ACTION: Original

DATE: 07/30/2025 9:03 AM

Common Sense Initiative

Mike DeWine, *Governor*
Jim Tressel, *Lt. Governor*

Joseph Baker, *Director*

Business Impact Analysis

Agency, Board, or Commission Name: Ohio Bureau of Workers' Compensation

Rule Contact Name and Contact Information:
Eva Dixon, (614) 644-8346, enotification@bwc.ohio

Regulation/Package Title (a general description of the rules' substantive content):

Chapter 4123-6 FYRR amended rules

Rule Number(s): 4123-6-01.2, 4123-6-02, 4123-6-02.2, 4123-6-02.3, 4123-6-02.4, 4123-6-02.5, 4123-6-02.6, 4123-6-02.7, 4123-6-02.21, 4123-6-02.51, 4123-6-03.7, 4123-6-03.9, 4123-6-04.3, 4123-6-07, 4123-6-10, 4123-6-20, 4123-6-20.1, 4123-6-21, 4123-6-21.1, 4123-6-21.8

Date of Submission for CSI Review: April 29, 2025

Public Comment Period End Date: May 13, 2025

Rule Type/Number of Rules:

New/___ rules

No Change/____ rules (FYR? ___)

Amended/_20___ rules (FYR? _Y__)

Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☒ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☐ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Chapter 4123-6 of the Administrative Code contains BWC rules implementing the Health Partnership Program (HPP), including rules establishing criteria for the payment of various specific medical services by BWC in State Insurance Fund claims.

   BWC enacted the bulk of the Chapter 4123-6 HPP operational rules (Ohio Administrative Code 4123-6-01 to 4123-6-19) rules in February 1996, the Chapter 4123-6 HPP medical rules (Ohio Administrative Code 4123-6-20 to 4123-6-46) in January and February 1997, and the Chapter 4123-6 Qualified Health Plan (QHP) rules (Ohio Administrative Code 4123-6-51 to 4123-6-71) in September 1996. The rules have been periodically updated as needed.

   BWC has reviewed these rules for five year rule review in accordance with Ohio Revised Code 119.04 and 106.03, and proposes the following changes:

   4123-6-01.2 Provisional treatment reimbursement approval – pilot program.

   - Change the period of time that the pilot program may be implemented from an end date of December 31, 2022, to a period of no more than three years.

   4123-6-02 Provider access to the HPP – generally

- Changes the period of time the Bureau may recertify providers from between one to three years to as determined by the Bureau.

4123-6-02.2 Provider access to the HPP – provider certification criteria.

- Removes language that a government or public ambulance, ambulette, or air ambulance service, ambulatory surgical center, durable medical equipment supplier, hospice, hospital, independent diagnostic testing facility (IDTF), nursing home, or free-standing urgent care facility be approved by the Centers for Medicare and Medicaid Services (CMS), while maintaining the requirement they be approved for Medicare.
- Removes the requirement that a dialysis center, free-standing radiology center, or sleep laboratory be approved by CMS or by an organization approved by CMS.
- Removes the requirement that a home health agency be approved by CMS and clarifies that the agency may be approved for Medicare or accredited by a deeming organization approved by CMS.
- Removes hospital (provider) based urgent care facilities or clinics from the list of facility types eligible to be credentialed and certified as hospitals.

4123-6-02.3 Provider access to the HPP – provider application and certification criteria.

- Removes a comma.

4123-6-02.4 Provider access to the HPP – provider recertification.

- Adds two commas.

4123-6-02.5 Provider access to the HPP – provider not certified.

- Clarifies a provider's duty to submit information missing from their provider certification or recertification application upon the Bureau's request.
- Provides the Bureau may deny certification or recertification if the provider fails to submit the requested information.

4123-6-02.6 Provider access to the HPP – selection by an MCO.

- Simplifies language detailing the MCOs' requirements regarding selection of providers for their provider panels.

4123-6-02.7 Provider access to the HPP – provider decertification procedures.

- Relocates language regarding provider correction plans.

- Revises the time frame when a provider who has twice received initial written notice under the rule must enter a correction plan with the Bureau, from two violations of the same workers' compensation statute or rule within three years to three violations within eighteen months.

4123-6-02.21 Provider access to the HPP – non-certified provider enrollment.

- Removed "shall" and replaced with "may" twice in the rule to give the Bureau discretion to lapse provider certification and enrollment for no billing activity.
- Removed language stating that lapse of provider certification or enrollment for no billing activity is not an adjudication and not subject to appeal.

4123-6-02.51 Provider access to the HPP – Denial of provider, entity or MCO enrollment or certification based on criminal conviction or civil action.

- Corrected "percent" from one word to two to comply with the Ohio Legislative Service Commission (LSC) rule drafting guidelines.

4123-6-03.7 MCO participation in the HPP – bureau's authority to decertify, to refuse to certify or recertify an MCO.

