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STATE OF OKLAHOMA

**WORKERS' COMPENSATION
COMMISSION**

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**TITLE 810. OKLAHOMA WORKERS' COMPENSATION
COMMISSION**

EMERGENCY ADMINISTRATIVE RULES

Summary of Comments and Responses of the Commission

This summary is intended to provide information to the public regarding the process that the Commission used to finalize the language of the emergency rules. This is not an exhaustive description of every comment received; rather, it represents a breakdown of the major areas of concern that were brought to the Commission, and a description of the reasoning behind the subsequent amendments which were made to the draft rules, in order to produce the final version adopted by the Commission.

The Commission would like to remind the reader that these are emergency rules, enacted so that the Commission can begin work on February 1, 2014. Sometime within the next 12-18 months, the Commission will be promulgating permanent rules which will replace these emergency rules. The Commission welcomes input from all interested parties during the lead-up to the permanent rulemaking process. Your feedback is important to us as we continue to fulfill our statutory mandate.

The Commission would like to thank those individuals and organizations who submitted written comments, as well as those who attended the public hearing on January 2, 2014. The input we received from the business, insurance, medical, and legal communities is invaluable as we embark on our mission of operating a system that is efficient, user-friendly, and beneficial to all parties who will make use of it.

I. Changes made as a result of public comments received

Chapter 1

No public comments were received for Chapter 1.

Chapter 2

A definition of “good cause” was added to provide guidance for administrative law judges in interpreting rule provisions that use the term.

Language regarding “knowledge, information, and belief” was removed from Rule 2-1-7; the language was deemed superfluous.

Several commenters requested that the Commission allow non-lawyer representatives to appear before the Commission on behalf of corporations, LLCs, insurers, group self-insurance associations, and own-risk employers. This is now authorized. The Commission will maintain a list of approved representatives, along with credentials showing full settlement authority. Non-lawyer representatives will be held to the same standards of conduct as attorneys, and will be expected to follow the same rules of procedure. If this privilege is abused, the Commission may remove persons from the approved list, or in the future may decide to revoke this provision in its entirety.

Counselors were added to the rule against *ex parte* communication, to avoid excessive entanglement of the counselor program with the ALJs and to avoid the appearance of impropriety.

The distance required for mileage reimbursement for employee medical care was increased to 40 miles, and the meal reimbursement rate was increased, to better reflect reality.

Rule 2-5-46 regarding permanent impairment was cleaned up and brought in line with the statute. Deviations from the AMA Guides must be supported by clear and convincing evidence.

Rule 2-5-52 regarding disqualification of ALJs was changed to require a showing of good cause.

The rules for appeals to the Commission en banc have been simplified and the time frames shortened.

Chapter 3

The Commission estimates that close to 70 percent of the public comments received were related to the rules of Chapter 3 regarding medical services. This is

understandable, as the bulk of the cost of the current Workers' Compensation system is derived from the cost of delivering health care to injured workers, and to administering the medical claims process. The mandate of the new Title 85A is to reduce costs and streamline the claims process, while still offering injured employees the full range of services that they need.

With the foregoing in mind, the Commission diligently reviewed and discussed the various options that the commenters presented. The Commission believes that the final version of Chapter 3 strikes the best balance between the needs of injured workers and the desires of employers and insurance carriers for simplicity and cost savings.

Closed formulary – the formulary has been further defined. All compound drugs are now excluded and will require preauthorization to trigger reimbursement by the employer or insurance carrier. In addition, drugs that are not preferred or addressed by the ODG, or that exceed the ODG, are not included in the formulary.

The transition period between the open and closed formulary has been eliminated. It was pointed out during the comment period that the transition period would introduce more confusion into the pharmacy claims process, and that the transition may not even be permitted under the Act. The Closed Formulary will instead be effective for injuries occurring on or after February 1, 2014.

The provisions for medical interlocutory orders have been removed. The preauthorization process should address the vast majority of off-formulary prescription requests. If an odd situation should arise where preauthorization is not possible, and a medical emergency exists, the Commission will handle it on an *ad hoc* basis. Failure to request preauthorization entitles the insurance carrier or employer to deny payment. There is also a 72 hour time window; if the carrier or employer fails to respond within that period, the preauthorization request is deemed approved.

Preauthorization is now clearly defined as limited to an evaluation of the medical necessity and reasonableness of the prescription; issues of liability and compensability should not be addressed for purposes of preauthorization. Also, the insurance carrier is now only required to send an Explanation of Benefits to the employee if it denies payment based on medical necessity or reasonableness.

