status for HIV, post-traumatic stress disorder, sickle cell anemia, spinal cord disease or injury, Tourette's syndrome, traumatic brain injury, and ulcerative colitis.
- **Colorado**: Cancer, glaucoma, HIV/AIDS positive, cachexia; severe pain; severe nausea; seizures, including those that are characteristic of epilepsy; persistent muscle spasms, including those that are characteristic of multiple sclerosis; PTSD. **Other conditions are subject to approval by the Colorado Board of Health.**
- **California**: Cancer, Anorexia, AIDS, Chronic pain, Cachexia, Persistent muscle spasms, Seizures, Severe nausea, Glaucoma, Arthritis, Migraines, **any other chronic or persistent medical symptom that substantially limits the ability of the person to conduct one or more major life activities** or, if not alleviated, may cause serious harm to the patient's safety or physical or mental health.

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Qualifying Conditions (cont'd)

- **Illinois:** Agitation of Alzheimer's disease; HIV/AIDS; Amyotrophic lateral sclerosis (ALS); Arnold-Chiari malformation; Cancer; Causalgia; Chronic inflammatory demyelinating polyneuropathy; Crohn's disease; CRPS (complex regional pain syndrome Type II); Dystonia; Fibrous Dysplasia; Glaucoma; Hepatitis C; Hydrocephalus; Hydromyelia; Interstitial cystitis; Lupus; Multiple Sclerosis; Muscular Dystrophy; Myasthenia Gravis; Myoclonus; Nail-patella syndrome; Neurofibromatosis; Parkinson's disease; Post-Concussion Syndrome; Post-Traumatic Stress Disorder (PTSD); Reflex sympathetic dystrophy; Residual limb pain; Rheumatoid arthritis; Seizures (including those characteristic of Epilepsy); Severe fibromyalgia; Sjogrens syndrome; Spinal cord disease (including but not limited to arachnoiditis); Spinal cord injury with damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity; Spinocerebellar ataxia; Syringomyelia; Tarlov cysts; Tourette syndrome; Traumatic brain injury; Cachexia/wasting syndrome; PTSD and terminal illness with a diagnosis of less than six months.

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Qualifying Conditions (cont'd)

- **Oklahoma**
  - **No** "qualifying medical conditions" required to make a patient eligible for medical marijuana use.
  - Rather, the license to use must be recommended "according to the accepted standards a reasonable and prudent physician would follow when recommending or approving any medication."

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Qualifying Use

- **Ohio**
  - Patients with qualifying medical conditions can use marijuana in the form of oils, edibles, plant material, tinctures, patches, and vapor.
  - Smoking marijuana is expressly prohibited.
- **Arkansas**
  - To be protected under the Arkansas Medical Marijuana Act, marijuana must be labeled from one of the Arkansas dispensaries.

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Qualifying Use (cont'd)

- **Oklahoma**
  - In July 2018, the Governor approved emergency rules to prohibit the smoking of medical marijuana. In August 2018, new rules were adopted to now permit smoking.
- **Florida**
  - Smoking medical marijuana is prohibited.

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Qualifying Place

- **Arizona permits persons to restrict marijuana use:**
  - Any nursing care institution, hospice, assisted living center, assisted living facility, assisted living home, residential care institution, adult day health care facility or adult foster care home may adopt reasonable restrictions on the use of marijuana by residents or persons receiving inpatient services.
  - Any person or establishment in lawful possession of that property may prohibit a guest, client, customer, or other visitor from using marijuana on or in that property.
  - An employer may prohibit the ingestion or marijuana in any workplace and may discipline an employee for ingesting marijuana in the workplace and/or working while under the influence of marijuana.

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Qualifying Place (cont'd)

California Recreational Use

Among other restricted places:

- Smoke marijuana or marijuana products in a location where smoking tobacco is prohibited.
- Smoke or ingest marijuana or marijuana products in any public place.
- Smoke or ingest marijuana or marijuana products while driving, operating, or riding in a motor vehicle, boat, vessel, aircraft, or other vehicle used for transportation.

California Medical Use

- In any place where smoking is prohibited by law.
- In or within 1,000 feet of the grounds of a school, recreation center, or youth center, unless the medical use occurs within a residence.
- On a school bus.
- While in a motor vehicle that is being operated.
- While operating a boat.

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Qualifying Place (cont'd)

- **Rhode Island** prohibits the smoking of marijuana:
  - In a school bus or other form of public transportation.
  - On any school grounds.
  - In any correctional facility.
  - In any public place.
  - In any licensed drug treatment facility in this state.
  - Where the exposure to the marijuana smoke significantly adversely affects the health, safety, or welfare of any children.

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Practical Question

- Can I fire an employee who smokes marijuana at work?
  - Yes, but…
    - **Maine**: can only prohibit smoking of marijuana if all smoking is prohibited on the premises.
    - **Maryland**: may prohibit only if the employer has a policy prohibiting marijuana use while at work.

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Discrimination Against Medical Marijuana Users

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Anti-Discrimination

Alaska	Maryland	**Pennsylvania**
Arizona	*Massachusetts*	North Dakota
Arkansas	*Michigan*	Ohio
California	**Minnesota**	**Oklahoma**
Colorado	Missouri	*Oregon*
Connecticut	Montana	**Rhode Island**
Delaware	*Nevada*	Utah
Florida	New Hampshire	*Vermont*
Hawaii	New Jersey	*Washington*
Illinois	New Mexico	*Washington, D.C.*
Maine	**New York**	**West Virginia**

State law explicitly includes employee non-discrimination protection.
States "legalizing" recreational marijuana use.

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Medical Marijuana User Status

- **Ohio.**
  - Nothing "[p]rohibits an employer from **refusing to hire**, discharging, disciplining, or otherwise taking an adverse employment action against a person with respect to hire, tenure, terms, conditions, or privileges of employment **because of that person's use, possession, or distribution of medical marijuana**." Ohio Revised Code §3796.28(A)(1).

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Medical Marijuana User Status (cont'd)

- **Ohio.**
  - Nothing "**[p]ermits a person to commence a cause of action against an employer** for refusing to hire, discharging, disciplining, discriminating, retaliating, or otherwise taking an adverse employment action against a person with respect to hire, tenure, terms, conditions, or privileges of employment related to medical marijuana." Ohio Revised Code §3796.28(A)(6).

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Medical Marijuana User Status (cont'd)

- **Pennsylvania.**
  - "No employer may discharge, threaten, refuse to hire or otherwise discriminate or retaliate against an employee regarding an employee's compensation, terms, conditions, location or privileges **solely on the basis of such employee's status as an individual who is certified to use medical marijuana**." 35 Pa. Stat. Ann. §10231.2103(b).

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Medical Marijuana User Status (cont'd)

- **Rhode Island.**
  - "No school, employer, or landlord may refuse to enroll, employ, or lease to, or otherwise penalize, a person solely for his or her status as a cardholder." R.I. Stat. §21-28.6-4.
- **Oklahoma.**
  - "Unless a failure to do so would cause an employer to imminently lose a monetary or licensing related benefit under federal law or regulations, an employer may not discriminate against a person in hiring, termination or imposing any term or condition of employment or otherwise penalize a person based upon:
    - 1. The person's status as a medical marijuana license holder; or
    - 2. ***The results of a drug test showing positive for marijuana or its components***." Ballot Initiative 788.

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Medical Marijuana User Status (cont'd)

- Arizona, Delaware, Minnesota, and Nevada, employers may not take an adverse employment action based on an individual's status as a cardholder unless not doing so would violate federal laws or regulations or cause an employer to lose a monetary or license-related benefit under federal law or regulations.
- Connecticut, Illinois, and Maine also prohibit discrimination on the basis of medical marijuana status.

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Practical Question

- Can I refuse to hire someone based only on the fact that the person is a medical marijuana card holder?
- **Yes** in Ohio, Oregon, Montana (if an employment contract has a provision prohibiting the use of marijuana)
- **No** in AZ, AR, CT, DE, IL, ME, MA, MN, NV, NY, PA, RI, WV

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Accommodation of Medical Marijuana Users in the Workplace

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Reasonable Accommodations

- **Ohio.**
  - Nothing "[r]equires an employer **to permit or accommodate** an employee's use, possession, or distribution of medical marijuana."
    Ohio Revised Code § 3796.28(A)(1).

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Reasonable Accommodations (cont'd)

- **New York.**
  - A certified medical marijuana patient "shall be deemed as having a 'disability'" under the state's human rights law. N.Y. Public Health Law, Title 5-A, §3369.
    - Does this mean "accommodation" is required as with any other "disability"?
    - If so, what accommodations can be made?
    - No further guidance is given.

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Practical Question

- Do I have to accommodate an employee's side effects of medical marijuana use?
  - Laws do not address this directly.
  - Nevada: employer must attempt to make reasonable accommodations for lawful use of medical marijuana, unless this would pose a threat to others, impose a hardship on the employer, or prohibit employee from fulfilling job responsibilities.

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Off-Duty Marijuana Use

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Off-Duty Marijuana Use (cont'd)

- **Lawful Off-Duty Use Statutes.**
  - **Colorado**: An employer may not fire an employee because that employee engaged in **any lawful activity off the employer's premises during nonworking hours** unless the restriction relates to a bona fide occupational requirement or is reasonably and rationally related to the employment activities and responsibilities of a particular employee or a particular group of employees; or is necessary to avoid, or avoid the appearance of, a conflict of interest with any of the employee's responsibilities to the employer. Colo. Rev. Stat. §24-34-402.5.
    - ***Coats v. Dish Network*, 2015 CO 44, 345 P.3d 849 (2015).**
      - Long-term, quadriplegic worker used medical marijuana at night. Failed a random drug test and was terminated solely for the positive result. No allegations that he was under the influence or impaired at work.
      - Supreme Court held that to be protected, an off-duty "lawful" use must be lawful under both state law and federal law.

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Off-Duty Marijuana Use (cont'd)

- **California**: No employee can be discharged or otherwise discriminated against ***for lawful conduct occurring during nonworking hours*** away from the employer's premises. An employee who is discharged, threatened with discharge, demoted, suspended, or discriminated against in any manner in the terms and conditions of his or her employment is entitled to reinstatement and reimbursement for lost wages and benefits. Labor Code §96 and §98.6.
- **New York**: Employers cannot make hiring or firing decisions, or otherwise discriminate against an employee or prospective employee ***because of legal use of consumable products*** or legal recreational activities outside of work hours, off of the employer's premises, and without use of the employer's equipment or other property. N.Y. Labor Code §201-d.
- **North Dakota**: An employer may not fail or refuse to hire a person, to discharge an employee, or to treat a person or employee adversely or unequally with respect to application, hiring, training, apprenticeship, tenure, promotion, upgrading, compensation, layoff, or a term, privilege, or condition of employment, ***because of participation in lawful activity off the employer's premises during nonworking hours which is not in direct conflict with the essential business-related interests of the employer***. N.D. Cent. Code § 14-02/4-03.

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Off-Duty Marijuana Use (cont'd)

- **Ohio.**
  - Nothing "[p]rohibits an employer from refusing to hire, **discharging, disciplining, or otherwise taking an adverse employment** action against a person with respect to hire, tenure, terms, conditions, or privileges of employment **because of that person's use, possession, or distribution of medical marijuana**." Ohio Revised Code §3796.28(A)(2).

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Off-Duty Marijuana Use (cont'd)

- **Ohio.**
  - Nothing "**[p]ermits a person to commence a cause of action against an employer** for refusing to hire, discharging, disciplining, discriminating, retaliating, or otherwise taking an adverse employment action against a person with respect to hire, tenure, terms, conditions, or privileges of employment related to medical marijuana." Ohio Revised Code §3796.28(A)(6).

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Practical Question

- An employee in a state without legalized recreational marijuana travels to California or Colorado for work and uses marijuana there. Upon return, employee tests positive. Or while in California, posts on Facebook a picture using marijuana.
  - Result in Ohio?
  - Result in states with lawful off-duty use laws?

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Lurking Discrimination Claims

- Assume that an applicant reveals that he uses medical marijuana.
  - The admission may reveal the presence of underlying disability or genetic condition.
- Assume that an employer only terminates minorities who test positive for medical marijuana.
  - This would be disparate treatment, and so actionable discrimination.

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Reasonable Accommodation and the Americans with Disabilities Act

- **Americans with Disabilities Act**
  - Current users of illegal drugs (marijuana) are not protected.
  - Medical marijuana users not entitled to reasonable accommodation.
  - Underlying condition itself may be a "disability" and may require a reasonable accommodation."
  - What's a reasonable accommodation for medical marijuana users?

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DOT Issues

- **U.S. Department of Transportation**
  - DOT "does not authorize medical marijuana under a state law to be a valid medical explanation for a transportation employee's positive drug test result."

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Discrimination: Protected Status

- ***Noffsinger v. SSC Niantic Operating Co.***, 2017 U.S. Dist. LEXIS 124960 (D. Conn. Aug 8, 2017).
  - Plaintiff took Marinol nightly for PTSD. She applied for a job, which was denied when her drug test came back positive for marijuana.
  - She sued, alleging a violation of Connecticut's Palliative Use of Marijuana Act (PUMA).

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Discrimination: Protected Status (cont'd)

- PUMA explicitly prohibits discrimination by schools, landlords, and employers:
  - "No employer may refuse to hire a person or may discharge, penalize, or threaten an employee **solely on the basis of such person's or employee's status** as a qualifying patient or primary caregiver." Conn. Gen. Stat. 21a-408.

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Discrimination: Protected Status (cont'd)

- Was PUMA claim preempted by the Controlled Substances Act, the Americans with Disabilities Act, and the Food, Drug and Cosmetic Act. NO.
- "A plaintiff who uses marijuana for medicinal purposes in compliance with Connecticut law **may maintain a cause of action against an employer who refuses to employ her for this reason**."

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Discrimination: Protected Status (cont'd)

- **Federal laws do not regulate employment decisions:**
  - The Controlled Substances Act does not preempt PUMA because the CSA does not "purport to regulate employment practices in any manner."
  - The CSA does **not** prohibit an employer from taking adverse action against an employee on the basis of the employee's state-authorized medical marijuana use.
  - Merely hiring a medical marijuana user does not violate the CSA or any other federal law (including the ADA).

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Discrimination: Reasonable Accommodation Required

- ***Barbuto v. Advantage Sales & Marketing***, 477 Mass. 456 (July 17, 2017).
  - Cristina Barbuto had to take a drug test to begin her job and said she had a certificate to use medical marijuana to manage Crohn's disease.
  - She used the drug off-hours, not before or during work.
  - She was terminated after a positive drug test.
  - She sued for disability discrimination under Massachusetts law. The trial court dismissed the case.

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Discrimination: Reasonable Accommodation Required (cont'd)

- The Massachusetts Supreme Judicial Court reversed.
  - Employees can sue for disability discrimination if they are fired or otherwise punished for using medical marijuana.
  - "Under Massachusetts law … the use and possession of medically prescribed marijuana by a qualifying patient is **as lawful as the use and possession of any other prescribed medication**."
  - "Where, in the opinion of the employee's physician, medical marijuana is the most effective medication for the employee's debilitating medical condition *** **an exception to an employer's drug policy to permit its use is a facially reasonable accommodation**."

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Discrimination: Reasonable Accommodation Required (cont'd)

- **No preemption by the Controlled Substances Act:**
  - "The fact that the employee's possession of medical marijuana is in violation of federal law **does not make it per se unreasonable as an accommodation**. The only person at risk of federal criminal prosecution for her possession of medical marijuana is the employee."
  - State law still requires an interactive process.
  - Employer can prove medical marijuana use cannot be accommodated without an undue hardship.

