

IN THE SUPREME COURT OF OHIO

State of Ohio ex rel. Karen S. Jordan :
: :
Relator-Appellant : Case No. 07-1901
: :
v. : On Appeal From The
: Judgment Of The Tenth
Industrial Commission of Ohio, et al. : District Court Of Appeals
: Case No. 06AP-908
: :
Respondents-Appellees. :

BRIEF OF RELATOR-APPELLANT, KAREN S. JORDAN

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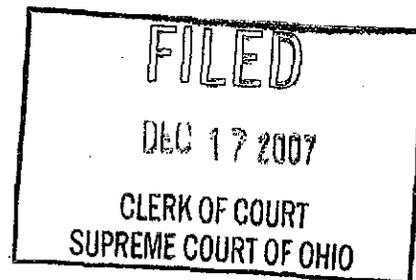


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R.C. 4123.66

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Art. II, Section 28 of the Ohio Constitution

Ohio Adm.Code 4123-6-21 (former version)

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STATEMENT OF FACTS

Relator-Appellant, Karen S. Jordan (Mrs. Jordan), was injured on June 28, 1984 while in the course of and arising out of her employment with Respondent, Buckeye Boxes, Inc. (the employer). See Supplement, pages 1, 7 (hereinafter, "S., p. x"). She filed a timely workers' compensation claim that was assigned claim number 84-37815. Id. To date, her claim has been allowed for the following conditions: derangement meniscus; right knee tear lateral meniscus; right knee and leg sprain; osteoarthritis right leg; major depressive disorder; osteomyelitis right leg; reflex sympathetic dystrophy/complex regional pain syndrome right lower extremity." (S., p. 1-2).

As the allowed conditions suggest, Mrs. Jordan's injury has been and continues to be severe. At all times relevant to this action, she was disabled and receiving temporary total disability compensation and she continues to receive such compensation at the time of the writing of this brief. (S., p. 3).

Mrs. Jordan has undergone extensive treatment for her right knee, including multiple arthroscopic surgeries and a total right knee replacement in June of 2004. (S., p. 7, 11-12). She had significant complications following her total right knee replacement and suffers from chronic pain as a result. (S., p. 13-15). In a letter dated January 7, 2005, Nelson Hendler, M.D. (Dr. Hendler), Mrs. Jordan's attending pain management specialist, submitted a report explaining the need for and function of the medications he was prescribing. (S., p. 16-17).

On January 18, 2005, the Ohio Bureau of Workers' Compensation (BWC) issued an order indicating that several of Mrs. Jordan's medications would no longer be reimbursed as of May 17, 2005. (S., p. 18). In response, Mrs. Jordan's treating physician, Francisco

Garabis, M.D. (Dr. Garabis), opined that the medications in question were necessary due to the allowed conditions in her workers' compensation claim and related right knee replacement surgery. (S., p. 19). Dr. Garabis warned that termination of the medications "would be detrimental to her medical care at this time." Id. Mrs. Jordan then filed a motion requesting that her medications remain covered. (S., p. 20).

On May 20, 2005, the BWC issued an order denying Mrs. Jordan's motion and refusing to pay for a number of medications. (S., p. 24). Mrs. Jordan appealed and a District Hearing Officer (DHO) of Respondent, Industrial Commission of Ohio (the commission), issued an order granting a general authorization for several types of medications. (S., p. 25). Mrs. Jordan appealed, requesting that the approved medications be explicitly enumerated by the commission. (S., p. 27). By order of a Staff Hearing Officer (SHO) of the commission dated August 18, 2005, the DHO order was modified "to specifically authorize the following medications, pursuant to [BWC] rules and regulation: Roxicodone; Soma; Sinequan; Klonopin; Lidoderm; Buspar." (S., p. 28).

At the time the SHO explicitly authorized Roxicodone, Soma, Sinequan, Klonopin, Lidoderm, and Buspar, the BWC deemed it proper to cover the cost of brand name medications under R.C. 4123.66 and Ohio Adm.Code 4123-6-21(F), if prior authorization were obtained. Mrs. Jordan obtained such prior authorization based on the August 18, 2005 SHO order.

Mrs. Jordan's pain problems continued and her physicians recommended ongoing, aggressive pain management. (S., p. 32-37). A BWC physician summarized Mrs. Jordan's condition as follows:

The factors preventing the injured worker from returning to work as a warehouse worker is the significant pain, medication and other medication

requirements and the continued symptom of pain. It prevents her from standing any length of time, o[r] doing repetitive upper and lower extremity work.

(S., p. 37).

On October 1, 2005, amendments to Ohio Adm.Code 4123-6-21 became effective. The amendments removed the provision that allowed for payment of brand name medications if prior authorization were obtained and specified that the cost of medications can never exceed the cost of a generic medication, if a generic exists. In apparent reliance on this change, the BWC, without prior notice to Mrs. Jordan, refused to pay the full cost of Roxicodone, Soma, Sinequan, Klonopin, Lidoderm, and Buspar, limiting payment to the cost of the generic forms of these medications.

The BWC's action caused Mrs. Jordan significant physical and financial hardship. Dr. Hendler documented Mrs. Jordan's intolerance to generic medications and requested that Mrs. Jordan have brand name medications only with her prescriptions dispensed as written. (S., p. 31). In addition, Mrs. Jordan obtained a report from her pharmacist setting forth the significant cost difference between the brand name and generic versions of her medications. (S., p. 30). Based on this information and the fact that the commission had previously granted payment for brand name medications, Mrs. Jordan filed a motion requesting that payment be made for Roxicodone, Soma, Sinequan, Klonopin, Lidoderm, and Buspar. (S., p. 38).

In an order dated March 14, 2006, the BWC denied Mrs. Jordan's motion, relying on the fact that Ohio Adm.Code 4123-6-21, as amended, did not cover any medications costs beyond the cost of generics. (S., p. 39-40). Mrs. Jordan filed a timely appeal. By DHO order dated April 28, 2006, the commission denied payment for brand name

medications based on Ohio Adm.Code 4123-6-21, as amended. (S., p. 41). Mrs. Jordan filed a timely appeal. (S., p. 43).

By SHO order dated May 31, 2007, the commission affirmed the BWC and DHO orders. (S., p. 44-45). The commission specifically found that Mrs. Jordan had obtained prior authorization for brand name medications prior to the October 1, 2005 effective date of the amendment to Ohio Adm.Code 4123-6-21. *Id.* The commission also found that the BWC refused to pay for brand name medications based on the amended version of the rule. *Id.* The commission noted that Mrs. Jordan “has medical evidence that she can not take generic medications” and that she “has presented evidence from the pharmacy she uses on how substantial the amount of the difference will be to her.” *Id.* Despite these findings, the commission still denied Mrs. Jordan’s motion, finding that the prior authorization of payment for brand name medications in the August 18, 2005 SHO order should be read to incorporate subsequent amendments to the BWC’s rules regarding payment of medications because “[i]t is reasonable to expect that rules will change from time to time.” *Id.*

Mrs. Jordan filed a timely appeal, but the commission refused to hear the matter for a third time by final order mailed on June 20, 2006. (S., p. 46). Because the commission abused its discretion by improperly applying the amended version of Ohio Adm.Code 4123-6-21 to her claim, Mrs. Jordan initiated an original action in mandamus in the Tenth District Court of Appeals. In a poorly reasoned decision, the appellate court upheld the commission’s order. See *State ex rel. Jordan v. Indus. Comm.*, 10th Dist. No. 06AP-908, 2007-Ohio-5157. Mrs. Jordan now appeals to this Court as of right.

ARGUMENT

Standard of Review

In order to prevail in a mandamus action, the relator must show a clear legal right to the relief sought and that the respondent has a clear legal duty to provide such relief. See *State ex rel. Pressley v. Indus. Comm.* (1967), 11 Ohio St.2d 141, paragraph 9 of the syllabus. To prevail in a workers' compensation mandamus action, the relator must show that the commission's decision constitutes an abuse of discretion. See *State ex rel. Pass v. CST Extraction Co.* (1996), 74 Ohio St.3d 373, 376.

Because the commission speaks only through its orders, mandamus review is limited solely to the evidence and reasoning set forth in the commission's order. See *State ex rel. Yellow Freight v. Indus. Comm.* (1994), 71 Ohio St.3d 139, 142. The commission is the ultimate arbiter of facts and the credibility of evidence. See *State ex rel. LTV Steel Co. v. Indus. Comm.* (2000), 88 Ohio St.3d 284, 287. Thus, courts may not disturb the commission's reasoning when it is supported by "some evidence." See *State ex rel. Eberhardt v. Flxible Corp.* (1994), 70 Ohio St.3d 649, 655. However, when the dispute involves the commission's interpretation of substantive law, the appellate court conducts a de novo review. See *State ex rel. Gen. Motors Corp. v. Indus. Comm.*, 10th Dist. No. 06AP-373, 2006-Ohio-6786, ¶ 17-18, citing *State ex rel. Zito v. Indus. Comm.* (1980), 64 Ohio St.2d 53, 55. The commission abuses its discretion when it errs as a matter of law. See *State ex rel. Morris v. Indus. Comm.* (1984), 14 Ohio St.3d 38, 40.

Proposition of Law

The Industrial Commission of Ohio abuses its discretion by applying Ohio Adm.Code 4123-6-21 retrospectively.

It is well-established law that payment for medical treatment in a workers' compensation claim is a substantive right that accrues at the time of the injury. See *Indus. Comm. v. Kamrath* (1928), 118 Ohio St. 1, paragraphs two and three of the syllabus, 3-4 ("the legal right imposed on the Commission to pay for medical expenses out of the state insurance fund is ... a substantive right which accrues at the time of the injury"); *State ex rel. Jeffrey v. Indus. Comm.* (1955), 164 Ohio St. 366, 367; *State ex rel. Brown v. Indus. Comm.* (1993), 68 Ohio St.3d 45, 46. It is also clear that statutes and administrative rules are presumed to apply prospectively unless expressly made retrospective. See R.C. 1.48; *Warren Cty. Bd. of Commrs. v. Lebanon* (1989), 43 Ohio St.3d 188, 189-190.

