PERMANENT RULES OF THE
OKLAHOMA WORKERS' COMPENSATION COMMISSION
EFFECTIVE AUGUST 27, 2015
(Supercedes Prior Emergency Rules of the Oklahoma Workers' Compensation Commission)

TITLE 810. OKLAHOMA WORKERS' COMPENSATION COMMISSION
CHAPTER 1. GENERAL INFORMATION

810:1-1-1. Purpose

(a) This Chapter has been adopted for the purpose of compliance with the Oklahoma Administrative Procedures Act, 75 O.S. § 250.1 et seq., and to describe the purposes, functions and processes of the Oklahoma Workers' Compensation Commission.

(b) The purpose of this Chapter is to set out a general description of the Oklahoma Workers' Compensation Commission, review the functions performed by the Commission, and briefly present an overview of the statutory role of the Commission, its organization and structure.

810:1-1-2. Definitions

In addition to the terms defined in 85A O.S. § 2, the following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Administrative Law Judge" means an Administrative Law Judge of the Commission to whom the Commission has delegated by order or otherwise, the authority to conduct a hearing.

"AWCA" means the Administrative Workers' Compensation Act, 85A O.S. § 1, et seq.

"Claimant" means a person who claims benefits for an alleged work injury, occupational disease or illness, or death, pursuant to the provisions of the AWCA.

"Commission" means the Oklahoma Workers' Compensation Commission, a designee, or an Administrative Law Judge to whom the Commission has delegated responsibility as authorized by 85A O.S. § 21(D).

"Executive Director" means the Executive Director of the Commission.

"Self-insurer" means any duly qualified individual employer or group self-insurance association authorized by the Commission to self-fund its workers' compensation obligations.

"Workers' Compensation Commission fee schedule" means a state mandated schedule of maximum allowable reimbursement levels for health care providers, including hospitals, ambulatory surgical centers, and inpatient rehabilitation facilities, rendering reasonable and necessary health care services and supplies to an injured employee for a compensable injury pursuant to the Oklahoma workers' compensation laws.

810:1-1-3. General description of the Oklahoma Workers' Compensation Commission

(a) **History.** The Oklahoma Workers' Compensation Commission was created pursuant to legislation enacted in 2013 and is responsible for administration of the Administrative Workers' Compensation Act, 85A O.S. § 1, et seq., except as otherwise provided by law.

(b) **Composition.** The Commission is comprised of three members who are appointed by the Governor and confirmed by the Senate for staggered terms. The initial appointments are for two (2), four (4) and six (6) years respectively, as determined by the Governor. Subsequent terms are for six (6) years. One of the initial appointments must be from a list of three (3) nominees selected by the Speaker of the Oklahoma House of Representatives. The Chair of the Commission is appointed by the Governor from among the Commission members. The Chair organizes, directs and develops administrative work, employs administrative staff within budgetary limitations, and performs other duties authorized by law or prescribed by the Commission. The Chair appoints an administrator who is the administrative officer of the

Commission and manages the activities of its employees and performs other duties prescribed by the Chair or Commission. The title of the administrative officer shall be Executive Director. The Commission may appoint as many Administrative Law Judges and other personnel as necessary within budgetary limitations to effectuate the AWCA.

(c) **Duties.** It is the Commission's responsibility to apply the law as set out in the AWCA. The Commission has adjudicative, administrative and regulatory functions. Those functions include providing fair and timely procedures for the resolution of workers' compensation disputes; monitoring claims and benefit payments to injured workers, processing settlements and requests for changes in physicians; ensuring that employers maintain required insurance coverage; processing and approving applications of employers to act as self-insurers; processing and approving applications related to independent physicians, mediators and case managers; developing and maintaining a workers' compensation fee schedule; providing legal information and assistance to interested persons who have questions concerning the Oklahoma workers' compensation law; and participating in programs to explain the law and functions of the Commission to the general public.

(d) **Main offices of Commission.** The main offices of the Commission are located at: Denver Davison Building, 1915 North Stiles Avenue, Oklahoma City, Oklahoma 73105.

810:1-1-4. Petitions to promulgate, amend or repeal rules

(a) Individuals or organizations who wish to petition the Commission to promulgate, amend or repeal a rule must submit a written request to the Executive Director, 1915 North Stiles Avenue, Oklahoma City, Oklahoma 73105. The request must include:

(1) A statement in support of the proposal made. The supporting statement should refer to the statutory basis for the proposal and include any specific objections to existing rules or practices, and set forth the policy considerations which support adoption of the proposal;

(2) The name, address and telephone number of the person making the request;

(3) The name, address and telephone number of the agency or organization the person represents, if any;

(4) The number used to identify the rule if the request is to amend or repeal an existing rule; and

(5) The proposed language if the request is to amend an existing rule or adopt a new rule.

(b) The Executive Director or the Executive Director's designee will present such petition at the next regularly scheduled meeting of the Commission for consideration and disposition. The petitioner shall be given reasonable notice of the date, time and place of such meeting, and shall be informed in writing within a reasonable period of time of the Commission's ruling in the matter.

810:1-1-5. Petition for declaratory ruling relating to rules

(a) Whenever any person has an actual controversy over the applicability of a specific rule in this Title, that person may petition the Commission for a declaratory ruling as to the applicability of the rule and its effect on the petitioner. In petitioning the Commission for a declaratory ruling, the following procedures must be followed:

(1) The petition must be in writing and submitted to the Executive Director, 1915 North Stiles Avenue, Oklahoma City, Oklahoma 73105;

(2) The petition shall state with specificity the rule in question;

(3) The petition shall state clearly and with specificity the basis for the action and the action or relief sought;

(4) The petition shall pose the specific question(s) to be answered by the Commission;

(5) The petitioner must allege that an actual controversy exists over the applicability of the rule and must state with specificity the nature of the controversy;

(6) The petitioner must have an interest which is directly affected by the rule in which a ruling is requested and must plainly state that interest in the petition;

(7) The petition must be accompanied by a memorandum setting forth all relevant facts and law in support thereof; and

(8) The petitioner or the petitioner's authorized representative shall print his or her name, address and telephone number on the petition and sign it.

(b) On receipt of the petition, the Commission may:

(1) conduct such hearing, investigation or inquiry as it deems proper;

(2) issue a written ruling; or

(3) decline to make a ruling when:

(A) The Commission lacks jurisdiction over the issue or issues presented;

(B) There is no actual controversy;

(C) The petitioner would not be directly affected by a resolution of the issue presented;

(D) The petitioner does not provide sufficient facts or other information on which the Commission may base a ruling;

(E) The issue on which a determination is sought is or should be the subject of other administrative or civil litigation or appeal; or

(F) It appears to the Commission that there is other good cause why a declaratory ruling should not be made.

(c) The petitioner shall be informed in writing within a reasonable period of time of the Commission's disposition of the matter.

810:1-1-6. Requests for agency public information

(a) Public access to Commission records is subject to the Oklahoma Open Records Act, 51 O.S. § 24A.1, et seq. and 85A O.S. § 120. Any person making a request for a Commission record shall comply with the following:

(1) The request must be in writing and directed to the Clerk of the Commission when the request is to access workers' compensation claims information, to the Commission's Insurance Division Director when the request is for workers' compensation insurance related information maintained by the Commission, or to the Executive Director for all other requests.

(2) Requests to access workers' compensation claims information are subject to the written request and search fee requirements of 85A O.S. § 120, unless an exemption outlined in the law applies. The Commission may request information of a requester sufficient to determine whether or not an exemption pertains.

(A) To access workers' compensation claim information, the request must be made in writing, on a form prescribed by the Commission. The request form requires identification of the person requesting the information and the person for whom a search is being made. The request form must contain an affidavit signed by the requester under penalty of perjury stating that the information sought is not requested for a purpose in violation of state or federal law. Those making a request shall pay the Commission One Dollar ($1.00) per search request, not to exceed One Dollar ($1.00) per claims record of a particular worker, plus applicable copy charges set forth in 85A O.S. § 119(A), any applicable fees according to the Oklahoma Open Records Act, 51 O.S. § 24A.5(3), and certification fees if any.

(B) Electronic searches of workers' compensation claims data using public terminals at the Commission's offices may be made. The search function permits searches using the name of a claimant or the Commission file number. Certain information related to the

search criteria will be displayed on the terminal. Access to additional claims information pertaining to the search results is subject to the written request and search fee requirements described in this Paragraph.

(3) Requests not subject to Paragraph (2) of this Subsection, should describe the record(s) requested, indicate the name of the party making the request, and have the party's mailing address and telephone number. The requesting party shall pay for copies and research of such records in accordance with 85A O.S. § 119(A) and the Oklahoma Open Records Act, 51 O.S. § 24A.5(3), and, if applicable, for certification of the record according to a fee established by the Commission if any.

(4) Copy charges may be waived at the Commission's discretion for copies requested by the media or by a public officer or public employee in the performance of his or her duties on behalf of a governmental entity.

(b) This Section does not apply to records specifically required by state or federal law, or by state or federal administrative rule, or by order of a court of competent jurisdiction, to be kept confidential, including, but not limited to, financial data obtained by or submitted to the Commission for the purpose of obtaining a license or permit and records subject to proprietary agreements, confidentiality orders and sealed exhibits.

810:1-1-7. Forms

(a) The Commission utilizes a wide variety of forms in the administration of the Administrative Workers' Compensation Act, 85A O.S. § 1, et. seq. The forms are subject to frequent change because of changes in the law and for administrative reasons.

(b) Forms are available from the Commission's Records Department at the main offices of the Commission, 1915 North Stiles Avenue, Oklahoma City, Oklahoma 73105 and may be accessed through the Commission website at http://www.wcc.ok.gov. Persons may contact the Commission's Counselor Division to request forms and general information about completing and submitting them.

TITLE 810. OKLAHOMA WORKERS' COMPENSATION COMMISSION
CHAPTER 10. PRACTICE AND PROCEDURE

SUBCHAPTER 1. GENERAL PROVISIONS

810:10-1-1. Purpose

This Chapter provides rules of practice and procedure, both informal and formal, to govern all workers' compensation proceedings coming before the Commission for disposition pursuant to the AWCA.

810:10-1-2. Scope

(a) The rules of this Chapter shall be known as the "Oklahoma Workers' Compensation Commission Rules of Practice and Procedure", and may be cited as OAC 810:10.

(b) The rules of this Chapter shall govern all proceedings before the Commission, the Commissioners, any Commission Administrative Law Judge, the Executive Director, or other officer or employee of the Commission, regarding and related to a work injury, occupational disease or illness, or death, occurring on and after February 1, 2014, as provided in the AWCA.

(c) The rules of this Chapter shall not be construed as limiting the Commission's authority to grant an exception, for good cause shown, to any rule contained herein, unless otherwise precluded by law.

810:10-1-3. Definitions

In addition to the terms defined in 85A O.S. § 2, the following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Acceptable Electronic Signature Technology" means technology that is capable of creating a signature that is unique to the person using it; is capable of verification, is under the sole control of the person using it, and is linked to the data in such a manner that if the data is changed, the electronic signature is invalidated.

"Administrative Law Judge" means an Administrative Law Judge of the Commission to whom the Commission has delegated by order or otherwise, the authority to conduct a hearing.

"Attorney" means an attorney licensed to practice law in Oklahoma and a member in good standing of the Oklahoma Bar Association, or an out-of-state attorney.

"AWCA" means the Administrative Workers' Compensation Act, 85A O.S. §§1, et seq.

"Business day" means a day that is not a Saturday, Sunday, or legal holiday.

"Certified workplace medical plan" means an organization that is certified by the Oklahoma State Department of Health to provide management of quality treatment to injured employees for injuries and diseases compensable pursuant to the workers' compensation laws of the State of Oklahoma.

"Claim for compensation" means a Commission prescribed form filed by or on behalf of an injured worker or the worker's dependents to initiate a claim for benefits pursuant to the AWCA for an alleged work injury, occupational disease or illness, or death.

"Claimant" means a person who claims benefits for an alleged work injury, occupational disease or illness, or death, pursuant to the provisions of the AWCA.

"Commission" means the Oklahoma Workers' Compensation Commission, a designee, or an Administrative Law Judge to whom the Commission has delegated responsibility as authorized by 85A O.S. § 21(D).

"Commission Chair" means the Chair of the Oklahoma Workers' Compensation Commission.

"Continuance" means postponing a hearing from the time or date set, and rescheduling it on a later time or date.

"Controverted claim" means there has been a contested hearing before the Commission over whether there has been a compensable injury or whether the employee is entitled to temporary total disability, temporary partial disability, permanent partial disability, permanent total disability, or death compensation.

"Discovery" means the process by which a party may, before the hearing, obtain evidence relating to the disputed issue or issues from the other parties and witnesses.

"Document" means any written matter filed in a cause, including any attached appendices.

"Electronic Signature" means an electronic symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

"Executive Director" means the Executive Director of the Commission.

"Good cause" means, in the context of a request for continuance or failure of a party to comply with the Rules of this Chapter, circumstances beyond the party's control or that the party could not reasonably foresee. In the context of a claim, defense, or order, it means a reasonable legal basis.

"Insurance carrier" means any stock company, mutual company, or reciprocal or interinsurance exchange authorized to write or carry on the business of workers' compensation insurance in this state, and includes an individual own risk employer or group self-insurance association duly authorized by the Commission to self fund its workers' compensation obligations.

"Joint Petition Settlement" means a settlement between the employer/insurance carrier and the employee, of all or some issues and matters in a claim for compensation.

"Legal holiday" means only those days declared legal holidays pursuant to 25 O.S. § 82.1 or by proclamation of the Governor of Oklahoma.

"Mediation" means the process of resolving disputes with the assistance of a mediator, outside of a formal administrative hearing.

"Out-of-state attorney" means a person who is not admitted to practice law in the State of Oklahoma, but who is admitted in another state or territory of the United States, the District of Columbia, or a foreign country.

"Pro se" means without an attorney.

"Proceeding" means any action, case, hearing, or other matter pending before the Commission.

"Representative" means a person designated in writing by an injured employee, person claiming a death benefit, employer, insurance carrier or health or rehabilitation provider, to assist or represent them before the Commission in a matter arising under the AWCA.

"Sanction" means a penalty or other punitive action or remedy imposed by the Commission on an insurance carrier, representative, employee, employer, or health care provider for an act or omission in violation of the AWCA or a rule, judgment, order, or decision of the Commission.

"Self-insurer" means any duly qualified individual employer or group self-insurance association authorized by the Commission to self fund its workers' compensation obligations.

"Subpoena" means a Commission issued writ commanding a person to attend as a witness to testify or to produce documents, including books, papers and tangible things, at a deposition or at a hearing.

"Workers' compensation fee schedule" means a state mandated schedule of maximum allowable reimbursement levels for health care providers, including hospitals, ambulatory surgical centers, and inpatient rehabilitation facilities, rendering reasonable and necessary health care services and supplies to an injured employee for a compensable injury pursuant to the Oklahoma workers' compensation laws.

810:10-1-4. Reporting injuries or deaths

(a) **Employer's first report of injury.**

(1) Within ten (10) days after the date of receipt of notice or of knowledge of death or injury that results in more than three days' absence from work for the injured employee, the employer shall send a report thereof to the Commission as provided in 85A O.S. § 63, on a form prescribed

by the Commission that includes, in addition to other required information, the worker's full name and date of birth, and the last four digits of the worker's Social Security number. The report shall be known as the Employer's First Notice of Injury. The employer also shall send the report to the employer's insurance carrier, if any, within the ten day period.

(2) The report shall contain the information required by 85A O.S. § 63 and any additional information prescribed by the Commission.

(b) **Additional reporting requirements.** Reports or additional reports with respect to the death, injury and of the condition of the employee shall be sent by the employer to the Commission at such time and in such manner as the Commission may prescribe.

(c) **Evidentiary effect of reports.** Any report provided pursuant to this Section shall not be evidence of any fact stated in the report in any proceeding with respect to the injury or death for which the report is made.

(d) **Sanctions.** Failure or refusal of an employer to comply with the reporting requirements of this Section may subject the employer to sanctions prescribed in 85A O.S. § 63.

810:10-1-5. Commencing temporary total disability compensation and medical benefits

(a) Upon receipt of notice or of knowledge that an employee has been injured, the employer has an obligation under the AWCA to provide that employee with reasonable and necessary medical treatment for the injury, and to pay temporary total disability compensation if the employee is unable to perform the employee's job, or any alternative work offered by the employer, for more than three (3) calendar days. No order from the Commission directing the employer to provide these benefits is required.

(b) The first installment of temporary total disability compensation is due on the fifteenth day after the employer has notice of the injury. By that date, all temporary total disability compensation then accrued shall be paid to the employee, and weekly installment payments shall be made thereafter, unless the employer controverts the employee's right to compensation as provided in 85A O.S. § 86 by timely filing a Commission prescribed Employer's Intent to Controvert Claim form with the Commission. To be timely, the employer must file the Employer's Intent to Controvert Claim within fifteen (15) days after notice of the injury, or by such later date as fixed by the Commission, in its discretion, upon the employer's written request for a filing extension. The request must be postmarked within the fifteen-day period after the employer has notice of the injury. The employer shall send a copy of the Employer's Intent to Controvert Claim to the employee and so certify on the form when filed. The employee may request a hearing before an Administrative Law Judge of the Commission no sooner than ten (10) days after filing a claim for compensation with the Commission as provided in 810:10-5-2.

810:10-1-6. Terminating temporary compensation

(a) Temporary compensation may be terminated if the worker has no claim for compensation on file with the Commission. If there is a claim for compensation on file, the employer may terminate temporary compensation without a Commission order only if one of the following events occurs:

(1) The employee returns to full-time employment;

(2) The employee, or if represented, the employee's attorney, receives written notification from the employer that the temporary total disability benefits were terminated for a cause stated in 85A O.S. § 45(A)(2). The cause shall be specified in the notice;

(3) The employee is incarcerated for a misdemeanor or felony conviction in this state or another jurisdiction;

(4) The employee files a permanent disability rating report or a request for hearing before the Commission on permanent disability;

(5) The parties voluntarily agree in writing to terminate temporary compensation;

(6) The employee dies; or

(7) Any other event that causes temporary compensation to be lawfully terminated without Commission order as provided in 85A O.S. § 62, or as otherwise permitted in the AWCA.

(b) In all other instances, temporary compensation may be terminated only by Commission order. An employer may request a hearing on the termination of temporary total disability benefits by filing a CC-Form-13 Request for Prehearing Conference with the Commission and concurrently mailing a copy thereof to the opposing parties. The CC-Form-13 mailed to the opposing parties shall include a copy of all evidentiary exhibits, including any medical report, relied upon by the employer in support of terminating temporary compensation.

(c) If an employer is found to have improperly terminated temporary compensation, the Commission may require the employer to file a new CC-Form-13 Request for Prehearing Conference and show full compliance with this Section before a hearing on the employer's request to terminate temporary compensation will be conducted.

(d) If the employee files an objection to the employer's termination of temporary total disability benefits within ten (10) days of the termination, the employee may request an expedited hearing on the issue of reinstatement of the benefits as provided in 85A O.S. § 45(A)(2).

810:10-1-7. Forms and other documents generally

(a) All forms, pleadings, proposed orders, correspondence or other documents submitted to the Commission shall:

(1) be typewritten or printed legibly on 8 ½" by 11" paper, unless electronically filed pursuant to rules of the Commission;

(2) refer to the Commission file number if assigned;

(3) bear the typed or printed name, mailing address, telephone number, and signature, of the person who prepared the document, including the firm name if applicable; and

(4) include the attorney's Oklahoma Bar Association number, if the document is submitted by an attorney licensed to practice law in Oklahoma.

(b) The signature of an attorney or party constitutes the following:

(1) a certification that the claim, request for benefits, request for additional benefits, controversion of benefits, request for a hearing, pleading, form, motion, or other paper has been read;

(2) that to the best of his or her knowledge, information, and belief formed after reasonable inquiry, it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law; and

(3) that it is not brought for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation.

(c) If a claim, request for benefits, request for additional benefits, request for hearing, pleading, motion, or other paper:

(1) is not signed, it shall be stricken unless it is signed promptly after the omission is called to the attention of the pleader or movant; or

(2) is signed in violation of the AWCA, the Commission, including Administrative Law Judges, on motion or on their own initiative, shall impose an appropriate sanction as prescribed in 85A O.S. § 83.

(d) An electronic signature using acceptable electronic signature technology may be used to sign a document or a form and shall have the same force and effect as a hand written signature.

(e) All documents filed with the Commission shall be served on all parties and shall have a certificate of service setting forth the manner of such service. A copy of all correspondence addressed to the Commission with respect to a pending matter shall be sent to all parties at the time it is sent to the Commission and shall list the parties to whom copies were sent.

(f) All forms filed with the Commission shall be file-stamped by the Clerk of the Commission on the date of receipt.

810:10-1-8. Display and use of an individual's Social Security number

Unless otherwise ordered or as otherwise provided by law, every filer may limit the employee's or the employee's dependent's Social Security number to only the last four digits of that number in all pleadings, papers, exhibits or other documents, or Commission forms prescribed by the Commission. The responsibility for following this provision rests solely with counsel, the parties, or any other filer. The Clerk of the Commission shall not have any duty to review documents for compliance with this provision. If a filer includes the Social Security number in any document filed with the Commission, the document becomes a public record as filed. Nothing in this Section shall impact the confidentiality of any records the Legislature has determined are confidential.

810:10-1-9. Who may appear before Commission

(a) Attorneys licensed to practice law in Oklahoma and members in good standing of the Oklahoma Bar Association may appear on behalf of parties to litigation before the Commission and in Joint Petition Settlement proceedings before the Commission. Legal interns licensed by the Oklahoma Supreme Court may appear on behalf of a party only on matters properly within the scope of their license. Out-of-state attorneys who have complied with the requirements of Chapter 1, Appendix 1, Article II, Section 5 of Title 5 of the Oklahoma Statutes may appear on behalf of a party with leave of the Commission. The attorney shall file an entry of appearance with the Commission as provided in 810:10-1-10.

(b) Persons other than licensed attorneys, including adjusters, may file standard, administrative reporting forms such as the Employer's First Notice of Injury and notice of compliance with payment and reporting obligations related to Multiple Injury Trust Fund assessments (85A O.S., § 31) and Self-insurance Guaranty Fund assessments (85A O.S., § 98), which are required by law and/or Commission rules, are not considered legal pleadings, and the submission of which in no way is intended as an act of legal representation. Persons other than licensed attorneys may not assume an advocate's role or introduce evidence or examine witnesses in proceedings before the Commission or an Administrative Law Judge.

(c) An individual may appear pro se or by an attorney. A corporation, limited liability company, insurance carrier, individual own risk employer, and group self-insurance association, may appear only by its attorney.

810:10-1-10. Contact information for service of notice; entry of appearance; leave to withdraw

(a) **Contact information for service of notice.**

(1) Each party, upon instituting or responding to any proceedings before the Commission, shall file with the Commission the party's address, or the name and address of any agent upon whom notices shall be served to such party or agent at the last address so filed with the Commission. A party, including a claimant acting pro se, shall promptly communicate any change of address to the Commission's Docket Office.

(2) An attorney of record, as defined in Subsection (d) of this Section, shall give notice of a change of address by providing the Commission's Docket Office with a copy of the letterhead containing the new address and a list containing the Oklahoma Bar Association number of each attorney member of the firm who regularly appears before the Commission.

(3) Notice and service of documents may be made as prescribed in 12 O.S. § 2005(B). It is the responsibility of parties to an action before the Commission to provide a current mailing address, and email address if available, to Commission staff. Notices and documents sent to the last known address or email address on file with the Commission, are presumed delivered in a timely manner, and presumed received.