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Reasonable Accommodation (or not)

- ***Garcia v. Tractor Supply Co.***, 154 F. Supp.3d 1225 (D.N.M. 2016).
  - Plaintiff suffered from HIV/AIDS, and used physician-recommended medical marijuana.
  - Terminated after a positive drug test. Claimed he was terminated "based on his serious medical condition and his physician's recommendation that he use medical marijuana."

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Reasonable Accommodation (or not)

(cont'd)

- Court noted that state medical marijuana law does not require employer accommodation.
- Court held that employee was lawfully fired for testing positive for marijuana.
- "To affirmatively require the employer to accommodate the Plaintiff's illegal drug use **would mandate the employer to permit the very conduct the Controlled Substances Act proscribes**."

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Discrimination in Hiring

- ***Callaghan v. Darlington Fabrics and the Moore Company***, 2017 R.I. Super. LEXIS 88 (May 23, 2017).
  - Christine Callaghan used medical marijuana for migraines. She applied for a paid internship, but was denied when it was learned she was a medical marijuana user.
  - The company had discriminated against a medical marijuana patient because of her status in violation of the state Civil Rights Act and medical marijuana law, **which prohibits discrimination based on cardholder status in matters of employment**.

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Discrimination in Hiring (cont'd)

- "This practice would place a patient who, by virtue of his or her condition, has to use medical marijuana once or twice a week in a worse position than a recreational user."
- "The only reason a given patient cardholder uses marijuana is to treat his or her disability. **This [employer's] policy prevents the hiring of individuals suffering disabilities best treated by medical marijuana."**

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Workers' Compensation

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Workers' Compensation

- **Ohio.**
  - Nothing "[a]ffects the authority of the administrator of workers' compensation **to grant rebates or discounts on premium rates** to employers that participate in a **drug-free workplace program** established in accordance with rules adopted by the administrator under Chapter 4123. of the Revised Code." Ohio Revised Code §3796.28(A)(6).

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Workers' Compensation (cont'd)

- **Ohio.**
  - **Rebuttable presumption that an employee is ineligible** for workers' compensation if he or she was under the influence of marijuana and that was the **proximate cause** of the injury, regardless of whether the marijuana use is recommended by a physician. Ohio Revised Code §4123.54.

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Workers' Compensation (cont'd)

- Ohio's Medical Marijuana Law does not specify whether workers' compensation covers medical marijuana. But it doesn't:
  - Regulations limit drugs to those approved by the FDA, which does not included marijuana.
  - BWC-funded prescriptions must be dispensed by a registered pharmacist from an enrolled provider. Medical marijuana will come from retail marijuana dispensaries.
  - BWC only reimburses drugs on its formulary.

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Workers' Compensation (cont.)

- Nevada: no workers' compensation if injury caused by effects of medical marijuana use.
- Vermont: employers don't have to cover medical marijuana expenses under workers' compensation

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Case Study – Michigan

- *Casias v. Wal-Mart Stores, Inc.*, 695 F.3d 428 (6th Cir. 2012): Sixth Circuit upheld the employer's right to terminate an employee who tested positive for marijuana following a workers' comp injury, despite his registry card for medical use of marijuana.
- *Todor v. Northland Farms*: Michigan Workers' Compensation Appellate Commission ruled that an insurer does not have to reimburse expenses for medical marijuana use.

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Unemployment Compensation

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Unemployment Compensation

- **Ohio.**
  - A person who is discharged from employment because of that person's use of medical marijuana shall be considered to have been **discharged for just cause *** if the person's use of medical marijuana was in violation of an employer's drug-free workplace policy**, zero-tolerance policy, or other formal program or policy regulating the use of medical marijuana." Ohio Revised Code §3796.28(B).

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Unemployment Compensation (cont'd)

- **Ohio.**
  - A person who is terminated for medical marijuana use is discharged for "just cause" if that use violated:
    - employer's drug-free workplace policy;
    - zero-tolerance policy; or
    - other formal program or policy regulating the use of medical marijuana.
  - The person will be ineligible to serve a waiting week or receive unemployment benefits for the duration of the person's unemployment.

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DRUG TESTING

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Drug Testing

- **Drug testing and drug-free workplaces?**
  - **Ohio.**
    - Nothing "[p]rohibits an employer from **establishing and enforcing a drug testing policy**, drug-free workplace policy, or zero-tolerance drug policy." Ohio Revised Code §3796.28(A)(3).

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Drug Testing (cont'd)

- Employers may prohibit marijuana use (including medical marijuana use) at work.
- Employers may prohibit possession of marijuana at work.
- Employers may treat medical marijuana the way they treat the use of legally prescribed drugs.

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Pot Holes Along the Way

- **Throwing out positive drug tests?**
  - **Oklahoma**
    - **"Employers may not take action against the holder of a medical marijuana license solely based upon the status of an employee as a medical marijuana license holder or the results of a drug test showing positive for marijuana or its components."**

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Pot Holes Along the Way (cont'd)

- **Hiring Challenges?**
  - Finding drug-free applicants: in 2013, **80-90% of applicants for shale jobs tested positive** (5,300 drug tests from Trumbull and Mahoning (Ohio) counties, conducted by Accord Occupational Health Services in Boardman).
  - By contrast, the positive rate of federally mandated programs, such as transportation jobs, is 3-4%.

(www.vindy.com, 02-13-2015).

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Practical Question

- Can I refuse to hire (or terminate) a person who tests positive for marijuana if he or she presents a medical marijuana card?
  - **YES**: CA, GA, MI, MT, OH, NM permit an employer to terminate employees who test positive for medical marijuana.
  - **NO**: AK, AZ, CT, DE, FL, HI, ME, MN, ND, OR, and DC only permit termination if the employee used marijuana at work or was under the influence of marijuana or the consumption resulted in negligence.
  - **???**: Statutes in IA, MD, NH, VT, and WA don't say either way.

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Practical Question

- Can I discipline an employee who is working under the influence of marijuana?
- **Yes** – but what does "under the influence mean"
  - Most states don't define the term
  - DE, DC, MD, RI, WV prohibit "undertaking any task under the influence of marijuana, when doing so would constitute negligence or professional malpractice."

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Practical Question

- "Under the influence"
  - Arkansas: "good faith belief" not based solely on a positive drug test
  - New York: if employer has a policy prohibiting working while impaired
  - Pennsylvania: when an employee's conduct "falls below the normal standard of care" for the job
  - And then there is Illinois…

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Practical Question

- 410 Ill. Comp. Stat. Ann. 130/50:

"An employer may consider a registered qualifying patient to be impaired when he or she manifests specific, articulable symptoms while working that decrease or lessen his or her performance of the duties or tasks of the employee's job position, including symptoms of the employee's speech, physical dexterity, agility, coordination, demeanor, irrational or unusual behavior, negligence or carelessness in operating equipment or machinery, disregard for the safety of the employee or others, or involvement in an accident that results in serious damage to equipment or property, disruption of a production or manufacturing process, or carelessness that results in any injury to the employee or others. If an employer elects to discipline a qualifying patient under this subsection, it must afford the employee a reasonable opportunity to contest the basis of the determination."

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Suggested Employer Best Practices

- **Review substance abuse policies.**
  - Clarify whether marijuana, including medical marijuana, is a prohibited substance.
  - Clarify whether an employer will accommodate medical marijuana and with what means (but be careful of the risk for negligent hiring or supervision).
- **Review workplace safety standards (OSHA).**
- **Know whether the Drug Free Workplace Act applies** (Federal Contractors and Grantees).

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Suggested Employer Best Practices (cont'd)

- **Decide on drug testing and clarify what will constitute a "hot" screen.**
  - Hair follicle testing: more accurate than urine or blood but still doesn't measure impairment or what it means to be "under the influence" of marijuana. Some states permit hair follicle testing (e.g., Arizona, Maryland), others do not (e.g., City of San Francisco, Connecticut, Maine, Ohio, Oregon).
  - Consider drug testing measurement levels that would more accurately indicate workplace impairment. Watch as the science develops in this area.
- **Communicate with employees. Educate supervisors on how to recognize substance abuse and impairment.**
- **Be consistent with discipline and termination actions for violations – treat similarly situated employees the same.**
  - Assess how to best handle post-employment "reasonable suspicion" testing.

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Some Final Thoughts on Marijuana in the Workplace

- Marijuana use and possession, whether medical or recreational, still remains illegal under federal law.
- State laws vary widely on what employers can and cannot do when an employee uses marijuana at work or off-duty.
- Employers are not required to permit or accommodate an employee's use, possession, or distribution of marijuana in the workplace, even if they are a registered medical marijuana user.
- Remember that drug testing doesn't measure actual on-the-job impairment when it comes to medical marijuana.

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Final Thoughts

- Employers should apply workplace policies fairly and consistently and be aware of potential discrimination claims. While medical marijuana use may not need not to be accommodated, the employee may have an underlying disability that may need to be.
- Federal restrictions on employment are not affected by state marijuana laws (OSHA, DOT, Drug-Free Workplace Act).

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QUESTIONS??

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TAB
C

Peter H. Mihaly
Pete Mihaly has practiced workers' compensation law with BWC since 1997. He is currently Director of BWC Legal Operations' Enterprise Legal Services unit, which is responsible for BWC contracts and administrative rules, and which also provides legal support to BWC's Medical Services Division. Pete is a graduate of Kent State University with a bachelor's in integrated life sciences. He is a double graduate of The Ohio State University with a juris doctorate and a master's in health administration. He is a member of both the Ohio State and Columbus Bar Associations.

MCO Issues

Pete Mihaly, J.D./M.H.A.
Director of Enterprise Legal Services
Ohio Bureau of Workers' Compensation

Ohio | Bureau of Workers' Compensation

Why MCOs?

R.C. 4121.44(B)

To implement the Health Partnership Program (HPP), BWC

"(1) Shall certify one or more external vendors, which shall be known as "managed care organizations," to provide medical management and cost containment services in the [HPP, and] . . .

(4) May enter into a contract with any [BWC certified MCO] to provide medical management and cost containment services in the [HPP]."

Ohio | Bureau of Workers' Compensation

Just the Facts

- Currently 12 MCOs
- Selected by employers during open enrollment periods
- Certified for 2 year periods
- Current MCO contract expires 12/31/2020
- MCO contract includes MCO Policy Reference Guide as an appendix

What are the MCOs supposed to do, anyway?

Ohio | Bureau of Workers' Compensation

First Report of Injury (FROI) Intake

- OAC 4123-6-02.8
- MCO contract:
  - MCOs may take the necessary information over the telephone or ask for a completed FROI form to be faxed to them
  - The MCO shall submit First Reports of Injury (FROIs) to BWC via Electronic Data Interchange (EDI) initial ASC X12 148 transactions

First Report of Injury (FROI) Intake

- Required data elements - Must be submitted to BWC by the MCO no later than
  - 3:00 P.M. Eastern Time the third FROI Business Day after the MCO's receipt of the FROI for 70% of the FROIs and
  - 3:00 P.M. Eastern Time the fifth FROI Business Day after the MCO's receipt of the FROI for 100% of the FROIs

First Report of Injury (FROI) Intake

- If an injury is reported to BWC from a source other than the MCO, BWC will generate a notice via EDI to the appropriate MCO within 1 business day
- The MCO is responsible to investigate and ensure that additional data elements are submitted

Provider Network

- The MCO shall have in place either
  - A formal provider network or
  - Arrangements and reimbursement agreements with a substantial number of the medical providers currently being utilized by injured workers
- The MCO shall not discriminate against any category of health care provider when establishing its network or arrangements with providers

Provider Network

- The MCO shall assist the injured worker in locating a BWC certified provider, whether in-state or out-of-state. This shall include, as needed
  - contacting providers near the injured worker to see if they will accept the injured worker, and
  - facilitating enrollment and/or certification of non-BWC certified providers willing to accept the injured worker if no BWC certified providers are available

Provider Network

- The MCO shall also assist the injured worker in locating a new BWC certified provider when needed due to access issues:
  - travel,
  - injured worker moved,
  - provider no longer in practice,
  - provider has been decertified,
  - etc.

Treatment Authorization

- MCO contract:
  - The MCO shall evaluate all medical treatment reimbursement requests submitted by the Physician of Record (POR) or eligible treating provider (on form C-9 or equivalent) using the following three-part "*Miller*" test (all parts must be met to authorize treatment reimbursement):

Treatment Authorization

- The requested services are reasonably related to the injury (allowed conditions)
- The requested services are reasonably necessary for treatment of the injury (allowed conditions)
- The costs of the services are medically reasonable

See also OAC 4123-6-16.2(B)(1) through (B)(3)

Treatment Authorization

- A Clinician (defined as a physician, registered nurse, or other Ohio certificate holder acting within the scope of his or her license) shall make all treatment reimbursement approvals that do not fall within standard treatment guidelines, pathways, or presumptive authorization guidelines
- A non-Clinician may make treatment reimbursement approvals for services that fall within standard treatment guidelines, pathways, or presumptive authorization guidelines

Treatment Authorization

- All treatment reimbursement denials shall be made by a registered nurse or a physician (as defined in OAC 4123-6-01) acting within the scope of his or her license, unless the MCO requests and BWC approves a Clinician with a different credential
- All treatment reimbursement decisions shall be made under the direction of the MCO Medical Director

Treatment Authorization

- Treatment reimbursement decisions shall be communicated in writing, with an appropriate explanation (including appropriate references to treatment guidelines in all denials) and appeal language as follows:
  - All treatment reimbursement decisions shall be sent to BWC and the provider
  - Treatment reimbursement denials shall also be provided to the injured worker and his or her representative, if any

Treatment Authorization

- Treatment reimbursement approvals shall also be provided to the injured worker and his or her representative, if any, and to the employer and its representative, if any, unless the employer or representative has waived, in writing, its right to receive notice
- The employer or representative may waive the right to receive all treatment reimbursement approvals, or may waive only the right to receive treatment reimbursement approvals in claims outside the employer's experience

Treatment Authorization

- The treatment reimbursement approval notification to the injured worker and his or her representative shall include a clear explanation of what treatment was approved for reimbursement, as well as any time frame allotted for completion of the treatment

Treatment Authorization

- In general, the MCO shall respond to a provider's treatment reimbursement request (submitted on form C-9 or equivalent) in an Active Claim within three (3) Business Days from the MCO's receipt of the request, either
  - authorizing,
  - denying,
  - dismissing, or
  - pending the request due to insufficient information

Treatment Authorization

- However, the MCO shall respond to a provider's *retroactive* treatment reimbursement request (submitted on form C-9 or equivalent) in an Active Claim within *30 calendar days* from the MCO's receipt of the request, either
  - authorizing,
  - denying,
  - dismissing, or
  - pending the request due to insufficient information

Treatment Authorization

- The MCO shall respond to a provider's treatment reimbursement request (submitted on form C-9 or equivalent) in an Inactive Claim by following the Claim Reactivation process set forth in OAC 4123-3-15

Treatment Authorization

- The MCOs' authority to dismiss C-9s is governed by OAC 4123-6-16.2(F), which states an MCO may dismiss medical treatment reimbursement requests *without prejudice* under specified circumstances
- Some of the specified circumstances for dismissal are for deficiencies which may be remedied and the treatment reimbursement request may then be refiled

Treatment Authorization

- The request has been submitted by a provider who is not enrolled with BWC and who refuses to become enrolled, or who is enrolled but non-certified and is ineligible for payment as a non-certified provider
- The request is not accompanied by supporting medical documentation that the provider has examined the injured worker within 30 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

Treatment Authorization

- The request duplicates a previous request that has been denied in a final administrative or judicial determination, is not accompanied by evidence of new and changed circumstances, and such evidence is not provided to the MCO upon request
- The MCO has requested supporting medical documentation from the provider necessary to the MCO's evaluation and determination, and such documentation is not provided to the MCO (**Proposed:** MCOs may not dismiss lumbar fusion surgery requests for this reason)

Treatment Authorization

- Some of the specified circumstances for dismissal are for deficiencies which may not be easily remedied
  - The underlying claim has been settled, and the dates of service requested are on or after the effective date of the settlement
  - The underlying claim has been disallowed or dismissed in its entirety

Treatment Authorization

- 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
- The services or supplies being requested are never covered by BWC pursuant to other BWC statutes or rules
- **Proposed:** The services or supplies are non-payable by BWC due to the bill not having been timely filed under OAC 4123-3-23

Treatment Authorization

- OAC 4123-6-20(E) states

"In accepting a workers' compensation case, a provider assumes the obligation to provide to the bureau, claimant, 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 claimant to obtain medical services, benefits or compensation."

