

AN ACT

To amend sections 742.38, 4113.21, 4121.125, 4121.44, 4123.29, 4123.343, 4123.512, 4123.53, 4123.54, 4123.56, 4123.57, 4123.66, 4123.68, 4123.71, 4123.84, 4125.05, 4125.051, 4125.07, 4167.01, 4167.02, and 4167.10 and to repeal sections 4123.72 and 4167.19 of the Revised Code to make changes to the Workers' Compensation Law, to prohibit a public employer from requiring an employee to pay for a medical examination as a condition of continued employment, to make appropriations for the Bureau of Workers' Compensation for the biennium beginning July 1, 2017, and ending June 30, 2019, and to provide authorization and conditions for the operation of the Bureau's programs.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 101.01. That sections 742.38, 4113.21, 4121.125, 4121.44, 4123.29, 4123.343, 4123.512, 4123.53, 4123.54, 4123.56, 4123.57, 4123.66, 4123.68, 4123.71, 4123.84, 4125.05, 4125.051, 4125.07, 4167.01, 4167.02, and 4167.10 of the Revised Code be amended to read as follows:

Sec. 742.38. (A)(1) The board of trustees of the Ohio police and fire pension fund shall adopt rules establishing minimum medical testing and diagnostic standards or procedures to be incorporated into physical examinations administered by physicians to prospective members of the fund. The standards or procedures shall include diagnosis and evaluation of the existence of any heart disease, cardiovascular disease, or respiratory disease. The rules shall specify the form of the physician's report and the information to be included in it.

The board shall notify all employers of the establishment of the minimum standards or procedures and shall include with the notice a copy of the standards or procedures. The board shall notify all employers of any changes made to the standards or procedures. Once the standards or

procedures take effect, employers shall cause each prospective member of the fund to submit to a physical examination that incorporates the standards or procedures.

(2) Division (A)(2) of this section applies to an employee who becomes a member of the fund on or after the date the minimum standards or procedures described in division (A)(1) of this section take effect. For each employee described in division (A)(2) of this section, the employer shall forward to the board a copy of the physician's report of a physical examination that incorporates the standards or procedures described in division (A)(1) of this section. If an employer fails to forward the report in the form required by the board on or before the date that is sixty days after the employee becomes a member of the fund, the board shall assess against the employer a penalty determined under section 742.353 of the Revised Code.

(B) Application for a disability benefit may be made by a member of the fund or, if the member is incapacitated as defined in rules adopted by the board, by a person acting on the member's behalf. Not later than fourteen days after receiving an application for a disability benefit from a member or a person acting on behalf of a member, the board shall notify the member's employer that an application has been filed. The notice shall state the member's position or rank. Not later than twenty-eight days after receiving the notice or filing an application on behalf of a member, the employer shall forward to the board a statement certifying the member's job description and any other information required by the board to process the application.

If the member applying for a disability benefit becomes a member of the fund prior to the date the minimum standards or procedures described in division (A)(1) of this section take effect, the board may request from the member's employer a copy of the physician's report of the member's physical examination taken on entry into the police or fire department or, if the employer does not have a copy of the report, a written statement certifying that the employer does not have a copy of the report. If an employer fails to forward the report or statement in the form required by the board on or before the date that is twenty-eight days after the date of the request, the board shall assess against the employer a penalty determined under section 742.353 of the Revised Code. The board shall maintain the information submitted under this division and division (A)(2) of this section in the member's file.

(C) For purposes of determining under division (D) of this section whether a member of the fund is disabled, the board shall adopt rules establishing objective criteria under which the board shall make the

determination. The rules shall include standards that provide for all of the following:

(1) Evaluating a member's illness or injury on which an application for disability benefits is based;

(2) Defining the occupational duties of a police officer or firefighter;

(3) Providing for the board to assign competent and disinterested physicians and vocational evaluators to conduct examinations of a member;

(4) Requiring a written report for each disability application that includes a summary of findings, medical opinions, including an opinion on whether the illness or injury upon which the member's application for disability benefits is based was caused or induced by the actual performance of the member's official duties, and any recommendations or comments based on the medical opinions;

(5) Providing for the board to consider the member's potential for retraining or reemployment.

(D) This division does not apply to members of the fund who have elected to receive benefits and pensions in accordance with division (A) or (B) of section 742.37 of the Revised Code or from a police relief and pension fund or a firemen's relief and pension fund in accordance with the rules of that fund in force on April 1, 1947.

As used in this division:

"Totally disabled" means a member of the fund is unable to perform the duties of any gainful occupation for which the member is reasonably fitted by training, experience, and accomplishments. Absolute helplessness is not a prerequisite of being totally disabled.

"Permanently disabled" means a condition of disability from which there is no present indication of recovery.

"Hazardous duty" has the same meaning as in 5 C.F.R. 550.902, as amended.

(1) A member of the fund who is permanently and totally disabled as the result of the performance of the member's official duties as a member of a police or fire department shall be paid annual disability benefits in accordance with division (A) of section 742.39 of the Revised Code. In determining whether a member of the fund is permanently and totally disabled, the board shall consider standards adopted under division (C) of this section applicable to the determination.

(2) A member of the fund who is permanently and partially disabled as the result of the performance of the member's official duties as a member of a police or fire department shall, if the disability prevents the member from performing those duties and impairs the member's earning capacity, receive

annual disability benefits in accordance with division (B) of section 742.39 of the Revised Code. In determining whether a member of the fund is permanently and partially disabled, the board shall consider standards adopted under division (C) of this section applicable to the determination.

(3)(a) A member of the fund who is permanently disabled as a result of heart disease or any cardiovascular or respiratory disease of a chronic nature, which disease or any evidence of which disease was not revealed by the physical examination passed by the member on entry into the department or another examination specified in rules the board adopts under section 742.10 of the Revised Code, is presumed to have incurred the disease while performing the member's official duties, unless the contrary is shown by competent evidence. The board may waive the requirement that the absence of disease be evidenced by a physical examination if competent medical evidence of a type specified in rules adopted under section 742.10 of the Revised Code is submitted documenting that the disease was not evident prior to or at the time of entry into the department.

(b) A member of the fund who is a member of a fire department, has been assigned to at least six years of hazardous duty as a member of a fire department, and is disabled as a result of cancer, is presumed to have incurred the cancer while performing the member's official duties if the member was exposed to an agent classified by the international agency for research on cancer or its successor agency as a group 1 or 2A carcinogen.

(c) The presumption described in division (D)(3)(b) of this section is rebuttable in any of the following situations:

(i) There is evidence that the member incurred the type of cancer being alleged before becoming a member of the department.

(ii) There is evidence that the member's exposure, outside the scope of the member'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.

(iii) There is evidence that shows, by a preponderance of competent scientific evidence, that exposure to the type of carcinogen alleged did not or could not have caused the cancer being alleged.

(iv) There is evidence that the member was not exposed to an agent classified by the international agency for research on cancer or its successor agency as a group 1 or 2A carcinogen.

~~(iv)~~(v) The member is seventy years of age or older.

(d) The presumption described in division (D)(3)(b) of this section does not apply if it has been more than ~~twenty~~ fifteen years since the member was

last assigned to hazardous duty as a member of a fire department.

(4) A member of the fund who has five or more years of service credit and has incurred a permanent disability not caused or induced by the actual performance of the member's official duties as a member of the department, or by the member's own negligence, shall if the disability prevents the member from performing those duties and impairs the member's earning capacity, receive annual disability benefits in accordance with division (C) of section 742.39 of the Revised Code. In determining whether a member of the fund is permanently disabled, the board shall consider standards adopted under division (C) of this section applicable to the determination.

(5) The board shall notify a member of its final action awarding a disability benefit to the member within thirty days of the final action. The notice shall be sent by certified mail, return receipt requested. Not later than ninety days after receipt of notice from the board, the member shall elect, on a form provided by the board, either to accept or waive the disability benefit award. If the member elects to waive the disability benefit award or fails to make an election within the time period, the award is rescinded. A member who later seeks a disability benefit award shall be required to make a new application, which shall be dealt with in accordance with the procedures used for original disability benefit applications.

A person is not eligible to apply for or receive disability benefits under this division, section 742.39 of the Revised Code, or division (C)(2), (3), (4), or (5) of former section 742.37 of the Revised Code unless the person is a member of the fund on the date on which the application for disability benefits is submitted to the fund.