(b) **Entry of appearance.**

(1) An entry of appearance shall be filed by any attorney or law firm representing any party in any proceeding before the Commission. No attorney or law firm will be recognized in any case before the Commission unless the attorney or law firm duly entered their written appearance. When an entry of appearance has been duly filed by a law firm, any attorney member of that firm may appear and be recognized by the Commission. All entries of appearance when filed shall be accompanied by a written authorization signed by the client and attorney identifying the attorney or law firm as the client's representative, as defined in 810:10-1-3, to provide services in the workers' compensation matter, including the presentation of evidence as provided in 85A O.S. § 71(C)(1)(a).

(2) An appearance on behalf of the employer/insurance carrier shall be filed no later than ten (10) days after the employer/insurance carrier's receipt of a file-stamped copy of a claimant's claim for compensation filed pursuant to 810:10-5-2. The entry of appearance for the employer/insurance carrier shall identify whether or not the employer is an active member of a certified workplace medical plan in which the claimant is potentially enrolled, and if so, the name of the plan.

(c) **Leave to withdraw.**

(1) Once an entry of appearance has been filed, Leave to Withdraw can only be had upon written order of the Commission following appropriate notice to the client and the opposing side. Substitution of Counsel may be had by filing with the Commission and serving on the opposing party a notification of the substitution, signed by the attorney of record, the substituted attorney and the client. Notification of the substitution when filed shall be accompanied by a written authorization signed by the client and substituted attorney identifying the attorney as the client's representative to provide services in the workers' compensation matter, including the presentation of evidence as provided in 85A O.S. § 71(C)(1)(a).

(2) Except when an attorney's representation has been terminated at the client's initiative, no attorney shall be allowed to withdraw as an attorney for a party when that attorney has signed the pleadings necessary to perfect an appeal to the Commission en banc. This prohibition shall apply until the appeal has been fully submitted to the Commission en banc for consideration. This prohibition shall not apply if another attorney has entered an appearance for the appealing party before the filing of the application to withdraw.

(d) **Attorney of record.**

(1) The attorney of record for the claimant in a case shall be the attorney signing the first claim for compensation filed in the case for the claimant as provided in 810:10-5-2. Any other attorney who files an entry of appearance on behalf of any party in the case or who is identified as a substitute attorney pursuant to a notice of substitution of attorney shall also be considered an attorney of record. The Commission shall send notices to all attorneys of record until a substitution of attorney has been filed or an Application for Leave to Withdraw has been filed and granted by the Commission. Various attorneys may appear before the Commission in a matter, but notice shall be sent only to those attorneys who are an "attorney of record" as defined in this Subsection.

(2) Attorneys of record who change law firms shall notify the Commission of the status of the representation of their clients, and shall immediately seek Leave to Withdraw, when appropriate.

810:10-1-11. Designation of agent for service of notice

(a) Each insurance carrier, as defined in 810:10-1-3, shall designate a single agent for service of notice by filing a Designation of Service Agent form with the Commission. A copy of the form may be obtained from the Commission at its main offices, or from the Commission's website.

(b) Once a claim for compensation is filed as provided in 810:10-5-2, if the employer is self-insured or insured by an insurance carrier, the Commission shall send all notices and correspondence to the designated agent, until an entry of appearance is filed as provided in 810:10-1-10. If no agent for service of notice is designated on a Designation of Service Agent form, notices and correspondence shall be sent to the:

(1) signatory on the self-insurance application, if the insurer is an individual own risk employer;

(2) Administrator of the group self-insurance association, if the insurer is a group self-insurance association;

(3) person designated to receive notice of service of process for an insurer as provided in 36 O.S. § 621, if the insurer is a foreign or alien insurance carrier; or

(4) service agent on file with the Oklahoma Secretary of State, if the insurer is a domestic insurance carrier.

(c) If the employer is uninsured or the Commission cannot determine insurance coverage, notice and correspondence shall be sent to the employer at the address supplied by the claimant on the claim for compensation form prescribed in 810:10-5-2. If the notice is returned to the Commission because the claimant has supplied the wrong address for the employer, the Commission shall so inform the claimant. The claimant has the obligation of providing the Commission with the proper address so notices and correspondence can be sent to the employer.

810:10-1-12. Prohibited communications

(a) Ex parte communications by an Administrative Law Judge of the Commission with any party, witness or medical provider are proscribed in 85A O.S. § 105, and may subject the Administrative Law Judge to disqualification from the action or matter upon presentation of an application for disqualification.

(b) Parties, attorneys, mediators, case managers, Commission counselors, Commissioners, vocational rehabilitation evaluators, witnesses and medical providers shall have no ex parte communications with the assigned Administrative Law Judge regarding the merits of a specific matter pending before the judge.

(c) Direct or indirect ex parte communications by a party or their attorney, agent, employees, or anyone else acting on their behalf, with a Commission appointed professional regarding specific cases or claimants are prohibited except as authorized in Paragraph (2) of this Subsection.

(1) For purposes of this Subsection, "Commission appointed professionals" means independent medical examiners, vocational rehabilitation counselors, case managers, and others who have been appointed by the Commission to provide services or treatment to the claimant. The term also includes the office staff of the professional and any physician who accepts a referral from a Commission appointed professional for treatment or evaluation of the claimant when such referral is authorized by the Commission. The term excludes a treating physician selected pursuant to 85A O.S. § 56 regarding change of physician.

(2) The following communications are permitted communications:

(A) Joint letter of the parties requesting information or opinions from the Commission appointed professional after approval by the assigned Administrative Law Judge;

(B) Communication with the staff of a Commission appointed independent medical examiner to schedule or verify an appointment, or to authorize diagnostic testing, treatment or surgery;

(C) Communication with a Commission appointed medical case manager concerning light duty issues consistent with the physician's restrictions;

(D) Any communication between the claimant and the Commission appointed professional necessary to complete the claimant's treatment, testing or evaluation; and

(E) Communication between Commission appointed professionals.

(3) Failure to comply with this Subsection may, in the discretion of the assigned Administrative Law Judge, result in the imposition of costs, a citation for contempt, or sanctions against the offending party.

(4) Instances of prohibited communications with a Commission appointed professional shall be communicated by the Commission appointed professional to the assigned Administrative Law Judge and all parties or counsel, in writing.

810:10-1-13. Time computation

(a) Generally. The time within which an act is to be done, as provided in the AWCA or this Title, shall be computed by excluding the first day and including the last day. If the last day is a legal holiday, it shall be excluded, and performance of that act shall be required on the next regular business day. Time limits related to filing dates shall be computed as provided in this Section from the date of filing as reflected by the date of the file stamp on the document.

(b) Time period of less than eleven days. When the period of time prescribed or allowed is less than eleven (11) days, intermediate legal holidays and any other day when the office of the Clerk of the Commission does not remain open for public business until the regularly scheduled closing time, shall be excluded from the computation.

SUBCHAPTER 3. INFORMAL DISPUTE RESOLUTION PROCESSES

810:10-3-1. Purpose

This Subchapter establishes procedures and standards governing alternative dispute resolution, including mediation, as an informal dispute resolution process for workers' compensation claims and issues, as authorized in 85A O.S. § 70 regarding preliminary conferences, 85A O.S. § 109 regarding the Commission counselor program, and 85A O.S. § 110 regarding alternative dispute resolution and mediation.

810:10-3-2. Policy

The Oklahoma Workers' Compensation Commission is committed to the use of alternative dispute resolution procedures in workers' compensation claims, and all parties to workers' compensation claims are encouraged to voluntarily consider mediation as an alternative to traditional trials for the resolution of their disputes. Such informal procedures can achieve the just, efficient and economical resolution of controversies while preserving the right to a full administrative hearing on demand.

810:10-3-3. Counselor program

(a) The Commission shall maintain a workers' compensation counselor program to assist injured employees, employers and persons claiming death benefits under the AWCA. The program shall be administered by the Counselor Division of the Commission.

(b) A Division counselor shall:

(1) meet with or otherwise provide information to injured employees;

(2) investigate complaints;

(3) communicate with employers, insurance carriers, individual own risk employers, group self-insurance associations, and health care providers on behalf of injured employees;

(4) provide informational seminars and workshops on workers' compensation for medical providers, insurance adjusters, and employee and employer groups; and

(5) develop informational materials for employees, employers and medical providers.

(c) Notice of the availability of the services of the counselor program and of the availability of mediation and other forms of alternative dispute resolution to assist injured workers shall be mailed to the injured worker within ten (10) days of the filing of the Employer's First Notice of Injury as provided in

810:10-1-4. Information about the counselor program and the availability of alternative dispute resolution also shall be made part of the Commission's training materials for self-insurers and claims representatives handling Oklahoma workers' compensation claims.

810:10-3-4. Mediation process, generally

All workers' compensation issues may be mediated except for disputes related to medical care under a certified workplace medical plan or claims against the Multiple Injury Trust Fund. Mediation shall be voluntary, informal, nonbinding (unless the parties enter into a settlement agreement) and strictly confidential. If an agreement is not reached, the results and statements made during the mediation are not admissible in any following proceeding except as provided in 810:10-3-10. Mediation may be by mutual agreement of the parties to a workers' compensation dispute or pursuant to a referral order by the assigned Administrative Law Judge as provided in 85A O.S. § 110(E) following the filing of a request for administrative hearing and assent of the parties to mediate. Parties may waive mediation and proceed directly to an administrative hearing. General information about mediation in workers' compensation may be obtained from the Commission's Counselor Division.

810:10-3-5. Preliminary conferences

(a) At the Commission's discretion the first prehearing conference shall be directed to the preliminary conference docket of a Benefit Review Officer of the Commission. Pursuant to 85A O.S. § 70, the Benefit Review Officer shall:

(1) assist unrepresented claimants to enable those persons to protect their rights in the workers' compensation system;

(2) narrow and define the disputed issues;

(3) facilitate informal dispute resolution and provide an opportunity for a binding settlement of some or all of the issues;

(4) prepare at the conclusion of the preliminary conference stipulations of all contested and uncontested issues which shall be signed by representatives of the parties and the Benefit Review Officer; and

(5) draft a written summary report of the conference within five (5) days after the preliminary conference is closed to be filed in the case.

(b) All unresolved contested issues shall be set by the Commission on the assigned Administrative Law Judge's docket upon the filing of a CC-Form-9 or CC-Form-13.

(c) Benefit Review Officers are authorized to advise unrepresented claimants and to approve Joint Petition Settlements which may result from a preliminary conference; provided, the same Benefit Review Officer who conferred with the claimant may not also approve the Joint Petition Settlement.

(d) A Mediation Conference as provided in this Section may be conducted by agreement of the parties to a workers' compensation dispute or pursuant to a referral order by the assigned Administrative Law Judge following the filing of a request for hearing and assent of the parties to mediate as provided in 85A O.S. § 110. All workers' compensation issues may be mediated except for disputes related to medical care under a certified workplace medical plan or claims against the Multiple Injury Trust Fund.

(e) A Mediation Conference set and conducted as provided in this Section shall be voluntary, informal, nonbinding and strictly confidential. The mediator is authorized to compel attendance at the conference, but is not authorized to compel settlement. Attendance by the parties, and/or a representative of each party having full authority to settle all issues, is required. Failure to attend a Mediation Conference pursuant to this Section without good cause is subject to sanctions for contempt as provided in 85A O.S. § 73(B).

(f) The Mediation Conference may be held in the county where the accident occurred, if the accident occurred in Oklahoma, unless otherwise agreed to by the parties, or as otherwise directed by the Commission. Mediation Conferences involving a nonresident claimant or an accident occurring outside

Oklahoma shall be held at the main offices of the Commission in Oklahoma City, Oklahoma, unless otherwise agreed to by the parties, or as otherwise directed by the Commission.

(g) A Mediation Conference may be concluded by any party at any time, by the mediator if in the mediator's discretion it is necessary or an impasse exists, or upon an agreement or settlement being reached by the parties. Whether or not an agreement or settlement is reached, upon conclusion of the conference, the mediator shall complete the Commission prescribed Report of Mediation Conference form and send a copy to each party. The original Report of Mediation shall be filed in the Commission case file, and if there is none, then shall be retained by the Counselor Division.

(h) Except as otherwise provided in Subsections (d) through (g) of this Section, a Mediation Conference conducted by a Commission Benefit Review Officer shall be conducted according to the policies and procedures applicable to mediation conferences of workers' compensation matters by private mediators as provided in 810:10-3-4, 810:10-3-7 through 810:10-3-11.

810:10-3-6. Certified mediators

(a) **Mediator list.** The Commission shall maintain a list of private mediators to serve as certified mediators for the Commission's alternative dispute resolution program. The list shall be placed on the Commission's website at http://www.wcc.ok.gov.

(b) **Qualifications.** To be eligible for appointment by the Commission to the list of certified workers' compensation mediators for a five-year period, the individual must:

(1) be an attorney or non-attorney who has worked in the area of Oklahoma workers' compensation benefits for at least five (5) years; and

(2) otherwise have complied with the requirements of 85A O.S. § 110.

(c) **Application for appointment.** To request appointment to the list of certified workers' compensation mediators, an individual shall:

(1) Submit a signed and completed Commission prescribed Mediator Application form and resume to the following address: Oklahoma Workers' Compensation Commission, Attention: COUNSELOR DIVISION, 1915 North Stiles Avenue, Oklahoma City, Oklahoma 73105. Illegible, incomplete or unsigned applications will not be considered by the Commission and shall be returned. A copy of the Mediator Application form may be obtained from the Commission at the address set forth in this Paragraph, or from the Commission's website at http://www.wcc.ok.gov; and

(2) Verify that the individual, if appointed, will:

(A) schedule a mediation session within thirty (30) days of the order appointing the mediator, unless otherwise agreed to by the parties;

(B) schedule mediation sessions for a minimum two (2) hour block of time, and not schedule more than one mediation session to take place at a time;

(C) submit biennially to the Counselor Division written verification of compliance with the continuing education requirements prescribed by 85A O.S. § 110(H); and

(D) accept as payment in full for services rendered, compensation not exceeding the rate or fee provided in 810:10-3-12.

(d) **Renewal process.**

(1) The Commission shall notify a certified mediator of the end of the mediator's five-year qualification period at least sixty (60) calendar days before the expiration of that period.

(2) Criteria for reappointment is the same criteria as for initial appointment in effect at the time of reappointment.

(e) **Revocation.**

(1) Removal of an individual from the list of certified workers' compensation mediators shall be by request of the mediator or by the Commission after notice and opportunity for hearing.

(2) The Commission may remove a mediator from the list of certified workers' compensation mediators for cause, including, but not limited to the following grounds:

(A) a material misrepresentation in information submitted to apply for appointment to the Commission's list of certified workers' compensation mediators;

(B) refusal or substantial failure to comply with this Section or other applicable Commission rules, and statutes.

(3) Proceedings related to revocation shall be governed by 810:10-5-50 on show cause hearings and the contested hearings rules set forth in Subchapter 5 of this Chapter.

810:10-3-7. Mediation without Commission order of referral

Mediation shall be voluntary and shall not be conducted without the consent of the parties. Parties to a workers' compensation dispute subject to mediation may mutually agree to mediation by a mediator certified by the Commission, to a preliminary conference pursuant to 810:10-3-5, to a Commission mediator pursuant to 85A O.S. § 110(D), or may schedule and proceed with mediation independent of the Commission's processes and with a mediator of their choice. A party may initiate voluntary mediation with a Commission certified mediator by submitting a request for mediation in writing to the Commission's Counselor Division. The Division shall contact the opposing party to ascertain whether or not there is an agreement to mediate. Failure of the opposing party to respond to a request for mediation within fifteen (15) days of notification thereof shall be deemed a refusal to mediate. If mediation is agreed to, the parties shall enter into and submit to the Division a signed, written consent to mediate. If the parties are unable to agree upon a mediator from the Commission's list of certified mediators or elect not to mediate using the preliminary conference process, the Division shall assign a certified mediator, taking into consideration the availability and location of the certified mediator.

810:10-3-8. Mediation by Commission order of referral

The Commission may order referral to mediation pursuant to an order by the assigned Administrative Law Judge as provided in 85A O.S. § 22(C)(9) and 85A O.S. § 110(E) following the filing of a request for administrative hearing and assent of the parties to mediate.

810:10-3-9. Mediator powers and responsibilities

The mediator:

(1) has a duty to be impartial and to advise all parties of any circumstances bearing on possible bias, prejudice or partiality;

(2) does not have the authority to impose a settlement upon the parties, but shall assist the parties to reach a satisfactory resolution of their dispute;

(3) may direct questions to any of the parties or their respective representatives to supplement or clarify information;

(4) may obtain expert advice concerning technical aspects of a claim, whenever necessary and with the consent of the parties;

(5) may conduct separate meetings known as caucuses with each party, but shall not use these meetings as a time to coerce any party to settle. No information from a caucus may be divulged without permission of the party participating in the caucus; and

(6) immediately following conclusion of mediation proceedings, report the results of the mediation to the Counselor Division on a Report of Mediation Conference form prescribed by the Commission. The report is required for all cases mediated by mutual agreement of the parties or pursuant to Commission order of referral, whether or not the parties reached an agreement.

810:10-3-10. Confidentiality of proceedings; attendance

(a) Mediation sessions are private and shall not be recorded or transcribed in any way. Those in attendance may take notes during the mediation but all notes shall be collected by the mediator at the end of each session and held in a confidential file until the mediation process is completed. When the mediation process is completed, whether or not an agreement is reached, all notes and other writings produced while a mediation is in session, except the written agreement or memorandum of understanding, shall be destroyed.

(b) The parties and one representative for each party may attend mediation sessions. The claimant shall be in attendance, unless all parties agree otherwise. A claimant may participate in mediation without counsel. Other persons may attend only with the consent of all parties and the mediator. Non-parties to the claim shall be advised by the mediator regarding confidentiality and are not allowed to participate in the mediation, but may confer privately with their sponsoring party. All persons attending a mediation session shall respect and maintain the total confidentiality of the session. Attendance at a mediation session shall be in person, except as otherwise authorized in advance by the assigned Administrative Law Judge, if any, or by agreement of the parties and the mediator.

(c) Evidence of statements made and conduct occurring in a mediation conference shall not be subject to discovery and shall be inadmissible in any proceeding in the action or other actions on the same claim. However, no evidence otherwise discoverable shall be inadmissible merely because it is presented or discussed in a mediation conference.

(d) No mediator shall be compelled to testify or produce evidence concerning statements made and conduct occurring in a mediation conference in any civil proceeding for any purpose, except for proceedings of the State Bar Association, disciplinary proceedings of any agency established to enforce standards of conduct for mediators, and proceedings to enforce laws concerning juvenile or elder care.

(e) Statistical information regarding use of mediation in workers' compensation is subject to public disclosure.

810:10-3-11. Concluding mediation

During the mediation conference, the parties may agree to resolve a particular issue, settle the entire claim or conclude the mediation without reaching an agreement or settlement. A mediation conference may be concluded by any party at any time, by the mediator if in the mediator's discretion it is necessary or an impasse exists, or upon an agreement being reached by the parties. If an agreement is reached, the agreement shall be reduced to writing by the mediator, then read and signed by the parties and their counsel, if any, and the mediator. If the agreement requires a Commission order, the order must be presented for approval. Whether or not the parties reached an agreement or mediated by mutual agreement or pursuant to Commission order of referral, the mediator shall report the results of the mediation as provided in 810:10-3-9.

810:10-3-12. Mediator fees

(a) A mediator certified by the Commission as provided in 810:10-3-6 shall be entitled to a fee that does not exceed One Hundred Dollars ($100.00) per hour, or portion thereof, for mediation conferences, not to exceed a total fee of Eight Hundred Dollars ($800.00) for any mediation conference, even though the conference may recess and reconvene subsequently on one or more dates. The employer or insurance carrier shall pay the mediator Two Hundred Dollars ($200.00) on or before the initial mediation session. This payment shall be applied against the Eight Hundred Dollars ($800.00) owed for the mediation conference. If the mediation is concluded at the initial mediation session, the mediator shall bill the employer or insurance carrier the remaining balance of the total fee. If the mediation conference is recessed and reconvened by the mediator, the respondent shall pay the remaining balance to the mediator on or before the first reconvened date. The mediator shall disclose the mediator's fees to the parties when scheduling

the initial mediation session. Mediators shall be entitled to reimbursement for mileage and necessary lodging expenses, limited to the provisions of the State Travel Reimbursement Act, 74 O.S. §§ 500.1, et. seq. These reimbursements shall be in addition to the fees set forth in this Subsection.

(b) Nothing in this Section shall prohibit a certified mediator from charging a flat fee for a mediation conference, subject to the limits specified in this Section.

SUBCHAPTER 5. HEARINGS CONDUCTED BY ADMINISTRATIVE LAW JUDGES AND COMMISSIONERS

PART 1. COMMENCEMENT OF CLAIMS AND REVIEW OF QUALIFIED EMPLOYER BENEFIT DETERMINATIONS

810:10-5-1. Purpose

This Subchapter establishes procedures and standards governing the commencement of claims for disposition by the Oklahoma Workers' Compensation Commission as provided in the AWCA.

810:10-5-2. Claim for compensation

(a) A claim for compensation for benefits for an injury, including a cumulative trauma injury and death, or occupational disease or illness, occurring on or after February 1, 2014, shall be commenced by filing, in quadruplicate, an executed notice form with the Commission that includes the employer's Federal Employer Identification Number and the worker's full name and date of birth, and the last four digits of the worker's Social Security number. The following forms shall be used, as appropriate:

(1) CC-Form-3 claim for compensation for benefits for a single event or cumulative trauma injury;

(2) CC-Form-3A claim for compensation for death benefits; and

(3) CC-Form-3B claim for compensation for occupational disease or illness benefits.

(b) A proceeding under 810:15-15-3 to address payment of disputed fees for health services (e.g. physician fees, hospital costs, etc.), vocational rehabilitation or medical case management, shall be commenced by filing an MFDR Form 19. A CC-Form-9 shall be filed to request a hearing on an MFDR Form 19 dispute.

(c) Within ten (10) days of the filing of a claim for compensation (i.e. CC-Form-3, CC-Form-3A or CC-Form-3B), the Commission shall mail or send electronically a copy of the claim form bearing the assigned file number to the service agent designated by the self-insured employer, group self-insurance association, or insurance carrier, or as otherwise directed in that Section[1].

[1] Should be 810:10-1-11.

810:10-5-3. Claim against the Multiple Injury Trust Fund

(a) A claim against the State Treasurer as custodian of the Multiple Injury Trust Fund shall be commenced by filing an executed CC-Form-3F. The CC-Form-3F shall list each of the claimant's prior adjudicated claims, the date of each injury, the file number and the percentage of permanent partial disability awarded for each injury. If the claimant claims a pre-existing obvious and apparent disability, the disability shall be fully described on the CC-Form-3F, but no percentage of impairment need be included. A CC-Form- 9 shall be filed to request a hearing. Upon filing the CC-Form-9, the claimant or the claimant's attorney, if any, shall mail a copy thereof to the Multiple Injury Trust Fund.

(b) The CC-Form-3F filed with the Commission shall be served on the State Treasurer and the Multiple Injury Trust Fund and shall have a certificate of service setting forth the manner of such service as required by 810:10-1-7.

(c) A notation on the CC-Form-3 or CC-Form-3B that the claimant is a previously impaired person shall not be deemed to commence a claim against the Multiple Injury Trust Fund. The CC-Form-3F must be filed in the claim in which benefits are sought and shall use that same Commission file number.
(d) All requests by the Multiple Injury Trust Fund for the appointment of an independent medical examiner shall be governed by 85A O.S. § 112 and 810:10-5-45.

