

In the
Supreme Court of Ohio

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

Appellee

-vs-

TIMOTHY MATHEWS

And

INDUSTRIAL COMMISSION OF OHIO

Appellants

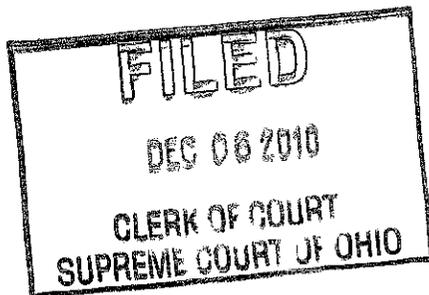
CASE NO. 2010-0955

On Appeal from the Franklin County Court
of Appeals, Tenth Appellate District – Case
No. 09-AP-180

**MERIT BRIEF OF APPELLEE
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INTRODUCTION

Sears originated this mandamus case because the Industrial Commission abused its discretion and erred as a matter of law when it granted Appellant Mathews' June 5, 2008 C-86 motion for payment of a \$50 invoice regarding treatment Mathews received from Dr. Urbanosky on September 22, 1998. What is at stake in this case is far greater than the \$50 payment of a medical bill. The Industrial Commission's erroneous decision requires Sears to pay the invoice for Mathews' treatment now subjecting Sears to future payments under Mathews' claim. But for the Industrial Commission's decision requiring payment of the September 22, 1998 invoice, Mathews' claim had long since lapsed pursuant to the applicable statute of limitations.

This case involves Mathews' request for payment of a single medical invoice for treatment Mathews received on September 22, 1998. Mathews' attorney submitted a letter asking for payment on March 12, 1999. At that time, Mathews' claim had been dormant for two years. Counsel for Mathews in the March 12, 1999 letter acknowledged that the bill was rejected.

When Sears, through its third party administrator, received the invoice around March 15, 1999, Sears advised Mathews' attorney that Sears would consider payment of the invoice if Mathews or his counsel provided a copy of the office notes related to the invoice so that Sears could determine whether the treatment was related to conditions allowed in the claim. Neither Mathews nor his counsel ever followed up with Sears again. More than nine years passed. No other activity on Mathews' claim occurred during this nine years.

Then, on June 5, 2008, Mathews filed a C-86 Motion with the Industrial Commission requesting payment of the 1998 invoice. Sears presented numerous grounds to the Industrial Commission regarding Mathews' request for payment of Dr. Urbanosky invoice. Sears

demonstrated that Mathews' request for payment was time-barred and, even if not time-barred, was not compensable because the treatment did not relate to an allowed condition in the claim.

The Tenth District Court of Appeals found that the Industrial Commission abused its discretion and ordered the Industrial Commission to vacate its SHO's Order of October 24, 2008 and enter an Order denying Mathews' motion requesting payment of the Dr. Urbanosky fee bill. The Tenth District agreed with the Magistrate that nothing in the record establishes a connection between the purpose of Mathews' visit and the allowed conditions. The Tenth District Court also found that nothing in the treatment note stated that the purpose of the visit was for diagnosis and determining whether certain conditions should be added to the claim. Mathews and the Industrial Commission appealed the decision of the Tenth District to this Court.

STATEMENT OF FACTS AND OF THE CASE

On or about October 13, 1987, Appellant Timothy Mathews ("Mathews") sustained an injury in the course of and arising out of his employment with Appellee Sears Roebuck & Company ("Sears") when he was pinned between a conveyor line and a movable conveyor. (Supplemental Record of Appellee Sears Roebuck & Company, pages 1-2, hereinafter "Supp. ____"). Appellant Mathews filed a claim for workers' compensation benefits, claim no. 956928-22, and his claim was subsequently allowed for torn muscles left leg; tears buttocks; and bladder, internal injuries. (Supp. 3). Following the October 13, 1987 incident, Appellant Mathews obtained medical care to treat the conditions allowed in his claim. (Supp. 3-8). The last time Mathews had any medical bills paid for under claim no. 956928-22 was on March 26, 1997. (Supp. 13 & 15) (payment ledger showing last payment on March 26, 1997). Mathews last had any compensation paid under claim no. 956928-22 on January 13, 1995. (Supp. 16). Appellant

Mathews received payment of a permanent partial disability award on January 13, 1995. (Supp. 16).

Frank Gates Service Company (“Frank Gates”) acted as the duly authorized administrator for Appellee Sears’ self-insured workers’ compensation program during the September 1998 through April 1999 timeframe. (Supp. 11-12 & 14-20). Attorney Stanley B. Dritz (“Dritz”), then-counsel for Appellant Mathews, sent Frank Gates a letter dated March 12, 1999. (Supp. 11). Attorney Dritz’s March 12, 1999 letter requested that Frank Gates, on behalf of Appellee Sears, make payment for a bill for services or treatment Dr. Urbanosky provided Appellant Mathews on September 22, 1998. (Supp. 9 & 11). Importantly, Mr. Dritz in his letter states, “[t]his was billed to your office for payment and **was rejected** on the basis that the claim had been inactive.” (Supp. 11) (Emphasis Added). Mr. Dritz continued on in the letter to say, “[i]s it really necessary to go further with regard to this billing to the extent that the claims needs to be activated and perhaps **the hearing held?**” (Supp. 11) (Emphasis Added). The bill that was the subject of Mr. Dritz’s letter reflects that on 12/22/98 Sears indicated that the claim was inactive. (Supp. 9).

Frank Gates, on behalf of Appellee Sears, received the letter of Mr. Dritz and Dr. Urbanosky invoice on March 15, 1999. (Supp. 9). Marcia L. Giesler, Account Manager for Frank Gates, sent Attorney Dritz a response letter dated April 21, 1999 regarding the Urbanosky invoice. (Supp. 12). The April 21, 1999 letter from Frank Gates stated that Appellee Sears would consider paying the Urbanosky invoice if Appellant Mathews could provide Frank Gates with the office notes to prove the **relationship and diagnosis** to his industrial injury. (Supp. 12). (Emphasis Added).

Neither Appellant Mathews nor his counsel responded to Frank Gates' request for additional information regarding the Urbanosky invoice. (Supp. 14-20). Neither Sears nor its authorized administrator heard anything regarding Appellant Mathews' claim for nine years. Then, on April 2, 2008, Appellant Mathews submitted for authorization a C-9 completed by Urological Associates, Inc. that requested approval for annual or bi-annual urological office visits. Appellee Sears, through its new third party administrator, Helmsman Management Services ("Helmsman"), denied approval of the April 2, 2008 C-9 because the statute of limitations for claim no. 956928-22 expired. (Supp. 13). After Helmsman refused to approve the C-9, based on expiration of the statute of limitations, Appellant Mathews sought to revive his claim by seeking payment of the Urbanosky invoice.

On June 5, 2008, Appellant Mathews filed a C-86 motion, requesting payment of the September 22, 1998 Urbanosky invoice. (Supp. 21). Appellant Mathews attached to his C-86 Motion a copy of (1) the Urbanosky invoice (Supp. 9); (2) Dr. Urbanosky's office notes from the September 22, 1998 treatment (Supp. 10); (3) Frank Gates Service Company's April 21, 1999 letter to Attorney Dritz (Supp. 12); and (4) a May 16, 2008 correspondence from Matthew K. Sherwood, Senior Claims Consultant for Helmsman confirming that Sears denied payment of the Urbanosky invoice (Supp. 13).