With the exception of persons who may make application for increased benefits as provided in division (D)(2) or (4) of this section or division (C)(3) or (5) of former section 742.37 of the Revised Code on or after July 24, 1986, or persons who may make application for benefits as provided in section 742.26 of the Revised Code, no person receiving a pension or benefit under this section or division (C) of former section 742.37 of the Revised Code may apply for any new, changed, or different benefit.

(E) Notwithstanding the requirement of section 742.41 of the Revised Code that all medical reports and recommendations required are privileged, the board shall submit to the administrator of workers' compensation any data necessary for the report required under section 4123.86 of the Revised Code.

Sec. 4113.21. (A) No private employer shall require any prospective employee or applicant for employment to pay the cost of a medical examination required by the employer as a condition of employment.

(B) No public employer shall require any employee, prospective employee, or applicant for employment to pay the cost of a medical examination required by the public employer as a condition of employment or continued employment.

(C) As used in this section:

~~(A) "Employer~~ (1) "Private employer" means any individual, partnership, trust, estate, joint-stock company, insurance company, common carrier, public utility, or corporation, whether domestic or foreign, or the receiver, trustee in bankruptcy, trustee, or the successor thereof, who has in employment three or more individuals at any one time within a calendar year.

~~(B)~~(2) "Public employer" means the United States, the state, any political subdivision of the state, and any agency of the United States, the state, or a political subdivision of the state.

(3) "Employee" means any person who may be permitted, required, or directed by any employer in consideration of direct or indirect gain or profit, to engage in any employment.

(D) Any employer who violates this section shall forfeit not more than one hundred dollars for each violation. The bureau of workers' compensation and the public utilities commission shall enforce this section.

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 maintaining and monitoring~~ 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~~ perform analyses using accepted insurance industry standards, including, but not limited to, standards promulgated by the actuarial standards board of the American academy of actuaries or techniques used 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~~ analyses 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, estimate of the unpaid liabilities, and funding requirements~~ estimate of the unpaid liabilities of the state insurance fund and all other funds specified in this chapter and Chapters 4123., 4127., and 4131. 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~~ estimate of unpaid liabilities 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~~ estimate of unpaid liabilities 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, analysis of the mortality, service, and injury rate of employees, and the payment of temporary total disability, permanent partial disability, experience used in estimating the future costs of awards for survivor benefits and permanent total disability~~ under sections 4123.56 to 4123.58 of the Revised Code to be used in the experience rating of an employer for purposes of premium calculation and to update the ~~actuarial assumptions~~ claim level reserves 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~~ monitoring 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 analysis of the unpaid liabilities~~ valuation analysis of the unpaid liabilities 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~~ funds and components evaluated;

(2) A description of the actuarial methods and assumptions ~~and actuarial cost method~~ used in the valuation analysis of the unpaid liabilities;

(3) A schedule showing the ~~effect~~ impact of ~~any~~ changes in the ~~compensation and benefit provisions, actuarial assumptions, or cost methods~~ estimates of the unpaid liabilities since the previous annual actuarial ~~valuation analysis~~ valuation analysis 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~~ to the actuarial mortality 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; and in actuarial accrued current estimates of unpaid 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 perform~~ actuarial ~~valuations~~ analyses 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. 4121.44. (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. 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. 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.

(Q) The administrator, in consultation with the health care quality assurance advisory committee created by the administrator or its successor committee, shall develop and periodically revise standards for maintaining an adequate number of providers certified by the bureau for each service currently being used by claimants. The standards shall ensure both of the following:

(1) That a claimant has access to a choice of providers for similar services within the geographic area that the claimant resides;

(2) That the providers within a geographic area are actively accepting new claimants as required in rules adopted by the administrator.

Sec. 4123.29. (A) The administrator of workers' compensation, subject to the approval of the bureau of workers' compensation board of directors, shall do all of the following:

(1) Classify occupations or industries with respect to their degree of hazard and determine the risks of the different classes according to the categories the national council on compensation insurance establishes that are applicable to employers in this state;

(2)(a) Fix the rates of premium of the risks of the classes based upon the total payroll in each of the classes of occupation or industry sufficiently large to provide a fund for the compensation provided for in this chapter and to maintain a state insurance fund from year to year. The administrator shall set the rates at a level that assures the solvency of the fund. Where the payroll cannot be obtained or, in the opinion of the administrator, is not an adequate measure for determining the premium to be paid for the degree of hazard, the administrator may determine the rates of premium upon such other basis, consistent with insurance principles, as is equitable in view of the degree of hazard, and whenever in this chapter reference is made to payroll or expenditure of wages with reference to fixing premiums, the reference shall be construed to have been made also to such other basis for fixing the rates of premium as the administrator may determine under this section.

(b) If an employer elects to obtain other-states' coverage, including limited other-states' coverage, pursuant to section 4123.292 of the Revised Code through the administrator, if the administrator elects to offer such coverage, calculate the employer's premium for the state insurance fund in the same manner as otherwise required under division (A) of this section and section 4123.34 of the Revised Code, except that the administrator may establish in rule an alternative calculation of the employer's premium to appropriately account for the expenditure of wages, payroll, or both attributable to the labor performed and services provided by that employer's employees when those employees performed labor and provided services in this state and in the other state or states for which the employer elects to secure other-states' coverage.

(c) If an employer elects to obtain other-states' coverage pursuant to section 4123.292 of the Revised Code through an other-states' insurer, calculate the employer's premium for the state insurance fund in the same manner as otherwise required under division (A) of this section and section 4123.34 of the Revised Code, except that when the administrator determines the expenditure of wages, payroll, or both upon which to base the employer's premium, the administrator shall use only the expenditure of wages, payroll, or both attributable to the labor performed and services provided by that employer's employees when those employees performed labor and provided services in this state only and to which the other-states' coverage does not apply. The administrator may adopt rules setting forth the information that an employer electing to obtain other-states' coverage through an other-states' insurer shall report for purposes of determining the expenditure of wages, payroll, or both attributable to the labor performed

and services provided in this state.

(d) The administrator in setting or revising rates shall furnish to employers an adequate explanation of the basis for the rates set.

(3) Develop and make available to employers who are paying premiums to the state insurance fund alternative premium plans. Alternative premium plans shall include retrospective rating plans. The administrator may make available plans under which an advanced deposit may be applied against a specified deductible amount per claim.

(4)(a) Offer to insure the obligations of employers under this chapter under a plan that groups, for rating purposes, employers, and pools the risk of the employers within the group provided that the employers meet all of the following conditions:

(i) All of the employers within the group are members of an organization that has been in existence for at least two years prior to the date of application for group coverage;

(ii) The organization was formed for purposes other than that of obtaining group workers' compensation under this division;

(iii) The employers' business in the organization is substantially similar such that the risks which are grouped are substantially homogeneous;

(iv) The group of employers consists of at least one hundred members or the aggregate workers' compensation premiums of the members, as determined by the administrator, are estimated to exceed one hundred fifty thousand dollars during the coverage period;

(v) The formation and operation of the group program in the organization will substantially improve accident prevention and claims handling for the employers in the group;

(vi) Each employer seeking to enroll in a group for workers' compensation coverage has an account in good standing with the bureau of workers' compensation. The administrator shall adopt rules setting forth the criteria by which the administrator will determine whether an employer's account is in good standing.

(b) If an organization sponsors more than one employer group to participate in group plans established under this section, that organization may submit a single application that supplies all of the information necessary for each group of employers that the organization wishes to sponsor.

(c) In providing employer group plans under division (A)(4) of this section, the administrator shall consider an employer group as a single employing entity for purposes of group rating. No employer may be a member of more than one group for the purpose of obtaining workers'

compensation coverage under this division.

(d) At the time the administrator revises premium rates pursuant to this section and section 4123.34 of the Revised Code, if the premium rate of an employer who participates in a group plan established under this section changes from the rate established for the previous year, the administrator, in addition to sending the invoice with the rate revision to that employer, shall ~~send a copy of that invoice~~ provide an explanation of the rate revision to the third-party administrator that administers the group plan for that employer's group.

