**As Introduced**

**132nd General Assembly**

**Regular Session** **H. B. No. 99**

**2017-2018**

**Representative Cera**

**Cosponsors: Representatives Rogers, O'Brien, Leland, Antonio, Ashford, Ramos, Miller, Boccieri, Smith, K., Leopre-Hagan**

# A BILL

To amend sections 109.84, 126.30, 145.2915, 2307.84, 2307.91, 2307.97, 2317.02, 2913.48, 3121.899, 3701.741, 3963.10, 4115.03, 4121.03, 4121.12, 4121.121, 4121.125, 4121.127, 4121.129, 4121.13, 4121.30, 4121.31, 4121.32, 4121.34, 4121.36, 4121.41, 4121.44, 4121.441, 4121.442, 4121.444, 4121.45, 4121.50, 4121.61, 4123.025, 4123.05, 4123.15, 4123.26, 4123.27, 4123.291, 4123.30, 4123.311, 4123.32, 4123.324, 4123.34, 4123.341, 4123.342, 4123.343, 4123.35, 4123.351, 4123.353, 4123.402, 4123.441, 4123.442, 4123.444, 4123.46, 4123.47, 4123.51, 4123.511, 4123.512, 4123.522, 4123.53, 4123.54, 4123.542, 4123.57, 4123.571, 4123.65, 4123.651, 4123.66, 4123.67, 4123.68, 4123.69, 4123.74, 4123.741, 4123.85, 4123.89, 4123.93, 4123.931, 4125.03, 4125.04, 4131.01, 4729.80, 5145.163, and 5503.08 and to enact sections 4133.01 to 4133.16 of the Revised Code to modify workers' compensation benefit amounts for occupational pneumoconiosis claims and to create the Occupational

Pneumoconiosis Board to determine medical findings for such claims.

## BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

**Section 1.** That sections 109.84, 126.30, 145.2915, 2307.84, 2307.91, 2307.97, 2317.02, 2913.48, 3121.899, 3701.741, 3963.10, 4115.03, 4121.03, 4121.12, 4121.121, 4121.125, 4121.127, 4121.129, 4121.13, 4121.30, 4121.31, 4121.32, 4121.34, 4121.36, 4121.41, 4121.44, 4121.441, 4121.442, 4121.444, 4121.45, 4121.50, 4121.61, 4123.025, 4123.05, 4123.15, 4123.26, 4123.27, 4123.291, 4123.30, 4123.311, 4123.32, 4123.324, 4123.34, 4123.341, 4123.342, 4123.343, 4123.35, 4123.351, 4123.353, 4123.402, 4123.441, 4123.442, 4123.444, 4123.46, 4123.47, 4123.51, 4123.511, 4123.512, 4123.522, 4123.53, 4123.54, 4123.542, 4123.57, 4123.571, 4123.65, 4123.651, 4123.66, 4123.67, 4123.68, 4123.69, 4123.74, 4123.741, 4123.85, 4123.89, 4123.93, 4123.931, 4125.03, 4125.04, 4131.01, 4729.80, 5145.163, and 5503.08 be amended and sections 4133.01, 4133.02, 4133.03, 4133.04, 4133.05, 4133.06, 4133.07, 4133.08, 4133.09, 4133.10, 4133.11, 4133.12, 4133.13, 4133.14, 4133.15, and 4133.16 of the Revised Code be enacted to read as follows:

**Sec. 109.84.** (A) Upon the written request of the governor, the industrial commission, the administrator of workers' compensation, or upon the attorney general's becoming aware of criminal or improper activity related to Chapter 4121. ~~or~~ , 4123., or 4133. of the Revised Code, the attorney general shall investigate any criminal or civil violation of law related to Chapter 4121. ~~or~~ , 4123., or 4133. of the Revised Code.

(B) When it appears to the attorney general, as a result of an investigation under division (A) of this section, that there is cause to prosecute for the commission of a crime or to pursue a civil remedy, ~~he~~ the attorney general may refer the evidence to the prosecuting attorney having jurisdiction of the matter, or to a regular grand jury drawn and impaneled pursuant to sections 2939.01 to 2939.24 of the Revised Code, or to a special grand jury drawn and impaneled pursuant to section 2939.17 of the Revised Code, or ~~he~~ the attorney general may initiate and prosecute any necessary criminal or civil actions in any court or tribunal of competent jurisdiction in this state. When proceeding under this section, the attorney general has all rights, privileges, and powers of prosecuting attorneys, and any assistant or special counsel designated by ~~him~~ the attorney general for that purpose has the same authority.

(C) The attorney general shall be reimbursed by the bureau of workers' compensation for all actual and necessary costs incurred in conducting investigations requested by the governor, the commission, or the administrator and all actual and necessary costs in conducting the prosecution arising out of such investigation.

**Sec. 126.30.** (A) Any state agency that purchases, leases, or otherwise acquires any equipment, materials, goods, supplies, or services from any person and fails to make payment for the equipment, materials, goods, supplies, or services by the required payment date shall pay an interest charge to the person in accordance with division (E) of this section, unless the amount of the interest charge is less than ten dollars. Except as otherwise provided in division (B), (C), or (D) of this section, the required payment date shall be the date on which payment is due under the terms of a written agreement between

the state agency and the person or, if a specific payment date is not established by such a written agreement, the required payment date shall be thirty days after the state agency receives a proper invoice for the amount of the payment due.

(B) If the invoice submitted to the state agency contains a defect or impropriety, the agency shall send written notification to the person within fifteen days after receipt of the invoice. The notice shall contain a description of the defect or impropriety and any additional information necessary to correct the defect or impropriety. If the agency sends such written notification to the person, the required payment date shall be thirty days after the state agency receives a proper invoice.

(C) In applying this section to claims submitted to the department of job and family services by providers of equipment, materials, goods, supplies, or services, the required payment date shall be the date on which payment is due under the terms of a written agreement between the department and the provider. If a specific payment date is not established by a written agreement, the required payment date shall be thirty days after the department receives a proper claim. If the department determines that the claim is improperly executed or that additional evidence of the validity of the claim is required, the department shall notify the claimant in writing or by telephone within fifteen days after receipt of the claim. The notice shall state that the claim is improperly executed and needs correction or that additional information is necessary to establish the validity of the claim. If the department makes such notification to the provider, the required payment date shall be thirty days after the department receives the corrected claim or such additional information as may be necessary to

establish the validity of the claim.

(D) In applying this section to invoices submitted to the bureau of workers' compensation for equipment, materials, goods, supplies, or services provided to employees in connection with an employee's claim against the state insurance fund, the public work-relief employees' compensation fund, the coal-workers pneumoconiosis fund, or the marine industry fund as compensation for injuries or occupational disease pursuant to Chapter 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code, the required payment date shall be the date on which payment is due under the terms of a written agreement between the bureau and the provider. If a specific payment date is not established by a written agreement, the required payment date shall be thirty days after the bureau receives a proper invoice for the amount of the payment due or thirty days after the final adjudication allowing payment of an award to the employee, whichever is later. Nothing in this section shall supersede any faster timetable for payments to health care providers contained in sections 4121.44 and 4123.512 of the Revised Code.

For purposes of this division, a "proper invoice" includes the claimant's name, claim number and date of injury, employer's name, the provider's name and address, the provider's assigned payee number, a description of the equipment, materials, goods, supplies, or services provided by the provider to the claimant, the date provided, and the amount of the charge. If more than one item of equipment, materials, goods, supplies, or services is listed by a provider on a single application for payment, each item shall be considered separately in determining if it is a proper invoice.

If prior to a final adjudication the bureau determines

that the invoice contains a defect, the bureau shall notify the provider in writing at least fifteen days prior to what would be the required payment date if the invoice did not contain a defect. The notice shall contain a description of the defect and any additional information necessary to correct the defect. If the bureau sends a notification to the provider, the required payment date shall be redetermined in accordance with this division after the bureau receives a proper invoice.

For purposes of this division, "final adjudication" means the later of the date of the decision or other action by the bureau, the industrial commission, or a court allowing payment of the award to the employee from which there is no further right to reconsideration or appeal that would require the bureau to withhold compensation and benefits, or the date on which the rights to reconsideration or appeal have expired without an application therefor having been filed or, if later, the date on which an application for reconsideration or appeal is withdrawn. If after final adjudication, the administrator of the bureau of workers' compensation or the industrial commission makes a modification with respect to former findings or orders, pursuant to Chapter 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code or pursuant to court order, the adjudication process shall no longer be considered final for purposes of determining the required payment date for invoices for equipment, materials, goods, supplies, or services provided after the date of the modification when the propriety of the invoices is affected by the modification.

(E) The interest charge on amounts due shall be paid to the person for the period beginning on the day after the required payment date and ending on the day that payment of the amount due is made. The amount of the interest charge that

remains unpaid at the end of any thirty-day period after the required payment date, including amounts under ten dollars, shall be added to the principal amount of the debt and thereafter the interest charge shall accrue on the principal amount of the debt plus the added interest charge. The interest charge shall be at the rate per calendar month that equals one-twelfth of the rate per annum prescribed by section 5703.47 of the Revised Code for the calendar year that includes the month for which the interest charge accrues.

(F) No appropriations shall be made for the payment of any interest charges required by this section. Any state agency required to pay interest charges under this section shall make the payments from moneys available for the administration of agency programs.

If a state agency pays interest charges under this section, but determines that all or part of the interest charges should have been paid by another state agency, the state agency that paid the interest charges may request the attorney general to determine the amount of the interest charges that each state agency should have paid under this section. If the attorney general determines that the state agency that paid the interest charges should have paid none or only a part of the interest charges, the attorney general shall notify the state agency that paid the interest charges, any other state agency that should have paid all or part of the interest charges, and the director of budget and management of the attorney general's decision, stating the amount of interest charges that each state agency should have paid. The director shall transfer from the appropriate funds of any other state agency that should have paid all or part of the interest charges to the appropriate funds of the state agency that paid the interest charges an

amount necessary to implement the attorney general's decision.

(G) Not later than forty-five days after the end of each fiscal year, each state agency shall file with the director of budget and management a detailed report concerning the interest charges the agency paid under this section during the previous fiscal year. The report shall include the number, amounts, and frequency of interest charges the agency incurred during the previous fiscal year and the reasons why the interest charges were not avoided by payment prior to the required payment date. The director shall compile a summary of all the reports submitted under this division and shall submit a copy of the summary to the president and minority leader of the senate and to the speaker and minority leader of the house of representatives no later than the thirtieth day of September of each year.

**Sec. 145.2915.** (A) As used in this section, "workers' compensation" means benefits paid under Chapter 4121. ~~or~~ , 4123., or 4133. of the Revised Code.

(B) A member of the public employees retirement system may purchase service credit under this section for any period during which the member was out of service with a public employer and receiving workers' compensation if the member returns to employment covered by this chapter.

(C) For credit purchased under this section:

(1) If the member is employed by one public employer, for each year of credit, the member shall pay to the system for credit to the employees' savings fund an amount equal to the employee contribution required under section 145.47 of the Revised Code that would have been paid had the member not been

out of service based on the salary of the member before the member was out of service. To this amount shall be added an amount equal to compound interest at a rate established by the public employees retirement board from the first date the member was out of service to the final date of payment.

(2) If the member is employed by more than one public employer, the member is eligible to purchase credit under this section and make payments under division (C)(1) of this section only for the position for which the member received workers' compensation. For each year of credit, the member shall pay to the system for credit to the employees' savings fund an amount equal to the employee contribution required under section 145.47 of the Revised Code that would have been paid had the member not been out of service based on the salary of the member earned for the position for which the member received workers' compensation before the member was out of service. To this amount shall be added an amount equal to compound interest at a rate established by the public employees retirement board from the first date the member was out of service to the final date of payment.

(D) The member may choose to purchase only part of such credit in any one payment, subject to board rules.

(E) If a member makes a payment under division (C) of this section, the employer to which workers' compensation benefits are attributed shall pay to the system for credit to the employers' accumulation fund an amount equal to the employer contribution required under section 145.48 or 145.49 of the Revised Code corresponding to that payment that would have been paid had the member not been out of service based on the salary of the member before the member was out of service.

Compound interest at a rate established by the board from

the later of the member's date of re-employment or January 7, 2013, to the date of payment shall be added to this amount if the employer pays all or any portion of the amount after the end of the earlier of the following:

(1) A period of five years;

(2) A period that is three times the period during which the member was out of service and receiving workers' compensation.

The period described in division (E)(1) or (2) of this section begins with the later of the member's date of re-employment or January 7, 2013.

(F) The number of years purchased under this section shall not exceed three. Credit purchased under this section may be combined pursuant to section 145.37 of the Revised Code with credit purchased or obtained under Chapter 3307. or 3309. of the Revised Code for periods the member was out of service and receiving workers' compensation, but not more than a total of three years of credit may be used in determining retirement eligibility or calculating benefits under section 145.37 of the Revised Code.

**Sec. 2307.84.** As used in sections 2307.84 to 2307.90 and 2307.901 of the Revised Code:

(A) "AMA guides to the evaluation of permanent impairment" means the American medical association's guides to the evaluation of permanent impairment (fifth edition 2000) as may be modified by the American medical association.

(B) "Board-certified internist" means a medical doctor who is currently certified by the American board of internal medicine.

(C) "Board-certified occupational medicine specialist" means a medical doctor who is currently certified by the American board of preventive medicine in the specialty of occupational medicine.

(D) "Board-certified oncologist" means a medical doctor who is currently certified by the American board of internal medicine in the subspecialty of medical oncology.

(E) "Board-certified pathologist" means a medical doctor who is currently certified by the American board of pathology.

(F) "Board-certified pulmonary specialist" means a medical doctor who is currently certified by the American board of internal medicine in the subspecialty of pulmonary medicine.

(G) "Certified B-reader" means an individual qualified as a "final" or "B-reader" as defined in 42 C.F.R. section 37.51(b), as amended.

(H) "Civil action" means all suits or claims of a civil nature in a state or federal court, whether cognizable as cases at law or in equity or admiralty. "Civil action" does not include any of the following:

(1) A civil action relating to any workers' compensation law;

(2) A civil action alleging any claim or demand made against a trust established pursuant to 11 U.S.C. section 524(g);

(3) A civil action alleging any claim or demand made against a trust established pursuant to a plan of reorganization confirmed under Chapter 11 of the United States Bankruptcy Code, 11 U.S.C. Chapter 11.

(I) "Competent medical authority" means a medical doctor who is providing a diagnosis for purposes of constituting prima-facie evidence of an exposed person's physical impairment that meets the requirements specified in section 2307.85 or 2307.86 of the Revised Code, whichever is applicable, and who meets the following requirements:

(1) The medical doctor is a board-certified internist, pulmonary specialist, oncologist, pathologist, or occupational medicine specialist.

(2) The medical doctor is actually treating or has treated the exposed person and has or had a doctor-patient relationship with the person.

(3) As the basis for the diagnosis, the medical doctor has not relied, in whole or in part, on any of the following:

(a) The reports or opinions of any doctor, clinic, laboratory, or testing company that performed an examination, test, or screening of the claimant's medical condition in violation of any law, regulation, licensing requirement, or medical code of practice of the state in which that examination, test, or screening was conducted;

(b) The reports or opinions of any doctor, clinic, laboratory, or testing company that performed an examination, test, or screening of the claimant's medical condition that was conducted without clearly establishing a doctor-patient relationship with the claimant or medical personnel involved in the examination, test, or screening process;

(c) The reports or opinions of any doctor, clinic, laboratory, or testing company that performed an examination, test, or screening of the claimant's medical condition that

required the claimant to agree to retain the legal services of the law firm sponsoring the examination, test, or screening.

(4) The medical doctor spends not more than twenty-five per cent of the medical doctor's professional practice time in providing consulting or expert services in connection with actual or potential tort actions, and the medical doctor's medical group, professional corporation, clinic, or other affiliated group earns not more than twenty per cent of its revenues from providing those services.

(J) "Exposed person" means either of the following, whichever is applicable:

(1) A person whose exposure to silica is the basis for a silicosis claim under section 2307.85 of the Revised Code;

(2) A person whose exposure to mixed dust is the basis for a mixed dust disease claim under section 2307.86 of the Revised Code.

(K) "ILO scale" means the system for the classification of chest x-rays set forth in the international labour office's guidelines for the use of ILO international classification of radiographs of pneumoconioses (2000), as amended.

(L) "Lung cancer" means a malignant tumor in which the primary site of origin of the cancer is inside the lungs.

(M) "Mixed dust" means a mixture of dusts composed of silica and one or more other fibrogenic dusts capable of inducing pulmonary fibrosis if inhaled in sufficient quantity.

(N) "Mixed dust disease claim" means any claim for damages, losses, indemnification, contribution, or other relief arising out of, based on, or in any way related to inhalation

of, exposure to, or contact with mixed dust. "Mixed dust disease claim" includes a claim made by or on behalf of any person who has been exposed to mixed dust, or any representative, spouse, parent, child, or other relative of that person, for injury, including mental or emotional injury, death, or loss to person, risk of disease or other injury, costs of medical monitoring or surveillance, or any other effects on the person's health that are caused by the person's exposure to mixed dust.

(O) "Mixed dust pneumoconiosis" means the interstitial lung disease caused by the pulmonary response to inhaled mixed dusts.

(P) "Nonmalignant condition" means a condition, other than a diagnosed cancer, that is caused or may be caused by either of the following, whichever is applicable:

(1) Silica, as provided in section 2307.85 of the Revised Code;

(2) Mixed dust, as provided in section 2307.86 of the Revised Code.

(Q) "Pathological evidence of mixed dust pneumoconiosis" means a statement by a board-certified pathologist that more than one representative section of lung tissue uninvolved with any other disease process demonstrates a pattern of peribronchiolar and parenchymal stellate (star-shaped) nodular scarring and that there is no other more likely explanation for the presence of the fibrosis.

(R) "Pathological evidence of silicosis" means a statement by a board-certified pathologist that more than one representative section of lung tissue uninvolved with any other disease process demonstrates a pattern of round silica nodules

and birefringent crystals or other demonstration of crystal structures consistent with silica (well-organized concentric whorls of collagen surrounded by inflammatory cells) in the lung parenchyma and that there is no other more likely explanation for the presence of the fibrosis.

(S) "Physical impairment" means any of the following, whichever is applicable:

(1) A nonmalignant condition that meets the minimum requirements of division (B) of section 2307.85 of the Revised Code or lung cancer of an exposed person who is a smoker that meets the minimum requirements of division (C) of section 2307.85 of the Revised Code;

(2) A nonmalignant condition that meets the minimum requirements of division (B) of section 2307.86 of the Revised Code or lung cancer of an exposed person who is a smoker that meets the minimum requirements of division (C) of section 2307.86 of the Revised Code.

(T) "Premises owner" means a person who owns, in whole or in part, leases, rents, maintains, or controls privately owned lands, ways, or waters, or any buildings and structures on those lands, ways, or waters, and all privately owned and state-owned lands, ways, or waters leased to a private person, firm, or organization, including any buildings and structures on those lands, ways, or waters.

(U) "Radiological evidence of mixed dust pneumoconiosis" means a chest x-ray showing bilateral rounded or irregular opacities in the upper lung fields graded by a certified B-reader as at least 1/1 on the ILO scale.

(V) "Radiological evidence of silicosis" means a chest x-

ray showing bilateral small rounded opacities (p, q, or r) in the upper lung fields graded by a certified B-reader as at least 1/1 on the ILO scale.

(W) "Regular basis" means on a frequent or recurring basis.

(X) "Silica" means a respirable crystalline form of silicon dioxide, including, but not limited to, alpha quartz, cristobalite, and trydmite.

(Y) "Silicosis claim" means any claim for damages, losses, indemnification, contribution, or other relief arising out of, based on, or in any way related to inhalation of, exposure to, or contact with silica. "Silicosis claim" includes a claim made by or on behalf of any person who has been exposed to silica, or any representative, spouse, parent, child, or other relative of that person, for injury, including mental or emotional injury, death, or loss to person, risk of disease or other injury, costs of medical monitoring or surveillance, or any other effects on the person's health that are caused by the person's exposure to silica.

(Z) "Silicosis" means an interstitial lung disease caused by the pulmonary response to inhaled silica.

(AA) "Smoker" means a person who has smoked the equivalent of one-pack year, as specified in the written report of a competent medical authority pursuant to section 2307.85 or 2307.86 and section 2307.87 of the Revised Code, during the last fifteen years.

(BB) "Substantial contributing factor" means both of the following:

(1) Exposure to silica or mixed dust is the predominate

cause of the physical impairment alleged in the silicosis claim or mixed dust disease claim, whichever is applicable.

(2) A competent medical authority has determined with a reasonable degree of medical certainty that without the silica or mixed dust exposures the physical impairment of the exposed person would not have occurred.

(CC) "Substantial occupational exposure to silica" means employment for a cumulative period of at least five years in an industry and an occupation in which, for a substantial portion of a normal work year for that occupation, the exposed person did any of the following:

(1) Handled silica;

(2) Fabricated silica-containing products so that the person was exposed to silica in the fabrication process;

(3) Altered, repaired, or otherwise worked with a silica-containing product in a manner that exposed the person on a regular basis to silica;

(4) Worked in close proximity to other workers engaged in any of the activities described in division (CC)(1), (2), or (3) of this section in a manner that exposed the person on a regular basis to silica.

(DD) "Substantial occupational exposure to mixed dust" means employment for a cumulative period of at least five years in an industry and an occupation in which, for a substantial portion of a normal work year for that occupation, the exposed person did any of the following:

(1) Handled mixed dust;

(2) Fabricated mixed dust-containing products so that the

person was exposed to mixed dust in the fabrication process;

(3) Altered, repaired, or otherwise worked with a mixed dust-containing product in a manner that exposed the person on a regular basis to mixed dust;

(4) Worked in close proximity to other workers engaged in any of the activities described in division (DD)(1), (2), or (3) of this section in a manner that exposed the person on a regular basis to mixed dust.

(EE) "Tort action" means a civil action for damages for injury, death, or loss to person. "Tort action" includes a product liability claim that is subject to sections 2307.71 to 2307.80 of the Revised Code. "Tort action" does not include a civil action for damages for a breach of contract or another agreement between persons.

(FF) "Veterans' benefit program" means any program for benefits in connection with military service administered by the veterans' administration under ~~title~~ Title 38 of the United States Code.

(GG) "Workers' compensation law" means Chapters 4121., 4123., 4127., ~~and~~ 4131., and 4133. of the Revised Code.

**Sec. 2307.91.** As used in sections 2307.91 to 2307.96 of the Revised Code:

(A) "AMA guides to the evaluation of permanent impairment" means the American medical association's guides to the evaluation of permanent impairment (fifth edition 2000) as may be modified by the American medical association.

(B) "Asbestos" means chrysotile, amosite, crocidolite, tremolite asbestos, anthophyllite asbestos, actinolite asbestos,

and any of these minerals that have been chemically treated or altered.

(C) "Asbestos claim" means any claim for damages, losses, indemnification, contribution, or other relief arising out of, based on, or in any way related to asbestos. "Asbestos claim" includes a claim made by or on behalf of any person who has been exposed to asbestos, or any representative, spouse, parent, child, or other relative of that person, for injury, including mental or emotional injury, death, or loss to person, risk of disease or other injury, costs of medical monitoring or surveillance, or any other effects on the person's health that are caused by the person's exposure to asbestos.

(D) "Asbestosis" means bilateral diffuse interstitial fibrosis of the lungs caused by inhalation of asbestos fibers.

(E) "Board-certified internist" means a medical doctor who is currently certified by the American board of internal medicine.

(F) "Board-certified occupational medicine specialist" means a medical doctor who is currently certified by the American board of preventive medicine in the specialty of occupational medicine.

(G) "Board-certified oncologist" means a medical doctor who is currently certified by the American board of internal medicine in the subspecialty of medical oncology.

(H) "Board-certified pathologist" means a medical doctor who is currently certified by the American board of pathology.

(I) "Board-certified pulmonary specialist" means a medical doctor who is currently certified by the American board of internal medicine in the subspecialty of pulmonary medicine.

(J) "Certified B-reader" means an individual qualified as a "final" or "B-reader" as defined in 42 C.F.R. section 37.51(b), as amended.

(K) "Certified industrial hygienist" means an industrial hygienist who has attained the status of diplomate of the American academy of industrial hygiene subject to compliance with requirements established by the American board of industrial hygiene.

(L) "Certified safety professional" means a safety professional who has met and continues to meet all requirements established by the board of certified safety professionals and is authorized by that board to use the certified safety professional title or the CSP designation.

(M) "Civil action" means all suits or claims of a civil nature in a state or federal court, whether cognizable as cases at law or in equity or admiralty. "Civil action" does not include any of the following:

(1) A civil action relating to any workers' compensation law;

(2) A civil action alleging any claim or demand made against a trust established pursuant to 11 U.S.C. section 524(g);

(3) A civil action alleging any claim or demand made against a trust established pursuant to a plan of reorganization confirmed under Chapter 11 of the United States Bankruptcy Code, 11 U.S.C. Chapter 11.

(N) "Exposed person" means any person whose exposure to asbestos or to asbestos-containing products is the basis for an asbestos claim under section 2307.92 of the Revised Code.

(O) "FEV1" means forced expiratory volume in the first second, which is the maximal volume of air expelled in one second during performance of simple spirometric tests.

(P) "FVC" means forced vital capacity that is maximal volume of air expired with maximum effort from a position of full inspiration.

(Q) "ILO scale" means the system for the classification of chest x-rays set forth in the international labour office's guidelines for the use of ILO international classification of radiographs of pneumoconioses (2000), as amended.

(R) "Lung cancer" means a malignant tumor in which the primary site of origin of the cancer is inside the lungs, but that term does not include mesothelioma.

(S) "Mesothelioma" means a malignant tumor with a primary site of origin in the pleura or the peritoneum, which has been diagnosed by a board-certified pathologist, using standardized and accepted criteria of microscopic morphology and appropriate staining techniques.

(T) "Nonmalignant condition" means a condition that is caused or may be caused by asbestos other than a diagnosed cancer.

(U) "Pathological evidence of asbestosis" means a statement by a board-certified pathologist that more than one representative section of lung tissue uninvolved with any other disease process demonstrates a pattern of peribronchiolar or parenchymal scarring in the presence of characteristic asbestos bodies and that there is no other more likely explanation for the presence of the fibrosis.

(V) "Physical impairment" means a nonmalignant condition

that meets the minimum requirements specified in division (B) of section 2307.92 of the Revised Code, lung cancer of an exposed person who is a smoker that meets the minimum requirements specified in division (C) of section 2307.92 of the Revised Code, or a condition of a deceased exposed person that meets the minimum requirements specified in division (D) of section 2307.92 of the Revised Code.

(W) "Plethysmography" means a test for determining lung volume, also known as "body plethysmography," in which the subject of the test is enclosed in a chamber that is equipped to measure pressure, flow, or volume changes.

(X) "Predicted lower limit of normal" means the fifth percentile of healthy populations based on age, height, and gender, as referenced in the AMA guides to the evaluation of permanent impairment.

(Y) "Premises owner" means a person who owns, in whole or in part, leases, rents, maintains, or controls privately owned lands, ways, or waters, or any buildings and structures on those lands, ways, or waters, and all privately owned and state-owned lands, ways, or waters leased to a private person, firm, or organization, including any buildings and structures on those lands, ways, or waters.

(Z) "Competent medical authority" means a medical doctor who is providing a diagnosis for purposes of constituting prima-facie evidence of an exposed person's physical impairment that meets the requirements specified in section 2307.92 of the Revised Code and who meets the following requirements:

(1) The medical doctor is a board-certified internist, pulmonary specialist, oncologist, pathologist, or occupational

medicine specialist.

(2) The medical doctor is actually treating or has treated the exposed person and has or had a doctor-patient relationship with the person.

(3) As the basis for the diagnosis, the medical doctor has not relied, in whole or in part, on any of the following:

(a) The reports or opinions of any doctor, clinic, laboratory, or testing company that performed an examination, test, or screening of the claimant's medical condition in violation of any law, regulation, licensing requirement, or medical code of practice of the state in which that examination, test, or screening was conducted;

(b) The reports or opinions of any doctor, clinic, laboratory, or testing company that performed an examination, test, or screening of the claimant's medical condition that was conducted without clearly establishing a doctor-patient relationship with the claimant or medical personnel involved in the examination, test, or screening process;

(c) The reports or opinions of any doctor, clinic, laboratory, or testing company that performed an examination, test, or screening of the claimant's medical condition that required the claimant to agree to retain the legal services of the law firm sponsoring the examination, test, or screening.

(4) The medical doctor spends not more than twenty-five per cent of the medical doctor's professional practice time in providing consulting or expert services in connection with actual or potential tort actions, and the medical doctor's medical group, professional corporation, clinic, or other affiliated group earns not more than twenty per cent of its

revenues from providing those services.

(AA) "Radiological evidence of asbestosis" means a chest x-ray showing small, irregular opacities (s, t) graded by a certified B-reader as at least 1/1 on the ILO scale.

(BB) "Radiological evidence of diffuse pleural thickening" means a chest x-ray showing bilateral pleural thickening graded by a certified B-reader as at least B2 on the ILO scale and blunting of at least one costophrenic angle.

(CC) "Regular basis" means on a frequent or recurring basis.

(DD) "Smoker" means a person who has smoked the equivalent of one-pack year, as specified in the written report of a competent medical authority pursuant to sections 2307.92 and 2307.93 of the Revised Code, during the last fifteen years.

(EE) "Spirometry" means the measurement of volume of air inhaled or exhaled by the lung.

(FF) "Substantial contributing factor" means both of the following:

(1) Exposure to asbestos is the predominate cause of the physical impairment alleged in the asbestos claim.

(2) A competent medical authority has determined with a reasonable degree of medical certainty that without the asbestos exposures the physical impairment of the exposed person would not have occurred.

(GG) "Substantial occupational exposure to asbestos" means employment for a cumulative period of at least five years in an industry and an occupation in which, for a substantial portion of a normal work year for that occupation, the exposed person

did any of the following:

(1) Handled raw asbestos fibers;

(2) Fabricated asbestos-containing products so that the person was exposed to raw asbestos fibers in the fabrication process;

(3) Altered, repaired, or otherwise worked with an asbestos-containing product in a manner that exposed the person on a regular basis to asbestos fibers;

(4) Worked in close proximity to other workers engaged in any of the activities described in division (GG)(1), (2), or (3) of this section in a manner that exposed the person on a regular basis to asbestos fibers.

(HH) "Timed gas dilution" means a method for measuring total lung capacity in which the subject breathes into a spirometer containing a known concentration of an inert and insoluble gas for a specific time, and the concentration of the inert and insoluble gas in the lung is then compared to the concentration of that type of gas in the spirometer.

(II) "Tort action" means a civil action for damages for injury, death, or loss to person. "Tort action" includes a product liability claim that is subject to sections 2307.71 to 2307.80 of the Revised Code. "Tort action" does not include a civil action for damages for a breach of contract or another agreement between persons.

(JJ) "Total lung capacity" means the volume of air contained in the lungs at the end of a maximal inspiration.

(KK) "Veterans' benefit program" means any program for benefits in connection with military service administered by the

veterans' administration under ~~title~~ Title 38 of the United States Code.

(LL) "Workers' compensation law" means Chapters 4121., 4123., 4127., ~~and~~ 4131., and 4133. of the Revised Code.

**Sec. 2307.97.** (A) As used in this section:

(1) "Asbestos" means chrysotile, amosite, crocidolite, tremolite asbestos, anthophyllite asbestos, actinolite asbestos, and any of these minerals that have been chemically treated or altered.

(2) "Asbestos claim" means any claim, wherever or whenever made, for damages, losses, indemnification, contribution, or other relief arising out of, based on, or in any way related to asbestos. "Asbestos claim" includes any of the following:

(a) A claim made by or on behalf of any person who has been exposed to asbestos, or any representative, spouse, parent, child, or other relative of that person, for injury, including mental or emotional injury, death, or loss to person, risk of disease or other injury, costs of medical monitoring or surveillance, or any other effects on the person's health that are caused by the person's exposure to asbestos;

(b) A claim for damage or loss to property that is caused by the installation, presence, or removal of asbestos.

(3) "Corporation" means a corporation for profit, including the following:

(a) A domestic corporation that is organized under the laws of this state;

(b) A foreign corporation that is organized under laws other than the laws of this state and that has had a certificate

of authority to transact business in this state or has done business in this state.

(4) "Successor" means a corporation or a subsidiary of a corporation that assumes or incurs, or had assumed or incurred, successor asbestos-related liabilities or had successor asbestos-related liabilities imposed on it by court order.

(5)(a) "Successor asbestos-related liabilities" means any liabilities, whether known or unknown, asserted or unasserted, absolute or contingent, accrued or unaccrued, liquidated or unliquidated, or due or to become due, if the liabilities are related in any way to asbestos claims and either of the following applies:

(i) The liabilities are assumed or incurred by a successor as a result of or in connection with an asset purchase, stock purchase, merger, consolidation, or agreement providing for an asset purchase, stock purchase, merger, or consolidation, including a plan of merger.

(ii) The liabilities were imposed by court order on a successor.

(b) "Successor asbestos-related liabilities" includes any liabilities described in division (A)(5)(a)(i) of this section that, after the effective date of the asset purchase, stock purchase, merger, or consolidation, are paid, otherwise discharged, committed to be paid, or committed to be otherwise discharged by or on behalf of the successor, or by or on behalf of a transferor, in connection with any judgment, settlement, or other discharge of those liabilities in this state or another jurisdiction.

(6) "Transferor" means a corporation or its shareholders

from which successor asbestos-related liabilities are or were assumed or incurred by a successor or were imposed by court order on a successor.

(B) The limitations set forth in division (C) of this section apply to a corporation that is either of the following:

(1) A successor that became a successor prior to January 1, 1972, if either of the following applies:

(a) In the case of a successor in a stock purchase or an asset purchase, the successor paid less then fifteen million dollars for the stock or assets of the transferor.

(b) In the case of a successor in a merger or consolidation, the fair market value of the total gross assets of the transferor, at the time of the merger or consolidation, excluding any insurance of the transferor, was less than fifty million dollars.

(2) Any successor to a prior successor if the prior successor met the requirements of division (B)(1)(a) or (b) of this section, whichever is applicable.

(C)(1) Except as otherwise provided in division (C)(2) of this section, the cumulative successor asbestos-related liabilities of a corporation shall be limited to either of the following:

(a) In the case of a corporation that is a successor in a stock purchase or an asset purchase, the fair market value of the acquired stock or assets of the transferor, as determined on the effective date of the stock or asset purchase;

(b) In the case of a corporation that is a successor in a merger or consolidation, the fair market value of the total

gross assets of the transferor, as determined on the effective date of the merger or consolidation.

(2)(a) If a transferor had assumed or incurred successor asbestos-related liabilities in connection with a prior purchase of assets or stock involving a prior transferor, the fair market value of the assets or stock purchased from the prior transferor, determined as of the effective date of the prior purchase of the assets or stock, shall be substituted for the limitation set forth in division (C)(1)(a) of this section for the purpose of determining the limitation of the liability of a corporation.

(b) If a transferor had assumed or incurred successor asbestos-related liabilities in connection with a merger or consolidation involving a prior transferor, the fair market value of the total gross assets of the prior transferor, determined as of the effective date of the prior merger or consolidation, shall be substituted for the limitation set forth in division (C)(1)(b) of this section for the purpose of determining the limitation of the liability of a corporation.

(3) A corporation described in division (C)(1) or (2) of this section shall have no responsibility for any successor asbestos-related liabilities in excess of the limitation of those liabilities as described in the applicable division.

(D)(1) A corporation may establish the fair market value of assets, stock, or total gross assets under division (C) of this section by means of any method that is reasonable under the circumstances, including by reference to their going-concern value, to the purchase price attributable to or paid for them in an arm's length transaction, or, in the absence of other readily available information from which fair market value can be

determined, to their value recorded on a balance sheet. Assets and total gross assets shall include intangible assets. A showing by the successor of a reasonable determination of the fair market value of assets, stock, or total gross assets is prima-facie evidence of their fair market value.

(2) For purposes of establishing the fair market value of total gross assets under division (D)(1) of this section, the total gross assets include the aggregate coverage under any applicable liability insurance that was issued to the transferor the assets of which are being valued for purposes of the limitations set forth in division (C) of this section, if the insurance has been collected or is collectable to cover the successor asbestos-related liabilities involved. Those successor asbestos-related liabilities do not include any compensation for any liabilities arising from the exposure of workers to asbestos solely during the course of their employment by the transferor. Any settlement of a dispute concerning the insurance coverage described in this division that is entered into by a transferor or successor with the insurer of the transferor before ~~the effective date of this section~~ April 7, 2005, is determinative of the aggregate coverage of the liability insurance that is included in the determination of the transferor's total gross assets.

(3) After a successor has established a reasonable determination of the fair market value of assets, stock, or total gross assets under divisions (D)(1) and (2) of this section, a claimant that disputes that determination of the fair market value has the burden of establishing a different fair market value.

(4)(a) Subject to divisions (D)(4)(b), (c), and (d) of

this section, the fair market value of assets, stock, or total gross assets at the time of the asset purchase, stock purchase, merger, or consolidation increases annually, at a rate equal to the sum of the following:

(i) The prime rate as listed in the first edition of the wall street journal published for each calendar year since the effective date of the asset purchase, stock purchase, merger, or consolidation, or, if the prime rate is not published in that edition of the wall street journal, the prime rate as reasonably determined on the first business day of the year;

(ii) One per cent.

(b) The rate that is determined pursuant to division (D)(4)(a) of this section shall not be compounded.

(c) The adjustment of the fair market value of assets, stock, or total gross assets shall continue in the manner described in division (D)(4)(a) of this section until the adjusted fair market value is first exceeded by the cumulative amounts of successor asbestos-related liabilities that are paid or committed to be paid by or on behalf of a successor or prior transferor, or by or on behalf of a transferor, after the time of the asset purchase, stock purchase, merger, or consolidation for which the fair market value of assets, stock, or total gross assets is determined.

(d) No adjustment of the fair market value of total gross assets as provided in division (D)(4)(a) of this section shall be applied to any liability insurance that is otherwise included in total gross assets as provided in division (D)(2) of this section.

(E)(1) The limitations set forth in division (C) of this

section shall apply to the following:

(a) All asbestos claims, including asbestos claims that are pending on ~~the effective date of this section~~ April 7, 2005, and all litigation involving asbestos claims, including litigation that is pending on ~~the effective date of this section~~ April 7, 2005;

(b) Successors of a corporation to which this section applies.

(2) The limitations set forth in division (C) of this section do not apply to any of the following:

(a) Workers' compensation benefits that are paid by or on behalf of an employer to an employee pursuant to any provision of Chapter 4121., 4123., 4127., ~~or~~ 4131., or 4133. of the Revised Code or comparable workers' compensation law of another jurisdiction;

(b) Any claim against a successor that does not constitute a claim for a successor asbestos-related liability;

(c) Any obligations arising under the "National Labor Relations Act," 49 Stat. 449, 29 U.S.C. 151 et seq., as amended, or under any collective bargaining agreement;

(d) Any contractual rights to indemnification.

(F) The courts in this state shall apply, to the fullest extent permissible under the Constitution of the United States, this state's substantive law, including the provisions of this section, to the issue of successor asbestos-related liabilities.

**Sec. 2317.02.** The following persons shall not testify in certain respects:

(A)(1) An attorney, concerning a communication made to the attorney by a client in that relation or concerning the attorney's advice to a client, except that the attorney may testify by express consent of the client or, if the client is deceased, by the express consent of the surviving spouse or the executor or administrator of the estate of the deceased client. However, if the client voluntarily reveals the substance of attorney-client communications in a nonprivileged context or is deemed by section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the attorney may be compelled to testify on the same subject.

The testimonial privilege established under this division does not apply concerning either of the following:

(a) A communication between a client in a capital case, as defined in section 2901.02 of the Revised Code, and the client's attorney if the communication is relevant to a subsequent ineffective assistance of counsel claim by the client alleging that the attorney did not effectively represent the client in the case;

(b) A communication between a client who has since died and the deceased client's attorney if the communication is relevant to a dispute between parties who claim through that deceased client, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction, and the dispute addresses the competency of the deceased client when the deceased client executed a document that is the basis of the dispute or whether the deceased client was a victim of fraud, undue influence, or duress when the deceased client executed a document that is the basis of the dispute.

(2) An attorney, concerning a communication made to the

attorney by a client in that relationship or the attorney's advice to a client, except that if the client is an insurance company, the attorney may be compelled to testify, subject to an in camera inspection by a court, about communications made by the client to the attorney or by the attorney to the client that are related to the attorney's aiding or furthering an ongoing or future commission of bad faith by the client, if the party seeking disclosure of the communications has made a prima-facie showing of bad faith, fraud, or criminal misconduct by the client.

(B)(1) A physician, advanced practice registered nurse, or dentist concerning a communication made to the physician, advanced practice registered nurse, or dentist by a patient in that relation or the advice of a physician, advanced practice registered nurse, or dentist given to a patient, except as otherwise provided in this division, division (B)(2), and division (B)(3) of this section, and except that, if the patient is deemed by section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the physician or advanced practice registered nurse may be compelled to testify on the same subject.

The testimonial privilege established under this division does not apply, and a physician, advanced practice registered nurse, or dentist may testify or may be compelled to testify, in any of the following circumstances:

(a) In any civil action, in accordance with the discovery provisions of the Rules of Civil Procedure in connection with a civil action, or in connection with a claim under Chapter 4123. or 4133. of the Revised Code, under any of the following circumstances:

(i) If the patient or the guardian or other legal representative of the patient gives express consent;

(ii) If the patient is deceased, the spouse of the patient or the executor or administrator of the patient's estate gives express consent;

(iii) If a medical claim, dental claim, chiropractic claim, or optometric claim, as defined in section 2305.113 of the Revised Code, an action for wrongful death, any other type of civil action, or a claim under Chapter 4123. or 4133. of the Revised Code is filed by the patient, the personal representative of the estate of the patient if deceased, or the patient's guardian or other legal representative.

(b) In any civil action concerning court-ordered treatment or services received by a patient, if the court-ordered treatment or services were ordered as part of a case plan journalized under section 2151.412 of the Revised Code or the court-ordered treatment or services are necessary or relevant to dependency, neglect, or abuse or temporary or permanent custody proceedings under Chapter 2151. of the Revised Code.

(c) In any criminal action concerning any test or the results of any test that determines the presence or concentration of alcohol, a drug of abuse, a combination of them, a controlled substance, or a metabolite of a controlled substance in the patient's whole blood, blood serum or plasma, breath, urine, or other bodily substance at any time relevant to the criminal offense in question.

(d) In any criminal action against a physician, advanced practice registered nurse, or dentist. In such an action, the testimonial privilege established under this division does not

prohibit the admission into evidence, in accordance with the Rules of Evidence, of a patient's medical or dental records or other communications between a patient and the physician, advanced practice registered nurse, or dentist that are related to the action and obtained by subpoena, search warrant, or other lawful means. A court that permits or compels a physician, advanced practice registered nurse, or dentist to testify in such an action or permits the introduction into evidence of patient records or other communications in such an action shall require that appropriate measures be taken to ensure that the confidentiality of any patient named or otherwise identified in the records is maintained. Measures to ensure confidentiality that may be taken by the court include sealing its records or deleting specific information from its records.

(e)(i) If the communication was between a patient who has since died and the deceased patient's physician, advanced practice registered nurse, or dentist, the communication is relevant to a dispute between parties who claim through that deceased patient, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction, and the dispute addresses the competency of the deceased patient when the deceased patient executed a document that is the basis of the dispute or whether the deceased patient was a victim of fraud, undue influence, or duress when the deceased patient executed a document that is the basis of the dispute.

(ii) If neither the spouse of a patient nor the executor or administrator of that patient's estate gives consent under division (B)(1)(a)(ii) of this section, testimony or the disclosure of the patient's medical records by a physician, advanced practice registered nurse, dentist, or other health care provider under division (B)(1)(e)(i) of this section is a

permitted use or disclosure of protected health information, as defined in 45 C.F.R. 160.103, and an authorization or opportunity to be heard shall not be required.

(iii) Division (B)(1)(e)(i) of this section does not require a mental health professional to disclose psychotherapy notes, as defined in 45 C.F.R. 164.501.

(iv) An interested person who objects to testimony or disclosure under division (B)(1)(e)(i) of this section may seek a protective order pursuant to Civil Rule 26.