Dr. Urbanosky's office note for September 22, 1998 demonstrated that she diagnosed Appellant Mathews with "mild L5 radiculopathy on the left." (Supp. 10). Review of the treatment note confirms that Dr. Urbanosky did not view his symptoms as related to his industrial injury that occurred over ten years earlier. (Supp. 10). The treatment note of September 22, 1998 does not contain any language therein that states the purpose of the visit is for diagnosis of symptoms possibly related to the industrial injury. (Supp. 10). The only area of

the body examined by Dr. Urbanosky on September 22, 1998 was with respect to the low back. (Supp. 10).

On September 3, 2008, a District Hearing Officer (“DHO”) conducted a hearing on Appellant Mathews’ June 5, 2008 C-86 motion for payment of the September 22, 1998 Urbanosky invoice. (Supp. 22). By order dated September 6, 2008, the DHO found jurisdiction under Ohio Revised Code section 4123.52 to consider Mathews’ request for payment of the \$50.00 Urbanosky invoice and granted authorization for payment of the bill. (Supp. 22-24).

On September 9, 2008, Sears, through Helmsman, timely filed an appeal of the September 6, 2008 DHO order. (Supp. 25). On October 24, 2008, a Staff Hearing Officer (“SHO”) held a hearing on Appellee Sears’ appeal. (Supp. 26). By order dated October 31, 2008, the SHO affirmed the September 6, 2008 order of the DHO. (Supp. 26-28). The SHO found that the 4/21/1999 letter of Frank Gates did not constitute the denial of payment. (Supp. 26). The SHO did not make any determination that the bill of Dr. Urbanosky had already been rejected when Mr. Dritz indicated the bill was already rejected in his March 12, 1999 letter. The SHO acknowledged that no lower back injury is allowed in the claim. (Supp. 26). However, the SHO found payment of the medical bill was reasonable because it was a referral to determine if a lower back injury was a part of the claim. (Supp. 26). Further, the SHO found there was jurisdiction to consider the issue under ORC 4123.52 because the date of filing of demand for payment of the bill is the date the bill was filed with Frank Gates and not the date Mathews filed his C-86 motion requesting payment of that bill. (Supp. 27).

On November 14, 2008, Appellee Sears, through Helmsman, timely filed an appeal of the SHO order dated October 31, 2008. (Supp. 29). By way of order dated November 20, 2008, the Industrial Commission (“commission”) denied Appellee Sears’ request for further appeal of the

October 31, 2008 SHO order. (Supp. 30-31). On December 8, 2008, Appellee Sears timely filed a Motion for Reconsideration of the Industrial Commission's November 20, 2008 order denying Appellee Sear's request for further review. (Supp. 32-43). By way of order mailed January 22, 2009, the commission denied Appellee Sears' request for reconsideration. (Supp. 44-45). After the commission refused Appellee Sears' request for further appeal and denied its Reconsideration, Sears filed a Mandamus Complaint.

LAW AND ARGUMENT

Standard of Review

For a 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. Pressly v. Indus. Comm.* (1967), 11 Ohio St.2d 141. Sears must show that the commission acted contrary to law or otherwise abused its discretion by issuing an order that is not supported by evidence in the administrative record. *State ex rel. Elliot v. Indus. Comm.* (1986), 26 Ohio St.3d 76, 78-79. (Emphasis Added). So long as there is "some evidence" in the file to support the decision of the commission, the court will not overturn that decision. *State ex rel. Stephenson v. Indus. Comm.* (1987), 31 Ohio St.3d 167, 170.

For the reasons that follow, Sears asserts that the commission abused its discretion in ordering the payment of the September 22, 1998 invoice of Dr. Urbanosky. The decision of the commission is not supported by any evidence contained within the administrative record and, thus, there is not "some evidence" in the file support the decision of the commission. Furthermore, the commission acted contrary to law by ordering payment of a bill that is not in relation to any allowed conditions in the claim nor was it for diagnosis of symptoms related to

the industrial injury. Therefore, a writ of mandamus is the appropriate remedy ordering the commission to deny for payment the fee bill of Dr. Urbanosky from September 22, 1998.

Sears' Proposition of Law No. 1

In order for the Industrial Commission to make a finding that medical treatment is for treatment of allowed conditions in the claim or for diagnosing conditions to quite possibly be added to the claim, there must be some evidence on the face of the medical treatment note to support this conclusion.

A. The commission abused its discretion because there is no relationship between the treatment on September 22, 1998 and the allowed conditions in the claim.

This Court, in *State ex rel. Miller v. Indus. Comm.* (1994), 71 Ohio St.3d 229, 232 laid out a three part test for the authorization of medical services: (1) are the medical services reasonably related to the allowed conditions; (2) are the services reasonably necessary; and (3) is the cost medically reasonable? Section 4123-6-25 of the Ohio Administrative Code specifically mandates that a self-insuring employer only pays for medical services "rendered as a direct result of an injury ... for which the claim was allowed." Section 4123-6-25 states in pertinent part:

Medical or other services to be approved for payment must be rendered as a direct result of an injury sustained or occupational disease contracted by a claimant in the course of and arising out of employment. The claim must be allowed by an order of either the bureau of workers' compensation or the industrial commission, or have been recognized by a self-insuring employer.

Ohio Admin. Code 4123-6-25(A) (formerly O.A.C. 4123-7-02 effective 2/1/10) (Emphasis Added). In fact, the administrative provisions make clear that a self-insuring employer need only consider payment of a bill for services related to the allowed conditions. Ohio Adm. Code 4123-6-25(A) (formerly O.A.C. 4123-7-03 effective 2/1/10) ("Medical supplies and services will be considered for payment by a self-insuring employer when they are medically necessary for the diagnosis and treatment of conditions allowed in the claim, are causally related to the conditions allowed in the claim, and are rendered by a health care provider.").

The SHO in his decision of October 31, 2008 specifically acknowledged that no lower back injury was allowed in the industrial injury. (Supp. 26). A complete review of the September 22, 1998 office note reveals that the purpose of Mathews' visit that day was for problems in his low back. The impression at that time was "mild L5 radiculopathy on the left." (Supp. 10). This condition is not allowed in the claim. Although the industrial injury is referenced in the beginning part of the note, there is no indication from the doctor that Mathews is there on September 22, 1998 for problems, symptoms, or conditions related to the industrial injury. In fact, the note reflects that overall he seems to have recovered well. (Supp. 10).

In order for Sears to accept for payment the September 22, 1998 office visit, the visit must be reasonably related to the allowed conditions in the claim. *Miller, supra* and Ohio Admin. Code section 4123-6-25. There is no indication from a review of the note itself that the treatment is for any allowed conditions in the claim. The SHO even acknowledges in his order that the treatment is for the low back and no such condition is allowed in the claim. The Tenth District Court of Appeals correctly pointed out that nothing in the record establishes any connection between the purpose of the claimant's office visit and the allowed conditions. *State ex rel. Sears v. Mathews* (10 Dist. Ct. App. No. 09AP-180) 2010-Ohio-1818 at ¶ 12. The Court of Appeals correctly concluded that in the absence of any evidence connecting the purpose of the visit with the allowed conditions in the claim the commission abused its discretion in concluding the visit was reasonably related to Mathews' injury. *Id.* Therefore, there is no basis by which the commission and Mathews can argue that the treatment of Mathews by Dr. Urbanosky on September 22, 1998 was for allowed conditions in the claim.

