

In the
Supreme Court of Ohio

STATE OF OHIO, ex rel.
SEARS ROEBUCK & CO.,

Appellee,

vs.

TIMOTHY MATHEWS,
et al.,

Appellants.

CASE NO. 2010-0955

On Appeal from the Franklin County
Court of Appeals, Tenth Appellate
District. Case No. 09AP-0180

MERIT BRIEF OF APPELLANT, INDUSTRIAL COMMISSION OF OHIO

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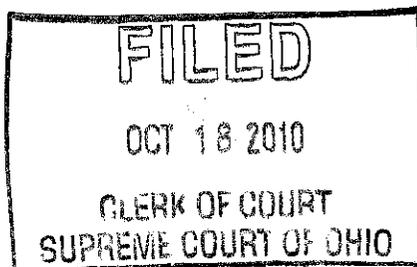


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INTRODUCTION

Self-insured status is a privilege earned by an employer in the Ohio workers' compensation system. R.C. 4123.35(B); *St. Paul Fire & Marine Ins. Co. v. Indus. Comm.* (1987), 30 Ohio St.3d 17, 19. Because that privilege permits a self-insured employer to stand in the shoes of the Bureau of Workers' Compensation ("bureau"), the statutes and rules demand responsibility on the part of the employer. The privilege further dictates that a self-insured employer administer its claims according to the same statutes and administrative code rules to which the bureau is subject. Accordingly, when a self-insured employer neither refuses, nor grants the payment of a medical bill, thus making no decision on the bill within 30 days as required by the rules, and then hides behind the statute of limitations by asserting that a claimant's workers' compensation claim is statutorily dead, that self-insured employer has run afoul of its obligations.

This case involves the actions a self-insured employer must take in paying bills, and whether Appellant, Industrial Commission of Ohio ("commission") acted within its discretion in finding that a bill was properly payable. Administratively, the commission ordered Appellee, Sears Roebuck & Co. ("Sears") to pay a 1998 bill for medical services rendered to Appellant, Timothy Mathews ("Mathews"), prompting Sears to file suit in mandamus. The appellate court held that the bill was not properly payable, finding that the doctor's visit was not reasonably related to the allowed conditions in Mathews's claim.

The appellate court's finding ignores that the commission need only meet the modest threshold of "some evidence" for its order to be upheld. It also ignores that if Sears had followed the rules, rejected the bill, and referred the matter to the commission, Mathews would have had an opportunity to submit additional evidence supporting the bill's payment. Sears flouted the

rules and evidence supports the bill's payment. The commission order must stand. The commission respectfully requests that this Court reverse the appellate court's decision and deny the writ of mandamus.

STATEMENT OF THE FACTS AND CASE

In 1987, Mathews was injured while working at Sears. Mathews was "caught by a conveyor and pinched between a mobile conveyor and a fixed conveyor line." (Supplement submitted by Industrial Commission of Ohio at 1, hereinafter "S. ___"). At the time this mandamus action began, his workers' compensation claim was allowed for torn muscles left leg, tears buttocks and bladder, and internal injuries. (S. 3, 21). Because Sears is a self-insured employer, the bureau sent a notice to both Sears and Mathews stating that Sears was responsible for making the initial decisions on all claim applications, motions, and requests, and that it must act upon a request within 30 days, notifying the injured worker and the bureau of its action. (S. 4). Specifically, the letter stated:

As a self-insuring employer, you are responsible for making initial decisions on all claim applications, motions, and requests. Under the rules of the Industrial Commission and Bureau of Workers' Compensation, particularly Rule 4123-3-13 and Rule 4123-19-03(L)(5) and (10), you must act upon this request within thirty (30) days, and notify the injured worker and the Bureau of your action. *Should you contest this matter, you must notify the injured worker of your objection and refer the contested matter to the Industrial Commission for a hearing in accordance with Section 4123.511(C) as provided in Am. Sub. H.B. 107.*

Id. Emphasis added. The rule referenced in the letter—4123-19-03(L)(5)—has now been renumbered Ohio Adm.Code 4123-19-03(K)(5).

Mathews received ongoing medical treatment for the allowed conditions in the decade following his injury. Some treatment occurred with the doctors at Greater Ohio Orthopedic Surgeons, Inc. ("Ohio Orthopedic"), initially with Dr. Marsalka, and later with Leah Urbanosky, M.D., after Dr. Marsalka's death. (S. 5-11). Dr. Urbanosky took over Mathews's care in

September 1998. Following a September 22, 1998, office visit, a \$50.00 bill was forwarded to Sears's third party administrator ("TPA"), Frank Gates Service Company ("Frank Gates"), for payment. (S. 12). On March 12, 1999, Mathews's former attorney, Attorney Dritz, sent a letter to Frank Gates acknowledging that the bill was unpaid because the claim had become inactive. (S. 13). Attorney Dritz explained that Mathews had been under the care of one or more doctors at Ohio Orthopedic, and Dr. Urbanosky recently had taken over his care. Id. Attorney Dritz requested Frank Gates advise him immediately if it was unwilling to pay the bill. Id.

Frank Gates responded to Attorney Dritz's letter on April 21, 1999, stating that it agreed to consider the bill's payment and requested Dr. Urbanosky's office notes for the date of service. (S. 14). A time stamp bearing the date of December 28, 1998, is imprinted on the office notes. (S. 15). Sears, through Frank Gates, never accepted, nor rejected payment for the office visit.

In April 2008, Mathews requested authorization to treat with Urological Associates, Inc., on a yearly basis. However, Helmsman Management Services, Inc., Sears's new TPA, denied the treatment. It sent a facsimile to the bureau explaining that it believed the claim was statutorily dead, erroneously noting that payment on the Dr. Urbanosky invoice had been "denied as the diagnosis of 'mild L5 radiculopathy on the left' is not an allowed condition of this claim." (S. 16). Mathews then moved the bureau for payment of the \$50.00 bill. (S. 17)

A district hearing officer ("DHO") granted the motion, finding that the claim was still active at the time Mathews submitted the bill to Sears for payment. (S. 18-20). The DHO relied on the fact that the Frank Gates letter of April 21, 1999, acknowledged the receipt of the bill and explicitly stated that payment would be considered. (S. 18). The DHO noted that Sears had paid for treatment related to his low back in the past, and recognized that Mathews's pelvis and thighs were crushed in the injury. Lastly, the DHO stated that Dr. Urbanosky's office notes set out the

physicians' prioritization of treating Mathews's more serious injuries first. *Id.*

Sears appealed, but a staff hearing officer ("SHO") affirmed the DHO's order. (S. 21-23). The SHO first noted the bill was timely submitted. *Id.* Secondly, the SHO found that the April 21, 1999, Frank Gates letter did not constitute a denial of payment because it explicitly acknowledged receipt of the bill and stated that payment would be considered. (S. 21).

Additionally, the SHO rejected Sears's four defenses to the payment of the bill, only one of which is relevant to this action. (S. 21-22). The SHO found that Dr. Urbanosky's treatment was reasonably related to the claim allowances. By virtue of the fact that Mathews had suffered severe internal injuries in the low back area, an orthopedic referral was reasonable to determine whether a low back condition was related to the claim. Moreover, the severity of the injuries to Mathews's mid-section made the exam reasonable in light of the location of the complaints and their consistency with his on-going medical problems for the allowed conditions. Sears filed suit in mandamus following the commission's denial of its request for reconsideration.

The magistrate recommended that the court issue a writ after finding that the office visit was unrelated to the claim allowances, and that there was no evidence in the record supporting the SHO's statement that a referral was made to determine whether a low back condition should be made part of the claim. Both the commission and Mathews filed objections, arguing that the commission is permitted broad discretion in the payment of medical services, and that the evidentiary record supported the bill's payment. Nonetheless, a majority of the appellate court judges adopted the magistrate's recommendation and granted the writ. The dissenting judge would have sustained the objections, finding that the commission correctly ordered Sears to pay the fee bill. Subsequently, Mathews and the commission filed appeals to this Court.

LAW AND ARGUMENT

I. The standard of review in mandamus is whether the commission acted contrary to law or committed a gross abuse of discretion.

For the Court to issue a writ of mandamus, Sears must demonstrate that it has a clear legal right to the relief sought and that the commission had a clear legal duty to provide such relief. *State ex rel. Pressley v. Indus. Comm.* (1967), 11 Ohio St.2d 141. To establish a basis for mandamus relief, Sears must show the commission abused its discretion by issuing an order not supported by evidence in the administrative record. *State ex rel. Elliott v. Indus. Comm.* (1986), 26 Ohio St.3d 76, 78-79. Where evidence in the record supports the commission's decision, courts will not disturb the administrative findings in a mandamus action. *State ex rel. Fiber-Lite Corp. v. Indus. Comm.* (1988), 36 Ohio St.3d 202. Here, a writ of mandamus must not issue because the commission's order requiring Sears to pay the fee bill is supported by "some evidence."

Industrial Commission's Proposition of Law No. 1:

The commission acts within its discretion in ordering payment of a bill resulting from an office visit related to the allowed conditions in a claim.

Evidence in the record supports the commission's finding that Matthews's 1998 office visit was reasonably related to the allowed conditions in his claim, which makes it properly payable. After discussing Matthews's work injury, indicating the claim allowances, and noting the history of his treatment, Dr. Urbanosky's treatment note reveals that Matthews felt heaviness in his left leg, associated with tingling into his foot. (S. 15). Matthews had minimal associated back pain or other radicular-type pains at that time. *Id.* *State ex rel. Miller v. Indus. Comm.* (1994), 71 Ohio St.3d 229, directs that medical services are properly payable when the services

are reasonably related and necessary to the industrial injury, and when the cost of the services is medically reasonable.

Dr. Urbanosky's treatment note is sufficient to meet the "some evidence" standard. Moreover, the commission acted within its discretion in finding that the treatment note supported the relationship between the treatment and the allowed conditions in Mathews's claim. This is because the determination of disputed facts is within the commission's final jurisdiction. *State ex rel. Allerton v. Indus. Comm.* (1982), 69 Ohio St.3d 96. Accordingly, the courts are not to evaluate and judge the credibility of evidence that was before the commission such that they undertake the role of "super commission." *State ex rel. Burley v. Coil Packaging, Inc.* (1987), 31 Ohio St.3d 18, 20. Thus, the commission's determination that Mathews's complaints of heaviness and tingling were reasonably related to the allowed conditions cannot be reweighed where the evidence supports the finding.

Not only did this Court set out the modest "some evidence" standard in *State ex rel. Stephenson v. Indus. Comm.* (1987), 31 Ohio St.3d 167, 170, but it also stated that "[i]t is basic law, without need of citation, that the Industrial Commission has considerable discretion in the performance of its duties; that its actions are presumed to be valid and performed in good faith and judgment, unless shown to be otherwise . . .". Here, Sears cannot show that the commission acted in bad faith or in bad judgment by ordering payment of the bill. Dr. Urbanosky's office note detailed the extent of Mathews's injuries, noting that there was a "severe crush-type injury to his pelvis and thighs," which required a left leg soft tissue surgery. (S. 15). From his complaints, Dr. Urbanosky's impression was radiculopathy. It is not necessary that this be an allowed condition in the claim before treatment is paid for, as radiculopathy can be a symptom, causing a radiating tingling sensation, rather than a stand-alone medical condition. See *State ex*

rel. Foor v. Rockwell Int'l (1997), 78 Ohio St.3d 396.

Equally possible is that the left leg muscle tear, for which Mathews had surgery, caused the heaviness and tingling sensations. Given that Mathews's claim is allowed for a left leg muscle tear, the location of the heaviness and tingling indicates that the symptoms Mathews felt are related to the claim allowances. Under the circumstances, it was reasonable for Mathews to seek treatment as the "radicular" symptoms may have originated in his soft tissue. Dr. Urbanosky instructed Mathews to return if his symptoms worsened. Even if her initial impression was incorrect, further evaluation may have revealed that these complaints stemmed from the already allowed conditions. This is especially true when Sears later allowed the claim for a left pelvis fracture, a left thigh laceration, and severe abdominal injuries. The documents showing the addition of these conditions to the claim were not before the commission when it ordered Sears to pay the bill, thus they are not before this Court.

Industrial Commission's Proposition of Law No. 2:

The commission acts within its discretion in ordering payment of a bill resulting from an office visit made for diagnostic purposes.

A. Dr. Urbanosky's treatment note reflects that Mathews sought a diagnosis for the heaviness and tingling he felt in his severely damaged left leg.

Again, Dr. Urbanosky diagnosed Mathews with mild radiculopathy, which the commission recognizes is not an allowed condition in the claim. Even so, the commission correctly ordered Sears to pay the bill either because the heaviness and tingling are symptoms of the allowed conditions of torn muscles left leg, tears buttocks and bladder, and internal injuries, or Mathews has a true radiculopathy indicative of the need to determine whether to add low back conditions to the claim. Either way, Mathews was entitled to have Sears pay for the visit. As the dissent aptly pointed out:

We are not here to decide whether or not the mild radiculopathy experienced by Tim Mathews should be the basis of an on-going course of treatment. We are here only to decide if Mathews could have a doctor diagnose, at Sears' cost, the cause of the feeling of heaviness and the tingling in his seriously injured left leg.

