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

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

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

(b) **Composition.** The Commission is comprised of three members who are appointed by the Governor and confirmed by the Senate for staggered terms. The initial appointments are for two (2), four (4) and six (6) years respectively, as determined by the Governor. Subsequent terms are for six (6) years. One of the initial appointments must be from a list of three (3) nominees selected by the Speaker of the Oklahoma House of Representatives. The Chair of the Commission is appointed by the Governor from among the Commission members. The Chair organizes, directs and develops administrative work, employs administrative staff within budgetary limitations, and performs other duties authorized by law or prescribed by the Commission. The Chair appoints an administrator who is the administrative officer of the Commission and manages the activities of its employees and performs other duties prescribed by the Chair or Commission. The title of the administrative officer shall be Executive Director. The Commission may appoint as many Administrative Law Judges and other personnel as necessary within budgetary limitations to effectuate the AWCA.

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

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

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

SUBCHAPTER 1. GENERAL PROVISIONS

810:10-1-3. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Pro se" means without an attorney.

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

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

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

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

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

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

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

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

(1) be typewritten or printed legibly on ~~8 2" by 11"~~8 ½" by 11" paper, unless electronically filed;

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

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

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

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

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

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

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

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

(1) is not signed, it shall be stricken unless it is signed promptly after the omission is called

to the attention of the pleader or movant; or

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

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

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

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

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

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

~~(b) A corporation, limited liability company, insurance carrier, individual own risk employer, and group self-insurance association, may appear only by its attorney, or by a designated representative with full settlement authority.~~

~~(c) Any entity listed in subsection (b), which desires to appear by non-lawyer representative, must submit the credentials of the designated representative to the Commission in advance of the representative's first appearance at a Commission proceeding. The Commission will maintain a record of the representative's credentials to facilitate subsequent appearances.~~

~~(d) Representatives attempting to appear without complying with subsection (c) will not be allowed to proceed on behalf of their respective party. Authorization to appear as a non-lawyer representative is a privilege which may be withdrawn at any time. Non-lawyer representatives shall be held to the same ethical standards as attorneys of record in Commission proceedings, and are expected to be familiar with and follow the rules of this Chapter. Misuse or abuse of this privilege with the intent of harassment or delay may result in sanctions being imposed against the representatives and/or parties involved.~~

~~(e) Individuals may appear pro se at any time.~~

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

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

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

(a) Each insurance carrier, as defined in 810:10-1-3, shall designate a single agent for service of notice by filing a Designation of Service Agent form with the Commission. A copy of the form may be

obtained from the Commission at its main offices, or from the Commission's website.

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

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

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

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

~~(4) President and Chief Executive Officer of CompSource Oklahoma, if the insurer is CompSource Oklahoma; or~~

~~(5)~~(4) service agent on file with the Oklahoma Secretary of State, if the insurer is a domestic insurance carrier.

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

810:10-1-12. Prohibited communications

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

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

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

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

(2) The following communications are permitted communications:

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

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

(C) Communication with a Commission appointed medical case manager concerning

light duty issues consistent with the physician's restrictions;

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

(E) Communication between Commission appointed professionals.

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

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

SUBCHAPTER 3. INFORMAL DISPUTE RESOLUTION PROCESSES

810:10-3-3. Counselor program

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

(b) A Division counselor shall:

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

(2) investigate complaints;

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

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

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

(c) Notice of the availability of the services of the counselor program and of the availability of mediation and other forms of alternative dispute resolution to assist injured workers shall be mailed to the injured worker within ten (10) days of the filing of the Employer's First Notice of Injury as provided in 810:10-1-4. Information about the counselor program and the availability of alternative dispute resolution also shall be made part of the Commission's training materials for self-insurers and claims representatives handling Oklahoma workers' compensation claims.

810:10-3-5. Preliminary conferences

~~(a) Pursuant to 85A O.S. § 70, the Counselor Division is directed to:~~

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

~~(2) facilitate informal dispute resolution and settlement of workers' compensation claims and issues through preliminary conferences, called Mediation Conferences.~~

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

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

(2) narrow and define the disputed issues;

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

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

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

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

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

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

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

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

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

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

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

The mediator:

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

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

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

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

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

(6) immediately following conclusion of mediation proceedings, report the results of the

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

SUBCHAPTER 5. HEARINGS CONDUCTED BY ADMINISTRATIVE LAW JUDGES AND COMMISSIONERS

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

810:10-5-2. Claim for compensation

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

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

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

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

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

(c) Within ten (10) days of the filing of a claim for compensation (i.e. CC-Form-3, CC-Form-3A or CC-Form-3B), the Commission shall mail or send electronically a copy of the claim form bearing the assigned file number to the service agent designated by the self-insured employer, group self-insurance association, or insurance carrier ~~or CompSource Oklahoma as provided in 810:10-1-11~~, or as otherwise directed in that Section.

