Ohio BWC

BWC claim process: Start to Finish

OP&F

Disability Retirement: New application changes due to cancer presumption

4123.68(X)

BWC cancer presumptive statute

742.38 (D)(3)(b)

OP&F cancer presumptive statute

Why BWC claims are Important:

- Workers' compensation system history
- Why file a claim
- How to file a claim
- How to handle the initial doctors visit
- PAPERWORK
- Additional conditions/Treatment issues

History of Workers' Compensation

About the ***Bureau of Workers' Compensation*** and the ***Industrial Commission***
BWC collects workers' compensation insurance premiums from employers, oversees the insurance system, and pays compensable claims to injured workers. The ***Industrial Commission*** of Ohio resolves claim disputes.

Pre-1911
An employee had to file a ***tort*** claim in court against the employer, alleging the employer was ***negligent***. The injured worker then had the burden of proving this negligence was the actual cause of the injury. The employer could raise several very effective affirmative defenses against the claim (i.e., assumption of risk, fellow servant doctrine, and contributory negligence). In most instances, injured workers received no wage replacement or coverage for medical expenses. In rare instances when injured workers won their tort lawsuits, they received large punitive damages awards that sometimes bankrupted their employer.

The Compromise

The ***Workers' Compensation Act passed in 1911***. It was in response to the unchecked and frequent workplace injuries and fatalities of the Industrial Era. The Act created a state insurance fund to compensate workers injured on the job. The Industrial Commission of Ohio ran the system until 1955 when the Bureau of Workers' Compensation was created.

In Ohio, workers' compensation is a ***no-fault system***. Both employees and employers gave up certain rights. ***Only after*** a workers' compensation dispute has totally worked its way through the administrative system of BWC and the Industrial Commission of Ohio can a party appeal a disputed legal matter into Ohio's court system.

Common Law Not Applicable

We find guidance on how to handle disputes from four sources: 1) Section 35, Article II, of the Ohio Constitution; 2) the Ohio Revised Code (mostly Chapters 4121 and 4123), 3) the Ohio Administrative Code; and 4) court decisions.

WHY and HOW to file a BWC claim

WHY:

- Medical expenses completely covered
- Temporary Total Disability vs Injury Leave
- Permanent Partial Disability Award

HOW:

- 1* year Statute of limitations
- Occupational Disease vs. Injury
  - Statute of limitations begins to run at the later date of the causal connection or lost time from work/no longer working for employer
- FROI
  - Forms/PAPERWORK

FROI

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

By signing this form, I:
- **Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;**
- **Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;**
- **Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;**
- **Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.

(R.C. 2913.48)

Injured worker and injury/disease/death info.

Last name, first name, middle initial | Social Security number | Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of birth

Home mailing address | Sex ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name

Wage rate $ _____ ☐ Hour ☐ Month ☐ Week Per: ☐ Year ☐ Other _____ | What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat | Regular work hours From _____ To _____

Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain. | Occupation or job title

Employer name

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street, city, state and ZIP code)

Date of injury/disease | Time of injury _____ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work _____ ☐ a.m. ☐ p.m. | Date last worked | Date returned to work

Date hired | State where hired | Date employer notified | State where supervised

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.) | Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature | Date | E-mail address | Telephone number | Work number ( )

Treatment info.

Health-care provider name | Telephone number ( ) | Fax number ( ) | Initial treatment date

Street address | City | State | 9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No | Is the injury causally related to the industrial incident? ☐ Yes ☐ No

E code | 11-digit BWC provider number | Date

Health-care provider signature

Employer info.

Employer policy number | Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

Telephone number ( ) | Fax number ( ) | E-mail address | Federal ID number | Manual number

Was employee treated in an emergency room? ☐ Yes ☐ No | Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification -** The employer certifies that the facts in this application are correct and valid.

☐ **Rejection -** The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only
☐ **Clarification -** The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title | Date | OSHA case number

BWC-1101 (Rev. 6/12/2014)
FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

This form meets **OSHA 301** requirements

Injured worker and injury/disease/de

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease	Time of injury	If fatal, give date of death	Time employee began work	Date last worked	Date returned to work
	_____ ☐ a.m. ☐ p.m.		_____ ☐ a.m. ☐ p.m.		