(Appendix of Appellant, Industrial Commission of Ohio at 13).

The commission is permitted to order payment for treatment for not-yet allowed conditions where a doctor suspects an additional condition should be made part of the claim, and the treatment is rendered for diagnostic purposes. *State ex rel. Jackson Tube Services v. Indus. Comm.* (2003), 99 Ohio St.3d 1, 2003-Ohio-2259. In *Jackson Tube*, the claimant tore his rotator cuff, but surgery failed to correct his shoulder pathology. His doctor recommended a second surgery and opined that the claimant suffered from four shoulder conditions, but only two of which were allowed in the claim. The commission authorized the surgery, stating that the:

Claimant's request for authorization and payment for medical services for the treatment of the allowed conditions is granted. Further, the Hearing Officer finds that Dr. Paley's request for authorization and payment for arthroscopic surgery on the left shoulder for diagnostic purposes is appropriate and necessary for the treatment of the claimant's left shoulder. Therefore, the arthroscopic procedure is authorized and payment is ordered.

Id. at 3. The employer filed suit in mandamus, however the commission's actions were affirmed on appeal.

The commission has broad discretion in authorizing the payment of medical services. See *State ex rel. Sugardale Foods, Inc. v. Indus. Comm.* (2000), 90 Ohio St.3d 383, 386 ("Based on a variety of statutes, we have consistently held that the BWC and the commission share the power to oversee and determine the reasonableness and necessity of health care expenditures."). Here, the SHO clearly and explicitly stated that "[a]lthough no lower back injury is allowed in the claim, in the context of the location and severity of the claimant's other injuries, and his

complaints at the time, this referral is a reasonable expense of the allowed industrial injury.” (S. 21).

Mathews had been treating with Ohio Orthopedic and Dr. Marsalka at least as far back as 1988, just a year following the injury, and Sears had been paying for that treatment. Admittedly, medical conditions cannot be implicitly recognized. Dr. Urbanosky did not need an actual referral to examine Mathews for diagnostic purposes. Rather, Mathews had been a patient of Dr. Marsalka, also at Ohio Orthopedic, in the years before Dr. Marsalka’s death. Dr. Urbanosky was merely taking over Mathews’s care; he did not need a referral. Additionally, it is disingenuous for Sears to ignore that Mathews had been treating with the orthopedic clinic (Sears had paid for the treatment for 11 years), then claim that any treatment rendered must be for non-allowed conditions.

Similar to the *Jackson Tube* claimant, Mathews’s injuries were internal and, therefore, could not be assessed externally. His injury occurred in 1987, and he has continued to seek treatment to the present day. The full extent of damage to Mathews’s mid-section, following this severe crushing injury, was not readily discernible in 1987. Even if a low back condition were not made part of his claim at the time of the 1998 office visit, it is not unreasonable to believe that less severe injuries would surface following the initial extensive treatment for the more severally injured parts of his body.

In short, as in *Jackson Tube*, Mathews required a diagnostic surgery to determine which, if any, conditions should be made a part of his claim. It was entirely reasonable for the commission to order payment for the diagnostic office examination Dr. Urbanosky performed when her patient, with whom Mathews had been treating for more than a decade at that point, came in complaining of tingling and heaviness. This exam was no different than the commission

ordering payment for an MRI or X-ray, even if the diagnoses which come out of the diagnostic test findings are not later allowed as conditions in a claim.

B. Sears should not benefit by disobeying the rules.

The dissent below pointed out that Sears acted improperly in refusing to make a decision on the bill's payment multiple times, and then asserting that Mathews's claim was statutorily dead.¹ As part of its obligations as a self-insured employer, Sears is responsible for making the initial determination of whether to pay a bill for medical services. Ohio Adm.Code 4123-19-03(I)(6). A self-insured employer has just thirty days after receiving a bill to pay or contest the matter. Ohio Adm.Code 4123-19-03(K)(5). Sears knew or should have known of this requirement as it had previously received the bureau's notice including that information. (S. 4).

Dr. Urbanosky's treatment note is "some evidence" on which the commission could rely to order Sears to pay the bill. However, there might have been additional evidence in the record to further support the causal connection to the work injury if Sears had followed the administrative code requirements. The TPA, Frank Gates, asserted that it needed the treatment notes to determine whether a causal connection existed, but as the dissent pointed out, Frank Gates already had Dr. Urbanosky's treatment notes in its possession, as shown by the time stamp on Dr. Urbanosky's record. (S. 15). Yet, Sears, through Frank Gates, failed to act even though Mathews had treated for years with this doctor, and even though it had the treatment notes. Not only did Sears never make a decision on the bill's payment, but it used its own dilatory actions to run out the time and then argued that the statute of limitations had run on Mathews's claim.

¹ The crux of Sears's argument was that the claim was dead under R.C. 4123.52 because no payment had been made within ten years of the last payment of compensation or medical benefits. The 1993 version of R.C. 4123.52 dictates that lost time claims remain open for ten years following the last payment of compensation or medical benefits, whichever is later. Here, Mathews's last medical benefits were paid in March 1997, and the April 21, 1999, application for payment tolled the statute. (S. 6). The result is that the commission retained jurisdiction to consider payment of the Dr. Urbanosky fee bill in 2008.

Sears cannot enjoy the benefits that flow from self-insured status without exercising responsibility in processing its claims, and truly acting in place of the bureau.

Even if Sears had denied the bill's payment, Mathews could have requested a commission hearing. Instead, Sears left the issue in limbo for ten years. Had Sears acted in accordance with the code, even if it rejected the bill, Mathews would have been on more equal footing with this corporation. He could have submitted Dr. Urbanosky's full chart as evidence. Again, it is disingenuous for Sears to use the defense of non-allowed conditions at this late stage when Mathews was given no opportunity to present additional evidence from his doctor contemporaneous to the treatment. Sears cannot hide behind its defense of non-allowed conditions when Mathews could have submitted additional evidence from the doctor, perhaps in the form of an addendum, to further explain the causal relationship that exists, if Sears had just followed the rules.

Moreover, in early 2009, following the commission hearing on the bill's payment, Sears sent copious medical records to Mathews's current counsel, who then sent them to the bureau. Again, these documents are not before this Court because the SHO did not have the opportunity to review them. However, if the evidence were made part of the record, it would further support the commission's order. The Court should grant, at the very most, a limited writ returning the matter for a new hearing for that evidence to be considered.

CONCLUSION

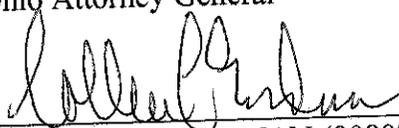
The commission respectfully requests that the Court reverse the Tenth District's decision granting Sears's request for a writ of mandamus. Evidence in the record supports the payment of Dr. Urbanosky's invoice for two reasons. First, the radicular symptoms Mathews felt could reasonably be attributed to the allowed conditions in his claim given the severity of his mid-

section crushing injuries and the location of the heaviness and tingling in his leg. Secondly, if Mathews had a true radiculopathy from an orthopedic problem, it was reasonable for Dr. Urbanosky to examine Mathews for diagnostic purposes. Again, as the dissent noted, even if Mathews would not be entitled to on-going treatment for the radiculopathy, a diagnostic visit was reasonable.

Lastly, Sears should not be permitted to hide behind *Miller* when its own inaction prevented a hearing on the matter at which additional evidence could have been produced. If Sears had acted according to the rules, and had timely made a decision on the bill, a commission hearing would have been scheduled. Sears cannot fail to act on an outstanding bill, allow ten years to pass, and then assert that the claim is statutorily dead or the treatment was related to non-allowed conditions.

Respectfully submitted,

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CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing *Merit Brief of Appellant, Industrial Commission of Ohio*, was sent to the following by regular U.S. Mail, postage prepaid, this

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APPENDIX

Second Notice of Appeal1
Judgment Entry, Court of Appeals, Tenth District4
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ORIGINAL

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Appellants.

CASE NO. 2010-0955

On Appeal from the
Franklin County Court of Appeals, Tenth
Appellate District. Case No. 09AP-0180

SECOND NOTICE OF APPEAL

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FILED
JUN 10 2010
CLERK OF COURT
SUPREME COURT OF OHIO

**NOTICE OF APPEAL OF APPELLANT
INDUSTRIAL COMMISSION OF OHIO**

Appellant, Industrial Commission of Ohio, gives notice of appeal to the Supreme Court of Ohio from the judgment of the Franklin County Court of Appeals, Tenth Appellate District, entered in Court of Appeals Case No. 09AP-0180 on April 27, 2010. A copy of the judgment entry is attached.

This case originated in the Franklin County Court of Appeals. Therefore, this is an appeal as of right.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that a copy of the Notice of Appeal was sent to Amy Thomas, counsel for Appellee, Sears Roebuck & Co., Reminger Co., LPA, 65 East State Street, 4th Floor, Columbus, Ohio 43215, and Matthew Cincione, counsel for Appellant, Timothy Mathews, 2200 West Fifth Avenue, 3rd Floor, Columbus, Ohio 43215, and, by regular U.S. Mail, postage pre-paid, this 16th day of June, 2010.



COLLEEN C. ERDMAN (0080765)
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1/1x

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

FILED
COURT OF APPEALS
FRANKLIN COUNTY, OHIO
2010 APR 27 PM 12:17
CLERK OF COURTS

State of Ohio ex rel. Sears Roebuck & Co., :

Relator, :

v. :

No. 09AP-180

Industrial Commission of Ohio
and Timothy Mathews, :

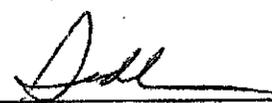
(REGULAR CALENDAR)

Respondents. :

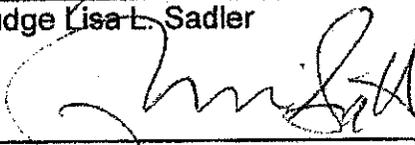
JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on April 27, 2010, the objections to the decision of the magistrate are overruled, the decision of the magistrate is approved and adopted by the court as its own, and it is the judgment and order of this court that a writ of mandamus issue against respondent, Industrial Commission of Ohio, ordering it to vacate its SHO's order of October 24, 2008, and to enter an order denying claimant's June 5, 2008 motion for payment of the fee bill. Costs shall be assessed equally against respondents.

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 Lisa L. Sadler



Judge Patrick M. McGrath

Colleen Erdman

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

FILED
COURT OF APPEALS
FRANKLIN CO. OHIO
2010 APR 27 PM 12:15
CLERK OF COURTS

State of Ohio ex rel. Sears Roebuck & Co., :

Relator, :

v. :

No. 09AP-180

Industrial Commission of Ohio
and Timothy Mathews, :

(REGULAR CALENDAR)

Respondents. :

D E C I S I O N

Rendered on April 27, 2010

ATTORNEY GENERAL'S OFFICE
WORKERS COMPENSATION SECTION

APR 29 2010

RECEIVED

Reminger Co., LPA, Amy S. Thomas, and Kevin R. Sanislo,
for relator.

Richard Cordray, Attorney General, and Colleen C. Erdman,
for respondent Industrial Commission of Ohio.

Butler, Cincione & DiCuccio, and Matthew P. Cincione, for
respondent Timothy Mathews.

IN MANDAMUS
ON OBJECTIONS TO THE MAGISTRATE'S DECISION

SADLER, J.

{¶1} Relator, Sears Roebuck & Co. ("relator"), filed this action seeking a writ of mandamus directing respondent, Industrial Commission of Ohio ("commission"), to

vacate its order granting the June 5, 2008 motion for payment of a fee bill for a September 22, 1998 office visit filed by the claimant, Timothy Mathews ("claimant").¹

{¶2} We referred this case to a magistrate of this court pursuant to Loc.R. 12(M) and Civ.R. 53. On December 7, 2009, the magistrate issued a decision, a copy of which is attached to this decision, granting the writ of mandamus. Respondents each filed objections to the magistrate's decision, and relator filed a memorandum contra. For the reasons that follow, we overrule the objections, and adopt the magistrate's decision.

{¶3} To summarize the facts set forth in the magistrate's decision, on October 13, 1987, claimant sustained an industrial injury during the course of his employment with relator. The industrial claim was initially certified by relator for "torn muscles left leg, tears buttocks and bladder, internal injuries." On September 22, 1998, claimant was examined by Dr. Leah R. Urbanosky. This examination resulted in the creation of an office note, which is quoted in its entirety in the magistrate's decision. The office note describes the nature of the injuries claimant suffered as a result of the 1987 incident, including crush-type injuries to the pelvis and thighs. The office note further states that claimant reported that his left leg felt heavy, and that he was experiencing tingling in his left foot. In the office note, Dr. Urbanosky gave her impression that claimant had mild L5 radiculopathy. Dr. Urbanosky further stated that claimant was at some risk of having a disk herniation even without his prior injuries, and that claimant should return for further evaluation if he experienced pain or numbness.

¹ Claimant and the commission will be referred to collectively as "respondents."

{¶4} By letter dated March 12, 1999, claimant's attorney forwarded a bill for the September 22, 1998 office visit to relator's third-party administrator ("TPA"). The letter indicates that the TPA had previously rejected payment of the bill because the claim had been inactive, and indicated that the TPA should advise counsel immediately if the bill was not going to be paid by relator. The TPA responded by letter dated April 21, 1999. In that letter, the TPA stated that the issue of payment of the bill would be reconsidered upon provision of the office note proving the relationship between the diagnosis and the October 1987 claim. Nothing in the record showed that claimant's counsel responded to the TPA's request for the office note.