A statute or administrative rule is applied retrospectively when it is applied to a right that existed prior to the promulgation of the rule in question. See *Murphy v. Ohio Dept. of Highway Safety* (1984), 18 Ohio App.3d 99, 100. See also Black's Law Dictionary (6th Ed. 1991) 914, defining "retrospective law" as:

A law which looks backward or contemplates the past; one which is made to affect acts or facts occurring, or rights accruing, before it came into force. Every statute which takes away or impairs vested rights acquired under existing laws, or creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past. One that relates back to a previous transaction and gives it a different legal effect from that which it had under the law when it occurred.

Accord, *Van Fossen v. Babcock & Wilcox Co.* (1988), 36 Ohio St.3d 100, 104:

Ordinarily, laws are enacted to regulate future conduct and are, in that respect, reasonable legislative acts. The difficulty arises when such

legislation attempts to regulate or prohibit that which has already occurred, since the General Assembly may not constitutionally impose a new standard upon past conduct.

The issue of whether a law applies retrospectively should not be confused with the issue of whether it can be applied retroactively from a constitutional perspective. See *id.* The issue of whether a law offends Art. II, Section 28 of the Ohio Constitution entails an analysis as to whether the law affects substantive rights or merely procedural/remedial rights. See *Van Fossen*, 36 Ohio St.3d at 106. However, as this Court has repeatedly held, the issue of constitutional retroactivity (substantive versus remedial rights) should not be reached unless the law complies with R.C. 1.48 and explicitly indicates that it is to be applied retrospectively (to rights that existed prior to the effective date of the new law). See *id.*, paragraph one of the syllabus; *Warren Cty. Bd. of Commrs.*, 43 Ohio St.3d at 189; *Kinser v. Coleman* (1986), 28 Ohio St.3d 259, 262 (silence on the issue of retrospective application fails to meet the requirement of a clearly expressed intent); *State ex rel. Kilbane v. Indus. Comm.* (2001), 91 Ohio St.3d 258, 259.

Mrs. Jordan was injured in 1984. At the time of her injury, the workers' compensation system did not limit the amount of payment for brand name medications. The only laws in effect at that time regarding medications were R.C. 4123.54 and former R.C. 4123.66. R.C. 4123.54 stated that employees who are injured in the course of and arising out of their employment are entitled to receive "the medical, nurse, and hospital services and medicines ... as are provided by this chapter." R.C. 4123.66 vested the commission¹ with the power to pay for medications "as it deems proper."

¹ The current version of the statute refers to the Administrator of the BWC instead of the commission with respect to payment for medicines.

In 1997, the BWC promulgated Ohio Adm.Code 4123-6-21. Under that rule, injured workers were responsible for the difference in cost between brand name medications and their generic equivalents unless prior authorization were obtained for the brand name medication. See former Ohio Adm.Code 4123-6-21(F). Thus, the BWC deemed it proper to pay for brand name medications if prior authorization were obtained.

Effective October 1, 2005, Ohio Adm.Code 4123-6-21 was amended. The amendment eliminated the prior authorization provision of Ohio Adm.Code 4123-6-21(F) and created Ohio Adm.Code 4123-6-21(I). The new provision states that the BWC will not pay more than the cost of the generic drug for any medication. In effect, the amendment eliminated payment for brand name medications if a generic form of the medication exists. Significantly, nothing in Ohio Adm.Code 4123-6-21(I) mentions retrospective application. The rule is silent on that issue.

Mrs. Jordan has a substantive right to payment for medications in her claim and that substantive right is based on the law in effect at the time of her injury. See *Kamrath*, 118 Ohio St. at 4; *Jeffrey*, 164 Ohio St. at 367; *Brown*, 68 Ohio St.3d at 46. Moreover, Mrs. Jordan sought and obtained prior authorization for brand name medications prior to the October 1, 2005 effective date of Ohio Adm.Code 4123-6-21(I). S., p. 28. The commission and the court of appeals conceded this fact in their decisions. See *Jordan*, at ¶ 4; S., p. 44. Thus, under any reasonable analysis, it is clear that Mrs. Jordan had established the right to payment for brand name medications prior to October 1, 2005.

After the creation of Ohio Adm.Code 4123-6-21(I), the BWC stopped paying for Mrs. Jordan's brand name medications and limited its payment to the cost of the associated generics. S., p. 44. The BWC's action clearly shows that it applied Ohio

Adm.Code 4123-6-21(I) retrospectively to Mrs. Jordan's claim. See *Murphy*, 18 Ohio App.3d at 100; Black's Law Dictionary (6th Ed. 1991) 914; *Van Fossen*, 36 Ohio St.3d at 104. Indeed, prior to October 1, 2005, the BWC paid for Mrs. Jordan's brand name medications; after that date, it did not. The application of the new rule to Mrs. Jordan's prior right prompted Mrs. Jordan's physician and pharmacist to document the medical and financial impact of this change and the commission noted these concerns in its decision. S., p. 30-31; 44-45. Because the promulgation of Ohio Adm.Code 4123-6-21(I) eliminated payment for brand name medications and the rule was applied to Mrs. Jordan's previously established right to such payment, it is obvious that the BWC applied the rule retrospectively to Mrs. Jordan's claim.

As this Court has made clear, an administrative rule can be applied retrospectively only if it explicitly provides for such application. See *Warren Cty. Bd. of Commrs.*, 43 Ohio St.3d at 189; R.C. 1.48. As a matter of law, the R.C. 1.48 analysis must be conducted first. See *id.* It is error to reach the question of constitutional retroactivity (substantive versus remedial rights) unless the rule expressly states that it is intended to apply retrospectively. See *id.*

In this case, Ohio Adm.Code 4123-6-21(I) is silent with respect to retrospective application. Accordingly, it fails to satisfy the R.C. 1.48 test and can be applied prospectively only. See *Kinser*, 28 Ohio St.3d at 262; *Kilbane*, 91 Ohio St.3d at 259. Thus, the application of Ohio Adm.Code 4123-6-21(I) to a claim that arose prior to October 1, 2005 is improper as a matter of law.

In its decision, the commission failed to follow the law. Instead of complying with the mandate of R.C. 1.48 and controlling authority from this Court, the commission

held that Mrs. Jordan should have expected the law regarding payment of her medications to change because the BWC, under R.C. 4123.66, has the right to pay for medications as it deems proper. S., p. 45. The fact that the BWC has the right to pay for medications as it deems proper does not trump the requirement of R.C. 1.48. Prior to October 1, 2005, the BWC obviously deemed it proper to pay for brand name medications because Mrs. Jordan established that right, a fact the commission conceded. S., p. 44. However, the commission failed to explain why the change effected by Ohio Adm.Code 4123-6-21(I) should be exempt from the R.C. 1.48. Just because the BWC deems it proper to eliminate payment for brand name medications does not mean it can apply such a change retrospectively. In order to do so, Ohio Adm.Code 4123-6-21(I) would have to explicitly provide for such application. The fact that the rule is silent on this issue prohibits it from being applied retrospectively. See *Kinser*, 28 Ohio St.3d at 262; *Kilbane*, 91 Ohio St.3d at 259.

Under the commission's logic, the BWC can change any rule with respect to payment of medications at any time simply because it deems such change to be proper. Injured workers are expected to accept such changes regardless of previously established rights. The commission's position is contrary to Ohio law as well as basic fairness. R.C. 1.48 and this Court's precedent cannot be ignored., yet that is precisely what the commission did in this case. Such action constitutes an abuse of discretion and the requested writ of mandamus must be issued.

Like the commission, the court of appeals erred in a number of respects. First, the court below was unable to correctly frame the issue before it. In paragraph one of its decision, the court stated that Mrs. Jordan is requesting the issuance of a writ ordering the

commission to authorize “brand name medications at a cost to her no greater than if she were receiving generic equivalents.” With due respect, that is not the relief that Mrs. Jordan is seeking. Instead, she is requesting that her brand name medications be covered as they were prior to October 1, 2005.

Second, in paragraph eight of its decision, the court confused the concept of retrospective application with the constitutional issue of retroactivity. The court stated that a statute is retroactive if it takes away or impairs vested rights, etc. However, the issue of vested or substantive rights is relevant only if the constitutional question is reached. As this Court has repeatedly held, it is error to reach the constitutional question if the rule fails to expressly provide for retrospective application. See *Van Fossen*, 36 Ohio St.3d at paragraph one of the syllabus; *Warren Cty. Bd. of Commrs.*, 43 Ohio St.3d at 189. The court of appeals erred as a matter of law by skipping the R.C. 1.48 test and jumping to the constitutional issue.

Third, the court of appeals held that Mrs. Jordan did not have a vested right to payment for brand name medications because there was no right to such payment in 1984. The flaw in this argument is that the law in 1984 did not prohibit such payments either. In 1984, R.C. 4123.54 provided broad coverage for medicines in the event of industrial injury. While it is true that the statute did not explicitly indicate that brand name drugs were covered, there is nothing to suggest that they were not. The court’s willingness to read coverage for brand name medications out of R.C. 4123.54 conflicts with the statutory mandate of liberal construction under R.C. 4123.95. Moreover, the 1997 promulgation of former Ohio Adm.Code 4123-6-21(F) clearly shows that the BWC deemed it proper to pay for brand name medications if prior authorization were obtained.

In paragraph four of its decision, the court conceded that Mrs. Jordan obtained such authorization. This concession conflicts with the court's subsequent finding that Mrs. Jordan failed to show a vested right to payment for brand name medications. It makes no sense to find that Mrs. Jordan established the right to payment for brand name medications and then in the next breath find that she did not. The court of appeals' decision is erroneous as a matter of law and common sense.