Date hired	State where hired	Date employer notified	State where supervised

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)	Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature	Date	E-mail address	Telephone number	Work number
				( )

Treatment info.

Health-care provider name	Telephone number	Fax number	Initial treatment date
	( )	( )	

Street address	City	State	9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No	Is the injury causally related to the industrial incident? ☐ Yes ☐ No

E code	11-digit BWC provider number	Date

Health-care provider signature

r info.

Employer policy number

Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

Telephone number	Fax number	E-mail address	Federal ID number	Manual number
( )	( )			

Was employee treated in an emergency room? ☐ Yes ☐ No	Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

Treatment Requests: C-9

Ohio | Bureau of Workers' Compensation

Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease

Fax note: To | Toll-free fax number | Phone number; From | Phone number | Fax number

• Instructions for completing the C-9 on reverse side.

IW

❶ Injured worker name | Claim number | Date of injury

II. Requested services

❷ Treating diagnosis for this request to include body part/levels. | ❸ Date service begins | Date service ends | Date of last exam or treatment

❹ Requested services with CPT/HCPCS codes (required) | Frequency | Duration

1.
2.
3.
4.

❺ Provide the two-digit facility site of service code as used by [illegible] centers for Medicare and Medicaid Services (CMS), if applicable.

III. Additional conditions

If you are recommending additional conditions to the claim, supporting documentation is required. **You may not use the C9 to request additional conditions for claims of self-insuring employers.**

❻ Provide diagnosis (narrative description only), and location and site for conditions you are requesting.

❼ In your opinion, based on the history from the injured worker, your clinical evaluation and expertise, is the diagnosis or condition causally related, either directly or proximately, to the alleged industrial accident or exposure?
☐ Yes, please attach explanation. ☐ No, please attach explanation.

IV. Physician/provider information

❽ Identify the provider who will render the requested services and the address where he or she will provide the services (required). Travel reimbursement may not be authorized when the service provided is available within 45 miles round trip from the injured worker's residence.

❾ Requesting physician/provider name and address (please print, type, or stamp) | ❿ Physician/provider/authorized signature (required) | ☐ POR ☐ Not POR — but treating physician/provider

Individual BWC provider number (required) | Date (M/D/Y) (required)

I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, or both.

V. MCO/Self-insuring employer decision

Managed care organization (MCO) — If this page is not faxed or mailed back to the submitting physician/provider within three business days of receipt or within five business days of receipt of information requested on the C-9-A, BWC shall deem the authorization for treatment granted subject to our policy, excluding retroactive requests.

☐ **Approved with disclaimer** — This medical payment authorization is based upon a claim or additional condition that BWC/IC is considering as of the date of the MCO's signature. If the claim or additional condition is ultimately disallowed, BWC may not cover the services/supplies to which this medical payment authorization applies. These services/supplies may be the responsibility of the injured worker (for MCO use only).

☐ Approved Date service begins ____ /____ /____ Date service ends ____ /____ /____

☐ Amended approval: _____

☐ Denied explanation: _____

You may file disputes to the decision in writing with supporting documentation to the MCO.

☐ Pending: The documentation requested must be submitted to the MCO case manager within 10 business days to allow for a treatment decision. Failure to respond may result in denial.

☐ Claim inactive: MCO cannot make a decision on this request, further investigation required. BWC will issue a decision in writing within 28 days.

☐ Withdrawn ☐ Dismissed _____

BWC claim status: ☐ Allowed ☐ Denied ☐ Pending

MCO company/Self-insuring employer name (please print, type or stamp) | MCO name and signature (print, type or stamp and sign)

MCO number | Telephone number ( ) | Date

Self-insuring employer

Self-insuring employer use only — Fax or mail this page to the submitting physician/provider within 10 days of receipt or the authorization for treatment shall be deemed granted, per Ohio Administrative Code 4123-19-03 (K)(5).

Self-insuring employer signature | Date

BWC-1113 (rev. 12/28/2011)
C-9 (Combines C-1-A & C-161)

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name			Claim number
Date of injury	Date of last appointment/examination	Date of this appointment/examination	Date of next appointment/examination

MEDCO-14 submission (Select one of the options below.)