810:10-5-4. Claim for death benefits
(a) Death claims must be filed by the personal representative of the deceased employee's estate if probate proceedings have begun. If no probate proceeding has been brought, a death claim may be filed by the surviving spouse, or where there is no such spouse, then by the next of kin of the deceased employee. If the latter is incompetent or a minor, the guardian of such person shall be the proper party-claimant.
(b) All persons who have or may assert a claim for death benefits shall be named in the claim and their addresses and relationship to the deceased shall be given.
(c) If there are any beneficiaries named in the claim whose current whereabouts are not known, notice to such persons shall be obtained by publication in the county in which the decedent last resided, and the county of the last known address of any such beneficiary. Publication shall be for one time per week for three (3) successive weeks.

810:10-5-5. Review of adverse benefit determination by qualified employers
(a) Except as otherwise provided by law, a claimant aggrieved by all or part of an adverse benefit determination upheld by a qualified employer's appeals committee pursuant to 85A O.S. § 211, may appeal the determination to the Commission en banc by filing an original and four (4) copies of a Commission prescribed CC-Form-211 Request for Review of Adverse Benefit Determination with the Commission within one (1) year after the claimant's receipt of notice that the determination, or part thereof, was upheld. The CC-Form-211 shall:

(1) include a copy of the adverse benefit determination being appealed to the Commission en banc; and

(2) clearly and concisely address each issue in the adverse benefit determination that the claimant wants reviewed, and state the relief sought. General allegations of error do not suffice. Allegations of error concerning matters not included in a timely filed CC-Form-211 shall be deemed waived.

(b) The Commission shall assign a file number to the CC-Form-211 upon receipt, and, within ten (10) days thereafter, shall mail or send an electronic copy thereof to the qualified employer.
(c) Proceedings related to oral argument before the Commission en banc and submission by the parties of written arguments as an aid to the Commission en banc shall be governed by 810:10-5-66(c)-(f). The qualified employer's written argument shall be accompanied by an appendix that includes a copy of the employer's benefit plan and the entire administrative record established by the internal process of the qualified employer's plan.
(d) Discovery related to a claim for review under this section shall be governed by Rule 810:10-5-31(c)-(d).

810:10-5-6. Commission relief regarding agreements to arbitrate
(a) An application for judicial relief involving an arbitration matter under the Workers' Compensation Arbitration Act, 85 A O.S. § 300, et seq., shall be made to the Commission by the filing of a CC-Form-300 Request for Proceeding Regarding Arbitration Agreement.

(b) The CC-Form-300 shall be served in the manner provided by law for the service of a summons in the filing of a civil action and shall have a certificate of service setting forth the manner of such service as required by 810:10-1-7.

810:10-5-7. Claim for discrimination or retaliation

(a) A claim for discrimination or retaliation as prescribed by 85A O.S. § 7 shall be commenced by filing an executed Commission prescribed CC-Form-3C Claim for Discrimination or Retaliation with the Commission. The CC-Form-3C shall be filed in the underlying workers' compensation claim filed pursuant to the Workers' Compensation Act and shall use that same Commission file number.

(b) The CC-Form-3C filed with the Commission shall be served on the respondent and shall have a certificate of service setting forth the manner of such service as required by 810:10-1-7.

(c) A CC-Form-9 must be filed to request a hearing. Upon filing the CC-Form-9, the claimant or the claimant's attorney, if any, shall mail a copy thereof to the respondent.

PART 3. SUBSEQUENT PLEADINGS

810:10-5-15. Response to initial pleading; notice of contested issues

(a) An employer or its insurance carrier may respond to any issue related to a claim and liability therefor, including a claim for compensation, a claim for payment of health care or rehabilitation expenses, or a claim against the Multiple Injury Trust Fund for combined disabilities, by timely filing a CC-Form-10 Answer and Notice of Contested Issues or an MFDR Form 10M, pursuant to 810:10-5-16 or 810:15-15-3, as appropriate.

(b) A general denial or failure to timely file a CC-Form-10 or MFDR Form 10M shall be taken as admitting all allegations in the claim form except jurisdictional issues; and

(1) the extent, if any, of the claimant's disability, for a CC-Form-3 or CC-Form-3B claim; or

(2) the amount due, if any, for a death claim.

(c) Unless excused by the Commission for good cause shown, denials and affirmative defenses shall be asserted on the CC-Form-10 or MFDR Form 10M, or shall be waived. No reply to the CC-Form-10 or MFDR Form 10M is required.

810:10-5-16. Request for administrative hearing and pretrial stipulations

(a) Any party may request an administrative hearing before the Commission on any issue by filing a CC-Form-9 Request for Hearing. As provided in 85A O.S. § 71(B)(2), the request for hearing shall clearly set forth the specific issues of fact or law in controversy and the contentions of the party applying for the hearing.

(b) When a CC-Form-9 is filed on the issues of permanent partial disability or permanent total disability, the claimant shall deliver a medical report to the opposing party. The name of the physician and the date of the report shall be noted on the CC-Form-9. No CC-Form-9 may be filed less than ten (10) days from the date the claimant has filed a claim for compensation as provided in 810:10-5-2 or 810:10-5-3.

(c) Objections to termination of temporary compensation made pursuant to 85A O.S. § 45(A)(2), and requests for temporary compensation or medical treatment, shall be set by the Commission on the assigned Administrative Law Judge's prehearing conference docket for expedited hearing, prior to being docketed for an administrative hearing, unless otherwise directed by the assigned judge. At the time of the prehearing conference, all parties, to the best of their ability, shall advise the Commission and all parties of the number of witnesses expected to be called at the administrative hearing.

(d) The procedure to request an administrative hearing for the termination of temporary compensation is governed by 810:10-1-6.

(e) In all cases, the employer or insurance carrier shall file a CC-Form-10 Answer and Notice of Contested Issues or MFDR Form 10M no later than thirty (30) days after the filing of the CC-Form-9. The CC-Form-10 or MFDR Form 10M may be amended at any time, not later than twenty (20) days before the date of the administrative hearing.

(f) Both the CC-Form-9, and the CC-Form-10 or MFDR Form 10M, shall list the names of all witnesses, including any expert witnesses, which the party intends to call at the time of the administrative hearing. Absent waiver by the opposing party, failure without good cause to comply with this Subsection may, in the discretion of the hearing officer or the Commission, result in a witness not listed being prohibited from testifying, or in the exclusion of the evidence if submitted at the administrative hearing.

(g) Except as otherwise provided in Subsection (h) of this Section, no later than twenty (20) days before the date of the administrative hearing, all parties shall exchange all documentary evidence, exhibits and a complete list of witnesses with all opposing parties.

(h) As provided in 85A O.S. § 72(C), any party proposing to introduce a medical report or testimony of a physician at the hearing on a controverted claim, shall furnish a copy of the written report of the physician's findings and opinions to the opposing party and to the Commission no later than seven (7) days before the date of the hearing. If no written report is available to a party, that party shall notify the opposing party and the Commission in writing of the name and address of the physician proposed to be used as a witness and the substance of the physician's testimony no later than seven (7) days before the date of the administrative hearing. Cross-examination of the physician is governed by 85A O.S. § 72(C)(2)(b).

(i) The time periods specified in Subsections (g) and (h) of this Section may be waived by agreement of the parties.

(j) Absent waiver by the opposing party, failure without good cause to comply with Subsections (g) or (h) of this Section, may, in the discretion of the hearing officer or the Commission, result in exclusion of the evidence if submitted at the administrative hearing.

810:10-5-17. Joinder and consolidation of proceedings

(a) **Joinder.**

(1) A claimant who desires to add additional employers and/or insurance carriers, shall promptly amend the claim for compensation (CC-Form-3, CC-Form-3A, or CC-Form-3B) and mail a copy of the amended claim form to all parties, including the additional employers and/or insurance carriers named. Mailing shall constitute service upon the additional parties.

(2) An employer or insurance carrier that desires to add additional employers and/or insurance carriers shall file a CC-Form-13 Request for Prehearing Conference on the issue, and mail a copy of the CC-Form-13 to all parties, including the additional employers and insurance carriers named. The Commission shall notify all parties of the date of the prehearing conference. At the prehearing conference, the Commission shall hear argument, and based upon its discretion, enter its order granting or denying the request.

(3) The additional employers and insurance carriers shall comply with 810:10-5-15.

(4) The Commission, in its discretion, may impose an appropriate sanction prescribed in 85A O.S. § 83(B) against a party or the party's attorney who, without good cause shown, frivolously joins another party.

(b) **Consolidation of proceedings.**

(1) **Consolidation to afford the parties a joint hearing stage.** Consolidation of multiple cases involving the same claimant may be made for hearing purposes only at the discretion of the Administrative Law Judge assigned to the lowest case number, upon request of either party. Cases consolidated for purposes of hearing only shall maintain individual case numbers and shall remain subject to separate filing fees prescribed in 85A O.S. § 118 and costs.

(2) **Consolidation of cases involving the same claim.** Cases involving the same claim shall be consolidated to the lowest case number.

(3) **Prehearing conference on consolidation request.** All motions and requests to consolidate shall be set for prehearing conference before the entry of a Commission order sustaining or overruling the motion for case consolidation.

810:10-5-18. Continuances

(a) A request for a continuance will not be granted as a matter of course. Any motion for a continuance may be granted only by the assigned Administrative Law Judge for good cause shown. All motions for continuance shall be signed by the party on whose behalf the motion is made.

(b) No continuance of an appeal scheduled for review by the Commission en banc is permitted before the date of an oral argument authorized as provided in 810:10-5-66 without approval of the Commission Chair, or in the absence of the Commission Chair, the Commission Vice Chair. Continuances requested on the date of the oral argument will be granted only upon a majority vote of the Commission en banc.

810:10-5-19. Pauper status

(a) A party may proceed without payment of fees and costs required under the AWCA or this Title upon a determination by the Commission or an Administrative Law Judge of the individual's pauper status. Any party making application to proceed as a pauper shall complete and file a CC-Form-99 with the Commission and serve a copy thereof on all other parties in the proceeding. The CC-Form-99 shall be prescribed by the Commission.

(b) The CC-Form-99 shall be set for prehearing conference before the assigned Administrative Law Judge before any hearing on the merits, with notice to all other parties in the proceeding. If filed at the time an appeal on an underlying issue is filed with the Commission en banc, the CC-Form-99 shall be addressed by the assigned Administrative Law Judge before the appeal is docketed for hearing.

(1) If the Administrative Law Judge denies the request for pauper status, the applicant may appeal the denial order to the Commission en banc within ten (10) days of its issuance as reflected by the file-stamped date on the order. The appeal to the Commission en banc shall be set on a priority basis. Payment of the cost of the appeal, including transcript costs and the filing fee, will be deferred pending resolution of the appeal.

(2) If the Commission en banc affirms the denial of pauper status, the applicant must either pay all of the deferred costs of the appeal or seek review of the Commission en banc's order by appealing it to the Supreme Court within twenty (20) days of when the Commission en banc's order was sent. Failure to do either shall result in dismissal of the underlying appeal to the Commission en banc upon motion of the opposing party. Only one appeal fee is due because the pauper status appeal is part of the original, underlying appeal.

(3) If pauper status is found by the Commission en banc, the deferred costs and fees shall be borne by the Commission, and the underlying appeal will be docketed for hearing.

PART 5. PREHEARING PROCEEDINGS

810:10-5-30. Prehearing conference

(a) Any party shall have the right to request a prehearing conference before the Commission on any issue by filing a CC-Form-13 Request for Prehearing Conference. The requesting party must certify on the request that the parties have conferred or attempted to confer in good faith, but have reached an impasse and are unable to resolve the issue.

(b) Except as otherwise provided in 810:10-3-5, the purpose of the prehearing conference is to permit an informal hearing between the parties and the Administrative Law Judge in an effort to resolve the case

or issues in the case before an administrative hearing, and to discuss the facts, identify the legal issues, present discovery requests, make all appropriate stipulations, and discuss such other matters as may facilitate consideration of the case.

(c) The Administrative Law Judge shall set the matter for prehearing conference on the Administrative Law Judge's docket or a Benefit Review Officer's docket, as appropriate, at the earliest available time after the filing of the CC-Form-13. Notice of the date, time and place of the prehearing conference shall be provided by the Commission to all parties or their attorneys of record.

(d) Nothing in this Section shall limit a party's right to request a conference with the assigned Administrative Law Judge at the time of the administrative hearing.

(e) The Commission, in its discretion, may order the appearance of any party or attorney at any prehearing conference or conference requested with the Administrative Law Judge at the time of the administrative hearing. Nothing in this Section shall limit the authority of an Administrative Law Judge to order a prehearing conference or conference at the time of the administrative hearing.

(f) The Commission may, in its discretion, impose an appropriate sanction prescribed in 85A O.S. § 83(B) against an offending party for failure to appear at a conference, appearance at a conference substantially unprepared, failure to participate in the conference in good faith, or for seeking the conference in an effort to delay, harass or increase costs.

810:10-5-31. Discovery

(a) **Generally.** Discovery in administrative proceedings before the Commission is governed by this Section.

(b) **Authority of the Administrative Law Judge.** Any party may commence with discovery methods such as depositions issuance of subpoenas and requests for production, prior to or after invoking the jurisdiction of the Administrative Law Judge. Discovery disputes may be resolved by filing a request for hearing. Administrative Law Judge, upon the judge's own motion or on the motion of either party, may permit or perform such discovery or other appropriate action as the judge decides is appropriate in the circumstances, taking into account the needs of the parties to the proceeding and other affected persons and the desirability of making the proceeding fair, expeditious, and cost-effective. If discovery is permitted or performed, the Administrative Law Judge may order a party to the proceeding to comply with the judge's discovery-related orders, issue subpoenas for the attendance of a witness and for the production of records and other evidence at a discovery proceeding, including a deposition, and take action against a noncomplying party as appropriate and consistent with 85A O.S. § 73(B) and 85A O.S. § 83(B).

(c) **Protective orders.** The Commission may issue a protective order to prevent the disclosure of privileged information, confidential information, trade secrets, and other information protected from disclosure to the extent a court could if the controversy were the subject of a civil action in this state, including any orders with respect to subpoenas and attendance of a witness as may be appropriate for the protection of persons, including an order quashing a subpoena, excusing attendance of witnesses, or limiting documents to be produced.

(d) **Subpoenas; costs; fees; service.** When a witness is required to appear or to produce documentary evidence, a subpoena shall be issued by an attorney authorized to practice law in Oklahoma or under the seal of the Clerk of the Commission. The party requesting the subpoena under the seal of the Commission shall fill it in before issuance. The subpoena may be served by certified mail with return receipt requested or it may be hand delivered. The party requesting the subpoena shall bear the cost of serving it. Except as otherwise provided by law or this Title for physician testimony, fees of a nonparty witness who is subpoenaed to appear before the Commission shall be the same as those allowed to witnesses appearing before the district courts of this state. Party witnesses are not entitled to witness fees.

(e) **Completion of discovery by the employer or insurance carrier in contested claims.** Pursuant to 85A O.S. § 111, if the compensability of a claim is contested, the employer or insurance carrier shall

complete and secure a medical evaluation of the claimant within sixty (60) days of the filing of a claim for compensation pursuant to 810:10-5-2.

(f) **Filing Discovery.** No depositions, interrogatories, interrogatory answers, requests for production of documents and things, requests for admissions, or responses thereto, shall be filed with the Commission, except as ordered by the assigned Administrative Law Judge.

PART 7. INITIAL AND SUBSEQUENT PROCEEDINGS

810:10-5-45. Submission to medical examination; appointment of medical or vocational expert; travel expenses

(a) **Submission to medical examination.** Upon reasonable advance notice from the employer or insurance carrier, the employee must submit to a medical examination by a physician selected by the employer or insurance carrier. If the claimant refuses to submit to the examination, the employer or insurance carrier may file a CC-Form-13 requesting the claimant's compensation and right to prosecute any proceeding under the AWCA be suspended during the period of refusal as provided in 85A O.S. § 50(E). The claimant must show cause at the hearing why the request of the employer or insurance carrier should not be granted.

(b) **Appointment of medical or vocational expert.** Appointment of an independent medical examiner is governed by 810:15-9-4. Appointment of a medical case manager is governed by 810:15-11-4. Appointment of a vocational rehabilitation provider is governed by 810:20-1-4.

(c) **Travel expenses.** The employer or insurance carrier shall reimburse the employee for the actual mileage in excess of twenty (20) miles round-trip to and from the claimant's home to the location of a medical service provider for all reasonable and necessary medical treatment, for vocational rehabilitation or retraining, for an evaluation by an independent medical examiner and for any evaluation, including an evaluation for vocational rehabilitation or vocational retraining, made at the respondent's request, but in no event in excess of six hundred (600) miles round-trip. Mileage and necessary lodging expenses are limited to the provisions of the State Travel Reimbursement Act, 74 O.S. §§ 500.1, et. seq. Meals will be reimbursed at a per diem rate of Fifteen Dollars ($15.00) per meal per four hours of travel status, not to exceed three meals per day.

810:10-5-46. Evaluation of permanent impairment

(a) **Generally.** Except for scheduled losses subject to 85A O.S. § 46(A) and as otherwise provided in this Section, evaluations of permanent impairment for injuries occurring on or after February 1, 2014 must be based solely on criteria established by the current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment as a proportionate loss of use of the body as a whole, using the conversion tables of the guides. Deviations from the Guides are permitted only when specifically provided for in the Guides, or pursuant to an alternative method of evaluation approved pursuant to 85A O.S. § 60 that deviates from or is used in place of or in combination with the Guides.

(b) **Change of condition.** Evaluations of permanent impairment which are prepared in support of a Motion of Change of Condition occurring on or after February 1, 2014 shall be performed using the appropriate edition of the AMA Guides, including any approved alternative method of evaluation developed as provided in 85A O.S. § 60 that deviates from or is used in place of or in combination with the Guides, in effect on the date of injury.

(c) **Hearing impairment.** The current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment, or any alternative method approved pursuant to 85A O.S. § 60 that deviates from or is used in place of or in combination with the Guides, in effect on the date of injury, shall be used to evaluate permanent impairment caused by hearing loss where the last exposure occurred on or after February 1, 2014. Objective findings necessary to prove permanent disability in occupational

hearing loss cases may be established by medically recognized and accepted clinical diagnostic methodologies, including, but not limited to audiological tests that measure air and bone conduction thresholds and speech discrimination ability. Differences in baseline hearing levels shall be confirmed by subsequent testing given within four (4) weeks of the initial baseline hearing level test.

(d) **Eye impairment.**

(1) The criteria for measuring and calculating the percentage of eye impairment for an injury occurring on or after February 1, 2014 shall be pursuant to this Subsection. A physician may deviate from the method of evaluation provided for in this Subsection or may use some other recognized method of evaluation, if the deviation or the method of evaluation is fully explained.

(2) Physicians should consult the American Medical Association's Guides to the Evaluation of Permanent Impairment regarding the equipment necessary to test eye function and for methods of evaluating vision loss. Evaluation of visual impairment may be based upon visual acuity for distance and near, visual fields and ocular motility with absence of diplopia.

(3) Use of corrective lenses may be considered in evaluating the extent of vision loss, 85A O.S. § 46(E).

810:10-5-47. Attorney fee disputes

(a) Under 85A O.S. § 82, in a controverted claim under the AWCA when the employer or insurance carrier has contested liability in whole or in part, the attorney for the employee or a dependent in whose favor the proceeding has been finally decided, is entitled to an award of attorney fees, subject to limitations in the AWCA.

(b) When a dispute arises among several attorneys as to the identity of claimant's attorney of record, or when several successive attorneys lay claim to a fee in the same case, the Administrative Law Judge shall decide the issues raised and allocate the fee allowed in proportion to the services rendered.

(c) Nothing in this Section precludes resolution of an attorney fee dispute by mediation or agreement of the parties, as appropriate.

810:10-5-48. Sessions, hearings and venue, generally

(a) **Open to the public.** Hearings of the Commission or any Administrative Law Judge on matters filed with the Commission for disposition will be open to the public. As allowed in 85A O.S. § 19(D), the Commission or any Commissioner may hold hearings in any city of this state. Consistent with 85A O.S. § 71(B)(4), hearings before an Administrative Law Judge shall be held at the Commission's main offices in Oklahoma City, Oklahoma, or at a designated location in Tulsa, Oklahoma, as determined by the Commission.

(b) **Time.** All hearings shall commence at the time designated in the notice of hearing or by order of the Commission.

(c) **Conduct before the Commission.** Conduct of attorneys before the Commission shall be governed by applicable rules of the Supreme Court of Oklahoma. All parties, witnesses, and observers will at all times maintain decorum, and will conduct themselves in such manner as to reflect respect for the authority and dignity of the Commission and its Administrative Law Judges. Upon violation of this provision, any person or party attending any proceeding before the Commission may be subject to sanctions for contempt as provided in 85A O.S. § 73(B).

(d) **Record of hearing.** Hearings before the Commission or an Administrative Law Judge shall be stenographically recorded by a Commission reporter. The Commission may contract for court reporter services. A transcript of proceedings will be made by a court reporter at the request and expense of the person ordering it, or at the request of the Commission, in which case, a copy will be made for any person requesting it, at that person's expense.

810:10-5-49. Rules of evidence

(a) **Generally.** The Commission and Administrative Law Judges and are not bound by technical or statutory rules of evidence or procedure, 85A O.S. § 72(A).

(b) **Presentation of evidence.** At the hearing, an opportunity shall be afforded all parties to present evidence and argument with respect to matters and issues involved, although the argument may be restricted to a presentation in written form, to cross-examine witnesses who testify, and to submit rebuttal evidence. During a hearing, irrelevant, immaterial, or unduly repetitious evidence shall be excluded.

(c) **Taking official notice.** The Administrative Law Judge may take official notice of the law of Oklahoma and other jurisdictions, facts that are judicially cognizable, and generally recognized facts within the Commission's specialized knowledge; provided all parties shall be notified either before or during the hearing of the material so noticed, and they shall be afforded an opportunity to contest the facts so noticed.

(d) **Documents.**

(1) A photographic copy of a document which is on file as part of the official records of the Commission will be received without further authentication.

(2) A photographic copy of a public record certified by the official custodian thereof will be received without further authentication. A written statement by such custodian of records that no record or entry of described character is found in his records shall be received as proof of absence of such record.

(3) A photographic copy of a document may be substituted for the original at the time the original is offered in evidence.

(4) A document may not be incorporated in the record by reference except by permission of the Commission or Administrative Law Judge. Any document so received must be precisely identified.

(5) The Commission or Administrative Law Judge may require that additional copies of exhibits be furnished for use by other parties of record.

(6) When evidence is offered which is contained in a book or document containing material not offered, the person offering the same shall extract or clearly identify the portion offered.

(7) The Commission or Administrative Law Judge may permit a party of record to offer a document as part of the record within a designated time after conclusion of the hearing.

(e) **Witnesses.** All witnesses who appear to testify during a hearing shall first be subject to oath or affirmation and any testimony submitted by deposition shall show on the face thereof that the witness was so qualified.

(f) **Prepared testimony.** Except as otherwise provided in Subsection (g) and (h) of this Section, written testimony of a witness in the form of a notarized affidavit may be received in lieu of direct examination.

(g) **Expert medical testimony.**

(1) Expert medical testimony may be offered by:

(A) a written medical report of the physician;

(B) deposition; or

(C) oral examination before the Commission or Administrative Law Judge.

(2) Medical opinions addressing compensability and permanent disability must be stated within a reasonable degree of medical certainty. Medical opinions concerning the existence or extent of permanent disability must be supported by competent medical testimony of a physician described in 85A O.S. § 45(C)(1) and shall be supported by objective findings as described in 85A O.S. § 2(31). The medical testimony must include the employee's percentage of permanent partial disability and whether or not the disability is job-related and caused by the accidental injury or occupational disease or illness.

