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~~ Commission 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.

810:10-1-5. 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 CC-Form-2A Employer's Intent to Controvert Claim form with the Commission. To be timely, the employer must file the ~~Employer's Intent to Controvert Claim~~ CC-Form-2A 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~~ filing of a CC-Form-2A-Extension Employer's Application and Authorization for Extension of Time to File CC-Form-2A form with the Commission. 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~~ CC-Form-2A 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.

810:10-5-5. Review of adverse benefit determination by qualified employers

(a) **Request for review.** 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) **Proceedings for review.** 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. The matter shall be set for oral argument before the Commission en banc or the assigned Administrative Law Judge in accordance with Part 10 of this Subchapter.

(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 record established by the employer's internal appeal process.~~ **Written arguments.** 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 Administrative Law Judge and 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.

(1) The employee shall have twenty (20) days after the filing of the CC-Form-211 within which to file an original and four (4) copies of the written argument with the Commission, with a copy served on the qualified employer.

(2) The qualified employer 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 employee. The qualified employer's written argument shall be accompanied by an appendix, firmly bound and indexed, that includes two-sided copies of the employer's benefit plan and the complete administrative record established by the internal appeal process.

~~(d) Discovery related to a claim for review under this section shall be governed by Rule 810:10-5-31(c)-(d).~~

810:10-5-7. 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~~ employer and shall have a certificate of service setting forth the manner of such service as required by 810:10-1-7. The employer may respond to the CC-Form-3C by timely filing an executed Commission prescribed CC-Form-10C Employer's Response to Claim for Workers' Compensation Discrimination or Retaliation pursuant to 810:10-5-15.

(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.

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 discrimination or retaliation, 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, CC-Form-10C, 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, CC-Form-10C, 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, CC-Form-10C, or MFDR Form 10M, or shall be waived. No reply to the CC-Form-10, CC-Form-10C, 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, CC-Form-10C, or MFDR Form 10M no later than thirty (30) days after the filing of the CC-Form-9. The CC-Form-10, CC-Form-10C, 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~~The CC-Form-9,~~ and the~~ CC-Form-10, CC-Form-10C, ~~or~~ and 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.

810:10-5-45. 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. If the claimant's failure to appear for the scheduled examination was without good cause, the Commission shall order the claimant to reimburse the respondent for payment of the physician's charge for the missed examination, but not in excess of Two Hundred Dollars ($200.00).

(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 the rate of Fifteen Dollars ($15.00) per meal per four hours of travel status, not to exceed three meals per day.

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~~ in accordance with (i) of this Section; 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.

(i) **Designation of record**. A designation of record shall be filed by the appealing party and a copy submitted to the court reporter and all other parties in the case concurrently with or before filing a Request for Review in all actions which are appealed to the Commission en banc. The cost of preparing the transcript shall be advanced immediately by the designating party. The transcript shall be prepared and sent to all parties to the appeal within forty-five (45) days from the date the designation of record is filed.

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

(a) **Enforcement**. 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.

(b) **Certification of Awards.** An application for an order directing certification to district court of any workers' compensation award may be heard after notice to the respondent and insurance carrier has been given at least ten (10) days before the scheduled trial thereon. At such trial the respondent and insurance carrier shall be afforded an opportunity to show good cause why the application should not be granted.

PART 10. PRACTICE AND PROCEDURE FOR THE REVIEW OF ADVERSE BENEFIT DETERMINATIONS UNDER THE OKLAHOMA EMPLOYEE INJURY BENEFIT ACT

810:10-5-72. Authority of the Commission; jurisdiction

(a) **Authority.** The Commission has adjudicative authority to render decisions in individual proceedings by claimants that have exhausted the remedies afforded by a qualified employer's benefit plan in accordance with 85A O.S. §211.

(b) **Jurisdiction.** The jurisdiction of the Commission, for the purposes of this Section, shall be invoked only

upon the timely filing of a CC-Form-211 Request for Review of Adverse Benefit Determination upon exhaustion of the internal appeals process of a benefit plan under the Oklahoma Employee Injury Benefit Act in accordance with 810:10-5-5.