1 ☐ I have never completed a MEDCO-14. ***Proceed to section 2.***
☐ I have previously completed a MEDCO-14, and all of the information remains the same. ***Proceed to and complete section 8.***
☐ I have previously completed a MEDCO-14, and I am providing updates appropriately checking Yes or No on each section.

Employment/Occupation (Complete this section and proceed to section 3.) (Updates Yes ☐ No ☐)

2 Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes - please indicate who (select all sources) provided the job description ☐ Injured worker ☐ Employer ☐ MCO ☐ BWC

Work status/Injured worker's capabilities (Updates Yes ☐ No ☐)

3A Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes ☐ No ☐
If yes, are the restrictions: ☐ Permanent ☐ Temporary ***Proceed to section 3B.***
If no, please check the box to indicate the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***

3B If there are restrictions, can the injured worker return to the full duties of his/her job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes, please check the box to indicate that the injured worker is released to work as of the date of this exam. ☐ ***Proceed to section 8.***
If no, please indicate when the injured worker could not do the job held on the date of injury for this period of restricted duty.
Date:_____/_____/_____.
Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty.
Date:_____/_____/_____. **Proceed to section 3C.**

3C **Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)**
If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible return to work date: _____/_____/_____.
The injured worker can perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker can perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker's dominant hand is: ☐ Left ☐ Right
The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both
If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely:
*Operate heavy machinery: ☐ Yes ☐ No *Drive: ☐ Yes ☐ No **Perform other critical job tasks as defined by any source listed above in section 2:* ☐ Yes ☐ No

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously																
Activity	N	O	F	C	Activity	N	O	F	C	Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C
Bend					Reach above shoulder					11 - 20 lbs.					26 to 40 lbs.				
Squat/kneel					Type/keyboard					21 - 40 lbs.					41 to 60 lbs.				
Twist/turn					Work with cold substances					41 - 60 lbs.					61 to 100 lbs.				
Climb					Work with hot substances					61 - 100 lbs.					100 + lbs.				

How many total hours can the injured worker work: _____ per week _____ per day?
In an eight-hour workday, how many total hours can the injured worker: Sit: ____ hours ☐ Continuously ☐ With break
Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break
Does the injured worker have any functional restrictions based only on allowed psychological conditions? ☐ Yes ☐ No If Yes, please describe in space provided below. Note: If Yes is indicated please reference the MEDCO-16 as needed.
Additionally, in this space, please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above. _____

Proceed to section 4.

MEDCO-14

Injured worker name	Claim number	Date of injury

Disability information (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed) (Updates Yes ☐ No ☐)

4A Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.

Narrative description of the work-related allowed condition	Site/location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

4B List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

Clinical findings: You can reference office notes in lieu of writing clinical findings below. (Updates Yes ☐ No ☐)

5 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.

Maximum medical improvement (MMI) (Updates Yes ☐ No ☐)

6 MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? Yes ☐ No ☐
If yes, give MMI date: _____/_____/_____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.

Vocational rehabilitation (Updates Yes ☐ No ☐)

7 Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?
Yes ☐ No ☐ If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

