THE OHIO BUREAU OF WORKERS' COMPENSATION (BUREAU)…

INITIAL ACTION STEPS

The Ohio Bureau of Workers' Compensation is the administrative branch of the workers' compensation system with the legislative authority to make the initial decision on all allowances, issues, settlements, and/or other matters pertaining to workers' compensation claims. The Bureau ensures all parties to the claim are meeting their responsibilities related to maintaining or restoring employability for the injured worker. The Bureau conducts annual reviews of employer risk and exposure to loss related to work injuries and sets premium rates. The Bureau processes claims, pays medical, and compensation benefits.

A physical injury, or disease, or death, accidental in nature, sustained in the course of employment and arising out of the employment, are all tests that the Bureau considers when determining the compensability of a claim. An injured worker must show by a preponderance of the evidence that the injury arose out of and was in the course of employment, and that there was a direct or proximate causal relationship between the injury, disease, or death, and the condition(s) and/or disability. In considering initial and subsequent claim allowances, the Bureau's customer care team (CCT) must determine whether the claim meets the "tests" for jurisdiction, coverage and compensability. There are statutory requirements mandating the timeframes for claim determinations outlined in Ohio Revised Code 4123.511(A) (1). This law also supports the practice of continuing to investigate the facts of the claim to make the appropriate decision.

Ohio Revised Code 4123.511 allows time for investigation of the claim and gathering of needed and/or missing evidence to determine jurisdiction, coverage and issues of compensability in the claim. If a review of the factual and medical evidence in the file supports an allowance of the claim, the Bureau issues an Order citing the evidence relied on to make the decision.

The Bureau's claims numbers have a two-digit prefix, followed by six digits (e.g., 10-123456). The two-digit prefix corresponds to the year the incident occurred as described on the FROI-1, (Hamilton County form, HamCo044). The Bureau maintains records of allowed conditions in a claim. Documentation in the claim must clearly endorse the authorization or denial of benefits and services in the claim. Documentation can come from a number of sources and some of it can be evidence. Hearing Officers rely on complete file documentation when weighing the evidence presented for a particular issue.

COMPENSATION

The Bureau may utilize an Initial Allowance Order (order) when granting the initial allowance of a claim and/or issuing payment of medical benefits and/or compensation.

For a medical only claim, this "Order" will address the payment of medical benefits.

For a lost time claim, this "Order" may address both the payment of medical benefits and compensation.

The Bureau will include the established amount of the full weekly wage (FWW)/average weekly wage (AWW) on the Initial Allowance Order for lost time claims.

The Bureau will also include the type of compensation to be paid and the period of the award.

If wage information is not available, wages are set based at the minimum Temporary Total Compensation rate for the year of injury.

When an injured worker is requesting Temporary Total Compensation the physician of record must complete their specific sections of Bureau form C-84, Request for Temporary Total Compensation, and sign it to indicate the injured worker is unable to work. The injured worker must complete Part I, of the C-84, Request for Temporary Total Compensation, then it is sent to the Bureau for processing. A new C-84, Request for Temporary Total Compensation, must be completed for each new period of disability.