(3) The fact that the medical report constitutes hearsay shall not be grounds for its exclusion; provided, objection to and request for cross-examination of a Commission appointed independent medical examiner is governed by 85A O.S. § 112(J).

(h) **Vocational rehabilitation and case management evidence.**

(1) Testimony of a vocational rehabilitation expert or medical case manager may be offered by:

(A) a written report of the vocational rehabilitation expert or medical case manager, as appropriate;

(B) deposition; or

(C) oral examination before the Commission or Administrative Law Judge.

(2) The fact that the report constitutes hearsay shall not be grounds for its exclusion.

(i) **Exhibits.** All exhibits shall be identified by the case style and Commission assigned file number before being submitted.

810:10-5-50. Setting of matters

(a) **General.** All contested hearings to decide the rights of interested persons under the AWCA shall be set before an Administrative Law Judge, except as otherwise provided by law or this Title.

(b) **Exceptions.** The Commission en banc shall hear appeals of decisions from Administrative Law Judges, 85A O.S. § 78, and review adverse benefit determinations made pursuant to 85A O.S. § 211 of the Oklahoma Injured Employee Benefit Act, 85A O.S. § 200.

(c) **Show cause hearings.** When a Commission Division contests a permit or license holder's compliance with state workers' compensation laws or Commission rules, the Division may cause notice to be issued to the permit or license holder to appear before an Administrative Law Judge or an administrative hearing officer designated by the Commission to show why the holder's permit or license should not be cancelled or revoked. The notice shall contain a date certain for the hearing. Failure to appear at the hearing may result in the cancellation or revocation of the permit or license. Appearances at the hearing are governed by 810:10-1-9. The permit or license holder is to bring all reports and payments for delinquent assessments or other documentation pertinent to the hearing to the show cause hearing. Evidence and witnesses may be presented at the hearing.

810:10-5-51. Assignment of Administrative Law Judge; notice of hearing

(a) The Commission shall assign a claim for compensation filed pursuant to 810:10-5-2 to an Administrative Law Judge who shall hold a hearing upon the request of an interested party or on the judge's own motion.

(b) If a hearing is ordered, at least ten (10) days' notice of the hearing shall be served on the claimant and other interested parties, personally or by mail as prescribed in 85A O.S. § 71(B)(4). The date, time and location of the hearing shall be specified in the notice. The hearing shall be held in Oklahoma City, Oklahoma or Tulsa, Oklahoma, as provided in 810:10-5-48. Objections to venue shall be filed and submitted to the assigned Administrative Law Judge within seven (7) days of receipt of the first hearing docket notice.

810:10-5-52. Disqualification of assigned Administrative Law Judge

(a) Any party who feels that a fair and impartial administrative hearing or other hearing cannot be received from the Administrative Law Judge to whom the matter is assigned, shall make written motion requesting the judge to withdraw from the case. That application shall set forth specific reasons constituting good cause for the motion. The Administrative Law Judge may withdraw by written order without further proceeding and immediately refer the matter to the Executive Director for reassignment.

(b) Any party aggrieved by an order of an Administrative Law Judge who refused to grant a written request to disqualify, or transfer a claim to the Executive Director for reassignment, may seek corrective

relief by invoking the jurisdiction of the Commission en banc in the manner and within the time provided by 85A O.S. § 78, with appeal possible thereafter to the Oklahoma Supreme Court if the relief sought by the petitioner was denied by the Commission en banc.

(c) An order of the assigned Administrative Law Judge or the Commission en banc which is favorable to the moving party may not be reviewed in any tribunal either by appeal or in any other procedural framework.

810:10-5-53. Hearings

(a) All hearings shall be conducted in a fair, impartial and expeditious manner. Administrative Law Judges shall hear claims sitting without a jury, 85A O.S. § 27(A).

(b) Every Administrative Law Judge appointed by the Commission shall have the power to:

(1) refer a matter to mediation as provided in 85A O.S. § 110 and Subchapter 3 of this Chapter;

(2) administer oaths and affirmations;

(3) regulate the course of the hearing;

(4) facilitate discovery as provided in 810:10-5-31;

(5) receive written stipulations and agreements of the parties;

(6) rule on the admissibility of evidence and objections thereto;

(7) determine the relevancy, materiality, weight and credibility of evidence;

(8) hold conferences for settlement or simplification of the issues;

(9) dispose of procedural requests, motions, or similar matters, and objections thereto;

(10) issue orders, including interlocutory orders for the proper and expeditious handling of the case;

(11) grant further hearings per 85A O.S. § 72(C) for the purpose of introducing additional evidence; and

(12) take such other action as authorized by law or this Section, or as may facilitate the orderly conduct and disposition of the hearing.

(c) Submission of evidence. Submission of evidence is addressed in 810:10-5-49.

(d) Written arguments. The Commission or Administrative Law Judge may require or allow the parties of record to submit written arguments and legal authority for their respective positions as an aid to the Commission or judge, and may designate the order and time for doing so and for replying to the submission.

(e) Closing the record. The record shall be closed when all parties of record have had an opportunity to be heard and to present evidence, and the Commission or Administrative Law Judge announces that the record of testimony and exhibits is closed.

810:10-5-54. Judgment or award of the Administrative Law Judge

The Administrative Law Judge shall issue written findings of fact and conclusions of law within thirty (30) days of submission of the case by the parties. The order shall be signed by the judge and include a certificate of service to all parties and attorneys of record. The order shall be filed with the Clerk of the Commission.

PART 9. POST ORDER RELIEF

810:10-5-66. Appeal of Commission Administrative Law Judge order

(a) **Request for Review.** Any party aggrieved by a judgment or award of an Administrative Law Judge, which party for purposes of this Section shall be known as the "appellant", may appeal the order to the Commission en banc by filing an original and two (2) copies of a Request for Review with the Commission within ten (10) days of when the order was issued as reflected by the file-stamped date on the order. The Request for Review shall:

(1) be in writing;

(2) include a copy of the order being appealed;

(3) clearly and concisely rebut each issue in the Administrative Law Judge's order that the appellant wants reviewed, and state the relief sought. General allegations of error do not suffice. Allegations of error concerning matters not included in a timely filed Request for Review shall be deemed waived;

(4) be served on all other parties of record, which for purposes of this Section shall be known as the "respondents";

(5) have a certificate of service setting forth the manner of such service as required by 810:10-1-7;

(6) be accompanied by a designation of record filed by the appealing party and a copy submitted to the Commission reporter and all parties in the case concurrently with or before filing a Request for Review; and

(7) be accompanied by a non-refundable filing fee in the sum of One Hundred Seventy-five Dollars ($175.00) pursuant to 85A O.S. § 78(B).

(b) **Timeliness of filings.** The timeliness of the filing of a Request for Review is governed by 810:10-1-13. Untimely Requests for Review do not invoke the jurisdiction of the Commission en banc and will not be reviewed by the Commission en banc.

(c) **Oral argument.** Oral argument before the Commission en banc shall be limited to ten (10) minutes per side, unless the time is enlarged by leave of the Commission en banc. Any party failing to appear when the appeal is called for oral argument shall be deemed to have waived the right to argue the case and the appeal shall be considered as submitted on the record.

(d) **Written argument.** In any case pending on a Request for Review, the parties of record shall submit written arguments, including a statement of facts and legal authority for their respective positions, as an aid to the Commission en banc. The written argument shall not exceed five (5) pages in length, and shall be double spaced and prepared in at least ten point font size on 8 ½" x 11" paper with one inch margins. No appendix or other documents shall be attached to the written argument. The appellant has twenty (20) days after the filing of the Request for Review within which to file an original and four (4) copies of the written argument with the Commission, with a copy served on all opposing parties. The opposing parties shall have ten (10) days within which to submit a response. When submitted, the original and four (4) copies of the response shall be filed with the Commission and a copy served on the appellant.

(e) **Dismissal for failure to file.** An appeal may be dismissed with prejudice by the Commission's Presiding Appellate Officer when appellant has failed to timely file the written argument and has failed to timely respond to the Commission’s order to file the required written argument.

(f) **Default judgment for failure to file.** Default judgment may be entered by the Commission's Presiding Appellate Officer against the opposing parties when opposing parties have failed to timely file the written response and have failed to timely respond to the Commission’s order to file the required written argument.

(g) **Description of appeal proceeding.**

(1) In appeals pursuant to this Section, the Commission en banc may:

(A) modify the decision of the Administrative Law Judge;

(B) reverse the decision of the Administrative Law Judge and render a new decision;

(C) reverse the decision of the Administrative Law Judge and remand the matter to the Administrative Law Judge with instructions or for a new administrative hearing; or

(D) affirm the decision of the Administrative Law Judge.

(2) The Commission en banc may reverse or modify the decision of an Administrative Law Judge only if it determines that the decision was against the clear weight of the evidence or was

contrary to law. Any judgment of the Commission en banc which reverses a decision of the Administrative Law Judge shall contain specific findings relating to the reversal.

(3) All proceedings of the Commission en banc shall be recorded by a court reporter, if requested by a party. Any party requesting a transcript of the proceedings shall bear the costs associated with its preparation. During the pendency of an appeal to the Commission en banc, the Administrative Law Judge shall retain jurisdiction over any issue not affected by the eventual ruling of the appellate body.

(h) **Appeal to Supreme Court.** An order of the Commission en banc may be appealed to the Oklahoma Supreme Court, as provided in 85A O.S. § 78, within twenty (20) days of being sent to the parties as reflected by the file-stamped date on the order.

810:10-5-67. [RESERVED]

810:10-5-68. Enforcement of compensation judgment or award

A final compensation judgment or award issued by the Commission or an Administrative Law Judge which has not been complied with by the employer or insurance carrier may be enforced as provided in 85A O.S. § 79.

PART 11. CONTEMPT

810:10-5-75. Contempt procedure

(a) **Commencement.** A cause filed for contempt for disobedience to or violation of law or a rule, order or judgment of the Commission shall be commenced by the filing of a verified complaint.

(b) **Complaint.** The complaint shall state:

(1) The name of the person, firm, trust, corporation, limited liability company or association against whom the complaint is made.

(2) Each law, rule or order of which violation is charged.

(3) In general terms, the acts or omissions constituting the violation of which complaint is made. If complaint is made of more than one violation, each violation shall be separately stated.

(c) **Citation.** When a complaint is filed, the Clerk of the Commission shall issue in the name of the state a citation directed to the person against whom complaint is made, which citation shall be accompanied by a copy of the complaint. The citation shall state:

(1) The name of the complainant and the date the complaint was filed.

(2) A brief description of the nature of the complaint.

(3) Reference to the accompanying copy of the complaint.

(4) The date upon which the complaint is set for hearing, which shall not be earlier than ten (10) days from the date the citation is served.

(5) A statement that, unless the person complained against shall on or before the date for hearing file a response to the complaint, the allegations and charges therein will be taken as confessed.

(d) **Service of citation.** Service of the citation for contempt may be made by a person directed to do so by order of the Commission. Service shall be made by mailing the citation for contempt by certified mail to the respondent's last known address as listed in Commission records. The respondent is responsible for notifying the Commission of any change of address.

(e) **Return of service.** The person making the service shall make his return thereof, and file the same with the Clerk of the Commission. The return shall show the time when the citation was received by him, and the time and manner the same was served by him, and such return shall be verified by the person making the service. Service of the citation for contempt on the respondent by certified mail shall be

considered effective if returned from the last known address as listed in Commission records for the following reasons, including, but not limited to:

(1) Signed for by any person at the address listed.

(2) Undeliverable - no forwarding address, forwarding address expired, unclaimed and/or refused.

(f) **Default.** If no response to the complaint is filed on or before the date set for hearing, or if a respondent fails to appear at the time set for hearing, as specified in the citation, the Commission may immediately proceed to hear the complaint. After hearing the evidence, the Commission shall impose such fine pursuant to 85 O.S. § 73(B) as the facts and circumstances warrant, or dismiss the complaint.

(g) **Response.** A respondent who desires a hearing shall, on or before the time specified in the citation for hearing, file a response to the merits of the cause and shall appear at the time set for hearing. The response shall include all objections and defenses of any nature to the complaint and may include a motion to dismiss the complaint for reason of insufficiency thereof or lack of jurisdiction.

(h) **Hearing procedures.** At the hearing, the Commission shall first hear all objections and defenses other than to the merits of the complaint and shall enter an appropriate order thereon. Amendments may be permitted upon terms that are just, with or without grant of a continuance. After all preliminary questions are heard, the Commission shall hear the merits of the complaint, and at the conclusion thereof, shall impose such fine pursuant to 85 O.S. § 73(B) as the facts and circumstances warrant, or dismiss the complaint.

(i) **Hearing date.** Every cause instituted under this Section shall be tried on its merits on the date specified in the citation, or at such other time to which such cause shall be continued for hearing by the Commission.

PART 13. DISMISSALS

810:10-5-85. Dismissals

(a) **Generally.** Except as otherwise required by law, unless good cause is shown, dismissal of a complaint shall be without prejudice.

(b) **Untimely prosecution or failure to prosecute claim.**

(1) The Commission, on motion and after notice and hearing, may dismiss a claim for compensation with prejudice if no bona fide request for hearing with respect to the claim has been made within six (6) months of the filing of claim. The Commission may set such claims on a disposition docket.

(2) The Commission shall dismiss a claim for additional compensation without prejudice to refiling of the claim within the limitation period specified in 85A O.S. § 69(B), if no bona fide request for hearing with respect to the claim has been filed within six (6) months after the filing of the claim for additional compensation. A claim for additional compensation is described in 85A O.S. § 69(B)(C)(D).

(c) **Request of party filing claim for compensation.** Voluntary dismissal of a claim for compensation pursuant to a request of the worker is authorized in 85A O.S. § 108. This law gives the injured worker, upon order of the Commission and payment of the $140.00 final award fee provided for in 85A O.S. § 118, the right to dismiss the worker's claim for compensation at any time before final submission of the case to the Commission for decision. The worker's application for dismissal shall be made on a Commission prescribed CC-Form-100. The dismissal shall be without prejudice, unless the Commission's order on the CC-Form-100 clearly identifies the dismissal as with prejudice. Prior to entering an order for dismissal with prejudice, the Commission may require notice and an evidentiary hearing.

PART 15. SETTLEMENTS

810:10-5-95. Joint petition settlements.

(a) Under 85A O.S. § 87 and 85A O.S. § 115, upon and after the filing of a claim for compensation, or, in the absence of a claim for compensation, the filing of the Employer's First Notice of Injury in a claim involving a pro se employee, the parties may engage in a compromise and release of any and all liability which is claimed to exist under the AWCA on account of the injury or occupational disease or illness, subject to approval by the Commission, an Administrative Law Judge, or a Benefit Review Officer.

(b) The parties in interest to a claim for compensation may settle upon and determine any and all issues and matters by agreement, subject to the terms and conditions of this Section.

(c) Any agreement submitted to the Commission, Administrative Law Judge or Benefit Review Officer of the Commission's Counselor Division, for approval shall be set forth in a Commission prescribed CC-Joint Petition Settlement. Nothing in this rule shall preclude the Multiple Injury Trust Fund from compromising a claim as authorized by 85A O.S. § 32(F).

(d) No CC-Joint Petition Settlement agreement shall be binding on the parties in interest unless it is approved by the Commission pursuant to 85A O.S. § 22, Administrative Law Judge of the Commission pursuant to 85A O.S. § 115, or a Commission Benefit Review Officer pursuant to 85A O.S. § 70. The CC-Joint Petition Settlement, including any attached appendix as provided in 85A O.S. § 115(B), identifying the outstanding issues that are subject to the Commission's continuing jurisdiction and possible reopen, shall be approved unless it is determined that:

(1) The agreement is unfair, unconscionable, or improper as a matter of law; or

(2) The agreement is the result of an intentional misrepresentation of a material fact; or

(3) The agreement, if for permanent disability, is not supported by competent medical evidence as required by 85 O.S. § 2(33).

(e) As used in this Section, "parties in interest" means the respondent (employer and the employer's insurance carrier if insured), and an employee. An employee who is not represented by legal counsel may effect a CC-Joint Petition Settlement upon the employer's filing of the Employer's First Notice of Injury as provided in 810:10-1-4, or the employee's filing of a claim for compensation (CC-Form-3 or CC-Form-3B), regarding the injury or occupational disease or illness which is the subject of the CC-Joint Petition Settlement.

(f) In no instance shall the total attorney's fee amount provided for in a CC-Joint Petition Settlement exceed the maximum attorney fee allowed by law.

(g) No CC-Joint Petition Settlement shall be made upon written interrogatory or deposition except in cases where the claimant is currently engaged in the military service of the United States, is outside of the state, is a nonresident of Oklahoma, or in cases of extreme circumstances.

(h) A stenographic record of the terms and conditions of an approved joint petition settlement and the understanding of the claimant concerning the effect of the settlement must be made by a Commission court reporter and transcribed at the expense of the employer or insurance carrier. Medical reports and other exhibits submitted in support of a CC-Joint Petition Settlement shall not be transcribed. The original exhibits or duplicate copies thereof shall be affixed to the original transcript and placed in the Commission file.

(i) A file-stamped copy of an approved CC-Joint Petition Settlement shall be mailed by the Commission to all unrepresented parties and attorneys of record.

(j) A CC-Joint Petition Settlement that fully and finally resolves all issues in a claim for compensation between the employee and the employer, shall not be deemed an adjudication of the rights between the medical or rehabilitation provider and the employer for reasonable and necessary medical and rehabilitation expenses incurred by the employee due to the injury before the file-stamped date of the approved CC-Joint Petition Settlement.

(k) Within seven (7) days of the date a medical provider provides initial treatment for a work-related accident, the medical provider shall provide notice in writing to the Commission, if and only if, a CC-Form-3 or CC-Form-3B has been filed with the Commission, and in all cases shall provide notice in writing to the patient's employer, and if known, the employer's insurance carrier. If the medical provider fails to provide the required notification, the medical provider forfeits any rights to future notification, including those circumstances where a case is fully and finally settled by a CC-Joint Petition Settlement, unless the medical provider is actually known to the employer or insurance carrier or is listed by the employee.

(l) If the issue of medical treatment is fully and finally settled by a CC-Joint Petition Settlement, the employee shall provide to the employer or insurance carrier a list of all medical providers known to the employee. The Commission prescribed Form CC-JPS shall be used for that purpose. Within ten (10) days from the file-stamped date of the CC-Joint Petition Settlement, the employer or insurance carrier shall send notice of the CC-Joint Petition Settlement to all medical providers listed by the employee and to all medical providers known to the employer or insurance carrier. The employee is liable for payment of any medical services rendered after the CC-Joint Petition Settlement is filed. The employee also is responsible for informing any future medical providers that the case or issue of medical treatment was fully and finally disposed of by a CC-Joint Petition Settlement and that the employee, rather than the employer or insurance carrier, is the party financially responsible for such services.

PART 17. FEES

810:10-5-105. Fees.

Fees payable to the Commission include:

(1) A fee of One Thousand Dollars ($1,000.00), payable by each carrier writing worker's compensation insurance in this state, upon securing a license to transact business in this state [85A O.S. § 29(A)];

(2) A fee of One Thousand Dollars ($1,000.00), payable by each self-insurer at the time it is approved to self-insure its obligations under the AWCA [85A O.S. § 29(B)];

(3) An annual fee of One Thousand Dollars ($1,000.00), payable by third-party administrators [85A O.S. § 29(C)];

(4) A fee of One Hundred Seventy-five Dollars ($175.00), payable by a party appealing an order or award of an Administrative Law Judge to the Commission en banc [85A O.S. § 78(B)];

(5) A fee of One Hundred Dollars ($100.00), for compiling and transmitting a record for appeal of a Commission order to the Oklahoma Supreme Court, payable by the appealing party [85A O.S. § 78(D)];

(6) A fee of One Hundred Forty Dollars ($140.00), payable by the party against whom an award becomes final (i.e. the employer or insurance carrier if there is an award of compensation, or the worker if there is a denial or dismissal of a claim for compensation) [85A O.S. § 118(A)]. Ten Dollars ($10.00) of the fee is payable by the Commission to the credit of the Attorney General's Workers' Compensation Fraud Unit Revolving Fund;

(7) A fee of One Hundred Thirty Dollars ($130.00), payable by the worker if the reopen request is to reopen on a change of condition for the worse, or payable by the employer or insurance carrier if the reopen request is to reopen on a change of condition for the better [85A O.S. § 118(B)];

(8) A fee of One Dollar ($1.00) per page, payable as a copy charge [85A O.S. § 119(A)];

(9) A fee of One Dollar ($1.00) per search request for prior claims records, not to exceed One Dollar ($1.00) per claims record of a particular worker [85A O.S. § 120(B)];

(10) A fee of Forty-five Dollars ($45.00), plus postage, if any, for a Commission handbook [85A O.S. § 20(B)]; and

(11) Such other fees as may be allowed by law or this Title.

TITLE 810. OKLAHOMA WORKERS' COMPENSATION COMMISSION
CHAPTER 15. MEDICAL SERVICES

SUBCHAPTER 1. GENERAL PROVISIONS

810:15-1-1. Purpose

This Chapter establishes procedures and standards governing medical matters over which the Commission has responsibility under the Administrative Workers' Compensation Act, 85A O.S., §§ 1, et seq.

810:15-1-2. Definitions

In addition to the terms defined in 85A O.S., § 2, the following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"AWCA" means the Administrative Workers' Compensation Act, 85A O.S., §§ 1, et seq.

"Brand name drug" means a drug marketed under a proprietary, trademark-protected name.

"Case manager" means a person who is a registered nurse with a current, active unencumbered license from the Oklahoma Board of Nursing, or possesses one or more of the of the following certifications:

(A) Certified Disability Management Specialist (CDMS);

(B) Certified Case Manager (CCM);

(C) Certified Rehabilitation Registered Nurse (CRRN);

(D) Case Manager - Certified (CMC);

(E) Certified Occupational Health Nurse (COHN); or

(F) Certified Occupational Health Nurse Specialist (COHN-S).

"Certified workplace medical plan" means an organization that is certified by the Oklahoma State Department of Health to provide management of quality treatment to injured employees for injuries and diseases compensable pursuant to the workers' compensation laws of the State of Oklahoma.

"Claimant" means a person who claims benefits for an alleged work injury, occupational disease or illness, or death pursuant to the provisions of the AWCA.

"Closed formulary" means all available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, excluding:

(A) drugs identified with a status of "N" in the current edition of the Official Disability Guidelines Treatment in Workers' Comp (ODG)/Appendix A, ODG Workers' Compensation Drug Formulary, and any updates thereto;

(B) any compound drug;

(C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care; and

(D) drugs that are not preferred, exceed or are not addressed by the ODG in effect on the date of treatment.

"Commission" means the Oklahoma Workers' Compensation Commission, a designee, or an administrative law judge to whom the Commission has delegated responsibility as authorized by 85A O.S., § 21(D).

"Compounding" means the preparation, mixing, assembling, packaging, or labeling of a drug or device:

(A) as a result of a practitioner's prescription drug order based on the practitioner-patient-pharmacist relationship in the course of professional practice;

(B) for administration to a patient by a practitioner as the result of a practitioner's initiative based on the practitioner-patient-pharmacist relationship in the course of professional practice;

(C) in anticipation of a prescription drug order based on a routine, regularly observed prescribing pattern; or

(D) for or as an incident to research teaching or chemical analysis and not for selling or dispensing except as may otherwise be allowed by law.

"Generic" or **"Generically equivalent"** means a drug that, when compared to the prescribed drug, is pharmaceutically equivalent and therapeutically equivalent.

"Independent medical examiner" means a licensed physician authorized to serve as a Commission appointed medical examiner as provided in the AWCA.