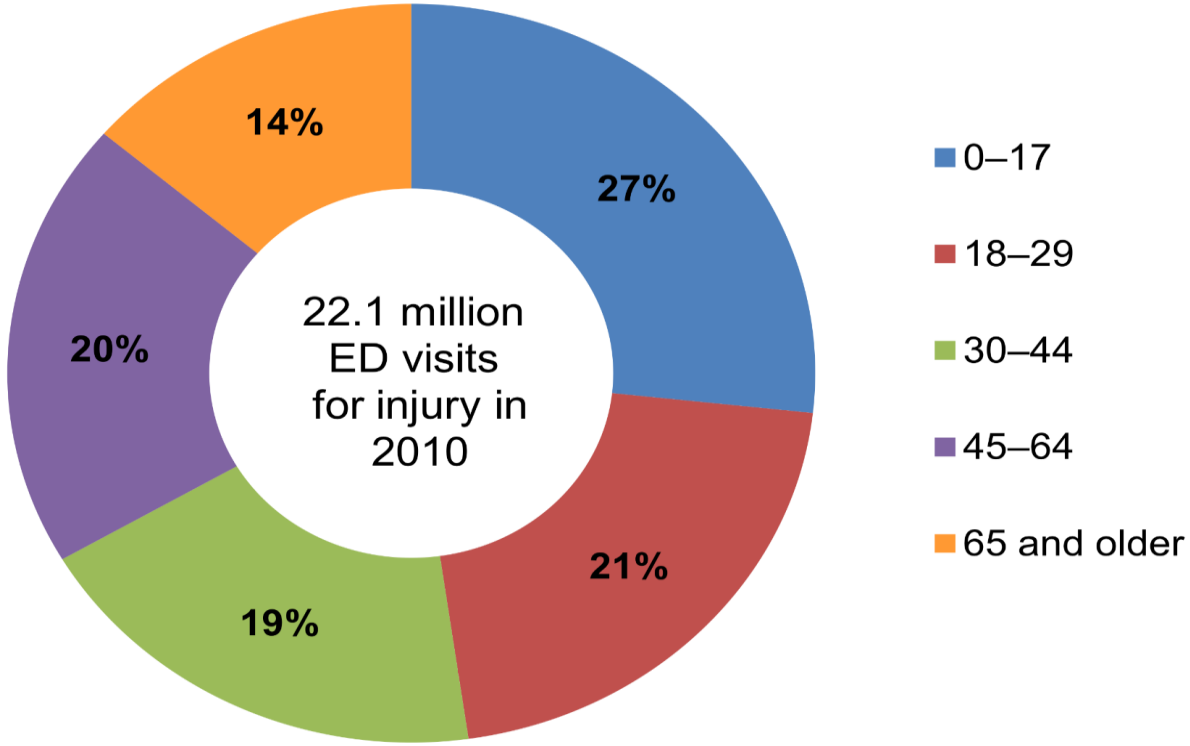
8 I certify the information on this form is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may be punished, under appropriate criminal provisions, by a fine or imprisonment or both.

Treating physician's name (please print legibly)		Address, city, state, nine-digit ZIP code	
Treating physician's signature			
BWC provider (Peach) number	Date	Telephone number	Fax number

BWC-3914 (Rev. Aug. 21, 2015)
MEDCO-14

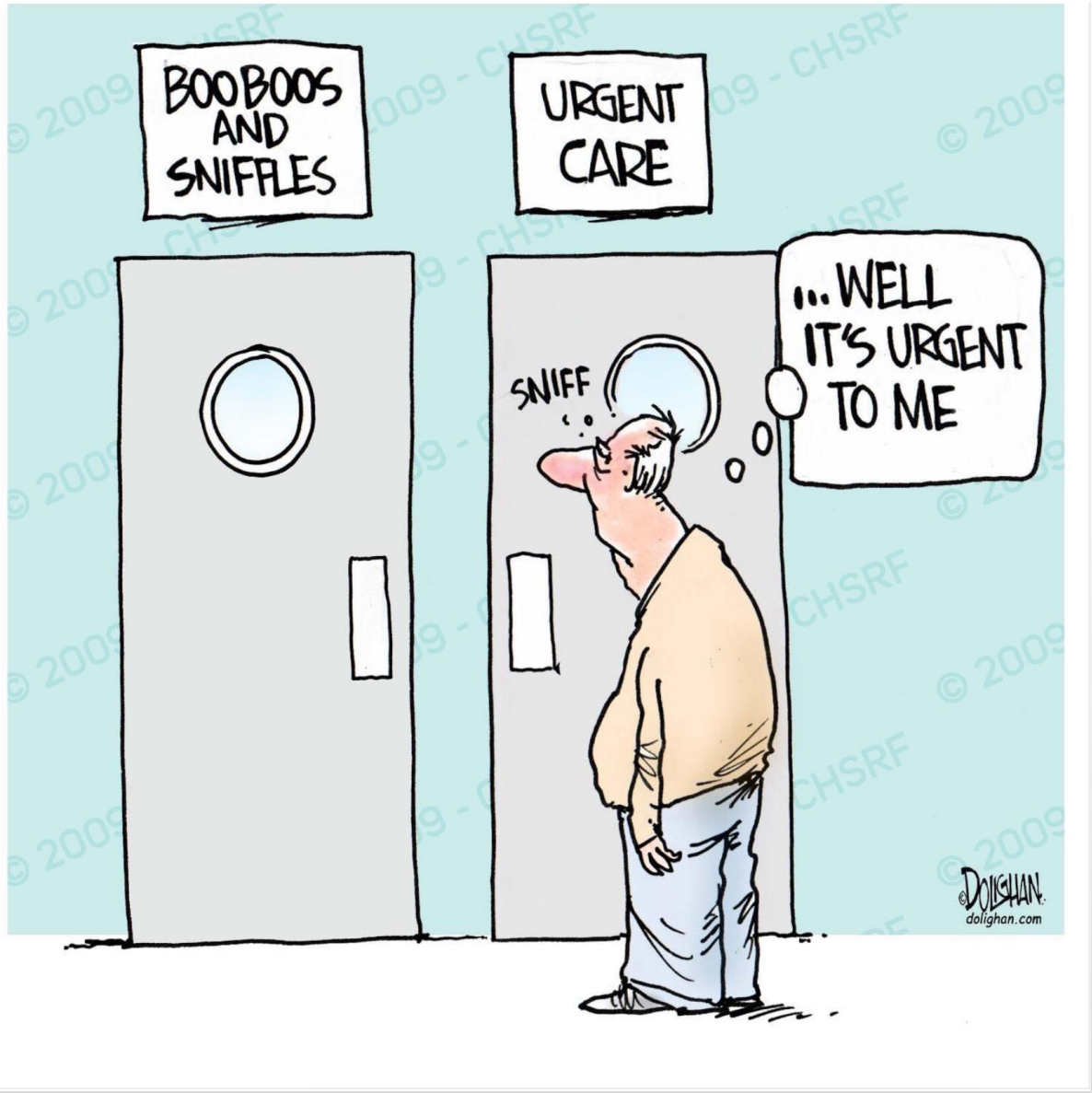
Importance of initial doctor visit:

Figure 1. Injury-related emergency department visits by age group



Source: Agency for Healthcare Research and Quality (AHRQ) Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2010

- Be sure to list all body parts injured and hurting
- Prior history
- Follow up with BWC provider
- You choose your Physician of Record



Reality vs. BWC Physician review

- Age
- BMI
- Pre-existing conditions
- Substantial Aggravation

Ohio Law and Firefighter Cancer Presumption

- Many years work in the process
- Majority of states, now including Ohio now have presumptive cancer legislation
- Ohio is unique in our statue funded workers' compensation system

R.C. 4123.68(X)

- (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.

R.C. 4123.68(X)

(2) The presumption described in division (X)(1) of this section is ***rebuttable*** in any of the following situations:
(a) There is evidence that the firefighter's exposure, outside the scope of the firefighter's official duties, to ***cigarettes, tobacco products, or other conditions presenting an extremely high risk for the development of the cancer alleged***, was probably a significant factor in the cause or progression of the cancer.
(b) There is evidence that the firefighter was ***not exposed*** to an agent classified by the international agency for research on cancer as a group 1 or 2A carcinogen.
(c) There is evidence that the firefighter incurred the type of cancer alleged ***before*** becoming a member of the fire department.
(d) The firefighter is ***70 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 20 years since the firefighter was last assigned to hazardous duty as a firefighter.
(4) Compensation for cancer contracted by a firefighter in the course of hazardous duty under division (X) of this section is payable only in the event of temporary total disability, permanent total disability, or death, in accordance with sections 4123.56, 4123.58, and 4123.59 of the Revised Code.
(5) As used in division (X) of this section , "hazardous duty" has the same meaning as in 5 C.F.R. 550.902, as amended.

BWC Policy:

Policy Name:	**FIREFIGHTERS WITH CANCER OCCUPATIONAL DISEASE CLAIMS**
Policy #:	CP-06-06
Code/Rule Reference:	O.R.C. 4123.68 (X); 5 C.F.R. 550.902, as amended
Effective Date:	04/06/17
Approved:	Rick Percy, Chief of Operational Policy, Analytics and Compliance (Signature on file)
Origin:	Claims Policy
Supersedes:	All Injury Management policies, directives and memos regarding firefighters with cancer occupational disease claims that predate the effective date of this policy.
History:	New 04/06/17
Review date:	04/06/20

BWC Policy:

IV. POLICY

A. It is the policy of BWC that the injured worker has the **burden of proof** and must submit evidence to establish that the presumption of causation has been met.