(e) In providing employer group plans under division (A)(4) of this section, the administrator shall establish a program designed to mitigate the impact of a significant claim that would come into the experience of a private, state fund group-rated employer or a taxing district employer for the first time and be a contributing factor in that employer being excluded from a group-rated plan. The administrator shall establish eligibility criteria and requirements that such employers must satisfy in order to participate in this program. For purposes of this program, the administrator shall establish a discount on premium rates applicable to employers who qualify for the program.

(f) In no event shall division (A)(4) of this section be construed as granting to an employer status as a self-insuring employer.

(g) The administrator shall develop classifications of occupations or industries that are sufficiently distinct so as not to group employers in classifications that unfairly represent the risks of employment with the employer.

(5) Generally promote employer participation in the state insurance fund through the regular dissemination of information to all classes of employers describing the advantages and benefits of opting to make premium payments to the fund. To that end, the administrator shall regularly make employers aware of the various workers' compensation premium packages developed and offered pursuant to this section.

(6) Make available to every employer who is paying premiums to the state insurance fund a program whereby the employer or the employer's agent pays to the claimant or on behalf of the claimant the first fifteen thousand dollars of a compensable workers' compensation medical-only claim filed by that claimant that is related to the same injury or occupational disease. No formal application is required; however, an employer must elect to participate by telephoning the bureau after July 1, 1995. Once an employer has elected to participate in the program, the employer will be responsible for all bills in all medical-only claims with a date of injury the

same or later than the election date, unless the employer notifies the bureau within fourteen days of receipt of the notification of a claim being filed that it does not wish to pay the bills in that claim, or the employer notifies the bureau that the fifteen thousand dollar maximum has been paid, or the employer notifies the bureau of the last day of service on which it will be responsible for the bills in a particular medical-only claim. If an employer elects to enter the program, the administrator shall not reimburse the employer for such amounts paid and shall not charge the first fifteen thousand dollars of any medical-only claim paid by an employer to the employer's experience or otherwise use it in merit rating or determining the risks of any employer for the purpose of payment of premiums under this chapter. A certified health care provider shall extend to an employer who participates in this program the same rates for services rendered to an employee of that employer as the provider bills the administrator for the same type of medical claim processed by the bureau and shall not charge, assess, or otherwise attempt to collect from an employee any amount for covered services or supplies that is in excess of that rate. If an employer elects to enter the program and the employer fails to pay a bill for a medical-only claim included in the program, the employer shall be liable for that bill and the employee for whom the employer failed to pay the bill shall not be liable for that bill. The administrator shall adopt rules to implement and administer division (A)(6) of this section. Upon written request from the bureau, the employer shall provide documentation to the bureau of all medical-only bills that they are paying directly. Such requests from the bureau may not be made more frequently than on a semiannual basis. Failure to provide such documentation to the bureau within thirty days of receipt of the request may result in the employer's forfeiture of participation in the program for such injury. The provisions of this section shall not apply to claims in which an employer with knowledge of a claimed compensable injury or occupational disease, has paid wages in lieu of compensation or total disability.

(B) The administrator, with the advice and consent of the board, by rule, may do both of the following:

(1) Grant an employer who pays the employer's annual estimated premium in full prior to the start of the policy year for which the estimated premium is due, a discount as the administrator fixes from time to time;

(2) Levy a minimum annual administrative charge upon risks where premium reports develop a charge less than the administrator considers adequate to offset administrative costs of processing.

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' pneumoconiosis, commonly referred to as "black lung disease";
- (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 administrator, in those 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 require that a settlement agreement approved pursuant to section 4123.65 of the Revised Code or a settlement agreement approved by a court of competent jurisdiction in this state be treated as an award of compensation granted by the administrator for the purpose of making a determination under this section.

(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 court under section 4123.512 of the Revised Code.

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 Except as otherwise provided in this division, 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 Either the claimant or the employer may file a notice of an intent to settle the claim within thirty days after the date of the receipt of the order appealed from or of the order of the commission

refusing to hear an appeal of a staff hearing officer's decision. The claimant or employer shall file notice of intent to settle with the administrator of workers' compensation, and the notice shall be served on the opposing party and the party's representative. The filing of the notice of intent to settle extends the time to file an appeal to one hundred fifty days, unless the opposing party files an objection to the notice of intent to settle within fourteen days after the date of the receipt of the notice of intent to settle. The party shall file the objection with the administrator, and the objection shall be served on the party that filed the notice of intent to settle and the party's representative. 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~~ five thousand 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.

(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. 4123.53. (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~~ (1) Except as provided in divisions (B)(2) and (3) of this section, 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~~ to schedule 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~~ schedule the examination for a date 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~~

(2) The administrator, for good cause, may waive the scheduling of a medical examination under division (B)(1) of this section. If the employee's employer objects to the administrator's waiver, the administrator shall refer the employee to the bureau medical section to schedule the examination or the administrator shall schedule the examination.

(3) 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. 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. 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 4121. 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~~ a controlled ~~substances~~ substance 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) at a level equal to or in excess of the cutoff concentration level for the particular substance as provided in section 40.87 of Title 49 of the Code of Federal Regulations, 49 C.F.R. 40.87, as amended.~~

(c) The employee, through a qualifying chemical test administered within thirty-two hours of an injury, is determined to have barbiturates, benzodiazepines, or 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 4121. 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, 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, 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. 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. 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. 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. 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. 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, 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. 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. 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. 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. 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 4121. 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 or a dependent during the period of confinement of the claimant or dependent 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 4121. 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. 4123.56. (A) Except as provided in division (D) of this section, in the case of temporary disability, an employee shall receive sixty-six and two-thirds per cent of the employee's average weekly wage so long as such disability is total, not to exceed a maximum amount of weekly compensation which is equal to the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code, and not less than a minimum amount of compensation which is equal to 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 unless the employee's wage is less than thirty-three and one-third per cent of the minimum statewide average weekly wage, in which event the employee shall receive compensation equal to the employee's full wages; provided that for the first twelve weeks of total disability the employee shall receive seventy-two per cent of the employee's full weekly wage, but not to exceed a maximum amount of weekly compensation which is equal to the lesser of the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code or one hundred per cent of the employee's net take-home weekly wage. In the case of a self-insuring employer, payments shall be for a duration based upon the medical reports of the attending physician. If the employer disputes the attending physician's report, payments may be terminated only upon application and hearing by a district hearing officer pursuant to division (C) of section 4123.511 of the Revised Code. Payments shall continue pending the determination of the matter, however payment shall not be made for the period when any employee has returned to work, when an employee's treating physician has made a written statement that the employee is capable of returning to the employee's former position of employment, when work within the physical capabilities of the employee is made available by the employer or another employer, or when the employee has reached the maximum medical improvement. Where the employee is capable of work activity, but the employee's employer is unable to offer the employee any employment, the employee shall register with the director of job and family services, who shall assist the employee in finding suitable employment. The termination of temporary total disability, whether by order or otherwise, does not preclude the commencement of temporary total disability at another point in time if the employee again becomes

temporarily totally disabled.

After two hundred weeks of temporary total disability benefits, the medical section of the bureau of workers' compensation shall schedule the claimant for an examination for an evaluation to determine whether or not the temporary disability has become permanent. A self-insuring employer shall notify the bureau immediately after payment of two hundred weeks of temporary total disability and request that the bureau schedule the claimant for such an examination.

When the employee is awarded compensation for temporary total disability for a period for which the employee has received benefits under Chapter 4141. of the Revised Code, the bureau shall pay an amount equal to the amount received from the award to the director of job and family services and the director shall credit the amount to the accounts of the employers to whose accounts the payment of benefits was charged or is chargeable to the extent it was charged or is chargeable.

If any compensation under this section has been paid for the same period or periods for which temporary nonoccupational accident and sickness insurance is or has been paid pursuant to an insurance policy or program to which the employer has made the entire contribution or payment for providing insurance or under a nonoccupational accident and sickness program fully funded by the employer, except as otherwise provided in this division compensation paid under this section for the period or periods shall be paid only to the extent by which the payment or payments exceeds the amount of the nonoccupational insurance or program paid or payable. Offset of the compensation shall be made only upon the prior order of the bureau or industrial commission or agreement of the claimant. If an employer provides supplemental sick leave benefits in addition to temporary total disability compensation paid under this section, and if the employer and an employee agree in writing to the payment of the supplemental sick leave benefits, temporary total disability benefits may be paid without an offset for those supplemental sick leave benefits.