(v) A person to whom protected health information is disclosed under division (B)(1)(e)(i) of this section shall not use or disclose the protected health information for any purpose other than the litigation or proceeding for which the information was requested and shall return the protected health information to the covered entity or destroy the protected health information, including all copies made, at the conclusion of the litigation or proceeding.

(2)(a) If any law enforcement officer submits a written statement to a health care provider that states that an official criminal investigation has begun regarding a specified person or that a criminal action or proceeding has been commenced against a specified person, that requests the provider to supply to the officer copies of any records the provider possesses that pertain to any test or the results of any test administered to the specified person to determine the presence or concentration of alcohol, a drug of abuse, a combination of them, a controlled substance, or a metabolite of a controlled substance in the person's whole blood, blood serum or plasma, breath, or urine at any time relevant to the criminal offense in question, and that conforms to section 2317.022 of the Revised Code, the provider,

except to the extent specifically prohibited by any law of this state or of the United States, shall supply to the officer a copy of any of the requested records the provider possesses. If the health care provider does not possess any of the requested records, the provider shall give the officer a written statement that indicates that the provider does not possess any of the requested records.

(b) If a health care provider possesses any records of the type described in division (B)(2)(a) of this section regarding the person in question at any time relevant to the criminal offense in question, in lieu of personally testifying as to the results of the test in question, the custodian of the records may submit a certified copy of the records, and, upon its submission, the certified copy is qualified as authentic evidence and may be admitted as evidence in accordance with the Rules of Evidence. Division (A) of section 2317.422 of the Revised Code does not apply to any certified copy of records submitted in accordance with this division. Nothing in this division shall be construed to limit the right of any party to call as a witness the person who administered the test to which the records pertain, the person under whose supervision the test was administered, the custodian of the records, the person who made the records, or the person under whose supervision the records were made.

(3)(a) If the testimonial privilege described in division (B)(1) of this section does not apply as provided in division (B)(1)(a)(iii) of this section, a physician, advanced practice registered nurse, or dentist may be compelled to testify or to submit to discovery under the Rules of Civil Procedure only as to a communication made to the physician, advanced practice registered nurse, or dentist by the patient in question in that

relation, or the advice of the physician, advanced practice registered nurse, or dentist given to the patient in question, that related causally or historically to physical or mental injuries that are relevant to issues in the medical claim, dental claim, chiropractic claim, or optometric claim, action for wrongful death, other civil action, or claim under Chapter 4123. or 4133. of the Revised Code.

(b) If the testimonial privilege described in division (B)(1) of this section does not apply to a physician, advanced practice registered nurse, or dentist as provided in division (B)(1)(c) of this section, the physician, advanced practice registered nurse, or dentist, in lieu of personally testifying as to the results of the test in question, may submit a certified copy of those results, and, upon its submission, the certified copy is qualified as authentic evidence and may be admitted as evidence in accordance with the Rules of Evidence. Division (A) of section 2317.422 of the Revised Code does not apply to any certified copy of results submitted in accordance with this division. Nothing in this division shall be construed to limit the right of any party to call as a witness the person who administered the test in question, the person under whose supervision the test was administered, the custodian of the results of the test, the person who compiled the results, or the person under whose supervision the results were compiled.

(4) The testimonial privilege described in division (B)(1) of this section is not waived when a communication is made by a physician or advanced practice registered nurse to a pharmacist or when there is communication between a patient and a pharmacist in furtherance of the physician-patient or advanced practice registered nurse-patient relation.

(5)(a) As used in divisions (B)(1) to (4) of this section, "communication" means acquiring, recording, or transmitting any information, in any manner, concerning any facts, opinions, or statements necessary to enable a physician, advanced practice registered nurse, or dentist to diagnose, treat, prescribe, or act for a patient. A "communication" may include, but is not limited to, any medical or dental, office, or hospital communication such as a record, chart, letter, memorandum, laboratory test and results, x-ray, photograph, financial statement, diagnosis, or prognosis.

(b) As used in division (B)(2) of this section, "health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner.

(c) As used in division (B)(5)(b) of this section:

(i) "Ambulatory care facility" means a facility that provides medical, diagnostic, or surgical treatment to patients who do not require hospitalization, including a dialysis center, ambulatory surgical facility, cardiac catheterization facility, diagnostic imaging center, extracorporeal shock wave lithotripsy center, home health agency, inpatient hospice, birthing center, radiation therapy center, emergency facility, and an urgent care center. "Ambulatory health care facility" does not include the private office of a physician, advanced practice registered nurse, or dentist, whether the office is for an individual or group practice.

(ii) "Emergency facility" means a hospital emergency department or any other facility that provides emergency medical services.

(iii) "Health care practitioner" has the same meaning as in section 4769.01 of the Revised Code.

(iv) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(v) "Long-term care facility" means a nursing home, residential care facility, or home for the aging, as those terms are defined in section 3721.01 of the Revised Code; a residential facility licensed under section 5119.34 of the Revised Code that provides accommodations, supervision, and personal care services for three to sixteen unrelated adults; a nursing facility, as defined in section 5165.01 of the Revised Code; a skilled nursing facility, as defined in section 5165.01 of the Revised Code; and an intermediate care facility for individuals with intellectual disabilities, as defined in section 5124.01 of the Revised Code.

(vi) "Pharmacy" has the same meaning as in section 4729.01 of the Revised Code.

(d) As used in divisions (B)(1) and (2) of this section, "drug of abuse" has the same meaning as in section 4506.01 of the Revised Code.

(6) Divisions (B)(1), (2), (3), (4), and (5) of this section apply to doctors of medicine, doctors of osteopathic medicine, doctors of podiatry, advanced practice registered nurses, and dentists.

(7) Nothing in divisions (B)(1) to (6) of this section affects, or shall be construed as affecting, the immunity from civil liability conferred by section 307.628 of the Revised Code or the immunity from civil liability conferred by section 2305.33 of the Revised Code upon physicians or advanced practice

registered nurses who report an employee's use of a drug of abuse, or a condition of an employee other than one involving the use of a drug of abuse, to the employer of the employee in accordance with division (B) of that section. As used in division (B)(7) of this section, "employee," "employer," and "physician" have the same meanings as in section 2305.33 of the Revised Code and "advanced practice registered nurse" has the same meaning as in section 4723.01 of the Revised Code.

(C)(1) A cleric, when the cleric remains accountable to the authority of that cleric's church, denomination, or sect, concerning a confession made, or any information confidentially communicated, to the cleric for a religious counseling purpose in the cleric's professional character. The cleric may testify by express consent of the person making the communication, except when the disclosure of the information is in violation of a sacred trust and except that, if the person voluntarily testifies or is deemed by division (A)(4)(c) of section 2151.421 of the Revised Code to have waived any testimonial privilege under this division, the cleric may be compelled to testify on the same subject except when disclosure of the information is in violation of a sacred trust.

(2) As used in division (C) of this section:

(a) "Cleric" means a member of the clergy, rabbi, priest, Christian Science practitioner, or regularly ordained, accredited, or licensed minister of an established and legally cognizable church, denomination, or sect.

(b) "Sacred trust" means a confession or confidential communication made to a cleric in the cleric's ecclesiastical capacity in the course of discipline enjoined by the church to which the cleric belongs, including, but not limited to, the

Catholic Church, if both of the following apply:

(i) The confession or confidential communication was made directly to the cleric.

(ii) The confession or confidential communication was made in the manner and context that places the cleric specifically and strictly under a level of confidentiality that is considered inviolate by canon law or church doctrine.

(D) Husband or wife, concerning any communication made by one to the other, or an act done by either in the presence of the other, during coverture, unless the communication was made, or act done, in the known presence or hearing of a third person competent to be a witness; and such rule is the same if the marital relation has ceased to exist;

(E) A person who assigns a claim or interest, concerning any matter in respect to which the person would not, if a party, be permitted to testify;

(F) A person who, if a party, would be restricted under section 2317.03 of the Revised Code, when the property or thing is sold or transferred by an executor, administrator, guardian, trustee, heir, devisee, or legatee, shall be restricted in the same manner in any action or proceeding concerning the property or thing.

(G)(1) A school guidance counselor who holds a valid educator license from the state board of education as provided for in section 3319.22 of the Revised Code, a person licensed under Chapter 4757. of the Revised Code as a licensed professional clinical counselor, licensed professional counselor, social worker, independent social worker, marriage and family therapist or independent marriage and family

therapist, or registered under Chapter 4757. of the Revised Code as a social work assistant concerning a confidential communication received from a client in that relation or the person's advice to a client unless any of the following applies:

(a) The communication or advice indicates clear and present danger to the client or other persons. For the purposes of this division, cases in which there are indications of present or past child abuse or neglect of the client constitute a clear and present danger.

(b) The client gives express consent to the testimony.

(c) If the client is deceased, the surviving spouse or the executor or administrator of the estate of the deceased client gives express consent.

(d) The client voluntarily testifies, in which case the school guidance counselor or person licensed or registered under Chapter 4757. of the Revised Code may be compelled to testify on the same subject.

(e) The court in camera determines that the information communicated by the client is not germane to the counselor-client, marriage and family therapist-client, or social worker-client relationship.

(f) A court, in an action brought against a school, its administration, or any of its personnel by the client, rules after an in-camera inspection that the testimony of the school guidance counselor is relevant to that action.

(g) The testimony is sought in a civil action and concerns court-ordered treatment or services received by a patient as part of a case plan journalized under section 2151.412 of the Revised Code or the court-ordered treatment or services are

necessary or relevant to dependency, neglect, or abuse or temporary or permanent custody proceedings under Chapter 2151. of the Revised Code.

(2) Nothing in division (G)(1) of this section shall relieve a school guidance counselor or a person licensed or registered under Chapter 4757. of the Revised Code from the requirement to report information concerning child abuse or neglect under section 2151.421 of the Revised Code.

(H) A mediator acting under a mediation order issued under division (A) of section 3109.052 of the Revised Code or otherwise issued in any proceeding for divorce, dissolution, legal separation, annulment, or the allocation of parental rights and responsibilities for the care of children, in any action or proceeding, other than a criminal, delinquency, child abuse, child neglect, or dependent child action or proceeding, that is brought by or against either parent who takes part in mediation in accordance with the order and that pertains to the mediation process, to any information discussed or presented in the mediation process, to the allocation of parental rights and responsibilities for the care of the parents' children, or to the awarding of parenting time rights in relation to their children;

(I) A communications assistant, acting within the scope of the communication assistant's authority, when providing telecommunications relay service pursuant to section 4931.06 of the Revised Code or Title II of the "Communications Act of 1934," 104 Stat. 366 (1990), 47 U.S.C. 225, concerning a communication made through a telecommunications relay service. Nothing in this section shall limit the obligation of a communications assistant to divulge information or testify when

mandated by federal law or regulation or pursuant to subpoena in a criminal proceeding.

Nothing in this section shall limit any immunity or privilege granted under federal law or regulation.

(J)(1) A chiropractor in a civil proceeding concerning a communication made to the chiropractor by a patient in that relation or the chiropractor's advice to a patient, except as otherwise provided in this division. The testimonial privilege established under this division does not apply, and a chiropractor may testify or may be compelled to testify, in any civil action, in accordance with the discovery provisions of the Rules of Civil Procedure in connection with a civil action, or in connection with a claim under Chapter 4123. or 4133. of the Revised Code, under any of the following circumstances:

(a) If the patient or the guardian or other legal representative of the patient gives express consent.

(b) If the patient is deceased, the spouse of the patient or the executor or administrator of the patient's estate gives express consent.

(c) If a medical claim, dental claim, chiropractic claim, or optometric claim, as defined in section 2305.113 of the Revised Code, an action for wrongful death, any other type of civil action, or a claim under Chapter 4123. or 4133. of the Revised Code is filed by the patient, the personal representative of the estate of the patient if deceased, or the patient's guardian or other legal representative.

(2) If the testimonial privilege described in division (J)(1) of this section does not apply as provided in division (J)(1)(c) of this section, a chiropractor may be compelled to

testify or to submit to discovery under the Rules of Civil Procedure only as to a communication made to the chiropractor by the patient in question in that relation, or the chiropractor's advice to the patient in question, that related causally or historically to physical or mental injuries that are relevant to issues in the medical claim, dental claim, chiropractic claim, or optometric claim, action for wrongful death, other civil action, or claim under Chapter 4123. or 4133. of the Revised Code.

(3) The testimonial privilege established under this division does not apply, and a chiropractor may testify or be compelled to testify, in any criminal action or administrative proceeding.

(4) As used in this division, "communication" means acquiring, recording, or transmitting any information, in any manner, concerning any facts, opinions, or statements necessary to enable a chiropractor to diagnose, treat, or act for a patient. A communication may include, but is not limited to, any chiropractic, office, or hospital communication such as a record, chart, letter, memorandum, laboratory test and results, x-ray, photograph, financial statement, diagnosis, or prognosis.

(K)(1) Except as provided under division (K)(2) of this section, a critical incident stress management team member concerning a communication received from an individual who receives crisis response services from the team member, or the team member's advice to the individual, during a debriefing session.

(2) The testimonial privilege established under division (K)(1) of this section does not apply if any of the following are true:

(a) The communication or advice indicates clear and present danger to the individual who receives crisis response services or to other persons. For purposes of this division, cases in which there are indications of present or past child abuse or neglect of the individual constitute a clear and present danger.

(b) The individual who received crisis response services gives express consent to the testimony.

(c) If the individual who received crisis response services is deceased, the surviving spouse or the executor or administrator of the estate of the deceased individual gives express consent.

(d) The individual who received crisis response services voluntarily testifies, in which case the team member may be compelled to testify on the same subject.

(e) The court in camera determines that the information communicated by the individual who received crisis response services is not germane to the relationship between the individual and the team member.

(f) The communication or advice pertains or is related to any criminal act.

(3) As used in division (K) of this section:

(a) "Crisis response services" means consultation, risk assessment, referral, and on-site crisis intervention services provided by a critical incident stress management team to individuals affected by crisis or disaster.

(b) "Critical incident stress management team member" or "team member" means an individual specially trained to provide

crisis response services as a member of an organized community or local crisis response team that holds membership in the Ohio critical incident stress management network.

(c) "Debriefing session" means a session at which crisis response services are rendered by a critical incident stress management team member during or after a crisis or disaster.

(L)(1) Subject to division (L)(2) of this section and except as provided in division (L)(3) of this section, an employee assistance professional, concerning a communication made to the employee assistance professional by a client in the employee assistance professional's official capacity as an employee assistance professional.

(2) Division (L)(1) of this section applies to an employee assistance professional who meets either or both of the following requirements:

(a) Is certified by the employee assistance certification commission to engage in the employee assistance profession;

(b) Has education, training, and experience in all of the following:

(i) Providing workplace-based services designed to address employer and employee productivity issues;

(ii) Providing assistance to employees and employees' dependents in identifying and finding the means to resolve personal problems that affect the employees or the employees' performance;

(iii) Identifying and resolving productivity problems associated with an employee's concerns about any of the following matters: health, marriage, family, finances, substance

abuse or other addiction, workplace, law, and emotional issues;

(iv) Selecting and evaluating available community resources;

(v) Making appropriate referrals;

(vi) Local and national employee assistance agreements;

(vii) Client confidentiality.

(3) Division (L)(1) of this section does not apply to any of the following:

(a) A criminal action or proceeding involving an offense under sections 2903.01 to 2903.06 of the Revised Code if the employee assistance professional's disclosure or testimony relates directly to the facts or immediate circumstances of the offense;

(b) A communication made by a client to an employee assistance professional that reveals the contemplation or commission of a crime or serious, harmful act;

(c) A communication that is made by a client who is an unemancipated minor or an adult adjudicated to be incompetent and indicates that the client was the victim of a crime or abuse;

(d) A civil proceeding to determine an individual's mental competency or a criminal action in which a plea of not guilty by reason of insanity is entered;

(e) A civil or criminal malpractice action brought against the employee assistance professional;

(f) When the employee assistance professional has the express consent of the client or, if the client is deceased or

disabled, the client's legal representative;

(g) When the testimonial privilege otherwise provided by division (L)(1) of this section is abrogated under law.

**Sec. 2913.48.** (A) No person, with purpose to defraud or knowing that the person is facilitating a fraud, shall do any of the following:

(1) Receive workers' compensation benefits to which the person is not entitled;

(2) Make or present or cause to be made or presented a false or misleading statement with the purpose to secure payment for goods or services rendered under Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code or to secure workers' compensation benefits;

(3) Alter, falsify, destroy, conceal, or remove any record or document that is necessary to fully establish the validity of any claim filed with, or necessary to establish the nature and validity of all goods and services for which reimbursement or payment was received or is requested from, the bureau of workers' compensation, or a self-insuring employer under Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code;

(4) Enter into an agreement or conspiracy to defraud the bureau or a self-insuring employer by making or presenting or causing to be made or presented a false claim for workers' compensation benefits;

(5) Make or present or cause to be made or presented a false statement concerning manual codes, classification of employees, payroll, paid compensation, or number of personnel, when information of that nature is necessary to determine the actual workers' compensation premium or assessment owed to the

bureau by an employer;

(6) Alter, forge, or create a workers' compensation certificate to falsely show current or correct workers' compensation coverage;

(7) Fail to secure or maintain workers' compensation coverage as required by Chapter 4123. of the Revised Code with the intent to defraud the bureau of workers' compensation.

(B) Whoever violates this section is guilty of workers' compensation fraud. Except as otherwise provided in this division, a violation of this section is a misdemeanor of the first degree. If the value of premiums and assessments unpaid pursuant to actions described in division (A)(5), (6), or (7) of this section, or of goods, services, property, or money stolen is one thousand dollars or more and is less than seven thousand five hundred dollars, a violation of this section is a felony of the fifth degree. If the value of premiums and assessments unpaid pursuant to actions described in division (A)(5), (6), or (7) of this section, or of goods, services, property, or money stolen is seven thousand five hundred dollars or more and is less than one hundred fifty thousand dollars, a violation of this section is a felony of the fourth degree. If the value of premiums and assessments unpaid pursuant to actions described in division (A)(5), (6), or (7) of this section, or of goods, services, property, or money stolen is one hundred fifty thousand dollars or more, a violation of this section is a felony of the third degree.

(C) Upon application of the governmental body that conducted the investigation and prosecution of a violation of this section, the court shall order the person who is convicted of the violation to pay the governmental body its costs of

investigating and prosecuting the case. These costs are in addition to any other costs or penalty provided in the Revised Code or any other section of law.

(D) The remedies and penalties provided in this section are not exclusive remedies and penalties and do not preclude the use of any other criminal or civil remedy or penalty for any act that is in violation of this section.

(E) As used in this section:

(1) "False" means wholly or partially untrue or deceptive.

(2) "Goods" includes, but is not limited to, medical supplies, appliances, rehabilitative equipment, and any other apparatus or furnishing provided or used in the care, treatment, or rehabilitation of a claimant for workers' compensation benefits.

(3) "Services" includes, but is not limited to, any service provided by any health care provider to a claimant for workers' compensation benefits and any and all services provided by the bureau as part of workers' compensation insurance coverage.

(4) "Claim" means any attempt to cause the bureau, an independent third party with whom the administrator or an employer contracts under section 4121.44 of the Revised Code, or a self-insuring employer to make payment or reimbursement for workers' compensation benefits.

(5) "Employment" means participating in any trade, occupation, business, service, or profession for substantial gainful remuneration.

(6) "Employer," "employee," and "self-insuring employer"

have the same meanings as in section 4123.01 of the Revised Code.

(7) "Remuneration" includes, but is not limited to, wages, commissions, rebates, and any other reward or consideration.

(8) "Statement" includes, but is not limited to, any oral, written, electronic, electronic impulse, or magnetic communication notice, letter, memorandum, receipt for payment, invoice, account, financial statement, or bill for services; a diagnosis, prognosis, prescription, hospital, medical, or dental chart or other record; and a computer generated document.

(9) "Records" means any medical, professional, financial, or business record relating to the treatment or care of any person, to goods or services provided to any person, or to rates paid for goods or services provided to any person, or any record that the administrator of workers' compensation requires pursuant to rule.

(10) "Workers' compensation benefits" means any compensation or benefits payable under Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code.

**Sec. 3121.899.** (A) The new hire reports filed with the department of job and family services pursuant to section 3121.891 of the Revised Code shall not be considered public records for purposes of section 149.43 of the Revised Code. The director of job and family services may adopt rules under section 3125.51 of the Revised Code governing access to, and use and disclosure of, information contained in the new hire reports.

(B) The department of job and family services may disclose information in the new hire reports to all of the following:

(1) Any child support enforcement agency and any agent under contract with a child support enforcement agency for the purposes listed in division (A) of section 3121.898 of the Revised Code;

(2) Any county department of job and family services and any agent under contract with a county department of job and family services for the purposes listed in division (B) of section 3121.898 of the Revised Code;

(3) Employees of the department of job and family services and any agent under contract with the department of job and family services for the purposes listed in divisions (B) and (C) of section 3121.898 of the Revised Code;

(4) The administrator of workers' compensation for the purpose of administering the workers' compensation system pursuant to Chapters 4121., 4123., 4127., ~~and~~ 4131., and 4133. of the Revised Code;

(5) To state agencies operating employment security and workers compensation programs for the purpose of administering those programs, pursuant to division (D) of section 3121.898 of the Revised Code.

**Sec. 3701.741.** (A) Each health care provider and medical records company shall provide copies of medical records in accordance with this section.

(B) Except as provided in divisions (C) and (E) of this section, a health care provider or medical records company that receives a request for a copy of a patient's medical record shall charge not more than the amounts set forth in this section.

(1) If the request is made by the patient or the patient's

personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

(a) Except as provided in division (B)(1)(b) of this section, with respect to data recorded on paper or electronically, the following amounts adjusted in accordance with section 3701.742 of the Revised Code:

(i) Two dollars and seventy-four cents per page for the first ten pages;

(ii) Fifty-seven cents per page for pages eleven through fifty;

(iii) Twenty-three cents per page for pages fifty-one and higher;

(b) With respect to data resulting from an x-ray, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scan and recorded on paper or film, one dollar and eighty-seven cents per page;

(c) The actual cost of any related postage incurred by the health care provider or medical records company.

(2) If the request is made other than by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

(a) An initial fee of sixteen dollars and eighty-four cents adjusted in accordance with section 3701.742 of the Revised Code, which shall compensate for the records search;

(b) Except as provided in division (B)(2)(c) of this section, with respect to data recorded on paper or

electronically, the following amounts adjusted in accordance with section 3701.742 of the Revised Code:

(i) One dollar and eleven cents per page for the first ten pages;

(ii) Fifty-seven cents per page for pages eleven through fifty;

(iii) Twenty-three cents per page for pages fifty-one and higher.

(c) With respect to data resulting from an x-ray, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scan and recorded on paper or film, one dollar and eighty-seven cents per page;

(d) The actual cost of any related postage incurred by the health care provider or medical records company.

(C)(1) On request, a health care provider or medical records company shall provide one copy of the patient's medical record and one copy of any records regarding treatment performed subsequent to the original request, not including copies of records already provided, without charge to the following:

(a) The bureau of workers' compensation, in accordance with Chapters 4121. ~~and~~ , 4123. , and 4133. of the Revised Code and the rules adopted under those chapters;

(b) The industrial commission, in accordance with Chapters 4121. ~~and~~ , 4123. , and 4133. of the Revised Code and the rules adopted under those chapters;

(c) The occupational pneumoconiosis board, in accordance with Chapter 4133. of the Revised Code;

(d) The department of medicaid or a county department of job and family services, in accordance with Chapters 5160., 5161., 5162., 5163., 5164., 5165., 5166., and 5167. of the Revised Code and the rules adopted under those chapters;

~~(d)~~ (e) The attorney general, in accordance with sections 2743.51 to 2743.72 of the Revised Code and any rules that may be adopted under those sections;

~~(e)~~ (f) A patient, patient's personal representative, or authorized person if the medical record is necessary to support a claim under Title II or Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 401 and 1381, as amended, and the request is accompanied by documentation that a claim has been filed.

(2) Nothing in division (C)(1) of this section requires a health care provider or medical records company to provide a copy without charge to any person or entity not listed in division (C)(1) of this section.

(D) Division (C) of this section shall not be construed to supersede any rule of the bureau of workers' compensation, the industrial commission, or the department of medicaid.

(E) A health care provider or medical records company may enter into a contract with either of the following for the copying of medical records at a fee other than as provided in division (B) of this section:

(1) A patient, a patient's personal representative, or an authorized person;

(2) An insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state or health insuring corporations holding a certificate

of authority under Chapter 1751. of the Revised Code.

(F) This section does not apply to medical records the copying of which is covered by section 173.20 of the Revised Code or by 42 C.F.R. 483.10.

**Sec. 3963.10.** This chapter does not apply with respect to any of the following:

(A) A contract or provider agreement between a provider and the state or federal government, a state agency, or federal agency for health care services provided through a program for medicaid or medicare;

(B) A contract for payments made to providers for rendering health care services to claimants pursuant to claims made under Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code;

(C) An exclusive contract between a health insuring corporation and a single group of providers in a specific geographic area to provide or arrange for the provision of health care services.

**Sec. 4115.03.** As used in sections 4115.03 to 4115.16 of the Revised Code:

(A) "Public authority" means any officer, board, or commission of the state, or any political subdivision of the state, authorized to enter into a contract for the construction of a public improvement or to construct the same by the direct employment of labor, or any institution supported in whole or in part by public funds and said sections apply to expenditures of such institutions made in whole or in part from public funds.

(B) "Construction" means any of the following:

(1) Except as provided in division (B)(3) of this section, any new construction of a public improvement, the total overall project cost of which is fairly estimated to be more than the following amounts and performed by other than full-time employees who have completed their probationary periods in the classified service of a public authority:

(a) One hundred twenty-five thousand dollars, beginning on September 29, 2011, and continuing for one year thereafter;

(b) Two hundred thousand dollars, beginning when the time period described in division (B)(1)(a) of this section expires and continuing for one year thereafter;

(c) Two hundred fifty thousand dollars, beginning when the time period described in division (B)(1)(b) of this section expires.

(2) Except as provided in division (B)(4) of this section, any reconstruction, enlargement, alteration, repair, remodeling, renovation, or painting of a public improvement, the total overall project cost of which is fairly estimated to be more than the following amounts and performed by other than full-time employees who have completed their probationary period in the classified civil service of a public authority:

(a) Thirty-eight thousand dollars, beginning on September 29, 2011, and continuing for one year thereafter;

(b) Sixty thousand dollars, beginning when the time period described in division (B)(2)(a) of this section expires and continuing for one year thereafter;

(c) Seventy-five thousand dollars, beginning when the time period described in division (B)(2)(b) of this section expires.

(3) Any new construction of a public improvement that involves roads, streets, alleys, sewers, ditches, and other works connected to road or bridge construction, the total overall project cost of which is fairly estimated to be more than seventy-eight thousand two hundred fifty-eight dollars adjusted biennially by the director of commerce pursuant to section 4115.034 of the Revised Code and performed by other than full-time employees who have completed their probationary periods in the classified service of a public authority;

(4) Any reconstruction, enlargement, alteration, repair, remodeling, renovation, or painting of a public improvement that involves roads, streets, alleys, sewers, ditches, and other works connected to road or bridge construction, the total overall project cost of which is fairly estimated to be more than twenty-three thousand four hundred forty-seven dollars adjusted biennially by the director of commerce pursuant to section 4115.034 of the Revised Code and performed by other than full-time employees who have completed their probationary periods in the classified service of a public authority.

(C) "Public improvement" includes all buildings, roads, streets, alleys, sewers, ditches, sewage disposal plants, water works, and all other structures or works constructed by a public authority of the state or any political subdivision thereof or by any person who, pursuant to a contract with a public authority, constructs any structure for a public authority of the state or a political subdivision thereof. When a public authority rents or leases a newly constructed structure within six months after completion of such construction, all work performed on such structure to suit it for occupancy by a public authority is a "public improvement." "Public improvement" does not include an improvement authorized by section 940.06 of the

Revised Code that is constructed pursuant to a contract with a soil and water conservation district, as defined in section 940.01 of the Revised Code, or performed as a result of a petition filed pursuant to Chapter 6131., 6133., or 6135. of the Revised Code, wherein no less than seventy-five per cent of the project is located on private land and no less than seventy-five per cent of the cost of the improvement is paid for by private property owners pursuant to Chapter 940., 6131., 6133., or 6135. of the Revised Code.

(D) "Locality" means the county wherein the physical work upon any public improvement is being performed.

(E) "Prevailing wages" means the sum of the following:

(1) The basic hourly rate of pay;

(2) The rate of contribution irrevocably made by a contractor or subcontractor to a trustee or to a third person pursuant to a fund, plan, or program;

(3) The rate of costs to the contractor or subcontractor which may be reasonably anticipated in providing the following fringe benefits to laborers and mechanics pursuant to an enforceable commitment to carry out a financially responsible plan or program which was communicated in writing to the laborers and mechanics affected:

(a) Medical or hospital care or insurance to provide such;

(b) Pensions on retirement or death or insurance to provide such;

(c) Compensation for injuries or illnesses resulting from occupational activities if it is in addition to that coverage required by Chapters 4121. ~~and~~ , 4123., and 4133. of the Revised

Code;

(d) Supplemental unemployment benefits that are in addition to those required by Chapter 4141. of the Revised Code;

(e) Life insurance;

(f) Disability and sickness insurance;

(g) Accident insurance;

(h) Vacation and holiday pay;

(i) Defraying of costs for apprenticeship or other similar training programs which are beneficial only to the laborers and mechanics affected;

(j) Other bona fide fringe benefits.

None of the benefits enumerated in division (E)(3) of this section may be considered in the determination of prevailing wages if federal, state, or local law requires contractors or subcontractors to provide any of such benefits.

(F) "Interested party," with respect to a particular contract for construction of a public improvement, means:

(1) Any person who submits a bid for the purpose of securing the award of the contract;

(2) Any person acting as a subcontractor of a person described in division (F)(1) of this section;

(3) Any bona fide organization of labor which has as members or is authorized to represent employees of a person described in division (F)(1) or (2) of this section and which exists, in whole or in part, for the purpose of negotiating with employers concerning the wages, hours, or terms and conditions of employment of employees;

(4) Any association having as members any of the persons described in division (F)(1) or (2) of this section.

(G) Except as used in division (A) of this section, "officer" means an individual who has an ownership interest or holds an office of trust, command, or authority in a corporation, business trust, partnership, or association.

**Sec. 4121.03.** (A) The governor shall appoint from among the members of the industrial commission the chairperson of the industrial commission. The chairperson shall serve as chairperson at the pleasure of the governor. The chairperson is the head of the commission and its chief executive officer.

(B) The chairperson shall appoint, after consultation with other commission members and obtaining the approval of at least one other commission member, an executive director of the commission. The executive director shall serve at the pleasure of the chairperson. The executive director, under the direction of the chairperson, shall perform all of the following duties:

(1) Act as chief administrative officer for the commission;

(2) Ensure that all commission personnel follow the rules of the commission;

(3) Ensure that all orders, awards, and determinations are properly heard and signed, prior to attesting to the documents;

(4) Coordinate, to the fullest extent possible, commission activities with the bureau of workers' compensation activities;

(5) Do all things necessary for the efficient and effective implementation of the duties of the commission.

The responsibilities assigned to the executive director of

the commission do not relieve the chairperson from final responsibility for the proper performance of the acts specified in this division.

(C) The chairperson shall do all of the following:

(1) Except as otherwise provided in this division, employ, promote, supervise, remove, and establish the compensation of all employees as needed in connection with the performance of the commission's duties under this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code and may assign to them their duties to the extent necessary to achieve the most efficient performance of its functions, and to that end may establish, change, or abolish positions, and assign and reassign duties and responsibilities of every employee of the commission. The civil service status of any person employed by the commission prior to November 3, 1989, is not affected by this section. Personnel employed by the bureau or the commission who are subject to Chapter 4117. of the Revised Code shall retain all of their rights and benefits conferred pursuant to that chapter as it presently exists or is hereafter amended and nothing in this chapter or Chapter 4123. of the Revised Code shall be construed as eliminating or interfering with Chapter 4117. of the Revised Code or the rights and benefits conferred under that chapter to public employees or to any bargaining unit.

(2) Hire district and staff hearing officers after consultation with other commission members and obtaining the approval of at least one other commission member;

(3) Fire staff and district hearing officers when the chairperson finds appropriate after obtaining the approval of at least one other commission member;

(4) Maintain the office for the commission in Columbus;

(5) To the maximum extent possible, use electronic data processing equipment for the issuance of orders immediately following a hearing, scheduling of hearings and medical examinations, tracking of claims, retrieval of information, and any other matter within the commission's jurisdiction, and shall provide and input information into the electronic data processing equipment as necessary to effect the success of the claims tracking system established pursuant to division (B)(14) of section 4121.121 of the Revised Code;

(6) Exercise all administrative and nonadjudicatory powers and duties conferred upon the commission by Chapters 4121., 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code;

(7) Approve all contracts for special services.

(D) The chairperson is responsible for all administrative matters and may secure for the commission facilities, equipment, and supplies necessary to house the commission, any employees, and files and records under the commission's control and to discharge any duty imposed upon the commission by law, the expense thereof to be audited and paid in the same manner as other state expenses. For that purpose, the chairperson, separately from the budget prepared by the administrator of workers' compensation, shall prepare and submit to the office of budget and management a budget for each biennium according to sections 101.532 and 107.03 of the Revised Code. The budget submitted shall cover the costs of the commission and staff and district hearing officers in the discharge of any duty imposed upon the chairperson, the commission, and hearing officers by law.

(E) A majority of the commission constitutes a quorum to transact business. No vacancy impairs the rights of the remaining members to exercise all of the powers of the commission, so long as a majority remains. Any investigation, inquiry, or hearing that the commission may hold or undertake may be held or undertaken by or before any one member of the commission, or before one of the deputies of the commission, except as otherwise provided in this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code. Every order made by a member, or by a deputy, when approved and confirmed by a majority of the members, and so shown on its record of proceedings, is the order of the commission. The commission may hold sessions at any place within the state. The commission is responsible for all of the following:

(1) Establishing the overall adjudicatory policy and management of the commission under this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code, except for those administrative matters within the jurisdiction of the chairperson, bureau of workers' compensation, and the administrator of workers' compensation under those chapters;

(2) Hearing appeals and reconsiderations under this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code;

(3) Engaging in rulemaking where required by this chapter or Chapter 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code.

**Sec. 4121.12.** (A) There is hereby created the bureau of workers' compensation board of directors consisting of eleven members to be appointed by the governor with the advice and consent of the senate. One member shall be an individual who, on account of the individual's previous vocation, employment, or

affiliations, can be classed as a representative of employees; two members shall be individuals who, on account of their previous vocation, employment, or affiliations, can be classed as representatives of employee organizations and at least one of these two individuals shall be a member of the executive committee of the largest statewide labor federation; three members shall be individuals who, on account of their previous vocation, employment, or affiliations, can be classed as representatives of employers, one of whom represents self-insuring employers, one of whom is a state fund employer who employs one hundred or more employees, and one of whom is a state fund employer who employs less than one hundred employees; two members shall be individuals who, on account of their vocation, employment, or affiliations, can be classed as investment and securities experts who have direct experience in the management, analysis, supervision, or investment of assets and are residents of this state; one member who shall be a certified public accountant; one member who shall be an actuary who is a member in good standing with the American academy of actuaries or who is an associate or fellow with the casualty actuarial society; and one member shall represent the public and also be an individual who, on account of the individual's previous vocation, employment, or affiliations, cannot be classed as either predominantly representative of employees or of employers. The governor shall select the chairperson of the board who shall serve as chairperson at the pleasure of the governor.

None of the members of the board, within one year immediately preceding the member's appointment, shall have been employed by the bureau of workers' compensation or by any person, partnership, or corporation that has provided to the

bureau services of a financial or investment nature, including the management, analysis, supervision, or investment of assets.

(B) Of the initial appointments made to the board, the governor shall appoint the member who represents employees, one member who represents employers, and the member who represents the public to a term ending one year after June 11, 2007; one member who represents employers, one member who represents employee organizations, one member who is an investment and securities expert, and the member who is a certified public accountant to a term ending two years after June 11, 2007; and one member who represents employers, one member who represents employee organizations, one member who is an investment and securities expert, and the member who is an actuary to a term ending three years after June 11, 2007. Thereafter, terms of office shall be for three years, with each term ending on the same day of the same month as did the term that it succeeds. Each member shall hold office from the date of the member's appointment until the end of the term for which the member was appointed.

Members may be reappointed. Any member appointed to fill a vacancy occurring prior to the expiration date of the term for which the member's predecessor was appointed shall hold office as a member for the remainder of that term. A member shall continue in office subsequent to the expiration date of the member's term until a successor takes office or until a period of sixty days has elapsed, whichever occurs first.

(C) In making appointments to the board, the governor shall select the members from the list of names submitted by the workers' compensation board of directors nominating committee pursuant to this division. The nominating committee shall submit

to the governor a list containing four separate names for each of the members on the board. Within fourteen days after the submission of the list, the governor shall appoint individuals from the list.

At least thirty days prior to a vacancy occurring as a result of the expiration of a term and within thirty days after other vacancies occurring on the board, the nominating committee shall submit an initial list containing four names for each vacancy. Within fourteen days after the submission of the initial list, the governor either shall appoint individuals from that list or request the nominating committee to submit another list of four names for each member the governor has not appointed from the initial list, which list the nominating committee shall submit to the governor within fourteen days after the governor's request. The governor then shall appoint, within seven days after the submission of the second list, one of the individuals from either list to fill the vacancy for which the governor has not made an appointment from the initial list. If the governor appoints an individual to fill a vacancy occurring as a result of the expiration of a term, the individual appointed shall begin serving as a member of the board when the term for which the individual's predecessor was appointed expires or immediately upon appointment by the governor, whichever occurs later. With respect to the filling of vacancies, the nominating committee shall provide the governor with a list of four individuals who are, in the judgment of the nominating committee, the most fully qualified to accede to membership on the board.

In order for the name of an individual to be submitted to the governor under this division, the nominating committee shall approve the individual by an affirmative vote of a majority of

its members.

(D) All members of the board shall receive their reasonable and necessary expenses pursuant to section 126.31 of the Revised Code while engaged in the performance of their duties as members and also shall receive an annual salary not to exceed sixty thousand dollars in total, payable on the following basis:

(1) Except as provided in division (D)(2) of this section, a member shall receive two thousand five hundred dollars during a month in which the member attends one or more meetings of the board and shall receive no payment during a month in which the member attends no meeting of the board.

(2) A member may receive no more than thirty thousand dollars per year to compensate the member for attending meetings of the board, regardless of the number of meetings held by the board during a year or the number of meetings in excess of twelve within a year that the member attends.

(3) Except as provided in division (D)(4) of this section, if a member serves on the workers' compensation audit committee, workers' compensation actuarial committee, or the workers' compensation investment committee, the member shall receive two thousand five hundred dollars during a month in which the member attends one or more meetings of the committee on which the member serves and shall receive no payment during any month in which the member attends no meeting of that committee.

(4) A member may receive no more than thirty thousand dollars per year to compensate the member for attending meetings of any of the committees specified in division (D)(3) of this section, regardless of the number of meetings held by a

committee during a year or the number of committees on which a member serves.

The chairperson of the board shall set the meeting dates of the board as necessary to perform the duties of the board under this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code. The board shall meet at least twelve times a year. The administrator of workers' compensation shall provide professional and clerical assistance to the board, as the board considers appropriate.

(E) Before entering upon the duties of office, each appointed member of the board shall take an oath of office as required by sections 3.22 and 3.23 of the Revised Code and file in the office of the secretary of state the bond required under section 4121.127 of the Revised Code.

(F) The board shall:

(1) Establish the overall administrative policy for the bureau for the purposes of this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code;

(2) Review progress of the bureau in meeting its cost and quality objectives and in complying with this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code;

(3) Submit an annual report to the president of the senate, the speaker of the house of representatives, and the governor and include all of the following in that report:

(a) An evaluation of the cost and quality objectives of the bureau;

(b) A statement of the net assets available for the

provision of compensation and benefits under this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code as of the last day of the fiscal year;

(c) A statement of any changes that occurred in the net assets available, including employer premiums and net investment income, for the provision of compensation and benefits and payment of administrative expenses, between the first and last day of the fiscal year immediately preceding the date of the report;

(d) The following information for each of the six consecutive fiscal years occurring previous to the report:

(i) A schedule of the net assets available for compensation and benefits;

(ii) The annual cost of the payment of compensation and benefits;

(iii) Annual administrative expenses incurred;

(iv) Annual employer premiums allocated for the provision of compensation and benefits.

(e) A description of any significant changes that occurred during the six years for which the board provided the information required under division (F)(3)(d) of this section that affect the ability of the board to compare that information from year to year.

(4) Review all independent financial audits of the bureau. The administrator shall provide access to records of the bureau to facilitate the review required under this division.

(5) Study issues as requested by the administrator or the governor;

(6) Contract with all of the following:

(a) An independent actuarial firm to assist the board in making recommendations to the administrator regarding premium rates;

(b) An outside investment counsel to assist the workers' compensation investment committee in fulfilling its duties;

(c) An independent fiduciary counsel to assist the board in the performance of its duties.

(7) Approve the investment policy developed by the workers' compensation investment committee pursuant to section 4121.129 of the Revised Code if the policy satisfies the requirements specified in section 4123.442 of the Revised Code~~.~~ ;

(8) Review and publish the investment policy no less than annually and make copies available to interested parties~~.~~ ;

(9) Prohibit, on a prospective basis, any specific investment it finds to be contrary to the investment policy approved by the board~~.~~ ;

(10) Vote to open each investment class and allow the administrator to invest in an investment class only if the board, by a majority vote, opens that class;

(11) After opening a class but prior to the administrator investing in that class, adopt rules establishing due diligence standards for employees of the bureau to follow when investing in that class and establish policies and procedures to review and monitor the performance and value of each investment class;

(12) Submit a report annually on the performance and value of each investment class to the governor, the president and minority leader of the senate, and the speaker and minority

leader of the house of representatives~~.~~;

(13) Advise and consent on all of the following:

(a) Administrative rules the administrator submits to it pursuant to division (B)(5) of section 4121.121 of the Revised Code for the classification of occupations or industries, for premium rates and contributions, for the amount to be credited to the surplus fund, for rules and systems of rating, rate revisions, and merit rating;

(b) The duties and authority conferred upon the administrator pursuant to section 4121.37 of the Revised Code;

(c) Rules the administrator adopts for the health partnership program and the qualified health plan system, as provided in sections 4121.44, 4121.441, and 4121.442 of the Revised Code;

(d) Rules the administrator submits to it pursuant to Chapter 4167. of the Revised Code regarding the public employment risk reduction program and the protection of public health care workers from exposure incidents.

As used in this division, "public health care worker" and "exposure incident" have the same meanings as in section 4167.25 of the Revised Code.

(14) Perform all duties required under this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code;

(15) Meet with the governor on an annual basis to discuss the administrator's performance of the duties specified in this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code;

(16) Develop and participate in a bureau of workers' compensation board of directors education program that consists of all of the following:

(a) An orientation component for newly appointed members;

(b) A continuing education component for board members who have served for at least one year;

(c) A curriculum that includes education about each of the following topics:

(i) Board member duties and responsibilities;

(ii) Compensation and benefits paid pursuant to this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code;

(iii) Ethics;

(iv) Governance processes and procedures;

(v) Actuarial soundness;

(vi) Investments;

(vii) Any other subject matter the board believes is reasonably related to the duties of a board member.

(17) Hold all sessions, classes, and other events for the program developed pursuant to division (F)(16) of this section in this state.

(G) The board may do both of the following:

(1) Vote to close any investment class;

(2) Create any committees in addition to the workers' compensation audit committee, the workers' compensation actuarial committee, and the workers' compensation investment

committee that the board determines are necessary to assist the board in performing its duties.

(H) The office of a member of the board who is convicted of or pleads guilty to a felony, a theft offense as defined in section 2913.01 of the Revised Code, or a violation of section 102.02, 102.03, 102.04, 2921.02, 2921.11, 2921.13, 2921.31, 2921.41, 2921.42, 2921.43, or 2921.44 of the Revised Code shall be deemed vacant. The vacancy shall be filled in the same manner as the original appointment. A person who has pleaded guilty to or been convicted of an offense of that nature is ineligible to be a member of the board. A member who receives a bill of indictment for any of the offenses specified in this section shall be automatically suspended from the board pending resolution of the criminal matter.

(I) For the purposes of division (G)(1) of section 121.22 of the Revised Code, the meeting between the governor and the board to review the administrator's performance as required under division (F)(15) of this section shall be considered a meeting regarding the employment of the administrator.