"Insurance carrier" means any stock company, mutual company, or reciprocal or interinsurance exchange authorized to write or carry on the business of workers' compensation insurance in this state, and includes an individual own risk employer or group self-insurance association duly authorized by the Commission to self fund its workers' compensation obligations.

"Maximum allowable reimbursement" or **"MAR"** means the maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with 85A O.S., § 50(H)(5).

"Medical emergency" means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain that in the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

"**Medical interlocutory order"** or **"MIO"** means a medical interlocutory order provided a prescribing doctor or pharmacy in instances where preauthorization denials of a previously prescribed and dispensed drug(s) excluded from the closed formulary poses an unreasonable risk of a medical emergency.

"Nonprescription drug" means a non-narcotic drug that may be sold without a prescription and that is labeled and packaged in compliance with state or federal law. This may also be referred to as over-the-counter medication.

"Official Disability Guidelines" or **"ODG"** means the current edition of the Official Disability Guidelines and the ODG Treatment in Workers' Comp, excluding the return to work pathways, published by the Work Loss Data Institute.

"Pharmaceutically equivalent" means drug products that have identical amounts of the same active chemical ingredients in the same dosage form and that meet the identical compendia or other applicable standards of strength, quality, and purity according to the United States Pharmacopoeia or another nationally recognized compendium.

"Preauthorization" means prospective approval obtained from the employer or insurance carrier by the requestor or injured employee before providing pharmaceutical services for which preauthorization is required. For purposes of this chapter, "preauthorization" relates to prospective evaluation of only the medical necessity and reasonableness of healthcare to be prescribed or provided to an injured employee.

"Prescribing doctor" means a physician or dentist who prescribes prescription drugs or over-the-counter medications in accordance with the physician's or dentist's license and state and federal laws and rules. For purposes of this Chapter, "prescribing doctor" includes an advanced practice nurse or physician assistant to whom a physician has delegated the authority to carry out or sign prescription drug orders, as and to the extent authorized by Oklahoma law, who prescribes prescription drugs or over-the-counter medication under the physician's supervision and in accordance with the health care practitioner's license and state and federal laws and rules.

"Prescription" means an order for a prescription or nonprescription drug to be dispensed.

"Prescription drug" means:

(A) a substance for which federal or state law requires a prescription before the substance may be legally dispensed to the public;

(B) a drug that under federal law is required, before being dispensed or delivered, to be labeled with the statement: "Caution: federal law prohibits dispensing without prescription"; "Rx only"; or another legend that complies with federal law; or

(C) a drug that is required by federal or state statute or regulation to be dispensed on prescription or that is restricted to use by a prescribing doctor only.

"Requestor" means the health care provider or designated representative, including office staff or a referral health care provider/health care facility that requests preauthorization.

"Retrospective review" means the process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee.

"Statement of medical necessity" means a written statement from the prescribing doctor to establish the need for treatments or services, or prescriptions, including the need for a brand name drug where applicable. A statement of medical necessity shall include:

(A) the injured employee's full name;

(B) date of injury;

(C) the last four digits of the injured employee's social security number;

(D) diagnosis code(s);

(E) whether the drug has previously been prescribed and dispensed, if known, and whether the inability to obtain the drug poses an unreasonable risk of a medical emergency; and

(F) how the prescription treats the diagnosis, promotes recovery, or enhances the ability of the injured employee to return to or retain employment.

"Substitution" means the dispensing of a drug or a brand of drug other than the drug or brand of drug ordered or prescribed.

"Therapeutically equivalent" means pharmaceutically equivalent drug products that, if administered in the same amounts, will provide the same therapeutic effect, identical in duration and intensity.

"Work-related injury" means a single event injury, cumulative trauma injury, or occupational disease or illness that arises out of and in the course of employment as provided in the AWCA.

"Workers' compensation fee schedule" means a state mandated schedule of maximum allowable reimbursement levels for health care providers, including hospitals, ambulatory surgical centers, and inpatient rehabilitation facilities, rendering reasonable and necessary health care services and supplies to an injured employee for a compensable injury pursuant to the Oklahoma workers' compensation laws.

SUBCHAPTER 3. WORKERS' COMPENSATION FEE SCHEDULE

810:15-3-1. Purpose

Workers' compensation fee schedules are intended to establish presumptively fair and reasonable charges for health care services and supplies which may be covered under the AWCA.

810:15-3-2. Applicability of 2012 workers' compensation fee schedule

(a) The Oklahoma workers' compensation fee schedule developed and adopted by the Workers' Compensation Court Administrator effective January 1, 2012 for health care services and supplies rendered on and after that date to an injured employee for a compensable work-related injury (the "2012 fee schedule"), shall remain in full force and effect, unless and until superseded by a fee schedule that is adopted by the Commission and approved by the Oklahoma Legislature, in accordance with 85A O.S., § 50(H), or as otherwise provided by law. Specific provisions contained in the AWCA as implemented in this Chapter take precedence over any conflicting provision adopted by or utilized in the 2012 fee schedule with respect to injuries occurring on and after February 1, 2014.

(b) The 2012 fee schedule may be viewed at the Commission's main offices and is available on the Commission's website at http://www.wcc.ok.gov.

SUBCHAPTER 5. PHARMACEUTICAL BENEFITS

810:15-5-1. Pharmaceutical services

(a) **Prescriptions.** A doctor providing care to an injured employee shall prescribe for the employee medically necessary prescription drugs and over-the-counter medication alternatives as clinically appropriate and applicable in accordance with state law and as provided by this Section.

(b) **OTC medications.** When prescribing an OTC medication alternative to a prescription drug, the doctor shall indicate on the prescription the appropriate strength of the medication and the approximate quantity of the OTC medication that is reasonably required by the nature of the compensable injury. The doctor shall prescribe OTC medications in lieu of a prescription drug when clinically appropriate.

(c) **Generic prescriptions.** The doctor shall prescribe generic prescription drugs when available and clinically appropriate. If in the medical judgment of the prescribing doctor a brand name drug is necessary, the doctor must specify on the prescription that brand name drugs be dispensed in accordance with applicable state and federal law, and must maintain documentation justifying the use of the brand name drug, in the patient's medical record.

(d) **Use of formulary.** When prescribing, the doctor shall choose medications and drugs from the formulary adopted by the Commission.

(e) **Statement of medical necessity.** The insurance carrier, employee or pharmacist may request a statement of medical necessity from the prescribing doctor. The prescribing doctor shall provide the statement of medical necessity to the requesting party no later than the fourteenth working day after receipt of a request.

(f) **Explanation of benefits.** In addition to other requirements regarding explanation of benefits (EOB) provided in the Oklahoma workers' compensation fee schedule, at the time an insurance carrier denies payment for medications for any reason related to medical necessity or reasonableness of health care, the insurance carrier shall also send the EOB to the injured employee and the prescribing doctor.

(g) **Billing and reimbursement.** Billing, reimbursement methodologies and the maximum allowable reimbursement for pharmaceutical services are subject to 85A O.S., § 50 and the Oklahoma workers' compensation fee schedule in effect on the date of service, unless the services are provided pursuant to a certified workplace medical plan or a written contract between the insurance carrier and provider as provided in 85A O.S., § 55(B).

810:15-5-2. Closed formulary

The Commission hereby adopts a closed formulary as defined in 810:15-1-2 for workers' compensation claims with a date of injury on and after February 1, 2014.

810:15-5-3. Requirements for use of closed formulary

(a) **Applicability.** The closed formulary adopted pursuant to 810:15-5-2 applies to all drugs that are prescribed and dispensed for outpatient use for claims with a date of injury on or after February 1, 2014.

(b) **Preauthorization for claims subject to the Commission's closed formulary.** Preauthorization is only required for drugs that are excluded from the closed formulary, as defined in this Chapter.

(c) **Preauthorization request.** The preauthorization request must include the prescribing doctor's drug regimen plan of care, and the anticipated dosage or range of dosages for the drugs. Failure to request preauthorization entitles an insurance carrier or employer to deny payment for the drug in question. If the insurance carrier or employer fails to respond to a preauthorization request within three (3) days, the request shall be deemed approved.

(d) **Preauthorization of intrathecal drug delivery systems.**

(1) An intrathecal drug delivery system requires preauthorization and the preauthorization request must include the prescribing doctor's drug regimen plan of care, and the anticipated dosage or range of dosages for the administration of pain medication.

(2) Refills of an intrathecal drug delivery system with drugs excluded from the closed formulary, which are billed using Healthcare Common Procedure Coding System (HCPCS) Level II J codes, require preauthorization on an annual basis. Preauthorization for these refills is also required whenever:

(A) the medications, dosage or range of dosages, or the drug regime proposed by the prescribing doctor differs from the medications, dosage or range of dosages, or drug regime previously preauthorized by that prescribing doctor; or

(B) there is a change in prescribing doctor.

(e) **Treatment guidelines.** Except as provided by this Subsection, the prescribing of drugs shall be in accordance with 810:15-7-1 relating to treatment guidelines. Prescription and nonprescription drugs included in the Commission's closed formulary may be prescribed and dispensed without preauthorization.

810:15-5-4. Medical Interlocutory Order

(a) The purpose of this Section is to provide a prescribing doctor or pharmacy an ability to obtain a medical interlocutory order (MIO) in instances where preauthorization denials of a previously prescribed and dispensed drug excluded from the closed formulary poses an unreasonable risk of a medical emergency as defined in 810:15-1-2.

(b) An MIO will be issued if the request for an MIO contains the following information:

(1) injured employee name;

(2) date of birth of injured employee;

(3) prescribing doctor's name;

(4) name of drug and dosage;

(5) MIO requestor's name (pharmacy or prescribing doctor);

(6) MIO requestor's contact information;

(7) a statement that a preauthorization request for a previously prescribed and dispensed drug, which is excluded from the closed formulary, has been denied by the insurance carrier;

(8) a statement that the preauthorization denial poses an unreasonable risk of a medical emergency as defined in 810:15-1-2;

(9) a statement that the potential medical emergency has been documented in the preauthorization process;

(10) a statement that the insurance carrier has been notified that a request for an MIO is being submitted to the Commission; and

(11) a signature and the following certification by the MIO requestor for Paragraphs (7) through (11) of this Subsection, "I hereby certify under penalty of perjury that the previously listed conditions have been met."

(c) A complete request for an MIO under this Section shall be processed and approved by the Commission in accordance with this Section. At the discretion of the Commission, an incomplete request for an MIO under this Section may be considered in accordance with this Section.

(d) The request for an MIO may be submitted on the designated Commission form. The form is available on the Commission's website, http://www.wcc.ok.gov. If the Commission form is not available, the written request must contain the provisions of Subsection (b) of this Section.

(e) The MIO requestor shall provide a copy of the MIO request to the insurance carrier, prescribing doctor, injured employee, and dispensing pharmacy, if known, on the date the request for MIO is submitted to the Commission.

(f) An approved MIO shall be effective retroactively to the date the complete request for an MIO is received by the Commission.
(g) The MIO shall continue in effect until the later of:
(1) final adjudication of a medical dispute regarding the medical necessity and reasonableness of the drug contained in the MIO;
(2) expiration of the period for a timely appeal; or
(3) agreement of the parties.
(h) A party shall comply with an MIO entered in accordance with this Section and the insurance carrier shall reimburse the pharmacy for prescriptions dispensed in accordance with an MIO.
(i) The insurance carrier shall notify the prescribing doctor, injured employee, and the dispensing pharmacy once reimbursement is no longer required in accordance with Subsection (g) of this Section.
(j) A party may seek to dispute, reverse or modify an MIO issued under this Section by filing a written request for a hearing before an Administrative Law Judge of the Commission.

SUBCHAPTER 7. TREATMENT GUIDELINES

810:15-7-1. Treatment guidelines

(a) Health care not subject to a certified workplace medical plan shall be provided using the ODG in effect at the time of treatment as the primary standard of reference for determining the frequency and extent of services presumed to be medically necessary and appropriate for compensable injuries under the AWCA, and in resolving such matters in the event a dispute arises; provided, per 85A O.S., § 16(B), a doctor providing care to an injured employee shall prescribe for the employee medically necessary prescription drugs and over-the-counter alternatives as clinically appropriate and recommended by the ODG, and as provided in Subchapter 5 of this Chapter.
(b) Health care provided by a certified workplace medical plan shall be in accordance with the plan's treatment guidelines. Pursuant to 85A O.S., § 64(B)(1), the plan's treatment guidelines shall be consistent with the ODG in effect at the time of treatment.
(c) Oklahoma Treatment Guidelines (OTG) adopted by the Physician Advisory Committee pursuant to 85 O.S., § 373(B)(6), effective April 2, 2012, for the prescription and dispensing of any controlled substance included in Schedule II of the Uniform Controlled Dangerous Substances Act, and pursuant to 85 O.S., § 373(B)(5), effective June 24, 2013, for medical treatment for injuries to the spine, are not applicable for care of injured employees with a work-related injury occurring on or after February 1, 2014. These OTG shall be superceded by any "Physician Advisory Committee Guidelines" (PACG) adopted by the Physician Advisory Committee pursuant to 85A O.S., § 17(B). The PACG shall be adopted only for:
(1) medical treatment not addressed by the latest edition of the ODG; and
(2) the prescription and dispensing of any controlled substance included in Schedule II of the Uniform Controlled Dangerous Substances Act if not addressed by the latest edition of the ODG.
(d) Information on how to access the ODG or any PACG may be found on the Commission's website, http://www.wcc.ok.gov.

SUBCHAPTER 9. INDEPENDENT MEDICAL EXAMINERS

810:15-9-1. Qualifications

(a) The Commission shall maintain a list of private physicians to serve as independent medical examiners. The list shall be placed on the Commission's website at http://www.wcc.ok.gov.
(b) To be eligible for appointment by the Commission to the list of qualified independent medical examiners, and for retention on the list, the physician must:
(1) have a valid, unrestricted professional license as a physician which is not probationary;

(2) have at least three (3) years' experience and competency in the physician's specific field of expertise and in the treatment of work-related injuries;

(3) be knowledgeable of workers' compensation principles and the workers' compensation system in Oklahoma, as demonstrated by prior experience and attend Commission sponsored educational programming at least once every two (2) years, including programming in the Official Disability Guidelines if a treating physician and/or in the American Medical Association's "Guides to the Evaluation of Permanent Impairment" if a physician rating permanent impairment;

(4) have in force and effect health care provider professional liability insurance from a domestic, foreign or alien insurer authorized to transact insurance in Oklahoma. The per claim and aggregate limits of the insurance must be at least One Million Dollars ($1,000,000.00);

(5) have no felony conviction under federal or state law within seven (7) years before the date of the physician's application to serve as a qualified independent medical examiner; and

(6) have a valid Oklahoma State Bureau of Narcotics and Dangerous Drugs Control (BNDD) registration and federal Drug Enforcement Agency (DEA) registration, as authorized by law for the physician's professional license.

(c) Physicians who are serving unexpired terms as qualified independent medical examiners for the Oklahoma Workers' Compensation Court on February 1, 2014 shall serve as qualified independent medical examiners for the Commission until their respective terms expire, unless voluntarily terminated by the physician or revoked by the Commission, and may reapply for successive qualification periods. The two year period in which to meet the educational requirement in 810:15-9-1(b)(3) commences with the independent medical examiner's first appointment or renewal after February 1, 2014.

810:15-9-2. Application and appointment process

(a) **Appointment.** Appointment of physicians to the list of qualified independent medical examiners, and maintenance and periodic validation of such list shall be by the Commission. Physician appointments shall be for a two-year period.

(b) **Application for appointment.** To request appointment to the list of qualified independent medical examiners, a physician shall:

(1) Submit a signed and completed Commission prescribed IME Application and Physician Disclosure forms to the following address: Oklahoma Workers' Compensation Commission, Attention: HEALTH SERVICES DIVISION, 1915 North Stiles Avenue, Oklahoma City, Oklahoma 73105. Illegible, incomplete or unsigned applications and disclosures will not be considered by the Commission and shall be returned. A copy of the IME Application and Physician Disclosure forms may be obtained from the Commission at the address set forth in this Paragraph, or from the Commission's website at http://www.wcc.ok.gov;

(2) Submit a current curriculum vitae, together with the IME Application and Physician Disclosure forms, to the address set forth in the preceding Paragraph; and

(3) Verify that the physician, if appointed, will:

(A) provide independent, impartial and objective medical findings in all cases that come before the physician;

(B) decline a request to serve as an independent medical examiner only for good cause shown;

(C) conduct an examination, if necessary, within forty-five (45) calendar days from the date of the order appointing the examiner, unless otherwise approved by the Commission, when necessary to render findings on the questions and issues submitted;

(D) prepare a written report in accordance with Commission rules which addresses the issues set out in the order of appointment;

(E) submit the report to the parties and the Commission within fourteen (14) calendar days of a required examination of the claimant and/or completion of necessary tests, or within fourteen (14) calendar days after receipt of necessary records and information if no examination and/or tests are required;

(F) accept as payment in full for services rendered as an independent medical examiner the fees established pursuant to 810:15-9-5;

(G) submit to a review pursuant to 810:15-9-3 and 85A O.S., § 112(H);

(H) submit annually to the Commission written verification of valid health care provider professional liability insurance as and if required in 810:15-9-1;

(I) notify the Commission in writing upon any change affecting the physician's qualifications as provided in 810:15-9-1; and

(J) comply with all applicable statutes and Commission rules.

(c) **Disclosure.** As part of the IME Application, the physician shall identify, on the Physician Disclosure form, any ownership or interest in a health care facility, business or diagnostic center that is not the physician's primary place of business, including any employee leasing arrangement between the physician and any health care facility that is not the physician's primary place of business. Failure to do so is grounds for the Commission to disqualify the physician from providing treatment under the AWCA.

810:15-9-3. Revocation

(a) Removal of a physician from the list of qualified independent medical examiners shall be by request of the independent medical examiner or by the Commission after notice and opportunity for hearing.

(b) The Commission may remove a physician from the list of qualified independent medical examiners for cause, including, but not limited to the following grounds:

(1) a material misrepresentation on the IME Application or Physician Disclosure forms;

(2) refusal or substantial failure to notify the Commission of any change affecting the physician's qualifications as provided in 810:15-9-1; or

(3) refusal or substantial failure to comply with this Subchapter, 85A O.S., § 112, or other applicable Commission rules and statutes.

(c) Proceedings related to revocation shall be governed by 810:10-5-50 on show cause hearings and the contested hearings rules set forth in Subchapter 5 of Chapter 10 of this Title.

(d) In arriving at a determination regarding whether to remove a physician from the list, the Commission may consider the character of the alleged violation and all of the attendant circumstances, and may confer with the Physician Advisory Committee created in 85A O.S., § 17, or other public or private medical consultants.

(e) A physician whose qualification to serve as independent medical examiner has been revoked by the Commission is not eligible to be selected as an independent medical examiner during the period of revocation.

810:15-9-4. Requests for assignment

(a) Appointment of an independent medical examiner from the Commission's list of independent medical examiners is governed by this Section. Appointments shall take into account the specialty, availability and location of the examiner. The independent medical examiner selected shall be certified by a recognized specialty board in the area or areas appropriate to the condition under review.

(b) Requests for the appointment of an independent medical examiner may be set for a prehearing conference, at the discretion of the Commission.

(c) An independent medical examiner may be appointed on any issue before the Commission, including to determine if further medical treatment is needed following a full duty release on all body parts by the treating physician. If surgery is recommended by a treating physician, upon request of the employer, an

independent medical examiner who is qualified to perform the type of surgery recommended shall be appointed to determine the reasonableness and necessity of the surgery.

(d) The parties shall send the employee's medical records to the independent medical examiner by regular mail within ten (10) calendar days of receipt of the Commission order assigning the examiner. If necessary, the independent medical examiner may contact persons in whose possession the records or information is located solely for the purpose of obtaining such records or information.

(e) An independent medical examiner's opinion is binding unless there is clear and convincing evidence to the contrary. Deviations by the Commission from the independent medical examiner's opinion must be explained.

810:15-9-5. Fees and costs

(a) Fees for services performed by a Commission appointed independent medical examiner shall be paid according to the following schedule:

(1) Diagnostic tests relevant to the questions or issues in dispute shall be paid by the employer or insurance carrier in accordance with the Oklahoma workers' compensation fee schedule; provided, diagnostic tests repeated sooner than six (6) months from the date of the test are not authorized for payment unless agreed to by the parties or ordered by the Commission for good cause shown.

(2) The review of records and information, including any treating physician evaluation and/or medical reports submitted by the parties, the performance of any necessary examinations, and the preparation of a written report as prescribed by Commission rules, shall be billed at the physician's usual and customary rate, not to exceed Three Hundred Dollars ($300.00) per hour or any portion thereof, not to exceed a maximum reimbursement of One Thousand Six Hundred Dollars ($1,600.00) per case. The Commission may permit exception to this provision, for good cause shown. Subject to reimbursement if appropriate, these costs shall be billed to, and initially paid by, the respondent.

(3) Reimbursement for medical testimony given in person or by deposition shall be paid by the employer or insurance carrier in accordance with the independent medical examiner's usual and customary charges, not to exceed Four Hundred Dollars ($400.00) per hour or any portion thereof, plus an allowance of One Hundred Dollars ($100.00) for 15 minute increments thereafter. Preparation time shall be reimbursed at the examiner's usual and customary charge, not to exceed Four Hundred Dollars ($400.00). A Four Hundred Dollar ($400.00) charge is allowable whenever a deposition or scheduled testimony is canceled by any party within three working days before the scheduled start of the deposition or scheduled testimony. The party canceling the deposition or scheduled testimony is responsible for the incurred cost.

(4) Amounts owed to the independent medical examiner for services are payable upon submission of the examiner's written report.

(5) The independent medical examiner may charge and receive up to Two Hundred Dollars ($200.00), to be paid initially by the employer or insurance carrier in the event the employee fails to appear for any scheduled examination, or if the examination is canceled by the employee or the respondent within forty-eight (48) hours of the scheduled time. The employer or insurance carrier shall be reimbursed by the employee if the failure to appear or the cancellation by the employee was without good cause. The independent medical examiner may not assess a cancellation charge for appointments canceled by the examiner.

(b) Failure to timely pay a Commission appointed independent medical examiner for services rendered pursuant to Commission order may result in the imposition of assessments or sanctions at the discretion of the administrative law judge or Commission, including a fine for contempt as provided in 85A O.S., § 73(B). Disputes regarding payment for services rendered by a Commission appointed independent medical

examiner that cannot be resolved by the examiner and the parties themselves, may be addressed by filing a request for hearing before an administrative law judge of the Commission as provided in 810:10-5-16, or by mediation, as appropriate.

810:15-9-6. Renewal process

(a) The Commission shall notify the independent medical examiner of the end of the examiner's two-year qualification period at least sixty (60) calendar days before the expiration of that period and shall apprise the examiner how to access the IME Application and Physician Disclosure forms for reapplication as an independent medical examiner.

(b) Criteria for reapplication shall be governed by 810:15-9-1 and 810:15-9-2. If a curriculum vitae (CV) was previously submitted with a request for independent medical examiner status, the physician does not have to resubmit the physician's CV, unless there have been material changes that would have bearing upon the applicant's qualifications.

SUBCHAPTER 11. MEDICAL CASE MANAGEMENT

810:15-11-1. Qualifications

(a) The Commission shall maintain a list of private medical case managers to serve as independent medical case managers. The list shall be placed on the Commission's website at http://www.wcc.ok.gov.