B. It is the policy of BWC that the injured worker **shall** provide information using BWC's *Presumption of Causation for Firefighter Cancer* (**C-265**) or its equivalent, in addition to the FROI.

C-265

Ohio | Bureau of Workers' Compensation

Presumption of Causation for Firefighter Cancer

Instructions
Complete the *First Report of an Injury, Occupational Disease or Death* (FROI-1) along with this form. Fax both forms to 1-866-336-8352, or send them to your local BWC customer service office. You must also submit a copy of both forms to your fire department.

Injured worker information

Name	Date of birth	Claim number, if available

First date of service as a firefighter	Last date of service as a firefighter (mark N/A if service continues)

Medical information

What is your cancer diagnosis?	When were you diagnosed with this type of cancer? (dd/mm/yy)

Name of the medical provider who made the cancer diagnosis?
(Please have your physician submit the written narrative medical diagnosis to BWC.)

Exposure information

Were you exposed, as a firefighter, to an agent classified by the International Agency for Research on Cancer (IARC) as a group 1 or 2A carcinogen? ☐ Yes ☐ No
If yes, select one or more of the examples below. If not listed below, please identify the agent under "other."
To view a complete list, visit http://monographs.iarc.fr/ENG/Classification/.

- o Arsenic and inorganic arsenic compounds
- o Asbestos
- o Benzene
- o Benzo[a]pyrene
- o 1,3-Butadiene
- o Cadmium
- o Creosote
- o Diesel engine exhaust
- o Dioxin
- o Formaldehyde
- o Lead compounds, inorganic
- o Polychlorinated biphenyls (PCB)
- o Shiftwork that involves circadian disruption
- o Silica, crystalline
- o Tetrachloroethylene aka Perchloroethylene
- o Trichloroethylene
- o Other: _____

History of hazardous duty

Have you been assigned to at least six years of hazardous duty as a fire fighter? ☐ Yes ☐ No
If yes, please provide a history of your hazardous duty as a firefighter. "Hazardous duty" means duty performed under circumstances in which an accident could result in serious injury or death.
Please list the dates of your most recent hazardous duty first. Attach more employment information if necessary.

Name of fire department for which you provided services

Address	City	State	ZIP code

When did the hazardous duty occur?
From ____/____/____ and if applicable, to ____/____/____

Name of fire department for which you provided services

Address	City	State	ZIP code

When did the hazardous duty occur?
From ____/____/____ and if applicable, to ____/____/____

Name of fire department for which you provided services

Address	City	State	ZIP code

When did the hazardous duty occur?
From ____/____/____ and if applicable, to ____/____/____

Applicant signature

I understand that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or self-insuring employers, or who knowingly accepts compensation to which that person is not entitled, is subject to criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Applicant signature	Date

BWC-1397
C-265

C. Cancer contracted by firefighters

1. BWC shall presume that a firefighter's cancer was contracted in the course of and arising out of the firefighter's employer when the following conditions are met:

a. IW worked as a firefighter;

b. IW worked hazardous duty for a minimum of six years;

c. IW was exposed to an agent classified by the International Agency for Research on Cancer (IARC) as a Group 1 or Group 2A carcinogen while working as a firefighter;

d. IW has been diagnosed with cancer by a medical provider;

e. The firefighter was first diagnosed, first received treatment or first quit work due to the cancer on or after April 6, 2017.

BWC Policy:

2. The presumption of causation may be rebutted when any of the following evidence is submitted:

a. IW is 70 years of age or older;

b. It has been more than 20 years since the firefighter was last assigned to hazardous duty as a firefighter;

c. IW was exposed to cigarettes, tobacco products or other conditions that present an extremely high risk for the development of the cancer alleged, and such exposure was probably a significant factor in the cause or progression of the cancer;

d. There is evidence that the firefighter was not exposed to an agent classified by the International Agency for Research on Cancer (IARC) as a Group 1 or Group 2A carcinogen while working as firefighter;

e. There is evidence that the firefighter incurred the type of cancer alleged prior to becoming a firefighter.

3. If the conditions to establish the presumption listed above in section IV.C.1. have been met and evidence has not been submitted to rebut the presumption, BWC shall allow the claim.

4. If evidence is submitted to rebut the presumption, BWC shall review the claim to determine whether the evidence is sufficient to rebut the presumption.