{¶5} On April 2, 2008, claimant submitted a C-9 completed by Urological Associates, Inc. The C-9 sought approval for office visits one or two times per year. The TPA denied the C-9 because the industrial claim had expired based on the statute of limitations applicable to such claims. On June 5, 2008, claimant moved for payment of the bill for the September 22, 1998 office visit. In support of the motion, claimant submitted the bill, Dr. Urbanosky's office note, and the April 21, 1999 letter from the TPA to claimant's counsel.

{¶6} After a September 3, 2008 hearing, a district hearing officer ("DHO") issued an order granting claimant's motion for payment of the bill. The DHO cited evidence offered at the hearing that relator had paid for treatment of claimant's lower back in the past. The DHO noted that:

It is significant to note that the Claimant's 10/13/1987 industrial injury involved a crush type injury to the Claimant's pelvis and thighs. The 09/22/1998 office notes of Dr. Urbanosky sets [sic] forth the priority of treating the Claimant's more serious injuries which required some seven surgeries.

{¶7} After an October 24, 2008 hearing, a staff hearing officer ("SHO") affirmed the DHO's order. The SHO found that the medical service provided was reasonably related to the allowed conditions, concluding that:

Claimant suffered severe internal injuries in the vicinity of the lower back. A referral to determine if a lower back injury was a part of these severe injuries was reasonable and indicated. Although no lower back injury is allowed in the claim, in the context of the location and severity of the claimant's other injuries, and his complaints at the time, this referral is a reasonable expense of the allowed industrial injury. This is demonstrated by the office notes of the medical service, notwithstanding the conclusion that the claimant did not have a medical condition which is a part of the allowed conditions in the claim.

The SHO further concluded that the bill had been timely submitted to the employer for payment, and that the commission had jurisdiction to consider the matter under R.C. 4123.52 because the application for payment was made within ten years following the date of the last payment of compensation or benefits.

{¶8} On November 20, 2008, another SHO sent a letter denying relator's administrative appeal from the October 24, 2008 SHO order. On January 22, 2009, the commission mailed an order denying relator's motion for reconsideration, which resulted in the filing of this action.

{¶9} The magistrate concluded that the writ sought by relator should be granted. The magistrate concluded that nothing in Dr. Urbanosky's office note related the symptoms for which claimant sought treatment to any of the allowed conditions. The magistrate concluded that the DHO erred by relying on unspecified evidence that relator had been paying for treatment on claimant's lower back, concluding that payment for such

treatment would not act to amend the claim to add additional conditions related to claimant's lower back. See *State ex rel. Schrichten v. Indus. Comm.*, 90 Ohio St.3d 436, 2000-Ohio-91. The magistrate also concluded that the SHO erred in concluding that the office visit was for the purpose of considering whether lower back conditions should be allowed as additional conclusions, finding that no evidence in the record supported this conclusion.

{¶10} Respondents each filed objections to the magistrate's decision. Since the objections present the same arguments, we will address both sets of objections together. Essentially, respondents argue that the magistrate erred by concluding that there was no evidence in the record to support the commission's decision to order payment of the bill.

{¶11} First, respondents argue that the magistrate erred by concluding that there was no evidence in the record to support the conclusion that the medical services for which payment was sought were reasonably related to the allowed conditions. Medical services must be paid for when those services are reasonably related to the industrial injury, and when the cost of the services is medically reasonable. *State ex rel. Miller v. Indus. Comm.*, 71 Ohio St.3d 229, 1994-Ohio-204.

{¶12} However, we agree with the magistrate's conclusion that nothing in the record establishes any connection between the purpose of claimant's office visit and the allowed conditions. Respondents point to Dr. Urbanosky's office note, in which she described claimant's industrial injury before discussing the symptoms for which claimant was seeking treatment. As pointed out by the magistrate, Dr. Urbanosky's discussion of the industrial injury creates, at most, an inference that there was a causal relationship between the radiculopathy identified by Dr. Urbanosky and claimant's industrial injury. In

the absence of any evidence directly connecting the purpose of the visit with the allowed industrial conditions, the commission abused its discretion by concluding that the office visit was reasonably related to claimant's allowed conditions.

{¶13} Next, respondents argue that it was reasonable for the commission to order payment for the medical services because a referral to determine whether claimant's lower back problems were related to claimant's industrial injury was reasonable, even if the allowance of additional conditions did not actually result. In *State ex rel. Jackson Tube Servs., Inc. v. Indus. Comm.*, 99 Ohio St.3d 1, 2003-Ohio-2259, the Supreme Court of Ohio concluded that when surgery or other medical services are necessary to determine whether additional conditions should be allowed, payment for that surgery or other medical service can be paid as being reasonably related to the claim, even if no additional conditions are allowed as a result.

{¶14} Here, the SHO concluded that the office visit with Dr. Urbanosky was for the purpose of obtaining a diagnosis regarding whether claimant's lower back problem was related to his industrial injury. However, nothing in Dr. Urbanosky's office note states that the purpose of the visit was diagnosis for the purpose of determining whether conditions should be added to the claim, nor does any other evidence in the record support this conclusion. Thus, the commission abused its discretion when it accepted the SHO's conclusion in this regard.

{¶15} Consequently, respondents' objections to the magistrate's decision are overruled. Having reviewed the magistrate's decision, we adopt the decision as our own. Therefore, relator's request for a writ of mandamus is granted ordering the Industrial

Commission of Ohio to vacate its SHO's order of October 24, 2008, and to enter an order denying claimant's June 5, 2008 motion for payment of the fee bill.

*Objections overruled;
writ of mandamus granted.*

McGRATH, J., concurs.
TYACK, P.J., dissents.

TYACK, P.J., dissenting.

{¶16} I would sustain the objections of the commission and of the injured worker. As a result, I would deny the request for a writ of mandamus.

{¶17} Timothy Mathews was seriously injured when he was caught by a conveyor and pinched between a mobile conveyor and a fixed conveyor line while working for Sears, Roebuck & Company ("Sears"), a self-insured employer. He suffered torn muscles of his left leg, torn buttocks, tears of his bladder and unspecified internal injuries. The injuries occurred on October 13, 1987.

{¶18} In 1994, the Ohio Bureau of Workers' Compensation ordered the payment of permanent partial disability of 24 percent. Clearly, the payment of benefits was continuing seven years later, so a medical examination related to the claim done in 1998 would not be time barred.

{¶19} As noted above, the industrial claim has been recognized for "internal injuries." Such a vague phrase to describe a recognized condition is not an ideal choice of language, but apparently means anything or something under the skin was injured.

{¶20} Mathews had surgery on his left leg and had a colostomy, but no back surgery.

{¶21} In 1998, Mathews went to see a doctor because his heavily injured left leg was feeling heavy and he was experiencing tingling down his leg into his left foot. The doctor, Leah Urbanosky of Greater Ohio Orthopedic Surgeons, Inc., diagnosed "mild L5 radiculopathy on the left."

{¶22} The bill for Dr. Urbanosky's examination was submitted to Frank Gates Service Company ("Gates"), which was handling the matter for Sears. In December 1998, payment was refused because "claim is inactive."

{¶23} In March 1999, counsel for Mathews sent another request for payment to Gates. Gates had earlier received a copy of the findings of Dr. Urbanosky with respect to current conditions, examination, impression, and plan for Timothy Mathews. The fact the document was received is evidence by a Gates file stamp reflecting it was received on December 28, 1998.

{¶24} Gates did not have the bill paid, but instead requested "the office notes" for the examination in April 1999 in order to decide whether to pay voluntarily.

{¶25} At some point in time Helmsman Management Services, Inc. ("Helmsman") apparently took over management of the file for Sears. Helmsman sent a fax on May 16, 2008 saying that "the claim is dead by statute" because no payments had been made on the claim since March 1997. Helmsman did not give any indication that it was aware that its predecessor Gates had left payment of the bill in limbo less than ten years earlier.

{¶26} A self-insured employer cannot refuse repeated requests for payment of a bill and then claim the file is dead because it has made no payment within the last 10 years. The Industrial Commission clearly was correct to reject this allegation made on behalf of Sears.

{¶27} The commission also was correct to find that the medical service was reasonably related to the original injury. Mathews had every right to have a doctor tell him what was going on when his seriously injured left leg began feeling heavy and he was experiencing pain and tingling down that leg into his foot.

{¶28} We are not here to decide whether or not the mild radiculopathy experienced by Timothy Mathews should be the basis for an on-going course of treatment. We are here only to decide if Mathews could have a doctor diagnose, at Sears' cost, the cause of the feeling of heaviness and the tingling in his seriously injured left leg. I believe that Mathews clearly had a right to have that diagnosis paid for as a part of his workers' compensation claim. I believe that the commission was completely correct in its handling of the matter.

{¶29} I would sustain the objections to the magistrate's decision and deny the request for a writ of mandamus.

APPENDIX

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

State of Ohio ex rel. Sears Roebuck & Co., :

Relator, :

v. : No. 09AP-180

Industrial Commission of Ohio : (REGULAR CALENDAR)
and Timothy Mathews, :

Respondents. :

MAGISTRATE'S DECISION

Rendered on December 7, 2009

Reminger Co., LPA, Amy S. Thomas and Kevin R. Sanislo,
for relator.

Richard Cordray, Attorney General, and Colleen C. Erdman,
for respondent Industrial Commission of Ohio.

Butler, Cincione & DiCuccio, and Matthew P. Cincione,
for respondent Timothy Mathews.

IN MANDAMUS

{¶30} In this original action, relator, Sears Roebuck & Co., requests a writ of mandamus ordering respondent Industrial Commission of Ohio ("commission") to vacate its order granting the June 5, 2008 motion of respondent Timothy Mathews

("claimant") for payment of a fee bill for a September 22, 1998 office visit, and to enter an order denying the motion.

Findings of Fact:

{¶31} 1. On October 13, 1987, claimant sustained an industrial injury in the course of and arising out of his employment with relator, a self-insured employer under Ohio's workers' compensation laws. On that date, claimant became pinched between a mobile conveyor and a fixed conveyor line. The industrial claim (No. 956928-22) was initially certified by relator for "torn muscles left leg; tears buttocks and bladder; internal injuries."

{¶32} 2. Claimant has attached to his brief filed in this action a November 9, 1987 letter from Associated Risk Services Corp. to claimant. The letter states:

This will acknowledge receipt of your claim for workers' compensation benefits for an injury suffered while in the employ of Sears, Roebuck and Co. Your claim is allowed for fracture pelvis, laceration left thigh, severe abdominal injuries. Should you have conditions other than listed above which you allege are the result of this compensable injury, please notify this office in writing.

{¶33} 3. Claimant has also attached to his brief filed in this action a May 8, 2009 letter from relator's counsel acknowledging the November 9, 1987 letter, stating:

* * * [T]he employer will be accepting the claim for the additional conditions of: fracture left pelvis; laceration left thigh; and severe abdominal injuries.

{¶34} 4. The stipulated record does not contain the November 9, 1987 or May 8, 2009 letters described above.

{¶35} 5. On September 22, 1998, claimant was examined by Leah R. Urbanosky, M.D., during a visit to the offices of Greater Ohio Orthopedic Surgeons Inc. The office visit generated an office note from Dr. Urbanosky.

{¶36} 6. By letter dated March 12, 1999, claimant's attorney forwarded a bill for the September 22, 1998 office visit to relator's third-party administrator ("TPA"). In the letter, claimant's attorney explained:

* * * This was billed to your office for payment and was rejected on the basis that the claim had been inactive. As your file should reflect, Mr. Mathews has been under the care of one or more physicians at Greater Ohio Orthopedic Surgeons, Inc. His previous physician recently died and Dr. Urbanosky has taken over Mr. Mathews' care.

* * *

If your client is unwilling to pay this bill, please advise me immediately in order that we may take the appropriate action relative to this matter. Your prompt response is appreciated.

{¶37} 7. Relator's TPA responded with a letter to claimant's counsel dated April 21, 1999. The letter states:

We are in receipt of your letter dated March 12, 1999 requesting the employer reconsider their position on the payment of the outstanding bill from Greater Ohio Orthopedic Surgeons for service date September 22, 1998.

We understand your concern regarding this one payment; however, Mr. Mathew's' [sic] has not received any medical treatment from this provider since February 6, 1996. The employer agrees to consider accepting payment for this date of service, but we request you provide us with the office notes to prove the relationship and diagnosis to his October 13, 1987 claim.

{¶38} 8. There is no evidence in the record showing that relator's counsel ever responded to the TPA's April 21, 1999 request for the office notes.

{¶39} 9. On April 2, 2008, claimant submitted for authorization a C-9 completed by Urological Associates, Inc. The C-9 sought approval for urological office visits one to two times per year.

{¶40} 10. Relator's TPA denied the C-9 on grounds that the industrial claim had expired because of the statute of limitations on industrial claims.

{¶41} 11. On June 5, 2008, claimant moved for payment of the bill for the September 22, 1998 office visit with Dr. Urbanosky. Besides the bill, claimant submitted Dr. Urbanosky's September 22, 1998 office note and the April 21, 1999 letter from relator's TPA.