810:10-5-73. Commission proceedings for review of adverse benefit determinations

(a) **Description of proceedings and standard of review.** The law in effect on the date of injury controls the substantive rights of the parties in review proceedings before the Commission.

(1) With respect to injuries occurring before November 1, 2015, de novo review proceedings shall be held before the Commission en banc in accordance with Subsection (c).

(2) With respect to injuries occurring on or after November 1, 2015, de novo review proceedings shall be held before an Administrative Law Judge in accordance with Subsection (d).

(3) Procedures related to written arguments in review proceedings before an Administrative Law Judge and the Commission en banc shall be governed by 810:10-5-5.

(b) **Oral arguments**. Oral arguments shall be limited to ten (10) minutes per side, unless the time is enlarged by leave of the Commission en banc or the assigned Administrative Law Judge. 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.

(c) **Proceedings for review by the Commission en banc**. Requests for review involving dates of injury occurring before November 1, 2015 shall be set for oral argument before the Commission en banc.

(1) The review of an adverse benefit determination by the Commission en banc shall be on the record established by the internal appeal process of the employer's benefit plan.

(2) After hearing oral arguments and reviewing the written arguments and record, the Commission en banc may:

(A) affirm the decision of the internal appeals committee;

(B) reverse the decision of the internal appeals committee;

(C) modify the decision of the internal appeals committee;

(D) remand the case for further proceedings; or

(E) take other action as the Commission en banc deems appropriate.

(d) **Proceedings for review by Administrative Law Judge**. Requests for review of claims involving dates of injury occurring on or after November 1, 2015 shall be assigned to an Administrative Law Judge for de novo review pursuant to 85A O.S. §211(B)(5).

(1) The review of an adverse benefit determination by the Administrative Law Judge shall be on the record established by the internal appeal process of the employer's benefit plan.

(2) After hearing oral arguments and reviewing the written arguments and record, the Administrative Law Judge may:

(A) affirm the decision of the internal appeals committee;

(B) reverse the decision of the internal appeals committee;

(C) modify the decision of the internal appeals committee;

(D) remand the case for further proceedings; or

(E) take other action as the Administrative Law Judge deems appropriate.

(e) **Appeal from the decision of Administrative Law Judge.** Any party aggrieved by the decision, judgment or award of the Administrative Law Judge may appeal to the Commission en banc within ten (10) days of the file-stamped date on the order. Review by the Commission en banc shall be on the record of the internal appeal process, written and oral arguments before the Administrative Law Judge, and the decision of the Administrative Law Judge. Proceedings shall be governed by 810:10-5-66(c) through (f).

(1) After hearing oral argument and reviewing the record and written arguments, the Commission en banc may:

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

(B) reverse the decision of the Administrative Law Judge;

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

(D) remand the case for further proceedings; or

(E) take other action as the Commission en banc deems appropriate.

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

(f) **Appeal from the decision of the Commission en banc.** Any party aggrieved by the decision, judgment or award of the Commission en banc may appeal to the Oklahoma Supreme Court within twenty (20) days of the file-stamped date of order issued by the Commission en banc.

810:15-1-2. Definitions

…

"Evaluation and management" means medical services including office visits, examinations, referrals and similar services as set forth in the 2012 fee schedule.

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. [See also 810:15-5-3 (relating to the Commission's adoption of a closed formulary) and 810:15-7-2 (relating to urine drug screening guidelines)].

(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.

810:15-3-3. Reimbursement for Evaluation and Management services

The reimbursement rate for Evaluation and Management services shall be no less than one hundred fifty percent (150%) of the Medicare Fee Schedule, in accordance with 85A O.S. §50(H)(3)(b).

810:15-3-4. Allowable reimbursement for advanced practice registered nurses

A certified advanced practice registered nurse shall be allowed eighty-five percent (85%) of the fee schedule allowance for Evaluation and Management services and other services performed within the advanced practice registered nurse's license and certification, subject to the conditions and procedures set forth in General Ground Rule 13 of the 2012 fee schedule.

