4123-6-01 **Definitions.**

As used in the rules of this chapter and Chapter 4123-7 of the Administrative Code:

(A) "Health partnership program" or "HPP" means:

The bureau of workers' compensation's comprehensive managed care program under the direction of the chief of ~~injury management~~ medical services as provided in sections 4121.44 and 4121.441 of the Revised Code.

(B) "Qualified health plan" or "QHP" means:

A health care plan sponsored by an employer or a group of employers which meets the standards for qualification ~~developed by the health care quality advisory council~~ under section 4121.442 of the Revised Code and is certified as a qualified health care plan with the bureau.

(C) "Managed care organization" or "MCO" means:

A vendor as defined under section 4121.44 of the Revised Code who has contracted with the bureau to provide medical management and cost containment services ~~as part of the HPP~~ as provided in sections 4121.44 and 4121.441 of the Revised Code. As used in these rules, a managed care organization is not a health care provider.

(D) "Physician" means:

~~As defined in division (B) of section 4730.01 of the Revised Code, a~~ A doctor of medicine, doctor of osteopathic medicine or surgery, or doctor of podiatric medicine who holds a current, valid certificate of licensure to practice medicine or surgery, osteopathic medicine or surgery, or podiatry under Chapter 4731. of the Revised Code; ~~as provided in section 4734.09 of the Revised Code,~~ a doctor of chiropractic who holds a current, valid certificate of licensure to practice chiropractic under Chapter 4734. of the Revised Code; ~~as provided in section 4731.151 of the Revised Code,~~ a doctor of mechanotherapy who holds a current, valid certificate of licensure to practice mechanotherapy under Chapter 4731. of the Revised Code and who was licensed prior to November 3, 1985; a psychologist who holds a current, valid certificate of licensure to practice psychology under Chapter 4732. of the Revised Code; or a dentist who holds a current, valid certificate of licensure to practice dentistry under Chapter 4715. of the Revised Code. A physician licensed pursuant to the equivalent law of another state shall qualify as a physician under this rule.

(E) "Physician of record" or "attending physician" means:

For the purposes of Chapters 4121. and 4123. of the Revised Code, the authorized

physician chosen by the employee to direct treatment.

(F) "Practitioner" means:

A physician, or a physical therapist, occupational therapist, optometrist, or any other person currently licensed and duly authorized to practice within ~~their~~ his or her respective health care field.

(G) "Health care provider" or "provider" means:

A physician or practitioner, or any person, firm, corporation, limited liability corporation, partnership, association, agency, institution, or other legal entity licensed, certified, or approved by a professional standard-setting body or by ~~a regulatory agency under title XIII or XIX of the Social Security Act~~ medicare or medicaid to provide ~~particular~~ medical services or supplies, including, but not limited to~~:~~ a ~~hospital,~~ qualified rehabilitation provider~~, pharmacist, or durable medical equipment supplier~~.

(H) "Credentialing" or "recredentialing" means:

A process by which the bureau validates or reviews the application of a provider for ~~eligibility for participation in the HPP~~ certification or recertification.

(I) "Certification" or "recertification" means:

A process by which the bureau approves a provider or MCO for participation in the HPP.

(J) "Provider application and agreement" means:

A bureau form which requests background information and documentation necessary for credentialing and which, if completed and signed by the provider and approved by the bureau, constitutes a written, contractual agreement between the bureau and ~~a~~ the provider. ~~The provider application and agreement may include a provider statement or affirmation that the statements made in the application and agreement are true.~~

(K) "Recertification application and agreement" means:

A ~~provider application and agreement~~ bureau form sent ~~by the bureau~~ to bureau certified providers as part of the provider recredentialing and recertification process which requests background information and documentation necessary for recredentialing and which, if completed and signed by the provider and approved

by the bureau, constitutes a written, contractual agreement between the bureau and the provider.

(L) "Bureau certified provider" means:

A credentialed provider who has completed and signed a provider application and agreement or recertification application and agreement with the bureau and is approved by the bureau for participation in the HPP.

(M) "Non-bureau certified provider" means:

A provider who has not completed and signed a provider application and agreement or recertification application and agreement with the bureau and is not approved by the bureau for participation in the HPP, or whose certification has lapsed and has not been reinstated pursuant to rule 4123-6-02.4 of the Administrative Code. ~~A non-bureau certified provider may participate in the HPP pursuant to rule 4123-6-02.7 of the Administrative Code~~.

(N) "Employee" means:

As used in the rules of this chapter, the term "employee" includes the terms "injured worker" and "claimant" and all employees of employers covered under HPP.

(O) "Emergency" means:

Medical services that are required for the immediate diagnosis and treatment of a condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency, but is necessary to determine whether an emergency exists.