{¶42} 12. Dr. Urbanosky's September 22, 1998 office note states in its entirety:

CURRENT CONDITION: Timothy is a 33-year-old male, followed previously by Dr. Marsalka, who was involved in a severe crush-type injury to his pelvis and thighs back in October of 1987. At that time, he required soft tissue surgery on his left leg and had to have a colostomy, as well as suprapubic tube and wear a Foley for a while. He did not require any pelvis or back surgery at the time and overall seems to have recovered well. He works as a chemist at Roxanne Labs. He states over the last two days or so his left leg has been feeling "heavy" with associated tingling into the dorsum of his left foot. He states it feels as if his leg falls asleep. However, the tingling seems to be constant. He has minimal associated back pain or other radicular-type pains at this time. He denies any frank weakness of his extremity, difficulties with urination or bowel movements including retention or incompetence.

EXAMINATION: On physical examination, has in touch sensation to pinprick, as well as light touch in the S1, L5, L4, L3, and L2 distributions on his lower extremities. He does have slightly increased two-point discrimination on the left in comparison with the right on the dorsum of his foot with consistent two-point distinction evident at 14 mm. on the left compared with 12 mm. on the right. He has negative straight leg raise while sitting and also while lying supine on both

extremities. He does have a mildly positive Lasegue on the left with dorsiflexion of the foot at approximately 60° with leg elevation. His reflexes are symmetric bilaterally for the patellar reflex, as well as the Achilles reflex. He does not have any evidence of motor weakness and demonstrates 5/5 strength on single leg toe raises totaling 20 on the bilateral extremities with no knee bending. He has 5/5 strength on toe dorsiflexion, ankle eversion, ankle dorsiflexion and on quads extension activities. He has no bony tenderness to palpation over the spine or SI joints. He is able to demonstrate good range of motion on flexion and extension, lateral rotation and lateral bending with minimal difficulty.

IMPRESSION: Mild L5 radiculopathy on the left.

PLAN: He has been encouraged to take his Motrin on a regular basis which he usually takes for migraines periodically. In addition, he has been encouraged to maintain his regular activities within the limits of any pain which presently is minimal. I have encouraged aerobic-type activities, as well as abdominal exercises and gradual back muscle strengthening-type exercises. I have encouraged him to minimize weight lifting-type activities which he wishes to begin at least until this numbness is resolved. He has been warned that being in his 30's he is, even without his prior injuries, at risk of having a disk herniation. Should this manifest itself with more pain or frank numbness or limping/weakness, I have encouraged him to return for further evaluation. At that time, we would consider possible epidural steroid injections. However, they are not indicated at this time. He is to see me back in four weeks or if there are any problems in the interim.

{¶43} 13. Following a September 3, 2008 hearing, a district hearing officer ("DHO") issued an order granting claimant's June 5, 2008 motion. The DHO's order explains:

The District Hearing Officer finds that the Industrial Commission has jurisdiction under R.C. 4123.52 to consider the merits of the Claimant's request. At the time that the Claimant submitted the 09/22/1998 bill in the amount of \$50.00 from Greater Ohio Orthopedic Surgeons to the self-insured employer for payment[,] the claim was still active.

The 04/21/1999 letter from the employer's representative acknowledges the receipt of the outstanding bill from the Greater Ohio Orthopedic Surgeons. The letter also indicates that payment will be considered upon submission of office notes.

Authorization is granted for the payment of the \$50.00 bill from Greater Ohio Orthopedic Surgeons. The authorization for the payment of this bill is based upon the 09/22/2008 [sic] office notes of Dr. Urbanosky. In addition, the evidence presented at hearing by Claimant's counsel indicated that the self-insured employer had been paying for treatment related to the low back area in the past. It is significant to note that the Claimant's 10/13/1987 industrial injury involved a crush type injury to the Claimant's pelvis and thighs. The 09/22/1998 office notes of Dr. Urbanosky sets forth the priority of treating the Claimant's more serious injuries which required some seven surgeries.

{¶44} 14. Relator administratively appealed the DHO's order of September 3, 2008.

{¶45} 15. Following an October 24, 2008 hearing, a staff hearing officer ("SHO") issued an order affirming the DHO's order of September 3, 2008. The SHO's order explains:

It is the order of the Staff Hearing Officer that the injured worker's C-86, filed 06/05/2008, is granted to the extent of this order.

The Staff Hearing Officer affirms the District Hearing Officer's direction that the self-insuring employer pay the \$50.00 bill from Greater Ohio Orthopedic Surgeons, date of service 09/22/1998. This bill was submitted to the employer soon after the service.

By 04/21/1999 letter[,] the employer's third part[y] administrator acknowledge[d] receipt of the letter and stated that the payment would be considered upon submission of office notes. This letter does not constitute the denial of payment.

The Staff Hearing Officer has considered [the] employer's four defenses to the payment of this bill, and finds none of them well taken.

First, the medical service is reasonably related to the allowed industrial injury. Claimant suffered severe internal injuries in the vicinity of the lower back. A referral to determine if a lower back injury was a part of these severe injuries was reasonable and indicated. Although no lower back injury is allowed in the claim, in the context of the location and severity of the claimant's other injuries, and his complaints at the time, this referral is a reasonable expense of the allowed industrial injury. This is demonstrated by the office notes of the medical service, notwithstanding the conclusion that the claimant did not have a medical condition which is a part of the allowed conditions in the claim.

Ohio Administrative Code 4123-3-23 is complied with. The fee bill under consideration was filed with the self-insuring employer within two years of the date of service. There is no obligation to file a C-86 or other demand for hearing which [sic] within any specific period following the TPA's request for further evidence on the facts of this claim. There was no denial by the employer of payment at this time.

Ohio Administrative Code 4123-7-01(B) is inapplicable, as this is a claim in which compensation has been paid.

Finally, the date of filing of demand for payment of this bill is the date on which the bill was filed with the third party administrator, not the date of filing of the C-86 under consideration. Consequently[,] there was an application made for payment of this bill within ten years following the date of last payment of compensation or benefits, and there is jurisdiction to consider the matter under Revised Code Section 4123.52.

{¶46} 16. On November 20, 2008, another SHO mailed an order refusing relator's administrative appeal from the SHO's order of October 24, 2008.

{¶47} 17. On January 22, 2009, the three-member commission mailed an order denying relator's motion for reconsideration.

{¶48} 18. On February 20, 2009, relator, Sears Roebuck & Co., filed this mandamus action.

Conclusions of Law:

{¶49} It is the magistrate's decision that this court issue a writ of mandamus, as more fully explained below.

{¶50} The Supreme Court of Ohio has articulated a three-pronged test for the authorization of medical services: (1) are the medical services reasonably related to the industrial injury, that is, the allowed conditions? (2) are the services reasonably necessary for treatment of the industrial injury? and (3) is the cost of such service medically reasonable? *State ex rel. Miller v. Indus. Comm.* (1994), 71 Ohio St.3d 229, 232.

{¶51} In *Miller*, the claimant sought authorization for a supervised weight loss program. The *Miller* court rejected the employer's position that the claimant was required to first obtain an additional claim allowance for obesity.

{¶52} Additionally identified conditions that may be related to an industrial injury must be formally recognized in the claim if they are to become the basis for compensation. *State ex rel. Jackson Tube Servs., Inc. v. Indus. Comm.*, 99 Ohio St.3d 1, 2003-Ohio-2259.

{¶53} Moreover, the Supreme Court of Ohio has repeatedly rejected the proposition that a medical condition is implicitly allowed when a self-insured employer authorizes and pays for surgery performed to treat the condition. *State ex rel. Schrichten v. Indus. Comm.* (2000), 90 Ohio St.3d 436, quoting *State ex rel. Griffith v. Indus. Comm.* (1999), 87 Ohio St.3d 154, 156.

{¶54} Moreover, the payment of TTD compensation for a medical condition that has never been formally allowed does not create an implicit claim allowance for that condition. *State ex rel. Turner v. Indus. Comm.* (2000), 89 Ohio St.3d 373.

{¶55} Where the authorization of surgery or diagnostic medical services is at issue, an exception can occur to the general requirement that formal allowance of medical conditions must be obtained prior to the authorization of the surgery or diagnostic services. In *Jackson Tube*, the industrial claim was allowed for a torn left rotator cuff and other injuries. In May 1998, Dr. Don D. Delcamp performed open surgery on the shoulder and repaired two tears. Despite the operation, the claimant continued to have shoulder problems. In May 2000, the claimant sought to change doctors and get further treatment.

{¶56} Dr. Jonathan J. Paley proposed a video arthroscopic surgery "to delineate the exact cause of the intra-articular problem." *Id.* at ¶5. He further proposed that he be authorized to repair the shoulder conditions found to need repair during the arthroscopic surgery. Dr. Paley pointed out that it would be unethical to subject the patient to additional risk by simply doing a surgical diagnostic procedure and then seeking additional claim allowances before proceeding with surgical repair. The commission authorized the surgical procedure as proposed by Dr. Paley, thus prompting a mandamus action from the employer.

{¶57} The *Jackson Tube* court upheld the commission's authorization, explaining:

This is a difficult issue. On one hand, claimant could not move for additional allowance beforehand, since without the surgery, the problematic conditions could not be identified.

On the other hand, self-insured JTS questions its recourse when ordered to pay for surgery that ultimately reveals any conditions to be nonindustrial. It also fears that payment could be interpreted as an implicit allowance of all of the conditions in the postoperative diagnosis.

* * *

JTS argues that *Miller* does not excuse additional allowance of conditions before surgery where the conditions are specific and can be assigned to a particular body part. It describes *Miller* as carving only a limited exception for those conditions unamenable to allowance because of their generalized nature—*Miller's* overall obesity, for example.

All agree that *Miller* was never intended to permit an employee to circumvent additional allowance by simply asserting a relationship to the original injury. The problem in this case, however, is that because any conditions are internal, claimant could not know what conditions to seek additional allowance for without first getting the diagnosis that only surgery could provide.

Id. at ¶22, 24-25.

{¶58} At issue here is whether the commission abused its discretion in determining that the September 22, 1998 office visit was reasonably related to the industrial injury.

{¶59} In this regard, the DHO's order states in part:

[T]he evidence presented at hearing by Claimant's counsel indicated that the self-insured employer had been paying for treatment related to the low back area in the past. It is significant to note that the Claimant's 10/13/1987 industrial injury involved a crush type injury to the Claimant's pelvis and thighs. The 09/22/1998 office notes of Dr. Urbanosky sets forth the priority of treating the Claimant's more serious injuries which required some seven surgeries.

{¶60} As earlier noted, the SHO's order states that the DHO's order is affirmed.

At issue here is the following paragraph of the SHO's order:

First, the medical service is reasonably related to the allowed industrial injury. Claimant suffered severe internal injuries in the vicinity of the lower back. A referral to determine if a lower back injury was a part of these severe injuries was reasonable and indicated. Although no lower back injury is allowed in the claim, in the context of the location and severity of the claimant's other injuries, and his complaints at the time, this referral is a reasonable expense of the allowed industrial injury. This is demonstrated by the office notes of the medical service, notwithstanding the conclusion that the claimant did not have a medical condition which is a part of the allowed conditions in the claim.

{¶61} Analysis begins with the observation that it was Dr. Urbanosky's "impresssion" that the symptomology complained of on September 22, 1998 was caused by or the result of a "[m]ild L5 radiculopathy on the left"—undisputedly a nonallowed condition. Nowhere in the office note does Dr. Urbanosky opine that "[m]ild L5 radiculopathy on the left" is a condition arising from the industrial injury of October 13, 1987. But even if Dr. Urbanosky had so opined, the problem would remain that the condition is not allowed.

{¶62} At best, it can perhaps be said that a casual relationship between "[m]ild L5 radiculopathy on the left" and the industrial injury is inferred or suggested by the fact that Dr. Urbanosky begins her office note by discussing the industrial injury. But again, even if causal relationship could be inferred by this initial discussion of the industrial injury, the problem remains that the condition has not been allowed.

{¶63} Clearly, the DHO erred by relying upon unspecified evidence that "the self-insured employer had been paying for treatment related to the low back area in the past." Clearly, that relator may have paid for treatment related to the low back does not automatically amend the claim to include the conditions related to the low back for

which treatment was provided and paid for. *Schrichten; Griffith*. To the extent that the SHO adopted the DHO's rationale in affirming the order, the SHO clearly erred.

{¶64} Endeavoring to circumvent the problem created by Dr. Urbanosky's finding that claimant's reported symptomology was caused by a nonallowed condition, the SHO finds that the office visit was a "referral to determine if a lower back injury" should be included in the allowed conditions of the claim. There is no evidence in the record to support this finding.

{¶65} It appears from the September 22, 1998 office note that claimant presented to Dr. Urbanosky's office seeking treatment for the symptoms reported to the doctor on that date. In the paragraph captioned "PLAN," Dr. Urbanosky sets forth a course of future conservative treatment. There is no indication in Dr. Urbanosky's office note that claimant was referred to her office for the purpose of determining whether a low back condition should be included in the claim. Thus, this is not a case, as suggested by the SHO, where a claimant was sent out for a medical examination to determine the extent of his or her injuries for purposes of amending the industrial claim.