The Staff Hearing Officer cannot opine on the medical necessity of the September 22, 1998 office visit. To the contrary, Ohio law is well-settled that the claimant must supply medical

evidence to show the services were necessary and are related to the allowed conditions. For example, the Tenth District Court of Appeals has recognized that although a claimant need not obtain advanced authorization for medical treatment, failure to do so subjects the claimant to potential non-payment for the services. As the Tenth District explained:

However, if there be no advance authorization, the employee runs the risk that the medical bill will not be paid in that the Industrial Commission may find from appropriate medical evidence that the treatment received was not reasonably necessary to treat the industrial injury. Of course, if the medical services received are not related to the allowed conditions, payment would not be forthcoming, even if medically necessary for the nonallowed condition.

State ex rel. Noland v. Indus. Comm., Tenth Dist. App. No. 86AP-594, 1987 Ohio App. Lexis 8493. (emphasis added); *see also State ex rel. Mercy Hosp. Anderson v. Indus. Comm.*, Tenth Dist. App. No. 91-AP-614, 1992 WL 142380 at 2. The situation presented by Mathews' September 22, 1998 office visit exactly mirrors the situation upon which the Tenth District commented in *Noland*. Dr. Urbanosky's medical services were not related to the allowed conditions in Mathews' claim even though the treatment was "medically necessary for the nonallowed condition." *Noland, supra*. As confirmed by the Tenth District, the injured worker is not entitled to receive payment for such treatment within the workers' compensation claim. The Staff Hearing Officer abused his discretion and erred as a matter of law by ignoring the basic requirement that medical services must relate to a condition allowed in a claim before the self-insuring employer must pay for such treatment.

The commission and Mathews in their respective Merit Briefs urge this Court to conclude that there is "some evidence" in the record linking the visit on September 22, 1998 to the allowed conditions in the claim. The commission wants this Court to believe that in determining the payment of the medical bill and its relatedness to the industrial claim that this was a weighing of the facts and disputed evidence, which is within the commission's final jurisdiction. See, e.g.

State ex rel. Allerton v. Indus. Comm. (1982), 69 Ohio St.3d 96. When the SHO made the decision to allow for processing and payment the September 22, 1998 visit, this was a legal determination. The SHO was not assigning weight or credibility to the September 22, 1998 note, but determining that it was properly payable (a legal determination) ostensibly under the progeny of *Miller*. Thus, the commission's argument with respect to weight and credibility is without merit.

Mathews and the commission also urge this Court to find in their favor on the basis that the problems Mathews was complaining of in his left leg on September 22, 1998 were the result of the allowed conditions in the claim. The arguments from Mathews and the commission are speculative at best. They cite to no medical opinion within the file to support their contentions that Mathews presented to Dr. Urbanosky on September 22, 1998 for problems and symptoms related to his lingering left leg problems. See, Ohio Admin Code section 4123-3-09(C) (The claimant is to carry the burden of proof). Mathews even admits in his Merit Brief that there were only two documents in front of the SHO that allowed the SHO to find in his favor. (Merit Brief of Appellant Respondent Timothy Mathews page 10, hereinafter "Mathews Brief page ____"). Those documents were the Dr. Urbanosky office note of September 22, 1998 and the claim information report detailing all of the paid medical and indemnity for the file. Thus, admittedly by Mathews, there are no other documents contained within the administrative record upon which the SHO could base his opinion that the treatment was for allowed conditions in the claim. This is problematic for Mathews and the commission because there is not "some evidence" upon which to allow payment of the September 22, 1998 visit for treatment of allowed conditions in the claim.

The Tenth District Court of Appeals correctly concluded that there is no connection between the office visit and the allowed conditions. Thus, this portion of the Court of Appeals' decision should not be disturbed.

B. There is no evidence supporting the SHO's decision that the purpose of the office visit was for the diagnosing and adding of conditions to the claim.

This Court in *State ex rel. Jackson Tube Servs., Inc. v. Indus. Comm.*, 2003-Ohio-2259, ¶26 held that the commission did not abuse its discretion in authorizing the diagnostic surgery of the claimant prior to those conditions being allowed in the claim. Of note, the claimant in *Jackson Tube* already had an allowed condition in the same body part (left shoulder) which was subject to the litigation for the arthroscopic surgery of the same shoulder. Also not to be ignored is the length that Dr. Paley, the claimant's requesting physician, went to, to explain in advance and in detail the reason why the surgery was needed. *Jackson Tube* at ¶10-12.

Although a claimant such as Mathews is permitted to request and presumably have treatment authorized in advance of certain conditions being allowed in the claim, this does not forego the injured worker's responsibility of proving a causal connection between the requested treatment and the industrial injury. See, Ohio Admin Code section 4123-3-09(C). An important factor not to be ignored from *Jackson Tube* is the lengthy report provided by the doctor to explain why the diagnostic procedure was necessary. This medical opinion from Dr. Paley, upon which the commission relied, allowed the SHO to undertake the three prong analysis from *Miller*. No such medical report exists in this case. No where in the September 22, 1998 note from Dr. Urbanosky does it say that the purpose of Mathews' visit that day is to determine additional diagnoses associated with the industrial injury. There is no explanation, at all, from Dr. Urbanosky upon which the SHO could conclude that the purpose of the visit on September 22, 1998 was for diagnostic purposes. Unlike the extensive medical opinion of Dr. Paley in

Jackson Tube, there is no opinion from Dr. Urbanosky that allowed the SHO to undertake the *Miller* analysis and fall under the protection of *Jackson Tube*. The decision of the Court Appeals was directly on point with this issue wherein the majority stated, “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.” *Sears* at ¶14. The SHO acted contrary to law and committed an abuse of discretion when he found, “this referral is a reasonable expense of the allowed industrial injury.” (Supp. 26).

Even though a person may have a prior worker’s compensation claim this should not automatically render treatment payable under the claim unless that person somehow shows a connection between treatment and the industrial injury. It is incumbent upon the injured worker, such as Mathews, to prove the three prongs under *Miller*. A thorough review of the September 22, 1998 office visit (as was done by the Court of Appeals) shows that the reason for the visit was because Mathews had low back pain. Dr. Urbanosky did not attribute those symptoms to the industrial injury nor did she even contemplate a possible diagnosis related to the injury. Thus, the treatment with Dr. Urbanosky on September 22, 1998 should not be payable under Mathews’ worker’s compensation claim.