**Sec. 4121.121.** (A) There is hereby created the bureau of workers' compensation, which shall be administered by the administrator of workers' compensation. A person appointed to the position of administrator shall possess significant management experience in effectively managing an organization or organizations of substantial size and complexity. A person appointed to the position of administrator also shall possess a minimum of five years of experience in the field of workers' compensation insurance or in another insurance industry, except as otherwise provided when the conditions specified in division (C) of this section are satisfied. The governor shall appoint

the administrator as provided in section 121.03 of the Revised Code, and the administrator shall serve at the pleasure of the governor. The governor shall fix the administrator's salary on the basis of the administrator's experience and the administrator's responsibilities and duties under this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code. The governor shall not appoint to the position of administrator any person who has, or whose spouse has, given a contribution to the campaign committee of the governor in an amount greater than one thousand dollars during the two-year period immediately preceding the date of the appointment of the administrator.

The administrator shall hold no other public office and shall devote full time to the duties of administrator. Before entering upon the duties of the office, the administrator shall take an oath of office as required by sections 3.22 and 3.23 of the Revised Code, and shall file in the office of the secretary of state, a bond signed by the administrator and by surety approved by the governor, for the sum of fifty thousand dollars payable to the state, conditioned upon the faithful performance of the administrator's duties.

(B) The administrator is responsible for the management of the bureau and for the discharge of all administrative duties imposed upon the administrator in this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code, and in the discharge thereof shall do all of the following:

(1) Perform all acts and exercise all authorities and powers, discretionary and otherwise that are required of or vested in the bureau or any of its employees in this chapter and

Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code, except the acts and the exercise of authority and power that is required of and vested in the bureau of workers' compensation board of directors or the industrial commission pursuant to those chapters. The treasurer of state shall honor all warrants signed by the administrator, or by one or more of the administrator's employees, authorized by the administrator in writing, or bearing the facsimile signature of the administrator or such employee under sections 4123.42 and 4123.44 of the Revised Code.

(2) Employ, direct, and supervise all employees required in connection with the performance of the duties assigned to the bureau by this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code, including an actuary, and may establish job classification plans and compensation for all employees of the bureau provided that this grant of authority shall not be construed as affecting any employee for whom the state employment relations board has established an appropriate bargaining unit under section 4117.06 of the Revised Code. All positions of employment in the bureau are in the classified civil service except those employees the administrator may appoint to serve at the administrator's pleasure in the unclassified civil service pursuant to section 124.11 of the Revised Code. The administrator shall fix the salaries of employees the administrator appoints to serve at the administrator's pleasure, including the chief operating officer, staff physicians, and other senior management personnel of the bureau ~~and~~ . The administrator shall establish the compensation of staff attorneys of the bureau's legal section and their immediate supervisors, and take whatever steps are necessary to provide adequate compensation for other staff attorneys. The

administrator shall establish the compensation of the members of the occupational pneumoconiosis board created in section 4133.07 of the Revised Code.

The administrator may appoint a person who holds a certified position in the classified service within the bureau to a position in the unclassified service within the bureau. A person appointed pursuant to this division to a position in the unclassified service shall retain the right to resume the position and status held by the person in the classified service immediately prior to the person's appointment in the unclassified service, regardless of the number of positions the person held in the unclassified service. An employee's right to resume a position in the classified service may only be exercised when the administrator demotes the employee to a pay range lower than the employee's current pay range or revokes the employee's appointment to the unclassified service. An employee who holds a position in the classified service and who is appointed to a position in the unclassified service on or after January 1, 2016, shall have the right to resume a position in the classified service under this division only within five years after the effective date of the employee's appointment in the unclassified service. An employee forfeits the right to resume a position in the classified service when the employee is removed from the position in the unclassified service due to incompetence, inefficiency, dishonesty, drunkenness, immoral conduct, insubordination, discourteous treatment of the public, neglect of duty, violation of this chapter or Chapter 124., 4123., 4125., 4127., 4131., 4133., or 4167. of the Revised Code, violation of the rules of the director of administrative services or the administrator, any other failure of good behavior, any other acts of misfeasance, malfeasance, or

nonfeasance in office, or conviction of a felony while employed in the civil service. An employee also forfeits the right to resume a position in the classified service upon transfer to a different agency.

Reinstatement to a position in the classified service shall be to a position substantially equal to that position in the classified service held previously, as certified by the department of administrative services. If the position the person previously held in the classified service has been placed in the unclassified service or is otherwise unavailable, the person shall be appointed to a position in the classified service within the bureau that the director of administrative services certifies is comparable in compensation to the position the person previously held in the classified service. Service in the position in the unclassified service shall be counted as service in the position in the classified service held by the person immediately prior to the person's appointment in the unclassified service. When a person is reinstated to a position in the classified service as provided in this division, the person is entitled to all rights, status, and benefits accruing to the position during the person's time of service in the position in the unclassified service.

(3) Reorganize the work of the bureau, its sections, departments, and offices to the extent necessary to achieve the most efficient performance of its functions and to that end may establish, change, or abolish positions and assign and reassign duties and responsibilities of every employee of the bureau. All persons employed by the commission in positions that, after November 3, 1989, are supervised and directed by the administrator under this section are transferred to the bureau in their respective classifications but subject to reassignment

and reclassification of position and compensation as the administrator determines to be in the interest of efficient administration. The civil service status of any person employed by the commission is not affected by this section. Personnel employed by the bureau or the commission who are subject to Chapter 4117. of the Revised Code shall retain all of their rights and benefits conferred pursuant to that chapter as it presently exists or is hereafter amended and nothing in this chapter or Chapter 4123. of the Revised Code shall be construed as eliminating or interfering with Chapter 4117. of the Revised Code or the rights and benefits conferred under that chapter to public employees or to any bargaining unit.

(4) Provide offices, equipment, supplies, and other facilities for the bureau.

(5) Prepare and submit to the board information the administrator considers pertinent or the board requires, together with the administrator's recommendations, in the form of administrative rules, for the advice and consent of the board, for classifications of occupations or industries, for premium rates and contributions, for the amount to be credited to the surplus fund, for rules and systems of rating, rate revisions, and merit rating. The administrator shall obtain, prepare, and submit any other information the board requires for the prompt and efficient discharge of its duties.

(6) Keep the accounts required by division (A) of section 4123.34 of the Revised Code and all other accounts and records necessary to the collection, administration, and distribution of the workers' compensation funds and shall obtain the statistical and other information required by section 4123.19 of the Revised Code.

(7) Exercise the investment powers vested in the administrator by section 4123.44 of the Revised Code in accordance with the investment policy approved by the board pursuant to section 4121.12 of the Revised Code and in consultation with the chief investment officer of the bureau of workers' compensation. The administrator shall not engage in any prohibited investment activity specified by the board pursuant to division (F)(9) of section 4121.12 of the Revised Code and shall not invest in any type of investment specified in divisions (B)(1) to (10) of section 4123.442 of the Revised Code. All business shall be transacted, all funds invested, all warrants for money drawn and payments made, and all cash and securities and other property held, in the name of the bureau, or in the name of its nominee, provided that nominees are authorized by the administrator solely for the purpose of facilitating the transfer of securities, and restricted to the administrator and designated employees.

(8) In accordance with Chapter 125. of the Revised Code, purchase supplies, materials, equipment, and services.

(9) Prepare and submit to the board an annual budget for internal operating purposes for the board's approval. The administrator also shall, separately from the budget the industrial commission submits, prepare and submit to the director of budget and management a budget for each biennium. The budgets submitted to the board and the director shall include estimates of the costs and necessary expenditures of the bureau in the discharge of any duty imposed by law.

(10) As promptly as possible in the course of efficient administration, decentralize and relocate such of the personnel and activities of the bureau as is appropriate to the end that

the receipt, investigation, determination, and payment of claims may be undertaken at or near the place of injury or the residence of the claimant and for that purpose establish regional offices, in such places as the administrator considers proper, capable of discharging as many of the functions of the bureau as is practicable so as to promote prompt and efficient administration in the processing of claims. All active and inactive lost-time claims files shall be held at the service office responsible for the claim. A claimant, at the claimant's request, shall be provided with information by telephone as to the location of the file pertaining to the claimant's claim. The administrator shall ensure that all service office employees report directly to the director for their service office.

(11) Provide a written binder on new coverage where the administrator considers it to be in the best interest of the risk. The administrator, or any other person authorized by the administrator, shall grant the binder upon submission of a request for coverage by the employer. A binder is effective for a period of thirty days from date of issuance and is nonrenewable. Payroll reports and premium charges shall coincide with the effective date of the binder.

(12) Set standards for the reasonable and maximum handling time of claims payment functions, ensure, by rules, the impartial and prompt treatment of all claims and employer risk accounts, and establish a secure, accurate method of time stamping all incoming mail and documents hand delivered to bureau employees.

(13) Ensure that all employees of the bureau follow the orders and rules of the commission as such orders and rules relate to the commission's overall adjudicatory policy-making

and management duties under this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code.

(14) Manage and operate a data processing system with a common data base for the use of both the bureau and the commission and, in consultation with the commission, using electronic data processing equipment, shall develop a claims tracking system that is sufficient to monitor the status of a claim at any time and that lists appeals that have been filed and orders or determinations that have been issued pursuant to section 4123.511 or 4123.512 of the Revised Code, including the dates of such filings and issuances.

(15) Establish and maintain a medical section within the bureau. The medical section shall do all of the following:

(a) Assist the administrator in establishing standard medical fees, approving medical procedures, and determining eligibility and reasonableness of the compensation payments for medical, hospital, and nursing services, and in establishing guidelines for payment policies which recognize usual, customary, and reasonable methods of payment for covered services;

(b) Provide a resource to respond to questions from claims examiners for employees of the bureau;

(c) Audit fee bill payments;

(d) Implement a program to utilize, to the maximum extent possible, electronic data processing equipment for storage of information to facilitate authorizations of compensation payments for medical, hospital, drug, and nursing services;

(e) Perform other duties assigned to it by the administrator.

(16) Appoint, as the administrator determines necessary, panels to review and advise the administrator on disputes arising over a determination that a health care service or supply provided to a claimant is not covered under this chapter or Chapter 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code or is medically unnecessary. If an individual health care provider is involved in the dispute, the panel shall consist of individuals licensed pursuant to the same section of the Revised Code as such health care provider.

(17) Pursuant to section 4123.65 of the Revised Code, approve applications for the final settlement of claims for compensation or benefits under this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code as the administrator determines appropriate, except in regard to the applications of self-insuring employers and their employees.

(18) Comply with section 3517.13 of the Revised Code, and except in regard to contracts entered into pursuant to the authority contained in section 4121.44 of the Revised Code, comply with the competitive bidding procedures set forth in the Revised Code for all contracts into which the administrator enters provided that those contracts fall within the type of contracts and dollar amounts specified in the Revised Code for competitive bidding and further provided that those contracts are not otherwise specifically exempt from the competitive bidding procedures contained in the Revised Code.

(19) Adopt, with the advice and consent of the board, rules for the operation of the bureau.

(20) Prepare and submit to the board information the administrator considers pertinent or the board requires, together with the administrator's recommendations, in the form

of administrative rules, for the advice and consent of the board, for the health partnership program and the qualified health plan system, as provided in sections 4121.44, 4121.441, and 4121.442 of the Revised Code.

(C) The administrator, with the advice and consent of the senate, shall appoint a chief operating officer who has a minimum of five years of experience in the field of workers' compensation insurance or in another similar insurance industry if the administrator does not possess such experience. The chief operating officer shall not commence the chief operating officer's duties until after the senate consents to the chief operating officer's appointment. The chief operating officer shall serve in the unclassified civil service of the state.

**Sec. 4121.125.** (A) The bureau of workers' compensation board of directors, based upon recommendations of the workers' compensation actuarial committee, may contract with one or more outside actuarial firms and other professional persons, as the board determines necessary, to assist the board in measuring the performance of Ohio's workers' compensation system and in comparing Ohio's workers' compensation system to other state and private workers' compensation systems. The board, actuarial firm or firms, and professional persons shall make such measurements and comparisons using accepted insurance industry standards, including, but not limited to, standards promulgated by the National Council on Compensation Insurance.

(B) The board may contract with one or more outside firms to conduct management and financial audits of the workers' compensation system, including audits of the reserve fund belonging to the state insurance fund, and to establish objective quality management principles and methods by which to

review the performance of the workers' compensation system.

(C) The board shall do all of the following:

(1) Contract to have prepared annually by or under the supervision of an actuary a report that meets the requirements specified under division (E) of this section and that consists of an actuarial valuation of the assets, liabilities, and funding requirements of the state insurance fund and all other funds specified in this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code;

(2) Require that the actuary or person supervised by an actuary referred to in division (C)(1) of this section complete the valuation in accordance with the actuarial standards of practice promulgated by the actuarial standards board of the American academy of actuaries;

(3) Submit the report referred to in division (C)(1) of this section to the standing committees of the house of representatives and the senate with primary responsibility for workers' compensation legislation on or before the first day of November following the year for which the valuation was made;

(4) Have an actuary or a person who provides actuarial services under the supervision of an actuary, at such time as the board determines, and at least once during the five-year period that commences on September 10, 2007, and once within each five-year period thereafter, conduct an actuarial investigation of the experience of employers, the mortality, service, and injury rate of employees, and the payment of temporary total disability, permanent partial disability, and permanent total disability under sections 4123.56~~ to~~<u>, 4123.57, 4123.58, 4133.12, 4133.13, and 4133.14</u> of the Revised Code to

update the actuarial assumptions used in the report required by division (C)(1) of this section;

(5) Submit the report required under division (F) of this section to the standing committees of the house of representatives and the senate with primary responsibility for workers' compensation legislation not later than the first day of November following the fifth year of the period that the report covers;

(6) Have prepared by or under the supervision of an actuary an actuarial analysis of any introduced legislation expected to have a measurable financial impact on the workers' compensation system;

(7) Submit the report required under division (G) of this section to the legislative service commission and the standing committees of the house of representatives and the senate with primary responsibility for workers' compensation legislation not later than sixty days after the date of introduction of the legislation.

(D) The administrator of workers' compensation and the industrial commission shall compile information and provide access to records of the bureau and the industrial commission to the board to the extent necessary for fulfillment of both of the following requirements:

(1) Conduct of the measurements and comparisons described in division (A) of this section;

(2) Conduct of the management and financial audits and establishment of the principles and methods described in division (B) of this section.

(E) The firm or person with whom the board contracts

pursuant to division (C)(1) of this section shall prepare a report of the valuation and submit the report to the board. The firm or person shall include all of the following information in the report that is required under division (C)(1) of this section:

(1) A summary of the compensation and benefit provisions evaluated;

(2) A description of the actuarial assumptions and actuarial cost method used in the valuation;

(3) A schedule showing the effect of any changes in the compensation and benefit provisions, actuarial assumptions, or cost methods since the previous annual actuarial valuation report was submitted to the board.

(F) The actuary or person whom the board designates to conduct an actuarial investigation under division (C)(4) of this section shall prepare a report of the actuarial investigation and shall submit the report to the board. The actuary or person shall prepare the report and make any recommended changes in actuarial assumptions in accordance with the actuarial standards of practice promulgated by the actuarial standards board of the American academy of actuaries. The actuary or person shall include all of the following information in the report:

(1) A summary of relevant decrement and economic assumption experience;

(2) Recommended changes in actuarial assumptions to be used in subsequent actuarial valuations required by division (C)(1) of this section;

(3) A measurement of the financial effect of the recommended changes in actuarial assumptions.

(G) The actuary or person whom the board designates to conduct the actuarial analysis under division (C)(6) of this section shall prepare a report of the actuarial analysis and shall submit that report to the board. The actuary or person shall complete the analysis in accordance with the actuarial standards of practice promulgated by the actuarial standards board of the American academy of actuaries. The actuary or person shall include all of the following information in the report:

(1) A summary of the statutory changes being evaluated;

(2) A description of or reference to the actuarial assumptions and actuarial cost method used in the report;

(3) A description of the participant group or groups included in the report;

(4) A statement of the financial impact of the legislation, including the resulting increase, if any, in employer premiums, in actuarial accrued liabilities, and, if an increase in actuarial accrued liabilities is predicted, the per cent of premium increase that would be required to amortize the increase in those liabilities as a level per cent of employer premiums over a period not to exceed thirty years.

(5) A statement of whether the employer premiums paid to the bureau of workers' compensation after the proposed change is enacted are expected to be sufficient to satisfy the funding objectives established by the board.

(H) The board may, at any time, request an actuary to make any studies or actuarial valuations to determine the adequacy of the premium rates established by the administrator in accordance with sections 4123.29 and 4123.34 of the Revised Code, and may

adjust those rates as recommended by the actuary.

(I) The board shall have an independent auditor, at least once every ten years, conduct a fiduciary performance audit of the investment program of the bureau of workers' compensation. That audit shall include an audit of the investment policies approved by the board and investment procedures of the bureau. The board shall submit a copy of that audit to the auditor of state.

(J) The administrator, with the advice and consent of the board, shall employ an internal auditor who shall report findings directly to the board, workers' compensation audit committee, and administrator, except that the internal auditor shall not report findings directly to the administrator when those findings involve malfeasance, misfeasance, or nonfeasance on the part of the administrator. The board and the workers' compensation audit committee may request and review internal audits conducted by the internal auditor.

(K) The administrator shall pay the expenses incurred by the board to effectively fulfill its duties and exercise its powers under this section as the administrator pays other operating expenses of the bureau.

**Sec. 4121.127.** (A) Except as provided in division (B) of this section, a fiduciary shall not cause the bureau of workers' compensation to engage in a transaction, if the fiduciary knows or should know that such transaction constitutes any of the following, whether directly or indirectly:

(1) The sale, exchange, or leasing of any property between the bureau and a party in interest;

(2) Lending of money or other extension of credit between

the bureau and a party in interest;

(3) Furnishing of goods, services, or facilities between the bureau and a party in interest;

(4) Transfer to, or use by or for the benefit of a party in interest, of any assets of the bureau;

(5) Acquisition, on behalf of the bureau, of any employer security or employer real property.

(B) Nothing in this section shall prohibit any transaction between the bureau and any fiduciary or party in interest if both of the following occur:

(1) All the terms and conditions of the transaction are comparable to the terms and conditions that might reasonably be expected in a similar transaction between similar parties who are not parties in interest.

(2) The transaction is consistent with fiduciary duties under this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code.

(C) A fiduciary shall not do any of the following:

(1) Deal with the assets of the bureau in the fiduciary's own interest or for the fiduciary's own account;

(2) In the fiduciary's individual capacity or in any other capacity, act in any transaction involving the bureau on behalf of a party, or represent a party, whose interests are adverse to the interests of the bureau or to the injured employees served by the bureau;

(3) Receive any consideration for the fiduciary's own personal account from any party dealing with the bureau in

connection with a transaction involving the assets of the bureau.

(D) In addition to any liability that a fiduciary may have under any other provision, a fiduciary, with respect to the bureau, shall be liable for a breach of fiduciary responsibility in any of the following circumstances:

(1) If the fiduciary knowingly participates in or knowingly undertakes to conceal an act or omission of another fiduciary, knowing such act or omission is a breach;

(2) If, by the fiduciary's failure to comply with this chapter or Chapter 4123., 4127., ~~or~~ 4131., or 4133. of the Revised Code, the fiduciary has enabled another fiduciary to commit a breach;

(3) If the fiduciary has knowledge of a breach by another fiduciary of that fiduciary's duties under this chapter and Chapters 4123., 4127., ~~and~~ 4131., and 4133. of the Revised Code, unless the fiduciary makes reasonable efforts under the circumstances to remedy the breach.

(E) Every fiduciary of the bureau shall be bonded or insured for an amount of not less than one million dollars for loss by reason of acts of fraud or dishonesty.

(F) As used in this section, "fiduciary" means a person who does any of the following:

(1) Exercises discretionary authority or control with respect to the management of the bureau or with respect to the management or disposition of its assets;

(2) Renders investment advice for a fee, directly or indirectly, with respect to money or property of the bureau;

(3) Has discretionary authority or responsibility in the administration of the bureau.

**Sec. 4121.129.** (A) There is hereby created the workers' compensation audit committee consisting of at least three members. One member shall be the member of the bureau of workers' compensation board of directors who is a certified public accountant. The board, by majority vote, shall appoint two additional members of the board to serve on the audit committee and may appoint additional members who are not board members, as the board determines necessary. Members of the audit committee serve at the pleasure of the board, and the board, by majority vote, may remove any member except the member of the committee who is the certified public accountant member of the board. The board, by majority vote, shall determine how often the audit committee shall meet and report to the board. If the audit committee meets on the same day as the board holds a meeting, no member shall be compensated for more than one meeting held on that day. The audit committee shall do all of the following:

(1) Recommend to the board an accounting firm to perform the annual audits required under division (B) of section 4123.47 of the Revised Code;

(2) Recommend an auditing firm for the board to use when conducting audits under section 4121.125 of the Revised Code;

(3) Review the results of each annual audit and management review and, if any problems exist, assess the appropriate course of action to correct those problems and develop an action plan to correct those problems;

(4) Monitor the implementation of any action plans created

pursuant to division (A)(3) of this section;

(5) Review all internal audit reports on a regular basis.

(B) There is hereby created the workers' compensation actuarial committee consisting of at least three members. One member shall be the member of the board who is an actuary. The board, by majority vote, shall appoint two additional members of the board to serve on the actuarial committee and may appoint additional members who are not board members, as the board determines necessary. Members of the actuarial committee serve at the pleasure of the board and the board, by majority vote, may remove any member except the member of the committee who is the actuary member of the board. The board, by majority vote, shall determine how often the actuarial committee shall meet and report to the board. If the actuarial committee meets on the same day as the board holds a meeting, no member shall be compensated for more than one meeting held on that day. The actuarial committee shall do both of the following:

(1) Recommend actuarial consultants for the board to use for the funds specified in this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code;

(2) Review and approve the various rate schedules prepared and presented by the actuarial division of the bureau or by actuarial consultants with whom the board enters into a contract.

(C)(1) There is hereby created the workers' compensation investment committee consisting of at least four members. Two of the members shall be the members of the board who serve as the investment and securities experts on the board. The board, by majority vote, shall appoint two additional members of the board

to serve on the investment committee and may appoint additional members who are not board members. Each additional member the board appoints shall have at least one of the following qualifications:

(a) Experience managing another state's pension funds or workers' compensation funds;

(b) Expertise that the board determines is needed to make investment decisions.

Members of the investment committee serve at the pleasure of the board and the board, by majority vote, may remove any member except the members of the committee who are the investment and securities expert members of the board. The board, by majority vote, shall determine how often the investment committee shall meet and report to the board. If the investment committee meets on the same day as the board holds a meeting, no member shall be compensated for more than one meeting held on that day.

(2) The investment committee shall do all of the following:

(a) Develop the investment policy for the administration of the investment program for the funds specified in this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code in accordance with the requirements specified in section 4123.442 of the Revised Code;

(b) Submit the investment policy developed pursuant to division (C)(2)(a) of this section to the board for approval;

(c) Monitor implementation by the administrator of workers' compensation and the bureau of workers' compensation chief investment officer of the investment policy approved by

the board;

(d) Recommend outside investment counsel with whom the board may contract to assist the investment committee in fulfilling its duties;

(e) Review the performance of the bureau of workers' compensation chief investment officer and any investment consultants retained by the administrator to assure that the investments of the assets of the funds specified in this chapter and Chapters 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code are made in accordance with the investment policy approved by the board and to assure compliance with the investment policy and effective management of the funds.

**Sec. 4121.13.** The administrator of workers' compensation shall:

(A) Investigate, ascertain, and declare and prescribe what hours of labor, safety devices, safeguards, or other means or methods of protection are best adapted to render the employees of every employment and place of employment and frequenters of every place of employment safe, and to protect their welfare as required by law or lawful orders, and establish and maintain museums of safety and hygiene in which shall be exhibited safety devices, safeguards, and other means and methods for the protection of life, health, safety, and welfare of employees;

(B) Ascertain and fix reasonable standards and prescribe, modify, and enforce reasonable orders for the adoption of safety devices, safeguards, and other means or methods of protection to be as nearly uniform as possible as may be necessary to carry out all laws and lawful orders relative to the protection of the life, health, safety, and welfare of employees in employments

and places of employment or frequenters of places of employment;

(C) Ascertain, fix, and order reasonable standards for the construction, repair, and maintenance of places of employment as shall render them safe;

(D) Investigate, ascertain, and determine reasonable classifications of persons, employments, and places of employment as are necessary to carry out the applicable sections of sections 4101.01 to 4101.16 and 4121.01 to 4121.29 of the Revised Code;

(E) Adopt reasonable and proper rules relative to the exercise of ~~his~~ the administrator's powers and authorities, and proper rules to govern ~~his~~ the administrator's proceedings and to regulate the mode and manner of all investigations and hearings, which rules shall not be effective until ten days after their publication; a copy of the rules shall be delivered at cost to every citizen making application therefor;

(F) Investigate all cases of fraud or other illegalities pertaining to the operation of the workers' compensation system and its several insurance funds and for that purpose, the administrator has every power of an inquisitorial nature granted to the industrial commission in this chapter and ~~Chapter~~ Chapters 4123. and 4133. of the Revised Code;

(G) Do all things convenient and necessary to accomplish the purposes directed in sections 4101.01 to 4101.16 and 4121.01 to 4121.28 of the Revised Code;

(H) Nothing in this section shall be construed to supersede section 4105.011 of the Revised Code in particular, or Chapter 4105. of the Revised Code in general.

**Sec. 4121.30.** (A) All rules governing the operating

procedure of the bureau of workers' compensation and the industrial commission shall be adopted in accordance with Chapter 119. of the Revised Code, except that determinations of the bureau, district hearing officers, staff hearing officers, the occupational pneumoconiosis board, and the commission, with respect to an individual employee's claim to participate in the state insurance fund are governed only by ~~Chapter~~ Chapters 4123. and 4133. of the Revised Code.

The administrator of workers' compensation and commission shall proceed jointly, in accordance with Chapter 119. of the Revised Code, including a joint hearing, to adopt joint rules governing the operating procedures of the bureau and commission.

(B) Upon submission to the bureau or the commission of a petition containing not less than fifteen hundred signatures of adult residents of the state, any individual may propose a rule for adoption, amendment, or rescission by the bureau or the commission. If, upon investigation, the bureau or commission is satisfied that the signatures upon the petition are valid, it shall proceed, in accordance with Chapter 119. of the Revised Code, to consider adoption, amendment, or rescission of the rule.

(C) The administrator shall make available electronically all rules adopted by the bureau and the commission and shall make available in a timely manner all rules adopted by the bureau and the commission that are currently in force.

(D) The rule-making authority granted to the administrator under this section does not limit the commission's rule-making authority relative to its overall adjudicatory policy-making and management duties under this chapter and Chapters 4123., 4127., ~~and~~ 4131., and 4133. of the Revised Code. The administrator

shall not disregard any rule adopted by the commission, provided that the rule is within the commission's rule-making authority.

**Sec. 4121.31.** (A) The administrator of workers' compensation and the industrial commission jointly shall adopt rules covering the following general topics with respect to this chapter and ~~Chapter~~ Chapters 4123. and 4133. of the Revised Code:

(1) Rules that set forth any general policy and the principal operating procedures of the bureau of workers' compensation or commission, including but not limited to:

(a) Assignment to various operational units of any duties placed upon the administrator or the commission by statute;

(b) Procedures for decision-making;

(c) Procedures governing the appearances of a claimant, employer, or their representatives before the agency in a hearing;

(d) Procedures that inform claimants, on request, of the status of a claim and any actions necessary to maintain the claim;

(e) Time goals for activities of the bureau or commission;

(f) Designation of the person or persons authorized to issue directives with directives numbered and distributed from a central distribution point to persons on a list maintained for that purpose.

(2) A rule barring any employee of the bureau or commission from having a workers' compensation claims file in the employee's possession unless the file is necessary to the performance of the employee's duties.

(3) All claims, whether of a state fund or self-insuring employer, be processed in an orderly, uniform, and timely fashion.

(4) Rules governing the submission and sending of applications, notices, evidence, and other documents by electronic means. The rules shall provide that where this chapter or Chapter 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code requires that a document be in writing or requires a signature, the administrator and the commission, to the extent of their respective jurisdictions, may approve of and provide for the electronic submission and sending of those documents, and the use of an electronic signature on those documents.

(B) As used in this section:

(1) "Electronic" includes electrical, digital, magnetic, optical, electromagnetic, facsimile, or any other form of technology that entails capabilities similar to these technologies.

(2) "Electronic record" means a record generated, communicated, received, or stored by electronic means for use in an information system or for transmission from one information system to another.

(3) "Electronic signature" means a signature in electronic form attached to or logically associated with an electronic record.

**Sec. 4121.32.** (A) The rules covering operating procedure and criteria for decision-making that the administrator of workers' compensation and the industrial commission are required to adopt pursuant to section 4121.31 of the Revised Code shall be supplemented with operating manuals setting forth the

procedural steps in detail for performing each of the assigned tasks of each section of the bureau of workers' compensation and commission. The administrator and commission jointly shall adopt such manuals. No employee may deviate from manual procedures without authorization of the section chief.

(B) Manuals shall set forth the procedure for the assignment and transfer of claims within sections and be designed to provide performance objectives and may require employees to record sufficient data to reasonably measure the efficiency of functions in all sections. The bureau shall perform periodic cost-effectiveness analyses that shall be made available to the general assembly, the governor, and to the public during normal working hours.

(C) The bureau and commission jointly shall develop, adopt, and use a policy manual setting forth the guidelines and bases for decision-making for any decision which is the responsibility of the bureau, district hearing officers, staff hearing officers, or the commission. Guidelines shall be set forth in the policy manual by the bureau and commission to the extent of their respective jurisdictions for deciding at least the following specific matters:

(1) Reasonable ambulance services;

(2) Relationship of drugs to injury;

(3) Awarding lump-sum advances for creditors;

(4) Awarding lump-sum advances for attorney's fees;

(5) Placing a claimant into rehabilitation;

(6) Transferring costs of a claim from employer costs to the statutory surplus fund pursuant to section 4123.343 of the

Revised Code;

(7) Utilization of physician specialist reports;

(8) Determining the percentage of permanent partial disability, temporary partial disability, temporary total disability, violations of specific safety requirements, an award under division (B) of section 4123.57 of the Revised Code, and permanent total disability.

(D) The bureau shall establish, adopt, and implement policy guidelines and bases for decisions involving reimbursement issues including, but not limited to, the adjustment of invoices, the reduction of payments for future services when an internal audit concludes that a health care provider was overpaid or improperly paid for past services, reimbursement fees, or other adjustments to payments. These policy guidelines and bases for decisions, and any changes to the guidelines and bases, shall be set forth in a reimbursement manual and provider bulletins.

Neither the policy guidelines nor the bases set forth in the reimbursement manual or provider bulletins referred to in this division is a rule as defined in section 119.01 of the Revised Code.

(E) With respect to any determination of disability under Chapter 4123. or 4133. of the Revised Code, when the physician makes a determination based upon statements or information furnished by the claimant or upon subjective evidence, the physician shall clearly indicate this fact in the physician's report.

(F) The administrator shall publish the manuals and make copies of all manuals available to interested parties at cost.

**Sec. 4121.34.** (A) District hearing officers shall hear the matters listed in division (B) of this section. District hearing officers are in the classified civil service of the state, are full-time employees of the industrial commission, and shall be persons admitted to the practice of law in this state. District hearing officers shall not engage in any other activity that interferes with their full-time employment by the commission during normal working hours.

(B) ~~District~~ (1) Except as provided in division (B)(2) of this section, district hearing officers shall have original jurisdiction on all of the following matters:

~~(1)~~ (a) Determinations under section 4123.57 of the Revised Code;

~~(2)~~ (b) All appeals from a decision of the administrator of workers' compensation under division (B) of section 4123.511 and section 4133.06 of the Revised Code;

~~(3)~~ (c) All other contested claims matters under this chapter and Chapters 4123., 4127., ~~and~~ 4131., and 4133. of the Revised Code, except those matters over which staff hearing officers have original jurisdiction.

(2) Division (B)(1) of this section does not apply to a claim that has been referred to the occupational pneumoconiosis board under section 4133.08 of the Revised Code.

(C) The administrator of workers' compensation shall make available to each district hearing officer the facilities and assistance of bureau employees and furnish all information necessary to the performance of the district hearing officer's duties.

**Sec. 4121.36.** (A) The industrial commission shall adopt

rules as to the conduct of all hearings before the commission and its staff and district hearing officers and the rendering of a decision and shall focus such rules on managing, directing, and otherwise ensuring a fair, equitable, and uniform hearing process. These rules shall provide for at least the following steps and procedures:

(1) Adequate notice to all parties and their representatives to ensure that no hearing is conducted unless all parties have the opportunity to be present and to present evidence and arguments in support of their positions or in rebuttal to the evidence or arguments of other parties;

(2) A public hearing;

(3) Written decisions;

(4) Impartial assignment of staff and district hearing officers and assignment of appeals from a decision of the administrator of workers' compensation to a district hearing officer located at the commission service office that is the closest in geographic proximity to the claimant's residence;

(5) Publication of a docket;

(6) The securing of the attendance or testimony of witnesses;

(7) Prehearing rules, including rules relative to discovery, the taking of depositions, and exchange of information relevant to a claim prior to the conduct of a hearing;

(8) The issuance of orders by the district or staff hearing officer who renders the decision.

(B) Every decision by a staff or district hearing officer

or the commission shall be in writing and contain all of the following elements:

(1) A concise statement of the order or award;

(2) A notation as to notice provided and as to appearance of parties;

(3) Signatures of each commissioner or appropriate hearing officer on the original copy of the decision only, verifying the commissioner's or hearing officer's vote;

(4) Description of the part of the body and nature of the disability recognized in the claim.

(C) The commission shall adopt rules that require the regular rotation of district hearing officers with respect to the types of matters under consideration and that ensure that no district or staff hearing officer or the commission hears a claim unless all interested and affected parties have the opportunity to be present and to present evidence and arguments in support of their positions or in rebuttal to the evidence or arguments of other parties.

(D) All matters which, at the request of one of the parties or on the initiative of the administrator and any commissioner, are to be expedited, shall require at least forty-eight hours' notice, a public hearing, and a statement in any order of the circumstances that justified such expeditious hearings.

(E) All meetings of the commission and district and staff hearing officers shall be public with adequate notice, including if necessary, to the claimant, the employer, their representatives, and the administrator. Confidentiality of medical evidence presented at a hearing does not constitute a

sufficient ground to relieve the requirement of a public hearing, but the presentation of privileged or confidential evidence shall not create any greater right of public inspection of evidence than presently exists.

(F) The commission shall compile all of its original memorandums, orders, and decisions in a journal and make the journal available to the public with sufficient indexing to allow orderly review of documents. The journal shall indicate the vote of each commissioner.

(G)(1) All original orders, rules, and memoranda, and decisions of the commission shall contain the signatures of two of the three commissioners and state whether adopted at a meeting of the commission or by circulation to individual commissioners. Any facsimile or secretarial signature, initials of commissioners, and delegated employees, and any printed record of the "yes" and "no" vote of a commission member or of a hearing officer on such original is invalid.

(2) Written copies of final decisions of district or staff hearing officers or the commission that are mailed to the administrator, employee, employer, and their respective representatives need not contain the signatures of the hearing officer or commission members if the hearing officer or commission members have complied with divisions (B)(3) and (G)(1) of this section.

(H) The commission shall do both of the following:

(1) Appoint an individual as a hearing officer trainer who is in the unclassified civil service of the state and who serves at the pleasure of the commission. The trainer shall be an attorney registered to practice law in this state and have

experience in training or education, and the ability to furnish the necessary training for district and staff hearing officers.

The hearing officer trainer shall develop and periodically update a training manual and such other training materials and courses as will adequately prepare district and staff hearing officers for their duties under this chapter and Chapter 4123. of the Revised Code. All district and staff hearing officers shall undergo the training courses developed by the hearing officer trainer, the cost of which the commission shall pay. The commission shall make the hearing officer manual and all revisions thereto available to the public at cost.

The commission shall have the final right of approval over all training manuals, courses, and other materials the hearing officer trainer develops and updates.

(2) Appoint a hearing administrator, who shall be in the classified civil service of the state, for each bureau service office, and sufficient support personnel for each hearing administrator, which support personnel shall be under the direct supervision of the hearing administrator. The hearing administrator shall do all of the following:

(a) Assist the commission in ensuring that district hearing officers comply with the time limitations for the holding of hearings and issuance of orders under section 4123.511 of the Revised Code. For that purpose, each hearing administrator shall prepare a monthly report identifying the status of all claims in its office and identifying specifically the claims which have not been decided within the time limits set forth in section 4123.511 of the Revised Code. The commission shall submit an annual report of all such reports to the standing committees of the house of representatives and of

the state to which matters concerning workers' compensation are normally referred.

(b) Provide information to requesting parties or their representatives on the status of their claim;

(c) Issue compliance letters, upon a finding of good cause and without a formal hearing in all of the following areas:

(i) Divisions (B) and (C) of section 4123.651 of the Revised Code;

(ii) Requests for the taking of depositions of bureau and commission physicians;

(iii) The issuance of subpoenas;

(iv) The granting or denying of requests for continuances;

(v) Matters involving section 4123.522 of the Revised Code;

(vi) Requests for conducting telephone pre-hearing conferences;

(vii) Any other matter that will cause a free exchange of information prior to the formal hearing.

(d) Ensure that claim files are reviewed by the district hearing officer prior to the hearing to ensure that there is sufficient information to proceed to a hearing;

(e) Ensure that for occupational disease claims under section 4123.68 of the Revised Code and for occupational pneumoconiosis claims under Chapter 4133. of the Revised Code that require a medical examination the medical examination is conducted prior to the hearing;

(f) Take the necessary steps to prepare a claim to proceed

to a hearing where the parties agree and advise the hearing administrator that the claim is not ready for a hearing.

(I) The commission shall permit any person direct access to information contained in electronic data processing equipment regarding the status of a claim in the hearing process. The information shall indicate the number of days that the claim has been in process, the number of days the claim has been in its current location, and the number of days in the current point of the process within that location.

(J)(1) The industrial commission may establish an alternative dispute resolution process for workers' compensation claims that are within the commission's jurisdiction under Chapters 4121., 4123., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code when the commission determines that such a process is necessary. Notwithstanding sections 4121.34 and 4121.35 of the Revised Code, the commission may enter into personal service contracts with individuals who are qualified because of their education and experience to act as facilitators in the commission's alternative dispute resolution process.

(2) The parties' use of the alternative dispute resolution process is voluntary, and requires the agreement of all necessary parties. The use of the alternative dispute resolution process does not alter the rights or obligations of the parties, nor does it delay the timelines set forth in section 4123.511 of the Revised Code.

(3) The commission shall prepare monthly reports and submit those reports to the governor, the president of the senate, and the speaker of the house of representatives describing all of the following:

(a) The names of each facilitator employed under a personal service contract;

(b) The hourly amount of money and the total amount of money paid to each facilitator;

(c) The number of disputed issues resolved during that month by each facilitator;

(d) The number of decisions of each facilitator that were appealed by a party;

(e) A certification by the commission that the alternative dispute resolution process did not delay any hearing timelines as set forth in section 4123.511 of the Revised Code for any disputed issue.

(4) The commission may adopt rules in accordance with Chapter 119. of the Revised Code for the administration of any alternative dispute resolution process that the commission establishes.

**Sec. 4121.41.** (A) The administrator of workers' compensation shall operate a program designed to inform employees and employers of their rights and responsibilities under ~~Chapter~~ Chapters 4123. and 4133. of the Revised Code and as part of that program prepare and distribute pamphlets, which clearly and simply explain at least all of the following:

(1) The rights and responsibilities of claimants and employers;

(2) The procedures for processing claims;

(3) The procedure for fulfilling employer responsibility;

(4) All applicable statutes of limitation;

(5) The availability of services and benefits;

(6) The claimant's right to representation in the processing of a claim or to elect no representation.

The administrator shall ensure that the provisions of this section are faithfully and speedily implemented.

(B) The bureau of workers' compensation shall maintain an ongoing program to identify employers subject to Chapter 4123. of the Revised Code and to audit employers to ensure an optimum level of premium payment. The bureau shall coordinate such efforts with other governmental agencies which have information as to employers who are subject to Chapter 4123. of the Revised Code.

(C) The administrator shall handle complaints through the service offices, the claims section, and the ombudsperson program. The administrator shall provide toll free telephone lines for employers and claimants in order to expedite the handling of complaints. The bureau shall monitor complaint traffic to ensure an adequacy of telephone service to bureau offices and shall compile statistics on complaint subjects. Based upon those compilations, the bureau shall revise procedures and rules to correct major problem areas and submit data and recommendations annually to the appropriate committees of the general assembly.

**Sec. 4121.44.** (A) The administrator of workers' compensation shall oversee the implementation of the Ohio workers' compensation qualified health plan system as established under section 4121.442 of the Revised Code.

(B) The administrator shall direct the implementation of the health partnership program administered by the bureau as set

forth in section 4121.441 of the Revised Code. To implement the health partnership program and to ensure the efficiency and effectiveness of the public services provided through the program, the bureau:

(1) Shall certify one or more external vendors, which shall be known as "managed care organizations," to provide medical management and cost containment services in the health partnership program for a period of two years beginning on the date of certification, consistent with the standards established under this section;

(2) May recertify managed care organizations for additional periods of two years; and

(3) May integrate the certified managed care organizations with bureau staff and existing bureau services for purposes of operation and training to allow the bureau to assume operation of the health partnership program at the conclusion of the certification periods set forth in division (B)(1) or (2) of this section;

(4) May enter into a contract with any managed care organization that is certified by the bureau, pursuant to division (B)(1) or (2) of this section, to provide medical management and cost containment services in the health partnership program.

(C) A contract entered into pursuant to division (B)(4) of this section shall include both of the following:

(1) Incentives that may be awarded by the administrator, at the administrator's discretion, based on compliance and performance of the managed care organization;

(2) Penalties that may be imposed by the administrator, at

the administrator's discretion, based on the failure of the managed care organization to reasonably comply with or perform terms of the contract, which may include termination of the contract.

(D) Notwithstanding section 119.061 of the Revised Code, a contract entered into pursuant to division (B)(4) of this section may include provisions limiting, restricting, or regulating any marketing or advertising by the managed care organization, or by any individual or entity that is affiliated with or acting on behalf of the managed care organization, under the health partnership program.

(E) No managed care organization shall receive compensation under the health partnership program unless the managed care organization has entered into a contract with the bureau pursuant to division (B)(4) of this section.

(F) Any managed care organization selected shall demonstrate all of the following:

(1) Arrangements and reimbursement agreements with a substantial number of the medical, professional and pharmacy providers currently being utilized by claimants.

(2) Ability to accept a common format of medical bill data in an electronic fashion from any provider who wishes to submit medical bill data in that form.

(3) A computer system able to handle the volume of medical bills and willingness to customize that system to the bureau's needs and to be operated by the managed care organization's staff, bureau staff, or some combination of both staffs.

(4) A prescription drug system where pharmacies on a statewide basis have access to the eligibility and pricing, at a

discounted rate, of all prescription drugs.

(5) A tracking system to record all telephone calls from claimants and providers regarding the status of submitted medical bills so as to be able to track each inquiry.

(6) Data processing capacity to absorb all of the bureau's medical bill processing or at least that part of the processing which the bureau arranges to delegate.

(7) Capacity to store, retrieve, array, simulate, and model in a relational mode all of the detailed medical bill data so that analysis can be performed in a variety of ways and so that the bureau and its governing authority can make informed decisions.

(8) Wide variety of software programs which translate medical terminology into standard codes, and which reveal if a provider is manipulating the procedures codes, commonly called "unbundling."

(9) Necessary professional staff to conduct, at a minimum, authorizations for treatment, medical necessity, utilization review, concurrent review, post-utilization review, and have the attendant computer system which supports such activity and measures the outcomes and the savings.

(10) Management experience and flexibility to be able to react quickly to the needs of the bureau in the case of required change in federal or state requirements.

(G)(1) The administrator may decertify a managed care organization if the managed care organization does any of the following:

(a) Fails to maintain any of the requirements set forth in

division (F) of this section;

(b) Fails to reasonably comply with or to perform in accordance with the terms of a contract entered into under division (B)(4) of this section;

(c) Violates a rule adopted under section 4121.441 of the Revised Code.

(2) The administrator shall provide each managed care organization that is being decertified pursuant to division (G)(1) of this section with written notice of the pending decertification and an opportunity for a hearing pursuant to rules adopted by the administrator.