Finally, it should be noted that the court of appeals decided a similar issue shortly after its decision in Mrs. Jordan's case. See *State ex rel. Noble v. Indus. Comm.*, 10th Dist. No. 06AP-1090, 2007-Ohio-6497. In *Noble*, the court made the same errors as in the instant action by skipping the R.C. 1.48 test and confusing retrospective application with constitutional retroactivity. However, the *Noble* court also noted the following:

Claimant is not being denied payment for medications. Rather, he is entitled to payment for the necessary medications prescribed by his physician but in generic rather than brand name form. Although the physician refers to some reactions to drugs, no evidence was presented showing that the generic equivalents to the drugs in question work any differently or fail to achieve the same results for claimant as the brand name drugs. Absent such evidence proving a need for brand name drugs for health and/or therapeutic effect, there is no basis for determining that claimant has been denied a vested right to medication.

See *Noble*, at ¶ 9. This language is significant because it implies that if Mr. Noble had evidence from his physician regarding the need for brand name medications, he would have established a vested right to payment for brand name medications. While this reasoning makes no sense, it is crucial to note that Mrs. Jordan presented the exact sort of evidence discussed in *Noble*. In fact, the commission noted the reports from Mrs. Jordan's physician and pharmacist regarding her need for brand name medications, but denied coverage for brand name medications anyway because "[i]t is reasonable to expect

that rules will change from time to time.” (S., p. 44-45). If medical proof of a need for brand name medications establishes a vested right to payment for such medications, then Mrs. Jordan satisfied that test. Therefore, court of appeals decision in this case conflicts with the result in *Noble*.

For all of the foregoing reasons, Mrs. Jordan respectfully urges this Court to grant the requested writ of mandamus. The decisions of the commission and court of appeals must be vacated and a new order issued which complies with Ohio law.

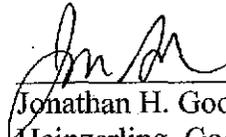
CONCLUSION

Mrs. Jordan has suffered from her industrial injury for over two decades. There is no medical dispute as to the seriousness of her ailments. Because of her intolerance to generic medications, she obtained authorization for brand name medications prior to the effective date of Ohio Adm.Code 4123-6-21(I). After the effective date of that rule, the BWC applied the new rule to Mrs. Jordan’s previously established right and refused to pay for brand name medications. The retrospective application of Ohio Adm.Code 4123-6-21(I) is contrary to R.C. 1.48 and this Court’s precedent because the rule fails to expressly provide for retrospective application.

The commission and the court of appeals erred as a matter of law by failing to follow R.C. 1.48 and this Court’s jurisprudence with respect to the retrospective application of laws. According to the commission and the court of appeals, the BWC has carte blanche to alter its coverage of medication under R.C. 4123.66 and claimants simply have to live with the changes regardless of previously established rights. Such an outcome is repugnant to R.C. 1.48 and basic fairness.

The commission abused its discretion by applying Ohio Adm.Code 4123-6-21(I) to Mrs. Jordan's claim. A writ of mandamus must be issued to correct the error and restore Mrs. Jordan's previously established right to payment for brand name medications.

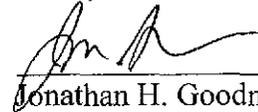
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CERTIFICATE OF SERVICE

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APPENDIX

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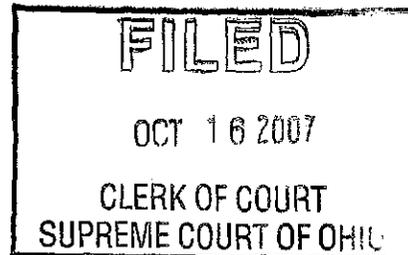
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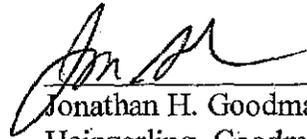


NOTICE OF APPEAL OF RELATOR-APPELLANT, KAREN JORDAN

Now comes Relator-Appellant Karen Jordan and hereby gives notice that she appeals from the judgment of the Franklin County Court of Appeals, Tenth Appellate District, in *State ex rel. Jordan v Indus. Comm.*, 10th Dist. No. 06AP-908, 2007-Ohio-5157. The date of the judgment entry of the Tenth District Court of Appeals is

September 28, 2007. This case involves an appeal as of right because the decision below was an action that originated in the court of appeals. A date-stamped copy of the judgment entry of the Tenth District Court of Appeals is attached hereto.

Respectfully submitted,

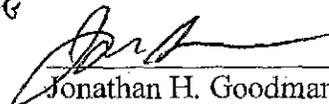


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Counsel for Relator-Appellant,
Karen Jordan

CERIFICATE OF SERVICE

The undersigned certifies that a true copy of the foregoing Notice of Appeal was served upon Stephen Plymale, Esq., Assistant Attorney General, Workers' Compensation Section, 150 East Gay Street, 22nd Floor, Columbus, Ohio 43215, and Christopher C. Russell, Esq., Porter, Wright, Morris & Arthur, 41 South High Street, Columbus, Ohio 43215, by regular U.S. Mail on this 15th day of October 2007.

6 JHG



Jonathan H. Goodman

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CLERK OF COURTS

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

State of Ohio ex rel. Karen S. Jordan, :

Relator, :

v. :

No. 06AP-908

Industrial Commission of Ohio
and Buckeye Boxes, Inc., :

(REGULAR CALENDAR)

Respondents. :

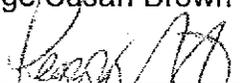
JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on September 28, 2007, the objections to the decision of the magistrate are sustained in part and overruled in part. This court adopts the magistrate's findings of fact, and the magistrate's recommendation that the writ be denied, however, we disagree with the magistrate's conclusions of law. Therefore, it is the judgment and order of this court that the requested writ of mandamus is denied. Costs are assessed against relator.

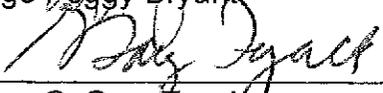
Within three (3) days from the filing hereof, the clerk of this court is hereby ordered to serve upon all parties not in default for failure to appear, notice of this judgment and its date of entry upon the journal.



Judge Susan Brown



Judge Peggy Bryant



Judge G. Gary Tyack

ON COMPUTER 12

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CLERK OF COURTS

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

State of Ohio ex rel. Karen S. Jordan, :

Relator, :

v. :

No. 06AP-908

Industrial Commission of Ohio :
and Buckeye Boxes, Inc., :

(REGULAR CALENDAR)

Respondents. :

D E C I S I O N

Rendered on September 28, 2007

*Heinzerling & Goodman, LLC, and Jonathan H. Goodman, for
relator.*

*Marc Dann, Attorney General, and Stephen D. Plymale, for
respondent Industrial Commission of Ohio.*

IN MANDAMUS
ON OBJECTIONS TO THE MAGISTRATE'S DECISION

BROWN, J.

{¶1} Relator, Karen S. Jordan, has filed an original action requesting that this court issue a writ of mandamus ordering respondent, Industrial Commission of Ohio ("commission"), to authorize her to receive brand name medications at a cost to her no greater than if she were receiving generic equivalents for the brand name medications.

{¶2} This matter was referred to a magistrate of this court pursuant to Civ.R. 53(C) and Loc. R. 12(M) of the Tenth District Court of Appeals. On February 6, 2007, the magistrate issued a decision, including findings of fact and conclusions of law, recommending that this court deny relator's request for a writ of mandamus. (Attached as Appendix A.)

{¶3} Relator has filed objections to the magistrate's decision, arguing that the magistrate erred in: (1) finding no evidence that relator requested or obtained authorization for brand name medications prior to the effective date of Ohio Adm.Code 4123-6-21(I); (2) finding that the statutory constitutional issue need not be reached; and (3) failing to apply the proper legal test in adjudicating relator's claims under R.C. 1.48 and Section 28, Article II, Ohio Constitution.

{¶4} At the outset, the commission concedes that the magistrate erred in determining, under the conclusions of law, that relator "has not presented evidence that she did, in fact, request and receive prior authorization for brand-name medications." (Magistrate's Decision, at ¶38.)

{¶5} The commission argues, however, that the magistrate did not err in denying the requested writ because relator has not shown an unqualified or absolute right to receive brand name medications. We agree.

{¶6} Relator's primary contention before the magistrate was that the commission abused its discretion by retroactively applying Ohio Adm.Code 4123-6-21(I) to a 1984 claim in violation of Section 28, Article II, Ohio Constitution. More specifically, relator argued that, in 1984, at the time of her injury, the law governing medications in the workers' compensation system did not prohibit reimbursement of brand name

medications. Relator argued that the promulgation of Ohio Adm.Code 4123-6-21(l), effective October 1, 2005, which essentially sets a "maximum allowable cost" for brand name drugs (i.e., making a claimant responsible for the difference in cost between a brand name and the maximum allowable cost), constituted a substantive change in the law which could not be retroactively applied to her. We find no merit to this argument.

{¶7} At the time of relator's injury, R.C. 4123.66 provided in part: [T]he industrial commission shall disburse and pay from the state insurance fund such amounts for * * * medicine as it deems proper[.] * * * The commission may adopt rules with respect to furnishing * * * medicine to injured or disabled employees entitled thereto, and for the payment therefor." In interpreting this statute, this court has previously held that such statute does "not contemplate full recovery of all pecuniary losses," and that the statute "gives the commission discretion not only to determine causal relationship, value and similar questions, but also to determine the total amount of medical award to be made for all medical services." (Emphasis sic.) *Luft v. Young* (1961), 114 Ohio App. 73, 75

{¶8} Under Ohio law, a statute is retroactive if it "takes away or impairs vested rights acquired under existing laws, or creates a new obligation, imposes a new duty, or attaches a new disability, in respect to transactions or considerations already past[.]" *Van Fossen v. Babcock & Wilcox Co.* (1988), 36 Ohio St.3d 100, 106, citing *Cincinnati v. Seanson* (1889), 46 Ohio St. 296, 303.

{¶9} Here, relator has not shown a vested right to reimbursement for brand name drugs. At the time of relator's injury, in 1984, there was no statutory right to any particular reimbursement amount for medicine; rather, the statutory scheme under R.C. 4123.66 vested the commission with discretion to pay amounts for medicine as "deem[ed]

proper," and to promulgate rules with respect to such payment. Therefore, despite relator's contention that the magistrate erred in failing to reach the statutory/constitutional argument, we reject relator's retroactivity claim, as relator has failed to show that the commission improperly applied Ohio Adm.Code 4123-6-21(I) to her 1984 claim.