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

~~(a) A claim for review of a qualified employer's adverse benefit determination pursuant to the Oklahoma Employee Injury Benefit Act, 85A O.S.§ 211, may be commenced by filing a claim for compensation as provided in 810:10-5-2. The claimant should note clearly on the appropriate form that the employer is a qualified employer, and attach supporting documentation from the employer which details the facts of the determination, as well as a position statement from the claimant.~~

~~(b) The qualified employer may file a response as provided below in 810:10-5-15.~~

~~(c) Within fifteen (15) days of receipt of notice that the claim has been filed, the employer shall transmit to the Commission a copy of the complete record of the case from the employer's internal appeals process.~~

~~(d) Upon receipt of the claim for review, the Commission may hear the matter en banc or refer the case to an Administrative Law Judge. Findings of fact contained in the employer's record shall be considered conclusively established, and shall not be disturbed unless clearly erroneous. The Commission may request additional information from either party prior to rendering a decision.~~

~~(e) The Commission may reverse all or part of the employer's benefit determination if contrary to applicable law, or to the terms of the employer's plan. Any such judgment of the Commission shall contain specific findings relating to the reversal.~~

(a) Except as otherwise provided by law, a claimant aggrieved by all or part of an adverse benefit determination upheld by a qualified employer's appeals committee pursuant to 85A O.S. § 211, may appeal the determination to the Commission en banc by filing an original and four (4) copies of a

Commission prescribed CC-Form-211 Request for Review of Adverse Benefit Determination with the Commission within one (1) year after the claimant's receipt of notice that the determination, or part thereof, was upheld. The CC-Form-211 shall:

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

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

(b) The Commission shall assign a file number to the CC-Form-211 upon receipt, and, within ten (10) days thereafter, shall mail or send an electronic copy thereof to the qualified employer.

(c) Proceedings related to oral argument before the Commission en banc and submission by the parties of written arguments as an aid to the Commission en banc shall be governed by 810:10-5-66(c)-(f). The qualified employer's written argument shall be accompanied by an appendix that includes a copy of the employer's benefit plan and the entire record established by the employer's internal appeal process.

810:10-5-6. Commission relief regarding agreements to arbitrate

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

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

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

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

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

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

PART 3. SUBSEQUENT PLEADINGS

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

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

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

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

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

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

MFDR Form 10M is required.

PART 5. PREHEARING PROCEEDINGS

810:10-5-30. Prehearing conference

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

(b) ~~The~~Except as otherwise provided in 810:10-3-5, the purpose of the prehearing conference is to permit an informal hearing between the parties and the Administrative Law Judge in an effort to resolve the case or issues in the case before an administrative hearing, and to discuss the facts, identify the legal issues, present discovery requests, make all appropriate stipulations, and discuss such other matters as may facilitate consideration of the case.

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

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

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

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

810:10-5-31. Discovery

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

(b) **Authority of the Administrative Law Judge.** ~~The~~Any party may commence with discovery methods such as depositions, issuance of subpoenas and requests for production, prior to or after invoking the jurisdiction of the Administrative Law Judge. Discovery disputes may be resolved by filing a CC-Form-13 requesting a prehearing conference. Administrative Law Judge, upon the judge's own motion or on the motion of either party, may permit or perform such discovery or other appropriate action as the judge decides is appropriate in the circumstances, taking into account the needs of the parties to the proceeding and other affected persons and the desirability of making the proceeding fair, expeditious, and cost-effective. If discovery is permitted or performed, the Administrative Law Judge may order a party to the proceeding to comply with the judge's discovery-related orders, issue subpoenas for the attendance of a witness and for the production of records and other evidence at a discovery proceeding, including a deposition, and take action against a noncomplying party as appropriate and consistent with 85A O.S. § 73(B) and 85A O.S. § 83(B).

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

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

(e) **Completion of discovery by the employer or insurance carrier in contested claims.** Pursuant to 85A O.S. § 111, if the compensability of a claim is contested, the employer or insurance carrier shall complete and secure a medical evaluation of the claimant within sixty (60) days of the filing of a claim for compensation pursuant to 810:10-5-2.

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

PART 7. INITIAL AND SUBSEQUENT PROCEEDINGS

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

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

(b) **Appointment of medical or vocational expert.** Appointment of an independent medical examiner is governed by ~~810:3-9-4~~810:15-9-4. Appointment of a medical case manager is governed by ~~810:3-11-4~~810:15-11-4. Appointment of a vocational rehabilitation provider is governed by ~~810:4-1-4~~810:20-1-4.