Treatment Authorization

- BWC form C-9A **Request for Additional Medical Documentation for C-9** states

  "We require medical documentation before we can determine your request. Please submit the documentation checked below and return it within 10 business days to allow for a treatment decision. **Failure to submit requested medical documentation may result in dismissal of the treatment request."**

Alternative Dispute Resolution (ADR)

- OAC 4123-6-16
  - The MCO shall have an ADR process for medical disputes between
    - the employer,
    - the IW, or
    - the provider

  and the MCO arising from the MCO's decision regarding a medical treatment reimbursement request (on form C-9 or equivalent)

Alternative Dispute Resolution (ADR)

- The MCO's ADR process shall consist of one independent level of professional review
  - If an individual POR provider type would be providing the services requested, the independent level of professional review shall consist of a peer review conducted by an individual licensed pursuant to the same section of the Revised Code as the provider who would be providing the services requested

Alternative Dispute Resolution (ADR)

- If an individual non-POR type provider would be providing the services requested, the independent level of professional review shall be conducted by an individual POR type provider whose scope of practice includes the services requested
- If the MCO has already obtained one or more peer reviews during previous disputes involving the same or similar treatment, the MCO may obtain a different perspective review from a differently licensed POR type

Alternative Dispute Resolution (ADR)

- If BWC suspends or removes a physician from the Disability Evaluators Panel ("DEP") for any reason other than the physician exceeded the statewide maximum reimbursement limit under the physician's DEP Agreement with BWC, the MCO shall not use the physician to perform any MCO scheduled IMEs, file reviews, or independent peer reviews

Alternative Dispute Resolution (ADR)

- If BWC suspends or removes a physician from the Disability Evaluators Panel ("DEP") because the physician exceeded the statewide maximum reimbursement limit under the physician's DEP Agreement with BWC, the MCO shall not use the physician to perform any MCO scheduled IMEs, file reviews, or independent peer reviews reimbursed by BWC

Alternative Dispute Resolution (ADR)

- The MCO does not have to obtain an ADR provider review when
  - The dispute relates to medical services that have been approved by the MCO pursuant to standard treatment guidelines, pathways, or presumptive authorization guidelines
  - The dispute relates to medical services for a condition that is not allowed in the claim, and allowance of the additional condition is not pending before BWC or the IC

Alternative Dispute Resolution (ADR)

- The MCO may pend an ADR dispute when
  - A same or similar treatment reimbursement request for which the MCO conducted an ADR provider review is pending before BWC or the IC
  - The treatment reimbursement request relates to medical services for a condition that is not allowed in the claim, and allowance of the additional condition is pending before BWC or the IC

Alternative Dispute Resolution (ADR)

- If, upon consideration of additional evidence or after agreement with the party that submitted the written medical dispute, the MCO reverses the decision under dispute or otherwise resolves the dispute to the satisfaction of the party, the MCO may issue a new decision and dismiss the dispute

Alternative Dispute Resolution (ADR)

- The MCO shall complete the ADR process and submit its recommended ADR decision to BWC electronically within 21 days of the MCO's receipt of the dispute
- The MCO may recommend that the employee be scheduled for an IME. This recommendation shall toll the MCO's time frame for completing the ADR process

Alternative Dispute Resolution (ADR)

- In such cases the MCO shall submit its recommended ADR decision to BWC electronically within 7 days after receipt of the IME report
- Within 2 business days after receipt of a recommended ADR decision from the MCO, BWC shall publish a final order. The provider and the MCO may not appeal the BWC order

Bill Payment

- The MCO shall submit medical provider bills electronically to BWC within 7 Business Days from the MCO's receipt of the bill
  - Prior to submitting provider bills electronically to BWC, the MCO shall provide clinical editing review to all bills
  - The MCO's clinical editing review must be performed systematically; however, the system may "flag" bills for further manual review
-

Bill Payment

- The MCO shall ensure that only eligible provider types are providing appropriate services and that the services are medically necessary for the diagnosis and treatment of, and are reasonably related to, the allowed conditions in the claim
- The MCO shall compare the medical services and supplies billed by the provider to the corresponding medical treatment reimbursement approval (on form C-9 or equivalent) to ensure the medical services and supplies billed match the medical services and supplies authorized

Bill Payment

- The MCO shall pay, at the MCO's expense, a penalty of $10.00 to the provider for every instance in which
  - the MCO denies a provider's bill due to lack of prior authorization, and
  - prior authorization either had been granted or was not required by the prior authorization and presumptive authorization policies set forth in the MCO Policy Reference Guide on the date of service

Bill Payment

- BWC shall make Electronic Fund Transfer ("EFT") to the MCO within 7 Business Days after receipt of a proper invoice and after a final adjudication permitting payment in the claim
- The MCO shall mail or electronically transfer payments to the provider within 7 calendar days from receipt of the EFT from BWC. The MCO shall pay to providers at least the amount electronically transferred by BWC to the MCO for reimbursement of provider services

Bill Payment

- The MCO shall have and use a system that tracks the status of provider bills at any stage of the bill adjudication process. Such a system must allow the MCO to respond to inquiries by authorized parties and to BWC as to the disposition of a bill and the expected payment date of a bill
- The MCO shall track and keep a copy of all provider bills that it has rejected ("Rejected Bills"). The MCO shall notify the provider of the Rejected Bill using the appropriate explanation of benefits (EOB) code

Bill Payment

- The MCO shall comply with BWC's Overpayment Recovery Policy and Bill Grievance Policy as set forth in the MCO Policy Reference Guide

Customer Service

- The MCO shall have administrative grievance policies and procedures in place and shall track all complaints and document resolutions
- The MCO shall acknowledge all inquiries (e-mail, fax, phone, mail), other than provider bill grievances and overpayments, within two 2 Business Days of receipt, and shall resolve or initiate resolution of all inquiries within five 5 Business Days of receipt

Customer Service

- The MCO shall have one toll-free telephone number and one toll-free fax telephone number available to external customers through which all types of issues can be addressed
- Customer service telephone lines shall be staffed during Normal Business Hours, Monday through Friday 9:00 A.M through 5:00 P.M. Eastern Time, on all Business Days

Confidentiality

- The MCO shall keep confidential all information obtained in the performance of the MCO contract that is confidential under BWC policy or state/federal law, including employer premium data subject to R.C. 4123.27 and claim file data subject to R.C. 4123.88

Confidentiality

- The MCO shall not copy, disclose, publish, or communicate BWC's confidential information to any person other than authorized representatives of BWC, unless BWC directs its release or such release is in accordance with OAC 4123-3-22
- The MCO acknowledges that release of any confidential information other than in accordance with OAC 4123-3-22 to any third parties is strictly forbidden without the express prior written authorization of BWC

Confidentiality

- The MCO shall comply with all applicable state and federal statutes and rules, and all BWC policies, for the protection of sensitive data and confidential medical, claim, and employer premium information, including but not limited to BWC's Sensitive Data Transmission and Confidential Personal Information (CPI) policies.
- The MCO shall comply with all electronic data security measures as may be required by Ohio law, Ohio DAS or other state agency Directive, and/or Executive Order of the Governor

Conflict of Interest

- The MCO and any other affiliated corporation or entity that has had or contemplates activities of any nature with the Ohio workers' compensation system, including but not limited to TPAs, medical or vocational rehabilitation providers, PEOs, and/or transitional work developers shall have complete separation of functions, offices, systems, and staff

Conflict of Interest

- The MCO shall provide to BWC upon request a description of the MCO's policy/plan to resolve the opportunity for and/or the appearance of conflict of interest resulting from the MCO's affiliation or relation to any other corporation or entity that has had or contemplates activities of any nature with the Ohio workers' compensation system, including but not limited to TPAs, medical or vocational rehabilitation providers, PEOs, and/or transitional work developers

See also OAC 4123-6-03.9

Questions?

Ohio | Bureau of Workers' Compensation

Looking for reminders, updates, tips and breaking news on workers' compensation?

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Our special investigations department uses Facebook in its efforts to detect and deter workers' compensation fraud.

Ohio | Bureau of Workers' Compensation

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Biographical Information for Cori Besse

Cori graduated from the University of Dayton School of law, cum laude, in 2006. At the beginning of her career, she practiced complex business litigation. In 2010, she began focusing exclusively on labor & employment law. She worked in Dinsmore & Shohl for four years, where she practiced management side employment law. In 2014, Cori left Dinsmore and opened a small firm in Blue Ash, where she and her law partner now represent individual clients and small businesses in all aspects of employment law. She also focuses a portion of her practice on consumer protection laws, such as the Fair Credit Reporting Act, the Telephone Consumer Practices Act and the Fair Debt Collection Practices Act.

ADA Concerns, Reasonable Accommodations, and Retaliatory Discharge Issues

WORKERS' COMPENSATION UPDATE
Cincinnati Bar Association
November 29, 2018

Cori R. Besse
The Law Firm of
Sadlowski & Besse L.L.C.

Intersection of ADAA and WC: Why Does It Matter?

- Exclusive remedies for workers' compensation claims do not apply to ADA claims
  - Separate set of rights and obligations
- Individuals with disabilities are in the workplace
  - Could create increased risk of work-related injuries

Americans with Disabilities Act, as Amended

- Who is covered?
  - Qualified individual with physical or mental impairment that substantially limits a major life activity
  - Entities with 15 or more employees (less under state law)
  - ADAA = Assume Disability Always Accommodate

ADAA: Unpacking the Definition

- Major Life Activities
  - Activities: seeing, hearing, breathing, reading, learning, communicating, working
  - Bodily Functions: respiratory, neurological, circulatory, reproductive, immune system functions, digestive
- Substantially limits
  - Not transient
  - But can be temporary or permanent

ADAA: Unpacking the Definition (con't)

- Qualified
  - Meets requirements for job and can perform the essential functions of the job, with or without a reasonable accommodation
- Essential Functions
  - Basic job duties that must be performed
- Reasonable Accommodation
  - Modifications to job functions or work environment that do not cause an undue hardship on the employer

ADAA: Unpacking the Definition (Con't)

- Undue Hardship
  - Unreasonably costly, substantial disruption, alter the nature of the operation of the business
  - Must consider employer's size, financial resources, nature of operations
  - Employer's burden
  - Must consider alternatives
- Direct threat
  - A significant risk of substantial harm to the health or safety of the individual or others
  - Cannot be eliminated

How Does the ADAA Intersect with WC Claims?

- Medical Examinations
  - After making conditional offer
  - When injured employee seeks to return to work
  - To ascertain extent of its WC liability
    - Must be limited to determining eligibility for workers' comp benefits
    - No fishing expedition under ADA
  - If employee asks for reasonable accommodation
- Hiring Decisions
  - Can't deny employment to person with disability due to increased risk of injury
  - Exception: direct threat

How Does the ADAA Intersect with WC Claims? (con't)

- Return to Work
  - Cannot require return to "full duty"
  - Cannot refuse to return to work because of increased risk of injury (unless direct threat)
  - Cannot refuse to return to work because WC determined "permanent disability" or "totally disabled"
  - Employer's responsibility to make determination, not physician's
  - Right to be reinstated to same position unless undue hardship

How Does the ADAA Intersect with WC Claims? (con't)

- Reasonable Accommodations
  - Cannot discharge employee temporarily unable to work unless undue hardship
  - Must reallocate job duties if not essential functions of job
  - Cannot unilaterally reassign to a different position without trying to accommodate first
  - Must reassign to unilateral vacant position if qualified
    - Do not have to "bump"
  - Does not have to give preferred accommodation, only effective one
  - Cannot substitute vocation rehabilitation services

Workers' Compensation Retaliation

- Ohio Rev. Code Sec. 4123.90: No employer shall discharge, demote, reassign, or take any punitive action against any employee because the employee filed a claim or instituted, pursued or testified in any proceedings under the workers' compensation act….
- Not actually limited solely to those who have filed a claim or instated proceedings
- Burden-shifting analysis

Workers' Compensation Retaliation

- Remedies are limited: reinstatement with backpay/lost wages and attorney's fees
- Very short statute of limitations
  - 90-days for notice
  - 180-days for filing

Establishing Workers' Compensation Retaliation Claim

- Prima Facie Case:
  - (1) filed a workers' compensation claim (or suffered a work-related injury or illness);
  - (2) experienced an adverse employment action, and;
  - (3) there was a causal connection between the filing of claim and the adverse action
- Third element usually at issue
- Very low burden

Establishing Causal Connection

- Factors courts consider when determining causal connection include:
  - Temporal proximity
  - Whether punitive action was directed toward the employee
  - A hostile attitude toward the employee once the claim was filed
  - Disparate treatment of the employee relative to others
  - Requests not to pursue a claim

Non-Retaliatory Justification

- Once employee established prima facie case, burden shifts to employer to provide a non-retaliatory justification for adverse employment action
- Burden of production, not persuasion

Pretext

- Once employer establishes non-retaliatory justification, burden shifts back to employee to establish the proffered reason was pretext
- Three methods for establishing pretext. Employee must show employer's decision:
  - (1) had no basis in fact,
  - (2) did not actually motivate the discharge, or
  - (3) was insufficient to motivate discharge

QUESTIONS?

TAB
E

Stephen Feagins, MD, MBA, FACP

Vice President Medical Affairs, Mercy Health – East Market
Medical Informatics Officer, Mercy Health – Cincinnati Region
Medical Director, Hamilton County Public Health
Chair, CarePATH Formulary and Medicine Informatics Committees
Chair, Clermont County Opiate Task Force Treatment Committee

Other stuff…

In 2012, Dr. Feagins was voted "physician of the year" at Mercy Anderson. He was a 2014 finalist in the Cincinnati Business Courier "healthcare heroes" in community outreach. He writes a weekly Medical Staff Update that is widely read within Mercy Health and which was named a finalist for the American College of Physician communication award. He was named "volunteer of the year" by the Anderson Township chamber of commerce in 2015. He is medical director of the Mercy Care Clinics and team physician for Anderson and Turpin High Schools. He was twice awarded the Nagel PTA "friend of students" award. He is a member of the Hamilton County and Clermont County Opiate Task Forces.

Dr. Feagins earned his medical degree from the University of Tennessee, an MBA from the University of Memphis, and a B.S. in Chemical Engineering from the University of Tennessee. He ran track at the University of Tennessee and was a member of the 1983 national championship team. He holds a CAQ in Sports Medicine and certification in Critical Care Air Transport. He was honorably discharged from the U.S. Air Force with the rank of major in 2001. He served as chief of medicine at Wright Patterson Air Force Base, leading humanitarian missions to Bolivia and El Salvador. Dr. Feagins was head team physician for Wittenberg University 2001-2009. He is Board Certified in Internal Medicine and a Fellow of the American College of Physicians. He will be serving as assistant sideline physician for FC Cincinnati.

Dr. Feagins was a member of the team from Mercy Health who opened the hospital in Cotes-der-fer, Haiti, in March 2017. He leads the medicine informatics team that created the "clinical opiate withdrawal scale" and "amphetamine toxicity" ordersets. He has championed dental care and syringe exchanges in Clermont and Hamilton counties.