{¶66} Given that the record fails to support the SHO's finding that claimant was referred to Dr. Urbanosky for a determination of whether the claim should be amended, this court need not determine whether such a referral would permit payment of the fee bill at issue.

{¶67} In summary, based upon the above analysis, there is no evidence to support the commission's finding that the September 22, 1998 office visit was reasonably related to the industrial injury.

{¶68} Accordingly, for all the above reasons, it is the magistrate's decision that this court issue a writ of mandamus ordering the commission to vacate its SHO's order of October 24, 2008, and to enter an order denying claimant's June 5, 2008 motion for payment of the fee bill.

AT JOHANNY G. GENERALI'S OFFICE
 NUMBERED COMMISSION SECTION

APR 9 2010

RECEIVED

ISI Kenneth W. Macke

 KENNETH W. MACKE
 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).

4123.35 Payment of premiums by employers.

(A) Except as provided in this section, every employer mentioned in division (B)(2) of section 4123.01 of the Revised Code, and every publicly owned utility shall pay semiannually in the months of January and July into the state insurance fund the amount of annual premium the administrator of workers' compensation fixes for the employment or occupation of the employer, the amount of which premium to be paid by each employer to be determined by the classifications, rules, and rates made and published by the administrator. The employer shall pay semiannually a further sum of money into the state insurance fund as may be ascertained to be due from the employer by applying the rules of the administrator, and a receipt or certificate certifying that payment has been made, along with a written notice as is required in section 4123.54 of the Revised Code, shall be mailed immediately to the employer by the bureau of workers' compensation. The receipt or certificate is prima-facie evidence of the payment of the premium, and the proper posting of the notice constitutes the employer's compliance with the notice requirement mandated in section 4123.54 of the Revised Code.

The bureau of workers' compensation shall verify with the secretary of state the existence of all corporations and organizations making application for workers' compensation coverage and shall require every such application to include the employer's federal identification number.

An employer as defined in division (B)(2) of section 4123.01 of the Revised Code who has contracted with a subcontractor is liable for the unpaid premium due from any subcontractor with respect to that part of the payroll of the subcontractor that is for work performed pursuant to the contract with the employer.

Division (A) of this section providing for the payment of premiums semiannually does not apply to any employer who was a subscriber to the state insurance fund prior to January 1, 1914, or who may first become a subscriber to the fund in any month other than January or July. Instead, the semiannual premiums shall be paid by those employers from time to time upon the expiration of the respective periods for which payments into the fund have been made by them.

The administrator shall adopt rules to permit employers to make periodic payments of the semiannual premium due under this division. The rules shall include provisions for the assessment of interest charges, where appropriate, and for the assessment of penalties when an employer fails to make timely premium payments. An employer who timely pays the amounts due under this division is entitled to all of the benefits and protections of this chapter. Upon receipt of payment, the bureau immediately shall mail a receipt or certificate to the employer certifying that payment has been made, which receipt is prima-facie evidence of payment. Workers' compensation coverage under this chapter continues uninterrupted upon timely receipt of payment under this division.

Every public employer, except public employers that are self-insuring employers under this section, shall comply with sections 4123.38 to 4123.41, and 4123.48 of the Revised Code in regard to the contribution of moneys to the public insurance fund.

(B) Employers who will abide by the rules of the administrator and who may be of sufficient financial ability to render certain the payment of compensation to injured employees or the dependents of killed employees, and the furnishing of medical, surgical, nursing, and hospital attention and services and medicines, and funeral expenses, equal to or greater than is provided for in sections 4123.52, 4123.55

to 4123.62, and 4123.64 to 4123.67 of the Revised Code, and who do not desire to insure the payment thereof or indemnify themselves against loss sustained by the direct payment thereof, upon a finding of such facts by the administrator, may be granted the privilege to pay individually compensation, and furnish medical, surgical, nursing, and hospital services and attention and funeral expenses directly to injured employees or the dependents of killed employees, thereby being granted status as a self-insuring employer. The administrator may charge employers who apply for the status as a self-insuring employer a reasonable application fee to cover the bureau's costs in connection with processing and making a determination with respect to an application.

All employers granted status as self-insuring employers shall demonstrate sufficient financial and administrative ability to assure that all obligations under this section are promptly met. The administrator shall deny the privilege where the employer is unable to demonstrate the employer's ability to promptly meet all the obligations imposed on the employer by this section.

(1) The administrator shall consider, but is not limited to, the following factors, where applicable, in determining the employer's ability to meet all of the obligations imposed on the employer by this section:

- (a) The employer employs a minimum of five hundred employees in this state;
- (b) The employer has operated in this state for a minimum of two years, provided that an employer who has purchased, acquired, or otherwise succeeded to the operation of a business, or any part thereof, situated in this state that has operated for at least two years in this state, also shall qualify;
- (c) Where the employer previously contributed to the state insurance fund or is a successor employer as defined by bureau rules, the amount of the buyout, as defined by bureau rules;
- (d) The sufficiency of the employer's assets located in this state to insure the employer's solvency in paying compensation directly;
- (e) The financial records, documents, and data, certified by a certified public accountant, necessary to provide the employer's full financial disclosure. The records, documents, and data include, but are not limited to, balance sheets and profit and loss history for the current year and previous four years.
- (f) The employer's organizational plan for the administration of the workers' compensation law;
- (g) The employer's proposed plan to inform employees of the change from a state fund insurer to a self-insuring employer, the procedures the employer will follow as a self-insuring employer, and the employees' rights to compensation and benefits; and
- (h) The employer has either an account in a financial institution in this state, or if the employer maintains an account with a financial institution outside this state, ensures that workers' compensation checks are drawn from the same account as payroll checks or the employer clearly indicates that payment will be honored by a financial institution in this state.

The administrator may waive the requirements of divisions (B)(1)(a) and (b) of this section and the requirement of division (B)(1)(e) of this section that the financial records, documents, and data be

certified by a certified public accountant. The administrator shall adopt rules establishing the criteria that an employer shall meet in order for the administrator to waive the requirement of division (B)(1)(e) of this section. Such rules may require additional security of that employer pursuant to division (E) of section 4123.351 of the Revised Code.

The administrator shall not grant the status of self-insuring employer to the state, except that the administrator may grant the status of self-insuring employer to a state institution of higher education, excluding its hospitals, that meets the requirements of division (B)(2) of this section.

(2) When considering the application of a public employer, except for a board of county commissioners described in division (G) of section 4123.01 of the Revised Code, a board of a county hospital, or a publicly owned utility, the administrator shall verify that the public employer satisfies all of the following requirements as the requirements apply to that public employer:

(a) For the two-year period preceding application under this section, the public employer has maintained an unvoted debt capacity equal to at least two times the amount of the current annual premium established by the administrator under this chapter for that public employer for the year immediately preceding the year in which the public employer makes application under this section.

(b) For each of the two fiscal years preceding application under this section, the unreserved and undesignated year-end fund balance in the public employer's general fund is equal to at least five per cent of the public employer's general fund revenues for the fiscal year computed in accordance with generally accepted accounting principles.

(c) For the five-year period preceding application under this section, the public employer, to the extent applicable, has complied fully with the continuing disclosure requirements established in rules adopted by the United States securities and exchange commission under 17 C.F.R. 240.15c 2-12.

(d) For the five-year period preceding application under this section, the public employer has not had its local government fund distribution withheld on account of the public employer being indebted or otherwise obligated to the state.

(e) For the five-year period preceding application under this section, the public employer has not been under a fiscal watch or fiscal emergency pursuant to section 118.023, 118.04, or 3316.03 of the Revised Code.

(f) For the public employer's fiscal year preceding application under this section, the public employer has obtained an annual financial audit as required under section 117.10 of the Revised Code, which has been released by the auditor of state within seven months after the end of the public employer's fiscal year.

(g) On the date of application, the public employer holds a debt rating of Aa3 or higher according to Moody's investors service, inc., or a comparable rating by an independent rating agency similar to Moody's investors service, inc.

(h) The public employer agrees to generate an annual accumulating book reserve in its financial statements reflecting an actuarially generated reserve adequate to pay projected claims under this

chapter for the applicable period of time, as determined by the administrator.

(i) For a public employer that is a hospital, the public employer shall submit audited financial statements showing the hospital's overall liquidity characteristics, and the administrator shall determine, on an individual basis, whether the public employer satisfies liquidity standards equivalent to the liquidity standards of other public employers.

(j) Any additional criteria that the administrator adopts by rule pursuant to division (E) of this section.

The administrator shall not approve the application of a public employer, except for a board of county commissioners described in division (G) of section 4123.01 of the Revised Code, a board of a county hospital, or publicly owned utility, who does not satisfy all of the requirements listed in division (B)(2) of this section.

(C) A board of county commissioners described in division (G) of section 4123.01 of the Revised Code, as an employer, that will abide by the rules of the administrator and that may be of sufficient financial ability to render certain the payment of compensation to injured employees or the dependents of killed employees, and the furnishing of medical, surgical, nursing, and hospital attention and services and medicines, and funeral expenses, equal to or greater than is provided for in sections 4123.52, 4123.55 to 4123.62, and 4123.64 to 4123.67 of the Revised Code, and that does not desire to insure the payment thereof or indemnify itself against loss sustained by the direct payment thereof, upon a finding of such facts by the administrator, may be granted the privilege to pay individually compensation, and furnish medical, surgical, nursing, and hospital services and attention and funeral expenses directly to injured employees or the dependents of killed employees, thereby being granted status as a self-insuring employer. The administrator may charge a board of county commissioners described in division (G) of section 4123.01 of the Revised Code that applies for the status as a self-insuring employer a reasonable application fee to cover the bureau's costs in connection with processing and making a determination with respect to an application. All employers granted such status shall demonstrate sufficient financial and administrative ability to assure that all obligations under this section are promptly met. The administrator shall deny the privilege where the employer is unable to demonstrate the employer's ability to promptly meet all the obligations imposed on the employer by this section. The administrator shall consider, but is not limited to, the following factors, where applicable, in determining the employer's ability to meet all of the obligations imposed on the board as an employer by this section:

- (1) The board as an employer employs a minimum of five hundred employees in this state;
- (2) The board has operated in this state for a minimum of two years;
- (3) Where the board previously contributed to the state insurance fund or is a successor employer as defined by bureau rules, the amount of the buyout, as defined by bureau rules;
- (4) The sufficiency of the board's assets located in this state to insure the board's solvency in paying compensation directly;
- (5) The financial records, documents, and data, certified by a certified public accountant, necessary to provide the board's full financial disclosure. The records, documents, and data include, but are not

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4123-19-03 Where an employer desires to secure the privilege to pay compensation, etc., directly.

(A) All employers granted the privilege to pay compensation directly shall demonstrate sufficient financial strength and administrative ability to assure that all obligations under section 4123.35 of the Revised Code will be met promptly. The administrator of workers' compensation shall deny the privilege to pay compensation, etc., directly, where the employer is unable to demonstrate its ability to promptly meet all the obligations under the rules of the commission and bureau and section 4123.35 of the Revised Code. The administrator shall consider, but shall not be limited to the factors in divisions (B)(1) and (B)(2) of section 4123.35 of the Revised Code where they are applicable in determining the employer's ability to meet all obligations under section 4123.35 of the Revised Code.

The administrator shall review all financial records, documents, and data necessary to provide a full financial disclosure of the employer, certified by a certified public accountant, including but not limited to, the balance sheets and a profit and loss history for the current year and the previous four years. For purposes of this rule, certified financial statements shall be construed by the administrator as audited by a certified public accountant, in accordance with generally accepted accounting principles, and shall include the certified public accountant's audit opinion.

(1) In determining whether to grant a waiver of the requirement of division (B)(1)(e) of section 4123.35 of the Revised Code for certified financial records, the administrator shall consider the following criteria and conditions.

(a) The administrator shall require reviewed financial statements, including full footnote disclosure, to be prepared and submitted in accordance with generally accepted accounting principles. For the purposes of this rule, "reviewed financial statements" shall mean financial statements that have been subject to procedures performed by a certified public accountant in accordance with AICPA Professional Standards, specifically, Statements on Standards for Accounting and Review Services, Section 100, Paragraph .24 through .38, December 1978.

(b) The administrator may utilize the services of a commercial credit reporting bureau to assist in the evaluation of an applicant's ability to meet its workers' compensation obligations. The cost of this commercial reporting service shall be assumed by the applicant employer.

(c) Notwithstanding the above criteria, the administrator may deem it necessary for an applicant employer to provide additional security to ensure meeting its workers' compensation obligations. The amount of such additional security shall be in the form and amount as determined by the administrator and provided prior to the granting of self-insurance. Pursuant to paragraph (F) of this rule, in the event of the default of the self-insuring employer, the bureau shall first seek reimbursement from the additional security, which shall be first liable and exhausted, before payment is made from the self-insuring employers' guaranty fund under section 4123.351 of the Revised Code.

(2) The administrator shall not grant the status of self-insuring employer to the state, except that the administrator may grant the status of self-insuring employer to a state institution of higher education, excluding its hospitals.