(c) **Travel expenses.** The employer or insurance carrier shall reimburse the employee for the actual mileage in excess of ~~forty (40)~~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.

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

(a) **Generally.** Except for amputation or permanent total loss of use of scheduled member injuries ~~as defined in 85A O.S. § 2(40) and as otherwise provided in this Section,~~as specifically set forth in 85A O.S. § 46(A), evaluations of permanent impairment for injuries occurring on or after February 1, 2014, shall be evaluated as a percentage of whole body impairment, not to exceed 350 weeks, 85A O.S. § 46(C), and must be based solely on criteria established by the current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. Deviations from the Guides are permitted only when specifically provided for in the Guides, or pursuant to an alternative method of

evaluation approved pursuant to 85A O.S. § 60 that deviates from or is used in place of or in combination with the Guides. Such deviations must be medically reasonable and necessary, as shown by clear and convincing evidence.

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

(c) **Hearing impairment.** The current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment, or any alternative method approved pursuant to 85A O.S. § 60 that deviates from or is used in place of or in combination with the Guides, in effect on the date of injury, shall be used to evaluate permanent impairment caused by hearing loss where the last exposure occurred on or after February 1, 2014. Objective findings necessary to prove permanent disability in occupational hearing loss cases may be established by medically recognized and accepted clinical diagnostic methodologies, including, but not limited to audiological tests that measure air and bone conduction thresholds and speech discrimination ability. Differences in baseline hearing levels shall be confirmed by subsequent testing given within four (4) weeks of the initial baseline hearing level test.

(d) **Eye impairment.**

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

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

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

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

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

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

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

(d) **Record of hearing.** ~~An audio recording of all hearings before the Commission or an Administrative Law Judge shall be made, and provided on digital media to any party upon request, and at no charge.~~Hearings before the Commission or an Administrative Law Judge shall be stenographically recorded by a Commission reporter. The Commission may contract for court reporter services. A transcript of proceedings will be made by a court reporter at the request and expense of the person

ordering it, or at the request of the Commission, in which case, a copy will be made for any person requesting it, at that person's expense.

810:10-5-49. Rules of evidence

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

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

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

(d) **Documents.**

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

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

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

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

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

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

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

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

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

(g) **Expert medical testimony.**

(1) Expert medical testimony may be offered by:

(A) a written medical report of the physician;

(B) deposition; or

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

(2) Medical opinions addressing compensability and permanent disability must be stated within a reasonable degree of medical certainty. Medical opinions concerning the existence or extent of permanent disability must be supported by competent medical testimony of a physician described in 85A O.S. § 45(C)(1) and shall be supported by objective findings as described in 85A O.S. § 2(31). The medical testimony must include the employee's percentage

of permanent partial disability and whether or not the disability is job-related and caused by the accidental injury or occupational disease or illness.

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

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

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

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

(B) deposition; or

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

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

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

810:10-5-50. Setting of matters

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

(b) **Exceptions.** The Commission en banc shall hear appeals of decisions from Administrative Law Judges, 85A O.S. § 78, and review adverse benefit determinations made pursuant to 85A O.S. § 211 of the Oklahoma Injured Employee Benefit Act, 85A O.S. § 200~~, and hear appeals of orders of the Workers' Compensation Court of Existing Claims, 85A O.S. § 400~~.

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

810:10-5-53. Hearings

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

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

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

(2) administer oaths and affirmations;

(3) regulate the course of the hearing;

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

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

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

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

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

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

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

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

evidence; and

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

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

(d) Written arguments. The Commission or Administrative Law Judge may require or allow the parties of record to submit written arguments and legal authority for their respective positions as an aid to the Commission or judge, and may designate the order and time for doing so and for replying to the submission. (e) Closing the record. The record shall be closed when all parties of record have had an opportunity to be heard and to present evidence, and the Commission or Administrative Law Judge announces that the record of testimony and exhibits is closed.

PART 9. POST ORDER RELIEF

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

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

(1) be in writing;

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

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

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

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

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

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

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

(c) **Oral argument.**

~~(1) Oral argument by the parties before the Commission en banc shall be permitted only at the discretion of the Commission.~~

~~(2)~~ 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 2" x 11"~~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 ~~two (2)~~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 ~~two (2)~~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.

~~(e)~~(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.