(H)(1) Information contained in a managed care organization's application for certification in the health partnership program, and other information furnished to the bureau by a managed care organization for purposes of obtaining certification or to comply with performance and financial auditing requirements established by the administrator, is for the exclusive use and information of the bureau in the discharge of its official duties, and shall not be open to the public or be used in any court in any proceeding pending therein, unless the bureau is a party to the action or proceeding, but the information may be tabulated and published by the bureau in statistical form for the use and information of other state departments and the public. No employee of the bureau, except as otherwise authorized by the administrator, shall divulge any information secured by the employee while in the employ of the bureau in respect to a managed care organization's application for certification or in respect to the business or other trade processes of any managed care organization to any person other than the administrator or to the employee's superior.

(2) Notwithstanding the restrictions imposed by division (H)(1) of this section, the governor, members of select or standing committees of the senate or house of representatives, the auditor of state, the attorney general, or their designees, pursuant to the authority granted in this chapter and Chapter 4123. of the Revised Code, may examine any managed care organization application or other information furnished to the bureau by the managed care organization. None of those individuals shall divulge any information secured in the exercise of that authority in respect to a managed care organization's application for certification or in respect to the business or other trade processes of any managed care organization to any person.

(I) On and after January 1, 2001, a managed care organization shall not be an insurance company holding a certificate of authority issued pursuant to Title XXXIX of the Revised Code or a health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code.

(J) The administrator may limit freedom of choice of health care provider or supplier by requiring, beginning with the period set forth in division (B)(1) or (2) of this section, that claimants shall pay an appropriate out-of-plan copayment for selecting a medical provider not within the health partnership program as provided for in this section.

(K) The administrator, six months prior to the expiration of the bureau's certification or recertification of the managed care organizations as set forth in division (B)(1) or (2) of this section, may certify and provide evidence to the governor, the speaker of the house of representatives, and the president

of the senate that the existing bureau staff is able to match or exceed the performance and outcomes of the managed care organizations and that the bureau should be permitted to internally administer the health partnership program upon the expiration of the certification or recertification as set forth in division (B)(1) or (2) of this section.

(L) The administrator shall establish and operate a bureau of workers' compensation health care data program. The administrator shall develop reporting requirements from all employees, employers, medical providers, managed care organizations, and plans that participate in the workers' compensation system. The administrator shall do all of the following:

(1) Utilize the collected data to measure and perform comparison analyses of costs, quality, appropriateness of medical care, and effectiveness of medical care delivered by all components of the workers' compensation system.

(2) Compile data to support activities of the selected managed care organizations and to measure the outcomes and savings of the health partnership program.

(3) Publish and report compiled data on the measures of outcomes and savings of the health partnership program and submit the report to the president of the senate, the speaker of the house of representatives, and the governor with the annual report prepared under division (F)(3) of section 4121.12 of the Revised Code. The administrator shall protect the confidentiality of all proprietary pricing data.

(M) Any rehabilitation facility the bureau operates is eligible for inclusion in the Ohio workers' compensation

qualified health plan system or the health partnership program under the same terms as other providers within health care plans or the program.

(N) In areas outside the state or within the state where no qualified health plan or an inadequate number of providers within the health partnership program exist, the administrator shall permit employees to use a nonplan or nonprogram health care provider and shall pay the provider for the services or supplies provided to or on behalf of an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code on a fee schedule the administrator adopts.

(O) No health care provider, whether certified or not, shall charge, assess, or otherwise attempt to collect from an employee, employer, a managed care organization, or the bureau any amount for covered services or supplies that is in excess of the allowed amount paid by a managed care organization, the bureau, or a qualified health plan.

(P) The administrator shall permit any employer or group of employers who agree to abide by the rules adopted under this section and sections 4121.441 and 4121.442 of the Revised Code to provide services or supplies to or on behalf of an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code through qualified health plans of the Ohio workers' compensation qualified health plan system pursuant to section 4121.442 of the Revised Code or through the health partnership program pursuant to section 4121.441 of the Revised Code. No amount paid under the qualified health plan system pursuant to section 4121.442 of the Revised Code by an employer who is a

state fund employer shall be charged to the employer's experience or otherwise be used in merit-rating or determining the risk of that employer for the purpose of the payment of premiums under this chapter, and if the employer is a self-insuring employer, the employer shall not include that amount in the paid compensation the employer reports under section 4123.35 of the Revised Code.

**Sec. 4121.441.** (A) The administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall adopt rules under Chapter 119. of the Revised Code for the health care partnership program administered by the bureau of workers' compensation to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code, and to regulate contracts with managed care organizations pursuant to this chapter.

(1) The rules shall include, but are not limited to, the following:

(a) Procedures for the resolution of medical disputes between an employer and an employee, an employee and a provider, or an employer and a provider, prior to an appeal under section 4123.511 of the Revised Code. Rules the administrator adopts pursuant to division (A)(1)(a) of this section may specify that the resolution procedures shall not be used to resolve disputes concerning medical services rendered that have been approved through standard treatment guidelines, pathways, or presumptive authorization guidelines.

(b) Prohibitions against discrimination against any

category of health care providers;

(c) Procedures for reporting injuries to employers and the bureau by providers;

(d) Appropriate financial incentives to reduce service cost and insure proper system utilization without sacrificing the quality of service;

(e) Adequate methods of peer review, utilization review, quality assurance, and dispute resolution to prevent, and provide sanctions for, inappropriate, excessive or not medically necessary treatment;

(f) A timely and accurate method of collection of necessary information regarding medical and health care service and supply costs, quality, and utilization to enable the administrator to determine the effectiveness of the program;

(g) Provisions for necessary emergency medical treatment for an injury or occupational disease provided by a health care provider who is not part of the program;

(h) Discounted pricing for all in-patient and out-patient medical services, all professional services, and all pharmaceutical services;

(i) Provisions for provider referrals, pre-admission and post-admission approvals, second surgical opinions, and other cost management techniques;

(j) Antifraud mechanisms;

(k) Standards and criteria for the bureau to utilize in certifying or recertifying a health care provider or a managed care organization for participation in the health partnership program;

(l) Standards for the bureau to utilize in penalizing or decertifying a health care provider from participation in the health partnership program.

(2) Notwithstanding section 119.061 of the Revised Code, the rules may include provisions limiting, restricting, or regulating any marketing or advertising by a managed care organization, or by any individual or entity that is affiliated with or acting on behalf of the managed care organization, under the health partnership program.

(B) The administrator shall implement the health partnership program according to the rules the administrator adopts under this section for the provision and payment of medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., ~~or~~ 4131., or 4133. of the Revised Code."

**Sec. 4121.442.** (A) The administrator of workers' compensation shall develop standards for qualification of health care plans of the Ohio workers' compensation qualified health plan system to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., ~~or~~ 4131., or 4133. of the Revised Code. In adopting the standards, the administrator shall use nationally recognized accreditation standards. The standards the administrator adopts must provide that a qualified plan provides for all of the following:

(1) Criteria for selective contracting of health care providers;

(2) Adequate plan structure and financial stability;

(3) Procedures for the resolution of medical disputes between an employee and an employer, an employee and a provider, or an employer and a provider, prior to an appeal under section 4123.511 of the Revised Code;

(4) Authorize employees who are dissatisfied with the health care services of the employer's qualified plan and do not wish to obtain treatment under the provisions of this section, to request the administrator for referral to a health care provider in the bureau's health care partnership program. The administrator must refer all requesting employees into the health care partnership program.

(5) Does not discriminate against any category of health care provider;

(6) Provide a procedure for reporting injuries to the bureau of workers' compensation and to employers by providers within the qualified plan;

(7) Provide appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service;

(8) Provide adequate methods of peer review, utilization review, quality assurance, and dispute resolution to prevent and provide sanctions for inappropriate, excessive, or not medically necessary treatment;

(9) Provide a timely and accurate method of reporting to the administrator necessary information regarding medical and health care service and supply costs, quality, and utilization to enable the administrator to determine the effectiveness of the plan;

(10) Authorize necessary emergency medical treatment for an injury or occupational disease provided by a health care provider who is not a part of the qualified health care plan;

(11) Provide an employee the right to change health care providers within the qualified health care plan;

(12) Provide for standardized data and reporting requirements;

(13) Authorize necessary medical treatment for employees who work in Ohio but reside in another state.

(B) Health care plans that meet the approved qualified health plan standards shall be considered qualified plans and are eligible to become part of the Ohio workers' compensation qualified health plan system. Any employer or group of employers may provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code through a qualified health plan.

**Sec. 4121.444.** (A) No person, health care provider, managed care organization, or owner of a health care provider or managed care organization shall obtain or attempt to obtain payments by deception under Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code to which the person, health care provider, managed care organization, or owner is not entitled under rules of the bureau of workers' compensation adopted pursuant to sections 4121.441 and 4121.442 of the Revised Code.

(B) Any person, health care provider, managed care organization, or owner that violates division (A) of this

section is liable, in addition to any other penalties provided by law, for all of the following penalties:

(1) Payment of interest on the amount of the excess payments at the maximum interest rate allowable for real estate mortgages under section 1343.01 of the Revised Code. The interest shall be calculated from the date the payment was made to the person, owner, health care provider, or managed care organization through the date upon which repayment is made to the bureau or the self-insuring employer.

(2) Payment of an amount equal to three times the amount of any excess payments;

(3) Payment of a sum of not less than five thousand dollars and not more than ten thousand dollars for each act of deception;

(4) All reasonable and necessary expenses that the court determines have been incurred by the bureau or the self-insuring employer in the enforcement of this section.

All moneys collected by the bureau pursuant to this section shall be deposited into the state insurance fund created in section 4123.30 of the Revised Code. All moneys collected by a self-insuring employer pursuant to this section shall be awarded to the self-insuring employer.

(C)(1) In addition to the monetary penalties provided in division (B) of this section and except as provided in division (C)(3) of this section, the administrator may terminate any agreement between the bureau and a person or a health care provider or managed care organization or its owner and cease reimbursement to that person, provider, organization, or owner for services rendered if any of the following apply:

(a) The person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization is convicted of or pleads guilty to a violation of sections 2913.48 or 2923.31 to 2923.36 of the Revised Code or any other criminal offense related to the delivery of or billing for health care benefits.

(b) There exists an entry of judgment against the person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization and proof of the specific intent of the person, health care provider, managed care organization, or owner to defraud, in a civil action brought pursuant to this section.

(c) There exists an entry of judgment against the person, health care provider, managed care organization, or its owner, or an officer, authorized agent, associate, manager, or employee of a person, provider, or organization in a civil action brought pursuant to sections 2923.31 to 2923.36 of the Revised Code.

(2) No person, health care provider, or managed care organization that has had its agreement with and reimbursement from the bureau terminated by the administrator pursuant to division (C)(1) of this section, or an owner, officer, authorized agent, associate, manager, or employee of that person, health care provider, or managed care organization shall do either of the following:

(a) Directly provide services to any other bureau provider or have an ownership interest in a provider of services that furnishes services to any other bureau provider;

(b) Arrange for, render, or order services for claimants during the period that the agreement of the person, health care provider, managed care organization, or its owner is terminated as described in division (C)(1) of this section;

(3) The administrator shall not terminate the agreement or reimbursement if the person, health care provider, managed care organization, or owner demonstrates that the person, provider, organization, or owner did not directly or indirectly sanction the action of the authorized agent, associate, manager, or employee that resulted in the conviction, plea of guilty, or entry of judgment as described in division (C)(1) of this section.

(4) Nothing in division (C) of this section prohibits an owner, officer, authorized agent, associate, manager, or employee of a person, health care provider, or managed care organization from entering into an agreement with the bureau if the provider, organization, owner, officer, authorized agent, associate, manager, or employee demonstrates absence of knowledge of the action of the person, health care provider, or managed care organization with which that individual or organization was formerly associated that resulted in a conviction, plea of guilty, or entry of judgment as described in division (C)(1) of this section.

(D) The attorney general may bring an action on behalf of the state and a self-insuring employer may bring an action on its own behalf to enforce this section in any court of competent jurisdiction. The attorney general may settle or compromise any action brought under this section with the approval of the administrator.

Notwithstanding any other law providing a shorter period

of limitations, the attorney general or a self-insuring employer may bring an action to enforce this section at any time within six years after the conduct in violation of this section terminates.

(E) The availability of remedies under this section and sections 2913.48 and 2923.31 to 2923.36 of the Revised Code for recovering benefits paid on behalf of claimants for medical assistance does not limit the authority of the bureau or a self-insuring employer to recover excess payments made to an owner, health care provider, managed care organization, or person under state and federal law.

(F) As used in this section:

(1) "Deception" means acting with actual knowledge in order to deceive another or cause another to be deceived by means of any of the following:

(a) A false or misleading representation;

(b) The withholding of information;

(c) The preventing of another from acquiring information;

(d) Any other conduct, act, or omission that creates, confirms, or perpetuates a false impression as to a fact, the law, the value of something, or a person's state of mind.

(2) "Owner" means any person having at least a five per cent ownership interest in a health care provider or managed care organization.

**Sec. 4121.45.** (A) There is hereby created a workers' compensation ombudsperson system to assist claimants and employers in matters dealing with the bureau of workers' compensation and the industrial commission. The industrial

commission nominating council shall appoint a chief ombudsperson. The chief ombudsperson, with the advice and consent of the nominating council, may appoint such assistant ombudspersons as the nominating council deems necessary. The position of chief ombudsperson is for a term of six years. A person appointed to the position of chief ombudsperson shall serve at the pleasure of the nominating council. The chief ombudsperson may not be transferred, demoted, or suspended during the person's tenure and may be removed by the nominating council only upon a vote of not fewer than nine members of the nominating council. The chief ombudsperson shall devote the chief ombudsperson's full time and attention to the duties of the ombudsperson's office. The administrator of workers' compensation shall furnish the chief ombudsperson with the office space, supplies, and clerical assistance that will enable the chief ombudsperson and the ombudsperson system staff to perform their duties effectively. The ombudsperson program shall be funded out of the budget of the bureau and the chief ombudsperson and the ombudsperson system staff shall be carried on the bureau payroll. The chief ombudsperson and the ombudsperson system shall be under the direction of the nominating council. The administrator and all employees of the bureau and the commission shall give the ~~the~~ ombudsperson system staff full and prompt cooperation in all matters relating to the duties of the chief ombudsperson.

(B) The ombudsperson system staff shall:

(1) Answer inquiries or investigate complaints made by employers or claimants under this chapter and ~~Chapter~~ Chapters 4123. and 4133. of the Revised Code as they relate to the processing of a claim for workers' compensation benefits;

(2) Provide claimants and employers with information regarding problems which arise out of the functions of the bureau, commission hearing officers, and the commission and the procedures employed in the processing of claims;

(3) Answer inquiries or investigate complaints of an employer as they relate to reserves established and premiums charged in connection with the employer's account;

(4) Comply with Chapter 102. and sections 2921.42 and 2921.43 of the Revised Code and the nominating council's human resource and ethics policies;

(5) Not express any opinions as to the merit of a claim or the correctness of a decision by the various officers or agencies as the decision relates to a claim for benefits or compensation.

For the purpose of carrying out the chief ombudsperson's duties, the chief ombudsperson or the ombudsperson system staff, notwithstanding sections 4123.27 and 4123.88 of the Revised Code, has the right at all reasonable times to examine the contents of a claim file and discuss with parties in interest the contents of the file as long as the ombudsperson does not divulge information that would tend to prejudice the case of either party to a claim or that would tend to compromise a privileged attorney-client or doctor-patient relationship.

(C) The chief ombudsperson shall:

(1) Assist any service office in its duties whenever it requires assistance or information that can best be obtained from central office personnel or records;

(2) Annually assemble reports from each assistant ombudsperson as to their activities for the preceding year

together with their recommendations as to changes or improvements in the operations of the workers' compensation system. The chief ombudsperson shall prepare a written report summarizing the activities of the ombudsperson system together with a digest of recommendations. The chief ombudsperson shall transmit the report to the nominating council.

(3) Comply with Chapter 102. and sections 2921.42 and 2921.43 of the Revised Code and the nominating council's human resource and ethics policies.

(D) No ombudsperson or assistant ombudsperson shall:

(1) Represent a claimant or employer in claims pending before or to be filed with the administrator, a district or staff hearing officer, the commission, or the courts of the state, nor shall an ombudsperson or assistant ombudsperson undertake any such representation for a period of one year after the ombudsperson's or assistant ombudsperson's employment terminates or be eligible for employment by the bureau or the commission or as a district or staff hearing officer for one year;

(2) Express any opinions as to the merit of a claim or the correctness of a decision by the various officers or agencies as the decision relates to a claim for benefits or compensation.

(E) The chief ombudsperson and assistant ombudspersons shall receive compensation at a level established by the nominating council commensurate with the individual's background, education, and experience in workers' compensation or related fields. The chief ombudsperson and assistant ombudspersons are full-time permanent employees in the unclassified service of the state and are entitled to all

benefits that accrue to such employees, including, without limitation, sick, vacation, and personal leaves. Assistant ombudspersons serve at the pleasure of the chief ombudsperson.

(F) In the event of a vacancy in the position of chief ombudsperson, the nominating council may appoint a person to serve as acting chief ombudsperson until a chief ombudsperson is appointed. The acting chief ombudsperson shall be under the direction and control of the nominating council and may be removed by the nominating council with or without just cause.

**Sec. 4121.50.** ~~Not later than July 1, 2012, the~~ The administrator of workers' compensation shall adopt rules in accordance with Chapter 119. of the Revised Code to implement a coordinated services program for claimants under this chapter or Chapter 4123., 4127., ~~or~~ 4131., or 4133. of the Revised Code who are found to have obtained prescription drugs that were reimbursed pursuant to an order of the administrator or of the industrial commission or by a self-insuring employer but were obtained at a frequency or in an amount that is not medically necessary. The program shall be implemented in a manner that is substantially similar to the coordinated services programs established for the medicaid program under sections 5164.758 and 5167.13 of the Revised Code.

**Sec. 4121.61.** (A) As used in sections 4121.61 to 4121.69 of the Revised Code, "self-insuring employer" has the same meaning as in section 4123.01 of the Revised Code.

(B) The administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall adopt rules, take measures, and make expenditures as it deems necessary to aid claimants who have sustained compensable injuries or incurred compensable

occupational diseases pursuant to Chapter 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code to return to work or to assist in lessening or removing any resulting handicap.

**Sec. 4123.025.** Any person, other than those covered by section 4123.03 of the Revised Code, who is injured, and the dependents of a deceased employee who is killed as the direct result of performing any act at the request or order of a duly authorized public official of the state, or any institution or agency thereof, or any political subdivision thereof, including a county, township, or municipal corporation, in time of emergency shall be entitled to all the benefits of ~~Chapter~~ <u>Chapters</u> 4123. <u>and 4133.</u> of the Revised Code. Any payments made from the state insurance fund pursuant to this section shall be charged to the surplus fund as created by division (B) of section 4123.34 of the Revised Code, in order to encourage participation of all persons in times of emergency.

**Sec. 4123.05.** The bureau of workers' compensation shall adopt rules to regulate and provide for the kind and character of notices, and the services thereof, in cases of injury, occupational disease, or death resulting from either, to employees, the nature and extent of the proofs and evidence, and the method of taking and furnishing the same, and to establish the right to benefits or compensation from the state insurance fund, the forms of application of those claiming to be entitled to benefits or compensation, and the method of making investigations, physical examinations, and inspections. Nothing in this section shall be interpreted as affecting or limiting the rule-making authority of the industrial commission under this chapter or Chapter 4121.<u> or 4133.</u> of the Revised Code.

**Sec. 4123.15.** (A) An employer who is a member of a

recognized religious sect or division of a recognized religious sect and who is an adherent of established tenets or teachings of that sect or division by reason of which the employer is conscientiously opposed to benefits to employers and employees from any public or private insurance that makes payment in the event of death, disability, impairment, old age, or retirement or makes payments toward the cost of, or provides services in connection with the payment for, medical services, including the benefits from any insurance system established by the "Social Security Act," 42 U.S.C.A. 30l, et seq., may apply to the administrator of workers' compensation to be excepted from payment of premiums and other charges assessed under this chapter and Chapter 4121. of the Revised Code with respect to, or if the employer is a self-insuring employer, from payment of direct compensation and benefits to and assessments required by this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code on account of, an individual employee who meets the requirements of this section. The employer shall make an application on forms provided by the bureau of workers' compensation which forms may be those used by or similar to those used by the United States internal revenue service for the purpose of granting an exemption from payment of social security taxes under 26 U.S.C.A. 1402(g) of the Internal Revenue Code, and shall include a written waiver signed by the individual employee to be excepted from all the benefits and compensation provided in this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code.

The application also shall include affidavits signed by the employer and the individual employee that the employer and the individual employee are members of a recognized religious sect or division of a recognized religious sect and are

adherents of established tenets or teaching of that sect or division by reason of which the employer and the individual employee are conscientiously opposed to benefits to employers and employees received from any public or private insurance that makes payments in the event of death, disability, impairment, old age, or retirement or makes payments toward the cost of, or provides services in connection with the payment for, medical services, including the benefits from any insurance system established by the "Social Security Act," 42 U.S.C.A. 301, et seq. If the individual is a minor, the guardian of the minor shall complete the waiver and affidavit required by this division.

(B) The administrator shall grant the waiver and exception to the employer for a particular individual employee if the administrator finds that the employer and the individual employee are members of a sect or division having the established tenets or teachings described in division (A) of this section, that it is the practice, and has been for a substantial number of years, for members of the sect or division of the sect to make provision for their dependent members which, in the administrator's judgment, is reasonable in view of their general level of hiring, and that the sect or division of the sect has been in existence at all times since December 31, 1950.

(C) A waiver and exception under division (B) of this section is effective on the date the administrator grants the waiver and exception. An employer who complies with this chapter and the employer's other employees, with respect to an individual employee for whom the administrator grants the waiver and exception, are entitled, as to that individual employee and as to all injuries and occupational diseases of the individual employee that occurred prior to the effective date of the waiver

and exception, to the protections of sections 4123.74 and 4123.741 of the Revised Code. On and after the effective date of the waiver and exception, the employer is not liable for the payment of any premiums or other charges assessed under this chapter or Chapter 4121. of the Revised Code, or if the individual is a self-insuring employer, the employer is not liable for the payment of any compensation or benefits directly or other charges assessed under this chapter or Chapter 4121. or 4133. of the Revised Code in regard to that individual employee, and is considered a complying employer under those chapters, and the employer and the employer's other employees are entitled to the protections of sections 4123.74 and 4123.741 of the Revised Code, as to that individual employee, and as to injuries and occupational diseases of that individual employee that occur on and after the effective date of the waiver and exception.

(D) A waiver and exception granted in regard to a specific employer and individual employee are valid for all future years unless the administrator determines that the employer, individual employee, or sect or division ceases to meet the requirements of this section. If the administrator makes this determination, the employer is liable for the payment of premiums and other charges assessed under this chapter and Chapter 4121. of the Revised Code, or if the employer is a self-insuring employer, the employer is liable for the payment of compensation and benefits directly and other charges assessed under those chapters and Chapter 4133. of the Revised Code, in regard to the individual employee for all injuries and occupational diseases of that individual that occur on and after the date of the administrator's determination, and the individual employee is entitled to all of the benefits and compensation provided in those chapters for an injury or

occupational disease that occurs on or after the date of the administrator's determination.

**Sec. 4123.26.** (A) Every employer shall keep records of, and furnish to the bureau of workers' compensation upon request, all information required by the administrator of workers' compensation to carry out this chapter and Chapter 4133. of the Revised Code.

(B) Except as otherwise provided in division (C) of this section, every private employer employing one or more employees regularly in the same business, or in or about the same establishment, shall submit a payroll report to the bureau. Until the policy year commencing July 1, 2015, a private employer shall submit the payroll report in January of each year. For a policy year commencing on or after July 1, 2015, the employer shall submit the payroll report on or before August fifteenth of each year unless otherwise specified by the administrator in rules the administrator adopts. The employer shall include all of the following information in the payroll report, as applicable:

(1) For payroll reports submitted prior to July 1, 2015, the number of employees employed during the preceding year from the first day of January through the thirty-first day of December who are localized in this state;

(2) For payroll reports submitted on or after July 1, 2015, the number of employees localized in this state employed during the preceding policy year from the first day of July through the thirtieth day of June;

(3) The number of such employees localized in this state employed at each kind of employment and the aggregate amount of

wages paid to such employees;

(4)~~(a)~~ If an employer elects to secure other-states' coverage or limited other-states' coverage pursuant to section 4123.292 of the Revised Code through either the administrator, if the administrator elects to offer such coverage, or an other-states' insurer the information required under divisions (B)(1) to (3) of this section and any additional information required by the administrator in rules the administrator adopts, with the advice and consent of the bureau of workers' compensation board of directors, to allow the employer to secure other-states' coverage or limited other-states' coverage.

(5)(a) In accordance with the rules adopted by the administrator pursuant to division (C) of section 4123.32 of the Revised Code, if the employer employs employees who are covered under the federal "Longshore and Harbor Workers' Compensation Act," 98 Stat. 1639, 33 U.S.C. 901 et seq., and under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code, both of the following amounts:

(i) The amount of wages the employer pays to those employees when the employees perform labor and provide services for which the employees are eligible to receive compensation and benefits under the federal "Longshore and Harbor Workers' Compensation Act";

(ii) The amount of wages the employer pays to those employees when the employees perform labor and provide services for which the employees are eligible to receive compensation and benefits under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code.

(b) The allocation of wages identified by the employer

pursuant to divisions (B)(5)(a)(i) and (ii) of this section shall not be presumed to be an indication of the law under which an employee is eligible to receive compensation and benefits.

(C) Beginning August 1, 2015, each employer that is recognized by the administrator as a professional employer organization shall submit a monthly payroll report containing the number of employees employed during the preceding calendar month, the number of those employees employed at each kind of employment, and the aggregate amount of wages paid to those employees.

(D) An employer described in division (B) of this section shall submit the payroll report required under this section to the bureau on a form prescribed by the bureau. The bureau may require that the information required to be furnished be verified under oath. The bureau or any person employed by the bureau for that purpose, may examine, under oath, any employer, or the officer, agent, or employee thereof, for the purpose of ascertaining any information which the employer is required to furnish to the bureau.

(E) No private employer shall fail to furnish to the bureau the payroll report required by this section, nor shall any employer fail to keep records of or furnish such other information as may be required by the bureau under this section.

(F) The administrator may adopt rules setting forth penalties for failure to submit the payroll report required by this section, including but not limited to exclusion from alternative rating plans and discount programs.

**Sec. 4123.27.** Information contained in the payroll report provided for in section 4123.26 of the Revised Code, and such

other information as may be furnished to the bureau of workers' compensation by employers in pursuance of that section, is for the exclusive use and information of the bureau in the discharge of its official duties, and shall not be open to the public nor be used in any court in any action or proceeding pending therein unless the bureau is a party to the action or proceeding. The information contained in the payroll report may be tabulated and published by the bureau in statistical form for the use and information of other state departments and the public. No person in the employ of the bureau, except those who are authorized by the administrator of workers' compensation, shall divulge any information secured by the person while in the employ of the bureau in respect to the transactions, property, claim files, records, or papers of the bureau or in respect to the business or mechanical, chemical, or other industrial process of any company, firm, corporation, person, association, partnership, or public utility to any person other than the administrator or to the superior of such employee of the bureau.

Notwithstanding the restrictions imposed by this section, the governor, select or standing committees of the general assembly, the auditor of state, the attorney general, or their designees, pursuant to the authority granted in this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code, may examine any records, claim files, or papers in possession of the industrial commission or the bureau. They also are bound by the privilege that attaches to these papers.

The administrator shall report to the director of job and family services or to the county director of job and family services the name, address, and social security number or other identification number of any person receiving workers' compensation whose name or social security number or other

identification number is the same as that of a person required by a court or child support enforcement agency to provide support payments to a recipient or participant of public assistance, as that term is defined in section 5101.181 of the Revised Code, and whose name is submitted to the administrator by the director under section 5101.36 of the Revised Code. The administrator also shall inform the director of the amount of workers' compensation paid to the person during such period as the director specifies.

Within fourteen days after receiving from the director of job and family services a list of the names and social security numbers of recipients or participants of public assistance pursuant to section 5101.181 of the Revised Code, the administrator shall inform the auditor of state of the name, current or most recent address, and social security number of each person receiving workers' compensation pursuant to this chapter whose name and social security number are the same as that of a person whose name or social security number was submitted by the director. The administrator also shall inform the auditor of state of the amount of workers' compensation paid to the person during such period as the director specifies.

The bureau and its employees, except for purposes of furnishing the auditor of state with information required by this section, shall preserve the confidentiality of recipients or participants of public assistance in compliance with section 5101.181 of the Revised Code.

**Sec. 4123.291.** (A) An adjudicating committee appointed by the administrator of workers' compensation to hear any matter specified in divisions (B)(1) to (7) of this section shall hear the matter within sixty days of the date on which an employer

files the request, protest, or petition. An employer desiring to file a request, protest, or petition regarding any matter specified in divisions (B)(1) to (7) of this section shall file the request, protest, or petition to the adjudicating committee on or before twenty-four months after the administrator sends notice of the determination about which the employer is filing the request, protest, or petition.

(B) An employer who is adversely affected by a decision of an adjudicating committee appointed by the administrator may appeal the decision of the committee to the administrator or the administrator's designee. The employer shall file the appeal in writing within thirty days after the employer receives the decision of the adjudicating committee. Except as otherwise provided in this division, the administrator or the designee shall hold a hearing and consider and issue a decision on the appeal if the decision of the adjudicating committee relates to one of the following:

(1) An employer request for a waiver of a default in the payment of premiums pursuant to section 4123.37 of the Revised Code;

(2) An employer request for the settlement of liability as a noncomplying employer under section 4123.75 of the Revised Code;

(3) An employer petition objecting to an assessment made pursuant to section 4123.37 of the Revised Code and the rules adopted pursuant to that section;

(4) An employer request for the abatement of penalties assessed pursuant to section 4123.32 of the Revised Code and the rules adopted pursuant to that section;

(5) An employer protest relating to an audit finding or a determination of a manual classification, experience rating, or transfer or combination of risk experience;

(6) Any decision relating to any other risk premium matter under Chapters 4121., 4123., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code;

(7) An employer petition objecting to the amount of security required under division (D) of section 4125.05 of the Revised Code and the rules adopted pursuant to that section.

An employer may request, in writing, that the administrator waive the hearing before the administrator or the administrator's designee. The administrator shall decide whether to grant or deny a request to waive a hearing.

(C) The bureau of workers' compensation board of directors, based upon recommendations of the workers' compensation actuarial committee, shall establish the policy for all adjudicating committee procedures, including, but not limited to, specific criteria for manual premium rate adjustment.

**Sec. 4123.30.** Money contributed by the employers mentioned in division (B)(1) of section 4123.01 of the Revised Code constitutes the "public fund" and the money contributed by employers mentioned in division (B)(2) of such section constitutes the "private fund." Each such fund shall be collected, distributed, and its solvency maintained without regard to or reliance upon the other. Whenever in this chapter reference is made to the state insurance fund, the reference is to such two separate funds but such two separate funds and the net premiums contributed thereto by employers after adjustments

and dividends, except for the amount thereof which is set aside for the investigation and prevention of industrial accidents and diseases pursuant to Section 35 of Article II, Ohio Constitution, any amounts set aside for actuarial services authorized or required by sections 4123.44 and 4123.47 of the Revised Code, and any amounts set aside to reinsure the liability of the respective insurance funds for the following payments, constitute a trust fund for the benefit of employers and employees mentioned in sections 4123.01, 4123.03, and 4123.73 of the Revised Code for the payment of compensation, medical services, examinations, recommendations and determinations, nursing and hospital services, medicine, rehabilitation, death benefits, funeral expenses, and like benefits for loss sustained on account of injury, disease, or death provided for by this chapter and Chapter 4133. of the Revised Code, and for no other purpose. This section does not prevent the deposit or investment of all such moneys intermingled for such purpose but such funds shall be separate and distinct for all other purposes, and the rights and duties created in this chapter and Chapter 4133. of the Revised Code shall be construed to have been made with respect to two separate funds and so as to maintain and continue such funds separately except for deposit or investment. Disbursements shall not be made on account of injury, disease, or death of employees of employers who contribute to one of such funds unless the moneys to the credit of such fund are sufficient therefor and no such disbursements shall be made for moneys or credits paid or credited to the other fund.

**Sec. 4123.311.** (A) The administrator of workers' compensation may do all of the following:

(1) Utilize direct deposit of funds by electronic transfer

for all disbursements the administrator is authorized to pay under this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code;

(2) Require any payee to provide a written authorization designating a financial institution and an account number to which a payment made according to division (A)(1) of this section is to be credited, notwithstanding division (B) of section 9.37 of the Revised Code;

(3) Contract with an agent to do both of the following:

(a) Supply debit cards for claimants to access payments made to them pursuant to this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code;

(b) Credit the debit cards described in division (A)(3)(a) of this section with the amounts specified by the administrator pursuant to this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code by utilizing direct deposit of funds by electronic transfer.

(4) Enter into agreements with financial institutions to credit the debit cards described in division (A)(3)(a) of this section with the amounts specified by the administrator pursuant to this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code by utilizing direct deposit of funds by electronic transfer.

(B) The administrator shall inform claimants about the administrator's utilization of direct deposit of funds by electronic transfer under this section and section 9.37 of the Revised Code, furnish debit cards to claimants as appropriate, and provide claimants with instructions regarding use of those debit cards.

(C) The administrator, with the advice and consent of the bureau of workers' compensation board of directors, shall adopt rules in accordance with Chapter 119. of the Revised Code regarding utilization of the direct deposit of funds by electronic transfer under this section and section 9.37 of the Revised Code.

**Sec. 4123.32.** The administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall adopt rules with respect to the collection, maintenance, and disbursements of the state insurance fund including all of the following:

(A) A rule providing for ascertaining the correctness of any employer's report of estimated or actual expenditure of wages and the determination and adjustment of proper premiums and the payment of those premiums by the employer;

(B) Such special rules as the administrator considers necessary to safeguard the fund and that are just in the circumstances, covering the rates to be applied where one employer takes over the occupation or industry of another or where an employer first makes application for state insurance, and the administrator may require that if any employer transfers a business in whole or in part or otherwise reorganizes the business, the successor in interest shall assume, in proportion to the extent of the transfer, as determined by the administrator, the employer's account and shall continue the payment of all contributions due under this chapter;

(C) A rule providing that an employer who employs an employee covered under the federal "Longshore and Harbor Workers' Compensation Act," 98 Stat. 1639, 33 U.S.C. 901 et seq., and this chapter and ~~Chapter~~ Chapters 4121. and 4133. of

the Revised Code shall be assessed a premium in accordance with the expenditure of wages, payroll, or both attributable to only labor performed and services provided by such an employee when the employee performs labor and provides services for which the employee is not eligible to receive compensation and benefits under that federal act.

(D) A rule providing for all of the following:

(1) If an employer fails to file a report of the employer's actual payroll expenditures pursuant to section 4123.26 of the Revised Code for private employers or pursuant to section 4123.41 of the Revised Code for public employers, the premium and assessments due from the employer for the period shall be calculated based on the estimated payroll of the employer used in calculating the estimated premium due, increased by ten per cent;

(2)(a) If an employer fails to pay the premium or assessments when due for a policy year commencing prior to July 1, 2015, the administrator may add a late fee penalty of not more than thirty dollars to the premium plus an additional penalty amount as follows:

(i) For a premium from sixty-one to ninety days past due, the prime interest rate, multiplied by the premium due;

(ii) For a premium from ninety-one to one hundred twenty days past due, the prime interest rate plus two per cent, multiplied by the premium due;

(iii) For a premium from one hundred twenty-one to one hundred fifty days past due, the prime interest rate plus four per cent, multiplied by the premium due;

(iv) For a premium from one hundred fifty-one to one

hundred eighty days past due, the prime interest rate plus six per cent, multiplied by the premium due;

(v) For a premium from one hundred eighty-one to two hundred ten days past due, the prime interest rate plus eight per cent, multiplied by the premium due;

(vi) For each additional thirty-day period or portion thereof that a premium remains past due after it has remained past due for more than two hundred ten days, the prime interest rate plus eight per cent, multiplied by the premium due.

(b) For purposes of division (D)(2)(a) of this section, "prime interest rate" means the average bank prime rate, and the administrator shall determine the prime interest rate in the same manner as a county auditor determines the average bank prime rate under section 929.02 of the Revised Code.

(c) If an employer fails to pay the premium or assessments when due for a policy year commencing on or after July 1, 2015, the administrator may assess a penalty at the interest rate established by the state tax commissioner pursuant to section 5703.47 of the Revised Code.

(3) Notwithstanding the interest rates specified in division (D)(2)(a) or (c) of this section, at no time shall the additional penalty amount assessed under division (D)(2)(a) or (c) of this section exceed fifteen per cent of the premium due.

(4) If an employer recognized by the administrator as a professional employer organization fails to make a timely payment of premiums or assessments as required by section 4123.35 of the Revised Code, the administrator shall revoke the professional employer organization's registration pursuant to section 4125.06 of the Revised Code.

(5) An employer may appeal a late fee penalty or additional penalty to an adjudicating committee pursuant to section 4123.291 of the Revised Code.

(6) If the employer files an appropriate payroll report within the time provided by law, the employer shall not be in default and division (D)(2) of this section shall not apply if the employer pays the premiums within fifteen days after being first notified by the administrator of the amount due.

(7) Any deficiencies in the amounts of the premium security deposit paid by an employer prior to July 1, 2015, shall be subject to an interest charge of six per cent per annum from the date the premium obligation is incurred. In determining the interest due on deficiencies in premium security deposit payments, a charge in each case shall be made against the employer in an amount equal to interest at the rate of six per cent per annum on the premium security deposit due but remaining unpaid sixty days after notice by the administrator.

(8) Any interest charges or penalties provided for in divisions (D)(2) and (7) of this section shall be credited to the employer's account for rating purposes in the same manner as premiums.

(E) A rule providing that each employer, on the occasion of instituting coverage under this chapter for an effective date prior to July 1, 2015, shall submit a premium security deposit. The deposit shall be calculated equivalent to thirty per cent of the semiannual premium obligation of the employer based upon the employer's estimated expenditure for wages for the ensuing six-month period plus thirty per cent of an additional adjustment period of two months but only up to a maximum of one thousand dollars and not less than ten dollars. The administrator shall

review the security deposit of every employer who has submitted a deposit which is less than the one-thousand-dollar maximum. The administrator may require any such employer to submit additional money up to the maximum of one thousand dollars that, in the administrator's opinion, reflects the employer's current payroll expenditure for an eight-month period.

(F) A rule providing that each employer, on the occasion of instituting coverage under this chapter, shall submit an application fee and an application for coverage that completely provides all of the information required for the administrator to establish coverage for that employer, and that the employer's failure to pay the application fee or to provide all of the information requested on the application may be grounds for the administrator to deny coverage for that employer.

(G) A rule providing that, in addition to any other remedies permitted in this chapter, the administrator may discontinue an employer's coverage if the employer fails to pay the premium due on or before the premium's due date.

(H) A rule providing that if after a final adjudication it is determined that an employer has failed to pay an obligation, billing, account, or assessment that is greater than one thousand dollars on or before its due date, the administrator may discontinue the employer's coverage in addition to any other remedies permitted in this chapter, and that the administrator shall not discontinue an employer's coverage pursuant to this division prior to a final adjudication regarding the employer's failure to pay such obligation, billing, account, or assessment on or before its due date.

(I) As used in divisions (G) and (H) of this section:

(1) "Employer" has the same meaning as in section 4123.01 of the Revised Code except that "employer" does not include the state, a state hospital, or a state university or college.

(2) "State university or college" has the same meaning as in section 3345.12 of the Revised Code and also includes the Ohio agricultural research and development center and OSU extension.

(3) "State hospital" means the Ohio state university hospital and its ancillary facilities and the medical university of Ohio at Toledo hospital.

**Sec. 4123.324.** (A) The administrator of workers' compensation shall adopt rules, for the purpose of encouraging economic development, that establish conditions under which any negative experience to be transferred to the account of an employer who is successor in interest under division (B) of section 4123.32 of the Revised Code may be reduced or waived.

(B) The administrator, in adopting rules under division (A) of this section, may not permit a waiver or reduction in experience transfer if the succession transaction is entered into for the purpose of escaping obligations under this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code.

**Sec. 4123.34.** It shall be the duty of the bureau of workers' compensation board of directors and the administrator of workers' compensation to safeguard and maintain the solvency of the state insurance fund and all other funds specified in this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code. The administrator, in the exercise of the powers and discretion conferred upon the administrator in section 4123.29 of the Revised Code, shall fix and maintain,

with the advice and consent of the board, for each class of occupation or industry, the lowest possible rates of premium consistent with the maintenance of a solvent state insurance fund and the creation and maintenance of a reasonable surplus, after the payment of legitimate claims for injury, occupational disease, and death that the administrator authorizes to be paid from the state insurance fund for the benefit of injured, diseased, and the dependents of killed employees. In establishing rates, the administrator shall take into account the necessity of ensuring sufficient money is set aside in the premium payment security fund to cover any defaults in premium obligations. The administrator shall observe all of the following requirements in fixing the rates of premium for the risks of occupations or industries:

(A) The administrator shall keep an accurate account of the money paid in premiums by each of the several classes of occupations or industries, and the losses on account of injuries, occupational disease, and death of employees thereof, and also keep an account of the money received from each individual employer and the amount of losses incurred against the state insurance fund on account of injuries, occupational disease, and death of the employees of the employer.

(B) A portion of the money paid into the state insurance fund shall be set aside for the creation of a surplus fund account within the state insurance fund. Any references in this chapter or in Chapter 4121., 4125., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code to the surplus fund, the surplus created in this division, the statutory surplus fund, or the statutory surplus of the state insurance fund are hereby deemed to be references to the surplus fund account. The administrator may transfer the portion of the state insurance fund to the surplus

fund account as the administrator determines is necessary to satisfy the needs of the surplus fund account and to guarantee the solvency of the state insurance fund and the surplus fund account. In addition to all statutory authority under this chapter and Chapter 4121. of the Revised Code, the administrator has discretionary and contingency authority to make charges to the surplus fund account. The administrator shall account for all charges, whether statutory, discretionary, or contingency, that the administrator may make to the surplus fund account. A revision of basic rates shall be made annually on the first day of July.

For policy years commencing prior to July 1, 2016, revisions of basic rates for private employers shall be in accordance with the oldest four of the last five calendar years of the combined accident and occupational disease experience of the administrator in the administration of this chapter, as shown by the accounts kept as provided in this section. For a policy year commencing on or after July 1, 2016, revisions of basic rates for private employers shall be in accordance with the oldest four of the last five policy years combined accident and occupational disease experience of the administrator in the administration of this chapter, as shown by the accounts kept as provided in this section.

Revisions of basic rates for public employers shall be in accordance with the oldest four of the last five policy years of the combined accident and occupational disease experience of the administrator in the administration of this chapter, as shown by the accounts kept as provided in this section.

In revising basic rates, the administrator shall exclude the experience of employers that are no longer active if the

administrator determines that the inclusion of those employers would have a significant negative impact on the remainder of the employers in a particular manual classification. The administrator shall adopt rules, with the advice and consent of the board, governing rate revisions, the object of which shall be to make an equitable distribution of losses among the several classes of occupation or industry, which rules shall be general in their application.

(C) The administrator may apply that form of rating system that the administrator finds is best calculated to merit rate or individually rate the risk more equitably, predicated upon the basis of its individual industrial accident and occupational disease experience, and may encourage and stimulate accident prevention. The administrator shall develop fixed and equitable rules controlling the rating system, which rules shall conserve to each risk the basic principles of workers' compensation insurance.

(D) The administrator, from the money paid into the state insurance fund, shall set aside into an account of the state insurance fund titled a premium payment security fund sufficient money to pay for any premiums due from an employer and uncollected.

The use of the moneys held by the premium payment security fund account is restricted to reimbursement to the state insurance fund of premiums due and uncollected.

(E) The administrator may grant discounts on premium rates for employers who meet either of the following requirements:

(1) Have not incurred a compensable injury for one year or more and who maintain an employee safety committee or similar

organization or make periodic safety inspections of the workplace.

(2) Successfully complete a loss prevention program prescribed by the superintendent of the division of safety and hygiene and conducted by the division or by any other person approved by the superintendent.