Mathews and the commission both suggest that because Sears paid for medical treatment during the past eleven years that the visit on September 22, 1998 was somehow automatically payable under the claim. (Mathews Brief page 10) (Merit Brief of Appellant Industrial Commission of Ohio page 9, hereinafter “Commission Brief page _____”). However, this Court has previously found that the payment of medical expenses by a self-insured employer does not implicitly allow conditions in a claim. *State ex rel. Schricten v. Indus. Comm.*, 2000-Ohio-91, ¶5 quoting *State ex rel. Griffith v. Indus. Comm.*, 1999-Ohio-310. Therefore, even though Sears

may have consistently paid for treatment in the past with the orthopedic provider for Mathews this does not automatically grant payment for the September 22, 1998 office visit. Mathews must still prove that the treatment is somehow for an allowed condition in the claim, *Miller*, supra, or that it was for the diagnosis of conditions to be added to the claim, *Jackson Tube*, supra. Neither of these positions is supported upon a review of the September 22, 1998 treatment note. Thus, this portion of the Court of Appeals' decision is also correct and should not be disturbed.

Sears' Proposition of Law No. 2

An injured worker should not be able to treat a medical bill as denied and thereafter seek the protections of R.C. 4123.52 when he or she never submitted further documentation proving the treatment is for allowed conditions or for diagnosing conditions in a claim.

Ohio Administrative Code section 4123-19-03(L)(4) requires the claimant to file with the employer and the bureau or commission the medical reports of the treating physician relating to the treatment for the allowed injury. (Effective 11-19-93) (Commission Brief page 42). Furthermore, the burden of proof is on the claimant to prove each essential element of the claim by a preponderance of the evidence including determining the right to compensation or benefits. Ohio Admin. Code. Section 4123-3-09(C)(3)(e).

Mathews has not presented enough evidence to prove the September 22, 1998 office visit is properly payable under his worker's compensation claim. There is no indication that the visit was for treatment of an allowed condition, or in consultation for a diagnosis of a new condition to possibly be associated with the claim. Much is raised by Mathews and the commission that Sears, as a self-insuring employer, should not benefit from its inactions. However, a closer review of the record is warranted on this issue. The commission and Mathews ignore a very significant fact from the March 12, 1999 letter.

In the March 12, 1999 letter, attorney Stanley Dritz says, “[t]his was billed to your office for payment and was **rejected** on the basis that the claim had been inactive.” (Emphasis Added). (Supp. 11). He continues, “[i]s it really necessary to go further with regard to this billing to the extent that the claim needs to be activated and perhaps **the hearing held?**” (Emphasis Added). (Supp. 11). This request by attorney Dritz was followed by the April 21, 1999 letter of Marcia L. Giesler of Frank Gates to attorney Dritz. In that letter, it is requested of the attorney to provide Frank Gates with office notes to prove the relationship and diagnosis to the worker’s compensation claim. (Supp. 12). There is no evidence in the record that attorney Dritz or Mathews ever responded to this letter with additional information.

The commission and Mathews concentrate very heavily on the April 21, 1999 letter from Frank Gates in their Briefs. Essentially, the Appellants argue that this letter from Frank Gates in 1999 left the claim in limbo because there was no denial by the self-insuring employer, Sears. What the commission and Mathews overlook is the March 12, 1999 letter from Dritz to Frank Gates where he says the bill was **rejected**. Thus, by the time the April 21, 1999 letter was generated, the September 22, 1998 bill that is the subject of this action was already denied by the self-insuring employer. Although admittedly a letter from Sears is not a part of the record, this is immaterial because counsel for Mathews sometime in late 1998 or early 1999 knew the bill was rejected. Additionally, attorney Dritz also contemplated having the hearing held to possibly reactivate the claim if Frank Gates was not going to act on the bill. Thus, Mathews and his attorney in March of 1999 were fully aware of the fact that a hearing would need to occur to have the September 22, 1998 billed paid.

The September 22, 1998 office note does contain a date stamp of December 28, 1998. (Supp. 10). Mathews and the commission also raise the issue that Sears was already in

possession of this treatment note when it was “re-requested” in the April 21, 1999 letter. This is immaterial because a review of the September 22, 1998 office note leads everyone to the same argument as above: the treatment is not for any allowed conditions in the claim. When Frank Gates sent the letter in April of 1999 they were presumably engaging in the same review that the Tenth District Court of Appeals did eleven years later. That review would be establishing the purpose of the visit and the allowed conditions in the claim.

What is also lost in the Briefs of the commission and Mathews is the fact that Mathews never responded to the April 21, 1999 letter, and very importantly he never sought treatment again under the claim until 2008. This is presumably because, as stated by Dr. Urbanosky in the September 22, 1998 note, “overall seems to have recovered well.” (Supp. 10). It was not until Mathews wanted to start treatment again in 2008 that he filed the C-86 motion on June 5, 2008 to order payment of the Dr. Urbanosky bill from September 22, 1998. (Supp. 21). Mathews should be held accountable for his inactions in failing to request payment of a bill more than ten years after the last payment of compensation in his claim. See, e.g. *Cocherl v. Ohio Dept. of Transportation*, Tenth Dist. App. No. 06AP-1100, 2007-Ohio-3325, ¶28 and Ohio Revised Code section 4123.52 (effective 10-20-93).

Mathews was on equal footing with Sears in 1999 and still is to this day. His counsel knew in March 1999, when he authored the letter, that the September 22, 1998 bill was **rejected**. His counsel also knew that a hearing may have to occur to address the issue. Mathews could have submitted more in writing to Frank Gates and Sears in 1999 but he did not. In fact, Mathews had another ten years to gather information and opinions to submit in support of his June 5, 2008 motion requesting payment of the bill. He did not. Presumably this is because the September 22, 1998 office visit has no connection to the work injury. It is Mathews, not Sears,

who bears the burden of proving payment for the fee bill. Ohio Admin. Code section 4123-3-09(C). As conceded by Mathews in his Merit Brief, there were only two documents in front of the SHO which allowed him to grant the payment of the bill: the Dr. Urbanosky note and the claim payment report. (Mathews Brief page 10). Even though Mathews had a considerable amount of time to build his case for payment of the treatment note, he was unable to accumulate any further evidence.

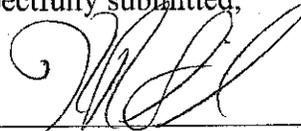
The inactions of Mathews should not be used to re-open a claim where the last activity on the claim occurred on March 26, 1997 in the form of payment of a medical bill, and the last compensation was paid on January 13, 1995. (Supp. 15). Mathews and his attorneys admittedly knew the September 22, 1998 visit with Dr. Urbanosky was rejected as of March 12, 1999, at the very latest. Frank Gates (after already rejecting the bill) on April 21, 1999 requested additional information to prove the connection between the visit and the claim. As of the time of the filing of his motion on June 5, 2008 and the SHO hearing on October 24, 2008 no such additional information ever came. A review of the only information ever presented, the September 22, 1998 note, leads to only one conclusion – the treatment is not related to the work injury.

CONCLUSION

The Industrial Commission abused its discretion and erred as a matter of law when it ordered Sears to pay the Urbanosky invoice. The Tenth District Court of Appeals correctly ruled in favor of Sears granting its writ of Mandamus ordering a denial of payment of the September 22, 1998 bill. There is no evidence within the record to establish that the treatment on September 22, 1998 is for allowed conditions in the claim or for diagnosing conditions that should become part of the claim. As such, Sears respectfully requests that this Court affirm the decision of the court below, and grant a writ of Mandamus ordering the Industrial Commission to

vacate its order requiring Sears to pay the Urbanosky invoice and enter an order denying Mathews' June 5, 2008 Motion...