As used in this division, "net take-home weekly wage" means the amount obtained by dividing an employee's total remuneration, as defined in section 4141.01 of the Revised Code, paid to or earned by the employee during the first four of the last five completed calendar quarters which immediately precede the first day of the employee's entitlement to benefits under this division, by the number of weeks during which the employee was paid or earned remuneration during those four quarters, less the amount of local, state, and federal income taxes deducted for each such week.

(B)(1) If an employee in a claim allowed under this chapter suffers a

wage loss as a result of returning to employment other than the employee's former position of employment due to an injury or occupational disease, the employee shall receive compensation at sixty-six and two-thirds per cent of the difference between the employee's average weekly wage and the employee's present earnings not to exceed the statewide average weekly wage. The payments may continue for up to a maximum of two hundred weeks, but the payments shall be reduced by the corresponding number of weeks in which the employee receives payments pursuant to division (A)(2) of section 4121.67 of the Revised Code.

(2) If an employee in a claim allowed under this chapter suffers a wage loss as a result of being unable to find employment consistent with the employee's disability resulting from the employee's injury or occupational disease, the employee shall receive compensation at sixty-six and two-thirds per cent of the difference between the employee's average weekly wage and the employee's present earnings, not to exceed the statewide average weekly wage. The payments may continue for up to a maximum of fifty-two weeks. The first twenty-six weeks of payments under division (B)(2) of this section shall be in addition to the maximum of two hundred weeks of payments allowed under division (B)(1) of this section. If an employee in a claim allowed under this chapter receives compensation under division (B)(2) of this section in excess of twenty-six weeks, the number of weeks of compensation allowable under division (B)(1) of this section shall be reduced by the corresponding number of weeks in excess of twenty-six, and up to fifty-two, that is allowable under division (B)(1) of this section.

(3) The number of weeks of wage loss payable to an employee under divisions (B)(1) and (2) of this section shall not exceed two hundred and twenty-six weeks in the aggregate.

(C) In the event an employee of a professional sports franchise domiciled in this state is disabled as the result of an injury or occupational disease, the total amount of payments made under a contract of hire or collective bargaining agreement to the employee during a period of disability is deemed an advanced payment of compensation payable under sections 4123.56 to 4123.58 of the Revised Code. The employer shall be reimbursed the total amount of the advanced payments out of any award of compensation made pursuant to sections 4123.56 to 4123.58 of the Revised Code.

(D) If an employee receives temporary total disability benefits pursuant to division (A) of this section and social security retirement benefits pursuant to the "Social Security Act," the weekly benefit amount under division (A) of this section shall not exceed sixty-six and two-thirds per cent

of the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code.

(E) If an employee is eligible for compensation under division (A) of this section, but the employee's full weekly wage has not been determined at the time payments are to commence under division (H) of section 4123.511 of the Revised Code, the employee shall receive 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. On determination of the employee's full weekly wage, the compensation an employee receives shall be adjusted pursuant to division (A) of this section.

If the amount of compensation an employee receives under this division is greater than the adjusted amount the employee receives under division (A) of this section that is based on the employee's full weekly wage, the excess amount shall be recovered in the manner provided in division (K) of section 4123.511 of the Revised Code. If the amount of compensation an employee receives under this division is less than the adjusted amount the employee receives under that division that is based on the employee's full weekly wage, the employee shall receive the difference between those two amounts.

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.

If an employee fails to respond to an attempt to schedule a medical examination by the bureau medical section, or fails to attend a medical

examination scheduled under this section without notice or explanation, the employee's application for a finding shall be dismissed without prejudice. The employee may refile the application. A dismissed application does not toll the continuing jurisdiction of the industrial commission under section 4123.52 of the Revised Code. The administrator shall adopt rules addressing the manner in which an employee will be notified of a possible dismissal and how an employee may refile an application for a determination.

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) 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. 4123.66. (A) In addition to the compensation provided for in this chapter, 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, 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 and if the employee was not receiving compensation or benefits under this chapter 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. 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.

(D)(1) Subject to the requirements of division (D)(2) of this section, the administrator may make a payment of up to five hundred dollars to either of the following:

(a) The centers of medicare and medicaid services, for reimbursement of conditional payments made pursuant to the "Medicare Secondary Payer Act," 42 U.S.C. 1395y;

(b) The Ohio department of medicaid, or a medical assistance provider to whom the department has assigned a right of recovery for a claim for which the department has notified the provider that the department intends to recoup the department's prior payment for the claim, for reimbursement under sections 5160.35 to 5160.43 of the Revised Code for the cost of medical assistance paid on behalf of a medical assistance recipient.

(2) The administrator may make a payment under division (D)(1) of this section if the administrator makes a reasonable determination that both of the following apply:

(a) The payment is for reimbursement of benefits for an injury or occupational disease.

(b) The injury or occupational disease is compensable, or is likely to be compensable, under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code.

(3) Any payment made pursuant to this division shall be charged to and paid from the surplus fund account created under section 4123.34 of the Revised Code.

(4) Nothing in this division shall be construed as limiting the centers of medicare and medicaid services, the department, or any other entity with a lawful right to reimbursement from recovering sums greater than five hundred dollars.

(5) The administrator may adopt rules, with the advice and consent of the bureau of workers' compensation board of directors, to implement this division.

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.

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 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) 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 shows, by a preponderance of competent scientific evidence, that exposure to the type of carcinogen alleged did not or could not have caused the cancer being alleged.

(c) 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.

~~(e)~~(d) There is evidence that the firefighter incurred the type of cancer alleged before becoming a member of the fire department.

~~(d)~~(e) 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~~ fifteen 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, working wage loss, permanent total disability, or death, in accordance with ~~sections~~ division (A) or (B)(1) of section 4123.56; and sections 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) 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 total disability, or death, in accordance with sections 4123.56,

4123.58, and 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 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. 4123.71. Every physician in this state attending on or called in to visit a patient whom ~~he~~ the physician believes to be suffering from an occupational disease as defined in section 4123.68 of the Revised Code shall, within forty-eight hours from the time of making such diagnosis, send to the bureau of workers' compensation a report stating:

- (A) Name, address, and occupation of patient;
- (B) Name and address of business in which employed;
- (C) Nature of disease;
- (D) Name and address of employer of patient;
- (E) Such other information as is reasonably required by the bureau.

The reports shall be made on blanks to be furnished by the bureau. ~~The mailing of~~ A physician who sends the report within the time stated, ~~in a stamped envelope addressed to the office of~~ the bureau is a in compliance with this section.

Reports made under this section shall not be evidence of the facts therein stated in any action arising out of a disease therein reported.

The bureau shall, within twenty-four hours after the receipt of the report, send a copy thereof to the employer of the patient named in the report.

Sec. 4123.84. (A) In all cases of injury or death, claims for compensation or benefits for the specific part or parts of the body injured shall be forever barred unless, within ~~two years~~ one year after the injury or death:

(1) Written or facsimile notice of the specific part or parts of the body claimed to have been injured has been made to the industrial commission or

the bureau of workers' compensation;

(2) The employer, with knowledge of a claimed compensable injury or occupational disease, has paid wages in lieu of compensation for total disability;

(3) In the event the employer is a self-insuring employer, one of the following has occurred:

(a) Written or facsimile notice of the specific part or parts of the body claimed to have been injured has been given to the commission or bureau or the employer has furnished treatment by a licensed physician in the employ of an employer, provided, however, that the furnishing of such treatment shall not constitute a recognition of a claim as compensable, but shall do no more than satisfy the requirements of this section;

(b) Compensation or benefits have been paid or furnished equal to or greater than is provided for in sections 4123.52, 4123.55 to 4123.62, and 4123.64 to 4123.67 of the Revised Code.

(4) Written or facsimile notice of death has been given to the commission or bureau.

(B) The bureau shall provide printed notices quoting in full division (A) of this section, and every self-insuring employer shall post and maintain at all times one or more of the notices in conspicuous places in the workshop or places of employment.

(C) The commission has continuing jurisdiction as set forth in section 4123.52 of the Revised Code over a claim which meets the requirement of this section, including jurisdiction to award compensation or benefits for loss or impairment of bodily functions developing in a part or parts of the body not specified pursuant to division (A)(1) of this section, if the commission finds that the loss or impairment of bodily functions was due to and a result of or a residual of the injury to one of the parts of the body set forth in the written notice filed pursuant to division (A)(1) of this section.