(b) To be eligible for appointment by the Commission to the list of qualified independent medical case managers, and for retention on the list, the applicant must:

(1) be a registered nurse with a current, active unencumbered license from the Oklahoma Board of Nursing, or possess one or more of the following certifications:

(A) Certified Disability Management Specialist (CDMS);

(B) Certified Case Manager (CCM);

(C) Certified Rehabilitation Registered Nurse (CRRN);

(D) Case Manager - Certified (CMC);

(E) Certified Occupational Health Nurse (COHN); or

(F) Certified Occupational Health Nurse Specialist (COHN-S);

(2) be highly experienced and competent in the field of medical case management as it relates to the care and treatment of work-related injuries;

(3) be knowledgeable of workers' compensation principles and the workers' compensation system in Oklahoma as demonstrated by prior experience and/or education;

(4) have no felony conviction under federal or state law within seven (7) years before the date of the applicant's application to serve as a qualified independent medical case manager; and

(5) have a valid professional license as a nurse or case manager certification as provided in Subsection (a) of this Section, which is not probationary or restricted.

(c) Case managers who are serving unexpired terms as qualified case managers for the Oklahoma Workers' Compensation Court on February 1, 2014 shall serve as qualified case managers for the Commission until their respective terms expire, unless voluntarily terminated by the case manager or revoked by the Commission, and may reapply for successive qualification periods.

810:15-11-2. Application and appointment process

(a) **Appointment.** Appointment of applicants to the list of qualified independent medical case managers, and maintenance and periodic validation of such list shall be by the Commission. Medical case manager appointments to the list shall be for a two year period.

(b) **Application for appointment.** To request appointment to the list of qualified medical case managers, an applicant shall:

(1) Submit a signed and completed Commission prescribed MCM Application form to the following address: Oklahoma Workers' Compensation Commission, Attention: HEALTH SERVICES DIVISION, 1915 North Stiles Avenue, Oklahoma City, Oklahoma, 73105. Illegible and incomplete or unsigned applications will not be considered by the Commission and shall be returned. A copy of the MCM Application form may be obtained from the Commission at the address set forth in this Paragraph, or from the Commission's website at http://www.wcc.ok.gov;

(2) Submit a current resume, together with the MCM Application form, to the Commission; and

(3) Verify that the applicant, if appointed, will:

(A) provide independent, impartial and objective medical case management services in all cases assigned to the case manager;

(B) decline a request to serve as a medical case manager only for good cause shown;

(C) meet with the claimant and appear at any appointments with treating physicians, as directed by the Commission, and when necessary to report findings or respond to questions and issues submitted by the Commission;

(D) submit an initial written report to the parties and Commission within twenty (20) calendar days from the date of the order appointing the case manager, or sooner as the particular circumstances of the medical care or treatment or inquiries from the Commission may necessitate. Progress reports shall be submitted as the particular circumstances of each case warrant, or as directed by the Commission;

(E) notify the Commission in writing upon any change affecting the medical case manager's qualifications as provided by statute or in 810:15-11-1; and

(F) comply with all applicable statutes, Commission rules, and orders in the case assigned.

(c) **Disclosure.** As part of the MCM Application, the case manager shall identify, on the application form, any employer, insurer, employee group, certified workplace medical plan, or representatives of the above with whom the case manager is under contract, or who regularly uses the services of the case manager.

810:15-11-3. Revocation

(a) Removal of a case manager from the list of qualified independent medical case managers shall be at the request of the case manager, or by the Commission after notice and opportunity for hearing.

(b) Grounds for removal include, but are not limited to:

(1) a material misrepresentation on the MCM Application for appointment to the list of qualified independent medical case managers;

(2) refusal or substantial failure to notify the Commission of any change affecting the case manager's qualifications as provided by statute or 810:15-11-1; or

(3) refusal or substantial failure to comply with this Subchapter, or other applicable Commission rules, statutes or orders in the specific case assigned.

(c) Proceedings related to revocation shall be governed by 810:10-5-50 on show cause hearings and the contested hearings rules set forth in Subchapter 5 of Chapter 10 of this Title.

(d) In arriving at a determination regarding whether to remove a case manager from the list, the Commission may consider the character of the alleged violation and all of the attendant circumstances, and may confer with the Physician Advisory Committee created in 85A O.S., § 17, or other public or private medical or case management consultants.

(e) A case manager whose qualification to serve as an independent medical case manager has been revoked by the Commission is not eligible to be selected as an independent medical case manager during the period of revocation.

810:15-11-4. Requests for assignment

(a) For cases not covered by a certified workplace medical plan, and where the employer, insurance company, or own risk employer does not provide case management, the Commission may grant case management on the request of any party or when the Commission determines that case management is appropriate. Nothing in this Section shall limit the Commission's ability to appoint a case manager by agreement of the parties, or as otherwise allowed by law.

(b) If the parties to a dispute cannot agree on an independent medical case manager of their own choosing, the Commission may appoint one from the list of qualified independent medical case managers maintained by the Commission.

(c) In order to be eligible for appointment in any given case, a qualified medical case manager:

(1) shall not have a financial interest in the claimant's award; and

(2) shall not have any financial interest in the employer's or insurer's business, nor regularly contract with or serve as a case manager for the employer, insurer, or employer's own risk group, or a certified workplace medical plan with which the employer or employer's own risk group contracts.

(d) The parties are encouraged to request the appointment of an independent medical case manager at a prehearing conference.

(e) Requests for the appointment of an independent medical case manager may be set for a prehearing conference, at the discretion of the Commission.

(f) Upon appointment, the parties shall send information and all medical records to the independent medical case manager, by regular mail, within ten (10) calendar days of receipt of the Commission order assigning the case manager.

(g) If a party makes a good faith effort to get medical records (including diagnostic films) and the records are unobtainable, then a letter to this effect shall be sent to the case manager with copies to all other parties and the Commission, together with information as to the known location of any such records or information not in either the attorney's or client's possession. If necessary, the case manager may contact persons in whose possession the records or information is located solely for the purpose of obtaining such records or information.

(h) The respondent shall pay all reasonable and customary charges of a medical case manager appointed by the Commission. Failure to timely pay a Commission appointed independent medical case manager for services rendered pursuant to Commission order may result in the imposition of assessments and sanctions by the administrative law judge or Commission, including a fine for contempt as provided in 85A O.S., § 73(B). Disputes regarding payment for services rendered by a Commission appointed independent medical case manager that cannot be resolved by the case manager and the parties themselves, may be addressed by filing a request for hearing before an administrative law judge of the Commission as provided in 810:10-5-16, or by mediation, as appropriate.

810:15-11-5. Renewal process

(a) The Commission shall notify the independent medical case manager of the end of the case manager's two-year qualification period at least sixty (60) calendar days before the expiration of that period and shall apprise the case manager how to access the MCM Application form for reapplication as an independent medical case manager.

(b) Criteria for reapplication shall be governed by 810:15-11-1 and 810:15-11-2. If a resume has been previously submitted to the Court with a request for independent medical case manager status, the case manager does not have to resubmit the case manager's resume, unless there have been material changes that would have bearing upon the applicant's qualifications.

SUBCHAPTER 13. CHANGE OF TREATING PHYSICIAN

810:15-13-1. Scope

(a) This Subchapter applies to requests to the Commission for a change of treating physician made by a claimant who is not subject to a certified workplace medical plan. These requests are authorized in 85A O.S. § 56(B).

(b) Requests for a change of treating physician sought by an injured employee of an employer that previously contracted with a certified workplace medical plan are not subject to this Subchapter. Such requests must be made by utilizing the plan's dispute resolution process on file with the State Department of Health.

810:15-13-2. Change of physician; no certified workplace medical plan

(a) A claimant seeking a change of treating physician pursuant to 85A O.S. § 56(B) for a work-related injury occurring on and after February 1, 2014, shall file a Commission prescribed Application for Change of Treating Physician with the Commission. Upon such application, the Commission shall grant one (1) change of treating physician. At that time, the employer shall provide the claimant a list of three (3) licensed physicians from which to select the replacement treating physician. Each physician listed shall be qualified to treat the affected body part or condition for which a change of physician is sought.

(b) Nothing in this Section is intended to preclude the parties from agreeing upon a change of physician without the necessity of complying with Subsection (a) of this Section, or from utilizing mediation to resolve a request for change of physician.

SUBCHAPTER 15. MEDICAL DISPUTE RESOLUTION

810:15-15-1. Definitions

In addition to the terms defined in 85A O.S., § 2 and 810:15-1-2, the following words and terms, when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Medical fee dispute" means a dispute that involves an amount of payment for health or rehabilitation services, medicines or supplies rendered to an injured employee. "Medical fee dispute" includes a health care provider dispute of the denial or reduction by the insurance carrier of a bill for services. "Medical fee dispute" does not include disputes that involve an amount of payment for health care services rendered to an injured employee by a certified workplace medical plan or pursuant to a written contract between the insurance carrier and provider as provided in 85A O.S., § 55(B).

"Medical fee dispute resolution" or **"MFDR"** means a process for resolution of a medical fee dispute.

810:15-15-2. Payment of charges

(a) As provided in 85A O.S., 50(H), payment for medical care required by the AWCA is due within forty-five (45) days of receipt by the employer or insurance carrier of a complete and accurate invoice. The late payment of medical charges, absent good cause, may subject the employer or insurance carrier to a Commission ordered penalty of up to twenty-five percent (25%) of any amount due under the Oklahoma workers' compensation fee schedule that remains unpaid. The Commission also may assess a civil penalty of up to Five Thousand Dollars ($5,000.00) per occurrence if the Commission finds a pattern of an employer or insurance carrier willfully and knowingly delaying payments for medical care. Any such fines and penalties assessed under the AWCA, upon collection, shall be deposited to the Workers' Compensation Fund created in 85A O.S., § 28.

(b) Medical care provided as recommended by the ODG is presumed reasonable, and also is presumed to be health care reasonably required. In order for the insurance carrier to deny payment for medical services that are recommended by the ODG, the denial must be supported by clear and convincing medical evidence. A medical provider whose services exceed, are not recommended, or are not addressed by the ODG, must support the deviation from the ODG by clear and convincing medical evidence, in writing to the insurance carrier, as a condition of payment for services rendered. Resolution of medical fee disputes involving deviation from the ODG are governed by 810:15-15-4.

810:15-15-3. Medical dispute resolution of fee disputes

(a) **Applicability.** This Section applies to a request to the Commission for a medical fee dispute resolution (MFDR) pertaining to an injury sustained by an injured employee on and after February 1, 2014. Medical fee dispute resolution requests involving an injury occurring before February 1, 2014 shall be resolved in accordance with the statutes and rules applicable to the Oklahoma Workers' Compensation Court of Existing Claims.

(b) **Provider Request for MFDR.** Requests by a health care provider for MFDR shall be filed and processed in the form and manner prescribed in this Section.

(1) **MFDR Form 19.** A provider may initiate proceedings to address a medical fee dispute by filing a Commission prescribed MFDR Form 19 with the Commission. A copy of the form may be obtained from the Commission at its main offices, or from the Commission's website.

(2) **Request for hearing.** A provider may request a hearing for determination of the issues raised on the MFDR Form 19 by filing a request for hearing before an administrative law judge of the Commission as provided in 810:2-5-16. The provider shall send a copy of the request for hearing, together with a copy of the MFDR Form 19 and the records and supporting documentation required in Paragraph (4) of this Subsection, to the insurance carrier. The insurance carrier shall file a response to the MFDR Form 19 as provided in Paragraph (5) of this Subsection.

(3) **Contents of MFDR Form 19.** The health care provider's MFDR Form 19 shall include the following information, and such other information as may be required on the form, and shall be signed by the provider under penalty of perjury:

(A) the name, address, and contact information of the provider;

(B) the name of the injured employee;

(C) the date of injury;

(D) the date(s) of the service(s) in dispute;

(E) the place of service;

(F) the treatment or service code(s) in dispute;

(G) the amount billed by the health care provider for the treatment(s) or service(s) in dispute;

(H) the amount paid by the workers' compensation insurance carrier for the treatment(s) or service(s) in dispute;

(I) the disputed amount for each treatment or service in dispute;

(J) a statement of whether or not there is a final decision regarding compensability, extent of injury, liability and/or medical necessity for the health care related to the dispute; and

(K) a position statement of the disputed issue(s) which includes:

(i) the provider's reasoning for why the disputed fees should be paid,

(ii) a discussion of how the AWCA, Commission rules, and/or the Oklahoma workers' compensation fee schedule impacts the disputed fee issues, including reference to the specific general instruction, ground rule or other provision of the

Oklahoma workers' compensation fee schedule serving as the basis for the requested reimbursement, and

(iii) a discussion of how the submitted documentation supports the provider's position for each disputed fee issue.

(4) **Supplemental records and documentation.** The following records and documentation applicable to a provider's MFDR Form 19 shall be sent by the provider to the insurance carrier as provided in Paragraph (2) of this Subsection, but shall not be attached to the MFDR Form 19 when the form is filed with the Commission:

(A) a paper copy of all medical bills related to the dispute, as originally submitted to the insurance carrier;

(B) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider;

(C) a copy of all applicable medical records related to the dates of service in the dispute; and

(D) any other documentation that the provider deems applicable to the medical fee dispute.

(5) **Respondent response.**

(A) The insurance carrier shall respond to the MFDR Form 19 by filing a Commission prescribed MFDR Form 10M within thirty (30) days of the file-stamped date of the CC-Form-9 Request for Hearing filed by the provider. The response shall provide any missing information not provided by the health care provider and known to the respondent. The MFDR Form 10M shall include the following information, and such other information as may be required on the form, and shall be signed by the respondent under penalty of perjury:

(i) the name, address, and contact information of the respondent; and

(ii) a position statement of the disputed issue(s) which includes:

(I) the respondent's reasoning for why the disputed fees should not be paid,

(II) a discussion of how the AWCA, Commission rules, and/or the Oklahoma workers' compensation fee schedule impacts the disputed fee issues, including reference to the specific general instruction, ground rule or other provision of the Oklahoma workers' compensation fee schedule serving as the basis for the respondent's position, and

(III) a discussion of how the submitted documentation supports the respondent's position for each disputed fee issue.

(B) The respondent shall send the MFDR Form 10M, together with the following records and documentation applicable to the respondent's MFDR Form 10M, to the provider. The records and documentation shall not be attached to the MFDR Form 10M when the form is filed with the Commission:

(i) a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider, related to the health care in dispute not submitted by the health care provider, or a statement certifying that the respondent did not receive the health care provider's disputed billing before the MFDR Form 19 dispute request;

(ii) a paper copy of all medical bills related to the dispute, if different from that originally submitted to the insurance carrier for reimbursement; and

(iii) a copy of any pertinent medical records or other documents relevant to the fee dispute not already provided by the health care provider.

(6) **Determination of allowable amounts.**

(A) **Audits.** Audits of medical bills to determine the amount allowable under the appropriate Oklahoma workers' compensation fee schedule may be offered by each party. Audits prepared by billing review services, medical bill audit services or in-house auditors may be submitted as evidence reflecting the methodology of the application of the fee schedule. The fee schedule sets maximum amounts allowable but does not prohibit a party from asserting a lesser amount should be paid.

(B) **Referral to the Health Services Division.**

(i) The Commission, at its discretion, may refer medical fee disputes which involve conflicting interpretations of the Oklahoma workers' compensation fee schedule and a reduction by the insurance carrier of the provider's bill for health care services determined to be medically necessary and appropriate for the injured employee's compensable injury, to the Commission's Health Services Division for a recommendation regarding the maximum reimbursement amount allowed under the fee schedule for the services rendered.

(ii) Medical fee disputes involving the denial by an insurance carrier of a bill for services based on denial of compensability of the injured employee's injury or occupational disease, length of treatment, necessity of treatment, unauthorized physician or other ground, shall not be referred to the Division.

(7) **Hearing dockets.** MFDR Form 19 hearings shall be scheduled initially on an administrative docket to determine the payment status of the disputed medical fee charges. If the charges are not paid before the administrative hearing or the parties are unable to resolve the dispute at the administrative hearing, the dispute shall be set on the assigned administrative law judge's hearing docket.

(8) **Appearances.** Appearances at the administrative docket and before the administrative law judge or Commission are governed by 810:10-1-9.

(9) **Mediation.** Nothing in this Subchapter is intended to preclude resolution of medical fee disputes by mediation or agreement of the parties, as appropriate.

810:15-15-4. Other medical disputes

Medical disputes not otherwise addressed by this Subchapter, including, but not limited to, matters of medical necessity or appropriateness, requests by an injured employee for a refund or reimbursement for health care paid by the employee, and requests initiated by the employer or insurance carrier pursuant to 85A O.S., § 55 for a determination of the reasonableness of charges for appropriate and necessary medical services and supplies rendered to an injured employee with a compensable work-related injury, may be addressed by filing a request for hearing before an administrative law judge of the Commission as provided in 810:10-5-16, by mediation, or by agreement of the parties, as appropriate.

TITLE 810. OKLAHOMA WORKERS' COMPENSATION COMMISSION
CHAPTER 20. VOCATIONAL REHABILITATION SERVICES

810:20-1-1. Purpose

This Chapter implements provisions of the Administrative Workers' Compensation Act, 85A O.S., §§ 1, et seq., which relate to vocational rehabilitation services.

810:20-1-2. Definitions

In addition to the terms defined in 85A O.S., § 2, the following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"AWCA" means the Administrative Workers' Compensation Act, 85A O.S., §§ 1, et seq.

"Claimant" means a person who claims benefits for an alleged work injury, occupational disease or illness, or death pursuant to the provisions of the AWCA, 85A O.S., §§ 1, et seq.

"Commission" means the Oklahoma Workers' Compensation Commission, a designee, or an administrative law judge to whom the Commission has delegated responsibility as authorized by 85A O.S., § 21(D).

"Disabled" means rendered unable, as the result of a work-related injury, to perform work for which the person has previous training or experience.

"Gainful employment" means the capacity to perform employment for wages for a period of time that is not part-time, occasional or sporadic.

"Insurance carrier" means any stock company, mutual company, or reciprocal or interinsurance exchange authorized to write or carry on the business of workers' compensation insurance in this state, and includes an individual own risk employer or group self-insurance association duly authorized by the Commission to self fund its workers' compensation obligations.

"Pre-injury or equivalent job" means the job that the claimant was working for the employer at the time the injury occurred or any other employment offered by the claimant's employer that pays at least one hundred percent (100%) of the employee's average weekly wage.

"Vocational rehabilitation" means the process of restoring the vocational functioning of a worker who experiences a work-related injury.

"Vocational rehabilitation services" means professional services reasonably necessary during or after, or both during and after, medical treatment to enable a disabled injured employee to return to gainful employment as soon as practical. "Vocational rehabilitation services" includes vocational evaluation, retraining and job placement.

"Work-related injury" means a single event injury, cumulative trauma injury, or occupational injury or illness that arises out of and in the course of employment as provided in the AWCA.

810:20-1-3. Contested vocational rehabilitation cases

(a) If vocational rehabilitation services are not voluntarily offered by the employer or the insurance carrier, and accepted by the injured employee entitled to such services, the Commission, upon request or on its own motion, may refer the employee to a vocational rehabilitation evaluator for evaluation of the practicability of, need for, and kind of service or training necessary and appropriate to restore the employee to gainful employment.

(b) If, upon receipt of the evaluator's written report, the parties dispute the report or are unable to agree on a vocational rehabilitation plan recommended by the evaluator and commence the vocational rehabilitation services, they may attempt to resolve the dispute through mediation or forego mediation and proceed directly to a contested case hearing before the assigned administrative law judge. The administrative law judge, after notice and affording the parties an opportunity to be heard and offer evidence, may order that the services recommended by the evaluator, or such other vocational

rehabilitation services as deemed appropriate by the administrative law judge, be provided at the expense of the employer or insurance carrier.

(c) Contested hearings before the administrative law judge shall be conducted as provided in Subchapter 5 of Chapter 10 of this Title.

810:20-1-4. Vocational Rehabilitation Director

To carry out the vocational rehabilitation provisions of AWCA and this Chapter, the Commission shall hire or contract for a Vocational Rehabilitation Director to oversee the vocational rehabilitation program of the Commission and focus on helping injured workers return to the work force. The Commission may hire such additional personnel, within budgetary constraints, as may be deemed necessary to assist the Vocational Rehabilitation Director.

810:20-1-5. Registry of private providers of vocational rehabilitation services

(a) The Commission shall maintain a registry of private providers of vocational rehabilitation services.

(b) To request to be included in the registry, a private provider of vocational rehabilitation services shall submit a signed and completed Commission prescribed VRS Registry form to the following address: Oklahoma Workers' Compensation Commission, Attention: HEALTH SERVICES DIVISION, 1915 North Stiles Avenue, Oklahoma City, Oklahoma 73105. Illegible, incomplete or unsigned registry forms will not be considered by the Commission and shall be returned. A copy of the VRS Registry form may be obtained from the Commission at the address set forth in this Subsection, or from the Commission's website at http://www.wcc.ok.gov.

(c) The registrant shall provide the following information, and such other additional information as may be required on the VRS Registry form:

(1) the private provider's name, business name (if applicable), business address, telephone number, and e-mail address;

(2) information describing the evaluation, assessment, assistance, placement or support services available from the private provider;

(3) the locations where the private provider renders services;

(4) a statement showing the private provider's education, training, or experience in vocational rehabilitation;

(5) information regarding any experience or education concerning workers' compensation principles of the Oklahoma workers' compensation system; and

(6) the private provider's professional credentials [e.g. Certified Rehabilitation Counselor (CRC), Certified Vocational Evaluator (CVE), Certified Disability Management Specialist (CDMS)].

(d) The registry shall be placed on the Commission's website at http://www.wcc.ok.gov.

TITLE 810. OKLAHOMA WORKERS' COMPENSATION COMMISSION
CHAPTER 25. WORKERS' COMPENSATION INSURANCE AND SELF INSURANCE

SUBCHAPTER 1. GENERAL PROVISIONS

810:25-1-1. Purpose

This Chapter establishes procedures and standards for proof of coverage (85A O.S., § 42); regulation of individual own risk employers, group self-insurance associations and third-party administrators for workers' compensation purposes (85A O.S., §§ 22, 29, 38, 102 and 103); and enforcement of workers' compensation insurance requirements (85A O.S., § 40), as authorized in the Administrative Workers' Compensation Act, 85A O.S., §§ 1, et seq.

810:25-1-2. Definitions

In addition to the terms defined in 85A O.S., § 2, the following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Administrator" means the person designated by the supervisory board of members of a group self-insurance association to oversee the financial affairs of the association, accept service of process on behalf of the association, act for and bind the association and members in all transactions either relating to or arising out of the operation of the association.

"Advisory loss costs" means the National Council on Compensation Insurance's projections of future claims costs and loss adjustment expenses by classification code.

"Aggregate excess insurance" means an insurance product that limits a group self-insurance association's annual aggregate liability to an agreed upon amount.

"Association" or **"Group Self-Insurance Association"** means a duly qualified group self-insurance association authorized by the Commission to self fund its workers' compensation obligations.

"AWCA" means the Administrative Workers' Compensation Act, 85A O.S., §§ 1, et seq.

"Board" or **"Members' Supervisory Board"** means the supervisory board of members of an association.

"Cancellation short rate penalty" means a penalty imposed on the member for cancelling its policy before the expiration date of the policy.

"Certified audit" means a financial audit performed by a certified public accountant, accompanied by the auditor's opinion regarding the audit.

"Claims reserves" means workers' compensation claim losses expected to be paid in the future, but does not include IBNR.

"Commission" means the Oklahoma Workers' Compensation Commission, a designee, or an administrative law judge to whom the Commission has delegated responsibility as authorized by 85A O.S., § 21(D).

"Common interest" means employers engaged in the same industry or members of an Oklahoma trade association that has been in business for at least five (5) years.

"Expense constant" means a flat charge included in a workers' compensation policy to cover the costs of issuing and servicing the policy.

"Experience modifier" means a modification to premium based on the claims history of the policyholder.