Respectfully submitted,



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CERTIFICATE OF SERVICE

The undersigned certifies that a true and accurate copy of the foregoing document was served via regular US mail, postage pre-paid, on **December 6, 2010** on the following:

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APPENDIX

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ORC Ann. 4123.52

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*** ARCHIVE MATERIAL ***

*** THIS DOCUMENT REFLECTS CHANGES RECEIVED THROUGH NOVEMBER 1, 1999 ***

TITLE XLI [41] LABOR AND INDUSTRY
CHAPTER 4123: WORKERS' COMPENSATION
[JURISDICTION OF COMMISSION]

ORC Ann. **4123.52** (Anderson 1999)

§ **4123.52** Continuing jurisdiction of commission.

The jurisdiction of the industrial commission and the authority of the administrator of workers' compensation over each case is continuing, and the commission may make such modification or change with respect to former findings or orders with respect thereto, as, in its opinion is justified. No modification or change nor any finding or award in respect of any claim shall be made with respect to disability, compensation, dependency, or benefits, after six years from the date of injury in the absence of the payment of medical benefits under this chapter, in which event the modification, change, finding, or award shall be made within six years after the payment of medical benefits, or in the absence of payment of compensation under section 4123.57, 4123.58, or division (A) or (B) of section 4123.56 of the Revised Code or wages in lieu of compensation in a manner so as to satisfy the requirements of section 4123.84 of the Revised Code, in which event the modification, change, finding, or award shall be made within ten years from the date of the last payment of compensation or from the date of death, nor unless written notice of claim for the specific part or parts of the body injured or disabled has been given as provided in section 4123.84 or 4123.85 of the Revised Code, and the commission shall not make any modification, change, finding, or award which shall award compensation for a back period in excess of two years prior to the date of filing application therefor. This section does not affect the right of a claimant to compensation accruing subsequent to the filing of any such application, provided the application is filed within the time limit provided in this section.

This section does not deprive the commission of its continuing jurisdiction to determine the questions raised by any application for modification of award which has been filed with the commission after June 1, 1932, and prior to the expiration of the applicable period but in respect to which no award has been granted or denied during the applicable period.

The commission may, by general rules, provide for the destruction of files of cases in which no further action may be taken.

The commission and administrator of workers' compensation each may, by general rules, provide for the retention and destruction of all other records in their possession or under their control pursuant to section 121.211 [121.21.1] and sections 149.34 to 149.36 of the Revised Code. The bureau of workers' compensation may purchase or rent required equipment for the document retention media, as determined necessary to preserve the records. Photographs, microphotographs, microfilm, films, or other direct document retention media, when properly identified, have the same effect as the original record and may be offered in like manner and may be received as evidence in any court where the original record could have been introduced.

HISTORY: GC § 1465-86; 103 v 72(88), § 39; 114 v 26; 115 v 423; 118 v 410; 122 v 268; Bureau of Code Revision, 10-1-53; 132 v H 268 (Eff 12-11-67); 137 v H 876 (Eff 7-26-78); 137 v H 1282 (Eff 1-1-79); 141 v H 238 (Eff 7-1-85); 143 v H 222 (Eff 11-3-89); 145 v H 107 (Eff 10-20-93); 147 v S 45.*

4123-3-09 Procedures in the processing of applications for benefits.

(A) Numbering and recording.

(1) Upon receipt, the bureau will assign a claim number to each initial application for benefits. The bureau shall provide the claim number to the claimant and employer. In cases where a deceased employee has filed, during his or her lifetime, an industrial claim for the injury or disability which is the subject matter of the death claim, the application for death benefits shall be assigned the original claim number.

(2) The claim number should be placed on all documents subsequently filed in each claim and the claim number should be given when inquiry is made concerning each claim.

(B) Initial review and processing of new claims.

Immediately after numbering and recording, all new claim applications, except applications of employees of self-insuring employers, shall be reviewed and processed by the bureau's claims specialists on the question of compensability. "Processing on the question of compensability" means making a determination on the validity of the industrial claim.

(1) Noncontested or undisputed claims.

A "contested or disputed claim," as used herein, is where the employer or the bureau of workers' compensation questions the validity of a claim for compensation or benefits. No claim shall be regarded as a contested or a disputed claim requiring a formal (public) hearing, solely by reason of incomplete information, unless every effort has been made to complete the record.

(a) If a state fund claim meets the statutory requirements of compensability, the claims specialist shall have authority to approve such claim for payment of medical bills and temporary total disability compensation. The approval of the claim must contain the description of the condition or conditions for which the claim is being allowed and part or parts of the body affected.

(b) In the processing of initial applications in state fund claims, requesting payment of compensation in addition to medical benefits, the claims specialist may approve temporary total disability compensation over a period not to exceed four weeks, without medical proof in the record, provided that the application has been properly completed and signed, certified by the employer and was otherwise noncontroversial. If medical proof was submitted with the initial application, the above limitation shall not apply. Upon approval of the claim the claimant shall be notified in writing that his or her attending physician's report will be necessary for consideration of any additional payment of compensation and an appropriate form shall be enclosed, with the necessary instructions, for the claimant's convenience.

(c) Immediately after the initial processing and execution of orders, claims shall be referred to the proper location for housing, as provided in division (B)(11) of section 4121.121 of the Revised Code.

(2) Contested or disputed claims.

(a) Contested or disputed claims as well as claims requiring investigation shall be referred, immediately after the initial review, to the appropriate office of the bureau from which investigation and determination of issues may be made most expeditiously.

(b) If the bureau or the employer contests the claim application and the claimant is not available for an adjudication due to the claimant's service in the armed services of the United States, the bureau shall continue the matter in accordance with the Servicemembers Civil Relief Act until such the as the claimant is available for adjudication of the claim.

(3) Applications for death benefits.

Immediately after numbering and recording, all applications for death benefits shall be referred to the appropriate office of the bureau from which investigation and determination of issues may be made most expeditiously. Every effort should be made to complete the investigation within the shortest time possible, depending on the facts and circumstances of each particular case, to enable prompt adjudication of such claims by the bureau.

(4) Contested (disputed) applications for workers' compensation benefits filed by employees of self-insuring employers shall be referred to the industrial commission for a hearing.

(C) Proof.

(1) In every instance the proof shall be of sufficient quantum and probative value to establish the jurisdiction of the bureau to consider the claim and determine the rights of the applicant to an award. "Quantum" means measurable quantity. "Probative" means having a tendency to prove or establish.

(2) Proof may be presented by affidavit, deposition, oral testimony, written statement, document, or other forms.