(F)(1) In determining the premium rates for the construction industry the administrator shall calculate the employers' premiums based upon the actual remuneration construction industry employees receive from construction industry employers, provided that the amount of remuneration the administrator uses in calculating the premiums shall not exceed an average weekly wage equal to one hundred fifty per cent of the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code.

(2) Division (F)(1) of this section shall not be construed as affecting the manner in which benefits to a claimant are awarded under this chapter or Chapter 4133. of the Revised Code.

(3) As used in division (F) of this section, "construction industry" includes any activity performed in connection with the erection, alteration, repair, replacement, renovation, installation, or demolition of any building, structure, highway, or bridge.

(G) The administrator shall not place a limit on the length of time that an employer may participate in the bureau of workers' compensation drug free workplace and workplace safety programs.

**Sec. 4123.341.** The administrative costs of the industrial commission, the bureau of workers' compensation board of

directors, the occupational pneumoconiosis board, and the bureau of workers' compensation shall be those costs and expenses that are incident to the discharge of the duties and performance of the activities of the industrial commission, the board, and the bureau under this chapter and Chapters 4121., 4125., 4127., 4131., 4133., and 4167. of the Revised Code, and all such costs shall be borne by the state and by other employers amenable to this chapter as follows:

(A) In addition to the contribution required of the state under sections 4123.39 and 4123.40 of the Revised Code, the state shall contribute the sum determined to be necessary under section 4123.342 of the Revised Code.

(B) The director of budget and management may allocate the state's share of contributions in the manner the director finds most equitably apportions the costs.

(C) The counties and taxing districts therein shall contribute such sum as may be required under section 4123.342 of the Revised Code.

(D) The private employers shall contribute the sum required under section 4123.342 of the Revised Code.

**Sec. 4123.342.** (A) The administrator of workers' compensation shall allocate among counties and taxing districts therein as a class, the state and its instrumentalities as a class, private employers who are insured under the private fund as a class, and self-insuring employers as a class their fair shares of the administrative costs which are to be borne by such employers under division (D) of section 4123.341 of the Revised Code, separately allocating to each class those costs solely attributable to the activities of the industrial commission and

those costs solely attributable to the activities of the bureau of workers' compensation board of directors, the occupational pneumoconiosis board, and the bureau of workers' compensation in respect of the class, allocating to any combination of classes those costs attributable to the activities of the industrial commission, bureau of workers' compensation board of directors, occupational pneumoconiosis board, or bureau in respect of the classes, and allocating to all four classes those costs attributable to the activities of the industrial commission, bureau of workers' compensation board of directors, occupational pneumoconiosis board, and bureau in respect of all classes. The administrator shall separately calculate each employer's assessment in the class, except self-insuring employers, on the basis of the following three factors: payroll, paid compensation, and paid medical costs of the employer for those costs solely attributable to the activities of the bureau of workers' compensation board of directors, the occupational pneumoconiosis board, and the bureau. The administrator shall separately calculate each employer's assessment in the class, except self-insuring employers, on the basis of the following three factors: payroll, paid compensation, and paid medical costs of the employer for those costs solely attributable to the activities of the industrial commission. The administrator shall separately calculate each self-insuring employer's assessment in accordance with section 4123.35 of the Revised Code for those costs solely attributable to the activities of the bureau of workers' compensation board of directors, the occupational pneumoconiosis board, and the bureau. The administrator shall separately calculate each self-insuring employer's assessment in accordance with section 4123.35 of the Revised Code for those costs solely attributable to the activities of the industrial commission. In a timely manner, the industrial commission shall

provide to the administrator, the information necessary for the administrator to allocate and calculate, with the approval of the chairperson of the industrial commission, for each class of employer as described in this division, the costs solely attributable to the activities of the industrial commission.

(B) The administrator shall divide the administrative cost assessments collected by the administrator into two administrative assessment accounts within the state insurance fund. One of the administrative assessment accounts shall consist of the administrative cost assessment collected by the administrator for the industrial commission. One of the administrative assessment accounts shall consist of the administrative cost assessments collected by the administrator for the bureau, the occupational pneumoconiosis board, and the bureau of workers' compensation board of directors. The administrator may invest the administrative cost assessments in these accounts on behalf of the bureau and the industrial commission as authorized in section 4123.44 of the Revised Code. In a timely manner, the administrator shall provide to the industrial commission the information and reports the commission deems necessary for the commission to monitor the receipts and the disbursements from the administrative assessment account for the industrial commission.

(C) The administrator or the administrator's designee shall transfer moneys as necessary from the administrative assessment account identified for the bureau, the occupational pneumoconiosis board, and the bureau of workers' compensation board of directors to the workers' compensation fund for the use of the bureau, the occupational pneumoconiosis board, and the bureau of workers' compensation board of directors. As necessary and upon the authorization of the industrial commission, the

administrator or the administrator's designee shall transfer moneys from the administrative assessment account identified for the industrial commission to the industrial commission operating fund created under section 4121.021 of the Revised Code. To the extent that the moneys collected by the administrator in any fiscal biennium of the state equal the sum appropriated by the general assembly for administrative costs of the industrial commission, bureau of workers' compensation board of directors, occupational pneumoconiosis board, and bureau for the biennium, the moneys shall be paid into the workers' compensation fund and the industrial commission operating fund of the state, as appropriate, and any remainder shall be retained in those funds and applied to reduce the amount collected during the next biennium.

Sections 4123.41, 4123.35, and 4123.37 of the Revised Code apply to the collection of assessments from public and private employers respectively, except that for boards of county hospital trustees that are self-insuring employers, only those provisions applicable to the collection of assessments for private employers apply.

**Sec. 4123.343.** This section shall be construed liberally to the end that employers shall be encouraged to employ and retain in their employment handicapped employees as defined in this section.

(A) As used in this section, "handicapped employee" means an employee who is afflicted with or subject to any physical or mental impairment, or both, whether congenital or due to an injury or disease of such character that the impairment constitutes a handicap in obtaining employment or would constitute a handicap in obtaining reemployment if the employee

should become unemployed and whose handicap is due to any of the following diseases or conditions:

(1) Epilepsy;

(2) Diabetes;

(3) Cardiac disease;

(4) Arthritis;

(5) Amputated foot, leg, arm, or hand;

(6) Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than seventy-five per cent bilaterally;

(7) Residual disability from poliomyelitis;

(8) Cerebral palsy;

(9) Multiple sclerosis;

(10) Parkinson's disease;

(11) Cerebral vascular accident;

(12) Tuberculosis;

(13) Silicosis;

(14) Psycho-neurotic disability following treatment in a recognized medical or mental institution;

(15) Hemophilia;

(16) Chronic osteomyelitis;

(17) Ankylosis of joints;

(18) Hyper insulinism;

(19) Muscular dystrophies;

(20) Arterio-sclerosis;

(21) Thrombo-phlebitis;

(22) Varicose veins;

(23) Cardiovascular, pulmonary, or respiratory diseases of a firefighter or police officer employed by a municipal corporation or township as a regular member of a lawfully constituted police department or fire department;

(24) ~~Coal miners'~~ Occupational pneumoconiosis~~, commonly referred to as "black lung disease"~~ as defined in section 4133.01 of the Revised Code;

(25) Disability with respect to which an individual has completed a rehabilitation program conducted pursuant to sections 4121.61 to 4121.69 of the Revised Code.

(B) Under the circumstances set forth in this section all or such portion as the administrator determines of the compensation and benefits paid in any claim arising hereafter shall be charged to and paid from the statutory surplus fund created under section 4123.34 of the Revised Code and only the portion remaining shall be merit-rated or otherwise treated as part of the accident or occupational disease experience of the employer. The provisions of this section apply only in cases of death, total disability, whether temporary or permanent, and all disabilities compensated under division (B) of section 4123.57 of the Revised Code. The administrator shall adopt rules specifying the grounds upon which charges to the statutory surplus fund are to be made. The rules shall prohibit as a grounds any agreement between employer and claimant as to the merits of a claim and the amount of the charge.

(C) Any employer who has in its employ a handicapped

employee is entitled, in the event the person is injured, to a determination under this section.

An employer shall file an application under this section for a determination with the bureau or commission in the same manner as other claims. An application only may be made in cases where a handicapped employee or a handicapped employee's dependents claim or are receiving an award of compensation as a result of an injury or occupational disease occurring or contracted on or after the date on which division (A) of this section first included the handicap of such employee.

(D) The circumstances under and the manner in which an apportionment under this section shall be made are:

(1) Whenever a handicapped employee is injured or disabled or dies as the result of an injury or occupational disease sustained in the course of and arising out of a handicapped employee's employment in this state and the administrator awards compensation therefor and when it appears to the satisfaction of the administrator that the injury or occupational disease or the death resulting therefrom would not have occurred but for the pre-existing physical or mental impairment of the handicapped employee, all compensation and benefits payable on account of the disability or death shall be paid from the surplus fund.

(2) Whenever a handicapped employee is injured or disabled or dies as a result of an injury or occupational disease and the administrator finds that the injury or occupational disease would have been sustained or suffered without regard to the employee's pre-existing impairment but that the resulting disability or death was caused at least in part through aggravation of the employee's pre-existing disability, the administrator shall determine in a manner that is equitable and

reasonable and based upon medical evidence the amount of disability or proportion of the cost of the death award that is attributable to the employee's pre-existing disability and the amount found shall be charged to the statutory surplus fund.

(E) The benefits and provisions of this section apply only to employers who have complied with this chapter through insurance with the state fund.

(F) No employer shall in any year receive credit under this section in an amount greater than the premium the employer paid.

(G) An order issued by the administrator pursuant to this section is appealable under section 4123.511 of the Revised Code but is not appealable to a court under section 4123.512 of the Revised Code.

**Sec. 4123.35.** (A) Except as provided in this section, and until the policy year commencing July 1, 2015, every private employer and every publicly owned utility shall pay semiannually in the months of January and July into the state insurance fund the amount of annual premium the administrator of workers' compensation fixes for the employment or occupation of the employer, the amount of which premium to be paid by each employer to be determined by the classifications, rules, and rates made and published by the administrator. The employer shall pay semiannually a further sum of money into the state insurance fund as may be ascertained to be due from the employer by applying the rules of the administrator.

Except as otherwise provided in this section, for a policy year commencing on or after July 1, 2015, every private employer and every publicly owned utility shall pay annually in the month

of June immediately preceding the policy year into the state insurance fund the amount of estimated annual premium the administrator fixes for the employment or occupation of the employer, the amount of which estimated premium to be paid by each employer to be determined by the classifications, rules, and rates made and published by the administrator. The employer shall pay a further sum of money into the state insurance fund as may be ascertained to be due from the employer by applying the rules of the administrator. Upon receipt of the payroll report required by division (B) of section 4123.26 of the Revised Code, the administrator shall adjust the premium and assessments charged to each employer for the difference between estimated gross payrolls and actual gross payrolls, and any balance due to the administrator shall be immediately paid by the employer. Any balance due the employer shall be credited to the employer's account.

For a policy year commencing on or after July 1, 2015, each employer that is recognized by the administrator as a professional employer organization shall pay monthly into the state insurance fund the amount of premium the administrator fixes for the employer for the prior month based on the actual payroll of the employer reported pursuant to division (C) of section 4123.26 of the Revised Code.

A receipt certifying that payment has been made shall be issued to the employer by the bureau of workers' compensation. The receipt is prima-facie evidence of the payment of the premium. The administrator shall provide each employer written proof of workers' compensation coverage as is required in section 4123.83 of the Revised Code. Proper posting of the notice constitutes the employer's compliance with the notice requirement mandated in section 4123.83 of the Revised Code.

The bureau shall verify with the secretary of state the existence of all corporations and organizations making application for workers' compensation coverage and shall require every such application to include the employer's federal identification number.

A private employer who has contracted with a subcontractor is liable for the unpaid premium due from any subcontractor with respect to that part of the payroll of the subcontractor that is for work performed pursuant to the contract with the employer.

Division (A) of this section providing for the payment of premiums semiannually does not apply to any employer who was a subscriber to the state insurance fund prior to January 1, 1914, or, until July 1, 2015, who may first become a subscriber to the fund in any month other than January or July. Instead, the semiannual premiums shall be paid by those employers from time to time upon the expiration of the respective periods for which payments into the fund have been made by them. After July 1, 2015, an employer who first becomes a subscriber to the fund on any day other than the first day of July shall pay premiums according to rules adopted by the administrator, with the advice and consent of the bureau of workers' compensation board of directors, for the remainder of the policy year for which the coverage is effective.

The administrator, with the advice and consent of the board, shall adopt rules to permit employers to make periodic payments of the premium and assessment due under this division. The rules shall include provisions for the assessment of interest charges, where appropriate, and for the assessment of penalties when an employer fails to make timely premium payments. The administrator, in the rules the administrator

adopts, may set an administrative fee for these periodic payments. An employer who timely pays the amounts due under this division is entitled to all of the benefits and protections of this chapter. Upon receipt of payment, the bureau shall issue a receipt to the employer certifying that payment has been made, which receipt is prima-facie evidence of payment. Workers' compensation coverage under this chapter continues uninterrupted upon timely receipt of payment under this division.

Every public employer, except public employers that are self-insuring employers under this section, shall comply with sections 4123.38 to 4123.41, and 4123.48 of the Revised Code in regard to the contribution of moneys to the public insurance fund.

(B) Employers who will abide by the rules of the administrator and who may be of sufficient financial ability to render certain the payment of compensation to injured employees or the dependents of killed employees, and the furnishing of medical, surgical, nursing, and hospital attention and services and medicines, and funeral expenses, equal to or greater than is provided for in sections 4123.52, 4123.55 to 4123.62, ~~and~~ 4123.64 to 4123.67, 4133.12, 4133.13, and 4133.14 of the Revised Code, and who do not desire to insure the payment thereof or indemnify themselves against loss sustained by the direct payment thereof, upon a finding of such facts by the administrator, may be granted the privilege to pay individually compensation, and furnish medical, surgical, nursing, and hospital services and attention and funeral expenses directly to injured employees or the dependents of killed employees, thereby being granted status as a self-insuring employer. The administrator may charge employers who apply for the status as a self-insuring employer a reasonable application fee to cover the

bureau's costs in connection with processing and making a determination with respect to an application.

All employers granted status as self-insuring employers shall demonstrate sufficient financial and administrative ability to assure that all obligations under this section are promptly met. The administrator shall deny the privilege where the employer is unable to demonstrate the employer's ability to promptly meet all the obligations imposed on the employer by this section.

(1) The administrator shall consider, but is not limited to, the following factors, where applicable, in determining the employer's ability to meet all of the obligations imposed on the employer by this section:

(a) The employer has operated in this state for a minimum of two years, provided that an employer who has purchased, acquired, or otherwise succeeded to the operation of a business, or any part thereof, situated in this state that has operated for at least two years in this state, also shall qualify;

(b) Where the employer previously contributed to the state insurance fund or is a successor employer as defined by bureau rules, the amount of the buyout, as defined by bureau rules;

(c) The sufficiency of the employer's assets located in this state to insure the employer's solvency in paying compensation directly;

(d) The financial records, documents, and data, certified by a certified public accountant, necessary to provide the employer's full financial disclosure. The records, documents, and data include, but are not limited to, balance sheets and profit and loss history for the current year and previous four

years.

(e) The employer's organizational plan for the administration of the workers' compensation law;

(f) The employer's proposed plan to inform employees of the change from a state fund insurer to a self-insuring employer, the procedures the employer will follow as a self-insuring employer, and the employees' rights to compensation and benefits; and

(g) The employer has either an account in a financial institution in this state, or if the employer maintains an account with a financial institution outside this state, ensures that workers' compensation checks are drawn from the same account as payroll checks or the employer clearly indicates that payment will be honored by a financial institution in this state.

The administrator may waive the requirements of division (B)(1)(a) of this section and the requirement of division (B)(1)(d) of this section that the financial records, documents, and data be certified by a certified public accountant. The administrator shall adopt rules establishing the criteria that an employer shall meet in order for the administrator to waive the requirements of divisions (B)(1)(a) and (d) of this section. Such rules may require additional security of that employer pursuant to division (E) of section 4123.351 of the Revised Code.

The administrator shall not grant the status of self-insuring employer to the state, except that the administrator may grant the status of self-insuring employer to a state institution of higher education, including its hospitals, that

meets the requirements of division (B)(2) of this section.

(2) When considering the application of a public employer, except for a board of county commissioners described in division (G) of section 4123.01 of the Revised Code, a board of a county hospital, or a publicly owned utility, the administrator shall verify that the public employer satisfies all of the following requirements as the requirements apply to that public employer:

(a) For the two-year period preceding application under this section, the public employer has maintained an unvoted debt capacity equal to at least two times the amount of the current annual premium established by the administrator under this chapter for that public employer for the year immediately preceding the year in which the public employer makes application under this section.

(b) For each of the two fiscal years preceding application under this section, the unreserved and undesignated year-end fund balance in the public employer's general fund is equal to at least five per cent of the public employer's general fund revenues for the fiscal year computed in accordance with generally accepted accounting principles.

(c) For the five-year period preceding application under this section, the public employer, to the extent applicable, has complied fully with the continuing disclosure requirements established in rules adopted by the United States securities and exchange commission under 17 C.F.R. 240.15c 2-12.

(d) For the five-year period preceding application under this section, the public employer has not had its local government fund distribution withheld on account of the public employer being indebted or otherwise obligated to the state.

(e) For the five-year period preceding application under this section, the public employer has not been under a fiscal watch or fiscal emergency pursuant to section 118.023, 118.04, or 3316.03 of the Revised Code.

(f) For the public employer's fiscal year preceding application under this section, the public employer has obtained an annual financial audit as required under section 117.10 of the Revised Code, which has been released by the auditor of state within seven months after the end of the public employer's fiscal year.

(g) On the date of application, the public employer holds a debt rating of Aa3 or higher according to Moody's investors service, inc., or a comparable rating by an independent rating agency similar to Moody's investors service, inc.

(h) The public employer agrees to generate an annual accumulating book reserve in its financial statements reflecting an actuarially generated reserve adequate to pay projected claims under this chapter for the applicable period of time, as determined by the administrator.

(i) For a public employer that is a hospital, the public employer shall submit audited financial statements showing the hospital's overall liquidity characteristics, and the administrator shall determine, on an individual basis, whether the public employer satisfies liquidity standards equivalent to the liquidity standards of other public employers.

(j) Any additional criteria that the administrator adopts by rule pursuant to division (E) of this section.

The administrator may adopt rules establishing the criteria that a public employer shall satisfy in order for the

administrator to waive any of the requirements listed in divisions (B)(2)(a) to (j) of this section. The rules may require additional security from that employer pursuant to division (E) of section 4123.351 of the Revised Code. The administrator shall not waive any of the requirements listed in divisions (B)(2)(a) to (j) of this section for a public employer who does not satisfy the criteria established in the rules the administrator adopts.

(C) A board of county commissioners described in division (G) of section 4123.01 of the Revised Code, as an employer, that will abide by the rules of the administrator and that may be of sufficient financial ability to render certain the payment of compensation to injured employees or the dependents of killed employees, and the furnishing of medical, surgical, nursing, and hospital attention and services and medicines, and funeral expenses, equal to or greater than is provided for in sections 4123.52, 4123.55 to 4123.62, ~~and~~ 4123.64 to 4123.67, 4133.12, 4133.13, and 4133.14 of the Revised Code, and that does not desire to insure the payment thereof or indemnify itself against loss sustained by the direct payment thereof, upon a finding of such facts by the administrator, may be granted the privilege to pay individually compensation, and furnish medical, surgical, nursing, and hospital services and attention and funeral expenses directly to injured employees or the dependents of killed employees, thereby being granted status as a self-insuring employer. The administrator may charge a board of county commissioners described in division (G) of section 4123.01 of the Revised Code that applies for the status as a self-insuring employer a reasonable application fee to cover the bureau's costs in connection with processing and making a determination with respect to an application. All employers

granted such status shall demonstrate sufficient financial and administrative ability to assure that all obligations under this section are promptly met. The administrator shall deny the privilege where the employer is unable to demonstrate the employer's ability to promptly meet all the obligations imposed on the employer by this section. The administrator shall consider, but is not limited to, the following factors, where applicable, in determining the employer's ability to meet all of the obligations imposed on the board as an employer by this section:

(1) The board has operated in this state for a minimum of two years;

(2) Where the board previously contributed to the state insurance fund or is a successor employer as defined by bureau rules, the amount of the buyout, as defined by bureau rules;

(3) The sufficiency of the board's assets located in this state to insure the board's solvency in paying compensation directly;

(4) The financial records, documents, and data, certified by a certified public accountant, necessary to provide the board's full financial disclosure. The records, documents, and data include, but are not limited to, balance sheets and profit and loss history for the current year and previous four years.

(5) The board's organizational plan for the administration of the workers' compensation law;

(6) The board's proposed plan to inform employees of the proposed self-insurance, the procedures the board will follow as a self-insuring employer, and the employees' rights to compensation and benefits;

(7) The board has either an account in a financial institution in this state, or if the board maintains an account with a financial institution outside this state, ensures that workers' compensation checks are drawn from the same account as payroll checks or the board clearly indicates that payment will be honored by a financial institution in this state;

(8) The board shall provide the administrator a surety bond in an amount equal to one hundred twenty-five per cent of the projected losses as determined by the administrator.

(D) The administrator shall require a surety bond from all self-insuring employers, issued pursuant to section 4123.351 of the Revised Code, that is sufficient to compel, or secure to injured employees, or to the dependents of employees killed, the payment of compensation and expenses, which shall in no event be less than that paid or furnished out of the state insurance fund in similar cases to injured employees or to dependents of killed employees whose employers contribute to the fund, except when an employee of the employer, who has suffered the loss of a hand, arm, foot, leg, or eye prior to the injury for which compensation is to be paid, and thereafter suffers the loss of any other of the members as the result of any injury sustained in the course of and arising out of the employee's employment, the compensation to be paid by the self-insuring employer is limited to the disability suffered in the subsequent injury, additional compensation, if any, to be paid by the bureau out of the surplus created by section 4123.34 of the Revised Code.

(E) In addition to the requirements of this section, the administrator shall make and publish rules governing the manner of making application and the nature and extent of the proof required to justify a finding of fact by the administrator as to

granting the status of a self-insuring employer, which rules shall be general in their application, one of which rules shall provide that all self-insuring employers shall pay into the state insurance fund such amounts as are required to be credited to the surplus fund in division (B) of section 4123.34 of the Revised Code. The administrator may adopt rules establishing requirements in addition to the requirements described in division (B)(2) of this section that a public employer shall meet in order to qualify for self-insuring status.

Employers shall secure directly from the bureau central offices application forms upon which the bureau shall stamp a designating number. Prior to submission of an application, an employer shall make available to the bureau, and the bureau shall review, the information described in division (B)(1) of this section, and public employers shall make available, and the bureau shall review, the information necessary to verify whether the public employer meets the requirements listed in division (B)(2) of this section. An employer shall file the completed application forms with an application fee, which shall cover the costs of processing the application, as established by the administrator, by rule, with the bureau at least ninety days prior to the effective date of the employer's new status as a self-insuring employer. The application form is not deemed complete until all the required information is attached thereto. The bureau shall only accept applications that contain the required information.

(F) The bureau shall review completed applications within a reasonable time. If the bureau determines to grant an employer the status as a self-insuring employer, the bureau shall issue a statement, containing its findings of fact, that is prepared by the bureau and signed by the administrator. If the bureau

determines not to grant the status as a self-insuring employer, the bureau shall notify the employer of the determination and require the employer to continue to pay its full premium into the state insurance fund. The administrator also shall adopt rules establishing a minimum level of performance as a criterion for granting and maintaining the status as a self-insuring employer and fixing time limits beyond which failure of the self-insuring employer to provide for the necessary medical examinations and evaluations may not delay a decision on a claim.

(G) The administrator shall adopt rules setting forth procedures for auditing the program of self-insuring employers. The bureau shall conduct the audit upon a random basis or whenever the bureau has grounds for believing that a self-insuring employer is not in full compliance with bureau rules or this chapter.

The administrator shall monitor the programs conducted by self-insuring employers, to ensure compliance with bureau requirements and for that purpose, shall develop and issue to self-insuring employers standardized forms for use by the self-insuring employer in all aspects of the self-insuring employers' direct compensation program and for reporting of information to the bureau.

The bureau shall receive and transmit to the self-insuring employer all complaints concerning any self-insuring employer. In the case of a complaint against a self-insuring employer, the administrator shall handle the complaint through the self-insurance division of the bureau. The bureau shall maintain a file by employer of all complaints received that relate to the employer. The bureau shall evaluate each complaint and take

appropriate action.

The administrator shall adopt as a rule a prohibition against any self-insuring employer from harassing, dismissing, or otherwise disciplining any employee making a complaint, which rule shall provide for a financial penalty to be levied by the administrator payable by the offending self-insuring employer.

(H) For the purpose of making determinations as to whether to grant status as a self-insuring employer, the administrator may subscribe to and pay for a credit reporting service that offers financial and other business information about individual employers. The costs in connection with the bureau's subscription or individual reports from the service about an applicant may be included in the application fee charged employers under this section.

(I) A self-insuring employer that returns to the state insurance fund as a state fund employer shall provide the administrator with medical costs and indemnity costs by claim, and payroll by manual classification and year, and such other information the administrator may require. The self-insuring employer shall submit this information by dates and in a format determined by the administrator. The administrator shall develop a state fund experience modification factor for a self-insuring employer that returns to the state insurance fund based in whole or in part on the employer's self-insured experience and the information submitted.

(J) On the first day of July of each year, the administrator shall calculate separately each self-insuring employer's assessments for the safety and hygiene fund, administrative costs pursuant to section 4123.342 of the Revised Code, and for the surplus fund under division (B) of section

4123.34 of the Revised Code, on the basis of the paid compensation attributable to the individual self-insuring employer according to the following calculation:

(1) The total assessment against all self-insuring employers as a class for each fund and for the administrative costs for the year that the assessment is being made, as determined by the administrator, divided by the total amount of paid compensation for the previous calendar year attributable to all amenable self-insuring employers;

(2) Multiply the quotient in division (J)(1) of this section by the total amount of paid compensation for the previous calendar year that is attributable to the individual self-insuring employer for whom the assessment is being determined. Each self-insuring employer shall pay the assessment that results from this calculation, unless the assessment resulting from this calculation falls below a minimum assessment, which minimum assessment the administrator shall determine on the first day of July of each year with the advice and consent of the bureau of workers' compensation board of directors, in which event, the self-insuring employer shall pay the minimum assessment.

In determining the total amount due for the total assessment against all self-insuring employers as a class for each fund and the administrative assessment, the administrator shall reduce proportionately the total for each fund and assessment by the amount of money in the self-insurance assessment fund as of the date of the computation of the assessment.

The administrator shall calculate the assessment for the portion of the surplus fund under division (B) of section

4123.34 of the Revised Code that is used for reimbursement to a self-insuring employer under division (H) of section 4123.512 of the Revised Code in the same manner as set forth in divisions (J)(1) and (2) of this section except that the administrator shall calculate the total assessment for this portion of the surplus fund only on the basis of those self-insuring employers that retain participation in reimbursement to the self-insuring employer under division (H) of section 4123.512 of the Revised Code and the individual self-insuring employer's proportion of paid compensation shall be calculated only for those self-insuring employers who retain participation in reimbursement to the self-insuring employer under division (H) of section 4123.512 of the Revised Code.

An employer who no longer is a self-insuring employer in this state or who no longer is operating in this state, shall continue to pay assessments for administrative costs and for the surplus fund under division (B) of section 4123.34 of the Revised Code based upon paid compensation attributable to claims that occurred while the employer was a self-insuring employer within this state.

(K) There is hereby created in the state treasury the self-insurance assessment fund. All investment earnings of the fund shall be deposited in the fund. The administrator shall use the money in the self-insurance assessment fund only for administrative costs as specified in section 4123.341 of the Revised Code.

(L) Every self-insuring employer shall certify, in affidavit form subject to the penalty for perjury, to the bureau the amount of the self-insuring employer's paid compensation for the previous calendar year. In reporting paid compensation paid

for the previous year, a self-insuring employer shall exclude from the total amount of paid compensation any reimbursement the self-insuring employer receives in the previous calendar year from the surplus fund pursuant to section 4123.512 of the Revised Code for any paid compensation. The self-insuring employer also shall exclude from the paid compensation reported any amount recovered under section 4123.931 of the Revised Code and any amount that is determined not to have been payable to or on behalf of a claimant in any final administrative or judicial proceeding. The self-insuring employer shall exclude such amounts from the paid compensation reported in the reporting period subsequent to the date the determination is made. The administrator shall adopt rules, in accordance with Chapter 119. of the Revised Code, that provide for all of the following:

(1) Establishing the date by which self-insuring employers must submit such information and the amount of the assessments provided for in division (J) of this section for employers who have been granted self-insuring status within the last calendar year;

(2) If an employer fails to pay the assessment when due, the administrator may add a late fee penalty of not more than five hundred dollars to the assessment plus an additional penalty amount as follows:

(a) For an assessment from sixty-one to ninety days past due, the prime interest rate, multiplied by the assessment due;

(b) For an assessment from ninety-one to one hundred twenty days past due, the prime interest rate plus two per cent, multiplied by the assessment due;

(c) For an assessment from one hundred twenty-one to one

hundred fifty days past due, the prime interest rate plus four per cent, multiplied by the assessment due;

(d) For an assessment from one hundred fifty-one to one hundred eighty days past due, the prime interest rate plus six per cent, multiplied by the assessment due;

(e) For an assessment from one hundred eighty-one to two hundred ten days past due, the prime interest rate plus eight per cent, multiplied by the assessment due;

(f) For each additional thirty-day period or portion thereof that an assessment remains past due after it has remained past due for more than two hundred ten days, the prime interest rate plus eight per cent, multiplied by the assessment due.

(3) An employer may appeal a late fee penalty and penalty assessment to the administrator.

For purposes of division (L)(2) of this section, "prime interest rate" means the average bank prime rate, and the administrator shall determine the prime interest rate in the same manner as a county auditor determines the average bank prime rate under section 929.02 of the Revised Code.

The administrator shall include any assessment and penalties that remain unpaid for previous assessment periods in the calculation and collection of any assessments due under this division or division (J) of this section.

(M) As used in this section, "paid compensation" means all amounts paid by a self-insuring employer for living maintenance benefits, all amounts for compensation paid pursuant to sections 4121.63, 4121.67, 4123.56, 4123.57, 4123.58, 4123.59, 4123.60, ~~and~~ 4123.64, 4133.12, 4133.13, and 4133.14 of the Revised Code,

all amounts paid as wages in lieu of such compensation, all amounts paid in lieu of such compensation under a nonoccupational accident and sickness program fully funded by the self-insuring employer, and all amounts paid by a self-insuring employer for a violation of a specific safety standard pursuant to Section 35 of Article II, Ohio Constitution and section 4121.47 of the Revised Code.

(N) Should any section of this chapter or Chapter 4121. of the Revised Code providing for self-insuring employers' assessments based upon compensation paid be declared unconstitutional by a final decision of any court, then that section of the Revised Code declared unconstitutional shall revert back to the section in existence prior to November 3, 1989, providing for assessments based upon payroll.

(O) The administrator may grant a self-insuring employer the privilege to self-insure a construction project entered into by the self-insuring employer that is scheduled for completion within six years after the date the project begins, and the total cost of which is estimated to exceed one hundred million dollars or, for employers described in division (R) of this section, if the construction project is estimated to exceed twenty-five million dollars. The administrator may waive such cost and time criteria and grant a self-insuring employer the privilege to self-insure a construction project regardless of the time needed to complete the construction project and provided that the cost of the construction project is estimated to exceed fifty million dollars. A self-insuring employer who desires to self-insure a construction project shall submit to the administrator an application listing the dates the construction project is scheduled to begin and end, the estimated cost of the construction project, the contractors and

subcontractors whose employees are to be self-insured by the self-insuring employer, the provisions of a safety program that is specifically designed for the construction project, and a statement as to whether a collective bargaining agreement governing the rights, duties, and obligations of each of the parties to the agreement with respect to the construction project exists between the self-insuring employer and a labor organization.

A self-insuring employer may apply to self-insure the employees of either of the following:

(1) All contractors and subcontractors who perform labor or work or provide materials for the construction project;

(2) All contractors and, at the administrator's discretion, a substantial number of all the subcontractors who perform labor or work or provide materials for the construction project.

Upon approval of the application, the administrator shall mail a certificate granting the privilege to self-insure the construction project to the self-insuring employer. The certificate shall contain the name of the self-insuring employer and the name, address, and telephone number of the self-insuring employer's representatives who are responsible for administering workers' compensation claims for the construction project. The self-insuring employer shall post the certificate in a conspicuous place at the site of the construction project.

The administrator shall maintain a record of the contractors and subcontractors whose employees are covered under the certificate issued to the self-insured employer. A self-insuring employer immediately shall notify the administrator

when any contractor or subcontractor is added or eliminated from inclusion under the certificate.

Upon approval of the application, the self-insuring employer is responsible for the administration and payment of all claims under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code for the employees of the contractor and subcontractors covered under the certificate who receive injuries or are killed in the course of and arising out of employment on the construction project, or who contract an occupational disease in the course of employment on the construction project. For purposes of this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code, a claim that is administered and paid in accordance with this division is considered a claim against the self-insuring employer listed in the certificate. A contractor or subcontractor included under the certificate shall report to the self-insuring employer listed in the certificate, all claims that arise under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code in connection with the construction project for which the certificate is issued.

A self-insuring employer who complies with this division is entitled to the protections provided under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code with respect to the employees of the contractors and subcontractors covered under a certificate issued under this division for death or injuries that arise out of, or death, injuries, or occupational diseases that arise in the course of, those employees' employment on that construction project, as if the employees were employees of the self-insuring employer, provided that the self-insuring employer also complies with this section. No employee of the contractors and subcontractors covered under

a certificate issued under this division shall be considered the employee of the self-insuring employer listed in that certificate for any purposes other than this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code. Nothing in this division gives a self-insuring employer authority to control the means, manner, or method of employment of the employees of the contractors and subcontractors covered under a certificate issued under this division.

The contractors and subcontractors included under a certificate issued under this division are entitled to the protections provided under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code with respect to the contractor's or subcontractor's employees who are employed on the construction project which is the subject of the certificate, for death or injuries that arise out of, or death, injuries, or occupational diseases that arise in the course of, those employees' employment on that construction project.

The contractors and subcontractors included under a certificate issued under this division shall identify in their payroll records the employees who are considered the employees of the self-insuring employer listed in that certificate for purposes of this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code, and the amount that those employees earned for employment on the construction project that is the subject of that certificate. Notwithstanding any provision to the contrary under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code, the administrator shall exclude the payroll that is reported for employees who are considered the employees of the self-insuring employer listed in that certificate, and that the employees earned for employment on the construction project that is the subject of that certificate, when determining those

contractors' or subcontractors' premiums or assessments required under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code. A self-insuring employer issued a certificate under this division shall include in the amount of paid compensation it reports pursuant to division (L) of this section, the amount of paid compensation the self-insuring employer paid pursuant to this division for the previous calendar year.

Nothing in this division shall be construed as altering the rights of employees under this chapter and Chapter 4121. of the Revised Code as those rights existed prior to September 17, 1996. Nothing in this division shall be construed as altering the rights devolved under sections 2305.31 and 4123.82 of the Revised Code as those rights existed prior to September 17, 1996.

As used in this division, "privilege to self-insure a construction project" means privilege to pay individually compensation, and to furnish medical, surgical, nursing, and hospital services and attention and funeral expenses directly to injured employees or the dependents of killed employees.

(P) A self-insuring employer whose application is granted under division (O) of this section shall designate a safety professional to be responsible for the administration and enforcement of the safety program that is specifically designed for the construction project that is the subject of the application.

A self-insuring employer whose application is granted under division (O) of this section shall employ an ombudsperson for the construction project that is the subject of the application. The ombudsperson shall have experience in workers'

compensation or the construction industry, or both. The ombudsperson shall perform all of the following duties:

(1) Communicate with and provide information to employees who are injured in the course of, or whose injury arises out of employment on the construction project, or who contract an occupational disease in the course of employment on the construction project;

(2) Investigate the status of a claim upon the request of an employee to do so;

(3) Provide information to claimants, third party administrators, employers, and other persons to assist those persons in protecting their rights under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code.

A self-insuring employer whose application is granted under division (O) of this section shall post the name of the safety professional and the ombudsperson and instructions for contacting the safety professional and the ombudsperson in a conspicuous place at the site of the construction project.

(Q) The administrator may consider all of the following when deciding whether to grant a self-insuring employer the privilege to self-insure a construction project as provided under division (O) of this section:

(1) Whether the self-insuring employer has an organizational plan for the administration of the workers' compensation law;

(2) Whether the safety program that is specifically designed for the construction project provides for the safety of employees employed on the construction project, is applicable to all contractors and subcontractors who perform labor or work or

provide materials for the construction project, and has as a component, a safety training program that complies with standards adopted pursuant to the "Occupational Safety and Health Act of 1970," 84 Stat. 1590, 29 U.S.C.A. 651, and provides for continuing management and employee involvement;

(3) Whether granting the privilege to self-insure the construction project will reduce the costs of the construction project;

(4) Whether the self-insuring employer has employed an ombudsperson as required under division (P) of this section;

(5) Whether the self-insuring employer has sufficient surety to secure the payment of claims for which the self-insuring employer would be responsible pursuant to the granting of the privilege to self-insure a construction project under division (O) of this section.

(R) As used in divisions (O), (P), and (Q), "self-insuring employer" includes the following employers, whether or not they have been granted the status of being a self-insuring employer under division (B) of this section:

(1) A state institution of higher education;

(2) A school district;

(3) A county school financing district;

(4) An educational service center;

(5) A community school established under Chapter 3314. of the Revised Code;

(6) A municipal power agency as defined in section 3734.058 of the Revised Code.

(S) As used in this section:

(1) "Unvoted debt capacity" means the amount of money that a public employer may borrow without voter approval of a tax levy;

(2) "State institution of higher education" means the state universities listed in section 3345.011 of the Revised Code, community colleges created pursuant to Chapter 3354. of the Revised Code, university branches created pursuant to Chapter 3355. of the Revised Code, technical colleges created pursuant to Chapter 3357. of the Revised Code, and state community colleges created pursuant to Chapter 3358. of the Revised Code.

**Sec. 4123.351.** (A) The administrator of workers' compensation shall require every self-insuring employer, including any self-insuring employer that is indemnified by a captive insurance company granted a certificate of authority under Chapter 3964. of the Revised Code, to pay a contribution, calculated under this section, to the self-insuring employers' guaranty fund established pursuant to this section. The fund shall provide for payment of compensation and benefits to employees of the self-insuring employer in order to cover any default in payment by that employer.

(B) The bureau of workers' compensation shall operate the self-insuring employers' guaranty fund for self-insuring employers. The administrator annually shall establish the contributions due from self-insuring employers for the fund at rates as low as possible but such as will assure sufficient moneys to guarantee the payment of any claims against the fund. The bureau's operation of the fund is not subject to sections 3929.10 to 3929.18 of the Revised Code or to regulation by the

superintendent of insurance.

(C) If a self-insuring employer defaults, the bureau shall recover the amounts paid as a result of the default from the self-insuring employers' guaranty fund. If a self-insuring employer defaults and is in compliance with this section for the payment of contributions to the fund, such self-insuring employer is entitled to the immunity conferred by section 4123.74 of the Revised Code for any claim arising during any period the employer is in compliance with this section.

(D)(1) There is hereby established a self-insuring employers' guaranty fund, which shall be in the custody of the treasurer of state and which shall be separate from the other funds established and administered pursuant to this chapter. The fund shall consist of contributions and other payments made by self-insuring employers under this section. All investment earnings of the fund shall be credited to the fund. The bureau shall make disbursements from the fund pursuant to this section.

(2) The administrator has the same powers to invest any of the surplus or reserve belonging to the fund as are delegated to the administrator under section 4123.44 of the Revised Code with respect to the state insurance fund. The administrator shall apply interest earned solely to the reduction of assessments for contributions from self-insuring employers and to the payments required due to defaults.

(3) If the bureau of workers' compensation board of directors determines that reinsurance of the risks of the fund is necessary to assure solvency of the fund, the board may:

(a) Enter into contracts for the purchase of reinsurance coverage of the risks of the fund with any company or agency

authorized by law to issue contracts of reinsurance;

(b) Require the administrator to pay the cost of reinsurance from the fund;

(c) Include the costs of reinsurance as a liability and estimated liability of the fund.

(E) The administrator, with the advice and consent of the board, may adopt rules pursuant to Chapter 119. of the Revised Code for the implementation of this section, including a rule, notwithstanding division (C) of this section, requiring self-insuring employers to provide security in addition to the contribution to the self-insuring employers' guaranty fund required by this section. The additional security required by the rule, as the administrator determines appropriate, shall be sufficient and adequate to provide for financial assurance to meet the obligations of self-insuring employers under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code.

(F) The purchase of coverage under this section by self-insuring employers is valid notwithstanding the prohibitions contained in division (A) of section 4123.82 of the Revised Code and is in addition to the indemnity contracts that self-insuring employers may purchase pursuant to division (B) of section 4123.82 of the Revised Code.

(G) The administrator, on behalf of the self-insuring employers' guaranty fund, has the rights of reimbursement and subrogation and shall collect from a defaulting self-insuring employer or other liable person all amounts the administrator has paid or reasonably expects to pay from the fund on account of the defaulting self-insuring employer.

(H) The assessments for contributions, the administration of the self-insuring employers' guaranty fund, the investment of the money in the fund, and the payment of liabilities incurred by the fund do not create any liability upon the state.

Except for a gross abuse of discretion, neither the board, nor the individual members thereof, nor the administrator shall incur any obligation or liability respecting the assessments for contributions, the administration of the self-insuring employers' guaranty fund, the investment of the fund, or the payment of liabilities therefrom.

**Sec. 4123.353.** (A) A public employer, except for a board of county commissioners described in division (G) of section 4123.01 of the Revised Code, a board of a county hospital, or a publicly owned utility, who is granted the status of self-insuring employer pursuant to section 4123.35 of the Revised Code shall do all of the following:

(1) Reserve funds as necessary, in accordance with sound and prudent actuarial judgment, to cover the costs the public employer may potentially incur to remain in compliance with this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code;

(2) Include all activity under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code in a single fund on the public employer's accounting records;

(3) Within ninety days after the last day of each fiscal year, prepare and maintain a report of the reserved funds described in division (A)(1) of this section and disbursements made from those reserved funds.

(B) A public employer who is subject to division (A) of

this section shall make the reports required by that division available for inspection by the administrator of workers' compensation and any other person at all reasonable times during regular business hours.

**Sec. 4123.402.** The department of administrative services shall act as employer for workers' compensation claims arising under this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code for all state agencies, offices, institutions, boards, or commissions except for public colleges and universities. The department shall review, process, certify or contest, and administer workers' compensation claims for each state agency, office, institution, board, and commission, except for a public college or university, unless otherwise agreed to between the department and a state agency, office, institution, board, or commission.

The department may enter into a contract with one or more third party administrators for claims management of a state agency, office, institution, board, or commission, except for a public college or university, for workers' compensation claims and for claims covered by the occupational injury leave program adopted pursuant to section 124.381 of the Revised Code.

**Sec. 4123.441.** (A) The administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors shall employ a person or designate an employee of the bureau of workers' compensation who is designated as a chartered financial analyst by the CFA institute and who is licensed by the division of securities in the department of commerce as a bureau of workers' compensation chief investment officer to be the chief investment officer for the bureau of workers' compensation. After ninety days after

September 29, 2005, the bureau of workers' compensation may not employ a bureau of workers' compensation chief investment officer, as defined in section 1707.01 of the Revised Code, who does not hold a valid bureau of workers' compensation chief investment officer license issued by the division of securities in the department of commerce. The board shall notify the division of securities of the department of commerce in writing of its designation and of any change in its designation within ten calendar days after the designation or change.

(B) The bureau of workers' compensation chief investment officer shall reasonably supervise employees of the bureau who handle investment of assets of funds specified in this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code with a view toward preventing violations of Chapter 1707. of the Revised Code, the "Commodity Exchange Act," 42 Stat. 998, 7 U.S.C. 1, the "Securities Act of 1933," 48 Stat. 74, 15 U.S.C. 77a, the "Securities Exchange Act of 1934," 48 Stat. 881, 15 U.S.C. 78a, and the rules and regulations adopted under those statutes. This duty of reasonable supervision shall include the adoption, implementation, and enforcement of written policies and procedures reasonably designed to prevent employees of the bureau who handle investment of assets of the funds specified in this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code, from misusing material, nonpublic information in violation of those laws, rules, and regulations.