(B) The employer shall secure from the bureau of workers' compensation proper application form(s) for completion. The completed application shall be filed with the bureau at least ninety days prior to the effective date of the employer's requested status as a self-insurer. The administrator may require that the application be accompanied by an application fee as established by bureau resolution to cover the cost of processing the application in accordance with section 4123.35 of the Revised Code. The application shall not be deemed complete until all required information is attached thereto. Prior to presentation to the administrator, applicable items listed in divisions (B)(1) and (B)(2) of section 4123.35 of the Revised Code shall be made available to the bureau and shall be reviewed by the bureau of workers' compensation. The bureau shall only accept applications which contain the required information.

(C) The bureau shall recognize only such application forms which provide answers to all questions asked and furnish such information as may be required.

(D) Return of the completed forms required by this rule and any additional information required by the bureau to process the employer's application should be submitted at least ninety days prior to the effective date of the employer's requested status as a self-insurer.

(1) If the administrator determines to grant the privilege of self-insurance, the bureau shall issue a "Finding of Facts" statement which has been prepared by the bureau, signed by the administrator, subject to all conditions outlined in paragraph (L)(3) of this rule.

(2) If the administrator determines not to grant the privilege of self-insurance, the bureau shall so notify the employer, whereupon the employer shall be required to continue to pay its full premium into the state insurance fund.

(E) All employers that have secured the privilege to pay compensation, etc., directly, will be required to make contributions as determined by the administrator to the self-insuring employers' guaranty fund established under section 4123.351 of the Revised Code, and, if an additional security is required by the bureau, in the amount or form that may be specified by the bureau. If the additional security is in the form of a surety bond, the bond shall be from a company approved by the bureau and authorized to do business in the state of Ohio by the Ohio department of insurance. The surety bond shall be in the form prescribed by the bureau. The penal amount of such additional security is to be fixed by the administrator.

(F) The surety bond or additional security furnished by the employer shall be for an amount and period as established by the bureau and may be periodically reviewed and reevaluated by the bureau. The surety bond or additional security shall provide on its face that the surety shall be responsible for the payment of all claims where the cause of action, as determined by the date of injury or date of occupational disease, arose during the liability of the surety bond or additional security. The liability under the surety bond or additional security and the rights and obligations of the surety shall be limited to reimbursement for the amounts paid from the surplus accounts of the state insurance fund by reason of the default of the self-insuring employer in accordance with division (B) of section 4123.82 of the Revised Code; however, in the event of such self-insuring employer's default, the bureau shall first seek reimbursement from the surety bond or additional security, which shall be first liable and exhausted, before payment is made from the self-insuring employers' guaranty fund established under section 4123.351 of the Revised Code. Upon default of the self-insuring employer, it

shall be the responsibility of the administrator of the bureau of workers' compensation to represent the interests of the state insurance fund and the self-insuring employers' guaranty fund. The administrator, on behalf of the self-insuring employers' guaranty fund, has the rights of reimbursement and subrogation and shall collect from a defaulting self-insuring employer or other liable person all amounts the bureau has paid or reasonably expects to pay from the guaranty fund on account of the defaulting self-insuring employer.

(G) The security herein required to be given by the employer shall be given to the state of Ohio, for the benefit of the disabled or the dependents of killed employees of the employer filing the same, and shall be conditioned for the payment by the employer of such compensation to disabled employees or the dependents of killed employees of such employer, and the furnishing to them of medical, surgical, nursing and hospital attention and services, medicines and funeral expenses equal to or greater than is provided by the Ohio workers' compensation law and for the full compliance with the rules and regulations of the commission and bureau and rules of procedure.

(H) If another or parent corporation or entity owns more than fifty per cent of the stock of an employer, such employer must furnish a contract of guaranty executed by the ultimate domestic parent corporation or entity. If the employer establishes to the bureau that such contract of guaranty cannot be given by the ultimate domestic parent corporation, then the bureau may, in its discretion, waive the requirement of a contract of guaranty. The bureau may require an alternative form of security.

(I) From the effective date of this rule, employees having one or more years of experience as a workers' compensation administrator for a self-insuring employer in Ohio shall be deemed sufficiently competent and knowledgeable to administer a program of self-insurance. Those self-insuring employers that employ workers' compensation administrators who have less than one year of experience as a workers' compensation administrator in Ohio shall not have its status as a self-insuring employer affected pending notification by bureau of workers' compensation as to whether mandatory attendance of the administrator at a bureau of workers' compensation training program is required. If the bureau determines that the administrator is not able to administer a self-insuring program, the bureau may direct mandatory attendance of the administrator at a bureau of workers' compensation training program until such time as the bureau determines that the administrator is sufficiently competent and knowledgeable to run such a workers' compensation program. The cost of the bureau's training of the administrator(s) under this rule will be borne by the self-insuring employer or self-insuring employer applicant. By accepting the privilege of self-insurance, an employer acknowledges that the ultimate responsibility for the administration of workers' compensation claims in accordance with the law and rules of the bureau of workers' compensation and the commission rests with that employer. The self-insuring employer's records and compliance with the bureau of workers' compensation and commission rules shall be subject to periodic audit by the bureau of workers' compensation.

A self-insuring employer or applicant shall designate one of its Ohio employees who is knowledgeable and experienced with the requirements of the Ohio Workers' Compensation Act and rules and regulations therein, as administrator of its self-insuring program. The requirement for an Ohio administrator may be waived at the discretion of the bureau. The name and telephone number of the Ohio administrator, or non-Ohio administrator where the Ohio requisite has been waived, shall be posted by the employer in a prominent place at all the employer's locations. The administrator's duties

shall include, but not be limited to:

- (1) Acting as liaison between the employer, the bureau of workers' compensation and the commission, and providing information to the agency upon request;
- (2) Providing assistance to claimants in the filing of claims and applications for benefits;
- (3) Providing information to claimants regarding the processing of claims and the benefits to which claimants may be entitled;
- (4) Providing the various forms to be used in seeking compensation or benefits;
- (5) Accepting or rejecting claims for benefits;
- (6) Approving the payment of compensation and benefits to, or on behalf of, claimants, pursuant to paragraph (K) of this rule.

This rule is not intended to prevent the hiring of an attorney or representative to assist the employer in the handling and processing of workers' compensation claims.

(J) Employers that are granted the privilege of paying compensation, etc., directly, in accordance with these rules and regulations shall file with the bureau a report of paid compensation annually, shall keep a record of all injuries and occupational diseases resulting in more than seven days of temporary total disability or death occurring to its employees and report the same to the bureau upon forms to be furnished by it, and shall observe all the rules and regulations of the commission and bureau and their rules of procedure with reference to determining the amount of compensation, etc., due to the disabled employee or the dependents of killed employees, and payment of the same. All employers granted the privilege of paying compensation, etc., directly shall annually report paid compensation electronically via the bureau's website.

If a self-insured employer fails to timely file its annual report of paid compensation, the bureau may estimate the amount of paid compensation and assess the employer based on this estimate pursuant to rule 4123-17-32 of the Administrative Code. If the employer subsequently provides the bureau with actual paid compensation figures, the bureau shall adjust the paid compensation and any assessment accordingly. A self-insured employer that is no longer a self-insured employer in Ohio and has failed to timely file a report of paid compensation shall be subject to this rule.

(K) Minimal level of performance as a criterion for granting and maintaining the privilege to pay compensation directly.

(1) The employer must be able to furnish or make arrangements for reasonable medical services during all working hours. A written explanation of what arrangements have been made or will be made to provide medical treatment shall be supplied with the application for self-insurance.

For an employer desiring to be first granted the privilege of self-insured status on or after the effective date of this rule, the employer shall provide to the bureau for the bureau's approval the employer's plan for the following:

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- (a) Criteria for the selective contracting of health care providers;
 - (b) Plan structure and financial stability for the medical management of claims;
 - (c) Procedures for the resolution of medical disputes between an employee and the employer, an employee and a provider, or the employer and a provider, prior to an appeal under section 4123.511 of the Revised Code;
 - (d) Upon the request of the bureau, provide a timely and accurate method of reporting to the administrator necessary information regarding medical and health care service and supply costs, quality, and utilization; and,
 - (e) Provide an employee the right to change health care providers.
- (2) The employer shall promptly pay the fees of outside medical specialists to whom the commission or bureau shall refer claimants for examination or where the commission or bureau refers the claim file for review and opinion by such specialist except as provided by law in cases where the claim was subsequently disallowed. Such fees shall be paid within the time limits provided for payment of medical bills under paragraph (K)(5) of this rule.
- (3) Every employer shall keep a record of all injuries and occupational diseases resulting in more than seven days of total disability or death as well as all contested or denied claims and shall report them to the bureau, and to the employee or the claimant's surviving dependents in accordance with rule 4123-3-03 of the Administrative Code.
- (4) The employer shall provide to the claimant and upon request, shall file with the bureau or the commission, medical reports relating thereto and received by it from the treating physician and physicians who have seen the claimant in consultation for the allowed injury or occupational disease, or any injury or occupational disease for which a claim has been filed. The claimant shall provide to the employer and, upon request, shall file with the bureau or the commission, medical reports relating thereto and received from the treating physician and physicians who have seen the claimant in consultation for the allowed injury or occupational disease or any injury or occupational disease for which a claim has been filed. The claimant shall honor the employer's request for appropriate written authorization to obtain medical reports to the extent that such reports pertain to the claim.
- (5) Within thirty days after receipt of a hospital, medical, nursing or medication bill duly incurred by the claimant, the employer shall either pay such bill, or if the employer contests any of such matters, shall notify the provider, the employee, and, only upon request, the bureau or commission in writing. Such written notice shall specifically state the reason for nonpayment. The employer's notification to the employee shall indicate that the employee has the right to request a hearing before the industrial commission. If the self-insuring employer allows a claim for benefits or compensation without a hearing or if the matter is heard by the industrial commission, the employer shall pay such benefits or compensation no later than twenty-one days from acquiring knowledge of the claim or the claimant's filing of the C-84 form, whichever is later, or no later than twenty-one days from the employer's receipt of the industrial commission order as provided by section 4123.511 of the Revised Code; provided that where the claimant is subject to a withholding order for support and the self-insuring employer is required to provide notice to the claimant's attorney pursuant to section 3121.0311 of the

Revised Code, the time for the employer to pay such compensation is extended pursuant to section 3121.0311 of the Revised Code. The employer shall approve a written request for a change of physicians within seven days of receipt of such request that includes the name of the physician and proposed treatment. The employer shall approve or deny a written request for treatment within ten days of the receipt of the request. If the employer fails to respond to the request, the authorization for treatment shall be deemed granted and payment shall be made within thirty days of receipt of the bill.

(6) The employer shall make its records and facilities available to the employees of the bureau at all reasonable times during regular business hours. A public employer shall make the reports required by section 4123.353 of the Revised Code available for inspection by the administrator of workers' compensation and any other person at all reasonable times during regular business hours.

(7) The employer shall pay all compensation as required by the workers' compensation laws of the state of Ohio. By becoming self-insuring, the employer agrees to abide by the rules and regulations of the bureau and commission and further agrees to pay compensation and benefits subject to the provisions of these rules. The self-insuring employer shall proceed to make payment of compensation or medical benefits without any previous order from the bureau or commission and shall start such payments as required under the Workers' Compensation Act, unless it contests the claim.

(8) The employer may notify the medical section and the claimant at least sixty days prior to the completion of the payment of two hundred weeks of compensation for temporary total disability with the request that the claimant be scheduled for examination by the medical section. Payment of temporary total disability compensation after two hundred weeks shall continue uninterrupted until further order of the commission up to the maximum required by law, unless the claimant has returned to work, or the treating physician has made a written statement that the claimant is capable of returning to his former position of employment or has reached maximum medical improvement or that the disability has become permanent, or, after hearing, an order is issued approving the termination of temporary total disability compensation.

(9) Upon written request by the claimant or claimant's representative, the employer shall make available for review all the employer's records pertaining to the claim. Such review is to be made at a reasonable time (not to exceed seventy-two hours) and place. The claimant, upon written request, shall provide the employer or its representative with an appropriate written authorization to obtain medical reports and records pertaining to the claim.

Except as provided for in this rule, an employer may not assess a fee or charge the claimant or the claimant's representative for the cost of providing a copy of the employer's records pertaining to the claim. Where the employer has previously provided a copy of the record or records pertaining to the claim to the claimant or the claimant's representative, the employer may charge a fee for the copies. The employer's fee shall be based upon the actual cost of furnishing such copies, not to exceed twenty-five cents per page.

(10) The employer shall inform a claimant, and the bureau of workers' compensation, in writing, within thirty days from the filing of the claim, as to what conditions it has recognized as related to the injury or occupational disease and what, if any, it has denied. The same timeframe shall apply when the employer rejects a medical only claim.

(11) The employer shall post notices of its self-insuring status indicating the location in the plant(s) for the filing of a claim and the job title and department of the employees designated by the employer to be the person or persons responsible for the processing of workers' compensation claims.

(12) A public employer, except for a board of county commissioners described in division (G) of section 4123.01 of the Revised Code, a board of a county hospital, or a publicly owned utility, who is granted the status of self-insuring employer pursuant to section 4123.35 of the Revised Code shall comply with the section 4123.353 of the Revised Code.