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Elizabeth Fox is a Staff Hearing Officer with the Industrial Commission of Ohio in the Cincinnati office. She was a District Hearing Officer with the Industrial Commission for ten years and was made a Staff Hearing Officer in 2006. Ms. Fox is a frequent speaker on workers' compensation issues to employer groups and at continuing legal education seminars. Ms. Fox graduated with a B.A. from Xavier University and received her J.D. degree from the University Of Cincinnati College Of Law.

Joseph W. Meyer is a Staff Hearing Officer with the Industrial Commission of Ohio. He has been with the Industrial Commission since 1995. During his time at the Commission, Mr. Meyer has served as a Hearing Administrator and as a hearing officer. Mr. Meyer has been a member of the Ohio bar since 1993. Prior to working for the Commission, he worked for a mid-sized law firm in the Dayton area representing employers in worker's compensation matters and labor disputes. Mr. Meyer has spoken at numerous CLEs on behalf of the Industrial Commission. He earned a B.S. degree from St. Alphonsus College, and a J.D. degree from the University Of Cincinnati College Of Law.

Memo K2 | Precise Order Writing

Every order shall clearly state the action taken. (For example: deny the C-9; pay temporary total disability compensation from 01/01/2015 to 02/12/2015; authorize ten physical therapy treatments.) Hearing officers shall aim for condensed, precise reasoning in their orders. The orders must delineate the evidence upon which the hearing officer is relying. The orders must also reflect that all evidence contained in the record has been reviewed and considered.

Any issue or issues under review at any level of the hearing process shall be addressed and considered independently on its merits. Hearing officers shall not use the terminology "deny and affirm" to deal with issues that come before them. Whether affirming, modifying, or vacating a prior decision, the order shall address each issue and sub-issue raised at hearing. In all cases, even when affirming the prior decision, the order shall state the rationale and evidence that was relied upon.

Hearing officers are not to "cut and paste" language from underlying orders or proposed draft orders provided by either party's representatives into their final orders. Should a hearing officer wish to adopt or incorporate language from the underlying order or proposed draft orders provided by either party's representatives, he or she shall paraphrase the language or use similar language in his or her decision. If the concepts and thoughts in the underlying order or proposed draft order provided by either party's representative are superb, a hearing officer can make those ideas his or her own by rewriting the order in his or her own words.

Hearing officers are not permitted to issue "form orders" in any case without the express prior approval of the Industrial Commission.

When first referring to a doctor and a report, hearing officers shall use "John Doe, M.D., dated 00/00/0000," not "Dr. Doe, dated 00/00/0000." Hearing officers shall not use "Dr. John Doe, M.D.," as it is redundant. Further references to the same doctor and report shall be listed as "Dr. Doe, dated 00/00/000."

This policy shall apply to all orders, regardless of the issues involved.

Effective: 08/15/2016

4121-3-15 Percentage of permanent partial disability

Effective: February 11, 2017

(A) Definitions

(1) For purpose of this rule, both an application for the determination of percentage of permanent partial disability and an application for an increase in the percentage of permanent partial disability will be referred to as an "application."

(2) For purpose of this rule, a substantial disparity means fifteen per cent or more difference.

(B) Procedure upon filing of objection to a tentative order issued by the bureau of workers' compensation under section 4123.57 of the Revised Code as a result of the filing of an application as defined in paragraph (A)(1) of this rule or in a claim where the administrator determines that there is a conflict of evidence, the matter is to be referred to the commission.

(1) Upon receipt of a written notification of an objection to a tentative order (filed within twenty days after receipt of the notice of a tentative order) issued by the bureau of workers' compensation pursuant to section 4123.57 of the Revised Code, or in a claim where the administrator determines that there is a conflict of evidence, the matter is to be referred to the commission. The commission will set the application for hearing before a district hearing officer. The party filing the objection shall also provide a copy of the objection to the opposing party if the opposing party is unrepresented, or in cases where the opposing party is represented, to the opposing party's representative, at the time that the written objection is filed from the tentative order issued by the bureau of workers' compensation.

(2) Notices of the hearing shall be mailed to the injured worker, employer, and their representatives and to the administrator at least two weeks in advance of the hearing date, except as provided in paragraph (C)(6) of rule 4121-3-09 of the Administrative Code.

(C) Procedures upon referral to a district hearing officer

(1) Should the employer file an objection to a tentative order and the employer desires to obtain a medical examination of the injured worker, the employer shall provide written notice at the time of the filing of the objection to the hearing administrator, and to the injured worker if the injured worker is unrepresented, or to the injured worker's representative, if the injured worker is represented, of the employer's intent to schedule a medical examination of the injured worker. The examination shall be conducted and the report of the medical examination submitted to the commission and to the injured worker if the injured worker is unrepresented, or to the injured worker's representative if the injured worker is represented within forty-five days of the date of the filing of the employer's objection to the tentative order.

(2) If the injured worker is the only party that files an objection to a tentative order and the injured worker intends to submit medical evidence not previously submitted in support of the injured worker's objection, copies of the medical evidence are to be provided to the employer in accordance with paragraphs (C)(4) and (C)(5) of this rule. Upon the employer's receipt of the medical evidence submitted by the injured worker, should the employer desire to obtain a medical examination of the injured worker, the employer shall schedule the examination within fourteen days of its receipt of the medical evidence submitted by the injured worker. The employer shall provide written notice of the employer's intent to schedule a medical examination of the injured worker to the hearing administrator and to the injured worker in cases where the injured worker is not represented, or to the injured worker's representative if the injured worker is represented. The medical examination shall be conducted and the report of the examination submitted to the commission and the injured worker if the injured worker is unrepresented, or to the injured worker's representative if the injured worker is represented within forty-five days from the date of the employer's receipt of the injured worker's medical evidence.

(3) Upon request and for good cause shown, the hearing administrator, or at hearing, the hearing officer may provide an extension of time, not to exceed thirty days, to allow submission of the employer's medical report described in paragraphs (C)(1) and (C)(2) of this rule.

(4) The parties or their representatives shall provide to each other, as soon as available and prior to the district hearing officer hearing, a copy of all the evidence the parties intend to submit at the district hearing officer hearing.

(5) In the event a party fails to comply with paragraph (C)(4) of this rule, the hearing officer may continue the claim to the end of the hearing docket, or to a future date with instructions to the parties or their representatives to comply with the rule.

(D) Procedure for obtaining the oral deposition, or submitting written interrogatories, to a commission or a bureau of workers' compensation physician who examined an injured worker or reviewed the claim file and issued an opinion as a result of an injured or disabled injured worker filing an application as defined in paragraph (A)(1) of this rule.

(1) If either the injured worker or the employer believe that the oral deposition, or the submission of written interrogatories, of the bureau of workers' compensation or the commission physician who examined the injured worker in connection with the application for the determination of the percentage of permanent partial disability, or who has submitted a report on the application for an increase in the percentage of permanent partial disability pursuant to a medical review or examination, is necessary for the proper determination of the percentage of permanent partial disability and there exists a substantial disparity as defined in paragraph (A)(2) of this rule between the report of the physician selected by the bureau of workers' compensation or the commission who is to be deposed and another medical report on file submitted on the issue of percentage of permanent partial disability that is to be adjudicated, or it appears that the estimate of disability made by the physician to be deposed was based, in part, on disability for which the claim has not been allowed, or an allowed disability was inadvertently omitted from consideration, such party shall make such request, in writing, to the hearing administrator, within ten days from the receipt of the examining or reviewing physician's report.

(2) In a claim where the injured worker or employer requests an oral deposition or the submission of written interrogatories to a bureau or commission physician as described in the paragraph (D)(1) of this rule but such party failed to receive a copy of the bureau or commission physician's medical report prior to the receipt of the notice of hearing, said party shall immediately after the receipt of the notice of hearing, request, in writing, to the hearing administrator that the hearing be continued and the deposition of the physician or the submission of interrogatories be taken prior thereto.

(3) Additional procedures on taking an oral deposition or submitting written interrogatories to a physician who performed an examination or a review on behalf of the bureau of workers' compensation or commission are set forth in paragraph (A)(8) of rule 4121-3-09 of the Administrative Code.

(E) Hearing officer guidelines for the adjudication of applications for the determination of the percentage of permanent partial disability and applications for an increase in the percentage of permanent partial disability:

(1) In the determination of percentage of permanent partial disability under division (A) of section 4123.57 of the Revised Code, hearing officers are to base a percentage of permanent partial disability award on medical or clinical findings reasonably demonstrable.

(2) If the hearing officer determines that the bureau of workers' compensation's medical examination and/or medical review is legally insufficient, the hearing officer may return the claim file to the bureau of workers' compensation for a second medical examination or medical review. If the hearing officer returns the claim file to the bureau of workers' compensation the hearing officer shall state in an interlocutory order the reason the claim file is being returned to the bureau of workers' compensation. The hearing officer shall also instruct the bureau of workers' compensation to return the claim to the commission for hearing upon completion of the medical examination or medical review. After the claim file is returned to the commission from the

bureau of workers' compensation, the hearing officer shall proceed with the hearing and render a decision based upon competent medical evidence submitted to the claim file, regardless of the legal sufficiency of the second bureau medical examination or review.

(3) An application for reconsideration, review, or modification which is filed within ten days of receipt of the decision of a district hearing officer issued under division (A) of section 4123.57 of the Revised Code shall be heard by a staff hearing officer and the decision of the staff hearing officer shall be final. At a hearing on reconsideration of a decision of a district hearing officer on the initial application for the determination of the percentage of permanent partial disability, the staff hearing officer may consider evidence that was not on file at the time of the district hearing officer hearing.

(F) This rule shall apply to the adjudication of an application as defined in paragraph (A)(1) of this rule filed on or after the effective date of this rule.

4123-3-15.1 Dismissal of an application for the determination of percentage of permanent partial disability.

(A) This paragraph of this rule applies to any employee's application for a determination of the percentage of permanent partial disability or for an increase of permanent partial disability filed on or after September 29, 2017.

(1) If an employee who files an application for a determination of percentage of permanent partial disability or for an increase of permanent partial disability fails to respond to the bureau's attempt to schedule a medical examination, or fails to attend a medical examination scheduled under section 4123.57 of the Revised Code without notice or explanation, the bureau shall dismiss the application without prejudice. The employee, the employer, or their representative may object to the bureau's tentative order dismissing the application within twenty days after receipt of the notice as provided in section 4123.57 of the Revised Code, and if the employee, the employer, or their representative timely notify the bureau of an objection, the bureau shall refer the matter to a district hearing officer for a hearing.

(a) The bureau shall contact the employee to schedule the employee for an examination on an application for a determination of percentage of permanent partial disability or for an increase of permanent partial disability. The bureau may use a variety of communication methods to contact the employee, such as by telephone, mail, or other methods, but the bureau shall not limit the contact to one method or one attempt if the bureau is not able to contact the employee on the first attempt. If the bureau is unable to contact the employee and the employee is represented, the bureau shall contact the employee's representative for assistance in scheduling the examination. The bureau shall document its contacts in the claim file. If the bureau attempts to contact the employee by mail and the mail is returned undeliverable, the bureau shall attempt to find a correct address for the employee and shall document the attempt in the claim file. If the employee fails to respond to the bureau's attempts to contact the employee to schedule the examination, the bureau shall dismiss the application.

(b) If the bureau schedules the employee for an examination on the employee's application for a determination of the percentage of permanent partial disability or for an increase of permanent partial disability and the employee fails to attend the examination, the bureau shall contact the employee for an explanation why the employee did not attend the examination. If the employee is represented, the bureau shall contact the employee's representative. If the employee provides an explanation for missing the examination, the bureau shall reschedule the employee for an examination. If the employee fails to respond or fails to provide an explanation, the bureau shall dismiss the application.

(2) If the bureau dismisses an employee's application for a determination of percentage of permanent partial disability or for an increase of permanent partial disability under this rule, the employee may refile an application as provided in paragraph (B) of rule 4123-3-15 of the Administrative Code. The employee shall file the application subject to the continuing jurisdiction limitations of section 4123.52 of the Revised Code. A dismissed application does not toll the continuing jurisdiction of the bureau or the industrial commission under section 4123.52 of the Revised Code.

(B) This paragraph of this rule applies to an employee's application for a determination of the percentage of the employee's permanent partial disability or for an increase of permanent partial disability filed under section 4123.57 of the Revised Code that has been suspended pursuant to division (C) of section 4123.53 of the Revised Code as of September 29, 2017.

(1) For an employee's application for a determination of the percentage of the employee's permanent partial

disability or for an increase of permanent partial disability filed under section 4123.57 of the Revised Code that has been suspended pursuant to division (C) of section 4123.53 of the Revised Code as of September 29, 2017, the bureau shall send a notice to the employee's last known address informing the employee that the bureau may dismiss the application unless the employee schedules a medical examination with the bureau within thirty days after receiving the notice.

(a) If the employee does not schedule a medical examination with the bureau within thirty days after receiving the notice provided in paragraph (B)(1) of this rule, the bureau may dismiss the application. The employee, the employer, or their representative may object to the bureau's tentative order dismissing the application within twenty days after receipt of the notice as provided in section 4123.57 of the Revised Code, and if the employee, the employer, or their representative timely notify the bureau of an objection, the bureau shall refer the matter to a district hearing officer for a hearing.

(b) For an employee whose application has been suspended who schedules an examination but fails to appear for the examination, the bureau shall follow the same procedure as provided in paragraph (A)(1)(b) of this rule.

(2) If the bureau dismisses an employee's application for a determination of percentage of permanent partial disability or for an increase of permanent partial disability under this rule, the employee may refile the application as provided in paragraph (B) of rule 4123-3-15 of the Administrative Code. The employee shall file the application subject to the continuing jurisdiction limitations of section 4123.52 of the Revised Code. A dismissed application does not toll the continuing jurisdiction of the bureau or the industrial commission under section 4123.52 of the Revised Code.

Effective: 6/18/18

4123-6-21 Payment for outpatient medication.

(A) Except as otherwise provided in rule 4123-6-21.6 of the Administrative Code, medication must be for the treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer. The bureau may deny a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of the allowed conditions in a claim.

(B) Medication may be prescribed by any treating provider authorized by law to prescribe such medication; however, reimbursement for medication shall be denied under the following circumstances:

(1) Reimbursement for prescriptions written by providers who are not enrolled with the bureau and who refuse to become enrolled shall be denied.

(2) Reimbursement for prescriptions written by providers who are enrolled but non-certified shall be denied except in the following situations:

(a) The prescription is written by a non-bureau certified provider during initial or emergency treatment of the claimant if the claimant's claim and treated conditions are subsequently allowed.

(b) The prescription is written by a non-bureau certified provider who is outside the state or within the state where no or an inadequate number of bureau certified providers exist and the MCO has determined that the treatment to be provided by the non-bureau certified provider is not reasonably available through a like bureau certified provider and has authorized the non-bureau certified provider to continue to provide the treatment.

(c) The prescription is written by a non-bureau certified provider for a claimant with a date of injury prior to October 20, 1993, the provider was the claimant's physician of record prior to October 20, 1993, and the claimant has continued treatment with that non-bureau-certified provider.

(C) Drugs covered are limited to those that are approved for human use in the United States by the food and drug administration (FDA) and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) The bureau may require prior authorization of certain drugs or therapeutic classes of drugs, and shall publish a list of all such drugs or therapeutic classes of drugs for which prior authorization is required.

(E) Drugs which fall into one of the following categories may be prior authorized by and reimbursed through the bureau's pharmacy benefits manager:

(1) Compounded sterile parenteral and non-parenteral drug products.