{¶10} Accordingly, while we adopt the magistrate's findings of fact, and the magistrate's recommendation that the writ be denied, we disagree with the magistrate's conclusions of law. Based upon the foregoing, we sustain in part relator's first objection, but overrule relator's second and third objections, and deny relator's request for a writ of mandamus.

*Objections sustained in part and overruled in part;
writ denied.*

BRYANT and TYACK, JJ., concur.

APPENDIX A

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

State of Ohio ex rel. Karen S. Jordan,	:	
	:	
Relator,	:	
	:	
v.	:	No. 06AP-908
	:	
Industrial Commission of Ohio	:	(REGULAR CALENDAR)
and Buckeye Boxes, Inc.,	:	
	:	
Respondents.	:	

NUNC PRO TUNC
MAGISTRATE'S DECISION

Rendered on February 6, 2007

Heinzerling & Goodman, LLC, and Jonathan H. Goodman, for relator.

Marc Dann, Attorney General, and Elise Porter, for respondent Industrial Commission of Ohio.

IN MANDAMUS

{¶11} Relator, Karen S. Jordan, has filed this original action requesting that this court issue a writ of mandamus ordering respondent Industrial Commission of Ohio ("commission") to authorize her to receive brand-name medications at a cost to relator which would be no greater if relator was receiving generic equivalents for those brand-

name medications. Relator contends that, pursuant to the doctrine of res judicata, the commission is required to permit her to receive that medication at no greater cost than if she was receiving generic equivalents and that any increase in the cost of brand-name medications cannot be passed on to her, because to do so, constitutes a retroactive application of the law which denies her a substantive right.

Findings of Fact:

{¶12} 1. Relator sustained a work-related injury on June 28, 1984, and her claim has been allowed for the following conditions: "derangement meniscus; right knee tear lateral meniscus; right knee and leg sprain; right osteoarthritis leg; major depressive disorder; right osteomyelitis leg; reflex sympathetic dystrophy/complex regional pain syndrome right lower extremity."

{¶13} 2. Relator has had several surgeries, including a total right knee replacement surgery in 2004. Relator has also received extensive periods of disability compensation.

{¶14} 3. In January 2005, approximately seven months following her right total knee replacement surgery, the Ohio Bureau of Workers' Compensation ("BWC") referred relator's file to L. J. Mascarennas, M.D., to review relator's use of prescription medication. Ultimately, Dr. Mascarennas concluded as follows:

Claimant is a 47-year-old female who struck her knee on a wooden skid. She was initially diagnosed with sprain of the Rt. knee and later with a tear of her lateral meniscus. Claimant underwent three arthroscopic procedures and eventually on 6/10/04 underwent a Rt. TKA performed by Dr. Fada. Claimant was admitted to Grant Medical Center on 11/12/04 because of possible osteomyelitis of the Rt. knee; however, it was proved that this was not the case. Claimant has been treated by Dr. Hendler in Maryland since 2002.

It is my medical opinion that this claimant's current symptomatology regarding her knee pain is reasonable[y] related to the allowed conditions in this claim. However, it has been over six months since her TKA. It is my recommendation that narcotic analgesics be tapered and discontinued over a period of 4 months. The use of muscle relaxants and NSAIDs are appropriate. The recent use of antibiotics for possible osteomyelitis is also appropriate. The use of anti-convulsants and Lidoderm are not warranted. The claimant does not have a psych allowance; therefore, the use of anti-anxiety medications and antidepressants are not indicated.

(Emphasis sic.)

{¶15} 4. By letter mailed January 18, 2005, relator was notified of the following:

As a result of the BWC's recent file review of all medical documentation in your claim, the following decisions have been made regarding reimbursement of on-going prescription medication-

[One] NARCOTIC ANALGESICS will no longer be reimbursed effective 5-17-2005 – this is to allow for a 4 month tapering period. ANTI-ANXIETY DRUGS, ANTICONVULSANTS, TOPICAL LOCAL ANESTHETICS and TRICYCLIC ANTIDEPRESSANT RELATED will no longer be reimbursed effective 1-17-2005. The treating physician has not provided any medical documentation to support the use of these medications in the treatment of the allowed conditions of this claim.

[Two] GLUCORTICOIDS, NSAIDS, QUINOLONONES and SKELETAL MUSCLE RELAXANTS were found warranted and will continue to be reimbursed.

Should the injured worker or employer or their representative disagree with this decision, they may file a Motion (Form C-86) with BWC. Any new evidence they wish to have reviewed should be included with the Motion. The evidence BWC considered in making this decision is available upon request.

(Emphasis sic.)

{¶16} 5. In response thereto, Francisco A. Garabis, M.D., one of relator's treating physicians, authored a letter dated March 12, 2005. Dr. Garabis stated:

* * * There is no doubt that she does have chronic pain syndrome that requires narcotic pain medications. These medications are necessary due to the allowed conditions (including osteoarthritis) and the total right knee replacement that was covered under this claim.

{¶17} 6. Thereafter, relator filed a C-86 motion requesting that "payment of her medications remain covered under [her] claim," and she submitted the March 12, 2005 report of Dr. Garabis as well as records related to her 2004 right knee replacement surgery.

{¶18} 7. A separate physician review was obtained from S. R. Dange, M.D., dated May 18, 2005. Dr. Dange outlined relator's treatment as well as her medications. Dr. Dange specifically noted that Dr. Garabis recommended narcotic medications for the nonallowed conditions, chronic pain syndrome, and ultimately concluded that the medical evidence in the file does not support the reinstatement of the medications for which reimbursement has been terminated.

{¶19} 8. By letter mailed May 20, 2005, the BWC rendered the following decision:

C86 Motion filed 4/6/05 where injured worker requested that medications denied per BWC Denial Order 1/18/05 be covered under this claim, is DENIED.

Terminated classifications of medications are as follows, Narcotic Analgesics, Anti-Anxiety Agents, Anticonvulsants, Topical Local Anesthetics, and Tricyclic Antidepressants.

This decision is based on:

[One] BWC Physician Medication Review on 5/18/05, where S.R. Dange MD opined the medical evidence does no [sic]

support the reinstatement of the medications for which the reimbursement has been previously terminated.

[Two] BWC Rules and Guidelines.

(Emphasis sic.)

{¶20} 9. Relator appealed and the matter was heard before a district hearing officer ("DHO") on June 24, 2005. The DHO determined that "the narcotic analgesics, muscle relaxants and topical local anesthetics prescribed by Dr. Hendler are to be paid for in this claim."

{¶21} 10. Because the DHO did not specifically list the medications which Dr. Hendler was prescribing, relator appealed for the following reasons:

* * * [T]o ensure that the approved medications are listed in the order. Ms. Jordan has experienced significant problems getting her prescriptions filled and an order that explicitly enumerates the approved medications would be very helpful.

{¶22} 11. The appeal was heard before a staff hearing officer ("SHO") on August 18, 2005. The SHO affirmed the prior DHO order yet modified it "to specifically authorize the following medications, pursuant to Bureau of Workers' Compensation rules and regulation[s]: Roxicodone; Soma; Sinequan; Klonopin; Lidoderm; Buspar."

{¶23} 12. On October 1, 2005, a new version of Ohio Adm.Code 4123-6-21 became effective. For purposes of this mandamus action, only one change is truly significant. Prior to October 1, 2005, subsection (F) had provided as follows:

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 which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau

established percentage of the dispensed brand name drug, *if prior authorization for the brand name drug is not obtained by the prescriber.*

(Emphasis added.)

{¶24} Effective October 1, 2005, subsection (F) was renumbered as subsection (I)

and now provides as follows:

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 which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug.

{¶25} 13. On February 6, 2006, relator filed the following C-86 motion:

Claimant, through counsel, requests that she be authorized to receive the following name-brand medications: Soma; Sinequan; Klonopin; Buspar; Cipro; and Roxicodone. These medications were previously authorized in this claim by SHO order dated 8/18/2005. However, the BWC refuses to pay for these name-brand drugs pursuant to its new prescription medication "policy." According to the BWC, specific name-brand drugs can be authorized only if they are ordered paid by the Industrial Commission based upon proof from the treating physician that the claimant is unable to take generic drugs.

Relator attached a copy of the August 18, 2005 SHO order which listed her medications, a December 19, 2005 report of Dr. Hendler indicating that relator claims that she cannot tolerate generic drugs because she gets an allergic reaction to them, and requesting that she have nothing but brand-name drugs. Relator also included a letter from her pharmacist which noted the estimated cost difference between the brand-name and generic drugs which relator was receiving.

{¶26} 14. By order mailed March 14, 2006, the BWC denied relator's request for full reimbursement for "Soma, Sinequan, Klonopin, Buspar, Cipro and Roxicodone brand name drug[s]," for the following reasons:

Reimbursement for all outpatient drugs are limited to the amount allowed by BWC's fee schedule. You are responsible for the total difference in cost between the brand name drug and the amount allowed for it by BWC's fee schedule if your physician designates that you receive or you choose to receive this brand name drug instead of its generic equivalent.

If you do not wish to pay the total difference in cost, other options available to you are to have your prescribing physician agree either to have a generic drug dispensed or to prescribe a different drug for you.

This decision is based on:

Ohio Administrative Code (OAC) 4123-6-21(I), which states that the Bureau of Workers' Compensation (BWC) does not reimburse in full for any brand name drug when an equivalent generic drug is available. An equivalent generic drug is available for the requested brand name drug.

{¶27} 15. Relator's appeal was heard before a DHO on April 28, 2006 and resulted in an order modifying the prior BWC order, yet denying relator the rate of reimbursement which she was requesting as follows:

It is the finding of the District Hearing Officer that the injured worker's [sic] requesting reimbursement for the prescriptions Soma, Sinequan, Klonopin, Buspar, Cipro, and Oxycodone.