- Removed two unnecessary commas.

4123-6-03.9 MCO participation in the HPP – MCO disclosure of relationship.

- Add "alternate employer organizations" to the list of MCO affiliated entities subject to the requirements of the rule.

4123-6-04.3 MCO scope of services – MCO medical management and claims management assistance.

- Adds language stating the MCO is not responsible for medical management and return to work services in a claim when the claim is assumed by the Bureau pursuant to O.A.C. 4123-6-04.6.

4123-6-07 Services and supplies never covered.

- Remove an unnecessary comma.

4123-6-10 Payment to providers.

- Updates the cross-references to rule O.A.C. 4123-19-03 due to renumbering of that rule.

4123-6-20 Obligation to submit medical documentation and reports.

- Corrects two typographical errors.

4123-6-20.1 Access to medical documentation.

- Changes “claimant” to “injured worker” to align with O.A.C. 4123-6-20.
- Incorporates language from recently amended R.C. 4123.651 to specify that only related medical information must be provided.

4123-6-21 Payment for outpatient medication.

- Removes language regarding claims recognized by self-insuring employers, as this rule applies to State Insurance Fund claims.
- Adds language that prescriptions from non-Bureau certified providers may be reimbursed if they meet the criteria of the first fill rule O.A.C. 4123-6-21.6.
- Incorporates by reference the Ohio Board of Pharmacy rules on opiate prescribing currently found in Bureau rule O.A.C. 4123-6-21.7 as that rule is being rescinded.
- Requires that reimbursement requests for non-sterile compounded prescriptions be pre-authorized.
- Adds home infusion services to the drugs which may be approved by the MCO as part of a comprehensive treatment plan.
- Adds that only pharmacy providers may receive a dispensing fee component.
- Adds language to allow for exceptions to the dispensing fee component when a prescription is filled in a state that has enacted a law requiring a different minimum dispensing fee.
- Establishes the dispensing fee for sterile and non-sterile compounded prescriptions.
- Clarifies the exception for the Bureau to override dispensing limitations when an emergency is declared to include a declaration by the Governor of the state in which the injured worker is located.
- Adds an exception for the Bureau to override dispensing limitations when medical necessity and appropriateness have been determined by the Bureau through the prior authorization process.
- **NEW:** Removes requirement that prescriber information within bills submitted electronically to the Bureau or the Bureau's PBM for payment include the prescriber’s DEA number.

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

- Duplicates the changes to dispensing fees made in O.A.C. 4123-6-21.
- Duplicates the scenarios where the Bureau may override dispensing fee limitations in O.A.C. 4123-6-21 so they also apply to self-insuring employers who utilize a pharmacy benefits manager.

- **NEW:** Removes requirement that prescriber information within bills submitted electronically to the self-insuring employer or its vendor for payment include the prescriber's DEA number.

4123-6-21.8 Reimburse for services to assist in the discontinuation of medications.

- Removes the time limits on reimbursement of inpatient and outpatient care for purposes of discontinuing medications.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

Authorize: 4121.12, 4121.121, 4121.30, 4121.31, 4121.44, 4121.441, 4123.05, 4123.66 Amplify: 4121.12, 4121.121, 4121.44, 4121.441, 4123.66

4. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
If yes, please briefly explain the source and substance of the federal requirement.

No.

5. **If the regulation implements a federal requirement, but includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

Not applicable.

6. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

The public purpose of the Chapter 4123-6 rules is to provide appropriate and clear direction of program parameters and service actions which all parties engaging in the administration, use, or provision of HPP related services to Ohio injured workers pursuant to addressing an allowed medical condition resulting from a workplace injury must adhere.

The provider certification rules 4123-6-02 through 4123-6-02.51 not only provide clarity to providers regarding baseline expectations Ohio has of providers to render services in the Ohio workers' compensation environment, but also ensure that providers are qualified to render requested services.

Outpatient medication rules 4123-6-21 and 41236-21.1 define the context, criteria, limitations and processes by which outpatient medications are covered by BWC and self insuring employers. The rules also define the types of providers who are eligible to write covered prescriptions as well as requirements for pharmacies that process the prescriptions. Payments for specific types of medications and the methodologies to be used to calculate those payments are defined in these rules.

The proposed rules also support the charge pursuant to R.C. 4123.66(A) which provides that the BWC Administrator "shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper," and that the Administrator "may adopt rules, with the advice and consent of the [BWC] board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefor."

7. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

Success will be measured by the providers' and employers' compliance with the modifications to the rules. Further, MCO compliance will be measured in accordance with the terms of the MCO contract, and administrative payments made to the MCOs based on their HPP operational performance. Additionally, success will be measured by the timely provision of services to injured workers, and the maintenance of costs within the annual fee schedule projections for the relevant services impacted by the recommended changes.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

No.