(a) "Parenteral" drugs are injectable medications. They may include those intended for use by the intrathecal, intravenous, intramuscular, or subcutaneous routes of administration.

(b) All compounded sterile drug products must be prepared and dispensed by a licensed and enrolled pharmacy provider that is able to demonstrate compliance with the standards contained in chapter 797 of the United States pharmacopeia (USP) in effect on the billed date of service.

(2) Drug efficacy study implementation (DESI) drugs or drugs that may have been determined to be identical, similar, or related;

(3) Compounded non-sterile prescriptions.

(a) Reimbursement for non-sterile compounded prescriptions shall only be considered for preparations

that contain not less than one nor more than three active pharmaceutical ingredients that have been issued a national drug code (NDC) number by the FDA, and that contain only one prescription drug from any specific therapeutic class of drugs (as defined in the edition of the "American Hospital Formulary Service Drug Information" in effect on the billed date(s) of service).

(b) Reimbursement for non-sterile compounded prescriptions shall only be considered upon the submission of both:

(i) A prior authorization request, and

(ii) A copy of the signed prescription that lists all active pharmaceutical ingredients and indicates the usual and customary cost of the prescription. The prescription must comply with the Ohio state board of pharmacy requirements for a valid prescription set forth in rules 4729-5-13 and 4729-5-30 of the Administrative Code.

(c) Approval for reimbursement of non-sterile compounded prescriptions will be for an initial period of ninety days with subsequent approvals contingent upon clinical documentation of improvement in both pain and function. Not more than one prescription for a non-sterile compounded prescription will be approved for reimbursement in any thirty day period.

(d) The bureau may approve reimbursement for a non-sterile compounded prescription for topical use only after the injured worker has been prescribed and has tried for at least thirty days, and the bureau has reimbursed, a commercially available topical prescription or over-the-counter product with documentation that the intended therapeutic benefit was not achieved or an unacceptable adverse event or allergic reaction occurred.

(F) Drugs which fall into one of the following categories may be approved and reimbursed by an MCO as part of a comprehensive treatment plan submitted by the physician of record or treating physician:

(1) Drugs for the treatment of obesity;

(2) Drugs for the treatment of infertility;

(3) Non-compounded parenteral drugs not intended for self-administration;

(4) Drugs used to aid in smoking cessation;

(5) Parenteral drugs used in the treatment of opioid dependency;

(6) Drugs dispensed to a claimant while the claimant is admitted to a hospital during an approved inpatient admission or during the course of an outpatient visit in a hospital.

(G) Payment for medications to pharmacy providers shall include both a product cost component and a dispensing fee component.

(1) Except as provided in this paragraph, product cost component shall be the lesser of the following: maximum allowable cost, if applicable, or the average wholesale price (AWP) of the commonly stocked package size minus fifteen per cent.

(a) For repackaged brand name medications, the product cost component shall be calculated using the AWP of the original labeler.

(b) For non-sterile compounded prescriptions, the product cost component shall be limited to the lesser of the usual and customary price or the AWP of the commonly stocked package size minus fifteen per

cent for each ingredient.

(c) The maximum reimbursement for any one compounded prescription will be four hundred dollars.

(2) The dispensing fee component for non-compounded prescriptions shall be three dollars and fifty cents. Only pharmacy providers are eligible to receive a dispensing fee.

(3) The dispensing fee component for non-sterile compounded prescriptions shall be eighteen dollars and seventy-five cents.

(4) The dispensing fee component for sterile compounded prescriptions shall be thirty-seven dollars and fifty cents.

(H) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined by the bureau. The bureau shall not reimburse any third-party pharmacy biller that submits pharmacy bills on behalf of a pharmacy provider or that has purchased pharmacy bills from a pharmacy provider for subsequent submission to the bureau for payment. Pharmacy providers are required to submit for billing the NDC number of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or the bureau's pharmacy benefit manager's payment system must be used for billing purposes. The pharmacy provider shall:

(1) Maintain a signature log verifying receipt by the injured worker of applicable covered medications;

(2) Include prescriber information within bills submitted electronically to the bureau or the bureau's pharmacy benefits manager for payment. The prescriber information must include the national provider identifier (NPI) or the drug enforcement administration (DEA) number;

(3) Not pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services for which payment may be made by the bureau, the bureau's pharmacy benefits manager, or MCO under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;

(4) Comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service.

(I) The bureau may establish a maximum allowable cost for single source or multi-source medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the FDA and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations" in effect on the billed date(s) of service. The methodology used to determine a maximum allowable cost for a qualified drug product shall be determined by the bureau. For multi-source drugs, the bureau may choose to utilize the maximum allowable cost list of a vendor or develop its own maximum allowable cost list. For single source drugs, the maximum allowable cost shall be the drug's AWP price minus fifteen per cent.

(J) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication for which single source or multi-source medications exist that are pharmaceutically and therapeutically equivalent, as defined in paragraph (I) of this rule, shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the AWP of the dispensed brand name drug minus fifteen percent. However, the bureau

may approve reimbursement of the dispensed brand name drug at the AWP of the drug minus fifteen per cent if the following circumstances are met:

(1) The injured worker has a documented, systemic allergic reaction which is consistent with known symptoms or clinical findings of a medication allergy; and

(2) The injured worker has been prescribed, and has tried, other A code drugs in the therapeutic class and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.

(K) The following dispensing limitations may be adopted by the bureau:

(1) The bureau may publish supply limitations for drugs which represent the maximum number of days supply that may be dispensed at any one time for a single prescription.

(2) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

(3) Requests submitted that exceed any published days supply limit or maximum quantity limit shall be denied. Denials may be overridden by the bureau in cases where medical necessity and appropriateness have been determined.

(4) Refills requested before seventy-five per cent of any published days supply limit has been utilized will be denied, except in cases where the dosage of a drug has been changed and has a new prescription number. Denials may be overridden by the bureau for the following documented reasons:

(a) Pharmacist entered previous wrong day supply;

(b) Out of country vacation or travel;

(c) Pharmacy will be closed for more than two days.

(d) An emergency or disaster, as defined in division (O) of section 4123.511 of the Revised Code, is declared by the governor of Ohio or the president of the United States.

(L) Except as otherwise provided in paragraph (F) of this rule, outpatient medications shall be billed to and reimbursed through the bureau's pharmacy benefits manager. Pharmacy providers must submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the bureau's pharmacy benefits manager's established bill processing system as a condition of provider enrollment or reimbursement. Submission by paper or by tape-to-tape will not be accepted by the bureau or the bureau's pharmacy benefits manager.

(M) Claimant reimbursement for medications shall be in accordance with rule 4123-6-26 of the Administrative Code. Claimant requests for reimbursement shall comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service. Claimant reimbursement may be limited to the following situations:

(1) Claimants whose medication is not payable under division (I) of section 4123.511 of the Revised Code on the date of service, but later becomes payable;

(2) Emergency situations where an enrolled pharmacy provider with point-of-service capabilities is not available;

(3) Claimants who reside out of the country.

(N) The bureau may formulate medication utilization protocols for select conditions or diseases consistent with current medical texts and peer reviewed medical literature.

Compliance with the established protocols shall be monitored through the on-line, point-of-service adjudication system. Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's refusal to reimburse for such medications.

(O) A "pharmacy provider" designation and provider number can be obtained by a provider who meets all the following criteria:

(1) Has a valid "terminal distributor of dangerous drugs" as defined in section 4729.01 of the Revised Code if located within Ohio; or an equivalent state license if located outside of Ohio; and,

(2) Has a valid DEA number; and,

(3) Has a licensed registered pharmacist in full and actual charge of a pharmacy; and,

(4) Has the ability and agrees to submit bills at the point of service.

All state and federal laws and regulations relating to the practice of pharmacy and the dispensing of medication by a duly licensed pharmacist must be observed.

(P) The bureau may contract with a pharmacy benefit manager to perform drug utilization review and on-line bill processing, maintain a pharmacy provider network and prior authorization program for medications, and provide management reports. The bureau or its vendor may also contract rebate agreements with drug manufacturers. The bureau may utilize other services or established procedures of the pharmacy benefits manager which may enable the bureau to control costs and utilization and detect fraud.

(Q) The bureau may identify circumstances under which it may consider reimbursement for pharmacist professional services (also known as cognitive services) when payment for such services results in a measurable, positive outcome. The bureau shall be responsible for developing the criteria which will be used to assess the compensability of billed pharmacist professional services. The bureau shall be responsible for developing the structure of the reporting of the measurable outcomes used to justify the payment of pharmacist professional services, which may include reimbursement for the dispensing fee component. The amount that could be reimbursed for pharmacist professional services shall be determined by the bureau.

(R) The bureau shall retain a registered pharmacist licensed in the state of Ohio to act as the full-time pharmacy program director to assist the bureau in the review of drug bills. The pharmacy program director may assist the bureau in determining the appropriateness, eligibility, and reasonableness of compensation payments for drug services. The bureau may adopt a drug formulary with the recommendation of the bureau's pharmacy and therapeutics committee established by rule 4123-6-21.2 of the Administrative Code, and may consult with the committee on the development and ongoing annual review of the drug formulary and other issues regarding medications.

Effective: 6/1/17
Prior Effective Dates: 1/27/97, 1/1/03, 10/1/05, 9/1/11, 1/1/12, 12/1/13, 11/13/15, 1/1/17

4123-6-21.1 Payment for outpatient medication by self-insuring employer.

(A) Medication must be for treatment of an occupational injury or disease in a claim either allowed by an order of the bureau or the industrial commission, or recognized by a self-insuring employer.

(B) Medication may be prescribed by any treating provider authorized by law to prescribe such medication.

(C) Drugs covered are limited to those that are approved for human use in the United States by the food and drug administration (FDA) and that are dispensed by a registered pharmacist from an enrolled pharmacy provider.

(D) A self-insuring employer may approve and reimburse for various drugs as a part of a comprehensive treatment plan submitted by the physician of record or a treating physician when reasonably related to and medically necessary for treatment of the allowed conditions in the claim, provided that such approval and reimbursement shall not constitute the recognition of any additional conditions in the claim even if such drugs are used to treat conditions that have not been allowed in the claim.

(E) Payment for medications to pharmacy providers shall include both a product cost component and a dispensing fee component.

(1) Except as provided in this paragraph, product cost component shall be the lesser of the following: maximum allowable cost established under paragraph (O) of this rule, if applicable, or the average wholesale price (AWP) of the commonly stocked package size minus fifteen per cent.

(a) For repackaged brand name medications, the product cost component shall be calculated using the AWP of the original labeler.

(b) For non-sterile compounded prescriptions, the product cost component shall be limited to the lesser of the usual and customary price or the AWP of the commonly stocked package size minus fifteen per cent for each ingredient.

(c) The maximum product cost component reimbursement for any one compounded prescription will be four hundred dollars.

(2) The dispensing fee component for non-compounded prescriptions shall be three dollars and fifty cents, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider pursuant to rule 4123-6-46 of the Administrative Code. Only pharmacy providers are eligible to receive a dispensing fee.

(3) The dispensing fee component for non-sterile compounded prescriptions shall be eighteen dollars and seventy-five cents.

(4) The dispensing fee component for sterile compounded prescriptions shall be thirty-seven dollars and fifty cents.

(F) The pharmacy provider is required to bill medication at their usual and customary charge. The amount paid to the provider will be the lesser of the provider's usual and customary charge or the reimbursement allowed as determined in paragraph (E) of this rule, unless the self-insuring employer has negotiated a payment rate with the provider pursuant to rule 4123-6-46 of the Administrative Code. Pharmacy providers are required to submit for billing the national drug code (NDC) number of the stock bottle from which the dispensed medication is obtained. Drugs may be dispensed in unit dose packaging, but the NDC number of the closest comparable bulk package listed in the bureau or vendor payment system must be used for billing purposes.

(G) The pharmacy provider shall:

(1) Maintain a signature log verifying receipt of applicable covered medications;

(2) Include prescriber information within bills submitted electronically to the self-insuring employer or its vendor for payment. The prescriber information must include the national provider identifier (NPI) or the drug enforcement administration (DEA) number;

(3) Not pay, allow, or give, or offer to pay, allow, or give, any consideration, money, or other thing of value to an injured worker (including but not limited to free or discounted medications or other goods or services) as an inducement to or in return for the injured worker ordering or receiving from the provider any medications or other goods or services for which payment may be made by the self-insuring employer or its vendor or QHP under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;

(4) Comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service.

(H) Claimant reimbursement for medications shall be in accordance with rule 4123-6-26 of the Administrative Code and shall at least be equal to the bureau's established rate for the medication, unless the self-insuring employer has negotiated a payment rate with the pharmacy provider utilized by the claimant pursuant to rule 4123-6-46 of the Administrative Code, in which case the claimant reimbursement shall be at least the rate negotiated with the provider. Claimant requests for reimbursement shall comply with all applicable billing instructions contained in the bureau's provider billing and reimbursement manual in effect on the billed date(s) of service. Requests for reimbursement must be paid within thirty days of receipt of the request.

(I) Self-insuring employers must obtain a drug utilization review from a physician before terminating payment for current medications, as follows:

(1) Before terminating payment for current medications, the self-insuring employer shall notify all parties to the claim (including authorized representatives) and the prescribing physician, in writing, that a physician drug review is being performed, or has been performed, regarding the necessity and appropriateness of the continued use of current medications (by therapeutic drug class).

(2) The written notice shall inform all parties to the claim (including authorized representatives) and the prescribing physician that they have twenty-one days from receipt of the notice to provide additional information and/or medical documentation to justify the need for continued use of the medications (by therapeutic drug class).

(3) The self-insuring employer shall provide all medically related information regarding the medications to an independent physician reviewer for review and opinion as to the necessity or appropriateness of the medications. If the self-insuring employer has obtained an independent physician reviewer's report prior to sending the notice required by paragraph (I)(1) of this rule and subsequently receives additional information and/or medical documentation pursuant to paragraph (I)(2) of this rule, the self-insuring employer shall provide the additional information and/or medical documentation to the independent physician reviewer and obtain an addendum. The independent physician reviewer's report (and addendum, if applicable) shall address the medical rationale, necessity and appropriateness of the drug treatment in the control of symptoms associated with the allowed conditions in the claim.

(4) When the independent physician reviewer's report (and addendum, if applicable) indicates the drug treatment is not medically necessary or appropriate for treatment or in the control of symptoms associated with the allowed conditions in the claim, the self-insuring employer may terminate reimbursement for the medications (by therapeutic drug class) effective as of the date of receipt of the

independent physician reviewer's report, or addendum if one is obtained, or in the case that a drug is in a therapeutic class that requires a "weaning-off" period, such other date as agreed to by the prescribing physician and self-insuring employer.

(5) In the event the self-insuring employer terminates reimbursement for the medications as set forth in paragraph (I)(4) of this rule, the self-insuring employer or its authorized representative shall provide all parties to the claim (including authorized representatives) and the prescribing physician with a copy of the independent physician reviewer's report (and addendum, if applicable) and the self-insuring employer shall notify the employee and the employee's representative in writing of its decision to terminate. The employer's notification to the employee and employee's representative shall indicate that the employee has the right to request a hearing before the industrial commission.

(6) In the event there is a dispute as to whether the drug treatment is medically necessary or appropriate for treatment of the symptoms associated with the allowed conditions in the claim, the disputed matter shall be adjudicated in accordance with paragraph (K)(5) of rule 4123-19-03 of the Administrative Code.

(J) Self-insuring employers may deny initial requests for a drug or therapeutic class of drugs as not being reasonably related to or medically necessary for the treatment of the allowed conditions in a claim.

(K) Self-insuring employers may utilize medication utilization protocols formulated by the bureau for select conditions or diseases consistent with current medical texts and peer reviewed medical literature.