The District Hearing Officer finds that we [sic] reimbursement for these prescriptions is limited to the amount of generic equivalent. The injured worker is responsible for the total difference in cost between the brand name drug and the amount allowed for it by the Bureau of Workers' Compensation's fee schedule. O.A.C. 4123-6-21(I) states that only generic prescriptions will be reimbursed in full unless a generic equivalent is not available.

Therefore, the injured worker's request to have the brand name prescriptions for Soma, Sinequan, Klonopin, Buspar, Cipro, and Oxycodone approved is denied.

This order is based [on] O.A.C. 4123.6-21(l) [sic].

{¶28} 16. Relator appealed the matter to an SHO who, by order dated May 31, 2006, upheld the prior DHO order as follows:

A Staff Hearing Officer order, dated 08/18/2005, authorized 5 prescription medications "pursuant to Bureau of Workers' Compensation rules and regulation." The injured worker has medical evidence that she can not take generic medications. Under O.A.C. 4123-6-21 a brand name prescription medication could be paid by the Bureau of Workers' Compensation if prior authorization was obtained. The injured worker initially received prior authorization and obtained the brand name medications. A change was made in O.A.C. 4123-6-21 that only allowed Bureau of Workers' Compensation payment of the generic amount. If an injured worker still desired the brand name medication, he or she would have to pay the difference. The effective date of the change in O.A.C. 4123-6-21 was 10/01/2005.

The Bureau of Workers' Compensation refused to pay the brand name amount and the injured worker filed a C-86 motion for the full payment of the brand name medications on 03/14/2006. The motion was denied by an Administrator's order of 03/14/2006. The Administrator's order was modified by a 04/28/2006 District Hearing Officer order, but in substance, the request for payment of the amount of the brand name medications was still denied.

The injured worker, through counsel, argues that such denial was improper and that the law in effect in 1984, the year of the date of injury, should govern. The injured worker, also, argues that this amounts to a substantive change in the law. The injured worker has presented evidence from the pharmacy she uses on how substantial the amount of the difference will be to her.

The Staff Hearing Officer, here finds the District Hearing Officer order to be correct in its holding. O.R.C. 4123.66 gives the Administrator of the Bureau of Workers' Compensation

authority to pay such bills. It, also, gives the Administrator power to adopt rules, with the advise [sic] and consent of the Workers' Compensation Oversight Commission. It is reasonable to expect that rules will change from time to time. The Staff Hearing Officer order of 08/18/2005 did not refer to specific wording in a rule. It simply authorized the medications "pursuant to Bureau of Workers' Compensation rules and regulations." The Staff Hearing Officer, here, finds that such general language would incorporate change, if any, in rules or regulations rather than be limited to specific language. Further, O.R.C. 4123.66 seems broad in its scope as to the Administrator's authority dealing with enactments of rules and regulations.

{¶29} 17. Thereafter, relator filed the instant mandamus action in this court.

Conclusions of Law:

{¶30} In this mandamus action, relator makes two arguments. First, relator contends that the commission's August 18, 2005 order wherein the SHO authorized that she receive Roxicodone, Soma, Sinequan, Klonopin, Lidoderm and Buspar is a final order and that, pursuant to the doctrine of res judicata, the commission is required to order the BWC to reimburse relator fully for those brand-name medications. Second, relator contends that the change in the Ohio Administrative Code, whereby it is now provided that claimants will be reimbursed only the amount of generic equivalents even if they desire or if their treating physician requests that they receive brand-name medications, cannot be applied to her because, as she argues, she previously received full reimbursement for the brand-name medications. Relator contends that any change in the reimbursement schedule constitutes a substantive change in the law which cannot be retroactively applied to her. For the reasons that follow, it is this magistrate's decision that relator's request for a writ of mandamus should be denied.

{¶31} The Supreme Court of Ohio has set forth three requirements which must be met in establishing a right to a writ of mandamus: (1) that relator has a clear legal right to the relief prayed for; (2) that respondent is under a clear legal duty to perform the act requested; and (3) that relator has no plain and adequate remedy in the ordinary course of the law. *State ex rel. Berger v. McMonagle* (1983), 6 Ohio St.3d 28.

{¶32} In her first argument, relator contends that the doctrine of res judicata requires that the commission order the BWC to continue to fully reimburse her for the brand-name medications in the same manner in which she asserts the BWC had been previously reimbursing her. Relator asserts that the August 18, 2005 SHO order requires the BWC to do so. As noted in the findings of fact, following the June 24, 2005 DHO order finding that relator should still receive the narcotic analgesics, muscle relaxants and topical local anesthetics prescribed by Dr. Hendler, relator appealed because the DHO order did not specifically list those medications. As such, in the commission's August 18, 2005 order, the SHO ordered the following: "[T]o specifically authorize the following medications, pursuant to Bureau of Workers' Compensation rules and regulation: Roxicodone; Soma; Sinequan; Klonopin; Lidoderm; Buspar."

{¶33} Contrary to relator's arguments, the SHO order did not provide that she would be reimbursed at any specific rate, nor did the order provide that she would actually receive the brand-name medications. Instead, as noted previously, pursuant to a file review, the BWC had informed relator that it was going to stop reimbursing her for specific medications beginning May 17, 2005, on grounds that her treating physician had not provided any medical documentation to support her use of those medications in the treatment of her allowed conditions. Ultimately, the commission determined that relator

should still receive those medications. However, contrary to relator's assertions, the SHO order did not compel the BWC to reimburse relator in a specific manner nor did that order specifically authorize that only brand-name medications would be dispensed, and relator's argument that the doctrine of res judicata somehow applies is not well-taken.

{¶34} Relator also contends that her right to specific reimbursement is a substantive right and that the commission and BWC are required by law to reimburse her in 2006 in the same manner in which she was reimbursed, or would have been reimbursed, as of the date of her injury in 1984. For the reasons that follow, the magistrate disagrees with relator's argument.

{¶35} Relator is correct when she states that compensation and benefits payable in a workers' compensation claim are governed by the law in effect on the date of the claimant's injury. See, e.g., *State ex rel. Brown v. Indus. Comm.* (1993), 68 Ohio St.3d 45. It is further understood that a statute or administrative rule cannot be applied retroactively if the application impairs a substantive right. See, Article II, Section 28, Ohio Constitution. Or, as the Supreme Court of Ohio stated in *State ex rel. Kilbane v. Indus. Comm.* (2001), 91 Ohio St.3d 258, 259:

* * * [E]ntitlement to workers' compensation, being a substantive right, is measured by the statutes in force on the date of her injury, [*Brown*]; however, the same is not true for laws affecting only the enforcement of that right, *Van Fossen v. Babcock & Wilcox Co.* (1988), 36 Ohio St.3d 100, 107-108[.]
* * *

{¶36} In the present case, relator has a substantive right to receive treatment and medication and to have her treatment and medication paid for, to a certain extent; however, the rate at which relator and other claimants are reimbursed for their medication

is not a substantive right. Further, relator always has been, and still is, permitted to request and receive brand-name medications instead of generic equivalents. However, the BWC has always had the authority to authorize and determine rates of reimbursement. Specifically, former R.C. 4123.66 gave the commission discretion to disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medications as deemed proper. Current R.C. 4123.66 provides the administrator of the BWC, instead of the commission, with the same discretion.

{¶37} As stated previously, relator has a right to receive treatment and medication. However, even that right is somewhat limited. It is conceivable that, at some point in the future, the commission may deny relator further treatment and may deny relator access to certain of the medications which she is currently taking. The fact that she is receiving certain treatment and certain medications today is not a guarantee that she will receive them in the future. Similarly, relator has no absolute guarantee that she will continue to be reimbursed at any specific rate.

{¶38} In the present case, the only evidence relator presented showing that she ever requested prior authorization to receive brand-name medications rather than generic ones is the February 6, 2006 C-86 motion which post-dates the change in the rule after the "prior authorization" language was removed. The magistrate realizes that relator contends that she has been receiving the brand-name medications for some time and that they have been fully paid for, but, just as relator had not demonstrated that res judicata applies, she likewise has not presented evidence that she did, in fact, request and receive prior authorization for brand-name medications. As such, it is this magistrate's opinion that the constitutional issue is not even reached in this case.

{¶39} However, even if the constitutional question is addressed, it is this magistrate's conclusion that the change is procedural and not substantive. Pursuant to R.C. 4123.54(A), relator has a right to receive, among other things, medication. However, she does not have an unqualified/absolute right to receive brand-name medications.

{¶40} The BWC has always been allowed to establish a maximum allowable cost for medications which are pharmaceutically and therapeutically equivalent by any method. Further, a claimant's right to reimbursement has always been limited as the reimbursement is not to exceed the BWC's established rate for the medication regardless of the price paid by the claimant for that medication. Claimants have always been allowed to request a brand-name medication and their physicians have always been allowed to request that the claimant receive a brand-name medication instead of the generic equivalent. Further, any medication which had an applicable maximum allowable cost price was reimbursed at a certain rate. As such, the changes in the Ohio Administrative Code indicate that there has always been discretion to determine the rates at which claimants were reimbursed for various medications and, as stated previously, the magistrate finds that there is no substantive right to continue to be reimbursed in the exact same manner and at the exact same rate.

{¶41} Based on the foregoing, it is this magistrate's conclusion that relator has not demonstrated that the commission abused its discretion and this court should deny relator's request for a writ of mandamus.

/s/ Stephanie Bisca Brooks
STEPHANIE BISCA BROOKS
MAGISTRATE

NOTICE TO THE PARTIES

Civ.R. 53(D)(3)(a)(iii) provides that a party shall not assign as error on appeal the court's adoption of any factual finding or legal conclusion, whether or not specifically designated as a finding of fact or conclusion of law under Civ.R. 53(D)(3)(a)(ii), unless the party timely and specifically objects to that factual finding or legal conclusion as required by Civ.R. 53(D)(3)(b).