(L) If a state insurance fund employer or a succeeding employer, as described in rule 4123-17-02 of the Administrative Code, applies for the privilege of paying compensation, etc., directly, by transferring from state fund to self-insurance, the actuary of the bureau shall determine the amount of the liability of such employer to the bureau for its proportionate share of any deficit in the fund. To determine an employer's liability under this rule, the actuary of the bureau shall develop a set of factors to be applied to the pure premium paid by an employer on payroll for a seven year period, as described below. The factors shall be based on the full past experience of the commission and bureau as reflected in the most recent calendar year end audited combined financial statement of the commission and bureau, and shall also accommodate any projected change in the financial condition of the fund for the current calendar year, or any additional period for which an audited combined financial statement is unavailable. The factors shall be revised annually effective July first based on the most recent calendar year audited combined financial statement and the projected change in the financial condition of the fund in the current calendar year or any additional period for which an audited combined financial statement is unavailable. The annually revised factors shall be adopted by rule 4123-17-40 of the Administrative Code, and filed with the secretary of state and the legislative service commission at least ten days prior to July first of each year. Factors effective July first of each year shall apply to all applications for self-insurance filed on or after July first of that year through June thirtieth of the following year. The revised factors shall be applied to the pure premium paid by the employer on payroll for the seven calendar accident years ending December thirty-first of the year preceding the year in which the factors are adopted under rule 4123-17-40 of the Administrative Code. In the event the audited combined financial statement of the commission and bureau reveals that no deficit exists, or in the event the application of the factors adopted by rule 4123-17-40 of the Administrative Code yields a negative number, the employer will incur no liability under this paragraph, but will not receive any refund for prior premiums paid except for those matters specifically addressed in paragraph (L)(2) of this rule. As used in this rule, "pure premium paid" means premiums actually paid under a base rating plan or an experience rating plan and minimum premium paid under a retrospective rating plan. It does not include premiums billed for actual claims costs, including reserves at the end of ten years, under a retrospective rating plan. Obligations under a retrospective rating plan remain the responsibility of the employer regardless of the employer's status. The same principles shall apply to cases of a merger by a self-insuring employer and a state fund employer under the self-insurer's status. In addition, the provisions listed below shall apply:

(1) Within thirty days of the receipt from the employer of the necessary forms and of a separate statement of assets and liabilities, the bureau will forward to the employer a letter stating the amount of liability (if any) due the state fund as outlined above and a copy of the computation of such liability (if any).

(2) Within thirty days of the date of mailing of the letter by the bureau as outlined in paragraph (L)(1)

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of this rule, the employer shall reply by a letter, signed in handwriting, acknowledging that the employer agrees with the amount of liability specified in the letter and that there are no protests or claims hearings pending which could affect the amount of the liability. If any such matters are pending and would affect the liability, they must be detailed and set forth in the letter from the employer. This letter must also acknowledge that any protest letters, applications for handicap reimbursement or other requests affecting the risk's state fund experience filed subsequent to the date of this letter shall be considered invalid for both rebate of premium on state fund experience and the calculation of liability cited above. This letter must also specify the suggested effective date of the transfer to self-insurance which the employer requests, subject to paragraph (B) of this rule which requires that the effective date must be at least ninety days after the date the application forms are received by the bureau. Failure to comply with the requirements set forth herein shall terminate further consideration of the application.

(3) Subsequent to the approval of the employer's self-insurance status and the effective date thereof by the administrator, the bureau shall issue a settlement sheet statement containing the adjustment required above and billing for an advance deposit as required by other rules of the commission. The employer shall pay the amounts required by this paragraph, pay the contribution to the self-insuring employers' guaranty fund under section 4123.351 of the Revised Code, submit a performance surety bond or additional security, if required by the bureau, and estimated final payroll report as a state fund risk, all within thirty days of the date of the mailing of the self-insured certificate.

(4) The final adjustments of all premiums due the state fund for the final payroll reports and final bureau audit (if any), as well as the pending protests, etc., as specified in paragraph (L)(2) of this rule, shall all be settled and paid within six months from the date of transfer from state fund to self-insuring status. Employer's records must be made available promptly for final audit which must also be completed within six months from the date of the transfer from state risk to self-insurance.

(M) If there is any change involving additions, mergers, or deletions of entities or ownership changes of a self-insuring employer, which would materially affect the administration of the employer's self-insuring employer program or the number of employees included in such program, the employer shall notify the bureau self-insuring employer's section within thirty days after the change occurs. Based upon the information provided or additional information requested by the bureau, the bureau will determine the effect of the change on the employer's self-insuring employer status, the adequacy of the employer's contribution to the self-insuring employers' guaranty fund, and the need for additional security.

(N) Public employers granted the privilege of self-insurance shall include volunteers and probationers performing services for the political subdivision as employees to be covered under the self-insurance policy.

Effective: 08/15/2007

R.C. 119.032 review dates: 03/01/2011

Promulgated Under: 119.03

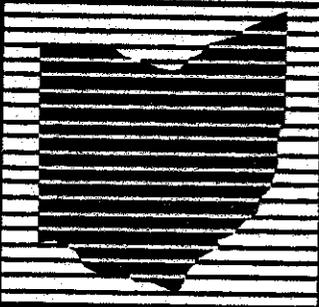
Statutory Authority: 4121.12, 4121.121, 4121.30, 4123.05
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Rule Amplifies: 4123.35, 4123.58

Prior Effective Dates: 7/1/76, 1/2/78, 12/11/78, 11/26/79, 2/17/81, 9/3/85, 8/22/86 (Emer.),
11/17/86 (Emer.), 1/10/87, 7/16/90, 11/23/92 (Emer.), 2/22/93, 12/17/01, 11/14/03, 10/30/06

OHIO MONTHLY RECORD

NOVEMBER 1993



FOR YOUR INFORMATION

Rules filed for the month are printed in numerical order.

Rules are published exactly as filed.

Emergency rules are printed with a vertical line in the margin and are effective for ninety days.

Annotations to recent cases construing administrative rules appear behind the blue tabbed divider.

Research aids appear behind the orange tabbed dividers and reference rules by rule number, agency, and topic.

The User's Guide gives a detailed explanation of how to use this publication.

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(continued on reverse side)

(C) "Self-insurance" is a privilege granted or denied by the administrator of workers' compensation. Once granted the privilege of self-insurance, the employer determines the first level of a claim and must have employees with a working knowledge of current Ohio workers' compensation law and all rules and regulations of the bureau of workers' compensation and the industrial commission. A self-insuring employer may, without any prior order from the commission or bureau, grant or refuse to grant any claim made under the Ohio Workers' Compensation Act. In granting a claim or awarding payment of compensation or benefits, the employer may provide to its employees compensation or benefits which are greater than those required by law. The employer may not pay compensation or benefits less than that which is required by law.

HISTORY: Eff. 11-19-93
1989-90 OMR 1333

Note: Effective 5-9-90, 4123-19-01, contains provisions of former 4121-9-01 (2-17-81).

CROSS REFERENCES

RC 4121.12, Bureau of workers' compensation
RC 4121.30, Adoption, publication, and proposal of rules
RC 4123.01, Definitions
RC 4123.30, Public fund; private fund; contributions; disbursements
RC 4123.35, Payments to state insurance fund; standards, surety bonds, applications, and rules for self-insurers

4123-19-03 Where an employer desires to secure the privilege to pay compensation, etc., directly

(A) All employers granted the privilege to pay compensation directly shall demonstrate sufficient financial strength and administrative ability to assure that all obligations under section 4123.35 of the Revised Code will be met promptly. The administrator of workers' compensation shall deny the privilege to pay compensation, etc., directly, where the employer is unable to demonstrate its ability to promptly meet all the obligations under the rules of the commission and bureau and section 4123.35 of the Revised Code. The administrator shall consider, but shall not be limited to the following factors where they are applicable in determining the employer's ability to meet all obligations under section 4123.35 of the Revised Code:

- (1) The employer shall have a minimum of five hundred employees in the state of Ohio unless the administrator, in the administrator's discretion, waives such requirement;
- (2) The employer shall have been operating in Ohio for a minimum period of two years, except an employer that either purchased, acquired or otherwise succeeded to the operation of a business (or part thereof) located in Ohio for at least two years shall also qualify; the administrator, in the administrator's discretion, may waive this requirement;
- (3) Where the employer previously had contributed to the state insurance fund or is a succeeding employer as defined in rule 4123-17-02 of the Administrative Code, the amount of the buy-out established by paragraph (M) of this rule;
- (4) Sufficiency of the employer's assets located within the state of Ohio to ensure solvency of the employer in the payment of compensation, etc., directly;
- (5) A review of all financial records, documents, and data necessary to provide a full financial disclosure of the employer, certified by a certified public accountant, including, but not limited to, the balance sheets and a profit and loss history for the current year and the previous four years; and the administrator, in the administrator's discretion, may waive this requirement pursuant to the criteria contained in paragraph (A)(9) of this rule;
- (6) The employer's organizational plan for the administration of the workers' compensation law;
- (7) The employer's proposed plan to inform employees of the change from state fund coverage to self-insurance, the procedures that will be followed by the employer as a self-insuring employer, and the rights of the employee to compensation and benefits;
- (8) The employer shall have either an account in a financial institution in this state, or if the employer maintains an account with a financial institution outside of this state, shall ensure that workers' compensation checks are drawn from the same account as

the payroll checks or the employer shall clearly indicate that payment will be honored by a financial institution in Ohio.

(9) In determining whether to grant a waiver of the requirement of paragraph (A)(5) of this rule for certified financial records, the administrator shall consider the following criteria and conditions.

(a) The administrator shall require reviewed financial statements, including full footnote disclosure, to be prepared and submitted in accordance with generally accepted accounting principles. For the purposes of this rule, "reviewed financial statements" shall mean financial statements that have been subject to procedures performed by a certified public accountant in accordance with AICPA Professional Standards, specifically, Statements on Standards for Accounting and Review Services, Section 100, Paragraph .24 through .38, December 1978.

(b) The administrator may utilize the services of a commercial credit reporting bureau to assist in the evaluation of an applicant's ability to meet its workers' compensation obligations. The cost of this commercial reporting service shall be assumed by the applicant employer.

(c) Notwithstanding the above criteria, the administrator may deem it necessary for an applicant employer to provide additional security to ensure meeting its workers' compensation obligations. The amount of such additional security shall be in the form and amount as determined by the administrator and paid prior to the granting of self-insurance. Pursuant to paragraph (G) of this rule, in the event of the default of the self-insuring employer, the bureau shall first seek reimbursement from the additional security, which shall be first liable and exhausted, before payment is made from the self-insuring employers' guaranty fund under section 4123.351 of the Revised Code.

No public employer, other than publicly owned utilities or a board of county hospital trustees, shall be permitted to secure the privilege to pay compensation, etc., directly.

(B) The employer shall secure directly from the Columbus central office of the bureau of workers' compensation proper application form(s) for completion. The completed application shall be filed with the bureau at least ninety days prior to the effective date of the employer's requested status as a self-insurer. The administrator may require that the application be accompanied by an application fee as established by bureau resolution to cover the cost of processing the application in accordance with section 4123.35 of the Revised Code. The application shall not be deemed complete until all required information is attached thereto. Prior to presentation to the administrator, applicable items listed in paragraphs (A)(1) to (A)(8) of this rule shall be made available to the bureau and shall be reviewed by the bureau of workers' compensation. The bureau shall only accept applications which contain the required information.

(C) Before mailing to the employer the necessary application form(s), the bureau shall stamp on the same its "designating number."

(D) The bureau shall recognize only such application forms which provide answers to all questions asked and furnish such information as may be required.

(E) Upon return of completed forms referred to above, the application will be reviewed by the administrator within a reasonable time.

(1) If the administrator determines to grant the privilege of self-insurance, the bureau shall issue a "Finding of Facts" statement which has been prepared by the bureau, signed by the administrator, subject to all conditions outlined in paragraph (M)(3) of this rule.

(2) If the administrator determines not to grant the privilege of self-insurance, the bureau shall so notify the employer, whereupon the employer shall be required to continue to pay its full premium into the state insurance fund.

(F) All employers, publicly owned utilities, and boards of county hospital trustees that have secured the privilege to pay compensation, etc., directly, will be required to make contributions as determined [sic] by the administrator to the self-insuring employers' guaranty fund established under section 4123.351 of the Revised Code, and, if an additional security is required by the bureau, in the amount or form that may be specified by the bureau. If the additional security is in the form of a surety bond, the bond shall be from a company approved by the bureau and authorized to do business in the state of Ohio by the Ohio department of insurance. The surety bond shall be in the form prescribed by the bureau. The penal amount of such additional security is to be fixed by the administrator by executive order.