Refusal to comply with the established protocols shall result in refusal of reimbursement for the medications which are not within the established protocols. This rule does not require the discontinuation of treatment with medications that are not within the established protocols, but simply states the bureau's or self-insured employer's refusal to reimburse for such medications.

(L) Through internal development or through vendor contracts, self-insuring employers may implement a point-of-service adjudication system. Upon implementation, a self-insuring employer may require pharmacy providers to submit bills for medication by an on-line point-of-service authorization terminal or a host-to-host link with the established bill processing system as a condition of reimbursement, and may refuse submission by paper or by tape-to-tape. Self-insuring employers utilizing a point-of-service adjudication system may refuse to reimburse any third-party pharmacy biller that submits pharmacy bills on behalf of a pharmacy provider or that has purchased pharmacy bills from a pharmacy provider for subsequent submission to the self-insuring employer for payment.

(M) Self-insuring employers utilizing a point of service adjudication system may require prior authorization of drugs or therapeutic classes of drugs which appear on the bureau's published list of drugs or therapeutic classes of drugs for which prior authorization is required.

(N) Self-insuring employers utilizing a point-of-service adjudication system may apply the following dispensing limitations, adopted by the bureau, to medications approved and reimbursed by the self-insuring employer:

(1) The bureau may publish maximum prescription quantities which represent the largest number of units per drug that may be dispensed at any one time for a single prescription.

(2) Requests submitted that exceed either the days supply limit or maximum quantity limit shall be denied; provided, however, that the pharmacy provider may still fill the prescription up to the days supply limit or maximum quantity limit, as applicable. Denials may be overridden by the self-insured employer in cases where medical necessity and appropriateness have been determined.

(3) Refills requested before seventy-five per cent of the days supply has been utilized will be denied, except

in cases where the dosage of a drug has been changed and has a new prescription number. Denials may be overridden by the self-insured employer for the following documented reasons:

(a) Pharmacist entered previous wrong day supply;

(b) Out of country vacation or travel;

(c) Pharmacy will be closed for more than two days.

(d) An emergency or disaster, as defined in division (O) of section 4123.511 of the Revised Code, is declared by the governor of Ohio or the president of the United States.

(O) Self-insuring employers utilizing a point-of-service adjudication system may apply the maximum allowable cost list of the point-of-service adjudication system vendor for multi-source medications which are pharmaceutically and therapeutically equivalent, that is, contain identical doses of the active ingredient and have the same biological effects as determined by the FDA and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations" in effect on the billed date(s) of service. For single source drugs, self-insuring employers utilizing a point-of-service adjudication system may utilize as a maximum allowable cost the drug's AWP minus fifteen per cent.

(P) Claimants who request a brand name drug or whose physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication for which single source or multi-source medications exist that are pharmaceutically and therapeutically equivalent, as defined in paragraph (O) of this rule, shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the AWP of the dispensed brand name drug minus fifteen per cent. However, the self-insuring employer or its vendor may approve reimbursement of the dispensed brand name drug at the AWP of the drug minus fifteen per cent if the following circumstances are met:

(1) The injured worker has a documented, systemic allergic reaction which is consistent with known symptoms or clinical findings of a medication allergy; and

(2) The injured worker has been prescribed, and has tried, other A code drugs in the therapeutic class and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.

(Q) A self-insuring employer has sufficient grounds to refuse to pay for the dispensing of drugs and other medications when a pharmacy provider fails to observe any state or federal law relating to his or her professional licensure or to the dispensing of drugs and other medication.

Effective: 6/1/17
Prior Effective Dates: 2/1/10, 9/1/11, 1/1/12, 12/1/13, 4/10/14, 11/13/15, 1/1/17

4123-6-21.3 Outpatient medication formulary.

(A) The administrator hereby adopts the formulary indicated in appendix A to this rule, developed with the recommendation of the bureau's pharmacy and therapeutics committee, effective May1, 2018.

(B) The formulary indicated in appendix A to this rule shall constitute the complete list of medications that are approved for reimbursement by the bureau for the treatment of an occupational injury or disease in an allowed claim. Except as otherwise provided in paragraph (F) of this rule, drugs not listed in the formulary are not eligible for reimbursement by the bureau.

(C) The formulary indicated in appendix A to this rule also contains specific reimbursement, prescribing or dispensing restrictions that have been placed on the use of listed drugs. The formulary will be reviewed annually and updated as necessary. The most current version will be electronically published by the bureau.

(D) Based upon current medical literature and generally accepted best clinical practices the bureau's pharmacy and therapeutics committee shall evaluate and make recommendations to the administrator regarding the addition, deletion, or modification of coverage of medications listed in the formulary. Requests for pharmacy and therapeutics committee action on a specific drug may be initiated by the bureau's administrator, chief of medical services, chief medical officer, or pharmacy director.

(E) The bureau shall develop policies to perform an expedited review process for clinically or therapeutically unique medications. The bureau shall also develop policies to address the timely review of new drug products.

(F) Notwithstanding paragraph (B) of this rule, in cases of medical necessity supported by clinical documentation and evidence of need the bureau may, with prior authorization, reimburse for new drugs approved for use in the United States by the food and drug administration (FDA) on or after the effective date of the formulary, and for new indications approved by the FDA on or after the effective date of the formulary for existing drugs that are not on the formulary, for a period not to exceed one hundred eighty days from the adjudication date of the first prescription for the requested drug.

(G) Notwithstanding appendix A to this rule, in cases of medical necessity supported by clinical documentation and evidence of need the bureau may, with prior authorization, reimburse for new dosage forms or strengths approved by the FDA on or after the effective date of the formulary for existing drugs that are on the formulary, for a period not to exceed one hundred eighty days from the adjudication date of the first prescription for the requested drug.

Effective: 5/1/18
Prior Effective Dates: 9/1/11, 2/1/12, 9/1/12, 4/1/13, 1/2/14, 9/1/214, 5/1/15, 12/1/15, 1/1/17, 10/1/17

4123-6-21.5 Standard dose tapering schedules.

The bureau hereby adopts the standard dose tapering (weaning) schedules for the prescription medications indicated in appendices A & B to this rule, developed with the recommendation of the bureau's pharmacy and therapeutics committee to safely implement denials for payment of the indicated medications, effective April 10, 2014.

These weaning schedules shall be applied to all denials for payment of the indicated medications by the bureau, self-insuring employers, MCOs, QHPs, and the industrial commission.

Effective: 4/10/14

4123-6-21.7 Utilization of opioids in the subacute or chronic phases of pain treatment for a work-related injury or occupational disease.

(A) Definitions.

For purposes of this rule:

(1) "Chronic phase of pain treatment" means that an injured worker is considered to be experiencing chronic pain or pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than twelve continuous weeks after the date of injury or occupational disease, or after a surgical intervention related to the allowed conditions of the claim.

(2) "Clinically meaningful improvement in pain and function" or "CMIF" means a measured and meaningful improvement in the ability of the injured worker to engage in activities of daily living, or to make progress toward accomplishing any daily activity goals established at the onset of treatment with emphasis on a possible return to work.

(3) "Clinically validated and appropriate drug testing methodology" means a chemical analysis of a specimen (e.g. urine, blood, saliva, hair) to identify presence or absence of parent drugs or their metabolites. For purposes of this rule, it is inclusive of both the immunoassay and a confirmation test such as gas chromatography, mass spectrometry or high-performance liquid chromatography.

(4) "Informed consent" has the same meaning as defined in rule 4731-29-01 of the Administrative Code.

(5) "Morphine equivalent dose" or "MED" means the equivalent daily amount of morphine represented by all of the opioids prescribed for an injured worker as measured by the conversion factors used by the Ohio board of pharmacy at the time the opioids are prescribed. This metric is used to approximate the total opioid load of an individual injured worker.

(6) "OARRS" means the "Ohio Automated Rx Reporting System" drug database established and maintained pursuant to section 4729.75 of the Revised Code.

(7) "Opioid" has the same meaning as "opiate" as defined in division (R) of section 3719.01 of the Revised Code.

(8) "Subacute phase of pain treatment" means that an injured worker is experiencing pain that has persisted after reasonable medical efforts have been made to relieve it and has continued, either continuously or episodically, for longer than six continuous weeks but less than twelve continuous weeks after the date of injury or occupational disease, or after a surgical intervention related to the allowed conditions of the claim.

(B) Current clinical literature has shown that long term utilization of opioids in workers' compensation claims is associated with an increased length of time until an injured worker returns to work. Therefore, it is highly recommended that prescribers consider and apply appropriate Ohio opioid prescribing guidelines prior to initially prescribing opioids to treat an injured worker, and continuously throughout the injured worker's course of opioid therapy.

This rule governs the bureau's reimbursement of opioid prescriptions used to treat a work related injury or occupational disease in the subacute phase of pain treatment, at high doses, or in the chronic phase of pain treatment, and for discontinuing opioids in the chronic phase of pain treatment. It is not meant to preclude, or substitute for, the prescriber's responsibility to exercise sound clinical judgment in light of current best

medical practices and appropriate Ohio opioid prescribing guidelines when treating injured workers.

(C) Effective October 1, 2016 for claims with a date of injury on or after September 1, 2016 and for all claims on or after January 1, 2017, reimbursement for opioid prescriptions used to treat a work related injury or occupational disease shall be limited to claims in which current best medical practices as implemented by Ohio state medical board rule 4731-21-02 of the Administrative Code and this rule are followed.

The bureau shall not reimburse for any further prescriptions for opioids, and prescribers should discontinue prescribing opioids, if the applicable criteria of Ohio state medical board rule 4731-21-02 of the Administrative Code and this rule are not met. A prescriber's failure to comply with the requirements of these rules may constitute endangerment to the health and safety of injured workers, and claims involving opioid prescribing not in compliance with these rules may be subject to peer review by the bureau of workers' compensation pharmacy and therapeutics (P&T) committee pursuant to rule 4123-6-21.2 of the Administrative Code, the bureau of workers' compensation stakeholders' health care quality assurance advisory committee (HCQAAC) pursuant to rule 4123-6-22 of the Administrative Code, or other peer review committee established by the bureau.

(D) Opioid utilization in the subacute phase of pain treatment.

(1) Reimbursement for opioid prescriptions for an injured worker during the subacute phase of pain treatment shall only be provided in claims where a prescriber has documented the following actions prior to either escalating the dosing regimen beyond fifty milligrams morphine equivalent dose (MED) per day, or prescribing opioids more than six weeks after the injured worker's date of injury or occupational disease or surgery related to allowed conditions in the claim, whichever occurs first:

(a) Development of an individualized treatment plan that is justified with clinical rationale.

(b) Establishment of a risk assessment through the use of a clinically validated tool for screening and assessment, the OARRS prescription reporting system, and a clinically validated and appropriate drug testing methodology.

(c) Documented response to treatment as demonstrated by CMIF in the injured worker.

(2) Because continuous utilization of opioid medications in the chronic phase of pain treatment is associated with substantial risk for harm, opioid prescribing or dose increases that do not result in CMIF are considered not medically necessary or appropriate in the Ohio workers' compensation system.

(E) Opioid utilization at high doses or in the chronic phase of pain treatment.

(1) Reimbursement for opioid prescriptions for an injured worker at doses greater than eighty milligrams MED per day or in the chronic phase of pain treatment shall only be provided in claims where a prescriber has documented the following actions prior to either escalating the dosing regimen beyond eighty milligram MED per day, or prescribing opioids more than twelve weeks after the injured worker's date of injury or occupational disease or surgery related to allowed conditions in the claim, whichever occurs first:

(a) Verification that the requirements of paragraphs (D)(1)(a) through (D)(1)(c) of this rule have been met.

(b) Documentation that reasonable alternatives to opioids have been tried and failed.

(2) Reimbursement for opioid prescriptions for an injured worker at doses greater than one hundred twenty milligrams MED per day or in the chronic phase of pain treatment shall only be provided in claims

where a prescriber has documented the following actions prior to either escalating the dosing regimen beyond one hundred twenty milligrams MED per day, or prescribing opioids more than twelve weeks after the injured worker's date of injury or occupational disease or surgery related to allowed conditions in the claim, whichever occurs first:

(a) Verification that the requirements of paragraphs (D)(1)(a) through (D)(1)(c) and paragraphs (E)(1) (a) and (E)(1)(b) of this rule have been met.

(b) Documentation of a risk benefit assessment of the injured worker to determine whether to continue opioid prescribing or to initiate weaning.

(c) Consultation with a pain management specialist if the injured worker's dose is above one hundred twenty milligrams MED per day and there is no demonstrated CMIF or special circumstance such as the need for compassionate care as defined in paragraph (G) of this rule.

(d) Evidence of the injured worker's informed consent and provision to the injured worker of written education materials regarding opioid analgesics.

(e) Appropriate additional consultations if the injured worker has a co-morbid substance use issue or poorly controlled mental health disorder.

(F) Discontinuing opioids in the chronic phase of pain treatment.

(1) Reimbursement for treatments required to assist an injured worker during the discontinuance of opioid prescriptions in the chronic phase of pain treatment shall only be provided in claims where the treatment record reflects the following actions more than twelve weeks after the injured worker's date of injury or occupational disease or surgery related to allowed conditions in the claim:

(a) Documentation in the medical record of an intent to discontinue opioid treatment of the injured worker in a timeframe consistent with the standard dose tapering schedules set forth in the appendix to rule 4123-6-21.5 of the Administrative Code in effect at the time the intent to discontinue opioid treatment of the injured worker is documented.

(b) Documentation in the medical record of a clear plan for tapering the injured worker's total opioid load as measured by daily MED.

(c) Monthly documentation of adherence with the plan.

(2) During the eighteen months subsequent to the date of the documented plan to discontinue opioid treatment, the bureau will reimburse appropriate and medically necessary formulary medications pursuant to an approved prior authorization request that documents use of such medications as adjuncts to withdrawal of opioid medications. During this eighteen month period, the bureau will also reimburse appropriate and medically necessary inpatient treatment for detoxification for up to thirty days and outpatient treatment for opioid use disorder, according to the version of patient placement criteria of the American society of addiction medicine (ASAM) in effect during this eighteen month period. Reimbursement is contingent on documentation of the following:

(a) Documentation of concurrence with the plan of treatment by the injured worker's physician of record or treating physician.

(b) All medications prescribed for treatment of pain and opioid withdrawal during this eighteen month period must be prescribed by a single designated prescriber selected by the injured worker. Any change in prescriber during this period must be approved by the administrator.

(c) Documentation of compliance by the injured worker as indicated by monthly OARRS reports and at least bi-monthly use of a clinically validated and appropriate drug testing method. Evidence of more than two events of non-compliance by the injured worker shall be cause for the bureau to cease reimbursement for all clinical interventions directed at treating opioid withdrawal.

(G) Compassionate care.

The administrator may grant an exemption to the requirements listed in paragraph (E) of this rule at the recommendation of either the bureau's chief medical officer or the P&T, HCQAAC, or other peer review committee established by the bureau, following review of the claim, if the injured worker's injuries or treatment history is such that strict application of this rule would offer no improvement in the injured worker's overall health, safety, or quality of life, or continuing care of the injured worker will require a prolonged course of surgeries or multiple surgical interventions.

Effective: 10/1/16

4123-6-32 Payment for lumbar fusion surgery.

Effective January 1, 2018, reimbursement for lumbar fusion surgery for treatment of allowed conditions in a claim resulting from an allowed industrial injury or occupational disease shall be limited to claims in which current best medical practices as implemented by this rule are followed.

This rule governs the bureau's reimbursement of lumbar fusion surgery to treat a work related injury or occupational disease. It is not meant to preclude, or substitute for, the surgeon's responsibility to exercise sound clinical judgment in light of current best medical practices when treating injured workers.