R.C. § 1.48

Baldwin's Ohio Revised Code Annotated Currentness

General Provisions

* Chapter 1. Definitions; Rules of Construction (Refs & Annos)

* Statutory Provisions (Refs & Annos)

⇒ **1.48 Statutes presumed prospective**

A statute is presumed to be prospective in its operation unless expressly made retrospective.

(1971 H 607, eff. 1-3-72)

APPENDIX P.22

R.C. § 4123.54

Baldwin's Ohio Revised Code Annotated Currentness

Title XLI. Labor and Industry

* Chapter 4123. Workers' Compensation (Refs & Annos)

* Compensation and Benefits

4123.54 Compensation in case of injury, disease or death; rebuttable presumption; agreement if work performed in another state; employers temporarily in Ohio; compensation not payable to prisoners

(A) Every employee, who is injured or who contracts an occupational disease, and the dependents of each employee who is killed, or dies as the result of an occupational disease contracted in the course of employment, wherever such injury has occurred or occupational disease has been contracted, provided the same were not:

(1) Purposely self-inflicted; or

(2) Caused by the employee being intoxicated or under the influence of a controlled substance not prescribed by a physician where the intoxication or being under the influence of the controlled substance not prescribed by a physician was the proximate cause of the injury, is entitled to receive, either directly from the employee's self-insuring employer as provided in section 4123.35 of the Revised Code, or from the state insurance fund, the compensation for loss sustained on account of the injury, occupational disease, or death, and the medical, nurse, and hospital services and medicines, and the amount of funeral expenses in case of death, as are provided by this chapter.

(B) For the purpose of this section, provided that an employer has posted written notice to employees that the results of, or the employee's refusal to submit to, any chemical test described under this division may affect the employee's eligibility for compensation and benefits pursuant to this chapter and Chapter 4121. of the Revised Code, there is a rebuttable presumption that an employee is intoxicated or under the influence of a controlled substance not prescribed by the employee's physician and that being intoxicated or under the influence of a controlled substance not prescribed by the employee's physician is the proximate cause of an injury under either of the following conditions:

(1) When any one or more of the following is true:

(a) The employee, through a qualifying chemical test administered within eight hours of an injury, is determined to have an alcohol concentration level equal to or in excess of the levels established in divisions (A)(1)(b) to (i) of section 4511.19 of the Revised Code;

(b) The employee, through a qualifying chemical test administered within thirty-two hours of an injury, is determined to have one of the following controlled substances not prescribed by the employee's physician in the employee's system that tests above the following levels in an enzyme multiplied immunoassay technique screening test and above the levels established in division (B)(1)(c) of this section in a gas chromatography mass spectrometry test:

(i) For amphetamines, one thousand nanograms per milliliter of urine;

(ii) For cannabinoids, fifty nanograms per milliliter of urine;

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(iii) For cocaine, including crack cocaine, three hundred nanograms per milliliter of urine;

(iv) For opiates, two thousand nanograms per milliliter of urine;

(v) For phencyclidine, twenty-five nanograms per milliliter of urine.

(c) The employee, through a qualifying chemical test administered within thirty-two hours of an injury, is determined to have one of the following controlled substances not prescribed by the employee's physician in the employee's system that tests above the following levels by a gas chromatography mass spectrometry test:

(i) For amphetamines, five hundred nanograms per milliliter of urine;

(ii) For cannabinoids, fifteen nanograms per milliliter of urine;

(iii) For cocaine, including crack cocaine, one hundred fifty nanograms per milliliter of urine;

(iv) For opiates, two thousand nanograms per milliliter of urine;

(v) For phencyclidine, twenty-five nanograms per milliliter of urine.

(d) The employee, through a qualifying chemical test administered within thirty-two hours of an injury, is determined to have barbiturates, benzodiazepines, methadone, or propoxyphene in the employee's system that tests above levels established by laboratories certified by the United States department of health and human services.

(2) When the employee refuses to submit to a requested chemical test, on the condition that that employee is or was given notice that the refusal to submit to any chemical test described in division (B)(1) of this section may affect the employee's eligibility for compensation and benefits under this chapter and Chapter 4121. of the Revised Code.

(C)(1) For purposes of division (B) of this section, a chemical test is a qualifying chemical test if it is administered to an employee after an injury under at least one of the following conditions:

(a) When the employee's employer had reasonable cause to suspect that the employee may be intoxicated or under the influence of a controlled substance not prescribed by the employee's physician;

(b) At the request of a police officer pursuant to section 4511.191 of the Revised Code, and not at the request of the employee's employer;

(c) At the request of a licensed physician who is not employed by the employee's employer, and not at the request of the employee's employer.

(2) As used in division (C)(1)(a) of this section, "reasonable cause" means, but is not limited to, evidence that an

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employee is or was using alcohol or a controlled substance drawn from specific, objective facts and reasonable inferences drawn from these facts in light of experience and training. These facts and inferences may be based on, but are not limited to, any of the following:

- (a) Observable phenomena, such as direct observation of use, possession, or distribution of alcohol or a controlled substance, or of the physical symptoms of being under the influence of alcohol or a controlled substance, such as but not limited to slurred speech, dilated pupils, odor of alcohol or a controlled substance, changes in affect, or dynamic mood swings;
 - (b) A pattern of abnormal conduct, erratic or aberrant behavior, or deteriorating work performance such as frequent absenteeism, excessive tardiness, or recurrent accidents, that appears to be related to the use of alcohol or a controlled substance, and does not appear to be attributable to other factors;
 - (c) The identification of an employee as the focus of a criminal investigation into unauthorized possession, use, or trafficking of a controlled substance;
 - (d) A report of use of alcohol or a controlled substance provided by a reliable and credible source;
 - (e) Repeated or flagrant violations of the safety or work rules of the employee's employer, that are determined by the employee's supervisor to pose a substantial risk of physical injury or property damage and that appear to be related to the use of alcohol or a controlled substance and that do not appear attributable to other factors.
- (D) Nothing in this section shall be construed to affect the rights of an employer to test employees for alcohol or controlled substance abuse.
- (E) For the purpose of this section, laboratories certified by the United States department of health and human services or laboratories that meet or exceed the standards of that department for laboratory certification shall be used for processing the test results of a qualifying chemical test.
- (F) The written notice required by division (B) of this section shall be the same size or larger then the certificate of premium payment notice furnished by the bureau of workers' compensation and shall be posted by the employer in the same location as the certificate of premium payment notice or the certificate of self-insurance.
- (G) If a condition that pre-existed an injury is substantially aggravated by the injury, and that substantial aggravation is documented by objective diagnostic findings, objective clinical findings, or objective test results, no compensation or benefits are payable because of the pre-existing condition once that condition has returned to a level that would have existed without the injury.

(H) Whenever, with respect to an employee of an employer who is subject to and has complied with this chapter, there is possibility of conflict with respect to the application of workers' compensation laws because the contract of employment is entered into and all or some portion of the work is or is to be performed in a state or states other than Ohio, the employer and the employee may agree to be bound by the laws of this state or by the laws of some other state in which all or some portion of the work of the employee is to be performed. The agreement shall be in writing and shall be filed with the bureau of workers' compensation within ten days after it is executed and shall remain in force until terminated or modified by agreement of the parties similarly filed. If the agreement is to be bound by the laws of this state and the employer has complied with this chapter, then the employee is entitled to compensation and benefits regardless of where the injury occurs or the disease is contracted and the rights of the employee and the employee's dependents under the laws of this state are the exclusive remedy against the

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employer on account of injury, disease, or death in the course of and arising out of the employee's employment. If the agreement is to be bound by the laws of another state and the employer has complied with the laws of that state, the rights of the employee and the employee's dependents under the laws of that state are the exclusive remedy against the employer on account of injury, disease, or death in the course of and arising out of the employee's employment without regard to the place where the injury was sustained or the disease contracted.

If any employee or the employee's dependents are awarded workers' compensation benefits or recover damages from the employer under the laws of another state, the amount awarded or recovered, whether paid or to be paid in future installments, shall be credited on the amount of any award of compensation or benefits made to the employee or the employee's dependents by the bureau.

If an employee is a resident of a state other than this state and is insured under the workers' compensation law or similar laws of a state other than this state, the employee and the employee's dependents are not entitled to receive compensation or benefits under this chapter, on account of injury, disease, or death arising out of or in the course of employment while temporarily within this state, and the rights of the employee and the employee's dependents under the laws of the other state are the exclusive remedy against the employer on account of the injury, disease, or death.

(I) Compensation or benefits are not payable to a claimant during the period of confinement of the claimant in any state or federal correctional institution, or in any county jail in lieu of incarceration in a state or federal correctional institution, whether in this or any other state for conviction of violation of any state or federal criminal law.

(2006 S 7, eff. 6-30-06; 2004 H 223, eff. 10-13-04; 2004 H 163, eff. 9-23-04; 2000 H 122, eff. 4-10-01; 1994 H 571, eff. 10-6-94; 1993 H 107, eff. 10-20-93; 1989 H 222; 1986 S 307; 1978 H 1282; 1976 S 545; 128 v 743; 1953 H 1; GC 1465-68)

HISTORICAL AND STATUTORY NOTES

Pre-1953 H 1 Amendments: 119 v 565; 117 v 109, § 1; 111 v 218; 103 v 79, § 21; 102 v 531

Amendment Note: 2006 S 7 substituted "(1)(c)" for "(3)" after "in division (B)" in the introductory paragraph of division (B)(1)(b); inserted "of this section" in division (B)(2); added new division (G); redesignated former divisions (G) and (H) as divisions (H) and (I), respectively; and inserted ", or in any county jail in lieu of incarceration in a state or federal correctional institution," in redesignated division (I).

Amendment Note: 2004 H 163 substituted "(1)(b) to (l)" for "(2) to (7)" in division (B)(1).