For purposes of this division, no bureau of workers' compensation chief investment officer shall be considered to have failed to satisfy the officer's duty of reasonable supervision if the officer has done all of the following:

(1) Adopted and implemented written procedures, and a

system for applying the procedures, that would reasonably be expected to prevent and detect, insofar as practicable, any violation by employees handling investments of assets of the funds specified in this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code;

(2) Reasonably discharged the duties and obligations incumbent on the bureau of workers' compensation chief investment officer by reason of the established procedures and the system for applying the procedures when the officer had no reasonable cause to believe that there was a failure to comply with the procedures and systems;

(3) Reviewed, at least annually, the adequacy of the policies and procedures established pursuant to this section and the effectiveness of their implementation.

(C) The bureau of workers' compensation chief investment officer shall establish and maintain a policy to monitor and evaluate the effectiveness of securities transactions executed on behalf of the bureau.

**Sec. 4123.442.** When developing the investment policy for the investment of the assets of the funds specified in this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code, the workers' compensation investment committee shall do all of the following:

(A) Specify the asset allocation targets and ranges, risk factors, asset class benchmarks, time horizons, total return objectives, and performance evaluation guidelines;

(B) Prohibit investing the assets of those funds, directly or indirectly, in vehicles that target any of the following:

(1) Coins;

(2) Artwork;

(3) Horses;

(4) Jewelry or gems;

(5) Stamps;

(6) Antiques;

(7) Artifacts;

(8) Collectibles;

(9) Memorabilia;

(10) Similar unregulated investments that are not commonly part of an institutional portfolio, that lack liquidity, and that lack readily determinable valuation.

(C) Specify that the administrator of workers' compensation may invest in an investment class only if the bureau of workers' compensation board of directors, by a majority vote, opens that class;

(D) Prohibit investing the assets of those funds in any class of investments the board, by majority vote, closed, or any specific investment in which the board prohibits the administrator from investing;

(E) Not specify in the investment policy that the administrator or employees of the bureau of workers' compensation are prohibited from conducting business with an investment management firm, any investment management professional associated with that firm, any third party solicitor associated with that firm, or any political action committee controlled by that firm or controlled by an investment management professional of that firm based on criteria that are

more restrictive than the restrictions described in divisions (Y) and (Z) of section 3517.13 of the Revised Code.

**Sec. 4123.444.** (A) As used in this section and section 4123.445 of the Revised Code:

(1) "Bureau of workers' compensation funds" means any fund specified in Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code that the administrator of workers' compensation has the authority to invest, in accordance with the administrator's investment authority under section 4123.44 of the Revised Code.

(2) "Investment manager" means any person with whom the administrator of workers' compensation contracts pursuant to section 4123.44 of the Revised Code to facilitate the investment of assets of bureau of workers' compensation funds.

(3) "Business entity" means any person with whom an investment manager contracts for the investment of assets of bureau of workers' compensation funds.

(4) "Financial or investment crime" means any criminal offense involving theft, receiving stolen property, embezzlement, forgery, fraud, passing bad checks, money laundering, drug trafficking, or any criminal offense involving money or securities, as set forth in Chapters 2909., 2911., 2913., 2915., 2921., 2923., and 2925. of the Revised Code or other law of this state, or the laws of any other state or the United States that are substantially equivalent to those offenses.

(B)(1) Before entering into a contract with an investment manager to invest bureau of workers' compensation funds, the administrator shall do both of the following:

(a) Request from any investment manager with whom the administrator wishes to contract for those investments a list of all employees who will be investing assets of bureau of workers' compensation funds. The list shall specify each employee's state of residence for the five years prior to the date of the administrator's request.

(b) Request that the superintendent of the bureau of criminal investigation and identification conduct a criminal records check in accordance with this section and section 109.579 of the Revised Code with respect to every employee the investment manager names in that list.

(2) After an investment manager enters into a contract with the administrator to invest bureau of workers' compensation funds and before an investment manager enters into a contract with a business entity to facilitate those investments, the investment manager shall request from any business entity with whom the investment manager wishes to contract to make those investments a list of all employees who will be investing assets of the bureau of workers' compensation funds. The list shall specify each employee's state of residence for the five years prior to the investment manager's request. The investment manager shall forward to the administrator the list received from the business entity. The administrator shall request the superintendent to conduct a criminal records check in accordance with this section and section 109.579 of the Revised Code with respect to every employee the business entity names in that list. Upon receipt of the results of the criminal records check, the administrator shall advise the investment manager whether the results were favorable or unfavorable.

(3) If, after a contract has been entered into between the

administrator and an investment manager or between an investment manager and a business entity for the investment of assets of bureau of workers' compensation funds, the investment manager or business entity wishes to have an employee who was not the subject of a criminal records check under division (B)(1) or (B)(2) of this section invest assets of the bureau of workers' compensation funds, that employee shall be the subject of a criminal records check pursuant to this section and section 109.579 of the Revised Code prior to handling the investment of assets of those funds. The investment manager shall submit to the administrator the name of that employee along with the employee's state of residence for the five years prior to the date in which the administrator requests the criminal records check. The administrator shall request that the superintendent conduct a criminal records check on that employee pursuant to this section and section 109.579 of the Revised Code.

(C)(1) If an employee who is the subject of a criminal records check pursuant to division (B) of this section has not been a resident of this state for the five-year period immediately prior to the time the criminal records check is requested or does not provide evidence that within that five-year period the superintendent has requested information about the employee from the federal bureau of investigation in a criminal records check, the administrator shall request that the superintendent obtain information from the federal bureau of investigation as a part of the criminal records check for the employee. If the employee has been a resident of this state for at least that five-year period, the administrator may, but is not required to, request that the superintendent request and include in the criminal records check information about that employee from the federal bureau of investigation.

(2) The administrator shall provide to an investment manager a copy of the form prescribed pursuant to division (C)(1) of section 109.579 of the Revised Code and a standard impression sheet for each employee for whom a criminal records check must be performed, to obtain fingerprint impressions as prescribed pursuant to division (C)(2) of section 109.579 of the Revised Code. The investment manager shall obtain the completed form and impression sheet either directly from each employee or from a business entity and shall forward the completed form and sheet to the administrator, who shall forward these forms and sheets to the superintendent.

(3) Any employee who receives a copy of the form and the impression sheet pursuant to division (C)(2) of this section and who is requested to complete the form and provide a set of fingerprint impressions shall complete the form or provide all the information necessary to complete the form and shall complete the impression sheets in the manner prescribed in division (C)(2) of section 109.579 of the Revised Code.

(D) For each criminal records check the administrator requests under this section, at the time the administrator makes a request the administrator shall pay to the superintendent the fee the superintendent prescribes pursuant to division (E) of section 109.579 of the Revised Code.

**Sec. 4123.46.** (A)(1) Except as provided in division (A)(2) of this section, the bureau of workers' compensation shall disburse the state insurance fund to employees of employers who have paid into the fund the premiums applicable to the classes to which they belong when the employees have been injured in the course of their employment, wherever the injuries have occurred, and provided the injuries have not been purposely self-

inflicted, or to the dependents of the employees in case death has ensued.

(2) As long as injuries have not been purposely self-inflicted, the bureau shall disburse the surplus fund created under section 4123.34 of the Revised Code to off-duty peace officers, firefighters, emergency medical technicians, and first responders, or to their dependents if death ensues, who are injured while responding to inherently dangerous situations that call for an immediate response on the part of the person, regardless of whether the person was within the limits of the person's jurisdiction when responding, on the condition that the person responds to the situation as the person otherwise would if the person were on duty in the person's jurisdiction.

As used in division (A)(2) of this section, "peace officer," "firefighter," "emergency medical technician," and "first responder~~,~~" ~~and "jurisdiction"~~ have the same meanings as in section 4123.01 of the Revised Code.

(B) All self-insuring employers, in compliance with this chapter, shall pay the compensation to injured employees, or to the dependents of employees who have been killed in the course of their employment, unless the injury or death of the employee was purposely self-inflicted, and shall furnish the medical, surgical, nurse, and hospital care and attention or funeral expenses as would have been paid and furnished by virtue of this chapter or Chapter 4133. of the Revised Code under a similar state of facts by the bureau out of the state insurance fund if the employer had paid the premium into the fund.

If any rule or regulation of a self-insuring employer provides for or authorizes the payment of greater compensation or more complete or extended medical care, nursing, surgical,

and hospital attention, or funeral expenses to the injured employees, or to the dependents of the employees as may be killed, the employer shall pay to the employees, or to the dependents of employees killed, the amount of compensation and furnish the medical care, nursing, surgical, and hospital attention or funeral expenses provided by the self-insuring employer's rules and regulations.

(C) Payment to injured employees, or to their dependents in case death has ensued, is in lieu of any and all rights of action against the employer of the injured or killed employees.

**Sec. 4123.47.** (A) The administrator of workers' compensation shall have an actuarial analysis of the state insurance fund and all other funds specified in this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code made at least once each year. The analysis shall be made and certified by recognized, credentialed property or casualty actuaries who shall be selected by the bureau of workers' compensation board of directors. The expense of the analysis shall be paid from the state insurance fund. The administrator shall make copies of the analysis available to the workers' compensation audit committee at no charge and to the public at cost.

(B) The auditor of state annually shall conduct an audit of the administration of this chapter<u> and Chapter 4133. of the Revised Code</u> by the industrial commission<u>, the occupational pneumoconiosis board,</u> and the bureau of workers' compensation and <u>of</u> the safety and hygiene fund. The cost of the audit shall be charged to the administrative costs of the bureau as defined in section 4123.341 of the Revised Code. The audit shall include audits of all fiscal activities, claims processing and handling,

and employer premium collections. The auditor shall prepare a report of the audit together with recommendations and transmit copies of the report to the industrial commission, the bureau of workers' compensation board of directors, the administrator, the governor, and to the general assembly. The auditor shall make copies of the report available to the public at cost.

(C) The administrator may retain the services of a recognized actuary on a consulting basis for the purpose of evaluating the actuarial soundness of premium rates and classifications and all other matters involving the administration of the state insurance fund. The expense of services provided by the actuary shall be paid from the state insurance fund.

**Sec. 4123.51.** The administrator of workers' compensation shall by published notices and other appropriate means endeavor to cause claims to be filed in the service office of the bureau of workers' compensation from which the investigation and determination of the claim may be made most expeditiously. A claim or appeal under this chapter or Chapter 4121., 4127., ~~or~~ 4131., or 4133. of the Revised Code may be filed with any office of the bureau of workers' compensation or the industrial commission, within the required statutory period, and is considered received for the purpose of processing the claims or appeals.

The administrator, on the form an employee or an individual acting on behalf of the employee files with the administrator or a self-insuring employer to initiate a claim under this chapter or Chapter 4121., 4127., ~~or~~ 4131., or 4133. of the Revised Code, shall include a statement that is substantially similar to the following statement in bold font

and set apart from all other text in the form:

"By signing this form, I elect to only receive compensation, benefits, or both that are provided for in this claim under Ohio's workers' compensation laws. I understand and I hereby waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or the death resulting from an injury or occupational disease, for which I am filing this claim. I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will not file and have not filed a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim."

**Sec. 4123.511.** (A) Within seven days after receipt of any claim under this chapter or Chapter 4133. of the Revised Code, the bureau of workers' compensation shall notify the claimant and the employer of the claimant of the receipt of the claim and of the facts alleged therein. If the bureau receives from a person other than the claimant written or facsimile information or information communicated verbally over the telephone indicating that an injury or occupational disease has occurred or been contracted which may be compensable under this chapter or Chapter 4133. of the Revised Code, the bureau shall notify the employee and the employer of the information. If the information is provided verbally over the telephone, the person providing the information shall provide written verification of the information to the bureau according to division (E) of section 4123.84 of the Revised Code. The receipt of the information in writing or facsimile, or if initially by telephone, the subsequent written verification, and the notice

by the bureau shall be considered an application for compensation under section 4123.84 or 4123.85 of the Revised Code, provided that the conditions of division (E) of section 4123.84 of the Revised Code apply to information provided verbally over the telephone. Upon receipt of a claim, the bureau shall advise the claimant of the claim number assigned and the claimant's right to representation in the processing of a claim or to elect no representation. If the bureau determines that a claim is determined to be a compensable lost-time claim, the bureau shall notify the claimant and the employer of the availability of rehabilitation services. No bureau or industrial commission employee shall directly or indirectly convey any information in derogation of this right. This section shall in no way abrogate the bureau's responsibility to aid and assist a claimant in the filing of a claim and to advise the claimant of the claimant's rights under the law.

The administrator of workers' compensation shall assign all claims and investigations to the bureau service office from which investigation and determination may be made most expeditiously.

The bureau shall investigate the facts concerning an injury or occupational disease and ascertain such facts in whatever manner is most appropriate and may obtain statements of the employee, employer, attending physician, and witnesses in whatever manner is most appropriate.

The administrator, with the advice and consent of the bureau of workers' compensation board of directors, may adopt rules that identify specified medical conditions that have a historical record of being allowed whenever included in a claim. The administrator may grant immediate allowance of any medical

condition identified in those rules upon the filing of a claim involving that medical condition and may make immediate payment of medical bills for any medical condition identified in those rules that is included in a claim. If an employer contests the allowance of a claim involving any medical condition identified in those rules, and the claim is disallowed, payment for the medical condition included in that claim shall be charged to and paid from the surplus fund created under section 4123.34 of the Revised Code.

(B)(1) Except as provided in division (B)(2) of this section, in claims other than those in which the employer is a self-insuring employer, if the administrator determines under division (A) of this section that a claimant is or is not entitled to an award of compensation or benefits, the administrator shall issue an order no later than twenty-eight days after the sending of the notice under division (A) of this section, granting or denying the payment of the compensation or benefits, or both as is appropriate to the claimant. Notwithstanding the time limitation specified in this division for the issuance of an order, if a medical examination of the claimant is required by statute, the administrator promptly shall schedule the claimant for that examination and shall issue an order no later than twenty-eight days after receipt of the report of the examination. The administrator shall notify the claimant and the employer of the claimant and their respective representatives in writing of the nature of the order and the amounts of compensation and benefit payments involved. The employer or claimant may appeal the order pursuant to division (C) of this section within fourteen days after the date of the receipt of the order. The employer and claimant may waive, in writing, their rights to an appeal under this division.

(2) Notwithstanding the time limitation specified in division (B)(1) of this section for the issuance of an order, if the employer certifies a claim for payment of compensation or benefits, or both, to a claimant, and the administrator has completed the investigation of the claim, the payment of benefits or compensation, or both, as is appropriate, shall commence upon the later of the date of the certification or completion of the investigation and issuance of the order by the administrator, provided that the administrator shall issue the order no later than the time limitation specified in division (B)(1) of this section.

(3) If an appeal is made under division (B)(1) or (2) of this section, the administrator shall forward the claim file to the appropriate district hearing officer within seven days of the appeal. In contested claims other than state fund claims, the administrator shall forward the claim within seven days of the administrator's receipt of the claim to the industrial commission, which shall refer the claim to an appropriate district hearing officer for a hearing in accordance with division (C) of this section.

(C) ~~If an employer or claimant timely appeals the order of the administrator issued under division (B) of this section or in the case of other contested claims other than state fund claims,~~ (1) Except as provided in division (C)(2) of this section, the commission shall refer ~~the~~ a claim to an appropriate district hearing officer according to rules the commission adopts under section 4121.36 of the Revised Code if an employer or claimant timely appeals any of the following:

(a) An order or determination of the administrator issued under division (B) of this section or section 4133.06 of the

Revised Code;

(b) A determination of the occupational pneumoconiosis board issued under section 4133.09 of the Revised Code;

(c) Other contested claims other than state fund claims.

(2) Division (C)(1) of this section does not apply to a claim that has been referred to the occupational pneumoconiosis board under section 4133.08 of the Revised Code.

The district hearing officer shall notify the parties and their respective representatives of the time and place of the hearing.

The district hearing officer shall hold a hearing on a disputed issue or claim within forty-five days after the filing of the appeal under this division and issue a decision within seven days after holding the hearing. The district hearing officer shall notify the parties and their respective representatives in writing of the order. Any party may appeal an order issued under this division pursuant to division (D) of this section within fourteen days after receipt of the order under this division.

(D) Upon the timely filing of an appeal of the order of the district hearing officer issued under division (C) of this section, the commission shall refer the claim file to an appropriate staff hearing officer according to its rules adopted under section 4121.36 of the Revised Code. The staff hearing officer shall hold a hearing within forty-five days after the filing of an appeal under this division and issue a decision within seven days after holding the hearing under this division. The staff hearing officer shall notify the parties and their respective representatives in writing of the staff hearing

officer's order. Any party may appeal an order issued under this division pursuant to division (E) of this section within fourteen days after receipt of the order under this division.

(E) Upon the filing of a timely appeal of the order of the staff hearing officer issued under division (D) of this section, the commission or a designated staff hearing officer, on behalf of the commission, shall determine whether the commission will hear the appeal. If the commission or the designated staff hearing officer decides to hear the appeal, the commission or the designated staff hearing officer shall notify the parties and their respective representatives in writing of the time and place of the hearing. The commission shall hold the hearing within forty-five days after the filing of the notice of appeal and, within seven days after the conclusion of the hearing, the commission shall issue its order affirming, modifying, or reversing the order issued under division (D) of this section. The commission shall notify the parties and their respective representatives in writing of the order. If the commission or the designated staff hearing officer determines not to hear the appeal, within fourteen days after the expiration of the period in which an appeal of the order of the staff hearing officer may be filed as provided in division (D) of this section, the commission or the designated staff hearing officer shall issue an order to that effect and notify the parties and their respective representatives in writing of that order.

Except as otherwise provided in this chapter and Chapters 4121., 4127., ~~and~~ 4131.<u>, and 4133.</u> of the Revised Code, any party may appeal an order issued under this division to the court pursuant to section 4123.512 of the Revised Code within sixty days after receipt of the order, subject to the limitations contained in that section.

(F) Every notice of an appeal from an order issued under divisions (B), (C), (D), and (E) of this section shall state the names of the claimant and employer, the number of the claim, the date of the decision appealed from, and the fact that the appellant appeals therefrom.

(G) All of the following apply to the proceedings under divisions (C), (D), and (E) of this section:

(1) The parties shall proceed promptly and without continuances except for good cause;

(2) The parties, in good faith, shall engage in the free exchange of information relevant to the claim prior to the conduct of a hearing according to the rules the commission adopts under section 4121.36 of the Revised Code;

(3) The administrator is a party and may appear and participate at all administrative proceedings on behalf of the state insurance fund. However, in cases in which the employer is represented, the administrator shall neither present arguments nor introduce testimony that is cumulative to that presented or introduced by the employer or the employer's representative. The administrator may file an appeal under this section on behalf of the state insurance fund; however, except in cases arising under section 4123.343 of the Revised Code, the administrator only may appeal questions of law or issues of fraud when the employer appears in person or by representative.

(H) Except as provided in section 4121.63 of the Revised Code and division (K) of this section, payments of compensation to a claimant or on behalf of a claimant as a result of any order issued under this chapter or Chapter 4133. of the Revised Code shall commence upon the earlier of the following:

(1) Fourteen days after the date the administrator issues an order under division (B) of this section or section 4133.06 of the Revised Code, unless that order is appealed or the claim has been referred to the occupational pneumoconiosis board, as applicable;

(2) Fourteen days after the date the occupational pneumoconiosis board makes a determination under section 4133.09 of the Revised Code;

(3) The date when the employer has waived the right to appeal a decision issued under division (B) of this section or Chapter 4133. of the Revised Code;

~~(3)~~ (4) If no appeal of an order has been filed under this section or to a court under section 4123.512 of the Revised Code, the expiration of the time limitations for the filing of an appeal of an order;

~~(4)~~ (5) The date of receipt by the employer of an order of a district hearing officer, a staff hearing officer, or the industrial commission issued under division (C), (D), or (E) of this section.

(I) Except as otherwise provided in division (B) of section 4123.66 of the Revised Code, payments of medical benefits payable under this chapter or Chapter 4121., 4127., ~~or~~ 4131., or 4133. of the Revised Code shall commence upon the earlier of the following:

(1) The date of the issuance of the staff hearing officer's order under division (D) of this section;

(2) The date of the final administrative or judicial determination.

(J) The administrator shall charge the compensation payments made in accordance with division (H) of this section or medical benefits payments made in accordance with division (I) of this section to an employer's experience immediately after the employer has exhausted the employer's administrative appeals as provided in this section or section 4133.06 of the Revised Code or has waived the employer's right to an administrative appeal under division (B) of this section or Chapter 4133. of the Revised Code, subject to the adjustment specified in division (H) of section 4123.512 of the Revised Code.

(K) Upon the final administrative or judicial determination under this section or section 4123.512 of the Revised Code of an appeal of an order to pay compensation, if a claimant is found to have received compensation pursuant to a prior order which is reversed upon subsequent appeal, the claimant's employer, if a self-insuring employer, or the bureau, shall withhold from any amount to which the claimant becomes entitled pursuant to any claim, past, present, or future, under Chapter 4121., 4123., 4127., ~~or~~ 4131., or 4133. of the Revised Code, the amount of previously paid compensation to the claimant which, due to reversal upon appeal, the claimant is not entitled, pursuant to the following criteria:

(1) No withholding for the first twelve weeks of temporary total disability compensation pursuant to ~~section~~ sections 4123.56 and 4133.12 of the Revised Code shall be made;

(2) Forty per cent of all awards of compensation paid pursuant to sections 4123.56 ~~and~~ , 4123.57, 4133.12, and 4133.13 of the Revised Code, until the amount overpaid is refunded;

(3) Twenty-five per cent of any compensation paid pursuant to ~~section~~ sections 4123.58 and 4133.14 of the Revised Code

until the amount overpaid is refunded;

(4) If, pursuant to an appeal under section 4123.512 of the Revised Code, the court of appeals or the supreme court reverses the allowance of the claim, then no amount of any compensation will be withheld.

The administrator and self-insuring employers, as appropriate, are subject to the repayment schedule of this division only with respect to an order to pay compensation that was properly paid under a previous order, but which is subsequently reversed upon an administrative or judicial appeal. The administrator and self-insuring employers are not subject to, but may utilize, the repayment schedule of this division, or any other lawful means, to collect payment of compensation made to a person who was not entitled to the compensation due to fraud as determined by the administrator or the industrial commission.

(L) If a staff hearing officer or the commission fails to issue a decision or the commission fails to refuse to hear an appeal within the time periods required by this section, payments to a claimant shall cease until the staff hearing officer or commission issues a decision or hears the appeal, unless the failure was due to the fault or neglect of the employer or the employer agrees that the payments should continue for a longer period of time.

(M) Except as otherwise provided in this section or section 4123.522 of the Revised Code, no appeal is timely filed under this section unless the appeal is filed with the time limits set forth in this section.

(N) No person who is not an employee of the bureau or

commission or who is not by law given access to the contents of a claims file shall have a file in the person's possession.

(O) Upon application of a party who resides in an area in which an emergency or disaster is declared, the industrial commission and hearing officers of the commission may waive the time frame within which claims and appeals of claims set forth in this section must be filed upon a finding that the applicant was unable to comply with a filing deadline due to an emergency or a disaster.

As used in this division:

(1) "Emergency" means any occasion or instance for which the governor of Ohio or the president of the United States publicly declares an emergency and orders state or federal assistance to save lives and protect property, the public health and safety, or to lessen or avert the threat of a catastrophe.

(2) "Disaster" means any natural catastrophe or fire, flood, or explosion, regardless of the cause, that causes damage of sufficient magnitude that the governor of Ohio or the president of the United States, through a public declaration, orders state or federal assistance to alleviate damage, loss, hardship, or suffering that results from the occurrence.

**Sec. 4123.512.** (A) The claimant or the employer may appeal an order of the industrial commission made under division (E) of section 4123.511 of the Revised Code in any injury or occupational disease case, other than a decision as to the extent of disability to the court of common pleas of the county in which the injury was inflicted or in which the contract of employment was made if the injury occurred outside the state, or in which the contract of employment was made if the exposure

occurred outside the state. If no common pleas court has jurisdiction for the purposes of an appeal by the use of the jurisdictional requirements described in this division, the appellant may use the venue provisions in the Rules of Civil Procedure to vest jurisdiction in a court. If the claim is for an occupational disease, the appeal shall be to the court of common pleas of the county in which the exposure which caused the disease occurred. Like appeal may be taken from an order of a staff hearing officer made under division (D) of section 4123.511 of the Revised Code from which the commission has refused to hear an appeal. The appellant shall file the notice of appeal with a court of common pleas within sixty days after the date of the receipt of the order appealed from or the date of receipt of the order of the commission refusing to hear an appeal of a staff hearing officer's decision under division (D) of section 4123.511 of the Revised Code. The filing of the notice of the appeal with the court is the only act required to perfect the appeal.

If an action has been commenced in a court of a county other than a court of a county having jurisdiction over the action, the court, upon notice by any party or upon its own motion, shall transfer the action to a court of a county having jurisdiction.

Notwithstanding anything to the contrary in this section, if the commission determines under section 4123.522 of the Revised Code that an employee, employer, or their respective representatives have not received written notice of an order or decision which is appealable to a court under this section and which grants relief pursuant to section 4123.522 of the Revised Code, the party granted the relief has sixty days from receipt of the order under section 4123.522 of the Revised Code to file

a notice of appeal under this section.

(B) The notice of appeal shall state the names of the administrator of workers' compensation, the claimant, and the employer; the number of the claim; the date of the order appealed from; and the fact that the appellant appeals therefrom.

The administrator, the claimant, and the employer shall be parties to the appeal and the court, upon the application of the commission, shall make the commission a party. The party filing the appeal shall serve a copy of the notice of appeal on the administrator at the central office of the bureau of workers' compensation in Columbus. The administrator shall notify the employer that if the employer fails to become an active party to the appeal, then the administrator may act on behalf of the employer and the results of the appeal could have an adverse effect upon the employer's premium rates or may result in a recovery from the employer if the employer is determined to be a noncomplying employer under section 4123.75 of the Revised Code.

(C) The attorney general or one or more of the attorney general's assistants or special counsel designated by the attorney general shall represent the administrator and the commission. In the event the attorney general or the attorney general's designated assistants or special counsel are absent, the administrator or the commission shall select one or more of the attorneys in the employ of the administrator or the commission as the administrator's attorney or the commission's attorney in the appeal. Any attorney so employed shall continue the representation during the entire period of the appeal and in all hearings thereof except where the continued representation becomes impractical.

(D) Upon receipt of notice of appeal, the clerk of courts shall provide notice to all parties who are appellees and to the commission.

The claimant shall, within thirty days after the filing of the notice of appeal, file a petition containing a statement of facts in ordinary and concise language showing a cause of action to participate or to continue to participate in the fund and setting forth the basis for the jurisdiction of the court over the action. Further pleadings shall be had in accordance with the Rules of Civil Procedure, provided that service of summons on such petition shall not be required and provided that the claimant may not dismiss the complaint without the employer's consent if the employer is the party that filed the notice of appeal to court pursuant to this section. The clerk of the court shall, upon receipt thereof, transmit by certified mail a copy thereof to each party named in the notice of appeal other than the claimant. Any party may file with the clerk prior to the trial of the action a deposition of any physician taken in accordance with the provisions of the Revised Code, which deposition may be read in the trial of the action even though the physician is a resident of or subject to service in the county in which the trial is had. The bureau of workers' compensation shall pay the cost of the stenographic deposition filed in court and of copies of the stenographic deposition for each party from the surplus fund and charge the costs thereof against the unsuccessful party if the claimant's right to participate or continue to participate is finally sustained or established in the appeal. In the event the deposition is taken and filed, the physician whose deposition is taken is not required to respond to any subpoena issued in the trial of the action. The court, or the jury under the instructions of the

court, if a jury is demanded, shall determine the right of the claimant to participate or to continue to participate in the fund upon the evidence adduced at the hearing of the action.

(E) The court shall certify its decision to the commission and the certificate shall be entered in the records of the court. Appeals from the judgment are governed by the law applicable to the appeal of civil actions.

(F) The cost of any legal proceedings authorized by this section, including an attorney's fee to the claimant's attorney to be fixed by the trial judge, based upon the effort expended, in the event the claimant's right to participate or to continue to participate in the fund is established upon the final determination of an appeal, shall be taxed against the employer or the commission if the commission or the administrator rather than the employer contested the right of the claimant to participate in the fund. The attorney's fee shall not exceed forty-two hundred dollars.

(G) If the finding of the court or the verdict of the jury is in favor of the claimant's right to participate in the fund, the commission and the administrator shall thereafter proceed in the matter of the claim as if the judgment were the decision of the commission, subject to the power of modification provided by section 4123.52 of the Revised Code.

(H)(1) An appeal from an order issued under division (E) of section 4123.511 of the Revised Code or any action filed in court in a case in which an award of compensation or medical benefits has been made shall not stay the payment of compensation or medical benefits under the award, or payment for subsequent periods of total disability or medical benefits during the pendency of the appeal. If, in a final administrative

or judicial action, it is determined that payments of compensation or benefits, or both, made to or on behalf of a claimant should not have been made, the amount thereof shall be charged to the surplus fund account under division (B) of section 4123.34 of the Revised Code. In the event the employer is a state risk, the amount shall not be charged to the employer's experience, and the administrator shall adjust the employer's account accordingly. In the event the employer is a self-insuring employer, the self-insuring employer shall deduct the amount from the paid compensation the self-insuring employer reports to the administrator under division (L) of section 4123.35 of the Revised Code. If an employer is a state risk and has paid an assessment for a violation of a specific safety requirement, and, in a final administrative or judicial action, it is determined that the employer did not violate the specific safety requirement, the administrator shall reimburse the employer from the surplus fund account under division (B) of section 4123.34 of the Revised Code for the amount of the assessment the employer paid for the violation.

(2)(a) Notwithstanding a final determination that payments of benefits made to or on behalf of a claimant should not have been made, the administrator or self-insuring employer shall award payment of medical or vocational rehabilitation services submitted for payment after the date of the final determination if all of the following apply:

(i) The services were approved and were rendered by the provider in good faith prior to the date of the final determination.

(ii) The services were payable under division (I) of section 4123.511 of the Revised Code prior to the date of the

final determination.

(iii) The request for payment is submitted within the time limit set forth in section 4123.52 of the Revised Code.

(b) Payments made under division (H)(1) of this section shall be charged to the surplus fund account under division (B) of section 4123.34 of the Revised Code. If the employer of the employee who is the subject of a claim described in division (H)(2)(a) of this section is a state fund employer, the payments made under that division shall not be charged to the employer's experience. If that employer is a self-insuring employer, the self-insuring employer shall deduct the amount from the paid compensation the self-insuring employer reports to the administrator under division (L) of section 4123.35 of the Revised Code.

(c) Division (H)(2) of this section shall apply only to a claim under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code arising on or after July 29, 2011, and in the case of Chapter 4133. of the Revised Code, a claim arising on or after the effective date of this amendment.

(3) A self-insuring employer may elect to pay compensation and benefits under this section directly to an employee or an employee's dependents by filing an application with the bureau of workers' compensation not more than one hundred eighty days and not less than ninety days before the first day of the employer's next six-month coverage period. If the self-insuring employer timely files the application, the application is effective on the first day of the employer's next six-month coverage period, provided that the administrator shall compute the employer's assessment for the surplus fund account due with respect to the period during which that application was filed

without regard to the filing of the application. On and after the effective date of the employer's election, the self-insuring employer shall pay directly to an employee or to an employee's dependents compensation and benefits under this section regardless of the date of the injury or occupational disease, and the employer shall receive no money or credits from the surplus fund account on account of those payments and shall not be required to pay any amounts into the surplus fund account on account of this section. The election made under this division is irrevocable.

(I) All actions and proceedings under this section which are the subject of an appeal to the court of common pleas or the court of appeals shall be preferred over all other civil actions except election causes, irrespective of position on the calendar.

This section applies to all decisions of the commission or the administrator on November 2, 1959, and all claims filed thereafter are governed by sections 4123.511 and 4123.512 of the Revised Code.

Any action pending in common pleas court or any other court on January 1, 1986, under this section is governed by former sections 4123.514, 4123.515, 4123.516, and 4123.519 and section 4123.522 of the Revised Code.

**Sec. 4123.522.** The employee, employer, and their respective representatives are entitled to written notice of any hearing, determination, order, award, or decision under this chapter and Chapter 4133. of the Revised Code and the administrator of workers' compensation and ~~his~~ the administrator's representative are entitled to like notice for orders issued under divisions (C) and (D) of section 4123.511

and section 4123.512 of the Revised Code. An employee, employer, or the administrator is deemed not to have received notice until the notice is received from the industrial commission or its district or staff hearing officers, the administrator, or the bureau of workers' compensation by both the employee and ~~his~~ the employee's representative of record, both the employer and ~~his~~ the employer's representative of record, and by both the administrator and ~~his~~ the administrator's representative.

If any person to whom a notice is mailed fails to receive the notice and the commission, upon hearing, determines that the failure was due to cause beyond the control and without the fault or neglect of such person or ~~his~~ the person's representative and that such person or ~~his~~ the person's representative did not have actual knowledge of the import of the information contained in the notice, such person may take the action afforded to such person within twenty-one days after the receipt of the notice of such determination of the commission. Delivery of the notice to the address of the person or ~~his~~ the person's representative is prima-facie evidence of receipt of the notice by the person.

**Sec. 4123.53.** (A) The administrator of workers' compensation or the industrial commission may require any employee claiming the right to receive compensation to submit to a medical examination, vocational evaluation, or vocational questionnaire at any time, and from time to time, at a place reasonably convenient for the employee, and as provided by the rules of the commission or the administrator of workers' compensation. A claimant required by the commission or administrator to submit to a medical examination or vocational evaluation, at a point outside of the place of permanent or temporary residence of the claimant, as provided in this

section, is entitled to have paid to the claimant by the bureau of workers' compensation the necessary and actual expenses on account of the attendance for the medical examination or vocational evaluation after approval of the expense statement by the bureau. Under extraordinary circumstances and with the unanimous approval of the commission, if the commission requires the medical examination or vocational evaluation, or with the approval of the administrator, if the administrator requires the medical examination or vocational evaluation, the bureau shall pay an injured or diseased employee the necessary, actual, and authorized expenses of treatment at a point outside the place of permanent or temporary residence of the claimant.

(B) When an employee initially receives temporary total disability compensation pursuant to section 4123.56 of the Revised Code for a consecutive ninety-day period, the administrator shall refer the employee to the bureau medical section for a medical examination to determine the employee's continued entitlement to such compensation, the employee's rehabilitation potential, and the appropriateness of the medical treatment the employee is receiving. The bureau medical section shall conduct the examination not later than thirty days following the end of the initial ninety-day period. If the medical examiner, upon an initial or any subsequent examination recommended by the medical examiner under this division, determines that the employee is temporarily and totally impaired, the medical examiner shall recommend a date when the employee should be reexamined. Upon the issuance of the medical examination report containing a recommendation for reexamination, the administrator shall schedule an examination and, if at the date of reexamination the employee is receiving temporary total disability compensation, the employee shall be

examined. The administrator shall adopt a rule, pursuant to Chapter 119. of the Revised Code, permitting employers to waive the administrator's scheduling of any such examinations.

(C) If an employee refuses to submit to any medical examination or vocational evaluation scheduled pursuant to this section or obstructs the same, or refuses to complete and submit to the bureau or commission a vocational questionnaire within thirty days after the bureau or commission mails the request to complete and submit the questionnaire the employee's right to have ~~his or her~~ the employee's claim for compensation considered, if the claim is pending before the bureau or commission, or to receive any payment for compensation theretofore granted, is suspended during the period of the refusal or obstruction. Notwithstanding this section, an employee's failure to submit to a medical examination or vocational evaluation, or to complete and submit a vocational questionnaire, shall not result in the dismissal of the employee's claim.

(D) Medical examinations scheduled under this section do not limit medical examinations provided for in other provisions of this chapter or Chapter 4121. or 4133. of the Revised Code.

**Sec. 4123.54.** (A) Except as otherwise provided in this division or divisions (I) and (K) of this section, every employee, who is injured or who contracts an occupational disease, and the dependents of each employee who is killed, or dies as the result of an occupational disease contracted in the course of employment, wherever the injury has occurred or occupational disease has been contracted, is entitled to receive the compensation for loss sustained on account of the injury, occupational disease, or death, and the medical, nurse, and

hospital services and medicines, and the amount of funeral expenses in case of death, as are provided by this chapter and Chapter 4133. of the Revised Code. The compensation and benefits shall be provided, as applicable, directly from the employee's self-insuring employer as provided in section 4123.35 of the Revised Code or from the state insurance fund. An employee or dependent is not entitled to receive compensation or benefits under this division if the employee's injury or occupational disease is either of the following:

(1) Purposely self-inflicted;

(2) Caused by the employee being intoxicated, under the influence of a controlled substance not prescribed by a physician, or under the influence of marihuana if being intoxicated, under the influence of a controlled substance not prescribed by a physician, or under the influence of marihuana was the proximate cause of the injury.

(B) For the purpose of this section, provided that an employer has posted written notice to employees that the results of, or the employee's refusal to submit to, any chemical test described under this division may affect the employee's eligibility for compensation and benefits pursuant to this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code, there is a rebuttable presumption that an employee is intoxicated, under the influence of a controlled substance not prescribed by the employee's physician, or under the influence of marihuana and that being intoxicated, under the influence of a controlled substance not prescribed by the employee's physician, or under the influence of marihuana is the proximate cause of an injury under either of the following conditions:

(1) When any one or more of the following is true:

(a) The employee, through a qualifying chemical test administered within eight hours of an injury, is determined to have an alcohol concentration level equal to or in excess of the levels established in divisions (A)(1)(b) to (i) of section 4511.19 of the Revised Code;

(b) The employee, through a qualifying chemical test administered within thirty-two hours of an injury, is determined to have one of the following controlled substances not prescribed by the employee's physician or marihuana in the employee's system that tests above the following levels in an enzyme multiplied immunoassay technique screening test and above the levels established in division (B)(1)(c) of this section in a gas chromatography mass spectrometry test:

(i) For amphetamines, one thousand nanograms per milliliter of urine;

(ii) For cannabinoids, fifty nanograms per milliliter of urine;

(iii) For cocaine, including crack cocaine, three hundred nanograms per milliliter of urine;

(iv) For opiates, two thousand nanograms per milliliter of urine;

(v) For phencyclidine, twenty-five nanograms per milliliter of urine.

(c) The employee, through a qualifying chemical test administered within thirty-two hours of an injury, is determined to have one of the following controlled substances not prescribed by the employee's physician or marihuana in the employee's system that tests above the following levels by a gas chromatography mass spectrometry test:

(i) For amphetamines, five hundred nanograms per milliliter of urine;

(ii) For cannabinoids, fifteen nanograms per milliliter of urine;

(iii) For cocaine, including crack cocaine, one hundred fifty nanograms per milliliter of urine;

(iv) For opiates, two thousand nanograms per milliliter of urine;

(v) For phencyclidine, twenty-five nanograms per milliliter of urine.

(d) The employee, through a qualifying chemical test administered within thirty-two hours of an injury, is determined to have barbiturates, benzodiazepines, methadone, or propoxyphene in the employee's system that tests above levels established by laboratories certified by the United States department of health and human services.

(2) When the employee refuses to submit to a requested chemical test, on the condition that that employee is or was given notice that the refusal to submit to any chemical test described in division (B)(1) of this section may affect the employee's eligibility for compensation and benefits under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code.

(C)(1) For purposes of division (B) of this section, a chemical test is a qualifying chemical test if it is administered to an employee after an injury under at least one of the following conditions:

(a) When the employee's employer had reasonable cause to

suspect that the employee may be intoxicated, under the influence of a controlled substance not prescribed by the employee's physician, or under the influence of marihuana;

(b) At the request of a police officer pursuant to section 4511.191 of the Revised Code, and not at the request of the employee's employer;

(c) At the request of a licensed physician who is not employed by the employee's employer, and not at the request of the employee's employer.

(2) As used in division (C)(1)(a) of this section, "reasonable cause" means, but is not limited to, evidence that an employee is or was using alcohol, a controlled substance, or marihuana drawn from specific, objective facts and reasonable inferences drawn from these facts in light of experience and training. These facts and inferences may be based on, but are not limited to, any of the following:

(a) Observable phenomena, such as direct observation of use, possession, or distribution of alcohol, a controlled substance, or marihuana, or of the physical symptoms of being under the influence of alcohol, a controlled substance, or marihuana, such as but not limited to slurred speech; dilated pupils; odor of alcohol, a controlled substance, or marihuana; changes in affect; or dynamic mood swings;

(b) A pattern of abnormal conduct, erratic or aberrant behavior, or deteriorating work performance such as frequent absenteeism, excessive tardiness, or recurrent accidents, that appears to be related to the use of alcohol, a controlled substance, or marihuana, and does not appear to be attributable to other factors;

(c) The identification of an employee as the focus of a criminal investigation into unauthorized possession, use, or trafficking of a controlled substance or marihuana;

(d) A report of use of alcohol, a controlled substance, or marihuana provided by a reliable and credible source;

(e) Repeated or flagrant violations of the safety or work rules of the employee's employer, that are determined by the employee's supervisor to pose a substantial risk of physical injury or property damage and that appear to be related to the use of alcohol, a controlled substance, or marihuana and that do not appear attributable to other factors.

(D) Nothing in this section shall be construed to affect the rights of an employer to test employees for alcohol or controlled substance abuse.

(E) For the purpose of this section, laboratories certified by the United States department of health and human services or laboratories that meet or exceed the standards of that department for laboratory certification shall be used for processing the test results of a qualifying chemical test.

(F) The written notice required by division (B) of this section shall be the same size or larger than the proof of workers' compensation coverage furnished by the bureau of workers' compensation and shall be posted by the employer in the same location as the proof of workers' compensation coverage or the certificate of self-insurance.

(G) If a condition that pre-existed an injury is substantially aggravated by the injury, and that substantial aggravation is documented by objective diagnostic findings, objective clinical findings, or objective test results, no

compensation or benefits are payable because of the pre-existing condition once that condition has returned to a level that would have existed without the injury.

(H)(1) Whenever, with respect to an employee of an employer who is subject to and has complied with this chapter and Chapter 4133. of the Revised Code, there is possibility of conflict with respect to the application of workers' compensation laws because the contract of employment is entered into and all or some portion of the work is or is to be performed in a state or states other than Ohio, the employer and the employee may agree to be bound by the laws of this state or by the laws of some other state in which all or some portion of the work of the employee is to be performed. The agreement shall be in writing and shall be filed with the bureau of workers' compensation within ten days after it is executed and shall remain in force until terminated or modified by agreement of the parties similarly filed. If the agreement is to be bound by the laws of this state and the employer has complied with this chapter and Chapter 4133. of the Revised Code, then the employee is entitled to compensation and benefits regardless of where the injury occurs or the disease is contracted and the rights of the employee and the employee's dependents under the laws of this state are the exclusive remedy against the employer on account of injury, disease, or death in the course of and arising out of the employee's employment. If the agreement is to be bound by the laws of another state and the employer has complied with the laws of that state, the rights of the employee and the employee's dependents under the laws of that state are the exclusive remedy against the employer on account of injury, disease, or death in the course of and arising out of the employee's employment without regard to the place where the

injury was sustained or the disease contracted. If an employer and an employee enter into an agreement under this division, the fact that the employer and the employee entered into that agreement shall not be construed to change the status of an employee whose continued employment is subject to the will of the employer or the employee, unless the agreement contains a provision that expressly changes that status.

(2) If an employee or the employee's dependents receive an award of compensation or benefits under this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code for the same injury, occupational disease, or death for which the employee or the employee's dependents previously pursued or otherwise elected to accept workers' compensation benefits and received a decision on the merits as defined in section 4123.542 of the Revised Code under the laws of another state or recovered damages under the laws of another state, the claim shall be disallowed and the administrator or any self-insuring employer, by any lawful means, may collect from the employee or the employee's dependents any of the following:

(a) The amount of compensation or benefits paid to or on behalf of the employee or the employee's dependents by the administrator or a self-insuring employer pursuant to this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code for that award;

(b) Any interest, attorney's fees, and costs the administrator or the self-insuring employer incurs in collecting that payment.