Bureau of Workers' Compensation

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(G) The surety bond or additional security furnished by the employer shall be for an amount and period as established by the bureau and may be periodically reviewed and reevaluated by the bureau. The surety bond or additional security shall provide on its face that the surety shall be responsible for the payment of all claims where the cause of action, as determined by the date of injury or date of occupational disease, arose during the liability of the surety bond or additional security. The liability under the surety bond or additional security and the rights and obligations of the surety shall be limited to reimbursement for the amounts paid from the surplus accounts of the state insurance fund by reason of the default of the self-insuring employer in accordance with division (B) of section 4123.82 of the Revised Code; however, in the event of such self-insuring employer's default, the bureau shall first seek reimbursement from the surety bond or additional security, which shall be first liable and exhausted, before payment is made from the self-insuring employers' guaranty fund established under section 4123.351 of the Revised Code. Upon default of the self-insuring employer, it shall be the responsibility of the administrator of the bureau of workers' compensation to represent the interests of the state insurance fund and the self-insuring employers' guaranty fund. The administrator, on behalf of the self-insuring employers' guaranty fund, has the rights of reimbursement and subrogation and shall collect from a defaulting self-insuring employer or other liable person all amounts the bureau has paid or reasonably expects to pay from the guaranty fund on account of the defaulting self-insuring employer.

(H) The security herein required to be given by the employer shall be given to the state of Ohio, for the benefit of the disabled or the dependents of killed employees of the employer filing the same, and shall be conditioned for the payment by the employer of such compensation to disabled employees or the dependents of killed employees of such employer, and the furnishing to them of medical, surgical, nursing and hospital attention and services, medicines and funeral expenses equal to or greater than is provided by the Ohio workers' compensation law and for the full compliance with the rules and regulations of the commission and bureau and rules of procedure.

(I) If another or parent corporation or entity owns more than fifty per cent of the stock of an employer, such employer must furnish a contract of guaranty executed by the ultimate domestic parent corporation or entity. If the employer establishes to the bureau that such contract of guaranty cannot be given by the ultimate domestic parent corporation, then the bureau may, in its discretion, waive the requirement of a contract of guaranty. The bureau may require an alternative form of security.

(J) From the effective date of this rule, employees having one or more years of experience as a workers' compensation administrator for a self-insuring employer in Ohio shall be deemed sufficiently competent and knowledgeable to administer a program of self-insurance. Those self-insuring employers that employ workers' compensation administrators who have less than one year of experience as a workers' compensation administrator shall not have its status as a self-insuring employer affected pending notification by the bureau of workers' compensation as to whether mandatory attendance training program is required. If the bureau determines that the administrator is not able to administer a self-insuring program, the bureau may direct mandatory attendance of the administrator at a bureau of workers' compensation training program until such time as the bureau determines that the administrator is sufficiently competent and knowledgeable to run such a workers' compensation program. The cost of the bureau's training of the administrator(s) under this rule will be borne by the self-insuring employer or self-insuring employer applicant. By accepting the privilege of self-insurance, an employer acknowledges that the ultimate responsibility for the administration of workers' compensation claims in accordance with the law and rules of the bureau of workers' compensation and the commission rests with that employer. The self-insuring employer's records and compliance with the bureau of workers' compensation and commission rules shall be subject to periodic audit by the bureau of workers' compensation.

A self-insuring employer or applicant shall designate one of its Ohio employees who is knowledgeable and experienced with the requirements of the Ohio Workers' Compensation Act and rules and regulations therein, as administrator of its self-insuring program. The requirement for an Ohio administrator may be waived at the discretion of the bureau. The name and telephone number of the Ohio administrator, or non-Ohio administrator where the Ohio requisite has been waived, shall be posted by the employer in a

prominent place at all the employer's locations. The administrator's duties shall include, but not be limited to:

(1) Acting as liaison between the employer, the bureau of workers' compensation and the commission, and providing information to the agency upon request;

(2) Providing assistance to claimants in the filing of claims and applications for benefits;

(3) Providing information to claimants upon request regarding the processing of claims and the benefits to which claimants may be entitled;

(4) Providing upon request the various forms to be used in seeking compensation or benefits;

(5) Accepting or rejecting claims for benefits;

(6) Approving the payment of compensation and benefits to, or on behalf of, claimants, pursuant to paragraph (L) of this rule.

This rule is not intended to prevent the hiring of an attorney or representative to assist the employer in the handling and processing of workers' compensation claims.

(K) Employers that are granted the privilege of paying compensation, etc., directly, in accordance with these rules and regulations shall file with the bureau a report of paid compensation annually, shall keep a record of all injuries and occupational diseases resulting in more than seven days of temporary total disability or death occurring to its employees and report the same to the bureau upon forms to be furnished by it, and shall observe all the rules and regulations of the commission and bureau and their rules of procedure with reference to determining the amount of compensation, etc., due to the disabled employee or the dependents of killed employees, and payment of the same.

(L) Minimal level of performance as a criterion for granting and maintaining the privilege to pay compensation directly.

(1) The employer must be able to furnish or make arrangements for reasonable medical services during all working hours, subject to approval by the bureau. A written explanation of what arrangements have been made or will be made to provide medical treatment shall be supplied with the application for self-insurance.

(2) The employer shall promptly pay the fees of outside medical specialists to whom the commission or bureau shall refer claimants for examination or where the commission or bureau refers the claim file for review and opinion by such specialist except as provided by law in cases where the claim was subsequently disallowed. Such fees shall be paid within the time limits provided for payment of medical bills under paragraph (L)(5) of this rule.

(3) Every employer shall keep a record of all injuries and occupational diseases resulting in more than seven days of total disability or death and shall report them to the bureau, and to the employee or the claimant's surviving dependents in accordance with rule 4123-3-03 of the Administrative Code.

(4) The employer shall file with the claimant and the bureau or the commission medical reports relating thereto and received by it from the treating physician and physicians who have seen the claimant in consultation for the allowed injury or occupational disease, or any injury or occupational disease for which a claim has been filed. The claimant shall file with the employer and the bureau or the commission medical reports relating thereto and received from the treating physician and physicians who have seen the claimant in consultation for the allowed injury or occupational disease or any injury or occupational disease for which a claim has been filed. The claimant shall honor the employer's request for appropriate written authorization to obtain medical reports and reports pertaining to the claim.

(5) The employer shall pay hospital, medical, nursing and bills for medication duly incurred by the claimant within thirty days after receipt of such bill or an order from the bureau or commission to do so unless the employer contests any of such matters, in which case it shall immediately notify the employee and the bureau or commission. The employer shall pay compensation due and payable under an order no later than twenty-one days after receipt of the order to do so. If the self-insuring employer allows a claim for benefits or compensation without a hearing, the employer shall pay such benefits or compensation no later than twenty-one days from acquiring knowledge of the claim or the claimant's filing of the request for a change of physicians within seven days of receipt of such request that includes the name of the physician and proposed treatment. The employer shall approve or deny a written request for treatment within ten days of the receipt of the request. If the employer fails to respond to the request, the authorization for treatment shall be deemed granted.

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(6) The employer shall make its records and facilities available to the employees of the bureau when notified that the bureau will make an audit during office hours.

(7) The employer shall pay all compensation as required by the workers' compensation laws of the state of Ohio. By becoming self-insuring, the employer agrees to abide by the rules and regulations of the bureau and commission and further agrees to pay compensation and benefits subject to the provisions of these rules. The self-insuring employer shall proceed to make payment of compensation or medical benefits without any previous order from the bureau or commission and shall start such payments as required under the Workers' Compensation Act, unless it contests the claim.

(8) The employer may notify the medical section and the claimant at least sixty days prior to the completion of the payment of two hundred weeks of compensation for temporary total disability with the request that the claimant be scheduled for examination by the medical section. Payment of temporary total disability compensation after two hundred weeks shall continue uninterrupted until further order of the commission up to the maximum required by law, unless the claimant has returned to work or the treating physician has made a written statement that the claimant is capable of returning to his former position of employment or has reached maximum medical improvement or that the disability has become permanent, or, after hearing, an order is issued approving the termination of temporary total disability compensation.

(9) Upon written request by the claimant or claimant's representative, the employer shall make available for review all the employer's medical records pertaining to the claim. Such review is to be made at a reasonable time and place. The claimant, upon written request, shall provide the employer or its representative with an appropriate written authorization to obtain medical reports and records pertaining to the claim.

(10) The employer shall inform a claimant, and the bureau of workers' compensation, in writing, within thirty days from the filing of the claim, as to what conditions it has recognized as related to the injury or occupational disease and what, if any, it refuses to recognize.

(11) The employer shall post notices of its self-insuring status indicating the location in the plant(s) for the filing of a claim and the job title and department of the employees designated by the employer to be the person or persons responsible for the processing of workers' compensation claims.

(M) If a state insurance fund employer or a succeeding employer, as described in rule 4123-17-02 of the Administrative Code, applies for the privilege of paying compensation, etc., directly, by transferring from state fund to self-insurance, the actuary of the bureau shall determine the amount of the liability of such employer to the bureau for its proportionate share of any deficit in the fund. To determine an employer's liability under this rule, the actuary of the bureau shall develop a set of factors to be applied to the pure premium paid by an employer on payroll for a seven year period, as described below. The factors shall be based on the full past experience of the commission and bureau as reflected in the most recent calendar year end audited combined financial statement of the commission and bureau, and shall also accommodate any projected change in the financial condition of the fund for the current calendar year, or any additional period for which an audited combined financial statement is unavailable. The factors shall be revised annually effective July first based on the most recent calendar year audited combined financial statement and the projected change in the financial condition of the fund in the current calendar year or any additional period for which an audited combined financial statement is unavailable. The annually revised factors shall be adopted by rule 4123-17-40 of the Administrative Code, and filed with the secretary of state and the legislative service commission at least ten days prior to July first of each year. Factors effective July first of each year shall apply to all applications for self-insurance filed on or after July first of that year through June thirtieth of the following year. The revised factors shall be applied to the pure premium paid by the employer on payroll for the seven calendar accident years ending December thirty-first of the year preceding the year in which the factors are adopted under rule 4123-17-40 of the Administrative Code. In the event the audited combined financial statement of the commission and bureau reveals that no deficit exists, or in the event the application of the factors adopted by rule 4123-17-40 of the Administrative Code yields a negative number, the employer will incur no liability under this paragraph, but will not receive any refund for prior premiums paid except for those matters specifically addressed in paragraph (M)(2) of this rule. As used in this rule, "pure premium paid"

means premiums actually paid under a base rating plan or an experience rating plan and minimum premium paid under a retrospective rating plan. It does not include premiums billed for actual claims costs, including reserves at the end of ten years, under a retrospective rating plan. Obligations under a retrospective rating plan remain the responsibility of the employer regardless of the employer's status. The same principles shall apply to cases of a merger by a self-insuring employer and a state fund employer under the self-insurer's status. In addition, the provisions listed below shall apply:

(1) Within thirty days of the receipt from the employer of the necessary forms and of a separate statement of assets and liabilities, the bureau will forward to the employer a letter stating the amount of liability (if any) due the state fund as outlined above and a copy of the computation of such liability (if any).

(2) Within thirty days of the date of mailing of the letter by the bureau as outlined in paragraph (M)(1) of this rule, the employer shall reply by a letter, signed in handwriting, acknowledging that the employer agrees with the amount of liability specified in the letter and that there are no protests or claims hearings pending which could affect the amount of the liability. If any such matters are pending and would affect the liability, they must be detailed and set forth in the letter from the employer. This letter must also acknowledge that any protest letters, applications for handicap reimbursement or other requests affecting the risk's state fund experience file subsequent to the date of this letter shall be considered invalid for both rebate of premium on state fund experience and the calculation of liability cited above. This letter must also specify the suggested effective date of the transfer to self-insurance which the employer requests, subject to paragraph (B) of this rule which requires that the effective date must be at least ninety days after the date the application forms are received by the bureau. Failure to comply with the requirements set forth herein shall terminate further consideration of the application.

(3) Subsequent to the approval of the employer's self-insurance status and the effective date thereof by the administrator, the bureau shall issue a settlement sheet statement containing the adjustment required above and billing for an advance deposit as required by other rules of the commission. The employer shall pay the amounts required by this paragraph, pay the contribution to the self-insuring employers' guaranty fund under section 4123.351 of the Revised Code, submit a performance surety bond or additional security, if required by the bureau, and estimated final payroll report as a state fund risk, all within thirty days of the date of the mailing of the administrator's executive order.

(4) The final adjustments of all premiums due the state fund for the final payroll reports and final bureau audit (if any), as well as the pending protests, etc., as specified in paragraph (M)(2) of this rule, shall all be settled and paid within six months from the date of transfer from state fund to self-insuring status. Employer's records must be made available promptly for final audit which must also be completed within six months from the date of the transfer from state risk to self-insurance.

(N) If there is any change involving additions, mergers, or deletions of entities or ownership changes of a self-insuring employer, which would materially affect the administration of the employer's self-insuring employer program or the number of employees included in such program, the employer shall notify the bureau self-insuring employer's section within thirty days after the change occurs. Notification shall be made in writing on the letterhead of the self-insuring employer and signed by an officer of the employer. Based upon the information provided or additional information requested by the bureau, the bureau will determine the effect of the change on the employer's self-insuring employer status, the adequacy of the employer's contribution to the self-insuring employers' guaranty fund, and the need for additional security.

HISTORY: Eff. 11-19-93

1992-93 OMR 860, 619; 1990-91 OMR 145

Note: Effective 7-16-90, 4123-19-03 contains provisions of former 4121-9-03 (1986-87 OMR 724).

CROSS REFERENCES

RC 4121.11, Rules of procedure
 RC 4121.13, Powers and duties of administrator
 RC 4121.30, Adoption, publication, and proposal of rules
 RC 4123.05, Rulemaking powers