

**TITLE 810. OKLAHOMA WORKERS' COMPENSATION COMMISSION
EMERGENCY RULES as approved by the Commission 1/16/2014**

CHAPTER 3 - Medical Services

Subchapter 1 - General Provisions

Section 810:3-1-1 Purpose

Section 810:3-1-2 Definitions

810:3-1-1. 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.

810:3-1-2. 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:

- (1) Certified Disability Management Specialist (CDMS);
- (2) Certified Case Manager (CCM);
- (3) Certified Rehabilitation Registered Nurse (CRRN);
- (4) Case Manager - Certified (CMC);
- (5) Certified Occupational Health Nurse (COHN); or
- (6) 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.

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

- (1) 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;
- (2) any compound drug;
- (3) 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
- (4) drugs that are not preferred, exceed or are not addressed by the ODG in effect on the date of treatment.

“**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).

“**Compounding**” means the preparation, mixing, assembling, packaging, or labeling of a

drug or device:

- (1) as a result of a practitioner's prescription drug order based on the practitioner-patient-pharmacist relationship in the course of professional practice;
- (2) 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;
- (3) in anticipation of a prescription drug order based on a routine, regularly observed prescribing pattern; or
- (4) 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:

- (1) placing the patient's health or bodily functions in serious jeopardy; or
- (2) serious dysfunction of any body organ or part.

"Nonprescription drug or over-the-counter medication" 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.

"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:

- (1) a substance for which federal or state law requires a prescription before the substance may be legally dispensed to the public;
- (2) 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
- (3) 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:

- (1) the injured employee’s full name;
- (2) date of injury;
- (3) the last four digits of the injured employee’s social security number;
- (4) diagnosis code(s);
- (5) 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
- (6) 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.

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Subchapter 3 - Workers’ Compensation Fee Schedule

Section 810:3-3-1 Purpose

Section 810:3-3-2 Applicability of 2012 workers’ compensation fee schedule

810:3-3-1. 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.

810:3-3-2. 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>.

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Subchapter 5 - Pharmaceutical Benefits

Section 810:3-5-1	Pharmaceutical services
Section 810:3-5-2	Closed formulary
Section 810:3-5-3	Requirements for use of closed formulary

810:3-5-1. 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).

810:3-5-2. Closed formulary

The Commission hereby adopts a closed formulary as defined in 810:3-1-2 for workers' compensation claims with a date of injury on and after February 1, 2014.

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

(a) **Applicability.** The closed formulary adopted pursuant to 810:3-5-2 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 seventy-two (72) hours, 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 810:3-7-1 relating to treatment guidelines. Prescription and nonprescription drugs included in the Commission's closed formulary may be prescribed and dispensed without preauthorization.

CHAPTER 3 - Medical Services

Subchapter 7 - Treatment guidelines

Section 810:3-7-1 Treatment guidelines

810:3-7-1. 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>.

CHAPTER 3 - Medical Services

Subchapter 9 - Independent Medical Examiners

Section 810:3-9-1	Qualifications
Section 810:3-9-2	Application and appointment process
Section 810:3-9-3	Revocation
Section 810:3-9-4	Requests for assignment
Section 810:3-9-5	Fees and costs
Section 810:3-9-6	Renewal process

810:3-9-1. 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;
- (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.

810:3-9-2. 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 810:3-9-5;

(G) submit to a review pursuant to 810:3-9-3 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 810:3-9-1;

(I) notify the Commission in writing upon any change affecting the physician's qualifications as provided in 810:3-9-1; 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.

810:3-9-3. 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 810:3-9-1; 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 810:2-5-50 on show cause hearings and the contested hearings rules set forth in Subchapter 5 of Chapter 2 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.

810:3-9-4. 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.

810:3-9-5. 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 810:2-5-16, or by mediation, as appropriate.

810:3-9-6. 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 810:3-9-1 and 810:3-9-2. 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.

CHAPTER 3 - Medical Services

Subchapter 11 - Medical Case Management

Section 810:3-11-1	Qualifications
Section 810:3-11-2	Application and appointment process
Section 810:3-11-3	Revocation
Section 810:3-11-4	Requests for assignment
Section 810:3-11-5	Renewal process

810:3-11-1. 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.

810:3-11-2. 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 810:3-11-1; 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.

810:3-11-3. 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 810:3-11-1; 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 810:2-5-50 on show cause hearings and the contested hearings rules set forth in Subchapter 5 of Chapter 2 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.

810:3-11-4. 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 810:2-5-16, or by mediation, as appropriate.

810:3-11-5. 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 810:3-11-1 and 810:3-11-2. 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.

CHAPTER 3 - Medical Services

Subchapter 13 - Change of Treating Physician

Section 810:3-13-1 Scope

Section 810:3-13-2 Change of physician; no certified workplace medical plan

810:3-13-1. 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.

810:3-13-2. 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.

CHAPTER 3 - Medical Services

Subchapter 15 - Medical Dispute Resolution

Section 810:3-15-1 Definitions

Section 810:3-15-2 Payment of charges

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

Section 810:3-15-4 Other medical disputes

810:3-15-1. Definitions

In addition to the terms defined in 85A O.S., §2 and 810:3-1-2, the following words and terms, when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

“Medical fee dispute resolution” or “MFDR” means a process for resolution of a medical fee dispute.

“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).

810:3-15-2. 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 810:3-15-4.

810:3-15-3. 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. Proceedings under this section must be initiated within one (1) year of the date the services were rendered which are the subject of the dispute. This limitation is jurisdictional and cannot be waived or tolled by the Commission.

(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 810:2-1-9.

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

810:3-15-4. 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 810:2-5-16, by mediation, or by agreement of the parties, as appropriate.