(3) If an employee or the employee's dependents receive an award of compensation or benefits under this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code and

subsequently pursue or otherwise elect to accept workers' compensation benefits or damages under the laws of another state for the same injury, occupational disease, or death the claim under this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code shall be disallowed. The administrator or a self-insuring employer, by any lawful means, may collect from the employee or the employee's dependents or other-states' insurer any of the following:

(a) The amount of compensation or benefits paid to or on behalf of the employee or the employee's dependents by the administrator or the self-insuring employer pursuant to this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code for that award;

(b) Any interest, costs, and attorney's fees the administrator or the self-insuring employer incurs in collecting that payment;

(c) Any costs incurred by an employer in contesting or responding to any claim filed by the employee or the employee's dependents for the same injury, occupational disease, or death that was filed after the original claim for which the employee or the employee's dependents received a decision on the merits as described in section 4123.542 of the Revised Code.

(4) If the employee's employer pays premiums into the state insurance fund, the administrator shall not charge the amount of compensation or benefits the administrator collects pursuant to division (H)(2) or (3) of this section to the employer's experience. If the administrator collects any costs incurred by an employer in contesting or responding to any claim pursuant to division (H)(2) or (3) of this section, the administrator shall forward the amount collected to that

employer. If the employee's employer is a self-insuring employer, the self-insuring employer shall deduct the amount of compensation or benefits the self-insuring employer collects pursuant to this division from the paid compensation the self-insuring employer reports to the administrator under division (L) of section 4123.35 of the Revised Code.

(5) If an employee is a resident of a state other than this state and is insured under the workers' compensation law or similar laws of a state other than this state, the employee and the employee's dependents are not entitled to receive compensation or benefits under this chapter or Chapter 4133. of the Revised Code, on account of injury, disease, or death arising out of or in the course of employment while temporarily within this state, and the rights of the employee and the employee's dependents under the laws of the other state are the exclusive remedy against the employer on account of the injury, disease, or death.

(6) An employee, or the dependent of an employee, who elects to receive compensation and benefits under this chapter or Chapter 4121., 4127., ~~or~~ 4131., or 4133. of the Revised Code for a claim may not receive compensation and benefits under the workers' compensation laws of any state other than this state for that same claim. For each claim submitted by or on behalf of an employee, the administrator or, if the employee is employed by a self-insuring employer, the self-insuring employer, shall request the employee or the employee's dependent to sign an election that affirms the employee's or employee's dependent's acceptance of electing to receive compensation and benefits under this chapter or Chapter 4121., 4127., ~~or~~ 4131., or 4133. of the Revised Code for that claim that also affirmatively waives and releases the employee's or the employee's dependent's

right to file for and receive compensation and benefits under the laws of any state other than this state for that claim. The employee or employee's dependent shall sign the election form within twenty-eight days after the administrator or self-insuring employer submits the request or the administrator or self-insuring employer shall dismiss that claim.

In the event a workers' compensation claim has been filed in another jurisdiction on behalf of an employee or the dependents of an employee, and the employee or dependents subsequently elect to receive compensation, benefits, or both under this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code, the employee or dependent shall withdraw or refuse acceptance of the workers' compensation claim filed in the other jurisdiction in order to pursue compensation or benefits under the laws of this state. If the employee or dependents were awarded workers' compensation benefits or had recovered damages under the laws of the other state, any compensation and benefits awarded under this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code shall be paid only to the extent to which those payments exceed the amounts paid under the laws of the other state. If the employee or dependent fails to withdraw or to refuse acceptance of the workers' compensation claim in the other jurisdiction within twenty-eight days after a request made by the administrator or a self-insuring employer, the administrator or self-insuring employer shall dismiss the employee's or employee's dependents' claim made in this state.

(I) If an employee who is covered under the federal "Longshore and Harbor Workers' Compensation Act," 98 Stat. 1639, 33 U.S.C. 901 et seq., is injured or contracts an occupational disease or dies as a result of an injury or occupational

disease, and if that employee's or that employee's dependents' claim for compensation or benefits for that injury, occupational disease, or death is subject to the jurisdiction of that act, the employee or the employee's dependents are not entitled to apply for and shall not receive compensation or benefits under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code. The rights of such an employee and the employee's dependents under the federal "Longshore and Harbor Workers' Compensation Act," 98 Stat. 1639, 33 U.S.C. 901 et seq., are the exclusive remedy against the employer for that injury, occupational disease, or death.

(J) Compensation or benefits are not payable to a claimant during the period of confinement of the claimant in any state or federal correctional institution, or in any county jail in lieu of incarceration in a state or federal correctional institution, whether in this or any other state for conviction of violation of any state or federal criminal law.

(K) An employer, upon the approval of the administrator, may provide for workers' compensation coverage for the employer's employees who are professional athletes and coaches by submitting to the administrator proof of coverage under a league policy issued under the laws of another state under either of the following circumstances:

(1) The employer administers the payroll and workers' compensation insurance for a professional sports team subject to a collective bargaining agreement, and the collective bargaining agreement provides for the uniform administration of workers' compensation benefits and compensation for professional athletes.

(2) The employer is a professional sports league, or is a

member team of a professional sports league, and all of the following apply:

(a) The professional sports league operates as a single entity, whereby all of the players and coaches of the sports league are employees of the sports league and not of the individual member teams.

(b) The professional sports league at all times maintains workers' compensation insurance that provides coverage for the players and coaches of the sports league.

(c) Each individual member team of the professional sports league, pursuant to the organizational or operating documents of the sports league, is obligated to the sports league to pay to the sports league any workers' compensation claims that are not covered by the workers' compensation insurance maintained by the sports league.

If the administrator approves the employer's proof of coverage submitted under division (K) of this section, a professional athlete or coach who is an employee of the employer and the dependents of the professional athlete or coach are not entitled to apply for and shall not receive compensation or benefits under this chapter and ~~Chapter~~ Chapters 4121. and 4133. of the Revised Code. The rights of such an athlete or coach and the dependents of such an athlete or coach under the laws of the state where the policy was issued are the exclusive remedy against the employer for the athlete or coach if the athlete or coach suffers an injury or contracts an occupational disease in the course of employment, or for the dependents of the athlete or the coach if the athlete or coach is killed as a result of an injury or dies as a result of an occupational disease, regardless of the location where the injury was suffered or the

occupational disease was contracted.

**Sec. 4123.542.** An employee or the dependents of an employee who receive a decision on the merits of a claim for compensation or benefits under this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code shall not file a claim for the same injury, occupational disease, or death in another state under the workers' compensation laws of that state. Except as otherwise provided in division (H) of section 4123.54 of the Revised Code, an employee or the employee's dependents who receive a decision on the merits of a claim for compensation or benefits under the workers' compensation laws of another state shall not file a claim for compensation and benefits under this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code for the same injury, occupational disease, or death.

As used in this section, "a decision on the merits" means a decision determined or adjudicated for compensability of a claim and not on jurisdictional grounds.

**Sec. 4123.57.** Partial disability compensation shall be paid as follows.

Except as provided in this section, not earlier than twenty-six weeks after the date of termination of the latest period of payments under section 4123.56 of the Revised Code, or not earlier than twenty-six weeks after the date of the injury or contraction of an occupational disease in the absence of payments under section 4123.56 of the Revised Code, the employee may file an application with the bureau of workers' compensation for the determination of the percentage of the employee's permanent partial disability resulting from an injury or occupational disease.

Whenever the application is filed, the bureau shall send a copy of the application to the employee's employer or the employer's representative and shall schedule the employee for a medical examination by the bureau medical section. The bureau shall send a copy of the report of the medical examination to the employee, the employer, and their representatives. Thereafter, the administrator of workers' compensation shall review the employee's claim file and make a tentative order as the evidence before the administrator at the time of the making of the order warrants. If the administrator determines that there is a conflict of evidence, the administrator shall send the application, along with the claimant's file, to the district hearing officer who shall set the application for a hearing.

The administrator shall notify the employee, the employer, and their representatives, in writing, of the tentative order and of the parties' right to request a hearing. Unless the employee, the employer, or their representative notifies the administrator, in writing, of an objection to the tentative order within twenty days after receipt of the notice thereof, the tentative order shall go into effect and the employee shall receive the compensation provided in the order. In no event shall there be a reconsideration of a tentative order issued under this division.

If the employee, the employer, or their representatives timely notify the administrator of an objection to the tentative order, the matter shall be referred to a district hearing officer who shall set the application for hearing with written notices to all interested persons. Upon referral to a district hearing officer, the employer may obtain a medical examination of the employee, pursuant to rules of the industrial commission.

(A) The district hearing officer, upon the application, shall determine the percentage of the employee's permanent disability, except as is subject to division (B) of this section, based upon that condition of the employee resulting from the injury or occupational disease and causing permanent impairment evidenced by medical or clinical findings reasonably demonstrable. The employee shall receive sixty-six and two-thirds per cent of the employee's average weekly wage, but not more than a maximum of thirty-three and one-third per cent of the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code, per week regardless of the average weekly wage, for the number of weeks which equals the percentage of two hundred weeks. Except on application for reconsideration, review, or modification, which is filed within ten days after the date of receipt of the decision of the district hearing officer, in no instance shall the former award be modified unless it is found from medical or clinical findings that the condition of the claimant resulting from the injury has so progressed as to have increased the percentage of permanent partial disability. A staff hearing officer shall hear an application for reconsideration filed and the staff hearing officer's decision is final. An employee may file an application for a subsequent determination of the percentage of the employee's permanent disability. If such an application is filed, the bureau shall send a copy of the application to the employer or the employer's representative. No sooner than sixty days from the date of the mailing of the application to the employer or the employer's representative, the administrator shall review the application. The administrator may require a medical examination or medical review of the employee. The administrator shall issue a tentative order based upon the evidence before the administrator, provided that if the

administrator requires a medical examination or medical review, the administrator shall not issue the tentative order until the completion of the examination or review.

The employer may obtain a medical examination of the employee and may submit medical evidence at any stage of the process up to a hearing before the district hearing officer, pursuant to rules of the commission. The administrator shall notify the employee, the employer, and their representatives, in writing, of the nature and amount of any tentative order issued on an application requesting a subsequent determination of the percentage of an employee's permanent disability. An employee, employer, or their representatives may object to the tentative order within twenty days after the receipt of the notice thereof. If no timely objection is made, the tentative order shall go into effect. In no event shall there be a reconsideration of a tentative order issued under this division. If an objection is timely made, the application for a subsequent determination shall be referred to a district hearing officer who shall set the application for a hearing with written notice to all interested persons. No application for subsequent percentage determinations on the same claim for injury or occupational disease shall be accepted for review by the district hearing officer unless supported by substantial evidence of new and changed circumstances developing since the time of the hearing on the original or last determination.

No award shall be made under this division based upon a percentage of disability which, when taken with all other percentages of permanent disability, exceeds one hundred per cent. If the percentage of the permanent disability of the employee equals or exceeds ninety per cent, compensation for permanent partial disability shall be paid for two hundred

weeks.

Compensation payable under this division accrues and is payable to the employee from the date of last payment of compensation, or, in cases where no previous compensation has been paid, from the date of the injury or the date of the diagnosis of the occupational disease.

When an award under this division has been made prior to the death of an employee, all unpaid installments accrued or to accrue under the provisions of the award are payable to the surviving spouse, or if there is no surviving spouse, to the dependent children of the employee, and if there are no children surviving, then to other dependents as the administrator determines.

(B) For purposes of this division, "payable per week" means the seven-consecutive-day period in which compensation is paid in installments according to the schedule associated with the applicable injury as set forth in this division.

Compensation paid in weekly installments according to the schedule described in this division may only be commuted to one or more lump sum payments pursuant to the procedure set forth in section 4123.64 of the Revised Code.

In cases included in the following schedule the compensation payable per week to the employee is the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code per week and shall be paid in installments according to the following schedule:

For the loss of a first finger, commonly known as a thumb, sixty weeks.

For the loss of a second finger, commonly called index

finger, thirty-five weeks.

For the loss of a third finger, thirty weeks.

For the loss of a fourth finger, twenty weeks.

For the loss of a fifth finger, commonly known as the little finger, fifteen weeks.

The loss of a second, or distal, phalange of the thumb is considered equal to the loss of one half of such thumb; the loss of more than one half of such thumb is considered equal to the loss of the whole thumb.

The loss of the third, or distal, phalange of any finger is considered equal to the loss of one-third of the finger.

The loss of the middle, or second, phalange of any finger is considered equal to the loss of two-thirds of the finger.

The loss of more than the middle and distal phalanges of any finger is considered equal to the loss of the whole finger. In no case shall the amount received for more than one finger exceed the amount provided in this schedule for the loss of a hand.

For the loss of the metacarpal bone (bones of the palm) for the corresponding thumb, or fingers, add ten weeks to the number of weeks under this division.

For ankylosis (total stiffness of) or contractures (due to scars or injuries) which makes any of the fingers, thumbs, or parts of either useless, the same number of weeks apply to the members or parts thereof as given for the loss thereof.

If the claimant has suffered the loss of two or more fingers by amputation or ankylosis and the nature of the

claimant's employment in the course of which the claimant was working at the time of the injury or occupational disease is such that the handicap or disability resulting from the loss of fingers, or loss of use of fingers, exceeds the normal handicap or disability resulting from the loss of fingers, or loss of use of fingers, the administrator may take that fact into consideration and increase the award of compensation accordingly, but the award made shall not exceed the amount of compensation for loss of a hand.

For the loss of a hand, one hundred seventy-five weeks.

For the loss of an arm, two hundred twenty-five weeks.

For the loss of a great toe, thirty weeks.

For the loss of one of the toes other than the great toe, ten weeks.

The loss of more than two-thirds of any toe is considered equal to the loss of the whole toe.

The loss of less than two-thirds of any toe is considered no loss, except as to the great toe; the loss of the great toe up to the interphalangeal joint is co-equal to the loss of one-half of the great toe; the loss of the great toe beyond the interphalangeal joint is considered equal to the loss of the whole great toe.

For the loss of a foot, one hundred fifty weeks.

For the loss of a leg, two hundred weeks.

For the loss of the sight of an eye, one hundred twenty-five weeks.

For the permanent partial loss of sight of an eye, the

portion of one hundred twenty-five weeks as the administrator in each case determines, based upon the percentage of vision actually lost as a result of the injury or occupational disease, but, in no case shall an award of compensation be made for less than twenty-five per cent loss of uncorrected vision. "Loss of uncorrected vision" means the percentage of vision actually lost as the result of the injury or occupational disease.

For the permanent and total loss of hearing of one ear, twenty-five weeks; but in no case shall an award of compensation be made for less than permanent and total loss of hearing of one ear.

For the permanent and total loss of hearing, one hundred twenty-five weeks; but, except pursuant to the next preceding paragraph, in no case shall an award of compensation be made for less than permanent and total loss of hearing.

In case an injury or occupational disease results in serious facial or head disfigurement which either impairs or may in the future impair the opportunities to secure or retain employment, the administrator shall make an award of compensation as it deems proper and equitable, in view of the nature of the disfigurement, and not to exceed the sum of ten thousand dollars. For the purpose of making the award, it is not material whether the employee is gainfully employed in any occupation or trade at the time of the administrator's determination.

When an award under this division has been made prior to the death of an employee all unpaid installments accrued or to accrue under the provisions of the award shall be payable to the surviving spouse, or if there is no surviving spouse, to the dependent children of the employee and if there are no such

children, then to such dependents as the administrator determines.

When an employee has sustained the loss of a member by severance, but no award has been made on account thereof prior to the employee's death, the administrator shall make an award in accordance with this division for the loss which shall be payable to the surviving spouse, or if there is no surviving spouse, to the dependent children of the employee and if there are no such children, then to such dependents as the administrator determines.

(C) Compensation for partial impairment under divisions (A) and (B) of this section is in addition to the compensation paid the employee pursuant to section 4123.56 of the Revised Code. A claimant may receive compensation under divisions (A) and (B) of this section.

In all cases arising under division (B) of this section, if it is determined by any one of the following: (1) the amputee clinic at University hospital, Ohio state university; (2) the opportunities for Ohioans with disabilities agency; (3) an amputee clinic or prescribing physician approved by the administrator or the administrator's designee, that an injured or disabled employee is in need of an artificial appliance, or in need of a repair thereof, regardless of whether the appliance or its repair will be serviceable in the vocational rehabilitation of the injured employee, and regardless of whether the employee has returned to or can ever again return to any gainful employment, the bureau shall pay the cost of the artificial appliance or its repair out of the surplus created by division (B) of section 4123.34 of the Revised Code.

In those cases where an opportunities for Ohioans with

disabilities agency's recommendation that an injured or disabled employee is in need of an artificial appliance would conflict with their state plan, adopted pursuant to the "Rehabilitation Act of 1973," 87 Stat. 355, 29 U.S.C.A. 701, the administrator or the administrator's designee or the bureau may obtain a recommendation from an amputee clinic or prescribing physician that they determine appropriate.

(D) ~~If an employee of a state fund employer makes application for a finding and the administrator finds that the employee has contracted silicosis as defined in division (Y), or coal miners' pneumoconiosis as defined in division (Z), or asbestosis as defined in division (BB) of section 4123.68 of the Revised Code, and that a change of such employee's occupation is medically advisable in order to decrease substantially further exposure to silica dust, asbestos, or coal dust and if the employee, after the finding, has changed or shall change the employee's occupation to an occupation in which the exposure to silica dust, asbestos, or coal dust is substantially decreased, the administrator shall allow to the employee an amount equal to fifty per cent of the statewide average weekly wage per week for a period of thirty weeks, commencing as of the date of the discontinuance or change, and for a period of one hundred weeks immediately following the expiration of the period of thirty weeks, the employee shall receive sixty-six and two-thirds per cent of the loss of wages resulting directly and solely from the change of occupation but not to exceed a maximum of an amount equal to fifty per cent of the statewide average weekly wage per week. No such employee is entitled to receive more than one allowance on account of discontinuance of employment or change of occupation and benefits shall cease for any period during which the employee is employed in an occupation in which the~

~~exposure to silica dust, asbestos, or coal dust is not substantially less than the exposure in the occupation in which the employee was formerly employed or for any period during which the employee may be entitled to receive compensation or benefits under section 4123.68 of the Revised Code on account of disability from silicosis, asbestosis, or coal miners' pneumoconiosis. An award for change of occupation for a coal miner who has contracted coal miners' pneumoconiosis may be granted under this division even though the coal miner continues employment with the same employer, so long as the coal miner's employment subsequent to the change is such that the coal miner's exposure to coal dust is substantially decreased and a change of occupation is certified by the claimant as permanent. The administrator may accord to the employee medical and other benefits in accordance with section 4123.66 of the Revised Code.~~

~~(E)~~ If a firefighter or police officer makes application for a finding and the administrator finds that the firefighter or police officer has contracted a cardiovascular and pulmonary disease as defined in division (W) of section 4123.68 of the Revised Code, and that a change of the firefighter's or police officer's occupation is medically advisable in order to decrease substantially further exposure to smoke, toxic gases, chemical fumes, and other toxic vapors, and if the firefighter, or police officer, after the finding, has changed or changes occupation to an occupation in which the exposure to smoke, toxic gases, chemical fumes, and other toxic vapors is substantially decreased, the administrator shall allow to the firefighter or police officer an amount equal to fifty per cent of the statewide average weekly wage per week for a period of thirty weeks, commencing as of the date of the discontinuance or change, and for a period of seventy-five weeks immediately

following the expiration of the period of thirty weeks the administrator shall allow the firefighter or police officer sixty-six and two-thirds per cent of the loss of wages resulting directly and solely from the change of occupation but not to exceed a maximum of an amount equal to fifty per cent of the statewide average weekly wage per week. No such firefighter or police officer is entitled to receive more than one allowance on account of discontinuance of employment or change of occupation and benefits shall cease for any period during which the firefighter or police officer is employed in an occupation in which the exposure to smoke, toxic gases, chemical fumes, and other toxic vapors is not substantially less than the exposure in the occupation in which the firefighter or police officer was formerly employed or for any period during which the firefighter or police officer may be entitled to receive compensation or benefits under section 4123.68 of the Revised Code on account of disability from a cardiovascular and pulmonary disease. The administrator may accord to the firefighter or police officer medical and other benefits in accordance with section 4123.66 of the Revised Code.

~~(F)~~ (E) An order issued under this section is appealable pursuant to section 4123.511 of the Revised Code but is not appealable to court under section 4123.512 of the Revised Code.

**Sec. 4123.571.** In connection with the procedural and remedial rights of employees, all claims which have accrued prior to ~~the effective date of this act~~ November 2, 1959, whether or not an application for claim has been filed, or whether or not jurisdiction has been established or whether or not an application for an award under divisions (A), (B), or (C)~~, or (D)~~ of section 4123.57 of the Revised Code has been filed shall be governed by the provisions of section 4123.57 of

the Revised Code, as amended by this act.

**Sec. 4123.65.** (A) A state fund employer or the employee of such an employer may file an application with the administrator of workers' compensation for approval of a final settlement of a claim under this chapter or Chapter 4133. of the Revised Code. The application shall include the settlement agreement, and except as otherwise specified in this division, be signed by the claimant and employer, and clearly set forth the circumstances by reason of which the proposed settlement is deemed desirable and that the parties agree to the terms of the settlement agreement. A claimant may file an application without an employer's signature in the following situations:

(1) The employer is no longer doing business in Ohio;

(2) The claim no longer is in the employer's industrial accident or occupational disease experience as provided in division (B) of section 4123.34 of the Revised Code and the claimant no longer is employed with that employer;

(3) The employer has failed to comply with section 4123.35 of the Revised Code.

If a claimant files an application without an employer's signature, and the employer still is doing business in this state, the administrator shall send written notice of the application to the employer immediately upon receipt of the application. If the employer fails to respond to the notice within thirty days after the notice is sent, the application need not contain the employer's signature.

If a state fund employer or an employee of such an employer has not filed an application for a final settlement under this division, the administrator may file an application

on behalf of the employer or the employee, provided that the administrator gives notice of the filing to the employer and the employee and to the representative of record of the employer and of the employee immediately upon the filing. An application filed by the administrator shall contain all of the information and signatures required of an employer or an employee who files an application under this division. Every self-insuring employer that enters into a final settlement agreement with an employee shall mail, within seven days of executing the agreement, a copy of the agreement to the administrator and the employee's representative. The administrator shall place the agreement into the claimant's file.

(B) Except as provided in divisions (C) and (D) of this section, a settlement agreed to under this section is binding upon all parties thereto and as to items, injuries, and occupational diseases to which the settlement applies.

(C) No settlement agreed to under division (A) of this section or agreed to by a self-insuring employer and the self-insuring employer's employee shall take effect until thirty days after the administrator approves the settlement for state fund employees and employers, or after the self-insuring employer and employee sign the final settlement agreement. During the thirty-day period, the employer, employee, or administrator, for state fund settlements, and the employer or employee, for self-insuring settlements, may withdraw consent to the settlement by an employer providing written notice to the employer's employee and the administrator or by an employee providing written notice to the employee's employer and the administrator, or by the administrator providing written notice to the state fund employer and employee. If an employee dies during the thirty-day waiting period following the approval of a settlement, the

settlement can be voided by any party for good cause shown.

(D) At the time of agreement to any final settlement agreement under division (A) of this section or agreement between a self-insuring employer and the self-insuring employer's employee, the administrator, for state fund settlements, and the self-insuring employer, for self-insuring settlements, immediately shall send a copy of the agreement to the industrial commission who shall assign the matter to a staff hearing officer. The staff hearing officer shall determine, within the time limitations specified in division (C) of this section, whether the settlement agreement is or is not a gross miscarriage of justice. If the staff hearing officer determines within that time period that the settlement agreement is clearly unfair, the staff hearing officer shall issue an order disapproving the settlement agreement. If the staff hearing officer determines that the settlement agreement is not clearly unfair or fails to act within those time limits, the settlement agreement is approved.

(E) A settlement entered into under this section may pertain to one or more claims of a claimant, or one or more parts of a claim, or the compensation or benefits pertaining to either, or any combination thereof, provided that nothing in this section shall be interpreted to require a claimant to enter into a settlement agreement for every claim that has been filed with the bureau of workers' compensation by that claimant under Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code.

(F) A settlement entered into under this section is not appealable under section 4123.511 or 4123.512 of the Revised Code.

**Sec. 4123.651.** (A) The employer of a claimant who is injured or disabled in the course of ~~his~~ the claimant's employment may require, without the approval of the administrator or the industrial commission, that the claimant be examined by a physician of the employer's choice one time upon any issue asserted by the employee or a physician of the employee's choice or which is to be considered by the commission. Any further requests for medical examinations shall be made to the commission which shall consider and rule on the request. The employer shall pay the cost of any examinations initiated by the employer.

(B) The bureau of workers' compensation shall prepare a form for the release of medical information, records, and reports relative to the issues necessary for the administration of a claim under this chapter or Chapter 4133. of the Revised Code. The claimant promptly shall provide a current signed release of the information, records, and reports when requested by the employer. The employer promptly shall provide copies of all medical information, records, and reports to the bureau and to the claimant or ~~his~~ the claimant's representative upon request.

(C) If, without good cause, an employee refuses to submit to any examination scheduled under this section or refuses to release or execute a release for any medical information, record, or report that is required to be released under this section and involves an issue pertinent to the condition alleged in the claim, ~~his~~ the employee's right to have ~~his~~ the employee's claim for compensation or benefits considered, if ~~his~~ the employee's claim is pending before the administrator, commission, occupational pneumoconiosis board, or a district or staff hearing officer, or to receive any payment for

compensation or benefits previously granted, is suspended during the period of refusal.

(D) No bureau or commission employee shall alter any medical report obtained from a health care provider the bureau or commission has selected or cause or request the health care provider to alter or change a report. The bureau and commission shall make any request for clarification of a health care provider's report in writing and shall provide a copy of the request to the affected parties and their representatives at the time of making the request.

**Sec. 4123.66.** (A) In addition to the compensation provided for in this chapter and Chapter 4133. of the Revised Code, the administrator of workers' compensation 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, in case death ensues from the injury or occupational disease, the administrator shall disburse and pay from the fund reasonable funeral expenses in an amount not to exceed fifty-five hundred dollars. The bureau of workers' compensation shall reimburse anyone, whether dependent, volunteer, or otherwise, who pays the funeral expenses of any employee whose death ensues from any injury or occupational disease as provided in this section. The administrator may adopt rules, with the advice and consent of the bureau of workers' compensation 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. In case an injury or industrial accident that injures an employee also causes damage to the employee's eyeglasses, artificial teeth or other denture, or hearing aid, or in the event an injury or occupational disease makes it necessary or advisable to replace,

repair, or adjust the same, the bureau shall disburse and pay a reasonable amount to repair or replace the same.

(B) The administrator, in the rules the administrator adopts pursuant to division (A) of this section, may adopt rules specifying the circumstances under which the bureau may make immediate payment for the first fill of prescription drugs for medical conditions identified in an application for compensation or benefits under section 4123.84 or 4123.85 of the Revised Code that occurs prior to the date the administrator issues an initial determination order under division (B) of section 4123.511 of the Revised Code. If the claim is ultimately disallowed in a final administrative or judicial order, and if the employer is a state fund employer who pays assessments into the surplus fund account created under section 4123.34 of the Revised Code, the payments for medical services made pursuant to this division for the first fill of prescription drugs shall be charged to and paid from the surplus fund account and not charged through the state insurance fund to the employer against whom the claim was filed.

(C)(1) If an employer or a welfare plan has provided to or on behalf of an employee any benefits or compensation for an injury or occupational disease and that injury or occupational disease is determined compensable under this chapter or Chapter 4133. of the Revised Code, the employer or a welfare plan may request that the administrator reimburse the employer or welfare plan for the amount the employer or welfare plan paid to or on behalf of the employee in compensation or benefits. The administrator shall reimburse the employer or welfare plan for the compensation and benefits paid if, at the time the employer or welfare plan provides the benefits or compensation to or on behalf of employee, the injury or occupational disease had not

been determined to be compensable under this chapter or Chapter 4133. of the Revised Code and if the employee was not receiving compensation or benefits under this chapter or Chapter 4133. of the Revised Code for that injury or occupational disease. The administrator shall reimburse the employer or welfare plan in the amount that the administrator would have paid to or on behalf of the employee under this chapter if the injury or occupational disease originally would have been determined compensable under this chapter or Chapter 4133. of the Revised Code. If the employer is a merit-rated employer, the administrator shall adjust the amount of premium next due from the employer according to the amount the administrator pays the employer. The administrator shall adopt rules, in accordance with Chapter 119. of the Revised Code, to implement this division.

(2) As used in this division, "welfare plan" has the same meaning as in division (1) of 29 U.S.C.A. 1002.

**Sec. 4123.67.** Except as otherwise provided in sections 3119.80, 3119.81, 3121.02, 3121.03, and 3123.06 of the Revised Code, compensation before payment shall be exempt from all claims of creditors and from any attachment or execution, and shall be paid only to the employees or their dependents. In all cases where property of an employer is placed in the hands of an assignee, receiver, or trustee, claims arising under any award or finding of the industrial commission or bureau of workers' compensation, pursuant to this chapter or Chapter 4133. of the Revised Code, including claims for premiums, and any judgment recovered thereon shall first be paid out of the trust fund in preference to all other claims, except claims for taxes and the cost of administration, and with the same preference given to claims for taxes.

**Sec. 4123.68.** Every employee who is disabled because of the contraction of an occupational disease or the dependent of an employee whose death is caused by an occupational disease, is entitled to the compensation provided by sections 4123.55 to 4123.59 and 4123.66 of the Revised Code subject to the modifications relating to occupational diseases contained in this chapter. An order of the administrator issued under this section is appealable pursuant to sections 4123.511 and 4123.512 of the Revised Code.

The following diseases are occupational diseases and compensable as such when contracted by an employee in the course of the employment in which such employee was engaged and due to the nature of any process described in this section. A disease which meets the definition of an occupational disease is compensable pursuant to this chapter though it is not specifically listed in this section.

A disease that is occupational pneumoconiosis as defined in section 4133.01 of the Revised Code is subject to the requirements and procedures specified in Chapter 4133. of the Revised Code.

SCHEDULE

Description of disease or injury and description of process:

(A) Anthrax: Handling of wool, hair, bristles, hides, and skins.

(B) Glanders: Care of any equine animal suffering from glanders; handling carcass of such animal.

(C) Lead poisoning: Any industrial process involving the use of lead or its preparations or compounds.

(D) Mercury poisoning: Any industrial process involving the use of mercury or its preparations or compounds.

(E) Phosphorous poisoning: Any industrial process involving the use of phosphorous or its preparations or compounds.

(F) Arsenic poisoning: Any industrial process involving the use of arsenic or its preparations or compounds.

(G) Poisoning by benzol or by nitro-derivatives and amido-derivatives of benzol (dinitro-benzol, anilin, and others): Any industrial process involving the use of benzol or nitro-derivatives or amido-derivatives of benzol or its preparations or compounds.

(H) Poisoning by gasoline, benzine, naphtha, or other volatile petroleum products: Any industrial process involving the use of gasoline, benzine, naphtha, or other volatile petroleum products.

(I) Poisoning by carbon bisulphide: Any industrial process involving the use of carbon bisulphide or its preparations or compounds.

(J) Poisoning by wood alcohol: Any industrial process involving the use of wood alcohol or its preparations.

(K) Infection or inflammation of the skin on contact surfaces due to oils, cutting compounds or lubricants, dust, liquids, fumes, gases, or vapors: Any industrial process involving the handling or use of oils, cutting compounds or lubricants, or involving contact with dust, liquids, fumes, gases, or vapors.

(L) Epithelion cancer or ulceration of the skin or of the

corneal surface of the eye due to carbon, pitch, tar, or tarry compounds: Handling or industrial use of carbon, pitch, or tarry compounds.

(M) Compressed air illness: Any industrial process carried on in compressed air.

(N) Carbon dioxide poisoning: Any process involving the evolution or resulting in the escape of carbon dioxide.

(O) Brass or zinc poisoning: Any process involving the manufacture, founding, or refining of brass or the melting or smelting of zinc.

(P) Manganese dioxide poisoning: Any process involving the grinding or milling of manganese dioxide or the escape of manganese dioxide dust.

(Q) Radium poisoning: Any industrial process involving the use of radium and other radioactive substances in luminous paint.

(R) Tenosynovitis and prepatellar bursitis: Primary tenosynovitis characterized by a passive effusion or crepitus into the tendon sheath of the flexor or extensor muscles of the hand, due to frequently repetitive motions or vibrations, or prepatellar bursitis due to continued pressure.

(S) Chrome ulceration of the skin or nasal passages: Any industrial process involving the use of or direct contact with chromic acid or bichromates of ammonium, potassium, or sodium or their preparations.

(T) Potassium cyanide poisoning: Any industrial process involving the use of or direct contact with potassium cyanide.

(U) Sulphur dioxide poisoning: Any industrial process in

which sulphur dioxide gas is evolved by the expansion of liquid sulphur dioxide.

(V) Berylliosis: Berylliosis means a disease of the lungs caused by breathing beryllium in the form of dust or fumes, producing characteristic changes in the lungs and, if caused by breathing beryllium in the form of fumes, demonstrated by x-ray examination, by biopsy or by autopsy.

This chapter does not entitle an employee or the employee's dependents to ~~compensation,~~ medical treatment~~,~~ or payment of funeral expenses for disability or death from berylliosis unless the employee has been subjected to injurious exposure to beryllium dust or fumes in the employee's employment in this state preceding the employee's disablement and only in the event of such disability or death resulting within eight years after the last injurious exposure; provided that such eight-year limitation does not apply to ~~disability or~~ death from exposure occurring after January 1, 1976. In the event of death following continuous total disability commencing within eight years after the last injurious exposure, the requirement of death within eight years after the last injurious exposure does not apply.

Before awarding compensation for partial or total disability or death due to berylliosis, the administrator of workers' compensation shall refer the claim to a qualified medical specialist for examination and recommendation with regard to the diagnosis, the extent of the disability, the nature of the disability, whether permanent or temporary, the cause of death, and other medical questions connected with the claim. An employee shall submit to such examinations, including clinical and x-ray examinations, as the administrator requires.

In the event that an employee refuses to submit to examinations, including clinical and x-ray examinations, after notice from the administrator, or in the event that a claimant for compensation for death due to berylliosis fails to produce necessary consents and permits, after notice from the administrator, so that such autopsy examination and tests may be performed, then all rights for compensation are forfeited. The reasonable compensation of such specialist and the expenses of examinations and tests shall be paid, if the claim is allowed, as part of the expenses of the claim, otherwise they shall be paid from the surplus fund.

(W) Cardiovascular, pulmonary, or respiratory diseases incurred by firefighters or police officers following exposure to heat, smoke, toxic gases, chemical fumes and other toxic substances: Any cardiovascular, pulmonary, or respiratory disease of a firefighter or police officer caused or induced by the cumulative effect of exposure to heat, the inhalation of smoke, toxic gases, chemical fumes and other toxic substances in the performance of the firefighter's or police officer's duty constitutes a presumption, which may be refuted by affirmative evidence, that such occurred in the course of and arising out of the firefighter's or police officer's employment. For the purpose of this section, "firefighter" means any regular member of a lawfully constituted fire department of a municipal corporation or township, whether paid or volunteer, and "police officer" means any regular member of a lawfully constituted police department of a municipal corporation, township or county, whether paid or volunteer.

This chapter does not entitle a firefighter, or police officer, or the firefighter's or police officer's dependents to compensation, medical treatment, or payment of funeral expenses for disability or death from a cardiovascular, pulmonary, or

respiratory disease, unless the firefighter or police officer has been subject to injurious exposure to heat, smoke, toxic gases, chemical fumes, and other toxic substances in the firefighter's or police officer's employment in this state preceding the firefighter's or police officer's disablement, some portion of which has been after January 1, 1967, except as provided in division ~~(E)~~ (D) of section 4123.57 of the Revised Code.

Compensation on account of cardiovascular, pulmonary, or respiratory diseases of firefighters and police officers is payable only in the event of temporary total disability, permanent total disability, or death, in accordance with section 4123.56, 4123.58, or 4123.59 of the Revised Code. Medical, hospital, and nursing expenses are payable in accordance with this chapter. Compensation, medical, hospital, and nursing expenses are payable only in the event of such disability or death resulting within eight years after the last injurious exposure; provided that such eight-year limitation does not apply to disability or death from exposure occurring after January 1, 1976. In the event of death following continuous total disability commencing within eight years after the last injurious exposure, the requirement of death within eight years after the last injurious exposure does not apply.

This chapter does not entitle a firefighter or police officer, or the firefighter's or police officer's dependents, to compensation, medical, hospital, and nursing expenses, or payment of funeral expenses for disability or death due to a cardiovascular, pulmonary, or respiratory disease in the event of failure or omission on the part of the firefighter or police officer truthfully to state, when seeking employment, the place, duration, and nature of previous employment in answer to an

inquiry made by the employer.

Before awarding compensation for disability or death under this division, the administrator shall refer the claim to a qualified medical specialist for examination and recommendation with regard to the diagnosis, the extent of disability, the cause of death, and other medical questions connected with the claim. A firefighter or police officer shall submit to such examinations, including clinical and x-ray examinations, as the administrator requires. In the event that a firefighter or police officer refuses to submit to examinations, including clinical and x-ray examinations, after notice from the administrator, or in the event that a claimant for compensation for death under this division fails to produce necessary consents and permits, after notice from the administrator, so that such autopsy examination and tests may be performed, then all rights for compensation are forfeited. The reasonable compensation of such specialists and the expenses of examination and tests shall be paid, if the claim is allowed, as part of the expenses of the claim, otherwise they shall be paid from the surplus fund.

(X)(1) Cancer contracted by a firefighter: Cancer contracted by a firefighter who has been assigned to at least six years of hazardous duty as a firefighter constitutes a presumption that the cancer was contracted in the course of and arising out of the firefighter's employment if the firefighter was exposed to an agent classified by the international agency for research on cancer or its successor organization as a group 1 or 2A carcinogen.

(2) The presumption described in division (X)(1) of this section is rebuttable in any of the following situations:

(a) There is evidence that the firefighter's exposure, outside the scope of the firefighter's official duties, to cigarettes, tobacco products, or other conditions presenting an extremely high risk for the development of the cancer alleged, was probably a significant factor in the cause or progression of the cancer.

(b) There is evidence that the firefighter was not exposed to an agent classified by the international agency for research on cancer as a group 1 or 2A carcinogen.

(c) There is evidence that the firefighter incurred the type of cancer alleged before becoming a member of the fire department.

(d) The firefighter is seventy years of age or older.

(3) The presumption described in division (X)(1) of this section does not apply if it has been more than twenty years since the firefighter was last assigned to hazardous duty as a firefighter.

(4) Compensation for cancer contracted by a firefighter in the course of hazardous duty under division (X) of this section is payable only in the event of temporary total disability, permanent total disability, or death, in accordance with sections 4123.56, 4123.58, and 4123.59 of the Revised Code.

(5) As used in division (X) of this section, "hazardous duty" has the same meaning as in 5 C.F.R. 550.902, as amended.

(Y) Silicosis: Silicosis means a disease of the lungs caused by breathing silica dust (silicon dioxide) producing fibrous nodules distributed through the lungs~~ and demonstrated by x-ray examination, by biopsy or by autopsy~~.

(Z) Coal miners' pneumoconiosis: Coal miners' pneumoconiosis, commonly referred to as "black lung disease," resulting from working in the coal mine industry and due to exposure to the breathing of coal dust~~, and demonstrated by x-ray examination, biopsy, autopsy or other medical or clinical tests~~.

This chapter does not entitle an employee or the employee's dependents to compensation, medical treatment, or payment of funeral expenses for disability or death from silicosis, asbestosis, or coal miners' pneumoconiosis unless the employee has been subject to injurious exposure to silica dust (silicon dioxide), asbestos, or coal dust in the employee's employment in this state preceding the employee's disablement, some portion of which has been after October 12, 1945, except as provided in division ~~(E)~~ (D) of section 4123.57 of the Revised Code.

Compensation on account of silicosis, asbestosis, or coal miners' pneumoconiosis are payable only in the event of temporary total disability, permanent partial disability, permanent total disability, or death, in accordance with ~~sections 4123.56, 4123.58, and~~ section 4123.59 and Chapter 4133. of the Revised Code. Medical, hospital, and nursing expenses are payable in accordance with this chapter. ~~Compensation, medical~~ Medical, hospital, and nursing expenses are payable only in the event of such disability or death resulting within eight years after the last injurious exposure; provided that such eight-year limitation does not apply to ~~disability or~~ death occurring after January 1, 1976, and further provided that such eight-year limitation does not apply to any asbestosis cases. In the event of death following continuous total disability commencing within eight years after the last injurious exposure, the requirement

of death within eight years after the last injurious exposure does not apply.

~~This chapter does not entitle an employee or the employee's dependents to compensation, medical, hospital and nursing expenses, or payment of funeral expenses for disability or death due to silicosis, asbestosis, or coal miners' pneumoconiosis in the event of the failure or omission on the part of the employee truthfully to state, when seeking employment, the place, duration, and nature of previous employment in answer to an inquiry made by the employer.~~

~~Before awarding compensation for disability or death due to silicosis, asbestosis, or coal miners' pneumoconiosis, the administrator shall refer the claim to a qualified medical specialist for examination and recommendation with regard to the diagnosis, the extent of disability, the cause of death, and other medical questions connected with the claim. An employee shall submit to such examinations, including clinical and x-ray examinations, as the administrator requires. In the event that an employee refuses to submit to examinations, including clinical and x-ray examinations, after notice from the administrator, or in the event that a claimant for compensation for death due to silicosis, asbestosis, or coal miners' pneumoconiosis fails to produce necessary consents and permits, after notice from the commission, so that such autopsy examination and tests may be performed, then all rights for compensation are forfeited. The reasonable compensation of such specialist and the expenses of examinations and tests shall be paid, if the claim is allowed, as a part of the expenses of the claim, otherwise they shall be paid from the surplus fund.~~

(AA) Radiation illness: Any industrial process involving

the use of radioactive materials.

Claims for compensation and benefits due to radiation illness are payable only in the event death or disability occurred within eight years after the last injurious exposure provided that such eight-year limitation does not apply to disability or death from exposure occurring after January 1, 1976. In the event of death following continuous disability which commenced within eight years of the last injurious exposure the requirement of death within eight years after the last injurious exposure does not apply.

(BB) Asbestosis: Asbestosis means a disease caused by inhalation or ingestion of asbestos~~, demonstrated by x-ray examination, biopsy, autopsy, or other objective medical or clinical tests~~.

All conditions, restrictions, limitations, and other provisions of this section, with reference to the payment of compensation or benefits on account of silicosis or coal miners' pneumoconiosis apply to the payment of compensation or benefits on account of any other occupational disease of the respiratory tract resulting from injurious exposures to dust.

The refusal to produce the necessary consents and permits for autopsy examination and testing shall not result in forfeiture of compensation provided the administrator finds that such refusal was the result of bona fide religious convictions or teachings to which the claimant for compensation adhered prior to the death of the decedent.

**Sec. 4123.69.** Every employee mentioned in section 4123.68 of the Revised Code and the dependents and the employer or employers of such employee shall be entitled to all the rights,

benefits, and immunities and shall be subject to all the liabilities, penalties, and regulations provided for injured employees and their employers by this chapter and Chapter 4133. of the Revised Code.

~~The administrator of workers' compensation shall have all of the powers, authority, and duties with respect to the collection, administration, and disbursement of the state occupational disease fund as are provided for in this chapter, providing for the collection, administration, and disbursement of the state insurance fund for the compensation of injured employees.~~

**Sec. 4123.74.** Employers who comply with section 4123.35 of the Revised Code shall not be liable to respond in damages at common law or by statute for any injury, or occupational disease, or bodily condition, received or contracted by any employee in the course of or arising out of ~~his~~ employment, or for any death resulting from such injury, occupational disease, or bodily condition occurring during the period covered by such premium so paid into the state insurance fund, or during the interval the employer is a self-insuring employer, whether or not such injury, occupational disease, bodily condition, or death is compensable under this chapter or Chapter 4133. of the Revised Code.

**Sec. 4123.741.** No employee of any employer, as defined in division (B) of section 4123.01 of the Revised Code, shall be liable to respond in damages at common law or by statute for any injury or occupational disease, received or contracted by any other employee of such employer in the course of and arising out of the latter employee's employment, or for any death resulting from such injury or occupational disease, on the condition that

such injury, occupational disease, or death is found to be compensable under sections 4123.01 to 4123.94~~, inclusive,~~ or Chapter 4133. of the Revised Code.