IMEs – The requirements for certification as an Independent Medical Examiner have been strengthened. This change is designed to ensure that IMEs approved by the Commission have the necessary knowledge and competency to evaluate workplace injuries.

Rule 3-13-2 regarding change of treating physician has been amended to conform to the Act. Several commenters pointed out that the previous language did not conform.

ODG – The Commission was asked by many commenters to make it clear that the Official Disability Guidelines were to be followed in all cases unless there was a compelling reason not to do so. As such, the rules now state that medical care provided under the ODG is presumed reasonable, and that presumption can only be overcome by clear and convincing evidence. Conversely, deviations from the ODG must also be supported by clear and convincing evidence. The Commission believes that this evidentiary standard provides all parties with as much certainty and predictability as possible in the provision of health care to injured workers. In addition, the Commission has implemented a 1 year limitation period for medical fee disputes.

Chapter 4

Section 4-1-3 was deleted and the remaining sections renumbered. It was pointed out during the comment period that this section may be overbroad in its scope, going beyond what the statute authorizes.

Chapter 5

Several changes were made to make it easier for small businesses to self-insure, including relaxing the requirements for financial security and excess insurance. These provisions will increase the number of employers eligible to self-insure, while maintaining Commission oversight and review. In addition to public comments received, the Oklahoma Insurance Department was consulted on these changes.

A request was received to reduce the length of time for surplus distributions by group self-insurance associations; the relevant section was amended.

II. Responses to other comments

Several interested parties requested that the Commission provide remote online access to case files, documents, and other information. The Commission intends to explore this issue, as well as the implementation of a comprehensive on-line filing and case management system, in the near future. At the current time the Commission does not have the resources to address this request in the context of the Emergency Rules.

There were several commenters that suggested more involvement for Independent Medical Examiners in the pre-hearing and hearing process. The Commission intends to streamline the hearing process as much as possible, and artificially introducing additional witnesses or evidence, which may not be needed in all cases, would be counterproductive to this goal.

There was some concern about the cost and practicality of the explanation of benefit requirements when preauthorization for medication is denied. The Commission

believes that these concerns, while valid, are somewhat speculative at this point. With the adoption of the closed formulary rules it becomes important to notify the patient and treating physician of the denial and the reason for it in a timely manner, so that alternate treatment can be prescribed without delay.

Several commenters requested that the Commission clarify whether the use of proprietary medication management tools will be permitted. The Commission would prefer to study this issue before issuing regulations. It therefore has not been included in the emergency rulemaking process. There were other minor issues of clarification which will be addressed in the future, when the Commission considers the initial set of permanent rules.

One commenter asked for clarification of the rules on when TTD can be terminated, and the process for filing a claim for compensation. The Commission believes that the Act, read in conjunction with the rules, provides sufficient guidance in these areas.

A number of comments were received requesting clarification or changes as to how the Commission will handle attorney fee disputes. The Commission would prefer to see how the system works under the emergency rules as written, before considering further changes down the line.

III. Changes authored by the Commission

Several changes were suggested by the Commissioners themselves. Aside from correction of scrivener's errors and clarification of terminology to avoid ambiguity, these changes primarily revolved around reducing costs and increasing efficiency of the claims process, and ensuring compliance with the statute.

The Commission does not plan to issue Certificates of Non-Coverage at this time. The Commission will study the issue and determine the best way to address the status of contractors and sole proprietors in the future. For this reason, the language related to CNCs has been deleted from the final version.

Several changes were made to reduce the requirements to use certified mail. This is a cost saving measure. Service of documents will be governed by 12 O.S. § 2005(B), which allows for service by regular mail, and electronic mail. The Commission may still use certified mail on an as-needed basis.

The requirement that all proceedings be recorded stenographically has been removed. This is also a cost saving measure. Instead, an audio recording will be made of all proceedings before ALJs, and a digital copy will be provided to all parties at no charge. Any party may request that the audio recording be transcribed, or that a court reporter be present at the proceeding. The party making such request shall be responsible for the cost.

In order to avoid entanglement between the Executive and Judicial branches which could be problematic, the Commission will review appeals from the Court of Existing Claims for procedural deficiencies only. If an appeal is to be decided on the merits, it will be summarily affirmed and sent to the Supreme Court.