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.

(f) **Appeals process for drugs excluded from the closed formulary**

(1) For situations in which the prescribing doctor determines and documents that a drug excluded from the closed formulary is medically necessary to treat an injured employee's compensable injury and has prescribed the drug, the prescribing doctor, other requestor, or injured employee must request approval of the drug by requesting preauthorization from the insurance carrier, or pursuant to the preauthorization requirements of a certified workplace medical plan, if the claim is subject to the plan.

(2) If preauthorization is requested by an injured employee or a requestor other than the prescribing doctor, and the injured employee or other requestor requests a statement of medical necessity, the prescribing doctor shall provide a statement of medical necessity as set forth in Subsection (e) of 810:15-5-1 to facilitate the preauthorization submission.

(3) If preauthorization for a drug excluded from the closed formulary is denied, the requestor may request a hearing before an administrative law judge of the Commission by filing a CC-Form-9 as provided in 810:10-5-16.

(4) In the event of an unreasonable risk of a medical emergency, an interlocutory order may be obtained in accordance with 810:15-5-4.

810:15-7-2. Controlled substance monitoring and drugs of abuse testing

One presumptive drug test is allowable at each individual office visit for chronic pain management. Definitive drug testing following a suspected abnormality on the presumptive drug test is permissible for not more than forty (40) individual definitive drug tests every twelve (12 months).

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. A physician may receive not more than Four Hundred Dollars

($400.00) in advance in order to schedule a deposition. The advance payment shall be applied against amounts owed for testimony fees.

(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.

810:25-1-2. 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:

…

"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.

"**Incurred loss**" means the total of the paid indemnity and medical losses plus claims reserves, reported by accident year.

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 for the two previous fiscal years, including balance sheet, statement of income statements, statement of cash flows and notes, and its financial statement for the previous year. If audited financial statements are unavailable, submit its financial statement for the two previous fiscal years signed by two (2) company executives, including balance sheet, statement of income, statement of cash flows and notes Renewal applicants may request waiver of the requirement for financial statements;

(4) Submit the employer's most recent available interim financial statements, including balance sheet, statement of income and statement of cash flows, in GAAP format; and

(5) ~~Provide such additional records and information germane to the application as may be required by the Commission.~~Submit a pro forma financial statement of the employer, showing the estimated revenues and expense for the remainder of the current fiscal year and for the next fiscal year; and

(6) 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.

810:25-9-7. 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. An out-of-state employer may request waiver of the license requirement for an in-house benefit administrator.

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~~ yearly workers' compensation losses paid for three (3) calendar or fiscal years immediately preceding the application date.

(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.

810:25-11-2. 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;~~ and include the following:

(A) An indemnity agreement and power of attorney executed by the employer;
(B) A joint and several liability agreement executed by the employer;
(C) The employer's current audited financial statement for the two previous fiscal years, including a balance sheet, statement of income, statement of cash flows, and notes;
(D) If audited financial statements are not available, the employer should provide the employer's financial statement for the two previous years signed by two (2) company executives, including a balance sheet, statement of income, statement of cash flows and notes;
(E) A balance sheet, income statement, and statement of cash flows for the current fiscal year; and
(F) A pro forma financial statement, showing the estimated revenues and expense for the remainder of the current fiscal year and the next fiscal year;

(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) 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.~~

(b) 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:

(1) The employer's current audited financial statement for the previous fiscal year, if available, including balance sheet, statement of income, statement of cash flows and notes;

(2) A balance sheet, income statement and statement of cash flows for the current fiscal year;

(3) A pro forma financial statement, showing the estimated revenues and expense for the next twelve months; and

(4) The estimated standard and discounted premium the applicant will pay during the period between the application and the association's renewal.

(c) The application will be reviewed by the Commission's Insurance Division. If the application is determined to be sufficient, the application will be approved. The application may be approved if the Commission has satisfactory proof of:

(1) The solvency of the applicant;

(2) The financial ability of the applicant to meet its obligations as a member; and

(3) A common interest with other members of the association, as defined in 810:25-1-2.