**Sec. 4123.85.** ~~In~~ Except as provided in Chapter 4133. of the Revised Code, in all cases of occupational disease, or death resulting from occupational disease, claims for compensation or benefits are forever barred unless, within two years after the disability due to the disease began, or within such longer period as does not exceed six months after diagnosis of the occupational disease by a licensed physician or within two years after death occurs, application is made to the industrial commission or the bureau of workers' compensation or to the employer if ~~he~~ the employer is a self-insuring employer.

**Sec. 4123.89.** For the purpose of this chapter and Chapter 4133. of the Revised Code, a minor is sui juris, and no other person shall have any cause of action or right to compensation for an injury to the minor employee, but in the event of the award of a lump sum of compensation to the minor employee, the sum shall be paid to the legally appointed guardian of the minor or in accordance with section 2111.05 of the Revised Code.

When it is found upon hearing by the industrial commission that an injury, occupational disease, or death of a minor working in employment which is prohibited by any law enacted by the general assembly was directly caused by a hazard of such prohibited employment, the commission shall assess an additional award of one hundred per cent of the maximum award established by law, to the amount of the compensation that may be awarded on account of such injury, occupational disease, or death, and paid in like manner as other awards. If the compensation is paid from the state fund, the premium of the employer shall be increased

in such amount, covering such period of time as may be fixed, as will recoup the state fund in the amount of the additional award.

**Sec. 4123.93.** As used in sections 4123.93 to 4123.932 of the Revised Code:

(A) "Claimant" means a person who is eligible to receive compensation, medical benefits, or death benefits under this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code.

(B) "Statutory subrogee" means the administrator of workers' compensation, a self-insuring employer, or an employer that contracts for the direct payment of medical services pursuant to division (P) of section 4121.44 of the Revised Code.

(C) "Third party" means an individual, private insurer, public or private entity, or public or private program that is or may be liable to make payments to a person without regard to any statutory duty contained in this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code.

(D) "Subrogation interest" includes past, present, and estimated future payments of compensation, medical benefits, rehabilitation costs, or death benefits, and any other costs or expenses paid to or on behalf of the claimant by the statutory subrogee pursuant to this chapter or Chapter 4121., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code.

(E) "Net amount recovered" means the amount of any award, settlement, compromise, or recovery by a claimant against a third party, minus the attorney's fees, costs, or other expenses incurred by the claimant in securing the award, settlement, compromise, or recovery. "Net amount recovered" does not include

any punitive damages that may be awarded by a judge or jury.

(F) "Uncompensated damages" means the claimant's demonstrated or proven damages minus the statutory subrogee's subrogation interest.

**Sec. 4123.931.** (A) The payment of compensation or benefits pursuant to this chapter or Chapter 4121., 4127., ~~or~~ 4131., or 4133. of the Revised Code creates a right of recovery in favor of a statutory subrogee against a third party, and the statutory subrogee is subrogated to the rights of a claimant against that third party. The net amount recovered is subject to a statutory subrogee's right of recovery.

(B) If a claimant, statutory subrogee, and third party settle or attempt to settle a claimant's claim against a third party, the claimant shall receive an amount equal to the uncompensated damages divided by the sum of the subrogation interest plus the uncompensated damages, multiplied by the net amount recovered, and the statutory subrogee shall receive an amount equal to the subrogation interest divided by the sum of the subrogation interest plus the uncompensated damages, multiplied by the net amount recovered, except that the net amount recovered may instead be divided and paid on a more fair and reasonable basis that is agreed to by the claimant and statutory subrogee. If while attempting to settle, the claimant and statutory subrogee cannot agree to the allocation of the net amount recovered, the claimant and statutory subrogee may file a request with the administrator of workers' compensation for a conference to be conducted by a designee appointed by the administrator, or the claimant and statutory subrogee may agree to utilize any other binding or non-binding alternative dispute resolution process.

The claimant and statutory subrogee shall pay equal shares of the fees and expenses of utilizing an alternative dispute resolution process, unless they agree to pay those fees and expenses in another manner. The administrator shall not assess any fees to a claimant or statutory subrogee for a conference conducted by the administrator's designee.

(C) If a claimant and statutory subrogee request that a conference be conducted by the administrator's designee pursuant to division (B) of this section, both of the following apply:

(1) The administrator's designee shall schedule a conference on or before sixty days after the date that the claimant and statutory subrogee filed a request for the conference.

(2) The determination made by the administrator's designee is not subject to Chapter 119. of the Revised Code.

(D) When a claimant's action against a third party proceeds to trial and damages are awarded, both of the following apply:

(1) The claimant shall receive an amount equal to the uncompensated damages divided by the sum of the subrogation interest plus the uncompensated damages, multiplied by the net amount recovered, and the statutory subrogee shall receive an amount equal to the subrogation interest divided by the sum of the subrogation interest plus the uncompensated damages, multiplied by the net amount recovered.

(2) The court in a nonjury action shall make findings of fact, and the jury in a jury action shall return a general verdict accompanied by answers to interrogatories that specify the following:

(a) The total amount of the compensatory damages;

(b) The portion of the compensatory damages specified pursuant to division (D)(2)(a) of this section that represents economic loss;

(c) The portion of the compensatory damages specified pursuant to division (D)(2)(a) of this section that represents noneconomic loss.

(E)(1) After a claimant and statutory subrogee know the net amount recovered, and after the means for dividing it has been determined under division (B) or (D) of this section, a claimant may establish an interest-bearing trust account for the full amount of the subrogation interest that represents estimated future payments of compensation, medical benefits, rehabilitation costs, or death benefits, reduced to present value, from which the claimant shall make reimbursement payments to the statutory subrogee for the future payments of compensation, medical benefits, rehabilitation costs, or death benefits. If the workers' compensation claim associated with the subrogation interest is settled, or if the claimant dies, or if any other circumstance occurs that would preclude any future payments of compensation, medical benefits, rehabilitation costs, and death benefits by the statutory subrogee, any amount remaining in the trust account after final reimbursement is paid to the statutory subrogee for all payments made by the statutory subrogee before the ending of future payments shall be paid to the claimant or the claimant's estate.

(2) A claimant may use interest that accrues on the trust account to pay the expenses of establishing and maintaining the trust account, and all remaining interest shall be credited to the trust account.

(3) If a claimant establishes a trust account, the statutory subrogee shall provide payment notices to the claimant on or before the thirtieth day of June and the thirty-first day of December every year listing the total amount that the statutory subrogee has paid for compensation, medical benefits, rehabilitation costs, or death benefits during the half of the year preceding the notice. The claimant shall make reimbursement payments to the statutory subrogee from the trust account on or before the thirty-first day of July every year for a notice provided by the thirtieth day of June, and on or before the thirty-first day of January every year for a notice provided by the thirty-first day of December. The claimant's reimbursement payment shall be in an amount that equals the total amount listed on the notice the claimant receives from the statutory subrogee.

(F) If a claimant does not establish a trust account as described in division (E)(1) of this section, the claimant shall pay to the statutory subrogee, on or before thirty days after receipt of funds from the third party, the full amount of the subrogation interest that represents estimated future payments of compensation, medical benefits, rehabilitation costs, or death benefits.

(G) A claimant shall notify a statutory subrogee and the attorney general of the identity of all third parties against whom the claimant has or may have a right of recovery, except that when the statutory subrogee is a self-insuring employer, the claimant need not notify the attorney general. No settlement, compromise, judgment, award, or other recovery in any action or claim by a claimant shall be final unless the claimant provides the statutory subrogee and, when required, the attorney general, with prior notice and a reasonable opportunity

to assert its subrogation rights. If a statutory subrogee and, when required, the attorney general are not given that notice, or if a settlement or compromise excludes any amount paid by the statutory subrogee, the third party and the claimant shall be jointly and severally liable to pay the statutory subrogee the full amount of the subrogation interest.

(H) The right of subrogation under this chapter is automatic, regardless of whether a statutory subrogee is joined as a party in an action by a claimant against a third party. A statutory subrogee may assert its subrogation rights through correspondence with the claimant and the third party or their legal representatives. A statutory subrogee may institute and pursue legal proceedings against a third party either by itself or in conjunction with a claimant. If a statutory subrogee institutes legal proceedings against a third party, the statutory subrogee shall provide notice of that fact to the claimant. If the statutory subrogee joins the claimant as a necessary party, or if the claimant elects to participate in the proceedings as a party, the claimant may present the claimant's case first if the matter proceeds to trial. If a claimant disputes the validity or amount of an asserted subrogation interest, the claimant shall join the statutory subrogee as a necessary party to the action against the third party.

(I) The statutory subrogation right of recovery applies to, but is not limited to, all of the following:

(1) Amounts recoverable from a claimant's insurer in connection with underinsured or uninsured motorist coverage, notwithstanding any limitation contained in Chapter 3937. of the Revised Code;

(2) Amounts that a claimant would be entitled to recover

from a political subdivision, notwithstanding any limitations contained in Chapter 2744. of the Revised Code;

(3) Amounts recoverable from an intentional tort action.

(J) If a claimant's claim against a third party is for wrongful death or the claim involves any minor beneficiaries, amounts allocated under this section are subject to the approval of probate court.

(K) Except as otherwise provided in this division, the administrator shall deposit any money collected under this section into the public fund or the private fund of the state insurance fund, as appropriate. Any money collected under this section for compensation or benefits that were charged pursuant to section 4123.932 of the Revised Code to the surplus fund account created in division (B) of section 4123.34 of the Revised Code and not charged to an employer's experience shall be deposited in the surplus fund account and not applied to an individual employer's account. If a self-insuring employer collects money under this section of the Revised Code, the self-insuring employer shall deduct the amount collected, in the year collected, from the amount of paid compensation the self-insured employer is required to report under section 4123.35 of the Revised Code.

**Sec. 4125.03.** (A) The professional employer organization with whom a shared employee is coemployed shall do all of the following:

(1) Pay wages associated with a shared employee pursuant to the terms and conditions of compensation in the professional employer organization agreement between the professional employer organization and the client employer;

(2) Pay all related payroll taxes associated with a shared employee independent of the terms and conditions contained in the professional employer organization agreement between the professional employer organization and the client employer;

(3) Maintain workers' compensation coverage, pay all workers' compensation premiums and manage all workers' compensation claims, filings, and related procedures associated with a shared employee in compliance with Chapters 4121. ~~and~~ , 4123., and 4133. of the Revised Code, except that when shared employees include family farm officers, ordained ministers, or corporate officers of the client employer, payroll reports shall include the entire amount of payroll associated with those persons;

(4) Provide written notice to each shared employee it assigns to perform services to a client employer of the relationship between and the responsibilities of the professional employer organization and the client employer;

(5) Maintain complete records separately listing the manual classifications of each client employer and the payroll reported to each manual classification for each client employer for each payroll reporting period during the time period covered in the professional employer organization agreement;

(6) Maintain a record of workers' compensation claims for each client employer;

(7) Make periodic reports, as determined by the administrator of workers' compensation, of client employers and total workforce to the administrator;

(8) Report individual client employer payroll, claims, and classification data under a separate and unique subaccount to

the administrator;

(9) Within fourteen days after receiving notice from the bureau of workers' compensation that a refund or rebate will be applied to workers' compensation premiums, provide a copy of that notice to any client employer to whom that notice is relevant.

(B) The professional employer organization with whom a shared employee is coemployed shall provide a list of all of the following information to the client employer upon the written request of the client employer:

(1) All workers' compensation claims, premiums, and payroll associated with that client employer;

(2) Compensation and benefits paid and reserves established for each claim listed under division (B)(1) of this section;

(3) Any other information available to the professional employer organization from the bureau of workers' compensation regarding that client employer.

(C)(1) A professional employer organization shall provide the information required under division (B) of this section in writing to the requesting client employer within forty-five days after receiving a written request from the client employer.

(2) For purposes of division (C) of this section, a professional employer organization has provided the required information to the client employer when the information is received by the United States postal service or when the information is personally delivered, in writing, directly to the client employer.

(D) Except as provided in section 4125.08 of the Revised Code and unless otherwise agreed to in the professional employer organization agreement, the professional employer organization with whom a shared employee is coemployed has a right of direction and control over each shared employee assigned to a client employer's location. However, a client employer shall retain sufficient direction and control over a shared employee as is necessary to do any of the following:

(1) Conduct the client employer's business, including training and supervising shared employees;

(2) Ensure the quality, adequacy, and safety of the goods or services produced or sold in the client employer's business;

(3) Discharge any fiduciary responsibility that the client employer may have;

(4) Comply with any applicable licensure, regulatory, or statutory requirement of the client employer.

(E) Unless otherwise agreed to in the professional employer organization agreement, liability for acts, errors, and omissions shall be determined as follows:

(1) A professional employer organization shall not be liable for the acts, errors, and omissions of a client employer or a shared employee when those acts, errors, and omissions occur under the direction and control of the client employer.

(2) A client employer shall not be liable for the acts, errors, and omissions of a professional employer organization or a shared employee when those acts, errors, and omissions occur under the direction and control of the professional employer organization.

(F) Nothing in divisions (D) and (E) of this section shall be construed to limit any liability or obligation specifically agreed to in the professional employer organization agreement.

**Sec. 4125.04.** (A) When a client employer enters into a professional employer organization agreement with a professional employer organization, the professional employer organization is the employer of record and the succeeding employer for the purposes of determining a workers' compensation experience rating pursuant to Chapter 4123. of the Revised Code.

(B) Pursuant to Section 35 of Article II, Ohio Constitution, and section 4123.74 of the Revised Code, the exclusive remedy for a shared employee to recover for injuries, diseases, or death incurred in the course of and arising out of the employment relationship against either the professional employer organization or the client employer are those benefits provided under Chapters 4121. ~~and~~ , 4123., and 4133. of the Revised Code.

**Sec. 4131.01.** As used in sections 4131.01 to 4131.06 of the Revised Code:

(A) "Federal act" means Title IV of the "Federal Coal Mine Health and Safety Act of 1969," 83 Stat. 742, 30 U.S.C.A. 801, as now or hereafter amended.

(B) "Coal-workers pneumoconiosis fund" means the fund created and administered pursuant to sections 4131.01 to 4131.06 of the Revised Code and does not refer, directly or indirectly, to any fund created and administered pursuant to Chapter 4123. or 4133. of the Revised Code.

(C) "Premium" means payment by or on behalf of an operator of a coal mine in Ohio who is required by the federal act to

secure the payment of benefits for which ~~he~~ the operator is liable under that act, which payments are to be credited to the coal-workers pneumoconiosis fund and does not refer, directly or indirectly, to premiums or contributions paid or required to be paid pursuant to Chapter 4123. of the Revised Code.

(D) "Subscriber" means an operator who has elected to subscribe to the coal-workers pneumoconiosis fund and whose election has been approved by the bureau of workers' compensation.

**Sec. 4133.01.** As used in this chapter:

(A) "Board-certified internist," "board-certified pathologist," and "board-certified pulmonary specialist" have the same meanings as in section 2307.84 of the Revised Code.

(B) "Occupational pneumoconiosis" means a disease of the lungs caused by the inhalation of minute particles of dust over a period of time due to causes and conditions arising out of and in the course of employment. "Occupational pneumoconiosis" includes all of the following diseases:

(1) Silicosis;

(2) Anthracosilicosis;

(3) Coal worker's pneumoconiosis, commonly known as black lung or miner's asthma;

(4) Silico-tuberculosis (silicosis accompanied by active tuberculosis of the lungs);

(5) Coal worker's pneumoconiosis accompanied by active tuberculosis of the lungs;

(6) Asbestosis;

(7) Siderosis;

(8) Anthrax;

(9) Any other dust diseases of the lungs and conditions and diseases caused by occupational pneumoconiosis not specifically designated in division (B) of this section.

(C) "Statewide average weekly wage" has the same meaning as in section 4123.62 of the Revised Code.

**Sec. 4133.02.** Except as otherwise provided in this chapter, Chapters 4121. and 4123. of the Revised Code apply to all claims arising under this chapter.

**Sec. 4133.03.** Except as provided in section 4133.05 of the Revised Code, all claims for compensation and benefits for disability or death due to occupational pneumoconiosis are forever barred unless an employee or an individual on behalf of an employee applies to the industrial commission or the bureau of workers' compensation or to the employer if the employer is a self-insuring employer not later than the following dates, as applicable:

(A) In the case of disability, not later than three years after the occurrence of either of the following, whichever is later:

(1) The last day of the last continuous period of sixty days or more during which the employee was exposed to the hazards of occupational pneumoconiosis;

(2) A diagnosed impairment due to occupational pneumoconiosis was made known to the employee by a physician.

(B) In the case of death, not later than two years after the date of the employee's death.

**Sec. 4133.04.** (A) When filing a claim for compensation and benefits for occupational pneumoconiosis, an employee or, if the employee is deceased, a dependent of the employee, shall submit to the administrator of workers' compensation or a self-insuring employer a written certification by a board-certified pulmonary specialist stating both of the following:

(1) That the employee is or was suffering from complicated pneumoconiosis or pulmonary massive fibrosis;

(2) That the occupational pneumoconiosis has or had resulted in pulmonary impairment as measured by the standards or methods used by the occupational pneumoconiosis board of at least fifteen per cent, as confirmed by valid and reproducible ventilatory testing.

(B) The pulmonary specialist shall disclose all evidence upon which the written certification is based, including all radiographic, pathologic, or other diagnostic test results the pulmonary specialist reviewed.

**Sec. 4133.05.** (A)(1) For a claim filed not later than three years after the last date of exposure to the hazards of occupational pneumoconiosis, the administrator of workers' compensation or a self-insuring employer shall determine all of the following:

(a) Whether the employee who is the subject of the claim was exposed to the hazards of occupational pneumoconiosis for a continuous period of not less than sixty days in the course of the employee's employment not later than three years before filing the claim;

(b) Whether the employee was exposed to the hazard in this state over a continuous period of not less than two years during

the ten years immediately preceding the date of last exposure to the hazard;

(c) Whether the employee was exposed to the hazard over a period of not less than ten years during the fifteen years immediately preceding the date of last exposure to the hazard.

(2) For a claim filed not later than three years after the date of diagnosis of occupational pneumoconiosis, the administrator or self-insuring employer shall determine whether the employee satisfies the requirements of divisions (A)(1)(b) and (c) of this section.

(B) For a claim filed by a dependent of an employee whose death is caused by occupational pneumoconiosis, the administrator or self-insuring employer shall determine all of the following:

(1) Whether the deceased employee was exposed to the hazards of occupational pneumoconiosis for a continuous period of not less than sixty days in the course of the employee's employment within ten years before filing the claim;

(2) Whether the deceased employee was exposed to the hazard in this state over a continuous period of not less than two years during the ten years immediately preceding the date of last exposure to the hazard;

(3) Whether the deceased employee was exposed to the hazard over a period of not less than ten years during the fifteen years immediately preceding the date of last exposure to the hazard.

(C) The administrator or self-insuring employer shall determine other nonmedical facts that, in the opinion of the administrator or self-insuring employer, are pertinent to a

decision on the validity of a claim.

(D) The administrator may allocate to and divide any charges resulting from an occupational pneumoconiosis claim among the employers for whom the employee who is the subject of the claim was employed up to sixty days during the period of three years immediately preceding the date of last exposure to the hazards of occupational pneumoconiosis. The administrator shall base the allocation on the time and degree of exposure the employee had with each employer.

**Sec. 4133.06.** (A) The administrator of workers' compensation or a self-insuring employer shall determine the nonmedical findings for an occupational pneumoconiosis claim filed under section 4133.05 of the Revised Code not later than ninety days after the administrator or self-insuring employer receives the claimant's application and the pulmonary specialist's written certification specified in section 4133.04 of the Revised Code. The administrator or self-insuring employer shall provide each interested party written notice of the determination.

(B) The administrator's or self-insuring employer's determination under this chapter is final unless the employer or claimant objects to the determination not later than sixty days after receipt of the notice described in division (A) of this section.

(C) If a claimant objects to the administrator's determination regarding the occupational pneumoconiosis claim for compensation and benefits, the claimant may appeal the claim in accordance with section 4123.511 or 4123.512 of the Revised Code. If an employer objects to the determination under this section, the administrator shall refer the claim to the

occupational pneumoconiosis board as if the objection had not been filed.

**Sec. 4133.07.** There is hereby created the occupational pneumoconiosis board within the bureau of workers' compensation to determine, under the direction and supervision of the administrator of workers' compensation, all medical questions relating to claims for compensation and benefits for occupational pneumoconiosis.

The board consists of five physicians in good professional standing holding a certificate issued under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery. Members shall be board-certified internists or board-certified pulmonary specialists. The administrator shall appoint the members to the board.

Not later than ninety days after the effective date of this section, the administrator shall appoint the initial members to the board. The administrator shall appoint three members to terms ending one year after the effective date of this section, two members to terms ending two years after that date, and one member to a term ending three years after that date. Thereafter, terms of office for all members are six years, with each term ending on the same day of the same month as did the term that it succeeds. Each member shall hold office from the date of appointment until the end of the term for which the member was appointed. Members may be reappointed.

Vacancies shall be filled in the same manner as original appointments. Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall hold office for the remainder of the term. Any member shall continue in office subsequent to the

expiration date of the member's term until a successor takes office, or until a period of sixty days has elapsed, whichever occurs first.

The administrator annually shall select from among the board members a chairperson. A majority of board members constitutes a quorum.

Members of the occupational pneumoconiosis board shall receive compensation for their service on the board and be reimbursed for travel and actual and necessary expenses incurred in the conduct of their official duties. The administrator shall establish the compensation of members in accordance with section 4121.121 of the Revised Code.

Sections 101.82 to 101.87 of the Revised Code do not apply to the occupational pneumoconiosis board.

**Sec. 4133.08.** (A) On referral to the occupational pneumoconiosis board, the board shall notify the claimant and administrator or self-insuring employer, as applicable, to appear before the board at a time and place stated in the notice. If the claimant is living, the claimant shall appear before the board at the specified time and place and submit to any examination, including clinical and x-ray examinations, required by the board.

If a licensed physician files an affidavit with the board that the claimant is physically unable to appear at the specified time and place, the board shall, on notice to the proper parties, change the time and place as may reasonably facilitate the hearing or examination of the claimant or may appoint a qualified specialist in the field of respiratory disease to examine the claimant on the board's behalf.

(B) The claimant and employer shall produce as evidence to the board all medical reports and x-ray examinations that are in the claimant's or employer's possession or control and that show the employee's past or present condition.

If the employee who is the subject of the claim is deceased, the notice specified in division (A) of this section may require the claimant to produce any consents and permits necessary so that an autopsy may be performed. If the board determines an autopsy is necessary to accurately and scientifically determine the cause of death, the board shall order the autopsy. The board shall designate a physician holding a certificate issued under Chapter 4731. of the Revised Code, board-certified pathologist, or any other specialist the board determines necessary to conduct the examination and tests to determine the cause of death and certify the findings in writing to the board. Notwithstanding section 4123.88 of the Revised Code, the findings are public records under section 149.43 of the Revised Code.

(C) In determining the presence of occupational pneumoconiosis, the board may consider x-ray evidence, but the board shall not give that evidence greater weight than any other type of evidence demonstrating occupational pneumoconiosis.

(D) If an employee refuses to submit to an examination, the employee's claim shall be suspended during the period of the refusal in accordance with section 4123.53 of the Revised Code. If a claimant fails to produce necessary consents and permits so that an autopsy may be performed, the claimant forfeits all rights for compensation and benefits under this chapter.

(E) The claimant and employer are entitled to be present at all examinations conducted by the board and to be represented

by attorneys and physicians.

**Sec. 4133.09.** (A) The occupational pneumoconiosis board, as soon as practicable after completing its investigation under section 4133.08 of the Revised Code, shall issue a written report on its determination of every medical question in controversy to the administrator of workers' compensation or self-insuring employer. The board shall send one copy of the report to the claimant and one copy to the claimant's employer if the employer is not a self-insuring employer.

(B) The board shall return to and file with the administrator or self-insuring employer all evidence and medical reports and x-ray examinations produced by or on behalf of the claimant or employer.

(C) The board shall include all of the following in its determination:

(1) Whether the employee contracted occupational pneumoconiosis and, if so, the percentage of permanent disability resulting from the occupational pneumoconiosis;

(2) Whether the exposure in the employment was sufficient to have caused the employee's occupational pneumoconiosis or to have perceptibly aggravated an existing occupational pneumoconiosis or other occupational disease;

(3) What, if any, physician appeared before the board on the claimant's or employer's behalf and what, if any, medical evidence was produced by or on the claimant's or employer's behalf.

(D)(1) It shall be presumed that the employee is suffering or if the employee is deceased, the deceased employee was suffering at the time of the employee's death, from occupational

pneumoconiosis that arose out of and in the course of employment if both of the following are shown:

(a) The employee has or had been exposed to the hazard of inhaling minute particles of dust in the course of and arising from the employee's employment for a period of ten years during the fifteen years immediately preceding the date of the employee's last exposure to the hazard;

(b) The employee has or had sustained a chronic respiratory disability.

(2) The presumption described in division (D)(1) of this section is not conclusive.

(E) If either party contests the board's determination in division (C) of this section, the party shall file an appeal with the industrial commission in accordance with section 4123.511 of the Revised Code.

(F)(1) Except as provided in division (F)(2) of this section, a claimant who receives a final determination from the board that the employee who is the subject of the claim has or had no evidence of occupational pneumoconiosis is barred for a period of three years from filing a new claim or pursuing a previously filed, but unruled upon, claim for occupational pneumoconiosis or requesting a modification of any prior ruling finding the employee not to be suffering from occupational pneumoconiosis.

The three-year period described in this division begins on the date of the board's decision or the date on which the employee's employment with the employer who employed the employee at the time designated as the employee's last date of exposure in the denied claim terminates, whichever is sooner.

For purposes of this division, an employee's employment is considered terminated if the employee has not worked for that employer for a period of more than ninety days.

The administrator or a self-insuring employer shall consolidate any previously filed but unruled upon claim with the claim in which the board's decision is made and must be denied together with the decided claim. The administrator or self-insuring employer shall not apply these limitations to a claim if doing so would later cause a claimant's claim to be forever barred for failing to file within the applicable time limitation.

(2) This division does not apply if the claimant demonstrates that the occupational pneumoconiosis has deteriorated.

**Sec. 4133.10.** The administrator of workers' compensation or a self-insuring employer may require a claimant to appear for examination before the occupational pneumoconiosis board. If the claimant is required to appear for a board examination, the party that referred the claimant to the board shall reimburse the claimant for loss of wages and reasonable traveling expenses and other expenses in connection with the examination.

**Sec. 4133.11.** An employee filing a claim for compensation and benefits for occupational pneumoconiosis shall receive medical, nurse, and hospital services in accordance with section 4123.66 of the Revised Code.

**Sec. 4133.12.** An employee who is awarded compensation for temporary total disability for occupational pneumoconiosis shall receive sixty-six and two-thirds per cent of the employee's average weekly wage so long as such disability is total. The

employee shall not receive an amount of weekly compensation that exceeds an amount that is equal to the statewide average weekly wage or that is less than an amount that is equal to thirty-three and one-third per cent of the statewide average weekly wage. In no event, however, shall the minimum weekly compensation exceed the level of compensation determined by using the federal minimum hourly wage.

The number of weeks of temporary total disability compensation an employee may receive for a single occupational pneumoconiosis claim shall not exceed one hundred four weeks.

**Sec. 4133.13.** (A) An employee who is awarded compensation for permanent partial disability for occupational pneumoconiosis shall receive sixty-six and two-thirds per cent of the employee's average weekly wage. The employee shall not receive an amount of weekly compensation that exceeds an amount that is equal to seventy per cent of the statewide average weekly wage or that is less than an amount equal to thirty-three and one-third per cent of the statewide average weekly wage. In no event, however, shall the minimum weekly compensation exceed the level of compensation determined by using the federal minimum hourly wage.

(B)(1) Except as provided in division (B)(2) of this section, an employee shall receive four weeks of compensation for each percentage of disability that the administrator of workers' compensation determines to be permanent.

(2) If an employee is released by the employee's treating physician to return to work at the position the employee held before the occupational pneumoconiosis occurred and the employee's preinjury employer does not offer the preinjury position or a comparable position to the employee when a

position is available, the award for the percentage of partial disability shall be computed on the basis of six weeks of compensation for each percentage of disability.

(C) The degree of permanent partial disability shall be determined by the degree of whole body medical impairment that an employee has suffered. Once the degree of an employee's medical impairment has been determined, that degree of impairment is the percentage of permanent partial disability that shall be awarded to the employee. The occupational pneumoconiosis board shall premise its decision on the degree of pulmonary function impairment that an employee suffers solely upon whole body medical impairment.

(D) The administrator shall adopt standards for determining an employee's degree of whole body medical impairment.

**Sec. 4133.14.** An employee who is awarded compensation for permanent total disability for occupational pneumoconiosis shall receive sixty-six and two-thirds per cent of the employee's average weekly wage. The employee shall not receive an amount of weekly compensation that exceeds an amount that is equal to one hundred per cent of the statewide average weekly wage or that is less than an amount that is equal to thirty-three and one-third per cent of the statewide average weekly wage. In no event, however, shall the minimum weekly compensation exceed the level of compensation determined by using the federal minimum hourly wage.

Permanent total disability compensation for occupational pneumoconiosis shall cease upon the employee reaching seventy years of age.

If an employee is determined to be permanently disabled due to occupational pneumoconiosis, the percentage of permanent disability shall be determined by the degree of medical impairment found by the occupational pneumoconiosis board.

In cases of permanent disability or death due to occupational pneumoconiosis accompanied by active tuberculosis of the lungs, compensation is payable for disability or death due to occupational pneumoconiosis alone.

**Sec. 4133.15.** Benefits in case of death due to occupational pneumoconiosis shall be paid in accordance with section 4123.60 of the Revised Code.

**Sec. 4133.16.** In computing compensation for occupational pneumoconiosis claims, the administrator of workers' compensation or a self-insuring employer shall deduct the amount of all prior compensation or benefits paid to the same claimant due to silicosis under this chapter or Chapter 4123. of the Revised Code, but a prior silicosis award shall not, in any event, preclude an award for occupational pneumoconiosis otherwise payable under this chapter.

**Sec. 4729.80.** (A) If the state board of pharmacy establishes and maintains a drug database pursuant to section 4729.75 of the Revised Code, the board is authorized or required to provide information from the database in accordance with the following:

(1) On receipt of a request from a designated representative of a government entity responsible for the licensure, regulation, or discipline of health care professionals with authority to prescribe, administer, or dispense drugs, the board may provide to the representative

information from the database relating to the professional who is the subject of an active investigation being conducted by the government entity.

(2) On receipt of a request from a federal officer, or a state or local officer of this or any other state, whose duties include enforcing laws relating to drugs, the board shall provide to the officer information from the database relating to the person who is the subject of an active investigation of a drug abuse offense, as defined in section 2925.01 of the Revised Code, being conducted by the officer's employing government entity.

(3) Pursuant to a subpoena issued by a grand jury, the board shall provide to the grand jury information from the database relating to the person who is the subject of an investigation being conducted by the grand jury.

(4) Pursuant to a subpoena, search warrant, or court order in connection with the investigation or prosecution of a possible or alleged criminal offense, the board shall provide information from the database as necessary to comply with the subpoena, search warrant, or court order.

(5) On receipt of a request from a prescriber or the prescriber's delegate approved by the board, the board shall provide to the prescriber a report of information from the database relating to a patient who is either a current patient of the prescriber or a potential patient of the prescriber based on a referral of the patient to the prescriber, if all of the following conditions are met:

(a) The prescriber certifies in a form specified by the board that it is for the purpose of providing medical treatment

to the patient who is the subject of the request;

(b) The prescriber has not been denied access to the database by the board.

(6) On receipt of a request from a pharmacist or the pharmacist's delegate approved by the board, the board shall provide to the pharmacist information from the database relating to a current patient of the pharmacist, if the pharmacist certifies in a form specified by the board that it is for the purpose of the pharmacist's practice of pharmacy involving the patient who is the subject of the request and the pharmacist has not been denied access to the database by the board.

(7) On receipt of a request from an individual seeking the individual's own database information in accordance with the procedure established in rules adopted under section 4729.84 of the Revised Code, the board may provide to the individual the individual's own database information.

(8) On receipt of a request from a medical director or a pharmacy director of a managed care organization that has entered into a contract with the department of medicaid under section 5167.10 of the Revised Code and a data security agreement with the board required by section 5167.14 of the Revised Code, the board shall provide to the medical director or the pharmacy director information from the database relating to a medicaid recipient enrolled in the managed care organization, including information in the database related to prescriptions for the recipient that were not covered or reimbursed under a program administered by the department of medicaid.

(9) On receipt of a request from the medicaid director, the board shall provide to the director information from the

database relating to a recipient of a program administered by the department of medicaid, including information in the database related to prescriptions for the recipient that were not covered or paid by a program administered by the department.

(10) On receipt of a request from a medical director of a managed care organization that has entered into a contract with the administrator of workers' compensation under division (B)(4) of section 4121.44 of the Revised Code and a data security agreement with the board required by section 4121.447 of the Revised Code, the board shall provide to the medical director information from the database relating to a claimant under Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code assigned to the managed care organization, including information in the database related to prescriptions for the claimant that were not covered or reimbursed under Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code, if the administrator of workers' compensation confirms, upon request from the board, that the claimant is assigned to the managed care organization.

(11) On receipt of a request from the administrator of workers' compensation, the board shall provide to the administrator information from the database relating to a claimant under Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code, including information in the database related to prescriptions for the claimant that were not covered or reimbursed under Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code.

(12) On receipt of a request from a prescriber or the prescriber's delegate approved by the board, the board shall provide to the prescriber information from the database relating

to a patient's mother, if the prescriber certifies in a form specified by the board that it is for the purpose of providing medical treatment to a newborn or infant patient diagnosed as opioid dependent and the prescriber has not been denied access to the database by the board.

(13) On receipt of a request from the director of health, the board shall provide to the director information from the database relating to the duties of the director or the department of health in implementing the Ohio violent death reporting system established under section 3701.93 of the Revised Code.

(14) On receipt of a request from a requestor described in division (A)(1), (2), (5), or (6) of this section who is from or participating with another state's prescription monitoring program, the board may provide to the requestor information from the database, but only if there is a written agreement under which the information is to be used and disseminated according to the laws of this state.

(15) On receipt of a request from a delegate of a retail dispensary licensed under Chapter 3796. of the Revised Code who is approved by the board to serve as the dispensary's delegate, the board shall provide to the delegate a report of information from the database pertaining only to a patient's use of medical marijuana, if both of the following conditions are met:

(a) The delegate certifies in a form specified by the board that it is for the purpose of dispensing medical marijuana for use in accordance with Chapter 3796. of the Revised Code.

(b) The retail dispensary or delegate has not been denied access to the database by the board.

(B) The state board of pharmacy shall maintain a record of each individual or entity that requests information from the database pursuant to this section. In accordance with rules adopted under section 4729.84 of the Revised Code, the board may use the records to document and report statistics and law enforcement outcomes.

The board may provide records of an individual's requests for database information to the following:

(1) A designated representative of a government entity that is responsible for the licensure, regulation, or discipline of health care professionals with authority to prescribe, administer, or dispense drugs who is involved in an active criminal or disciplinary investigation being conducted by the government entity of the individual who submitted the requests for database information;

(2) A federal officer, or a state or local officer of this or any other state, whose duties include enforcing laws relating to drugs and who is involved in an active investigation being conducted by the officer's employing government entity of the individual who submitted the requests for database information.

(C) Information contained in the database and any information obtained from it is confidential and is not a public record. Information contained in the records of requests for information from the database is confidential and is not a public record. Information contained in the database that does not identify a person, including any licensee or registrant of the board or other entity, may be released in summary, statistical, or aggregate form.

(D) Information contained in the database may be provided

only as expressly permitted in law, including any information contained in the database that relates to any person, including any licensee or registrant of the board or other entity.

(E) A pharmacist or prescriber shall not be held liable in damages to any person in any civil action for injury, death, or loss to person or property on the basis that the pharmacist or prescriber did or did not seek or obtain information from the database.

**Sec. 5145.163.** (A) As used in this section:

(1) "Customer model enterprise" means an enterprise conducted under a federal prison industries enhancement certification program in which a private party participates in the enterprise only as a purchaser of goods and services.

(2) "Employer model enterprise" means an enterprise conducted under a federal prison industries enhancement certification program in which a private party participates in the enterprise as an operator of the enterprise.

(3) "Injury" means a diagnosable injury to an inmate supported by medical findings that it was sustained in the course of and arose out of authorized work activity that was an integral part of the inmate's participation in the Ohio penal industries program.

(4) "Inmate" means any person who is committed to the custody of the department of rehabilitation and correction and who is participating in an Ohio penal industries program that is under the federal prison industries enhancement certification program.

(5) "Federal prison industries enhancement certification program" means the program authorized pursuant to 18 U.S.C.

1761.

(6) "Loss of earning capacity" means an impairment of the body of an inmate to a degree that makes the inmate unable to return to work activity under the Ohio penal industries program and results in a reduction of compensation earned by the inmate at the time the injury occurred.

(B) Every inmate shall be covered by a policy of disability insurance to provide benefits for loss of earning capacity due to an injury and for medical treatment of the injury following the inmate's release from prison. If the enterprise for which the inmate works is a customer model enterprise, Ohio penal industries shall purchase the policy. If the enterprise for which the inmate works is an employer model enterprise, the private participant shall purchase the policy. The person required to purchase the policy shall submit proof of coverage to the prison labor advisory board before the enterprise begins operation.

(C) Within ninety days after an inmate sustains an injury, the inmate may file a disability claim with the person required to purchase the policy of disability insurance. Upon the request of the insurer, the inmate shall be medically examined, and the insurer shall determine the inmate's entitlement to disability benefits based on the medical examination. The inmate shall accept or reject an award within thirty days after a determination of the inmate's entitlement to the award. If the inmate accepts the award, the benefits shall be paid upon the inmate's release from prison. The amount of disability benefits payable to the inmate shall be reduced by sick leave benefits or other compensation for lost pay made by Ohio penal industries to the inmate due to an injury that rendered the inmate unable to

work. An inmate shall not receive disability benefits for injuries occurring as the result of a fight, assault, horseplay, purposely self-inflicted injury, use of alcohol or controlled substances, misuse of prescription drugs, or other activity that is prohibited by the department's or institution's inmate conduct rules or the work rules of the private participant in the enterprise.

(D) Inmates are not employees of the department of rehabilitation and correction or the private participant in an enterprise.

(E) An inmate is ineligible to receive compensation or benefits under Chapter 4121., 4123., 4127., ~~or~~ 4131.<u>, or 4133.</u> of the Revised Code for any injury, death, or occupational disease received in the course of, and arising out of, participation in the Ohio penal industries program. Any claim for an injury arising from an inmate's participation in the program is specifically excluded from the jurisdiction of the Ohio bureau of workers' compensation and the industrial commission of Ohio.

(F) Any disability benefit award accepted by an inmate under this section shall be the inmate's exclusive remedy against the insurer, the private participant in an enterprise, and the state. If an inmate rejects an award or a disability claim is denied, the inmate may bring an action in the court of claims within the appropriate period of limitations.

(G) If any inmate who is paid disability benefits under this section is reincarcerated, the benefits shall immediately cease but shall resume upon the inmate's subsequent release from incarceration.

**Sec. 5503.08.** Each state highway patrol officer shall, in addition to the sick leave benefits provided in section 124.38 of the Revised Code, be entitled to occupational injury leave. Occupational injury leave of one thousand five hundred hours with pay may, with the approval of the superintendent of the state highway patrol, be used for absence resulting from each independent injury incurred in the line of duty, except that occupational injury leave is not available for injuries incurred during those times when the patrol officer is actually engaged in administrative or clerical duties at a patrol facility, when a patrol officer is on a meal or rest period, or when the patrol officer is engaged in any personal business. The superintendent of the state highway patrol shall, by rule, define those administrative and clerical duties and those situations where the occurrence of an injury does not entitle the patrol officer to occupational injury leave. Each injury incurred in the line of duty which aggravates a previously existing injury, whether the previously existing injury was so incurred or not, shall be considered an independent injury. When its use is authorized under this section, all occupational injury leave shall be exhausted before any credit is deducted from unused sick leave accumulated under section 124.38 of the Revised Code, except that, unless otherwise provided by the superintendent of the state highway patrol, occupational injury leave shall not be used for absence occurring within seven calendar days of the injury. During that seven calendar day period, unused sick leave may be used for such an absence.

When occupational injury leave is used, it shall be deducted from the unused balance of the patrol officer's occupational injury leave for that injury on the basis of one hour for every one hour of absence from previously scheduled

work.

Before a patrol officer may use occupational injury leave, the patrol officer shall:

(A) Apply to the superintendent for permission to use occupational injury leave on a form that requires the patrol officer to explain the nature of the patrol officer's independent injury and the circumstances under which it occurred; and

(B) Submit to a medical examination. The individual who conducts the examination shall report to the superintendent the results of the examination and whether or not the independent injury prevents the patrol officer from attending work.

The superintendent shall, by rule, provide for periodic medical examinations of patrol officers who are using occupational injury leave. The individual selected to conduct the medical examinations shall report to the superintendent the results of each such examination, including a description of the progress made by the patrol officer in recovering from the independent injury, and whether or not the independent injury continues to prevent the patrol officer from attending work.

The superintendent shall appoint to conduct medical examinations under this division individuals authorized by the Revised Code to do so, including any physician assistant, clinical nurse specialist, certified nurse practitioner, or certified nurse-midwife.

A patrol officer is not entitled to use or continue to use occupational injury leave after refusing to submit to a medical examination or if the individual examining the patrol officer reports that the independent injury does not prevent the patrol

officer from attending work.

A patrol officer who falsifies an application for permission to use occupational injury leave or a medical examination report is subject to disciplinary action, including dismissal.

The superintendent shall, by rule, prescribe forms for the application and medical examination report.

Occupational injury leave pay made according to this section is in lieu of such workers' compensation benefits as would have been payable directly to a patrol officer pursuant to sections 4123.56 ~~and~~ , 4123.58, 4133.12, and 4133.14 of the Revised Code, but all other compensation and benefits pursuant to ~~Chapter~~ Chapters 4123. and 4133. of the Revised Code are payable as in any other case. If at the close of the period, the patrol officer remains disabled, the patrol officer is entitled to all compensation and benefits, without a waiting period pursuant to section 4123.55 of the Revised Code based upon the injury received, for which the patrol officer qualifies pursuant to ~~Chapter~~ Chapters 4123. and 4133. of the Revised Code. Compensation shall be paid from the date that the patrol officer ceases to receive the patrol officer's regular rate of pay pursuant to this section.

Occupational injury leave shall not be credited to or, upon use, deducted from, a patrol officer's sick leave.

**Section 2.** That existing sections 109.84, 126.30, 145.2915, 2307.84, 2307.91, 2307.97, 2317.02, 2913.48, 3121.899, 3701.741, 3963.10, 4115.03, 4121.03, 4121.12, 4121.121, 4121.125, 4121.127, 4121.129, 4121.13, 4121.30, 4121.31, 4121.32, 4121.34, 4121.36, 4121.41, 4121.44, 4121.441, 4121.442,

4121.444, 4121.45, 4121.50, 4121.61, 4123.025, 4123.05, 4123.15, 4123.26, 4123.27, 4123.291, 4123.30, 4123.311, 4123.32, 4123.324, 4123.34, 4123.341, 4123.342, 4123.343, 4123.35, 4123.351, 4123.353, 4123.402, 4123.441, 4123.442, 4123.444, 4123.46, 4123.47, 4123.51, 4123.511, 4123.512, 4123.522, 4123.53, 4123.54, 4123.542, 4123.57, 4123.571, 4123.65, 4123.651, 4123.66, 4123.67, 4123.68, 4123.69, 4123.74, 4123.741, 4123.85, 4123.89, 4123.93, 4123.931, 4125.03, 4125.04, 4131.01, 4729.80, 5145.163, and 5503.08 of the Revised Code are hereby repealed.

**Section 3.** Sections 1 and 2 of this act apply to claims for compensation and benefits for disability or death due to occupational pneumoconiosis arising on or after the effective date of this act.

**Section 4.** The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the following sections, presented in this act as composites of the sections as amended by the acts indicated, are the resulting version of the sections in effect prior to the effective date of the section as presented in this act:

Section 4121.12 of the Revised Code, as amended by Sub. H.B. 123, Am. Sub. H.B. 153, and Sub. S.B. 171 of the 129th General Assembly.

Section 4121.125 of the Revised Code, as amended by Sub. H.B. 123, Am. Sub. H.B. 153, and Sub. S.B. 171 of the 129th General Assembly.