(D) Any claim pending before the administrator, the commission, or a court on December 11, 1967, in which the remedy is affected by this section is governed by this section.

(E) Notwithstanding the requirement that the notice required to be given to the bureau, commission, or employer under this section is to be in writing or facsimile, the bureau may accept, assign a claim number, and process a claim when notice is provided verbally over the telephone. Immediately upon receipt of notice provided verbally over the telephone, the bureau shall send a written or facsimile notice to the employer of the bureau's receipt of the verbal notice. Within fifteen days after receipt of the bureau's written or facsimile notice, the employer may in writing or facsimile either verify or

not verify the verbal notice. If the bureau does not receive the written or facsimile notification from the employer or receives a written or facsimile notification verifying the verbal notice within such time period, the claim is validly filed and such verbal notice tolls the statute of limitations in regard to the claim filed and is considered to meet the requirements of written or facsimile notice required by this section.

(F) As used in division (A)(3)(b) of this section, "benefits" means payments by a self-insuring employer to, or on behalf of, an employee for a hospital bill, a medical bill to a licensed physician or hospital, or an orthopedic or prosthetic device.

Sec. 4125.05. (A) Not later than thirty days after the formation of a professional employer organization, a professional employer organization operating in this state shall register with the administrator of workers' compensation on forms provided by the administrator. Following initial registration, each professional employer organization shall register with the administrator annually on or before the thirty-first day of December. Commonly owned or controlled applicants may register as a professional employer organization reporting entity or register individually. Registration as a part of a professional employer organization reporting entity shall not disqualify an individual professional employer organization from participating in a group-rated plan under division (A)(4) of section 4123.29 of the Revised Code.

(B) Initial registration and each annual registration renewal shall include all of the following:

(1) A list of each of the professional employer organization's client employers current as of the date of registration for purposes of initial registration or current as of the date of annual registration renewal, or within fourteen days of adding or releasing a client, that includes the client employer's name, address, federal tax identification number, and bureau of workers' compensation risk number;

(2) A fee as determined by the administrator;

(3) The name or names under which the professional employer organization conducts business;

(4) The address of the professional employer organization's principal place of business and the address of each office it maintains in this state;

(5) The professional employer organization's taxpayer or employer identification number;

(6) A list of each state in which the professional employer organization has operated in the preceding five years, and the name, corresponding with each state, under which the professional employer organization operated in

each state, including any alternative names, names of predecessors, and if known, successor business entities;

(7) The most recent financial statement prepared and audited pursuant to division (B) of section 4125.051 of the Revised Code;

(8) If there is any deficit in the working capital required under division (A) of section 4125.051 of the Revised Code, a bond, irrevocable letter of credit, or securities with a minimum market value in an amount sufficient to cover the deficit in accordance with the requirements of that section;

(9) An attestation of the accuracy of the data submissions from the chief executive officer, president, or other individual who serves as the controlling person of the professional employer organization.

(C) Upon terms and for periods that the administrator considers appropriate, the administrator may issue a limited registration to a professional employer organization or professional employer organization reporting entity that provides all of the following items:

(1) A properly executed request for limited registration on a form provided by the administrator;

(2) All information and materials required for registration in divisions (B)(1) to (6) of this section;

(3) Information and documentation necessary to show that the professional employer organization or professional employer organization reporting entity satisfies all of the following criteria:

(a) It is domiciled outside of this state.

(b) It is licensed or registered as a professional employer organization in another state.

(c) It does not maintain an office in this state.

(d) It does not participate in direct solicitations for client employers located or domiciled in this state.

(e) It has fifty or fewer shared employees employed or domiciled in this state on any given day.

(D)(1) The administrator, with the advice and consent of the bureau of workers' compensation board of directors, may adopt rules in accordance with Chapter 119. of the Revised Code to require, in addition to the requirement under division (B)(8) of this section, a professional employer organization to provide security in the form of a bond or letter of credit assignable to the Ohio bureau of workers' compensation not to exceed an amount equal to the premiums and assessments incurred for the most recent policy year, prior to any discounts or dividends, to meet the financial obligations of the professional employer organization pursuant to this chapter and Chapters 4121. and 4123. of the Revised Code.

(2) A professional employer organization may appeal the amount of the security required pursuant to rules adopted under division (D)(1) of this section in accordance with section 4123.291 of the Revised Code.

(3) A professional employer organization shall pay premiums and assessments for purposes of Chapters 4121. and 4123. of the Revised Code on a monthly basis pursuant to division (A) of section 4123.35 of the Revised Code.

(E) Notwithstanding division (D) of this section, a professional employer organization that qualifies for self-insurance or retrospective rating under section 4123.29 or 4123.35 of the Revised Code shall abide by the financial disclosure and security requirements pursuant to those sections and the rules adopted under those sections in place of the requirements specified in division (D) of this section or specified in rules adopted pursuant to that division.

(F) Except to the extent necessary for the administrator to administer the statutory duties of the administrator and for employees of the state to perform their official duties, all records, reports, client lists, and other information obtained from a professional employer organization and professional employer organization reporting entity under divisions (A), (B), and (C) of this section are confidential and shall be considered trade secrets and shall not be published or open to public inspection.

(G) The list described in division (B)(1) of this section shall be considered a trade secret.

(H) The administrator shall establish the fee described in division (B)(2) of this section in an amount that does not exceed the cost of the administration of the initial and renewal registration process.

(I) A financial statement required under division (B)(7) of this section for initial registration shall be the most recent financial statement of the professional employer organization or professional employer organization reporting entity of which the professional employer organization is a member and shall not be older than thirteen months. For each registration renewal, the professional employer organization shall file the required financial statement within one hundred eighty days after the end of the professional employer organization's or professional employer organization reporting entity's fiscal year. A professional employer organization may apply to the administrator for an extension beyond that time if the professional employer organization provides the administrator with a letter from the professional employer organization's auditor stating the reason for delay and the anticipated completion date.

(J) Multiple, unrelated professional employer organizations shall not

combine together for purposes of obtaining workers' compensation coverage or for forming any type of self-insurance arrangement available under this chapter. Multiple, unrelated professional employer organization reporting entities shall not combine together for purposes of obtaining workers' compensation coverage or for forming any type of self-insurance arrangement available under this chapter.

(K) The administrator shall maintain a list of professional employer organizations and professional employer organization reporting entities registered under this section that is readily available to the public by electronic or other means.

Sec. 4125.051. (A) A professional employer organization, or a professional employer organization reporting entity of which the professional employer organization is a member, shall maintain positive working capital at initial or annual registration, as reflected in the financial statements submitted to the bureau. If a deficit in working capital is reflected in the financial statements submitted to the bureau, the professional employer organization or the professional employer organization reporting entity shall do both of the following for that registration period:

(1) Obtain a bond, irrevocable letter of credit, or securities with a minimum market value in an amount sufficient to cover the deficit in working capital;

(2) Submit to the administrator of workers' compensation a quarterly financial statement for each calendar quarter during which there is a deficit in working capital, accompanied by an attestation of the chief executive officer, president, or other individual who serves as the controlling person of the professional employer organization that all wages, taxes, workers' compensation premiums, and employee benefits have been paid by the professional employer organization or members of the professional employer organization reporting entity.

The bond, letter of credit, or securities required under division (A)(1) of this section shall be held by a depository designated by the administrator and shall secure payment by the professional employer organization or professional employer organization reporting entity of all taxes, wages, benefits, or other entitlements due or otherwise pertaining to shared employees, if the professional employer organization or professional employer organization reporting entity does not make those payments when due.

(B) A professional employer organization, or a professional employer organization reporting entity of which the professional employer organization is a member, shall prepare financial statements in accordance

with generally accepted accounting principles and submit them for registration and registration renewal under section 4125.05 of the Revised Code.

The financial statements shall be audited by an independent certified public accountant authorized to practice in the jurisdiction in which that accountant is located.

(1) The resulting report of the auditor shall not include either of the following:

(a) A qualification or disclaimer of opinion as to adherence to generally accepted accounting principles;

(b) A statement expressing substantial doubt about the ability of the professional employer organization or professional employer organization reporting entity to continue as a going concern.