Amendment Note: 2004 H 223 inserted "qualifying" preceding "chemical test" throughout division (B)(1); rewrote the first paragraph of division (B), therefrom designating division (B)(1); redesignated former divisions (B)(1), (2), (3), and (4) as subdivisions (B)(1)(a), (b), (c), and (d), respectfully; redesignated former subdivisions (B)(2)(a), (b), (c), (d), and (e) as subdivisions (B)(1)(b)(i), (ii), (iii), (iv), and (v), respectfully; redesignated former subdivision (B)(3)(a), (b), (c), (d), and (e) as subdivisions (B)(1)(c)(i), (ii), (iii), (iv), and (v), respectfully; rewrote the first paragraph of former division (B)(5), thereby designating new division (B)(2); added new division (C); designated the second paragraph of former division (B)(5) as division (G); and designated the final paragraph of former division (B)(5) as division (H).

Amendment Note: 2000 H 122 designated the former first paragraph as division (A); redesignated former division (A) as new division (A)(1); redesignated the first paragraph of former division (B) as new division (A)(2); added new divisions (B)(1) through (B)(5); and made changes to reflect gender neutral language.

Amendment Note: 1994 H 571 substituted "correctional" for "penal" in the final paragraph.

Amendment Note: 1993 H 107 inserted "self-insuring" in the first paragraph of division (B); and added "any state or federal" throughout the final paragraph.

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R.C. § 4123.66

Baldwin's Ohio Revised Code Annotated Currentness

Title XLI. Labor and Industry

* Chapter 4123. Workers' Compensation (Refs & Annos)

* Compensation and Benefits

*4123.66 Additional compensation

<Note: See also following version of this section with later effective date.>

(A) In addition to the compensation provided for in this chapter, the administrator of workers' compensation shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper and, in case death ensues from the injury or occupational disease, the administrator shall disburse and pay from the fund reasonable funeral expenses in an amount not to exceed fifty-five hundred dollars. The bureau of workers' compensation shall reimburse anyone, whether dependent, volunteer, or otherwise, who pays the funeral expenses of any employee whose death ensues from any injury or occupational disease as provided in this section. The administrator may adopt rules, with the advice and consent of the workers' compensation oversight commission, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefor. In case an injury or industrial accident that injures an employee also causes damage to the employee's eyeglasses, artificial teeth or other denture, or hearing aid, or in the event an injury or occupational disease makes it necessary or advisable to replace, repair, or adjust the same, the bureau shall disburse and pay a reasonable amount to repair or replace the same.

(B)(1) If an employer or a welfare plan has provided to or on behalf of an employee any benefits or compensation for an injury or occupational disease and that injury or occupational disease is determined compensable under this chapter, the employer or a welfare plan may request that the administrator reimburse the employer or welfare plan for the amount the employer or welfare plan paid to or on behalf of the employee in compensation or benefits. The administrator shall reimburse the employer or welfare plan for the compensation and benefits paid if, at the time the employer or welfare plan provides the benefits or compensation to or on behalf of employee, the injury or occupational disease had not been determined to be compensable under this chapter and if the employee was not receiving compensation or benefits under this chapter for that injury or occupational disease. The administrator shall reimburse the employer or welfare plan in the amount that the administrator would have paid to or on behalf of the employee under this chapter if the injury or occupational disease originally would have been determined compensable under this chapter. If the employer is a merit-rated employer, the administrator shall adjust the amount of premium next due from the employer according to the amount the administrator pays the employer. The administrator shall adopt rules, in accordance with Chapter 119. of the Revised Code, to implement this division.

(2) As used in this division, "welfare plan" has the same meaning as in division (1) of 29 U.S.C.A. 1002.

(2002 S 227, eff. 4-9-03; 1995 H 7, eff. 9-1-95; 1993 H 107, eff. 10-20-93; 1989 H 222; 1986 S 307; 1978 H 1282; 1973.H 417; 132 v H 268; 128 v 743; 126 v 1015; 1953 H 1; GC 1465-89)

<Note: See also following version of this section with later effective date.>

R.C. § 4123.66, OH ST § 4123.66

Current through 2007 File 36 of the 127th GA (2007-2008),
apv. by 12/14/07, and filed with the Secretary of State by 12/14/07.

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R.C. § 4123.95

Baldwin's Ohio Revised Code Annotated Currentness

Title XLI. Labor and Industry

Chapter 4123. Workers' Compensation (Refs & Annos)

Miscellaneous Provisions

4123.95 Liberal construction

Sections 4123.01 to 4123.94, inclusive, of the Revised Code shall be liberally construed in favor of employees and the dependents of deceased employees.

(128 v 743; eff. 11-2-59)

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OH Const. Art. II, § 28

Baldwin's Ohio Revised Code Annotated Currentness

Constitution of the State of Ohio

▣ Article II, Legislative (Refs & Annos)

⇒ **O Const II Sec. 28 Retroactive laws; laws impairing obligation of contracts**

The general assembly shall have no power to pass retroactive laws, or laws impairing the obligation of contracts; but may, by general laws, authorize courts to carry into effect, upon such terms as shall be just and equitable, the manifest intention of parties, and officers, by curing omissions, defects, and errors, in instruments and proceedings, arising out of their want of conformity with the laws of this state.

(1851 constitutional convention, adopted eff. 9-1-1851)

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

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

- (a) Additional allowance;
- (b) Re-activation;
- (c) Authorization of expenditures from the surplus fund;
- (d) Return to modified or alternative work;
- (e) Maximum medical improvement;
- (f) Rehabilitation;
- (g) A new injury while receiving treatment in the claim.

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

(D) In accepting a workers' compensation case, a medical 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 documentation relating to the claim required by the bureau and necessary for the claimant to obtain medical services, benefits or compensation. A medical provider may not assess a fee or charge the bureau, claimant, employer, or their representatives, or industrial commission, MCO, or QHP, for the costs of completing any bureau form or documentation required under this rule which is necessary for the claimant to obtain medical services, benefits, or compensation.

HISTORY: Eff. 1-27-97; 1-15-99; 1-1-01

Cross-References to Related Sections

Additional payments for medical or funeral expenses, RC § 4123.66.

Bureau of workers' compensation created, RC § 4121.12.1.

Health care partnership program, RC § 4121.44.1.

Qualified health plan system, RC § 4121.44.

Rule-making authority of administrator does not limit commission's authority, RC § 4121.30.

Rules covering general topics, RC § 4121.31.

Rules for bureau of workers' compensation, RC § 4123.05.

Workers' compensation, administrator of bureau to take oath, RC § 4121.12.

4123-6-21 Payment for medication

(A) 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.

(B) Medication must be prescribed by the physician of record in the industrial claim or by the treating physician.

(C) An allowed condition in the claim must be included as an FDA-approved use of a prescribed medication or be widely accepted as an appropriate use of a prescribed medication in order for the medication to be considered for reimbursement.

(D) Payment for medications to pharmacy providers shall include a product cost component and a dispensing fee component. The product cost component shall be the lesser of the following: maximum allowable cost, if applicable, or the average wholesale price of the commonly stocked package size plus or minus a percentage. The dispensing fee component will be a flat rate fee. The percentage amount added or subtracted from the average wholesale price and the dispensing fee rate shall be subject to annual review. Payment for extemporaneous or simple compounded medications will be made at the same rate as that of other medications. 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 or its agent. Pharmacy providers are required to submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained.

(E) A maximum allowable cost may be established for 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 Food and Drug Administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations." The methodology used to determine a maximum allowable cost for a qualified drug product shall be determined by the medical management and cost containment division's medical policy department and shall be subject to annual review. The bureau may choose to utilize the maximum allowable cost list for a vendor or utilize other available methodologies such as the health care finance administration's federal upper limit (FUL) list.

(F) 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 which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug, if prior authorization for the brand name drug is not obtained by the prescriber.

(G) Through internal development or through vendor contracts, an on-line point-of-service adjudication system may be implemented. Upon implementation, pharmacy providers may be required 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 provider enrollment or reimbursement. Submission by paper or by tape-to-tape may be refused upon implementation of an on-line point-of-service system.

(H) Claimant reimbursement shall not exceed the bureau's established rate for the medication regardless of the price paid by the claimant. Upon implementation of a point-of-service system, claimant reimbursement may be limited to the following situations:

(1) Claimants whose claims are not allowed on the date of service.

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

(3) Claimants who reside out of the country.

(I) The bureau or its agent may formulate medication utilization protocols for select conditions or diseases consistent with one or more of the following:

(1) Compendia consistent of the following:

(a) "United States Pharmacopoeia-Drug Information";

(b) "American Medical Association Drug Evaluations";

(c) "Drug Facts and Comparisons"; or,

(2) 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.

(J) 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 4729.02 of the Revised Code if located within Ohio; or an equivalent state license if located outside of Ohio; and,

(2) Has a valid drug enforcement agency (DEA) number; and,

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

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

(K) Medications dispensed to a claimant while the claimant is admitted to a hospital during an approved

inpatient admission or to a claimant during the course of an outpatient visit in a hospital are excluded from this rule. Charges for this medication should be filed on the standard hospital billing form approved for use by the bureau. Providers who do not qualify as a pharmacist but who may administer parenteral medications to injured workers should bill for those administered parenteral medications using the appropriate CPT code on the appropriate billing form.

(L) The bureau may contract with a vendor 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, be responsible for maintaining a drug formulary, and establish and enforce dispensing limitations. The bureau or its agent may utilize other services or established procedures of the vendor which may enable the bureau or its agent to control costs and utilization and detect fraud.

(M) The bureau or its agent will consider reimbursement for compounded parenteral and sterile product prescriptions and parenteral and enteral nutrition products at a rate established by the administrator with the assistance of the bureau's medical management and cost containment division as authorized by section 4121.121 of the Revised Code. The method of reimbursement may include, but is not limited to, use of per diem rates, percent of allowed charge, usual, customary and reasonable rates, or rates based on ingredient cost of the therapy.

(N) The bureau or its agent may consider reimbursement for pharmacist professional services (also known as cognitive services) on a case-by-case basis if which payment for such services results in a measurable positive outcome. The bureau or its agent shall be responsible for developing the criteria which will be used to assess the compensability of billed pharmacist professional services. The bureau or its agent shall be responsible for developing the structure of the reporting of the measurable outcomes used to justify the payment of pharmacist professional services. The amount that could be reimbursed for pharmacist professional services shall be determined by the bureau's medical management and cost containment division.