5. BWC may, in rare situations, obtain an independent physician file review or independent medical examination for a firefighter alleging cancer as an occupational disease.

6. If the presumption is not met in accordance with section IV.C.1., or the presumption is rebutted as outlined in section IV.C.2., BWC shall refer to the *Occupational Disease Claims* policy for further processing of the claim.

BWC Policy:

D. Compensation for a firefighter with a claim for cancer presumptively allowed under the law shall be limited to:

1. Temporary Total Disability compensation;

2. Permanent Total Disability compensation;

3. Death Benefits.

E. BWC will follow all other applicable policies for processing benefits once BWC has presumptively allowed a firefighter's claim for cancer.

Industrial Commission Policy: Memo C3

4123.85 and White v. Mayfield

Pursuant to White v. Mayfield, the disability date necessary for the application of the statute of limitations contained in R.C. 4123.85 occurs when the injured worker **first became aware through medical diagnosis that he or she was suffering from such disease, the date on which the injured worker first received medical treatment for such disease, or the date the injured worker first quit work on account of such disease, whichever date is the latest.** It is the Industrial Commission's position that where there has not been a request for disability compensation or where the injured worker retired prior to being diagnosed with an occupational disease that involves a long latency period, the claim is timely filed. Claims are only untimely filed pursuant to White where the claim has been filed more than two years after diagnosis and first medical treatment and two years after the injured worker quit work on account of the disease. If an injured worker has not yet quit work on account of the disease, the two-year period has not begun to run.

This position is consistent with R.C. 4123.68 that provides that a claim may be compensable to the extent of payment of medical and hospital bills even if the injured worker is not disabled from work due to the disease. The limitation period begins to run when the latest of the three elements in White occurs. If the last element has not yet occurred, R.C. 4123.85 has not begun to run. Therefore, the claim application is to be found timely filed.

NOTE: White v. Mayfield, 37 Ohio St.3d 11, 532 N.E.2d 497 (1988).

OP&F Disability:

- New application:
- Same presumption applies
- BWC temporary total disability is not off-set by payment of OP&F disability retirement
- ORC 742.38(D)(3)(b)

(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 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) 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 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 742.39of 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.

Section M: CANCER PRESUMPTION Questionnaire

Ohio law provides that a member of a fire department who is disabled as a result of cancer is presumed to have incurred the cancer while performing his or her official duties under certain circumstances. The presumption can be rebutted in certain situations.

To assist OP&F in identifying if you are eligible for this presumption, please complete the following information:

1	☐ Yes ☐ No	Are you currently an employee of the fire department listed in Section A of this Disability Benefit Application?
2	☐ Yes ☐ No	Have you been assigned to at least six years of hazardous duty as a firefighter (Hazardous duty is defined as duty performed under circumstances in which an accident could result in serious injury or death)?
3	☐ Yes ☐ No	Have you been exposed to an agent classified by the International Agency for Research on Cancer or its successor (IARC) as a Group 1 or 2A carcinogen?
4	☐ Yes ☐ No	Has it been less than 20 years since you were were last assigned to hazardous duty as a member of a fire department?
5	☐ Yes ☐ No	Are you under the age of 70?
6	☐ Yes ☐ No	Are you currently or have you ever been a tobacco user? If yes... ...Describe tobacco use: _____ ...at what age did you first use tobacco: _____ ...if you have quit using tobacco, provide date: _____
7	☐ Yes ☐ No	Are you receiving workers' compensation for your cancer diagnosis?
8	☐ Yes ☐ No	Have you undergone genetic testing for cancer?

Please list the specific type of cancer(s) that has been diagnosed:

Type of cancer	Date of diagnosis

List the names and addresses of all doctors, hospitals and other health care providers who have treated your cancer diagnosis:

Health care provider	Date of first treatment	Address, city, state	Phone

Notary public requirement - Cancer Presumption

The notary public in good standing must sign in the space provided in this section and affix their seal.

State of _____, County of _____, ss:

The foregoing *Cancer Presumption Questionnaire* was sworn or affirmed before me and signed in my presence by the member named in the foregoing Section A, this _____ day of _____, 20_____.

Affix Seal here	Notary's signature: Print name: My commission expires:

Questions, Comments, Concerns?

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