(2) However, if a professional employer organization does not have at least twelve months of operating history on which to base financial statements, the financial statements shall be reviewed by a certified public accountant.

(3) Notwithstanding division (B)(1)(a) of this section, if a professional employer organization or professional employer organization reporting entity is a subsidiary or is related to a variable interest entity, the professional employer organization or professional employer organization reporting entity may submit financial statements of the professional employer organization or professional employer organization reporting entity.

(C) The bureau shall deny initial or annual registration to an applicant or professional employer organization reporting entity that does not meet the requirements of this section.

(D) Professional employer organizations in a professional employer organization reporting entity may satisfy the requirements of this section on a combined or consolidated basis provided that each member of the professional employer organization reporting entity guarantees each other members' satisfaction of the requirements under division (A) of this section.

For purposes of satisfying the registration and registration renewal requirements described in division (B)(7) of section 4125.05 of the Revised Code, a professional employer organization reporting entity may submit a combined or consolidated financial statement that satisfies the requirements of this section. If the combined or consolidated financial statement includes entities that are not professional employer organizations or that are not in the professional employer organization reporting entity, the controlling entity of the professional employer organization reporting entity that is submitting the consolidated or combined financial statement shall guarantee

that the professional employer organizations of the professional employer organization reporting entity have satisfied the requirements under division (A) of this section ~~and shall include supplemental combining schedules to guarantee that the requirements under division (A) of this section are satisfied by the professional employer organization or professional employer organization reporting entity.~~

Sec. 4125.07. (A) As used in this section, "self-insuring employer" has the same meaning as in section 4123.01 of the Revised Code.

(B) Not later than ~~fourteen~~ thirty calendar days after the date on which a professional employer organization agreement is terminated, the professional employer organization is adjudged bankrupt, the professional employer organization ceases operations within the state of Ohio, or the registration of the professional employer organization is revoked, the professional employer organization shall submit to the administrator of workers' compensation and each client employer associated with that professional employer organization a completed workers' compensation lease termination notice form provided by the administrator. The completed form shall include all client payroll and claim information listed in a format specified by the administrator and notice of all workers' compensation claims that have been reported to the professional employer organization in accordance with its internal reporting policies.

(C)(1) If a professional employer organization that is a self-insuring employer is required to submit a workers' compensation lease termination notice form under division (B) of this section, not later than ~~fourteen~~ thirty calendar days after the lease termination the professional employer organization shall submit all of the following to the administrator for any years necessary for the administrator to develop a state fund experience modification factor for each client employer involved in the lease termination:

(a) The payroll of each client employer involved in the lease termination, organized by manual classification and year;

(b) The medical and indemnity costs of each client employer involved in the lease termination, organized by claim;

(c) Any other information the administrator may require to develop a state fund experience modification factor for each client employer involved in the lease termination.

(2) The administrator may require a professional employer organization to submit the information required under division (C)(1) of this section at additional times after the initial submission if the administrator determines that the information is necessary for the administrator to develop a state

fund experience modification factor.

(3) The administrator may revoke or refuse to renew a professional employer organization's status as a self-insuring employer if the professional employer organization fails to provide information requested by the administrator under division (C)(1) or (2) of this section.

(D) The administrator shall use the information provided under division (C) of this section to develop a state fund experience modification factor for each client employer involved in a lease termination with a professional employer organization that is a self-insuring employer.

(E) A professional employer organization shall report any transfer of employees between related professional employer organization entities or professional employer organization reporting entities to the administrator within fourteen calendar days after the date of the transfer on a form prescribed by the administrator. The professional employer organization or professional employer organization reporting entity shall include in the form all client payroll and claim information regarding the transferred employees listed in a format specified by the administrator and a notice of all workers' compensation claims that have been reported to the professional employer organization or professional employer organization reporting entity in accordance with the internal reporting policies of the professional employer organization or professional employer organization reporting entity.

(F) Prior to entering into a professional employer organization agreement with a client employer, a professional employer organization shall disclose in writing to the client employer the reporting requirements that apply to the professional employer organization under division (C) of this section and that the administrator must develop a state fund experience modification factor for each client employer involved in a lease termination with a professional employer organization that is a self-insuring employer.

Sec. 4167.01. As used in this chapter:

(A) "Public employer" means any of the following:

- (1) The state and its instrumentalities;
- (2) Any political subdivisions and their instrumentalities, including any county, county hospital, municipal corporation, city, village, township, park district, school district, state institution of higher learning, public or special district, state agency, authority, commission, or board;

(3) Any other branch of public employment not mentioned in division (A)(1) or (2) of this section.

(B) "Public employee" means any individual who engages to furnish services subject to the direction and control of a public employer, including those individuals working for a private employer who has contracted with a

public employer and over whom the national labor relations board has declined jurisdiction. "Public employee" does not mean any of the following:

~~(1) A firefighter, an emergency medical technician basic, an emergency medical technician intermediate, a paramedic, or a peace officer employed by a public employer as defined in division (A)(2) of this section; or any member of the organized militia ordered to duty by state authority pursuant to Chapter 5923. of the Revised Code; or a firefighter, an emergency medical technician basic, an emergency medical technician intermediate, or a paramedic employed by a private employer that is organized as a nonprofit fire company or life squad that contracts with a public employer to provide fire protection or emergency medical services;~~

~~(2) Any person employed as a correctional officer in a county or municipal corporation correctional institution, whether the county or municipal corporation solely or in conjunction with each other operates the institution;~~

~~(3) Any person who engages to furnish services subject to the direction and control of a public employer but does not receive compensation, either directly or indirectly, for those services;~~

~~(4)(3) Any forest-fire investigator, natural resources officer, wildlife officer, or preserve officer.~~

(C) "Public employee representative" means an employee organization certified by the state employment relations board under section 4117.05 of the Revised Code as the exclusive representative of the public employees in a bargaining unit.

(D) "Employment risk reduction standard" means a standard which requires conditions, or the adoption or use of one or more practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe and healthful employment and places of employment.

(E) "Ohio employment risk reduction standard" means any risk reduction standard adopted or issued under this chapter.

(F) "Undue hardship" means any requirement imposed under this chapter or a rule or order issued thereunder that would require a public employer to take an action with significant difficulty or expense when considered in light of all of the following factors:

(1) The nature and cost of the action required under this chapter;

(2) The overall financial resources of the public employer involved in the action;

(3) The number of persons employed by the public employer at the particular location where the action may be required;

(4) The effect on expenses and resources or the impact otherwise of the action required upon the operations of the public employer at the location where the action may be required;

(5) The overall size of the public employer with respect to the number of its public employees;

(6) The number, type, and location of the public employer's operations, including the composition, structure, and functions of the workforce of the public entity;

(7) The geographic separateness, administrative, or fiscal relationship of the public employer's operations to the whole public employer.

Sec. 4167.02. (A) The administrator of ~~worker's~~ workers' compensation shall operate and enforce the public employment risk reduction program created by this chapter.

(B) The administrator shall do all of the following:

(1) Adopt rules, with the advice and consent of the bureau of workers' compensation board of directors and in accordance with Chapter 119. of the Revised Code, for the administration and enforcement of this chapter; ~~including rules covering standards.~~ The administrator shall include both of the following in the rules:

(a) Standards the administrator shall follow in issuing an emergency temporary Ohio employment risk reduction standard under section 4167.08 of the Revised Code and in issuing a temporary variance and a variance from an Ohio employment risk reduction standard or part thereof under section 4167.09 of the Revised Code;

(b) Standards and procedures for an effective safety partnership agreement program for public employers and employees that promotes voluntary compliance with this chapter.

(2) Do all things necessary and appropriate for the administration and enforcement of this chapter.

(C) In carrying out the responsibilities of this chapter, the administrator may use, with the consent of any federal, state, or local agency, the services, facilities, and personnel of such agency, with or without reimbursement, and may retain or contract with experts, consultants, and organizations for services or personnel on such terms as the administrator determines appropriate.