HISTORY: Eff. 1-27-97

Cross-References to Related Sections

Additional payments for medical or funeral expenses, RC 4123.66.

Bureau of workers' compensation created, RC § 4121.12.1

Health care partnership program, RC § 4121.44.1.

Qualified health plan system, RC § 4121.44.

Rule-making authority of administrator does not limit commission's authority, RC § 4121.30.

Rules covering general topics, RC § 4121.31.

Rules for bureau of workers' compensation, RC § 4123.05

OAC 4123-6-21

Ohio Admin. Code § 4123-6-21

BALDWIN'S OHIO ADMINISTRATIVE CODE ANNOTATED
4123 WORKERS' COMPENSATION BUREAU
CHAPTER 4123-6. HEALTH PARTNERSHIP PROGRAM (HPP)

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Rules are current through September 30, 2006;
Appendices are current through March 31, 2004

4123-6-21 Payment for outpatient medication

(A) 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 therapeutic class of drugs as not being reasonably related to or medically necessary for treatment of the allowed conditions in a claim.

(B) Medication must be prescribed by the physician of record in the industrial claim or by the treating physician, or by such other treating provider as may be authorized by law to prescribe such medication.

(C) Drugs covered are limited to those that are approved for use in the United States by the food and drug administration 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 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) Drug efficacy study implementation (DESI) drugs or drugs that may have been determined to be identical, similar, or related;

(4) Extemporaneous or simple compounded prescriptions;

(5) Injectable drugs not intended for self-administration;

(6) Drugs used to aid in smoking cessation;

(7) 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.

Drugs approved by the MCO under this rule shall not be reimbursed through the bureau's pharmacy benefits management vendor.

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

(1) The product cost component shall be the lesser of the following: maximum allowable cost, if applicable, or the average wholesale price of the commonly stocked package size plus or minus a percentage. The percentage amount added or subtracted from the average wholesale price shall be determined by the bureau, and shall be subject to annual review.

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(2) The dispensing fee component shall be a flat rate fee, which shall be subject to annual review.

(a) Only pharmacy providers are eligible to receive a dispensing fee.

(b) The dispensing fee may include an additional incentive component for pharmacy providers that accept assignment.

(c) Except as provided below, dispensing fees shall be limited to one dispensing fee per patient per generic code number (GCN) per rolling twenty-five days. Exceptions to the single dispensing fee are:

(i) Cases where the physician has prescribed a second round of medication within the twenty-five day period;

(ii) Cases where the physician has changed the dosage;

(iii) Cases where the medication did not last for the intended days supply;

(iv) Cases where the medication has been lost, stolen or destroyed;

(v) Controlled substances (which are limited to two dispensing fees per twenty-five days).

(G) 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. Pharmacy providers are required to submit for billing the national drug code 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.

(H) The bureau may establish a maximum allowable cost for 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 food and drug administration (FDA) and designated by an "A" code value in the FDA publication, "Approved Drug Products With Therapeutic Equivalence Evaluations." The methodology used to determine a maximum allowable cost for a qualified drug product shall be determined by the medical policy department and shall be subject to annual review. The bureau may choose to utilize the maximum allowable cost list of a vendor or develop its own maximum allowable cost list.

(I) 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 which has an applicable maximum allowable cost price shall be liable for the product cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug.

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

(1) The bureau may publish a list of drugs identifying those drugs that are considered "chronic" medications. Drugs not identified as "chronic" medications shall be considered "acute" medications.

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

(3) 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

(4) 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.

(5) 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 noncontrolled drug has been increased and has a new

prescription number. Denials may be overridden by the bureau for the following documented reasons:

- (a) Previous supply was lost, stolen or destroyed;
- (b) Pharmacist entered previous wrong day supply;
- (c) Out of country vacation or travel;
- (d) Hospital or police kept the medication.

(K) Through internal development or through vendor contracts, an on-line point-of-service adjudication system may be implemented. Upon implementation, pharmacy providers may be required 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 provider enrollment or reimbursement. Submission by paper or by tape-to-tape may be refused upon implementation of an on-line point-of-service system.

(L) Claimant reimbursement for medications shall not exceed the bureau's established rate for the medication regardless of the price paid by the claimant. Upon implementation of a point-of-service system, claimant reimbursement may be limited to the following situations:

- (1) Claimants whose claims are not allowed on the date of service;
- (2) Emergency situations where an enrolled pharmacy provider with point-of-service capabilities is not available;
- (3) Claimants who reside out of the country.

(M) The bureau may formulate medication utilization protocols for select conditions or diseases consistent with one or more of the following

- (1) Compendia consistent of the following:
 - (a) "United States Pharmacopoeia - Drug Information";
 - (b) "American Medical Association Drug Evaluations";
 - (c) "Drug Facts and Comparisons"; or,
- (2) 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.

(N) 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 4729.02 of the Revised Code if located within Ohio; or an equivalent state license if located outside of Ohio; and,
- (2) Has a valid drug enforcement agency (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 relating to the practice of pharmacy and the dispensing of medication by a duly licensed pharmacist must be observed.

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(O) The bureau may contract with a vendor 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, and be responsible for maintaining a drug formulary. The bureau may utilize other services or established procedures of the vendor which may enable the bureau to control costs and utilization and detect fraud.

(P) 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. The amount that could be reimbursed for pharmacist professional services shall be determined by the bureau's medical policy department.

(Q) The bureau shall secure the services of a pharmacist to assist the bureau in the review of drug bills. The bureau may employ a staff pharmacist on a full or part-time basis or may contract for such services. The pharmacist may assist the bureau in determining the appropriateness, eligibility, and reasonableness of compensation payments for drug services. The bureau may consult with a pharmacy and therapeutics committee, which shall be a subcommittee of the stakeholders' health care quality assurance advisory committee established by rule 4123-6-22 of the Administrative Code, on the development and ongoing annual review of a drug formulary and other issues regarding medications.

(R) The bureau will publish line by line billing instructions in a health care provider billing and reimbursement manual. At least thirty days written notice will be given prior to required changes in billing procedures.

HISTORY: 2004-05 OMR pam. #11 (R-E), eff. 10-1-05; 2002-03 OMR 1447 (A), eff. 1-1-03; 1996-97 OMR 1380 (E), eff. 1-27-97

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RETREAT

fense of others. Model Penal Code §§ 3.04(2), 3.05(2). See Retreat to the wall.

Retreat to the wall. A common law requirement that an endangered person use all reasonable means to avoid the necessity of taking human life before resorting to deadly force in self-defense. The requirement is abandoned now in the majority of jurisdictions, which hold that one assaulted in a place where he has a right to be is under no duty to retreat before using deadly force in self-defense. See Model Penal Code §§ 3.04(2), 3.05(2). See also Self defense.

Retrial. A new trial of an action which has already been once tried. See also Rehearing; Trial (New trial; Trial de novo). Compare Mistrial.

Retribution. Something given or demanded in payment. In criminal law, it is punishment based on the theory which bears its name and based strictly on the fact that every crime demands payment in the form of punishment. See also Restitution.

Retro /rétrow/. Lat. Back; backward; behind. *Retrofeodum*, a rerefief, or *arriere* fief.

Retroactive. Process of acting with reference to past occurrences. See also Retrospective.

Retroactive inference. The inferring of a previous fact from present conditions by a trier of facts.

Retroactive law. "Retroactive" or "retrospective" laws are generally defined from a legal viewpoint as those which take away or impair vested rights acquired under existing laws, create new obligations, impose a new duty, or attach a new disability in respect to the transactions or considerations already past. One which is intended to act on things that are past. A statute which creates a new obligation on transactions or considerations already past or destroys or impairs vested rights. Such laws may be unenforceable because violative of the ex post facto clause of the U.S. Const., Art. I, Sec. 9, Cl. 3. See also Retrospective law.

Retrospective. Looking backward; contemplating what is past; having reference to a state of things existing before the act in question.

Retrospective law. A law which looks backward or contemplates the past; one which is made to affect acts or facts occurring, or rights accruing, before it came into force. Every statute which takes away or impairs vested rights acquired under existing laws, or creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past. One that relates back to a previous transaction and gives it a different legal effect from that which it had under the law when it occurred. See also Ex post facto; Retroactive law.

Return. To bring, carry, or send back; to place the custody of; to restore; to re-deliver. "Return" means that something which has had prior existence will be brought or sent back.

The act of a sheriff, constable, marshal, or other ministerial officer, in delivering back to the court a writ, notice, process or other paper, which he was required to serve or execute, with a brief account of his doings under the mandate, the time and mode of service or execution, or his failure to accomplish it, as the case may be. Also the indorsement made by the officer upon the writ or other paper, stating what he has done under the time and mode of service, etc. Such return (proof of service) is required under Rule of Civil Procedure 4. See False return; Return day, below.

A schedule of information required by governmental bodies, such as the tax return required by the Internal Revenue Service. See Joint tax return; Tax return.

Merchandise which is brought back to the seller for credit or refund.

Profit on sale, or income from investment (usually expressed as annual percentage rate). See Income; Profit; Rate (Rate of return); Return on assets; Return on equity; Revenue.

The report made by the court, body of magistrates, returning board, or other authority charged with the official counting of the votes cast at an election.

Fair return. See Fair return on investment.

Return day. The day named in a writ or process upon which the officer is required to return. Under Fed.R.Civil P. 4 the person serving the process shall make proof of service (return) to the court promptly and in any event within the time during which the person served must respond to the process.

Day on which votes cast are counted and the official result is declared.

Return of premium. The repayment of the whole or a ratable part of the premium paid for a policy of insurance, upon the cancellation of the contract before the time fixed for its expiration.

Returnable. To be returned; requiring a return. When a writ or process is said to be "returnable" on a certain day, it is meant that on that day the officer must return it.

Return day. See Return.

Return of capital. The recovery of the original investment in a project or investment; the return of principal.

Return of process. See Return.

Return on assets. Ratio of net income to total assets. See Return on equity.