"IBNR" means incurred but not reported reserves. It includes a reserve for claims that have been incurred, but not yet reported to the individual own risk employer or group self-insurance association, as applicable, and reserves for adverse loss development on known claims. "Incurred loss" means the total of the paid indemnity and medical losses plus claims reserves, reported by accident year.

"Joint and several liability" means mutual and individual responsibility of members for the liabilities of the association.

"Loss portfolio transfer" means the transfer of the liabilities of the association to an insurance carrier for an agreed upon premium.

"Member" means an individual member of an association.

"NCCI" means the National Council on Compensation Insurance, a national source for information on workers' compensation insurance, tools and services, and the provider of advisory ratemaking and statistical services in Oklahoma.

"Partnership" means a type of unincorporated business organization in which two or more individuals own the business and are equally liable for its debts.

"Pro forma financial statement" means a hypothetical financial statement showing revenues and expenses that may be recognized in the upcoming fiscal year.

"Proof of coverage" means the statutory filings of workers' compensation policy information to the NCCI.

"**Scopes Manual"** is a catalog of four-digit workers' compensation codes based on the nature of business and estimated risk to its workers.

"Self insured retention" means the individual own risk employer's or group self-insurance association's retained amount of risk under a specific excess insurance policy, before the liability is transferred to an insurance carrier.

"Sole proprietor" means an individual who is sole owner of a business that is neither a partnership nor an incorporated or limited liability company.

"Solvency" means a member whose assets are greater than its liabilities and who is capable of meeting its financial obligations to the association.

"Specific excess insurance" means an insurance product that limits the liability of an individual own risk employer or group self-insurance association specific occurrence liability to an agreed upon amount.

"Standard premium" means experience modified workers' compensation premium that has not been discounted.

"Statutory limits" means an insurance carrier's amount of liability under a specific excess insurance policy, capped at the maximum amount allowed by statute.

"TPA" or **"Third-Party Administrator"** means any person defined in 36 O.S., § 1442 of the Third-Party Administrator Act as an "administrator".

"Unearned premium" means the share of the members' premiums applicable to the unexpired portion of the policy terms.

810:25-1-3. Proceedings related to permit actions

The Commission may deny an application, refuse to issue or renew, or revoke a permit for Individual Own Risk Employer (Subchapter 9 of this Chapter), Group Self-Insurance Association (Subchapter 11 of this Chapter) or Third-Party Administrator (Subchapter 13 of this Chapter) as provided in this Chapter. Proceedings related to such Commission actions shall be governed by 810:10-5-50 on show cause hearings and the contested hearings rules set forth in Subchapter 5 of Chapter 10 of this Title.

SUBCHAPTER 3. PROOF OF COVERAGE

810:25-3-1. Proof of coverage requirements

(a) Any insurer issuing a policy to provide benefits pursuant to the AWCA, or group self-insurance association approved by the Commission, must report its statutorily required notices of insurance coverage and cancellation electronically with the Commission using the NCCI Proof of Coverage (POC) system. To do so, the insurer must elect with the NCCI to use the NCCI POC system, authorize the NCCI to make the

required filings on behalf of the insurer, and report its policy information, including, but not limited to, new and renewal policies, binders, cancellations, reinstatements, and endorsements, with the NCCI in accordance with NCCI reporting requirements for the State of Oklahoma.

(b) Compliance with 85A O.S., § 42(B) is required to effect cancellation of a workers' compensation insurance policy. Notice of intent to cancel provided to NCCI or to the Commission pursuant to 85A O.S., § 42(B) does not constitute service upon the insured employer of notice of intent to cancel.

(c) An insurer shall electronically file its cancellations with the NCCI, in lieu of mailing to the Commission. The date the cancellation is electronically received by the NCCI will constitute the beginning date for the ten and thirty day waiting periods referenced in 85A O.S., § 42(B)(2) for the cancellation to become effective.

(d) A policy must be reported to the NCCI no later than thirty (30) days after the effective date of the policy. Every named insured and covered location in the State of Oklahoma must be reported as well. The date the policy is first received by the NCCI will count as the received date for purposes of this deadline. For purposes of mid-year endorsements or jurisdictional additions to policies, the date the original policy was received by the NCCI will count as the received date for purposes of this deadline. Any insurer who fails to timely and accurately file their policies with the NCCI, shall be subject to a fine by the Commission of not more than One Thousand Dollars ($1,000.00) as determined by the Commission.

SUBCHAPTER 7. ENFORCEMENT OF WORKERS' COMPENSATION INSURANCE REQUIREMENTS

810:25-7-1. Proof of insurance

(a) Whenever the Commission has reason to believe that an employer is required to secure the payment of compensation under the AWCA and has failed to do so, the Commission may make reasonable inquiry of the employer and demand proof of current workers' compensation insurance coverage compliant with 85A O.S., § 38 or documentation substantiating the employer's exemption from coverage requirements.

(b) As authorized in 85A O.S., § 40, if no proof of insurance or exemption is provided; or the documentation offered does not substantiate a claimed exemption or is not current, valid proof of insurance in accordance with 85A O.S., § 38; or the employer fails to respond in a timely manner, the Commission shall serve on the employer a proposed judgment declaring the employer to be in violation of the workers' compensation insurance coverage requirements mandated by law and assess a monetary fine against the employer in an amount not to exceed One Thousand Dollars ($1,000.00) per day of violation.

810:25-7-2. Hearing process and consent agreements

(a) A proposed judgment issued under 810:25-7-1 may be contested by the employer as provided in 85A O.S., § 40, and is subject to a hearing process conducted pursuant to 85A O.S., § 70 through 78.

(b) An employer served with a proposed judgment, may waive its right to a contested hearing and execute a consent agreement with the Commission for a reduced penalty. The employer shall secure the payment of compensation within the meaning of 85A O.S., § 38 as a condition to executing a consent agreement. In determining the rate of reduction in penalty, consideration shall be given to the appropriateness of the penalty in light of the business of the employer charged, the gravity of the violation and the extent to which the employer charged has complied with the provisions of 85A O.S. § 38 or has otherwise attempted to remedy the consequences of the violation.

(c) The consent agreement becomes void if the employer defaults on payment under the agreement or if the agreement was obtained by fraud or misrepresentation of a material fact.

(d) The Commission may institute collection proceedings independently or in District Court, including, but not limited to, an asset hearing, garnishment of income and wages, judgment lien against personal and/or business properties, upon any penalties becoming final under the provisions of 85A O.S. § 40.

810:25-7-3. Interference of duty

No person shall interfere with, obstruct or hinder by force or otherwise, the Commission or its personnel while in the performance of their duties, or refuse to properly answer questions asked by the Commission or its personnel, pertaining to the Commission's enforcement of the workers' compensation insurance coverage requirements mandated by the AWCA.

810:25-7-4. Injunctive relief against a noncompliant employer

As authorized in 85A O.S., § 40, if an employer fails to comply with workers' compensation insurance coverage requirements or pay any civil penalty assessed against it after a judgment issued under 810:25-7-1 becomes final, the Commission may pursue relief in district court to enjoin the employer from engaging in further employment during the period of noncompliance.

SUBCHAPTER 9. INDIVIDUAL OWN RISK EMPLOYER PERMIT

810:25-9-1. Application for Individual Own Risk Employer Permit

(a) To request a permit to self fund its workers' compensation obligations as authorized in 85A O.S., § 38(A)(3), an employer shall:

(1) Submit a signed and completed Application for Individual Own Risk Employer Permit on a form prescribed by the Commission, together with all required supporting documentation and attachments completed in their entirety, at least sixty (60) days before the desired effective date of the permit, to the following address: Oklahoma Workers' Compensation Commission, Attention: INSURANCE DIVISION, 1915 North Stiles Avenue, Oklahoma City, Oklahoma 73105. The application shall be signed under penalty of perjury by an authorized representative of the employer. Illegible, incomplete or unsigned applications will not be considered and shall be returned. A copy of the application form may be obtained from the Commission at the address set forth in this Paragraph, or from the Commission's website;

(2) Pay to the Commission a nonrefundable application fee of One Thousand Dollars ($1,000.00) with the Application for Individual Own Risk Employer Permit;

(3) Submit its current audited financial statement or financial statement signed by two (2) company executives, including balance sheet, income statements and notes, and its financial statement for the previous year. Renewal applicants may request waiver of the requirement for financial statements;

(4) Submit the employer's most recent available interim financial statements; and

(5) Provide such additional records and information germane to the application as may be required by the Commission.

(b) The application shall be reviewed by the Commission's Insurance Division. If the application is determined to be sufficient, the Division will issue a permit licensing the applicant to carry its own risk without compensation insurance, for a period of one year. If the application is determined to be deficient, the Division will notify the applicant thereof, stating the reasons for the deficiency. If the deficiency cannot be resolved within the stated time frame from the Division, the application will be denied.

(c) An applicant may withdraw its pending Application for Individual Own Risk Employer Permit at any time. Once withdrawn, no further action regarding the application will be taken by the Commission and the Commission's file on the application request will be considered closed.

(d) The Commission's Insurance Division may extend or amend an existing permit, in its discretion, if necessary for the completion of a renewal application or a change in facts of the permit.

810:25-9-2. Minimum eligibility requirements

(a) Unless waived as provided in Subsection (b) of this Section and except for governmental entities subject to 810:25-9-11, to be eligible for an Individual Own Risk Employer Permit, the applicant must:

(1) have been continuously engaged in business for not less than three (3) years immediately preceding the Application for Individual Own Risk Employer Permit;

(2) have at least one hundred (100) employees (all states included); and

(3) have at least One Million Dollars ($1,000,000.00) in net assets.

(b) An applicant that does not satisfy the minimum eligibility requirements of Subsection (a) of this Section, may petition the Commission for a waiver of the requirements. The Commission may waive some or all of the requirements for good cause, subject to any security deposit and/or excess insurance requirements determined by the Commission to be appropriate should the permit be approved.

810:25-9-3. Financial information review

(a) Factors used to determine an applicant's financial ability to pay compensation to its employees include:

(1) Profit and loss history;

(2) Profitability, solvency, debt and liquidity ratios;

(3) Cash flow;

(4) Ratio of net worth to annual workers' compensation losses.

(5) Source and reliability of financial information;

(6) Excess insurance coverage;

(7) Number of employees;

(8) Workers' compensation loss history;

(9) Estimated manual premium; and

(10) Other relevant factors as determined by the Commission.

(b) An Application for Individual Own Risk Employer Permit may be denied if the employer cannot demonstrate its ability to pay its compensation obligations.

810:25-9-4. Security deposit

(a) As a condition to self fund its workers' compensation obligations, an employer approved as an individual own risk employer shall post acceptable security with the Commission, in such form and amount as determined by the Commission.

(b) Acceptable forms of security, are:

(1) An irrevocable letter of credit issued by a financial institution, whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). The financial institution must be approved in advance by the Commission. The letter of credit must be on a form prescribed by the Commission, include an automatic renewal clause, and cannot be non-renewed without at least sixty (60) days' prior written notice to the Commission. The letter of credit shall be made payable to the Commission. The Commission may make demand and collect on the posted letter of credit in whole or in part, in the case of actual or imminent default of the employer to pay compensation liabilities, or the cancellation of the letter of credit without an adequate replacement;

(2) A surety bond from an admitted or surplus lines insurer with an AM Best Rating of B+ or better, and on a form prescribed by the Commission; and

(3) Such other forms of security approved by the Commission.

(c) The amount of the security deposit shall be determined by the Commission after evaluating the financial ability of the individual own risk employer to pay its compensation and workers' compensation exposure. The determination may include consideration of a factor for IBNR for the prior claims' years and the permit year applied for. The Commission may require an actuarial report of estimated claims reserves

and IBNR from a Commission approved actuary. The minimum amount of the security required in Subsection (b)(1) or (b)(2) of this Section shall be the greater of:

(1) One Hundred Thousand Dollars ($100,000.00); or

(2) The employer's average yearly incurred workers' compensation losses for three (3) calendar or fiscal years immediately preceding the application date; or

(3) If the company is a renewal applicant, the amount of outstanding claims reserves for the employer, as determined by an approved third-party administrator or benefits administrator. Outstanding reserves submitted by an approved self-insured entity or organization must use a standardized approach to assessing future exposure. All future liabilities should be reserved to at least the "most probable outcome." The Commission defines "most probable outcome" as the expected amount of money to cover a claim based upon information known at the time of the report. An organization or entity that discounts either future indemnity or medical payouts based upon present value or a reduced life expectancy must identify said claims and acknowledge the potential future value.

(d) The security required of an individual own risk employer, and any proceeds thereof collected upon demand, including any interest thereon, shall be maintained by the Commission as provided in the AWCA until each claim for workers' compensation benefits is paid, settled or lapses under the AWCA, and costs of administration of those claims are paid, or until the security is released by the Commission as provided in 810:25-9-19.

810:25-9-5. Renewals

The criteria for renewal of an individual own risk employer permit shall be the same as that for a new applicant.

810:25-9-6. Effectiveness of previously authorized permits, security deposits and guaranties

(a) Individual own risk employer permits previously authorized by the Workers' Compensation Court Administrator pursuant to 85 O.S., § 351 and in effect on January 31, 2014 shall remain in full force and effect for the duration of the permit term thereafter, unless voluntarily terminated by the own risk employer or revoked by the Commission.

(b) All security deposits and parental guaranties posted by an individual own risk employer with the Workers' Compensation Court Administrator pursuant to 85 O. S., § 351 before February 1, 2014 as a condition for the own risk employer to self fund its workers' compensation obligations, which are maintained by the Court Administrator and in effect on January 31, 2014, shall remain in full force and effect, pursuant to their respective terms, on and after February 1, 2014, notwithstanding assumption by the Commission of the Court Administrator's regulatory responsibilities regarding individual own risk employers beginning February 1, 2014. At that time, the Commission shall be considered the successor entity to the Workers' Compensation Court Administrator in all respects regarding the security deposit and parental guaranty, with full power and authority in its own name to make demand and collect thereon in the same manner and to the same extent as and if the Commission were the Court Administrator. The Commission may require an individual own risk employer to post an adequate replacement security deposit or parental guaranty, or both, made payable to the Commission.

810:25-9-7. Claims administration

An individual own risk employer must use a third-party administrator licensed by the Commission, or an in-house benefits administrator approved by the Commission, to adjust its workers' compensation claims. The in-house benefits administrator must hold a current and unrestricted workers' compensation adjuster license for the State of Oklahoma.

810:25-9-8. Excess insurance

The Commission may require an individual own risk employer to provide proof of excess coverage with such terms and conditions as is commensurate with the employer's ability to pay the benefits required by the provisions of the AWCA. Such excess insurance must be from an admitted or surplus lines insurer with an AM Best Rating of B+ or better. The self insured retention must be approved by the Commission, and the excess carrier's limits of liability must be statutory. An amount less than statutory limits must be approved in advance by the Commission. Aggregate excess insurance may be required by the Commission if necessary.

810:25-9-9. Additional named insureds

(a) Subsidiaries, subdivisions, and affiliated employers may be included on the individual own risk employer permit as additional named insureds. A schedule listing the additional employers' names, addresses and federal employer identification numbers (FEIN) must be submitted. The additional employers' workers' compensation losses, payroll and employee counts must be aggregated with the primary permit holder and included on the application. A guaranty from the primary permit holder for these additional employers must be submitted in accordance with 810:25-9-10.

(b) A subsidiary may apply for a separate individual own risk employer permit from its parent company if desired, but must meet all qualifications of this Subchapter.

810:25-9-10. Parental guaranty

(a) A parental guaranty, on a form approved by the Commission, must be submitted for any additional named insured included on the permit.

(b) If the individual own risk employer has a parent company that is not included on the permit, and the employer is relying on its parent company's financial statements to apply, then a parental guaranty, on a form approved by the Commission, must be submitted from the parent company for its subsidiary.

810:25-9-11. Governmental entities

(a) Governmental entities may carry their own risk without insurance as provided in 85A O.S. § 107. They must apply using the same application form as private employers, and submit the same required documents, with the exception of interim financial statements. Governmental entities will be exempted from posting a security deposit if they make an appropriation into a segregated workers' compensation fund. The amount of the appropriation must be at least the entity's average amount of workers' compensation losses paid during the preceding three (3) years.

(b) Certain public trust employers will be required to post a security deposit in lieu of an appropriation. The Commission will make this determination at the time of application review.

810:25-9-12. Interim monitoring

An individual own risk employer may be placed on quarterly reporting by the Commission for purposes of monitoring its financial condition and workers' compensation loss history. Companies on quarterly reporting shall submit financial statements and loss runs to the Commission within sixty (60) days after the end of each of their fiscal quarters. An adjustment in the individual own risk employer's security deposit may be required after the Commission reviews the quarterly results.

810:25-9-13. Notification of changed status

(a) An individual own risk employer must notify the Commission of any change in its financial condition or ownership in the interim period between applications, such as a net financial loss, which may impact the employer's financial ability to pay its compensation. Failure to notify the Commission in a timely manner may result in revocation of the own risk permit. If there is a change in majority ownership of an individual

own risk employer, the own risk privilege granted to the employer shall be at the discretion of the Commission and the new entity shall be required to qualify under this Subchapter.

(b) The Commission reserves the right to audit any insureds that they have determined a concern exists with an insureds ability to meet its financial obligations. These audits will focus on the reserve estimates and ensure that all claims are reserved to at least the "most probable outcome". The Commission defines "most probable outcome" as the expected amount of money to cover a claim based upon information known at the time of the report. The costs of these audits will be borne by the individual own risk employer and/or association.

810:25-9-14. Revocation of permit

(a) The individual own risk employer permit may be revoked by the Commission at any time upon reasonable notice and hearing, for good cause shown, including, but not limited to, failure to comply with the rules of the Commission; failure to pay compensation when due; and financial impairment of the employer which has or will bring the employer below the minimum net worth requirement of 810:25-9-2.

(b) The employer is expected to secure its workers' compensation obligations at all times as provided by law, notwithstanding the revocation. Failure to do so may subject the employer to sanctions pursuant to 85A O.S., § 40 and enforcement proceedings as provided in Subchapter 7 of this Chapter.

810:25-9-15. Assessments

An individual own risk employer must pay all applicable Multiple Injury Trust Fund assessments (85A O.S., § 31) and all Self Insurance Guaranty Fund assessments (85A O.S., § 98), when due and timely report payment thereof to the Commission as prescribed by law. Failure to do so is grounds for revocation of the individual own risk employer permit, imposition of fines by the Commission, or both revocation and fines.

810:25-9-16. Medicare reporting

An individual own risk employer shall comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), including all MMSEA workers' compensation reporting requirements, to the extent and as provided by Federal law.

810:25-9-17. Designation of service agent

An individual own risk employer must designate a service agent to receive service of notice. The designation must be on a form prescribed by the Commission and filed with the Commission as provided in 810:10-1-11.

810:25-9-18. Former own risk employers; continuing requirements

(a) A former individual own risk employer remains responsible for:

(1) Paying all workers' compensation obligations incurred during its period as an approved individual own risk employer;

(2) Reporting its workers' compensation losses on an annual basis to the Commission, on a form prescribed by the Commission;

(3) Paying Self Insurance Guaranty Fund assessments as provided in 85A O.S., § 98; and

(4) Maintaining an adequate security deposit with the Commission.

(b) A former individual own risk employer is not liable for Multiple Injury Trust Fund assessments for periods beyond the last quarter in which it was an active own risk employer.

810:25-9-19. Release of security deposit

(a) A security deposit posted with the Commission as required by 810:25-9-4 must remain in place, at its existing amount, for two years after an individual own risk employer voluntarily leaves self-insurance.

The Commission may review the adequacy or excess of the security deposit in advance of the own risk permit termination date and require modifications to the security deposit amount as necessary.

(b) A security deposit may be reduced at the Commission's discretion after the two year waiting period upon application by the employer and submission of current financial statements and workers' compensation loss runs.

(c) A security deposit may be released at the Commission's discretion upon application by the employer and submission of current financial statements and a signed and notarized affidavit, from a duly authorized officer of the employer, affirming that all workers' compensation claims incurred under the own risk permit of the employer have been permanently closed, and the statute of repose for reopening the claims has passed.

(d) The security deposit shall be released in full by the Commission within a reasonable period following receipt of proof of an assumption agreement or equivalent, from a licensed insurance carrier, whereby the claims liability under the individual own risk employer permit is transferred to and assumed by the insurance company. The assumption agreement or equivalent may be entered into before expiration of the two year waiting period provided in Subsection (a) of this Section.

SUBCHAPTER 11. GROUP SELF-INSURANCE ASSOCIATION PERMIT

810:25-11-1. Application

(a) Two or more employers having a common interest, as defined in Section 810:25-1-2, may be approved by the Commission as a group self-insurance association for the purpose of entering into agreements to pool their liabilities under the AWCA. Such application shall be made on a form prescribed by the Commission and shall be verified by the oath of at least two members of the board or the administrator.

(b) The application shall be reviewed by the Commission's Insurance Division. If the application is determined to be sufficient, the Division will issue a permit licensing the applicant to act as a group self-insurance association, for a period of one year. If the application is determined to be deficient, the Division will notify the applicant thereof, stating the reasons for the deficiency. If the deficiency cannot be resolved within the stated time frame from the Division, the application will be denied.

(c) The association's application may be approved if the Commission has satisfactory proof of:

(1) The solvency of each member of the association;

(2) The financial ability of each employer to meet its obligations as a member;

(3) The ability of the association to pay or cause to be paid the compensation in the amount and manner and when due as provided in the AWCA;

(4) A minimum collective net worth of the members of at least Two Million Dollars ($2,000,000.00);

(5) Standard premium of Five Hundred Thousand Dollars ($500,000.00) at the start up date of the association; and

(6) The common interest of the members as defined in 810:25-1-2.

(d) Any application so approved shall be subject to all conditions and requirements of this Subchapter. In order to determine continued compliance with the law and this Subchapter, the application shall be reviewed on an annual basis or whenever deemed necessary by the Commission.

(e) An applicant may withdraw its pending Application for Group Self-Insurance Association Permit at any time. Once withdrawn, no further action regarding the application will be taken by the Commission and the Commission's file on the application request will be considered closed.

(f) The Commission's Insurance Division may extend or amend an existing permit, in its discretion, if necessary for the completion of a renewal application or a change in facts of the permit.

810:25-11-2. Additional application requirements

The Application for Group Self-Insurance Association Permit provided for in 810:25-11-1 shall be submitted at least sixty (60) days before the desired effective date, bound in a hardcover notebook, and accompanied by all of the following:

(1) A One Thousand Dollar ($1,000.00) nonrefundable application fee, made payable to the Commission;

(2) A sample of the members' indemnity agreement and power of attorney, as required by 810:25-11-15, binding the association and each member thereof, jointly and severally, to comply with the provisions of the AWCA;

(3) An executed copy of the application of each employer for membership in the association. The application must be on a form approved by the Commission, include an indemnity agreement and power of attorney executed by the employer, a joint and several liability agreement executed by the employer, and a current balance sheet;

(4) A pro forma financial statement of the association, showing the estimated revenues and expense the first fiscal year of the association;

(5) A statement of the collective net worth of the members of the association;

(6) The estimated standard and discounted premium each association member will pay during the first fiscal year of the association;

(7) A listing of the type, amount and eligibility requirements of discounts available for the association members;

(8) Projected expenses for the association for the first fiscal year, in dollar amount and a percentage of the standard premium to be generated;

(9) Specific and aggregate excess insurance binders for the first fiscal year;

(10) Underwriting guidelines that will be used by the association;

(11) A copy of the association's bylaws and any other governing instruments of the proposed association;

(12) A designation of the initial members' supervisory board and of the administrator of the association, including properly executed biographical affidavits for each;

(13) The name and contact information of the association's TPA, including a copy of the contract between the association and the TPA;

(14) A copy of all fidelity bonds and errors and omissions policies secured by the association, its administrator, its TPA, and other organizations providing services;

(15) Copies of all marketing materials to be utilized by the association;

(16) If the TPA does not provide safety, marketing, underwriting, or accounting services, the name or names of the organization or organizations who will, and a copy of the contract between the association and these organizations;

(17) A designation of the association's auditing and actuarial firms; and

(18) A list of workers' compensation rates to be charged to its members, broken down by classification code. The rates should be calculated in accordance with 810:25-11-8.