(P) "Medical management and cost containment services" means: ~~those~~

Those services provided by an MCO pursuant to its contract with the bureau, including return to work management services, that promote the rendering of high-quality, cost-effective medical care that focuses on minimizing the physical, emotional, and financial impact of a work-related injury or illness and promotes a safe return to work.

(Q) "Medically necessary" means:

Services which are reasonably necessary for the diagnosis or treatment of disease, illness, and injury, and meet accepted guidelines of medical practice. A medically

necessary service must be reasonably related to the illness or injury for which it is performed regarding type, intensity, and duration of service and setting of treatment.

(R) "Authorization" or "prior authorization" means:

Notification by ~~an authorized representative of~~ the MCO~~,~~ that a specific treatment, service, or equipment is medically necessary for the diagnosis and/or treatment of an allowed condition, except that the bureau reserves the authority to authorize or prior authorize the following services: caregiver services, home and van modifications, and return to work management services pursuant to paragraph (D) of rule 4123-6-04.6 of the Administrative Code.

(S) "Dispute resolution" means:

Procedures ~~developed by the MCO or the bureau to resolve~~ for the resolution of medical disputes prior to filing an appeal under section 4123.511 of the Revised Code.

(T) "Provider outcome measurement" means:

A medical management analysis tool used by the bureau or MCO which at a minimum, utilizes line item detail from a medical bill and employee specific information including, but not limited to, demographics, diagnosis allowances ~~return-to-work~~ return to work and ~~remain-at-work~~ remain at work statistics, and other data regarding treatment~~,~~ to evaluate a health care provider on the basis of cost, utilization and treatment outcomes efficiency and compliance with bureau requirements.

(U) "Utilization review" means:

The assessment of an employee's medical care by the MCO. This assessment typically considers medical necessity, the appropriateness of the place of care, level of care, and the duration, frequency or quality of services provided in relation to the allowed condition being treated.

(V) "Treatment guidelines" ~~mean~~ means:

Guidelines of medical practice developed through consensus of practitioner representatives~~,~~ that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions.

(W) "Formulary" means:

A list of medications determined to be safe and effective by the food and drug administration which the bureau shall consider for reimbursement. The list shall be regularly reviewed and updated by the bureau to reflect current medical standards of drug therapy.

(X) "Medication" means:

The same as drug as defined by division ~~(C)~~ (D) of section ~~4729.02~~ 4729.01 of the Revised Code.

(Y) "Injury" means:

For the purposes of the rules of this chapter and Chapter 4123-7 of the Administrative Code only, an injury as defined in division (C) of section 4123.01 of the Revised Code or an occupational disease as defined in division (F) of section 4123.01 of the Revised Code.

(Z) "Return to work services" means:

Services to support an injured worker in returning to employment where the injured worker is experiencing difficulty as a result of conditions related to an allowed lost time claim.

(AA) "Remain at work services" means:

Services to support an injured worker or employee in continued employment where the injured worker is experiencing difficulties performing a job as a result of conditions related to an allowed medical only claim.

(BB) "Transitional work" means:

A work-site program that provides an individualized interim step in the recovery of an injured worker with job restrictions resulting from the allowed conditions in the claim. Developed in conjunction with the employer and the injured worker, or with others as needed, including, but not limited to the collective bargaining agent (where applicable), the physician of record, rehabilitation professionals, and the MCO, a transitional work program assists the injured worker in progressively performing the duties of a targeted job.

(CC) "Hospital" means:

An institution that provides facilities for surgical and medical diagnosis and treatment of bed patients under the supervision of staff physicians and furnishes twenty-four hour-a-day care by registered nurses.

(1) For the purposes of the rules of this chapter of the Administrative Code relating to hospitals, "inpatient" means:

An injured worker is considered to be an inpatient when he or she has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. An injured worker is considered an inpatient if there is a formal order for admission from the physician. The determination of an inpatient stay is not based upon the number of hours involved. If it later develops during the uninterrupted stay that the injured worker is discharged, transferred to another inpatient unit within the hospital, transferred to another hospital, transferred to another state psychiatric facility or expires and does not actually use a bed overnight, the order from the attending physician addressing the type of encounter will define the status of the stay.

(2) For the purposes of the rules of this chapter of the Administrative Code relating to hospitals, "outpatient" means:

The injured worker is not receiving inpatient care, as "inpatient" is defined in paragraph (CC)(1) of this rule, but receives outpatient services at a hospital. An outpatient encounter cannot exceed seventy-two hours of uninterrupted duration.

(DD) "Urgent care facility" means:

A facility where ambulatory care is provided outside a hospital emergency department and is available on a walk in, non-appointment basis.

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