(3) The burden of proof is upon the claimant (applicant for workers' compensation benefits) to establish each essential element of the claim by preponderance of the evidence. Essential elements shall include, but will not be limited to:

(a) Establishing that the applicant is one of the persons who under the act have the right to file a claim for workers' compensation benefits;

(b) That the application was filed within the time period as required by law;

(c) That the alleged injury or occupational disease was sustained or contracted in the course of and arising out of employment;

(d) In death claims, that death was the direct and proximate result of an injury sustained or occupational disease contracted in the course of and arising out of employment; the necessary causal relationship between an injury or occupational disease and death may be established by submission of sufficient evidence to show that the injury or occupational disease aggravated or accelerated a pre-existing condition to such an extent that it substantially hastened death;

(e) Any other material issue in the claim, which means a question that must be established in order to determine claimant's right to compensation and/or benefits.

"Preponderance of the evidence" means greater weight of evidence, taking into consideration all the evidence presented. Burden of proof does not necessarily relate to the number of witnesses or quantity of evidence submitted, but to its quality, such as merit, credibility and weight. The obligation of the claimant is to make proof to the reasonable degree of probability. A mere possibility is conjectural, speculative and does not meet the required standard.

(4) The bureau or commission may, at any point in the processing of an application for benefits, require the employee to submit to a physical examination or may refer a claim for investigation.

(5) Procedure on employer's request for medical examination of the claimant by a doctor of employer's choice.

The employer may require a medical examination of the employee as provided in section 4123.651 of the Revised Code under the following circumstances:

(a) Such an examination, if requested, shall be in lieu of any rights under paragraph (C)(5)(b) of this rule and in no event will the claimant be examined on the same issue by a physician of the employer's choice more than one time. The exercise of this examination right shall not be allowed to delay the timely payment of benefits or scheduled hearings. Requests for further examinations will be made to the bureau or commission following the provisions of paragraph (C)(5)(b) of this rule. The cost of any examination initiated by the employer shall be paid by the employer including any fee required by the doctor, and the payment of all of the claimant's traveling and meal expenses, in a manner and at the rates as established by the bureau from time to time. If employed, the claimant will also be compensated for any loss of wages arising from the scheduling of an examination.

All reasonable expenses shall be paid by the employer immediately upon receipt of the billing, and the employer shall provide the claimant with a proper form to be completed by the claimant for reimbursement of such expenses.

The employer shall promptly inform the bureau or the commission, as well as the claimant's representative, as to the time and place of the examination, and the questions and information provided to the doctor. A copy of the examination report shall be submitted to the bureau or commission and to the claimant's representative upon the employer's receipt of the report from the doctor.

Emergency treatment does not constitute an examination by the employer for the purposes of this rule. Treatment by a company doctor as the treating physician constitutes an examination for the purposes of this rule. The procedure set forth in paragraph (C)(5)(a) of this rule shall be applicable to claims where the date of injury or the date of disability in occupational disease claims occur on or after August 22, 1986.

(b) If after one medical examination of the claimant under paragraph (C)(5)(a) of this rule, an employer asserts that a medical examination of the claimant by a doctor of the employer's choice is essential in the defense of the claim by the employer, a written request may be filed with the bureau

for that purpose. In such request the employer shall state the date of the last examination of the claimant by a doctor of employer's choice on the question pending. If there was no such prior examination, the request must so indicate.

(c) If the claim is pending before the industrial commission or its hearing officers and the question sought to be clarified by such examination is not within the jurisdiction of the bureau (for example: permanent total disability), the request shall be referred, forthwith, to the industrial commission or to the appropriate hearing officer, as the case may be, for further consideration.

(d) If the question sought to be clarified by the requested examination is within the bureau's jurisdiction (for example: temporary total disability in otherwise undisputed claim, allowance of additional condition), the bureau shall immediately act upon the request.

If, upon a review of the claim file the bureau is of the opinion that the request should be denied for the reason that the claimant has been recently examined by a doctor of the employer's choice, or for any other reason indicating that further examination would not be pertinent to the defense of the claim, based on the facts and circumstances of each particular case, the matter shall be referred, forthwith, to the appropriate district hearing officer for further consideration. In cases of temporary total disability, a medical examination performed within the past thirty days shall be regarded as "recent." If the question involves additional allowance of claim for an additional condition allegedly causally related to the allowed injury or occupational disease, a medical examination performed within the past sixty to ninety days may be regarded as "recent," depending on the nature and type of the condition and/or disability.

(e) All reasonable expenses incurred by the claimant in submitting to such examination, including any travel expense that the claimant may properly incur, shall be paid by the employer immediately upon receipt of the billing. Payment for traveling expenses shall not require an order of the bureau or commission, unless there is a dispute. The employer shall provide the claimant with a proper form to be completed by the claimant for reimbursement for traveling expenses. In addition, if the request for such examination is filed on or after January 1, 1979, and the claimant sustains lost wages as a result of such examination, the employer shall reimburse the claimant for such lost wages within three weeks from the date of examination. Expenses incurred by the claimant and wages lost by reason of attending such examination are not to be paid in the claim.

(f) The employer shall make arrangements for such examination within fifteen days from the date of receipt of the order of approval. The examination shall be performed not later than within thirty days from the date of the receipt of approval.

The doctor's report shall be filed with the bureau immediately upon its receipt. Failure of the employer to comply with this rule shall not delay further action in the claim, unless it is established that the omission was due to causes beyond the employer's control.

(6) Procedure for obtaining the deposition of an examining physician. Authority to allow depositions is within the exclusive jurisdiction of the industrial commission. Any such request, if filed with the bureau, shall be referred, forthwith, to the industrial commission for further consideration.

(D) Hearings and orders issued pursuant thereto.

- (1) Unless required by law or by the circumstances of the claim, the claim shall be adjudicated without a formal hearing.
 - (2) Disputed or contested claims shall be set for a formal (public) hearing on the question of allowance before the district hearing officers. A "disputed or contested claim," as used herein, is where the employer or the bureau of workers' compensation questions the validity of a claim for compensation or benefits. No claim shall be regarded as a contested or disputed claim requiring a formal (public) hearing, solely by reason of incomplete information unless every effort has been made to complete the record (see paragraph (F) of this rule).
 - (3) Upon the request of the industrial commission, the bureau shall assist the district hearing officers in administrative matters preliminary to formal (public) hearings, such as: the setting and publication of dockets, preparation and mailing notices of hearing, assistance in handling requests for continuance of hearing, etc. In addition, the bureau shall make available to each district hearing officer the facilities and assistance of bureau employees, as needed. In all such matters the bureau shall follow the procedural rules of the industrial commission.
 - (4) If prior to or after a formal hearing it is apparent that additional information is necessary for proper adjudication of a claim, the bureau shall be responsible for securing the necessary information.
 - (5) The administrator of the bureau of workers' compensation, or his or her designee, shall be given a reasonable advance notice of all formal hearings affecting the state insurance fund and/or the surplus fund. Such notice shall be in writing, sent by inter-office mail. In emergency hearings such notice may be by telephone in addition to inter-office mail. Time limits applicable to advance notification of other parties under the rules of the commission shall apply herein.
 - (6) The administrator or his or her designee may appear at such hearings to represent the interest of the state insurance fund and/or the surplus fund.
 - (7) The bureau shall make payment on orders of the commission, and district or staff hearing officers in accordance with law and rules of the bureau and the industrial commission.
 - (8) If the administrator or his or her designee is of the opinion that an emergency exists which requires an immediate hearing of a claim, he or she may request an emergency hearing. "Emergency," as used herein, means a sudden, generally unexpected occurrence or set of circumstances demanding immediate action. Such request shall be made in accordance with the rule of the industrial commission on emergency hearings (rule 4121-3-30 of the Administrative Code).
- (E) Representation of claimants and employers before the bureau. Representation of claimants and employers before the bureau is a matter of individual free choice. The bureau does not require representation nor does it prohibit it. No one other than an attorney at law, authorized to practice in the state of Ohio, shall be permitted to represent claimants for a fee before the bureau.
- (F) Procedure governing the appearances of a claimant, employer or their representatives before the bureau.
- (1) If the bureau or the parties believe that clarification of issues will facilitate the processing of the

claim, the claimant, employer, and/or their duly authorized representatives (see rule 4123-3-22 of the Administrative Code) shall be given an opportunity to be heard by the bureau (service office director, section director or their designee) on questions pertaining to the claim pending before the bureau.

