Ohio Administrative Code

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

Effective: July 1, 2019

(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. "Processing on the question of compensability" means making a determination on the validity of the industrial claim.

(1) Uncontested 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 or other appropriate 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.

(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 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 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.

(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 claimant questions the decision of the bureau regarding a request 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 In the event the employer or claimant object to the decision of the

bureau, such objection shall be made in writing with rationale and supporting evidence, as appropriate.

(3) 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.

(4) 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.

(5) 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 as defined in 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) If the bureau or the parties believe that clarification of issues will facilitate the processing of the claim, the claimant, employer, and their duly authorized representatives, as defined in rule 4123-3-22 of the Administrative Code, shall be given an opportunity to provide additional evidence on questions pertaining to the claim pending before the bureau.

The 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.