A provider's failure to comply with the requirements of this rule may constitute endangerment to the health and safety of injured workers, and claims involving lumbar fusion surgery not in compliance with this rule may be subject to peer review by the bureau of workers' compensation stakeholders' health care quality assurance advisory committee (HCQAAC) pursuant to rule 4123-6-22 of the Administrative Code or other peer review committee established by the bureau.

(A) Prerequisites to consideration of lumbar fusion surgery.

Authorization for lumbar fusion shall be considered only in cases in which the following criteria are met:

(1) Conservative care.

(a) Except as otherwise provided in paragraph (A)(1)(c) of this rule, the injured worker must have had at least sixty days of conservative care for low back pain, with an emphasis on:

(i) Physical reconditioning;

(ii) Avoidance of opioids, when possible; and

(iii) Avoidance of provider catastrophizing the explanation of lumbar MRI findings.

(b) The injured worker's comprehensive conservative care plan may include, but is not limited to, one or more of the following:

(i) Relative rest/ice/heat;

(ii) Anti-inflammatories;

(iii) Pain management / physical medicine rehabilitation program;

(iv) Chiropractic / osteopathic treatment;

(v) Physical medicine treatment as set forth in rule 4123-6-30 of the Administrative Code;

(vi) Interventional spine procedures / injections.

(c) The requirement of a trial of at least sixty days of conservative care prior to consideration of lumbar fusion surgery may be waived with prior approval from the MCO in cases of:

(i) progressive functional neurological deficit;

(ii) spinal fracture;

(iii) tumor;

(iv) infection;

(v) emergency / trauma care; and/or

(vi) other catastrophic spinal pathology causally related to the injured worker's allowed conditions.

(2) The operating surgeon requesting authorization for lumbar fusion surgery must have personally evaluated the injured worker on at least two occasions prior to requesting authorization for lumbar fusion surgery.

(3) The injured worker must have undergone a comprehensive evaluation, coordinated by both the injured worker's physician of record or treating physician and the operating surgeon, in which all of the following have been documented:

(a) Utilization and correlation of all of the following tools:

(i) Visual analog scale (VAS);

(ii) Pain diagram;

(iii) Oswestry low back disability questionnaire.

(b) A comprehensive orthopedic / neurological examination, including documentation of all of the following categories:

(i) Gait;

(ii) Spine (deformities, range of motion, palpation);

(iii) Hips and sacroiliac joints;

(iv) Motor;

(v) Sensation;

(vi) Reflexes;

(vii) Upper motor neuron signs.

(c) Diagnostic testing.

(i) Lumbar X-rays (including flexion/extension views), lumbar MRI, or lumbar CT (with or without myelography) must be performed;

(ii) Electromyography (EMG) / nerve conduction study (NCS) may be performed if questions still remain during surgical planning.

(d) Discussion and consideration of opportunities for vocational rehabilitation.

(e) Review of current and previous medications taken.

(i) If opioid management is in process, review for best practices;

(ii) Consider impact of surgery on opioid load.

(f) Health behavioral assessment (pre-surgical).

Biopsychosocial factors that may affect treatment of the injured worker's allowed lumbar conditions are considered modifiable conditions that may change the need for surgery or improve surgical outcomes if appropriately addressed, and must be addressed if identified in the assessment.

(g) Accounting and assessment of the following co-morbidities to stratify additional associated risks:

(i) Smoking;

(ii) Body mass index (BMI);

(iii) Diabetes;

(iv) Coronary artery disease;

(v) Peripheral vascular disease.

The co-morbidities indicated above are considered modifiable conditions that may improve surgical outcomes if appropriately addressed, and must be addressed if identified in the assessment.

(h) The injured worker, the physician of record or treating physician, and the operating surgeon must have reviewed and signed the educational document, "What BWC Wants You to Know About Lumbar Fusion Surgery," attached as an appendix to this rule.

(B) Authorization for lumbar fusion surgery where the injured worker has no prior history of lumbar surgery.

(1) Authorization for lumbar fusion shall be considered in cases where the injured worker has no prior history of lumbar surgery only when the injured worker remains highly functionally impaired despite a trial of at least sixty days of conservative care as provided in paragraph (A)(1)(a) of this rule (unless waived with prior approval by the MCO pursuant to paragraph (A)(1)(c) of this rule) and one or more of the following are present:

(a) Mechanical low back pain with instability of the lumbar segment and no history of lumbar surgery.

(b) Spondylolisthesis of twenty-five per cent or more with one or more of the following:

(i) Objective signs/symptoms of neurogenic claudication;

(ii) Objective signs/symptoms of unilateral or bilateral radiculopathy, which are corroborated by neurologic examination and by MRI or CT (with or without myelography);

(iii) Instability of the lumbar segment.

(c) Lumbar radiculopathy with stenosis and bilateral spondylolysis.

(d) Lumbar stenosis necessitating decompression in which facetectomy of greater than or equal to fifty per cent or more is required.

(e) Primary neurogenic claudication and/or radiculopathy associated with lumbar spinal stenosis in conjunction with spondylolisthesis or lateral translation of three mm or greater or bilateral pars defect.

(f) Degenerative disc disease (DDD) associated with significant instability of the lumbar segment.

(g) Spinal stenosis, disc herniation, or other neural compressive lesion requiring extensive, radical

decompression with removal of greater than fifty per cent of total facet volume at the associated level.

The surgeon must document why the surgical lesion would require radical decompression through the pars interarticularis (critical stenosis, recurrent stenosis with extensive scarring, far lateral lesion).

(2) For purposes of this paragraph, instability of the lumbar segment is defined as at least four mm of anterior/posterior translation at L3-4 and L4-5, or five mm of translation at L5-S1, or eleven degrees greater end plate angular change at a single level, compared to an adjacent level.

(C) Request for lumbar fusion surgery where the injured worker has a history of prior lumbar surgery.

(1) If a trial of at least sixty days of conservative care as provided in paragraph (A)(1)(a) of this rule has failed to relieve symptoms (or has been waived with prior approval by the MCO pursuant to paragraph (A)(1)(c) of this rule) and the injured worker has had a prior laminectomy, discectomy, or other decompressive procedure at the same level, lumbar fusion should be considered for approval only if the injured worker has one or more of the following:

(a) Mechanical (non-radicular) low back pain with instability at the same or adjacent levels.

(b) Mechanical (non-radicular) low back pain with pseudospondylolisthesis, rotational deformity, or other condition leading to a progressive, measureable deformity.

(c) Objective signs/symptoms compatible with neurogenic claudication or lumbar radiculopathy that is supported by EMG/NCS, lumbar MRI, or CT and detailed by a clinical neurological examination in the presence of instability of three mm lateral translation with at least two prior decompression surgeries at the same level.

(d) Evidence from post laminectomy structural study of either:

(i) One hundred per cent loss of facet surface area unilaterally; or

(ii) Fifty per cent combined loss of facet surface area bilaterally.

(e) Documented pseudoarthrosis or nonunion, with or without failed hardware, in the absence of other neural compressive lesion.

(2) For purposes of this paragraph, instability of the lumbar segment is defined as at least four mm of anterior/posterior translation at L3-4 and L4-5, or five mm of translation at L5-S1, or eleven degrees greater end plate angular change at a single level, compared to an adjacent level.

(D) Lumbar fusion surgical after care.

Both the physician of record or treating physician and the operating surgeon must follow the injured worker until the injured worker has reached maximum medical improvement (MMI) for the allowed lumbar conditions.

(1) In the first six months post-operatively, the injured worker must be seen by both the physician of record or treating physician and the operating surgeon at least every two months to monitor the injured worker's progress, rehabilitation needs, behavioral patterns or changes, and return to work willingness and/or status.

During this period, the physician of record or treating physician and the operating surgeon shall

determine the following:

(a) Fusion status;

(b) Pain and functional status;

(c) MMI status of injured worker;

(d) Residual level of functional capacity;

(e) Appropriateness for vocational rehabilitation.

(2) From six months to one year post-operatively, if the injured worker continues to experience significant functional impairment despite the lumbar fusion, the following actions are recommended:

(a) Pain and functional status (repeat VAS / pain diagram / Oswestry)

(b) Repeat baseline orthopedic / neurological examination;

(c) Repeat health behavioral assessment;

(d) Revisit appropriate diagnostic imaging.

(e) Coordinate with MCO to develop a plan of care / return to functional status.

Effective: 1/1/18

4123-6-32
Appendix

What BWC Wants You to Know About Lumbar Fusion Surgery

(Applies to all workers considering lumbar fusion, regardless of diagnosis)

Ohio Bureau of Workers' Compensation wants you to have the highest quality of care. That can only occur if you know how lumbar fusion surgery may affect your health and recovery. BWC is providing the following instructional form to aid in the process. BWC requires your physician to discuss this information before the surgery, so you can make the best informed decision. In preparation, please study this form, and discuss the information with your healthcare team. Afterwards, you, your physician of record, and your operating surgeon should sign the form. **THIS IS NOT A SURGICAL CONSENT FORM.**

Studies have shown the following post-operative outcomes:

- General Lumbar Fusion Outcomes

  a. The chance of an injured worker no longer being disabled 2 years after lumbar fusion is 32%.

  b. More than 50% of workers who received lumbar fusion through the Washington workers' compensation program felt that both pain and functional recovery were no better or were worse after lumbar fusion.

  c. Smoking at the time of fusion greatly increases the risk of failed fusion

  d. Pain relief, even when present, is **NOT** likely to be 100%

  e. The use of spine stabilization hardware (metal devices) in Washington workers nearly doubled the chances of having another surgery

  f. Lumbar fusion for the diagnoses of disc degeneration, disc herniation, and/or radiculopathy in work comp setting is associated with significant increase in disability, opiate use, prolonged work loss, and poor return to work status.

- Ohio Specific Lumbar Fusion Outcomes Study: (2 year follow-up – 1450 total patients)

a. Back pain patients treated with fusion were able to return to work (activity) only 26% of the time, workers treated non-surgically were able to return to work (activity) 67% of the time.

b. Re-operation rate was 27% in fused patients

c. Complications occurred in 36% of fused patients

d. Narcotic use increased 41% in fused patients, and continued for over 2 years in 76% of fused patients

e. 17 of the fused patients died during the course of the study and 11 non-surgical patients

- National/International Lumbar Fusion Statistics

  a. Surgical fusion outcomes are **NOT** better than cognitive therapy and exercise

  b. Surgical fusion for previous herniated disk is **NOT** better than non-operative treatment

  c. Surgical satisfaction was reportedly high even in injured workers with ongoing pain and no improvement in function observed

  d. Some patients described less pain, improvement of 1 or 2 points on a 10 point pain scale, but any functional benefit of having a fusion was not demonstrated

- Opioid use has been associated with significant long term morbidity and mortality in both surgical and non-surgical patients. Back pain patients are at risk for long term opioid use. Fusion patients have greater narcotic/opioid usage than non-operative patients.

What is expected of you if you proceed to have lumbar fusion surgery:

If the BWC/MCO authorizes your surgery, your surgeon will continue to see you at least every two months for six months after surgery. As your surgeon, I expect you to actively participate in your recovery and rehabilitation plan both prior to and following your surgery.

By signing this form, we (the injured worker, physician & surgeon), attest that we have discussed the information presented here, we understand this information, and we wish to proceed with the fusion surgery. **We also understand that this information does NOT take place of, and is separate and distinct from, any surgical form that we will complete prior to surgery.**

_____ _____

Injured Worker

Date:___/____/_____

Physician of Record

Date:____/_____/_____

_____

Operating Surgeon

Date:____/_____/_____

Memo D8 | Temporary Total Disability Certification for Physical and Psychological Conditions

During the first six weeks after the date of injury, temporary total disability can be certified by a physician, certified nurse practitioner, clinical nurse specialist, psychologist, or physician assistant who has examined the injured worker.

Both during and after six weeks from the date of injury, certification of temporary total disability for physical conditions may be submitted by a Medical Doctor, Doctor of Osteopathy, Doctor of Podiatric Medicine, or Chiropractor.

Both during and after six weeks from the date of injury, certification of temporary total disability for psychological conditions may only be submitted by a Psychologist, Medical Doctor, or Doctor of Osteopathy.

NOTE: *Adjudications Before the Ohio Industrial Commission* Memo M5.

Memo F4 | Loss of Use of Vision and/or Hearing Secondary to a Traumatic Brain Injury

R.C. 4123.57(B) does not permit an award for loss of vision or hearing resulting from the loss of brain stem functioning. To be entitled to an award for loss of vision or hearing, evidence must demonstrate an actual loss of function of the eyes or ears.

NOTE: State ex rel. Smith v. Indus. Comm., 138 Ohio St.3d 312, 2014-Ohio-513, 6 N.E.3d 1142.

Memo F6 | Orders Awarding Scheduled Losses

When awarding compensation for a scheduled loss, hearing officers shall provide a start date for the award. In the case of amputation or actual loss, the start date is the date of amputation or loss. In the case of a loss of use, the start date is the date of the earliest medical evidence being relied upon to make the award. However, pursuant to R.C. 4123.52, in no case shall the start date be earlier than two years prior to the filing of the application seeking the award.

NOTE: State ex rel. Estate of Sziraki v. Adm. Bur. of Workers' Comp., 137 Ohio St.3d 201, 2013-Ohio-4007, 998 N.E.2d 1074.

Memo S11 | Request for Allowance of a Condition by Either Direct Causation, Aggravation/ Substantial Aggravation, or Flow-Through, and Jurisdiction to Rule at Hearing

If there is evidence on file or presented at hearing to support the theories of direct causation, aggravation (date of injury or disability prior to August 25, 2006)/substantial aggravation (date of injury or disability on or after August 25, 2006), or flow-through, a request to allow a condition in a claim is to be broadly construed to cover those theories of causation. The hearing officer shall address the origin of the condition under those alleged theories of causation without referring the claim back to the prior hearing level or the Bureau of Workers' Compensation. Where a new theory, not formerly requested, is raised at hearing or where new evidence regarding an alternative theory of causation is submitted by any party, hearing officers and/or hearing administrators shall ensure that all parties are given adequate opportunity to obtain evidence in support of their position by continuing the hearing for a period of at least 30 days, unless the parties agree that less time is sufficient for obtaining the necessary evidence. The hearing officers and/or hearing administrators shall state in their order or compliance letter the period of time allotted to obtain the necessary evidence.

NOTE: Ohio Adm.Code 4121-3-09(A)(1)(b).

Memo B3 | Injuries Caused by Idiopathic Causes

When a fall is unexplained, the claimant has the burden of eliminating idiopathic causes. In order to meet that burden, the claimant must present persuasive proof the fall was not caused by a pre-existing physical weakness, condition, or disease. Once a claimant eliminates idiopathic causes, an inference arises that the fall is traceable to an ordinary risk, albeit unidentified, to which the claimant was exposed on the employment premises.

Furthermore, a claimant's statement of general good health prior to the fall is sufficient to meet the burden of elimination – expert testimony and/or medical evidence is unnecessary.

NOTE: Waller v. Mayfield, 37 Ohio St.3d 118, 524 N.E.2d 458 (1988); Smith v. Apex Div., Cooper Indus., Inc., 88 Ohio App.3d 247, 623 N.E.2d 700 (2d Dist.1993).

Memo D5 | Voluntary Abandonment

Voluntary abandonment is an affirmative defense to requests for compensation for temporary total disability and permanent total disability. There are three types of voluntary abandonment. When an employer or the Bureau of Workers' Compensation asserts the defense of voluntary abandonment, hearing officers shall specifically identify the type(s) of abandonment the employer or the Bureau of Workers' Compensation is asserting and then address each type separately in their order. What follows are the types of actions the courts have deemed to constitute a voluntary abandonment.