(2) The parties may appear before the bureau together, at the same time, or separately, at different times, as circumstances may require; they may choose to be or not to be represented; a duly authorized representative may appear on behalf of a party, without the party being present.

(3) Evidence may be submitted in writing or offered orally. Oral statements shall be reduced to writing by the bureau's authorized personnel.

(4) The new evidence shall be made a part of the claim file to be considered by the bureau when the determination is made on the issue pending before the bureau.

Effective: 11/05/2009

R.C. 119.032 review dates: 02/01/2014

Promulgated Under: 119.03

Statutory Authority: 4121.12, 4121.121

Rule Amplifies: 4121.121, 4121.43, 4123.651

Prior Effective Dates: 10/9/76; 1/16/78; 12/21/79; 8/22/86 (Emer.); 11/17/86 (Emer.); 1/10/87, 2/10/09

OAC Ann. 4123-6-25

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2010 through October 15, 2010 ***

4123 Bureau of Workers' Compensation
Chapter 4123-6 Health Partnership Program

OAC Ann. 4123-6-25 (2010)

4123-6-25. Payment for medical supplies and services.

(A) Medical or other services to be approved for payment must be rendered as a direct result of an injury sustained or occupational disease contracted by a claimant in the course of and arising out of employment. The claim must be allowed by an order of either the bureau of workers' compensation or the industrial commission, or have been recognized by a self-insuring employer.

Medical supplies and services will be considered for payment when they are medically necessary for the diagnosis and treatment of conditions allowed in the claim, are causally related to the conditions allowed in the claim, and are rendered by a health care provider. Payment for services rendered to a claimant shall be paid to a health care provider only when the provider has either delivered, rendered or directly supervised the examination, treatment, evaluation or any other medically necessary and related services provided to the claimant. By submitting any fee bill to the bureau, in either hardcopy or electronic format, the health care provider affirms that **medical supplies and services** have been provided to the claimant as required by this rule.

Providers billing for services rendered shall follow the procedures set forth in the bureau's provider billing and reimbursement manual in effect on the billed date of service.

(B) Services rendered by health care providers are subject to review for coding requirements outlined in paragraph (C) of this rule. Payments to health care providers may be adjusted based upon these guidelines.

(C) Coding systems. (1) Billing codes. (a) Practitioners are required to use the edition of the health care financing administration's centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS) in effect on the billed date of service to indicate the procedure or service rendered to injured workers.

(b) Inpatient and outpatient hospital services must be billed using the national uniform billing committee's revenue center codes.

(c) Outpatient medication services must be billed pursuant to the requirements described in the bureau's provider billing and reimbursement manual.

(d) To insure accurate data collection, the bureau shall adopt a standardized coding structure which shall be adopted by any MCO, QHP, or self-insuring employer.

(2) Diagnosis codes. Providers must use the appropriate "International Classification of Diseases, clinical modification" codes for the condition(s) treated to indicate diagnoses.

(D) Prior to services being delivered, the provider must make reasonable effort to notify the

claimant, bureau, MCO, or QHP or self-insuring employer when the provider has knowledge that the services may not be related to the claimed or allowed condition(s) related to the industrial injury or illness, or that a service is non-covered. The provider may not knowingly bill or seek payment from the bureau, MCO, QHP or self-insured employer for services that are not related to the claimed or allowed condition(s) related to the industrial injury or illness. The provider may not knowingly mislead or direct providers of ancillary services to bill or seek payment for services that are not related to the claimed or allowed condition.

The provider may not bill or seek payment from the claimant for services determined as medically unnecessary through the use of bona fide peer review based on accepted treatment guidelines.

History:Effective: 02/01/2010.

R.C. 119.032 review dates: 11/17/2009 and 11/01/2014.

Promulgated Under: 119.03.

Statutory Authority: 4121.12, 4121.121, 4121.30, 4121.31, 4123.05.

Rule Amplifies: 4121.121, 4121.44, 4121.441, 4123.66.

Prior Effective Dates: 2/12/97, 4/1/07.

Source: **Ohio > Find Statutes, Regulations, Administrative Materials & Court Rules > OH - Ohio Administrative Code** 

Terms: **"medical supplies and services"** (Edit Search | Suggest Terms for My Search)

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1987 Ohio App. LEXIS 8493, *

State of Ohio, ex rel. Marjorie **Noland**, Relator, v. The Industrial Commission of Ohio, and
Frigidaire Division, General Motors Corporation, Respondents

No. 86AP-594

Court of Appeals of Ohio, Tenth Appellate District, Franklin County

1987 Ohio App. LEXIS 8493

August 27, 1987, Decided

DISPOSITION: [*1] *Referee's report adopted and writ granted.*

CASE SUMMARY:

PROCEDURAL POSTURE: Relator employee sought a writ of mandamus to compel respondent Industrial Commission of Ohio to vacate its order denying payment of medical expenses incurred by relator employee and to issue an order requiring respondent self-insured employer to pay a portion of such expenses.

OVERVIEW: The employer refused to make payment of certain medical expenses incurred by the employee who then sought an order from the Industrial Commission ordering the self-insured employer to make payment. Instead, a district hearing officer denied the employee's motion without explanation or reason other than to state that the self-insured employer was not responsible for the payment of the hospital and medical bills requested by the employee. The court issued the writ holding that the hearing officer failed to perform the mandatory statutory duty of setting forth the reasons for his decision and, at the very least, the employee was entitled to relief. The court held further that the Industrial Commission had no authority to adopt rules denying the exercise by an employee of the rights granted by Ohio Rev. Code Ann. § 4123.651, including the free choice of a physician. The broad discretion of the Industrial Commission was merely to approve or disapprove the cost of such services.

OUTCOME: The court adopted and approved the referee's report as supplemented and modified and granted a writ of mandamus ordering the Industrial Commission to vacate its order denying payment and to conduct further hearings to determine whether or not the employee was entitled to have the medical bills in question paid by the self-insured employer.

