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Ohio Administrative Code

Rule 4123-18-21 Wage loss payments to injured workers who complete rehabilitation plans.

Effective: May 15, 2023

(A) For purposes of this rule:

(1) "Successful return to work" as a result of an approved vocational rehabilitation plan means that the injured worker has obtained employment no later than sixty days from the date of closure of the injured worker's approved comprehensive vocational rehabilitation plan or has retained employment following the closure of the injured worker's job retention plan, and the employment:

(a) Is within the physical and/or psychiatric limitations caused by the impairments resulting from the allowed conditions in the claim in which the injured worker completed the comprehensive vocational rehabilitation plan or job retention plan; and

(b) Is reasonable in comparison with the return to work goals of the comprehensive vocational rehabilitation plan or job retention plan completed by the injured worker.

(2) "Suitable employment" and "comparably paying work" have the same meaning as in rule 4125-1-01 of the Administrative Code.

(B) In claims with a date of injury on or after August 22, 1986, the bureau will make living maintenance wage loss payments to injured workers who complete an approved comprehensive vocational rehabilitation plan or job retention plan, successfully return to work as defined in paragraph (A)(1) of this rule, and experience a wage loss while employed as a consequence of the physical and/or psychiatric limitation caused by the impairments resulting from the allowed conditions in the claim.

(1) An injured worker may request living maintenance wage loss payments by submitting an application for living maintenance wage loss (on form RH-18 or equivalent) and medical documentation of their physical and/or psychiatric limitations.

(2) Subsequent applications for living maintenance wage loss payments must be submitted by the injured worker before the specified end date of the documented restrictions or every six months, whichever occurs first.

(a) If the physical or psychiatric limitations are temporary, medical documentation regarding the ongoing status of the restrictions must be submitted with any subsequent application for living maintenance wage loss payments.

(b) If the physical or psychiatric limitations are permanent, the bureau may request supplemental medical documentation be submitted with subsequent applications.

(3) If an injured worker voluntarily limits their income by choosing to work fewer hours or by accepting a job which does not constitute suitable employment which is comparably paying work, the injured worker's living maintenance wage loss benefits will be calculated as sixty-six and two-thirds per cent of the difference between the greater of the injured worker's full weekly wage or average weekly wage on the claim for which the injured worker underwent a rehabilitation plan and the weekly wage the injured worker would have earned had the injured worker not voluntarily limited their income.

(a) In determining whether an injured worker has voluntarily limited their income, the bureau may review all relevant factors set forth in rule 4125-1-01 of the Administrative Code in determining whether the injured worker has returned to suitable employment which is comparably paying work.

(b) An injured worker who wishes to change jobs after the initial receipt of living maintenance wage loss payments must notify the bureau. The bureau will review the criteria set forth in paragraph (A)(3)(a) of this rule to ensure that the job the injured worker wishes to change to constitutes suitable employment which is comparably paying work.

(4) If the injured worker accepts employment below the reasonable expectations of the return to work goals of the vocational rehabilitation plan, or if the injured worker can reasonably be expected to obtain different employment for which earnings are more comparable to those prior to the injury, the injured worker may be required to make a good faith effort to search for suitable employment which is comparably paying work. The bureau will consider factors such as the goals of the

vocational rehabilitation plan, the labor market, the skills and work history of the injured worker, and any other factors that would assist in making such determination.

(5) To receive living maintenance wage loss payments under this rule after approval of these benefits by the bureau, an injured worker must provide proof of earnings at least every four weeks, or on a quarterly basis if the injured worker has a substantial variation in income, in the form of pay stubs, payroll reports from the injured worker's current employer, or a wage statement on form RH-94(A) or equivalent.

(6) Living maintenance wage loss payments are charged to the surplus fund established by section 4123.34 of the Revised Code.

(C) The bureau will calculate living maintenance wage loss payment amounts based upon the information submitted by the injured worker pursuant to paragraph (B)(4) of this rule. Payments will be sixty-six and two-thirds per cent of the difference between the greater of the injured worker's full weekly wage or average weekly wage on the claim for which the injured worker underwent a rehabilitation plan and the weekly wage received while employed up to a maximum per week equal to the statewide average weekly wage.

(D) Payments may continue for up to a maximum of two hundred weeks but will be reduced by the corresponding number of weeks in which an injured worker receives payments pursuant to division (B) of section 4123.56 of the Revised Code.

(E) Facts supporting a decision concerning the eligibility or non-eligibility of an injured worker for living maintenance wage loss will be documented in the bureau's order approving or denying the living maintenance wage loss. The bureau's order approving or denying living maintenance wage loss may be appealed to the industrial commission pursuant to section 4123.511 of the Revised Code.