Sec. 4167.10. (A) In order to carry out the purposes of this chapter, the administrator of workers' compensation or the administrator's designee shall, as provided in this section, enter without delay during normal working hours and at other reasonable times, to inspect and investigate any plant, facility, establishment, construction site, or any other area, workplace, or

environment where work is being performed by a public employee of a public employer, and any place of employment and all pertinent conditions, structures, machines, apparatus, devices, equipment, and materials therein, and question privately any public employer, administrator, department head, operator, agent, or public employee. The authority to inspect and investigate includes the taking of environmental samples, the taking and obtaining of photographs related to the purposes of the inspection or investigation, the examination of records required to be kept under section 4167.11 of the Revised Code and other documents and records relevant to the inspection and investigation, the issuance of subpoenas, and the conducting of tests and other studies reasonably calculated to serve the purposes of implementing and enforcing this chapter. Except as provided in this section, the administrator or the administrator's designee shall conduct scheduled inspections and investigations only pursuant to rules adopted under section 4167.02 of the Revised Code, a request to do so by a public employee or public employee representative, or the notification the administrator receives pursuant to division (B) of section 4167.06 of the Revised Code and only if the administrator or the administrator's designee complies with this section. The administrator or the administrator's designee shall conduct all requested or required inspections within a reasonable amount of time following receipt of the request or notification.

(B)(1) Any public employee or public employee representative who believes that a violation of an Ohio employment risk reduction standard exists that threatens physical harm, or that an imminent danger exists, may request an inspection by giving written notice to the administrator or the administrator's designee of the violation or danger. The notice shall set forth with reasonable particularity the grounds for the notice, and shall be signed by the public employee or public employee representative. The names of individual public employees making the notice or referred to therein shall not appear in the copy provided to the public employer pursuant to division (B)(2) of this section and shall be kept confidential.

(2) If, upon receipt of a notification pursuant to division (B)(1) of this section, the administrator determines that there are no reasonable grounds to believe that a violation or danger exists, the administrator shall inform the public employee or public employee representative in writing of the determination. If, upon receipt of a notification, the administrator determines that there are reasonable grounds to believe that a violation or danger exists, the administrator shall, within one week, excluding Saturdays, Sundays, and any legal holiday as defined in section 1.14 of the Revised Code, after receipt of the notification, notify the public employer, by

certified mail, return receipt requested, of the alleged violation or danger. The notice provided to the public employer or the public employer's agent shall ~~contain a copy of the notice provided to the administrator by the public employee or the public employee representative under division (B)(1) of this section and shall~~ inform the public employer of the alleged violation or danger and that the administrator or the administrator's designee will investigate and inspect the public employer's workplace as provided in this section. The public employer must respond to the administrator, in a method determined by the administrator, concerning the alleged violation or danger, within thirty days after receipt of the notice. If the public employer does not correct the violation or danger within the thirty-day period or if the public employer fails to respond within that time period, the administrator or the administrator's designee shall investigate and inspect the public employer's workplace as provided in this section. The administrator or the administrator's designee shall not conduct any inspection prior to the end of the thirty-day period unless requested or permitted by the public employer. The administrator may, at any time upon the request of the public employer, inspect and investigate any violation or danger alleged to exist at the public employer's place of employment.

(3) The authority of the administrator or the administrator's designee to investigate and inspect a premises pursuant to a public employee or public employee representative notification is not limited to the alleged violation or danger contained in the notification. The administrator or the administrator's designee may investigate and inspect any other area of the premises where there is reason to believe that a violation or danger exists. In addition, if the administrator or the administrator's designee detects any obvious or apparent violation at any temporary place of employment while en route to the premises to be inspected or investigated, and that violation presents a substantial probability that the condition or practice could result in death or serious physical harm, the administrator or the administrator's designee may use any of the enforcement mechanisms provided in this section to correct or remove the condition or practice.

(4) If, during an inspection or investigation, the administrator or the administrator's designee finds any condition or practice in any place of employment that presents a substantial probability that the condition or practice could result in death or serious physical harm, after notifying the employer of the administrator's intent to issue an order, the administrator shall issue an order, or the administrator's designee shall issue an order after consultation either by telephone or in person with the administrator and upon the recommendation of the administrator, which prohibits the

employment of any public employee or any continuing operation or process under such condition or practice until necessary steps are taken to correct or remove the condition or practice. The order shall not be effective for more than fifteen days, unless a court of competent jurisdiction otherwise orders as provided in section 4167.14 of the Revised Code.

(C) In making any inspections or investigations under this chapter, the administrator or the administrator's designee may administer oaths and require, by subpoena, the attendance and testimony of witnesses and the production of evidence under oath. Witnesses shall receive the fees and mileage provided for under section 119.094 of the Revised Code. In the case of contumacy, failure, or refusal of any person to comply with an order or any subpoena lawfully issued, or upon the refusal of any witness to testify to any matter regarding which the witness may lawfully be interrogated, a judge of the court of common pleas of any county in this state, on the application of the administrator or the administrator's designee, shall issue an order requiring the person to appear and to produce evidence if, as, and when so ordered, and to give testimony relating to the matter under investigation or in question. The court may punish any failure to obey the order of the court as a contempt thereof.

(D) If, upon inspection or investigation, the administrator or the administrator's designee believes that a public employer has violated any requirement of this chapter or any rule, Ohio employment risk reduction standard, or order adopted or issued pursuant thereto, the administrator or the administrator's designee shall, with reasonable promptness, issue a citation to the public employer. The citation shall be in writing and describe with particularity the nature of the alleged violation, including a reference to the provision of law, Ohio employment risk reduction standard, rule, or order alleged to have been violated. In addition, the citation shall fix a time for the abatement of the violation, as provided in division (H) of this section. The administrator may prescribe procedures for the issuance of a notice with respect to minor violations and for enforcement of minor violations that have no direct or immediate relationship to safety or health.

(E) Upon receipt of any citation under this section, the public employer shall immediately post the citation, or a copy thereof, at or near each place an alleged violation referred to in the citation occurred.

(F) The administrator may not issue a citation under this section after the expiration of six months following the final occurrence of any violation.

(G) If the administrator issues a citation pursuant to this section, the administrator shall mail the citation to the public employer by certified mail, return receipt requested. The public employer has fourteen days after receipt

of the citation within which to notify the administrator that the employer wishes to contest the citation. If the employer notifies the administrator within the fourteen days that the employer wishes to contest the citation, or if within fourteen days after the issuance of a citation a public employee or public employee representative files notice that the time period fixed in the citation for the abatement of the violation is unreasonable, the administrator shall hold an adjudication hearing in accordance with Chapter 119. of the Revised Code.

(H) In establishing the time limits in which a public employer must abate a violation under this section, the administrator shall consider the costs to the public employer, the size and financial resources of the public employer, the severity of the violation, the technological feasibility of the public employer's ability to comply with requirements of the citation, the possible present and future detriment to the health and safety of any public employee for failure of the public employer to comply with requirements of the citation, and such other factors as the administrator determines appropriate. The administrator may, after considering the above factors, permit the public employer to comply with the citation over a period of up to two years and may extend that period an additional one year, as the administrator determines appropriate.

(I) Any public employer may request the administrator to conduct an employment risk reduction inspection of the public employer's place of employment. The administrator or the administrator's designee shall conduct the inspection within a reasonable amount of time following the request. Neither the administrator nor any other person may use any information obtained from the inspection for a period not to exceed three years in any proceeding for a violation of this chapter or any rule or order issued thereunder nor in any other action in any court in this state.

SECTION 101.02. That existing sections 742.38, 4113.21, 4121.125, 4121.44, 4123.29, 4123.343, 4123.512, 4123.53, 4123.54, 4123.56, 4123.57, 4123.66, 4123.68, 4123.71, 4123.84, 4125.05, 4125.051, 4125.07, 4167.01, 4167.02, and 4167.10 of the Revised Code are hereby repealed.

SECTION 105.01. That sections 4123.72 and 4167.19 of the Revised Code are hereby repealed.

SECTION 201.10. All items in this section are hereby appropriated out of

any moneys in the state treasury to the credit of the designated fund. For all appropriations made in this act, those in the first column are for fiscal year 2018, and those in the second column are for fiscal year 2019.