CORE TERMS: medical services, Industrial, medical expenses, injured employee, self-insured, claimant, industrial injury, referee, ordering, medical bills, hearing officer, authorization, mandatory, writ of mandamus, reasonably necessary, vacate, medical evidence, approve, referee's report, medically necessary, mandamus, salient, doctor

LEXISNEXIS(R) HEADNOTES

Administrative Law > Separation of Powers > Jurisdiction
Workers' Compensation & SSDI > Administrative Proceedings > Evidence > Medical Evidence
Workers' Compensation & SSDI > Benefit Determinations > Medical Benefits > Employee Rights

HN1 ↓ The Industrial Commission of Ohio has no authority to adopt rules denying the exercise by an employee of the rights granted by Ohio Rev. Code Ann. § 4123.651,

including the free choice of a physician. The broad discretion of the Industrial Commission is to approve or disapprove the cost of such services.

Administrative Law > Separation of Powers > Jurisdiction
Workers' Compensation & SSDI > Administrative Proceedings > Claims > General Overview
Workers' Compensation & SSDI > Compensability > Injuries > General Overview

HN2 A determination by the Industrial Commission of Ohio is solely for three purposes:

(1) to determine whether the medical services are reasonably related to the industrial injury, that is the allowed conditions, (2) to determine whether the medical services are reasonably necessary for treatment of the industrial injury, that is the allowed conditions; and (3) to determine whether the cost of such service is medically reasonable. Advance approval is not required since advance approval is purported to be required only to determine necessity of treatment (as opposes to consultation) by a specialist. Advance authorization is also required for surgical procedures and hospitalization. Mandatory pre-authorization is inconsistent with the rights granted upon injured employees by statute, especially since Ohio Rev. Code Ann. § 4123.95 requires the statutes to be construed liberally for the benefit of injured employees.

COUNSEL: HOCHMAN & HORWITZ CO., MR. JOHN W. REED, JR., and MR. JEFFREY P. STARTZMAN, for relator.

MR. ANTHONY J. CELEBREZZE, JR., Attorney General, MR. MERL H. WAYMAN, for respondent Industrial Commission of Ohio.

MESSRS. COWDEN, PFARRER, CREW & BECKER, MR. GARY T. BRINSFIELD, for respondent Frigidaire Division, General Motors Corporation.

JUDGES: WHITESIDE, J., REILLY and McCORMAC, JJ., concur.

OPINION BY: WHITESIDE

OPINION

IN MANDAMUS

WHITESIDE, J.

This original action in mandamus was referred to a referee who has rendered a report recommending that this court grant a writ of mandamus ordering respondent Industrial Commission to vacate its order denying payment of medical expenses incurred by relator, Majorie Noland, and to issue an order finding the relator entitled to payment of a portion of such expenses and to conduct further proceedings upon the issue of medical expenses. No objections have been filed to the referee's report.

After a review of the evidence and the report of the referee, this court adopts the referee's findings of fact and finds that the referee has essentially correctly applied the applicable law to the facts but that **[*2]** some additional considerations are required.

Here, the self-insured employer, respondent Frigidaire Division, General Motors Corporation, refused to make payment of certain medical expenses incurred by relator who then sought an order from respondent Industrial Commission ordering the self-insured employer to make payment. Instead, a district hearing officer denied relator's motion without explanation or reason other than to state that "[t]he self-insured employer is not responsible for the payment

of the hospital and medical bills requested by the claimant." Thus, the hearing officer failed to perform the mandatory statutory duty of setting forth the reasons for his decision and, at the very least, relator is entitled to relief pursuant to *State, ex rel. Mitchell, v. Robbins & Myers, Inc.* (1983), 6 Ohio St. 3d 481.

Respondent Industrial Commission and respondent employer rely upon certain rules of the Industrial Commission as a predicate for denial of the payment of medical expenses, contending that such rules require approval of the employer as to medical treatment to be sought by the injured employee before the self-insured employer can be responsible for payment of [*3] such medical expense. We rejected a similar contention in *Parsley v. Internat'l. Harvester* (1984), 15 Ohio App. 3d 38, in which we noted that ^{HN1} the respondent Industrial Commission has no authority to adopt rules denying the exercise by an employee of the rights granted by R.C. 4123.651, including the free choice of a physician. The Supreme Court noted a similar conclusion in *State, ex rel. Campbell, v. Indus. Comm.* (1971) 28 Ohio St. 2d 154 at 157, although payment of the full extent of medical services desired and sought by the employee were not authorized because there was probative medical evidence supporting the determination of the respondent Industrial Commission. As the Supreme Court noted, the broad discretion of the Industrial Commission is "to approve or disapprove the cost of such services."

There is nothing in *Campbell* suggesting that the respondent Industrial Commission has the authority to determine from whom the claimant shall seek medical services, nor whether the claimant shall seek medical services, nor the nature of the medical services sought by the claimant. Rather, ^{HN2} the determination by respondent Industrial Commission is solely for three purposes: [*4] (1) to determine whether the medical services are reasonably related to the industrial injury, that is the allowed conditions, (2) to determine whether the medical services are reasonably necessary for treatment of the industrial injury, that is the allowed conditions; and (3) to determine whether the cost of such service is medically reasonable.

Even the rules recognize that advance approval is not required since advance approval is purported to be required only to determine necessity of treatment (as opposes to consultation) by a specialist. Advance authorization is also required for surgical procedures and hospitalization. As we have noted in *Parsley*, mandatory preauthorization is inconsistent with the rights granted upon injured employees by statute, especially since R.C. 4123.95 requires the statutes to be construed liberally for the benefit of injured employees.

Advance approval serves a very salient purpose in that it enables the injured employee to ascertain whether or not payment will be made for the medical services he receives prior to the time that such services are rendered. Although advance authorization serves a salient purpose and may be desirable in most instances, [*5] it is not a mandatory prerequisite to the entitlement of an injured employee to compensation in the nature of payment for the reasonably necessary medical expenses incurred as a result of an industrial injury. However, if there be no advance authorization, the employee runs the risk that the medical bill will not be paid in that the Industrial Commission may find from appropriate medical evidence that the treatment received was not reasonably necessary to treat the industrial injury. Of course, if the medical services received are not related to the allowed conditions, payment would not be forthcoming, even if medically necessary for the non allowed condition.

In this case, it is impossible to determine the reason why the hearing officer denied payment of medical services. As the referee points out, there appears to be no basis whatsoever for denial of payment of some of the medical services since even the employer admits there was advance approval and that the medical services were necessary for treatment of the allowed condition. Accordingly, we must grant a writ of mandamus ordering respondent Industrial Commission to vacate its order denying payment and to conduct further hearings [*6] to determine whether or not relator is entitled to have the medical bills in question paid by the self-insured employer. Obviously, if medical services are duplicative in nature, that is if the claimant unnecessarily seeks and obtained the same medical services from two different doctors, payment to only one doctor would be required.

For the foregoing reasons, we adopt and approve the referee's report as supplemented and modified herein and grant a writ of mandamus ordering respondent Industrial Commission to vacate its order denying payment for medical expenses incurred by relator, and to conduct further hearings and make further determination as to whether the claimed medical expenses incurred by relator were reasonably medically necessary for treatment of the allowed conditions resulting from the industrial injury and, if so, and to the extent that they are, to issue an order requiring respondent employer to make payment of such medical expenses and in such decision to state specific findings and the reasons therefor as well as the evidence relied upon.

REILLY and McCORMAC, JJ., concur.

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