Development of the Regulation

9. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
If applicable, please include the date and medium by which the stakeholders were initially contacted.

The proposed rules were published for stakeholder comment on April 1, 2025, with a comment period open through April 14, 2025, and notice was e-mailed to the following lists of stakeholders:

- BWC's Managed Care Organizations
- BWC's Medical Services Division's medical provider stakeholder list - 68 persons representing 56 medical provider associations/groups
- BWC's Healthcare Quality Assurance Advisory Committee
- Ohio Association for Justice
- Employer Organizations
  - Council of Smaller Enterprises (COSE)
  - Ohio Manufacturers' Association (OMA)
  - National Federation of Independent Business (NFIB)
  - Ohio Chamber of Commerce
- BWC's Self-Insured Division's employer distribution list
- BWC's Employer Services Division's Third-Party Administrator (TPA) distribution list.
- Ohio Medical and Pharmacy Boards

Stakeholder responses received by BWC are summarized on the May 2025 Stakeholder Feedback Summary Spreadsheet.

10. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

As noted in the May 2025 Stakeholder Feedback Summary Spreadsheet, one stakeholder suggested during the CSI comment period that BWC amend paragraph (G)(1) of proposed rule OAC 4123-6-21.1 to remove the requirement that prescriber information within bills submitted electronically to the self-insuring employer or its vendor for payment include the prescriber's DEA number. In response, BWC has revised both proposed OAC 4123-6-21 and 4123-6-21.1 to remove the requirement.

11. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

None.

12. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**
Alternative regulations may include performance-based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to

comply.

None. No regulatory alternatives which could be considered have been identified.

The regulations pursuant to the requirements of Ohio Revised Code 44121.44, 4121.441, and 4123.66 are designed to provide appropriate and clear direction of program parameters and service actions which all parties engaging in the administration, use or provision of HPP related services to Ohio injured workers pursuant to addressing an allowed medical condition resulting from a workplace injury must adhere.

13. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

BWC is the only state agency responsible for regulating HPP related medical services for Ohio's workers' compensation programs.

14. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

Once the rules are approved and through the JCARR process, the BWC staff impacted by the rules will be informed of the effective date. The various units of the Medical Services Division of BWC will coordinate communication and training to internal BWC staff, the MCOs, and providers. BWC's Medical Services Division will also ensure that relevant sections of the MCO Policy Guide and the Provider Billing and Reimbursement manuals are updated to reflect appropriate rule modifications.

Adverse Impact to Business

15. Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:

a. Identify the scope of the impacted business community, and

All HPP services providers, self-insuring employers, and MCOs.

b. Quantify and identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance, etc.).

The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a representative business. Please include the source for your information/estimated impact.

Impact is in the nature of HPP services providers', self-insured employers', and MCOs' time for reviewing or receiving education on the changes, as well as applying any modifications to relevant systems. Estimated time which HPP services providers, employers, and MCOs may need to adjust to the changes is at less than 15 hours.

Providers must submit sufficient documentation to the Bureau to demonstrate they meet the minimum credentialing criteria in the rules to participate in the Health Partnership Program. Providers who fail to meet the minimum credentialing criteria set forth in the rules are ineligible to participate in the Health Partnership Program.

Medication may only be prescribed by a treating provider that is authorized by law to prescribe medication. The pharmacy provider must include prescriber information with the bills submitted electronically for payment, including the prescriber's NPI and DEA number, the pharmacy provider must submit for billing the national drug code of the stock bottle from which the dispensed medication is obtained.

16. Are there any proposed changes to the rules that will reduce a regulatory burden imposed on the business community? Please identify. *(Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability, eliminating requirements, reducing compliance time or fees, or other related factors).*

No.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

BWC is attempting to meet the legislative intent by setting forth appropriate and clear direction of program parameters and service actions which all parties engaging in the administration, use or provision of HPP services to Ohio injured workers pursuant to addressing an allowed medical condition resulting from a workplace injury must adhere. The rules have been reviewed and appropriately modified to add additional clarity of program parameters and service actions which all parties engaging in the administration, use or provision of HPP services need to take to ensure service access, quality and cost efficiencies.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

No. The rules are to provide guidance and clarity of program parameters and actions which all parties engaging in the administration, use or provision of HPP services must take to ensure service access, quality and cost efficiencies, and timely provider reimbursements, which leads to quality medical care, as well as a successful and safe return to work for injured workers.

19. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Not applicable.

20. What resources are available to assist small businesses with compliance of the regulation?

The MCOs have a responsibility in the contract they sign with BWC to provide training and support to all providers they utilize in managing the medical care of their injured workers. Additionally, by contract the MCOs are responsible for providing education and support to injured workers and employers on all workers' compensation services and programs including medical services. The various units of the Medical Services Division will also provide support and direction to impacted businesses regardless of size with respect to meeting Bureau regulations.