810:25-11-3. Approval of new members of the association

A new membership may not become effective without Commission approval. All applications for membership, in a form approved by the Commission, shall be filed with the Commission. The application shall include evidence of the execution of the indemnity agreement, power of attorney, and joint and several liability agreement, as required by 810:25-11-15, with signed approval of the applicant by the association, and shall be accompanied by a current balance sheet and income statement of the association and the applicant. The Commission shall approve new members upon finding that the applicant is solvent,

that the applicant has the financial ability to meet its obligations as a member, and proof that the applicant is in compliance with the legal requirements specified in this subchapter.

810:25-11-4. Investment and reserve requirements

(a) The members' supervisory board of an association may, in its discretion, invest its funds in either of the following investments:

(1) Savings accounts or certificates of deposit in a Federal Deposit Insurance Corporation (FDIC) insured institution; or

(2) Direct obligations of the United States Treasury, either as notes, bonds, or bills that are backed by the full faith and credit of the United States Government.

(b) An association shall maintain unearned premium and claims reserves computed in a matter acceptable to the Commission.

810:25-11-5. Financial and related reports

(a) On or before the one hundred twentieth (120) day after the end of its fiscal year, every association shall file a certified audit of its annual financial condition prepared by a certified public accountant acceptable to the Commission. Audits must include a complete breakdown of all monies collected by the association, including the amount discounted and a complete breakdown of expenses. The audit should footnote and analyze completely all paid claims and claims reserved but not reported. A footnote must also be included to indicate if payments to contracted parties are in accordance with current contracts.

(b) An interim financial statement shall be filed sixty (60) days following the midyear fiscal anniversary of the association. This statement need not be audited, but should reflect pertinent data regarding income, claims reserves and IBNR, standard premium, discounts, interest earned, expense constant fees, as well as a breakdown of the association's expenses.

(c) An actuarial report of the association's estimated reserves must be filed with the certified financial audit required in Subsection (a) of this Section. The reserves recommended by the actuarial report must be used by the association. If the actuary gives a range of reserves, the association should use the midrange or higher. The actuary completing the report should be a member in good standing with the Casualty Actuarial Society.

810:25-11-6. Excess insurance

(a) A group self-insurance association must obtain specific and aggregate excess insurance from an admitted or surplus lines insurer with an AM Best Rating of B+ or better. The self insured retention must be approved by the Commission and the excess carrier's limits of liability must be statutory. An amount less than statutory limits must be approved in advance by the Commission. The attachment point of the aggregate excess insurance should not exceed one hundred percent (100%) of an association's estimated standard premium, unless authorized by the Commission.

(b) The policy required in Subsection (a) of this Section must not be terminable for any reason except upon thirty (30) days' written notice by certified mail or overnight courier to the Commission and the association.

(c) Copies of the complete policy required by Subsection (a) of this Section must be filed with the Commission.

(d) Under certain conditions, an irrevocable letter of credit may be presented in lieu of aggregate excess insurance. The form and amount of the letter of credit must be approved by the Commission.

(e) Two or more group self-insurance associations may pool together to purchase aggregate excess insurance, upon application and approval of the Commission and the excess carrier.

810:25-11-7. Operating expenses

The maximum operating expenses of the association should not exceed thirty-three percent (33%) of the standard premium. These expenses include the following:

(1) Administrator's fee;
(2) TPA fee;
(3) Marketing fees, billing and collection fees, and sales commissions;
(4) General operating expenses, including audits and actuarial reports;
(5) Cost of excess insurance; and
(6) Any other fees approved by the Commission.

810:25-11-8. Rates, experience modifications, and discounts

(a) All workers' compensation rates to be charged to its members must be approved in advance by the Commission. The rates should be based on the latest advisory loss costs provided by the National Council on Compensation Insurance (NCCI), must be actuarially certified, and must be sufficient to cover the association's estimated losses and expenses for the upcoming year. The actuary's report must accompany the rate request to the Commission. The actuary must be a member in good standing with the Casualty Actuarial Society.

(b) Experience modifiers for the members must be promulgated by the NCCI an annual basis.

(c) All premium discounts must be approved by the Commission. The aggregate of all discounts allowed to a member cannot exceed twenty-five percent (25%) of the member's standard premium. Types of acceptable discounts include:

(1) Prompt Pay;
(2) Safety program;
(3) Premium volume;
(4) Experience rated; and
(5) Other discounts approved by the Commission.

(d) Changes in discounts must be approved by the Commission.

810:25-11-9. Premium deposits

On the association's effective date, the premium deposit of at least twenty-five percent (25%) of the first year's discounted premium payable by each member of the association, shall have been paid into a designated depository, which shall certify receipt of same to the Commission. The balance of the first year's premium shall be paid, either in quarterly or monthly installments at the discretion of the board, no later than the end of the ninth month of the association's fiscal year. For subsequent years, the board of each association shall determine the amount of advance deposit required, or if the deposit shall remain permanent, with distribution only after termination of the membership and all premium audits and adjustments completed, and all premiums due paid in full. The Commission may require an association to make its deposits permanent.

810:25-11-10. Surplus distributions

(a) Any surplus monies may be declared refundable by the board, and the amount of such declaration shall be a fixed liability of the association at the time of the declaration. The date and manner of the distribution shall be declared by the board. The manner of the distribution shall be in accordance with the association's bylaws. The board shall submit the distribution request to the Commission, with all supporting documents. The payment of any distribution shall not be made without Commission approval.

(b) The following distribution guidelines shall apply:

(1) Distributions from profitable years can be assigned to unprofitable years;

(2) Full and final distributions of all surplus remaining for a particular year cannot be made until all claims incurred during that year are permanently closed;

(3) Distributions will not be approved if the association has an overall deficit, or the distribution will place the association in an overall deficit; and

(4) Distributions shall be made in a equitable manner as provided in the association's bylaws.

810:25-11-11. Deficits and assessments

(a) If the association incurs a deficit for a particular year, the board must address the issue with the Commission. If the loss is significant, the board may be required to increase rates or to reduce expenses and discounts to return the group to profitability. If the cumulative net worth of the association is in a deficit position, the board may be required to assess its membership to make up the deficit. If an assessment is made, it shall be done in an equitable manner in accordance with the association's bylaws.

(b) The following assessment guidelines shall apply:

(1) Assessments must be declared by the board, and approved by the Commission. On the date the declaration is made, the assessment can be recorded as a receivable on the association's financial statements;

(2) A member cannot be assessed for a deficit in a fiscal year it was not a member;

(3) The assessment can be payable over a thirty-six (36) month period, or shorter time frame, if desired by the board or required by the Commission; and

(4) Any member who does not pay its assessment when due, shall be cancelled from the group with ten (10) days' notice to the member and the Commission.

810:25-11-12. Renewal applications

(a) An application for renewal of a group self-insurance association permit shall be submitted at least sixty (60) days before the expiration date of the existing permit, bound in a hardcover notebook, and accompanied by all of the following:

(1) A One Thousand Dollar ($1,000.00) nonrefundable application fee, made payable to the Commission;

(2) A sample of the members' indemnity agreement and power of attorney, as required by 810:25-11-15, binding the association and each member thereof, jointly and severally, to comply with the provisions of the AWCA;

(3) A copy of the association's current audited financial statements, unaudited midyear statements, and all current actuarial reports;

(4) An attestation from the administrator or board that the collective net worth of the members of the association exceeds Two Million Dollars ($2,000,000.00);

(5) The estimated standard and discounted premium each association member will pay during the next fiscal year of the association;

(6) A listing of the type, amount and eligibility requirements of discounts available for the association members, including scheduled discounts;

(7) Projected expenses for the association for the next fiscal year, in dollar amount and a percentage of the standard premium to be generated;

(8) Specific and aggregate excess insurance binders for the next fiscal year, and copies of the policies for the current year;

(9) Underwriting guidelines that are used by the association;

(10) A copy of the association's bylaws and any other governing instrument;

(11) A designation of the members' supervisory board and of the administrator of the association;

(12) The name and contact information of the association's TPA, including a copy of the contract between the association and the TPA;

(13) A copy of all fidelity bonds and errors and omissions policies secured by the association, its administrator, its TPA, and other organizations providing services;

(14) Copies of all marketing materials utilized by the association;

(15) If the TPA does not provide safety, marketing, underwriting, or accounting services, the name or names of the organization or organization who does, and a copy of the contract between the association and these organizations;

(16) A list of workers' compensation rates to be charged to its members, broken down by classification code. The rates should be calculated in accordance with 810:25-11-8;

(17) Copies of the minutes of all board meetings held during the current year;

(18) A report of the premiums paid and losses incurred by each member of the association during the current fiscal year;

(19) Affidavit from the chairman of the board that the association is and has been in full compliance with the rules of the Commission during the current fiscal year;

(20) Confirmation of proof of coverage filings made with the NCCI; and

(21) A listing of investments currently held by the association.

(b) The renewal application shall be reviewed and processed by the Commission in the same manner as the original application.

810:25-11-13. Security deposit

A group self-insurance association may be required to post an irrevocable letter of credit with the Commission, in an amount determined by the Commission. The actual amount of the letter of credit will be determined by the Commission after evaluating the financial status of the association, including the following:

(1) The association's available surplus;

(2) The gap between the amount of premium estimated to be collected and the attachment point of the aggregate excess insurance policy; and

(3) The financial strength of the collective membership.

810:25-11-14. Letter of credit requirements

(a) An irrevocable letter of credit authorized pursuant to 810:25-11-6 or required pursuant to 810:25-11-13 must be issued by a state or national chartered bank, whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). The bank must be approved in advance by the Commission. The letter of credit must be on a form prescribed by the Commission, include an automatic renewal clause, and cannot be non-renewed without sixty (60) days' prior written notice to the Commission. The letter of credit shall be made payable to the Commission. The Commission may make demand and collect on the posted letter of credit in whole or in part, in the case of actual or imminent default of the association to pay compensation liabilities, or the cancellation of the letter of credit without an adequate replacement.

(b) All letters of credit referenced in Subsection (a) of this Section, and any proceeds thereof collected upon demand, including any interest thereon, shall be maintained by the Commission as provided in the AWCA until each claim for workers' compensation benefits is paid, settled or lapses under the AWCA, and costs of administration of those claims are paid, or until otherwise released by the Commission.

810:25-11-15. Indemnity agreements and power of attorney

(a) Every member of a group self-insurance association shall execute an indemnity agreement and power of attorney which shall set forth the rights, privileges and obligations of the member and the

association and the powers and duties of the administrator. Such indemnity agreement and power of attorney shall be subject to the approval of the Commission and shall contain in substance the following:

(1) An agreement on a form approved by the Commission, under which each member agrees to assume and discharge, jointly and severally, liability under the AWCA of any and all employers party to such agreement;

(2) Provisions requiring that the members' supervisory board designate and appoint an administrator empowered to accept service of process on behalf of the association and authorized to act for and bind the association and members in all transactions either relating to or arising out of the operation of the association;

(3) Provisions for the right of substitution of the administrator and revocation of the power of attorney and right hereunder; and

(4) Provisions that clearly state all of the coverages of the policy.

(b) One copy of the indemnity agreement and power of attorney shall remain in the member's possession at the time the application for membership is made. One copy must be filed with the Commission.

(c) An affidavit of acknowledgment of joint and several liability, on a form approved by the Commission, must accompany the indemnity agreement and power of attorney, one copy shall remain with the member, and one copy must be filed with the Commission.

810:25-11-16. Administrator

The members' supervisory board must designate an administrator to administer the financial affairs of the association, who shall furnish a fidelity bond with the association as obligee, in amount sufficient to protect the association against the misappropriation or misuse of any monies or securities. The amount of the bond shall be determined by the Commission and evidence of such shall be filed with the Commission.

810:25-11-17. Third-party administration

(a) The association must contract with a third party to provide claims adjusting, underwriting, industrial safety engineering, marketing and accounting functions. More than one organization can be contracted with to provide these services. The company providing the claims adjusting and marketing must be licensed by the Commission.

(b) All copies of contracts between the association and any organization providing services to association shall be filed with the Commission. Any change in contract must be filed with the Commission ten (10) days' before the effective date.

(c) Any contract with a TPA for claims adjusting must state the TPA agrees to handle all claims incurred to their conclusion, unless approval to transfer the claims is obtained from the Commission before such transfer.

(d) A company providing marketing services to a self-insurance program must be approved by the Commission's Insurance Division. The company requesting approval must submit to the Commission's Insurance Division all marketing material prior to being utilized by an association.

810:25-11-18. Termination of members

A member of an association may not be terminated unless at least ten (10) days' written notice has been given to the member and the Commission if the termination is due to nonpayment of premium or assessment. If the cancellation is for other reasons, then the member may not be terminated unless at least thirty (30) days' written notice is given to the member and the Commission.

810:25-11-19. Revocation

(a) The group self-insurance association permit may be revoked by the Commission at any time upon reasonable notice and hearing, for good cause shown, including, but not limited to, failure to comply with the rules of the Commission; failure to pay compensation when due; and financial impairment of the association which has or will make the association insolvent. The association will be given forty five (45) days to cancel its members and for the members to obtain alternative workers' compensation coverage authorized by law.

(b) The association's members are expected to secure their workers' compensation obligations at all times as provided by law, notwithstanding the revocation. Failure to do so may subject the member to sanctions pursuant to 85A O.S., § 40 and enforcement proceedings as provided in Subchapter 7 of this Chapter.

810:25-11-20. Examination of association

Whenever the Commission deems it expedient for the protection of the interests of the people of the State of Oklahoma, it may make or direct to be made an examination into the affairs of any association, member, marketing firm, or TPA approved in the State of Oklahoma.

810:25-11-21. Responsibilities of members' supervisory board

(a) The members' supervisory board shall be responsible for holding and managing the assets and directing the affairs of an association and shall be elected in the manner prescribed by the association's governing instruments. All board members must be members of the association. A board member shall not be an owner, officer, or employee of any entity under contract with the association.

(b) The board shall supervise the finances of the association and the association's operations to such extent as may be necessary to assure conformity with this Subchapter, the members' indemnity agreement and power of attorney, and the association's governing instruments. The members' supervisory board shall take all necessary precautions to safeguard the assets of the association, including, but not limited to the following:

(1) Monitoring the financial condition of each member of the association, and doing all other acts to the extent necessary to assure that each member continues to be able to fulfill the obligations of membership. The board shall promptly report to the Commission any grounds for believing that either a change in any member's financial condition, withdrawal of a member, or any other circumstances might affect the association's ability to meet its obligations;

(2) Retaining control of all monies either collected or disbursed by and for the association. All loss funds of any type shall remain in the custody of the board or the authorized administration; provided, however, if a revolving fund is established for payment of compensation due, and other related expenses, for the use of any authorized TPA, the TPA shall furnish a fidelity bond covering its employees, with the association as obligee, in an amount sufficient to protect all monies placed in the revolving fund;

(3) Having the accounts and records of the association audited annually or at any time the Commission deems necessary. The Commission may prescribe a uniform accounting system to be used by group self-insurance associations and/or TPAs and the type of audits to be made in order that it may determine the solvency of the association. Copies of the audit shall be filed with the Commission within one hundred twenty (120) days after the close of the fiscal year. An association's fiscal year may not be changed without prior Commission approval;

(4) Active efforts to collect delinquent accounts resulting from any unpaid premiums by members. Any member of an association who fails to pay the required premiums after due notice shall be ineligible for the self-insurance privilege until such past due account, including cost of collection, has been paid;

(5) The members' supervisory board shall hire legal counsel when deemed to be necessary to represent the membership in contested workers' compensation matters. Board members will be responsible for monitoring fees paid to legal counsel;

(6) Neither the members' supervisory board nor the administrator shall utilize any of the monies collected as premiums for anything unrelated to the purposes of the group self-insurance association, to workers' compensation, or to securing the members' liability under the AWCA. Furthermore, they shall be prohibited from borrowing any monies from the association without advising the Commission of the nature and purpose of the loan and obtaining the Commission's approval. The board may, at its discretion, invest its funds in accordance with 810:25-11-4;

(7) The members' supervisory board shall assure that the administrator of the association and all records necessary to verify the accuracy and completeness of records submitted to the Commission, are maintained at a central location within the State of Oklahoma;

(8) The members' supervisory board and the Commission should be notified in writing of all disputes regarding proper rate classification codes. The Commission may appoint a professional to review the Scopes Manual to determine the applicable classification code. The expense of the professional service will be paid for by the association;

(9) The members' supervisory board shall notify the Commission at least ten (10) days before all board meetings. Copies of the minutes of all board meetings shall be submitted to the Commission within thirty (30) days of the date of the meeting;

(10) The Commission must be notified within ten (10) days of any change in the association's board. Any new board member must submit to the Commission a properly executed biographical affidavit; and

(11) The members' supervisory board may designate a marketing firm or individuals to market the association's program. The marketer or marketers of an association's program must be either licensed insurance agents in the State of Oklahoma, or approved by the Commission. All marketing materials must be submitted to the Commission before being utilized by an association. Each sales interview must include a clear presentation of a proposed member's joint and several liability.

810:25-11-22. Miscellaneous operating guidelines

(a) The assets of a group self-insurance association and control thereof are property of the members under the direction of its supervisory board members.

(b) The association's standard premium by the end of its first fiscal year and for all subsequent fiscal years shall not be less than One Million Dollars ($1,000,000.00);

(c) Any change in the bylaws and/or contracts with the association must be filed promptly with the Commission.

(d) Any false or misleading solicitation of membership in the group self-insurance association may be cause for cancellation of approval of the TPA, marketing organization, and the group self-insurance association as a whole.

(e) Any recalculation of premium, due to experience modification, cannot be retroactive more than one hundred eighty (180) days.

(f) A cancellation short rate penalty may not be changed if the member has been a member of the association at least twelve (12) months before the cancellation.

(g) Any trade membership dues must be collected separate from the group self-insurance association. Services provided by the trade association must be fully explained to members joining the trade association.

(h) A separate safety program may not be sold to a member by a marketer of the association.

(i) At least ninety percent (90%) of all expense constant fees collected shall be deposited directly into the association's general revenues. No portion of these fees may be paid to any group or individual contracted with the association in an amount greater than that of the normal sales commission allowed.

(j) All billing and receiving will be supervised and reviewed by the TPA and the administrator of the association. All monies must be deposited promptly in the association's designated Oklahoma depository account.
(k) Wrongfully changing employee classification codes or rates are grounds for immediate revocation of the approval of the TPA, marketing organization, and the group self-insurance association as a whole.
(l) The members' supervisory board can be reimbursed its travel and incidental expenses incurred during its services as a member of the board. Board members may not be paid a salary. (m) A group self-insurance association shall comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), including all MMSEA workers' compensation reporting requirements, to the extent and as provided by Federal law.

810:25-11-23. Winding down of association's affairs
(a) The members' supervisory board, the administrator, and the TPA shall remain in place if the association relinquishes its approval, and shall wind down the affairs of the association. A change in board membership, administrator, or TPA, must be approved by the Commission.
(b) A loss portfolio transfer or equivalent may be obtained by the association to transfer its liability to a licensed insurance company.
(c) Annual financial statements, as required in 810:25-11-5, will still be required once an association relinquishes its approval, unless otherwise approved by the Commission.
(d) Distributions of surplus, as referenced in 810:25-11-10, may be made upon application to the Commission. A full and final release of all funds from the association will not be allowed absent compliance with the criteria specified in 85A O.S., § 102(B).

810:25-11-24. Effectiveness of previously authorized permits and security deposits
(a) Group self-insurance association permits previously authorized by the Workers' Compensation Court Administrator pursuant to 85 O.S., § 351 and in effect on January 31, 2014 shall remain in full force and effect for the duration of the permit term thereafter, unless voluntarily terminated by the association or revoked by the Commission.
(b) All security deposits posted by a group self-insurance association with the Workers' Compensation Court Administrator pursuant to 85 O. S., § 351 before February 1, 2014 as a condition for the association to self fund its workers' compensation obligations, which are maintained by the Court Administrator and in effect on January 31, 2014, shall remain in full force and effect, pursuant to their respective terms, on and after February 1, 2014, notwithstanding assumption by the Commission of the Court Administrator's regulatory responsibilities regarding group self-insurance associations beginning February 1, 2014. At that time, the Commission shall be considered the successor entity to the Workers' Compensation Court Administrator in all respects regarding the security deposit, with full power and authority in its own name to make demand and collect thereon in the same manner and to the same extent as and if the Commission were the Court Administrator. The Commission may require a group self-insurance association to post an adequate replacement security deposit, made payable to the Commission.

SUBCHAPTER 13. THIRD-PARTY ADMINISTRATOR PERMIT FOR WORKERS' COMPENSATION PURPOSES

810:25-13-1. Application
(a) Any person desiring authorization to act as a TPA for workers' compensation purposes shall make application on a form prescribed by the Commission. The application must be completed in its entirety, including all attachments and supporting documents required in the application, and submitted at least thirty (30) days before the desired effective date of the permit. A One Thousand Dollar ($1,000.00) nonrefundable application fee, made payable to the Commission, must be submitted with the application.

The applicant must receive approval from the Commission before contracting with any client to provide administrative services for Oklahoma workers' compensation self-insurers.

(b) The application shall be reviewed by the Commission's Insurance Division. If the application is determined to be sufficient, the Division will issue a permit licensing the applicant as a Third-Party Administrator, for a period of one year. If the application is determined to be deficient, the Division will notify the applicant thereof, stating the reasons for the deficiency. If the deficiency cannot be resolved within the stated time from the Division, the application will be denied.

(c) An applicant may withdraw its pending Application for approval as a TPA for workers' compensation purposes at any time. Once withdrawn, no further action regarding the application will be taken by the Commission and the Commission's file on the application request will be considered closed.

(d) The Commission's Insurance Division may extend or amend an existing permit, in its discretion, if necessary for the completion of a renewal application or a change in facts of the permit.

810:25-13-2. Renewals

The criteria for renewal of a TPA permit shall be the same as that for a new applicant.

810:25-13-3. Termination or revocation of authority

(a) Any TPA may surrender its authority to act as a TPA for workers' compensation purposes by notifying the Commission in writing of the effective date of the surrender.

(b) The TPA permit may be revoked by the Commission at any time upon reasonable notice for good cause shown, including, but not limited to, failure to comply with the rules of the Commission.

810:25-13-4. Operating requirements

The TPA must:

(1) Have adequate personnel on staff to handle the volume and type of work. The TPA may subcontract for services not provided by the TPA, but requested from the self-insurer;

(2) Be financially solvent, and must report its financial statements on an annual basis to the Commission in an approved form and manner;

(3) Maintain an adequate Errors and Omissions policy;

(4) Maintain an adequate Fidelity Bond;

(5) Establish claims reserves at the most likely outcome. Best case reserving is not allowed.

(6) Undergo a triennial audit of its claims handling, claims reserving, and internal controls, by independent professionals;

(7) Retain its independence when setting claim reserves. The TPA shall not let the self-insurer influence the amount of the reserve or the closing of a claim;

(8) Maintain an Oklahoma office, if handling a group self-insurance association program; and

(9) Maintain adequate computerized records and paper claims files on each claim. A copy of this information must be made available for the Commission's review at all times upon request.