1. **Voluntary Retirement:** A voluntary retirement is one that is not causally related to the allowed conditions in the claim. If an injured worker retires due to his or her allowed conditions, the retirement is considered to be involuntary and is not a bar to the receipt of compensation. Conversely, when an injured worker retires due to a reason other than the allowed conditions, the retirement is considered to be voluntary and will bar the receipt of compensation.

2. **Termination:** A discharge from employment can constitute a voluntary abandonment if the termination is the result of the injured worker's violation of a written work rule that (1) clearly defined the prohibited conduct, (2) had been previously identified by the employer as a dischargeable offense, and (3) was known or should have been known to the employee.

    - The work rule must be in writing regardless of whether the rule should be common sense.

    - The requirement of a written work rule can be satisfied by a written job description containing specific job duties combined with a written employee handbook that sets out specific behavior expectations. This requirement can also be satisfied by a series of formal "write-ups" or progressive discipline, which placed the employee on notice that further infractions may result in termination. Hearing officers must determine that an injured worker has actually engaged in conduct prohibited by a written work rule in order to make a finding of voluntary abandonment.

    - As to negligent or careless actions that result in termination, there may be situations in which the nature or degree of the conduct, though not characterized as willful, may rise to such a level of indifference or disregard for the employer's workplace rules/policies to support a finding of voluntary abandonment.

    - When an employee is terminated after a workplace injury for conduct prior to and unrelated to the workplace injury, his or her termination does not amount to a voluntary abandonment of employment for purposes of temporary total disability compensation when (1) the discovery of the dischargeable offense occurred because of the injury and (2) at the time of the termination, the employee was medically incapable of returning to work as a result of the workplace injury.

3. **Abandonment of the Workforce:** A departure from employment with no re-entry into the workforce can constitute a voluntary abandonment. Such an abandonment depends upon the injured worker's intent at the time of the departure. This intent can be inferred from words spoken, acts done, and other objective facts. The following examples illustrate fact situations in which the courts have found an intent to abandon the workforce:

    - Medical evidence of maximum medical improvement or an ability to perform modified duty work can support a finding of voluntary abandonment if the evidence demonstrates the injured worker was capable of performing work before his or her departure from employment.
    - Medical evidence that indicates that the injured worker was suffering from non allowed conditions at the time of departure can support a finding of voluntary abandonment.
    - A lack of medical evidence that the allowed conditions were disabling at the time of the departure can support a finding that a departure was not injury-induced.

    The foregoing list of examples is not intended to be all-inclusive. Hearing officers must consider the facts of each case to determine whether the requisite intent exists.

NOTE: State ex rel. Louisiana-Pacific Corp. v. Indus. Comm., 72 Ohio St.3d 401, 650 N.E.2d 469 (1995); State ex rel. McKnabb v. Indus. Comm., 92 Ohio St.3d 559, 752 N.E.2d 254 (2001); State ex rel. Feick v. Wesley Cmty. Servs., 10th Dist. No. 04AP-166, 2005-Ohio-3986; State ex rel. Brown v. Hoover Universal, 132 Ohio St.3d 520, 2012-Ohio-3895, 974 N.E.2d 1198; State ex rel. Black v. Indus. Comm., 137 Ohio St.3d 75, 2013-Ohio-4550, 997 N.E.2d 536; State ex rel. Roxbury v. Indus. Comm., 138 Ohio St.3d 91, 2014-Ohio-84, 3 N.E.3d 1190; State ex rel. Floyd v. Formica Corp., 140 Ohio St.3d 260, 2014-Ohio-3614, 17 N.E.3d 547; State ex rel. Cordell v. Pallet Cos., Inc., 2016-Ohio-8446, reconsideration denied, 148 Ohio St.3d 1428, 2017-Ohio-905, 71 N.E.3d 299 (2017).

Memo S3 | Subpoenas – Compliance

In the event that a subpoena has been issued to produce specific records relating to a claim and at the hearing it is discovered that the subpoena has not been complied with, the matter pending shall be continued and the claim file referred to the Office of Legal Counsel in order to initiate appropriate compliance measures (Motion to Compel).

Ohio | Bureau of Workers' Compensation

Medical Marijuana and its IMPACT ON BWC

What does OHIO'S medical marijuana LAW SAY?

In 2016, the Ohio General Assembly set up the framework to legalize medical marijuana in Ohio, effective Sept. 8, 2018. It was approved for certain medical conditions, including pain that is either chronic and severe or intractable, PTSD, and traumatic brain injuries. At this time, the only legal forms of medical marijuana will be edibles, oils, patches, plant material and tinctures. Vaporization is permitted. It cannot be smoked or combusted. Home growth is prohibited.

The Ohio Department of Commerce is tasked with regulating the licensure of medical marijuana cultivators and processors, as well as the laboratories that test medical marijuana. The state of Ohio Board of Pharmacy will license retail dispensaries and register patients and their caregivers. Additionally, the State Medical Board of Ohio will regulate physicians' requirements and procedures for applying for and maintaining certificates to recommend medical marijuana and maintain the list of conditions for which medical marijuana can be recommended.

What is the IMPACT of the new law ON BWC?

The impact of the new law on BWC and its programs is limited. It does not adversely affect the Drug-free Safety Program, will not require BWC to pay for patient access to marijuana, and expressly states that an employee whose injury was the result of being intoxicated or under the influence of marijuana is not eligible for workers' compensation.

Specifically:

1. Nothing in the law requires an employer to accommodate an employee's use of medical marijuana;
2. The law does NOT prohibit an employer from refusing to hire, discharging, or taking an adverse employment action because of a person's use of medical marijuana;
3. The law specifies that marijuana is covered under "rebuttable presumption." In general, this means that an employee whose injury was the result of being intoxicated or under the influence of marijuana is not eligible for workers' compensation. This is the case regardless of whether the marijuana use is recommended by a physician;
4. While the law does not specifically address reimbursement for medical marijuana recommended for injured workers, Ohio law already has rules and statutes in place that limit what medications are reimbursable by BWC.
   - Administrative code provides that drugs covered by BWC are limited to those that are approved by the United States Food and Drug Administration. Marijuana has not been approved by the FDA and remains a Schedule I illegal drug under federal law.
   - BWC-funded prescriptions must be dispensed by a registered pharmacist from an enrolled provider. Medical marijuana will be dispensed from retail marijuana dispensaries, not from enrolled pharmacies.
   - BWC only reimburses drugs that are on its pharmaceutical formulary, which is a complete list of medications approved for reimbursement by BWC. Drugs not on the list are not eligible for reimbursement, and under BWC's current rules, it cannot be included in the formulary, nor is it otherwise eligible for reimbursement.

What can EMPLOYERS DO?

The best way employers can protect their workers and themselves is to establish a **drug-free workplace**, or, if they already have one, to review and update it if necessary. This is important because certain sections of the new law reference the use of medical marijuana in violation of an employer's drug-free workplace policy, zero-tolerance policy or other formal program or policy regulating the use of medical marijuana. For what this means to your specific workplace, consult your human resources or legal department.

August, 2018

Industrial Commission Policies

IC Resolutions

IC Rules

Guidelines for Non-Attorney Representatives

Other IC Policies

Quick Links

Office Locations
IC Fact Sheets
Frequently Asked Questions
Commissioner Bios
Reports & Newsletters
Medical Specialist Resources
Adjudications Before the Ohio Industrial Commission (PDF)
Ombuds Office
Visit the BWC Website
Supreme Court of Ohio Website
Commission Member Orders
Industrial Commission Meeting Minutes

IC Policies

The public, injured workers, employers and their representatives may learn about how the Industrial Commission (IC) conducts hearings by accessing IC policies and guidelines.

IC Resolutions
IC hearings are administrative processes which follow these guidelines.

IC Rules
Rules of the Ohio Administrative Code adopted by the IC.

Adjudications Before the Ohio Industrial Commission
IC hearing officers follow these guidelines when making decisions. This document replaces the Hearing Officer Manual.

Commission Member Orders
Commission member orders are available by month and year. They can also be serached by keyword.

Ohio Administrative Code (OAC) and Ohio Revised Code (ORC)
Link to the list of OAC and ORC rules and statutes relative to workers' compensation located on Bureau of Workers' Compensation's Web site.

Staff Hearing Officer Manual and District Hearing Officer Manual (Coming Soon!)
Training material used by district hearing officers and staff hearing officers.

Docketing Policy
IC policy on hearing "block-out" dates.

Public Records Policy and Procedures
IC policy on public records requests.

I.C.O.N.

I.C.O.N. is your online resource for managing your hearing file. Logon to file appeals, objections, continuances, cancellations, request services, and view or add documents to your hearing folder.

Contact

We're here to help! Call, fax or email us at askIC@ic.ohio.gov with questions and concerns.

Forms

Download individual PDFs of IC forms.

IC Policies

Get the information you need to comply with IC rules, resolutions, policies and guidelines.

The Appeals Process

Confused about the process or what is expected of you? Visit the Appeals Process section to learn the ins and outs of workers' compensation claims and hearings.

Telephone Hearing Request Guidelines

Guidelines used for processing requests by parties for participation in hearings by telephone.

Jurisdiction Memo

Memo regarding jurisdiction issues.

NOTE: Adobe Acrobat Reader is required to view some of the above links. If you do not have Adobe Acrobat Reader, you may download it here for free.

Ohio | Industrial Commission

STAFF HEARING OFFICER TRAINING MANUAL

STAFF HEARING OFFICER TRAINING MANUAL

Updated September 2018

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CHAPTER ONE: APPEALS/C-92 RECONS

I. APPEALS

A. Jurisdiction

A party has 14 days from receipt of the District Hearing Officer order to file an appeal, or else the Staff Hearing Officer does not have jurisdiction.

B. De Novo

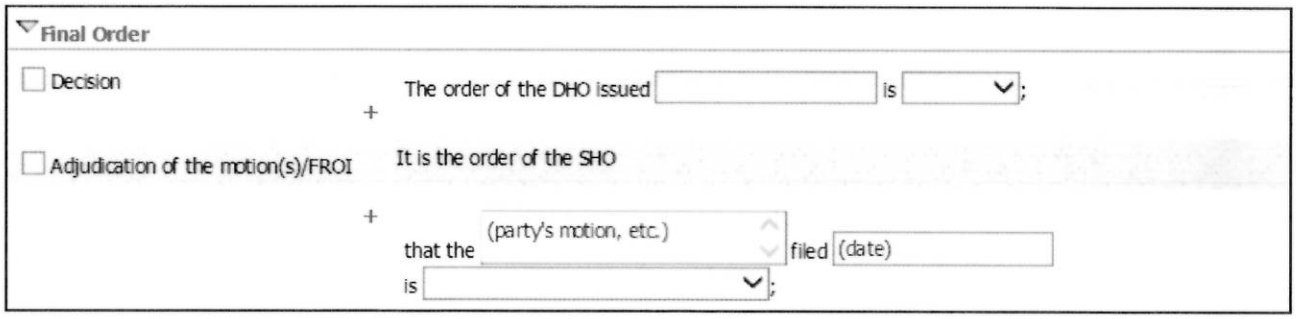
Staff Hearing Officer appeal hearings are de novo; a Staff Hearing Officer is not required to accept any of the findings or determinations of the District Hearing Officer.

Memo K2: Precise Order Writing

a. An issue or issues under review at any level of the hearing process will be addressed and considered independently on its merits. Hearing Officers will not use the terminology "deny and affirm" to deal with issues which come before them. Whether affirming, modifying or vacating a prior decision, the order shall address each issue and sub- issue raised at hearing. In all cases, even when affirming the prior decision, the order shall state the rationale and evidence which was relied upon.

b. Hearing Officers are not to "cut and paste" language from underlying orders into their final orders. Should a Hearing Officer wish to adopt or incorporate language from the underlying order, he or she should paraphrase the language or use similar language in his or her decision. If the concepts and thoughts in the underlying order are superb, a Hearing Officer can make those ideas his or her own by rewriting the order in his or her own words.

C. Case Manager Worksheet (very basic)



II. C-92 APPLICATION RECONSIDERATIONS

A. Jurisdiction

Applications for reconsideration of a District Hearing Officer order on permanent partial disability must be filed within **ten days** of receipt of the District Hearing Officer order.

1. The Supreme Court has held that the Industrial Commission has no authority to award an injured worker permanent-partial-disability compensation when the worker has been previously found to be permanently totally disabled in the same claim, even when the new finding is based on a condition or conditions in the claim that formed no part of the basis for the prior finding of permanent total disability. *State ex rel. Ohio Presbyterian Retirement Servs., Inc. v. Indus. Comm.* 150 Ohio St.3d 102 (2016), 79 N.E.3d 522, 2016-Ohio-8024.

B. Evidence

Initial Applications: evidence may be submitted between the District Hearing Officer and Staff Hearing Officer hearings by either party.

Applications for increase (even based on newly allowed conditions): evidence may not be submitted after the District Hearing Officer hearing. The Staff Hearing Officer may only consider evidence that was filed before the District Hearing Officer hearing. See State ex rel. Grimm v. Indus. Comm., 10th Dist. Franklin No. 07AP-761, 2008-Ohio-1800; Ohio Adm.Code 4121-3-15(E)(3).

C. Appeals

C-92s are not subject to appeal, so the 14-day language should never be included.

Instead, the only option for further review is for the aggrieved party to file a request for reconsideration to the full Commission.

D. Case Manager Worksheet

For a final order on the merits, there are three umbrella options, like usual: affirm, modify, or vacate.

Under each decision, there are checkbox subcategories that will comprise your decision. The bottom field is your support where you can input physicians' names and report dates. The "+" button allows you to add more than one report.

Case Manager Worksheet for C-92 Reconsiderations (next page):

TAB
G

Stephen Feagins, MD, MBA, FACP

Vice President Medical Affairs, Mercy Health – East Market
Medical Informatics Officer, Mercy Health – Cincinnati Region
Medical Director, Hamilton County Public Health
Chair, CarePATH Formulary and Medicine Informatics Committees
Chair, Clermont County Opiate Task Force Treatment Committee

Other stuff…

In 2012, Dr. Feagins was voted "physician of the year" at Mercy Anderson. He was a 2014 finalist in the Cincinnati Business Courier "healthcare heroes" in community outreach. He writes a weekly Medical Staff Update that is widely read within Mercy Health and which was named a finalist for the American College of Physician communication award. He was named "volunteer of the year" by the Anderson Township chamber of commerce in 2015. He is medical director of the Mercy Care Clinics and team physician for Anderson and Turpin High Schools. He was twice awarded the Nagel PTA "friend of students" award. He is a member of the Hamilton County and Clermont County Opiate Task Forces.

Dr. Feagins earned his medical degree from the University of Tennessee, an MBA from the University of Memphis, and a B.S. in Chemical Engineering from the University of Tennessee. He ran track at the University of Tennessee and was a member of the 1983 national championship team. He holds a CAQ in Sports Medicine and certification in Critical Care Air Transport. He was honorably discharged from the U.S. Air Force with the rank of major in 2001. He served as chief of medicine at Wright Patterson Air Force Base, leading humanitarian missions to Bolivia and El Salvador. Dr. Feagins was head team physician for Wittenberg University 2001-2009. He is Board Certified in Internal Medicine and a Fellow of the American College of Physicians. He will be serving as assistant sideline physician for FC Cincinnati.

Dr. Feagins was a member of the team from Mercy Health who opened the hospital in Cotes-der-fer, Haiti, in March 2017. He leads the medicine informatics team that created the "clinical opiate withdrawal scale" and "amphetamine toxicity" ordersets. He has championed dental care and syringe exchanges in Clermont and Hamilton counties.