BWC BUREAU OF WORKERS' COMPENSATION

Dedicated Purpose Fund Group

7023	855407	Claims, Risk and Medical Management	\$	115,598,050	\$	118,300,550
7023	855408	Fraud Prevention	\$	12,791,260	\$	12,791,260
7023	855409	Administrative Services	\$	109,472,100	\$	109,472,100
7023	855410	Attorney General Payments	\$	4,621,850	\$	4,621,850
8220	855606	Coal Workers' Fund	\$	154,000	\$	154,000
8230	855608	Marine Industry	\$	57,000	\$	57,000
8250	855605	Disabled Workers Relief Fund	\$	173,000	\$	173,000
8260	855609	Safety and Hygiene Operating	\$	22,000,000	\$	22,000,000
8260	855610	Safety Grants	\$	15,000,000	\$	15,000,000
8260	855611	Health and Safety Initiative	\$	6,000,000	\$	6,000,000
8260	855612	Safety Campaign	\$	2,500,000	\$	0
TOTAL DPF Dedicated Purpose Fund Group			\$	288,367,260	\$	288,569,760

Federal Fund Group

3490	855601	OSHA Enforcement	\$	1,653,900	\$	1,653,900
3FW0	855614	BLS SOII Grant	\$	195,104	\$	195,104
3FW0	855615	NIOSH Grant	\$	200,000	\$	200,000
TOTAL FED Federal Fund Group			\$	2,049,004	\$	2,049,004
TOTAL ALL BUDGET FUND GROUPS			\$	290,416,264	\$	290,618,764

WORKERS' COMPENSATION FRAUD UNIT

Of the foregoing appropriation item 855410, Attorney General Payments, \$828,200 in each fiscal year shall be used to fund the expenses of the Workers' Compensation Fraud Unit within the Attorney General's Office. These payments shall be processed at the beginning of each quarter of each fiscal year and deposited into the Workers' Compensation Section Fund (Fund 1950) used by the Attorney General.

SAFETY AND HYGIENE

Notwithstanding section 4121.37 of the Revised Code, the Treasurer of State shall remit \$22,000,000 cash in fiscal year 2018 and \$22,000,000 cash in fiscal year 2019 from the State Insurance Fund to the state treasury to the credit of the Safety and Hygiene Fund (Fund 8260).

SAFETY GRANTS

Notwithstanding section 4121.37 of the Revised Code, the Treasurer of State shall remit \$15,000,000 in cash in fiscal year 2018 and \$15,000,000 in cash in fiscal year 2019 from the State Insurance Fund to the state treasury to the credit of the Safety and Hygiene Fund (Fund 8260) to be used for Safety Grants.

HEALTH AND SAFETY INITIATIVE

Notwithstanding section 4121.37 of Revised Code, the Treasurer of State shall remit \$6,000,000 in cash in fiscal year 2018 and \$6,000,000 in cash in fiscal year 2019 from the State Insurance Fund to the state treasury to the credit of the Safety and Hygiene Fund (Fund 8260). These amounts shall be used under appropriation item 855611, Health and Safety Initiative, for the purpose of creating and operating a health and wellness program.

SAFETY CAMPAIGN

Notwithstanding section 4121.37 of the Revised Code, the Treasurer of State shall remit \$2,500,000 in cash in fiscal year 2018 from the State Insurance Fund to the state treasury to the credit of the Safety and Hygiene Fund (Fund 8260). These amounts shall be used under appropriation item 855612, Safety Campaign, for the purpose of creating and operating a statewide safety awareness and education campaign.

OSHA ON-SITE CONSULTATION PROGRAM

A portion of the foregoing appropriation item 855609, Safety and Hygiene Operating, may be used to provide the state match for federal funding of the Occupational Safety and Health Administration's On-site Consultation Program operated by the Division of Safety and Hygiene.

VOCATIONAL REHABILITATION

The Bureau of Workers' Compensation and the Opportunities for Ohioans with Disabilities Agency may enter into an interagency agreement for the provision of vocational rehabilitation services and staff to mutually eligible clients. The Bureau may provide funds from the State Insurance Fund to fund vocational rehabilitation services and staff in accordance with the interagency agreement.

SECTION 201.20. DEPUTY INSPECTOR GENERAL FOR BWC AND OIC FUNDING

To pay for the FY 2018 costs related to the Deputy Inspector General for the Bureau of Workers' Compensation and Industrial Commission, on July 1, 2017, and January 1, 2018, or as soon as possible thereafter, the Director of Budget and Management shall transfer \$212,500 in cash from the Workers' Compensation Fund (Fund 7023) to the Deputy Inspector General for the Bureau of Workers' Compensation and Industrial Commission Fund (Fund 5FT0).

To pay for the FY 2019 costs related to the Deputy Inspector General for the Bureau of Workers' Compensation and Industrial Commission, on July 1, 2018, and January 1, 2019, or as soon as possible thereafter, the Director of Budget and Management shall transfer \$212,500 in cash from

the Workers' Compensation Fund (Fund 7023) to the Deputy Inspector General for the Bureau of Workers' Compensation and Industrial Commission Fund (Fund 5FT0).

If additional amounts are needed, the Inspector General may seek Controlling Board approval for additional transfers of cash and to increase the amount appropriated in appropriation item 965604, Deputy Inspector General for the Bureau of Workers' Compensation and Industrial Commission.

SECTION 707.10. The amendment made by this act to section 742.38 of the Revised Code applies only to an application for a disability benefit pursuant to Chapter 742. of the Revised Code that is filed on or after the effective date of this section.

SECTION 741.10. The amendment by this act to section 4123.57 of the Revised Code applies to any application for a determination of the percentage of permanent partial disability filed on or after the effective date of this section.

SECTION 741.20. Sections 4123.512 and 4123.84 of the Revised Code, division (J) of section 4123.54 of the Revised Code, and divisions (X)(2) and (3) of section 4123.68 of the Revised Code, as amended by this act, apply to a claim under Chapters 4121., 4123., 4127., and 4131. of the Revised Code arising on or after the effective date of this section.

SECTION 741.30. If, on the effective date of this section, an employee's application for a determination of the percentage of the employee's permanent partial disability filed under section 4123.57 of the Revised Code has been suspended pursuant to division (C) of section 4123.53 of the Revised Code, the Administrator of Workers' Compensation shall send a notice to the employee's last known address informing the employee that the application may be dismissed unless the employee schedules a medical examination with the Bureau of Workers' Compensation medical section within thirty days after receiving the notice. If the employee does not schedule a medical examination with the Bureau medical section within thirty days after receiving the notice or fails to attend an examination scheduled with the Bureau medical section, notwithstanding division (C) of section 4123.53 of the Revised Code, the Administrator may dismiss the

application. The employee may refile the application. A dismissed application does not toll the continuing jurisdiction of the Industrial Commission under section 4123.52 of the Revised Code.

SECTION 741.40. The amendment by this act to division (X)(4) of section 4123.68 of the Revised Code applies to any claim pending on the effective date of this section and to any claim filed on or after that date.

SECTION 801.10. Law contained in the Main Operating Appropriations Act of the 132nd General Assembly that applies generally to the appropriations made in that act also applies generally to the appropriations made in this act.

SECTION 806.10. The provisions of law contained in this act, and their applications, are severable. If any provision of law contained in this act, or if any application of any provision of law contained in this act, is held invalid, the invalidity does not affect other provisions of law contained in this act and their applications that can be given effect without the invalid provision or application.

SECTION 812.10. Except as otherwise specifically provided in this act, the amendment, enactment, or repeal by this act of a section of law is exempt from the referendum under Ohio Constitution, Article II, Section 1d and section 1.471 of the Revised Code and therefore takes effect immediately when this act becomes law.

SECTION 812.20. The amendment, enactment, or repeal by this act of the divisions and sections of law listed below are subject to the referendum under Ohio Constitution, Article II, Section 1c and therefore take effect on the ninety-first day after this act is filed with the Secretary of State:

All Revised Code sections in Sections 101.01 and 105.01 of this act;
Sections of this act prefixed with the number "707." or "741."

SECTION 815.10. Section 4121.125 of the Revised Code is presented in this act as a composite of the section as amended by Sub. H.B. 123, Am. Sub. H.B. 153, and Sub. S.B. 171 of the 129th General Assembly. 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 composite is the resulting version of the section in effect prior to the effective date of the section as presented in this act.

Speaker _____ *of the House of Representatives.*

President _____ *of the Senate.*

Passed _____, 20____

Approved _____, 20____

Governor.

Sub. H. B. No. 27

132nd G.A.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ___ day of _____, A. D. 20____.

Secretary of State.

File No. _____ Effective Date _____