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

810:10-5-67. ~~Appeal of order issued by judge of the Court of Existing Claims~~[RESERVED]

~~(a) Any party aggrieved by an order of a judge of the Workers' Compensation Court of Existing Claims, 85A O.S. § 400, entered on or after February 1, 2014, may appeal the order to the Commission in the same manner and subject to the same time lines as applicable to appeals to the Commission en banc of orders by a Commission Administrative Law Judge.~~

~~(b) 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.~~

~~(c) Decisions by the Court of Existing Claims will be reviewed by the Commission only for procedural deficiencies and to ensure that the record is complete. If the Commission is satisfied as to the same, the Court of Existing Claims order will be affirmed and an appeal to the Oklahoma Supreme Court may be commenced thereafter, in accordance with statute.~~

PART 13. DISMISSALS

810:10-5-85. Dismissals

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

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

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

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

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

PART 15. SETTLEMENTS

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

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

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

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

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

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

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

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

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

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

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

(h) ~~The Commission is not required to stenographically report or prepare a record of joint petition settlement hearings.The Commission, an Administrative Law Judge or a Counselor Division counselor shall record the hearing at no cost to the parties. Nothing in this Subsection is intended to preclude a transcript of the settlement proceedings being made by a~~will be made by the ~~court reporter at the request and expense of the person ordering it.~~ A stenographic record of the terms and conditions of an approved joint petition settlement and the understanding of the claimant concerning the effect of the settlement must be made by a Commission court reporter and transcribed at the expense of the employer or insurance carrier. Medical reports and other exhibits submitted in support of a CC-Joint Petition Settlement shall not be transcribed. The original exhibits or duplicate copies thereof shall be affixed to the original transcript and placed in the Commission file.

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

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

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

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

PART 17. FEES

810:10-5-105. Fees. Fees payable to the Commission include:

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

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

(c) An annual fee of One Thousand Dollars ($1,000.00), payable by third-party administrators [85A

O.S. § 29(C)];

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

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

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

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

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

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

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

~~(j)~~(k) Such other fees as may be allowed by law or this Title.

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

SUBCHAPTER 1. GENERAL PROVISIONS

810:15-1-2. Definitions

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

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

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

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

(A) Certified Disability Management Specialist (CDMS);
(B) Certified Case Manager (CCM);
(C) Certified Rehabilitation Registered Nurse (CRRN);
(D) Case Manager - Certified (CMC);
(E) Certified Occupational Health Nurse (COHN); or
(F) Certified Occupational Health Nurse Specialist (COHN-S).

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

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

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

(A) drugs identified with a status of "N" in the current edition of the Official Disability Guidelines Treatment in Workers' Comp (ODG)/Appendix A, ODG Workers' Compensation Drug Formulary, and any updates thereto;
(B) any compound drug;
(C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care; and
(D) drugs that are not preferred, exceed or are not addressed by the ODG in effect on the date of treatment.

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

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

(A) as a result of a practitioner's prescription drug order based on the practitioner-patient-pharmacist relationship in the course of professional practice;
(B) for administration to a patient by a practitioner as the result of a practitioner's initiative based on the practitioner-patient-pharmacist relationship in the course of professional practice;
(C) in anticipation of a prescription drug order based on a routine, regularly observed prescribing pattern; or
(D) for or as an incident to research teaching or chemical analysis and not for selling or dispensing except as may otherwise be allowed by law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Prescription drug" means:

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

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

(C) a drug that is required by federal or state statute or regulation to be dispensed

on prescription or that is restricted to use by a prescribing doctor only.

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

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

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

(A) the injured employee's full name;

(B) date of injury;

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

(D) diagnosis code(s);

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

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

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

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

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

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

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 ~~seventy-two (72) hours~~three (3) days, the request shall be deemed approved.

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

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

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

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

regime previously preauthorized by that prescribing doctor; or

(B) there is a change in prescribing doctor.

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

810:15-5-4. Medical Interlocutory Order

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

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

(1) injured employee name;

(2) date of birth of injured employee;

(3) prescribing doctor's name;

(4) name of drug and dosage;

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

(6) MIO requestor's contact information;

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

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

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

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

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

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

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

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

(f) An approved MIO shall be effective retroactively to the date the complete request for an MIO is received by the Commission.

(g) The MIO shall continue in effect until the later of:

(1) final adjudication of a medical dispute regarding the medical necessity and reasonableness of the drug contained in the MIO;

(2) expiration of the period for a timely appeal; or

(3) agreement of the parties.

(h) A party shall comply with an MIO entered in accordance with this Section and the insurance carrier shall reimburse the pharmacy for prescriptions dispensed in accordance with an MIO.

(i) The insurance carrier shall notify the prescribing doctor, injured employee, and the dispensing pharmacy once reimbursement is no longer required in accordance with Subsection (g) of this Section.

(j) A party may seek to dispute, reverse or modify an MIO issued under this Section by filing a written request for a hearing before an Administrative Law Judge of the Commission.

SUBCHAPTER 9. INDEPENDENT MEDICAL EXAMINERS

810:15-9-1. Qualifications

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

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

(1) have a valid, unrestricted professional license as a physician which is not probationary;

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

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

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

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

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

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

810:15-9-3. Revocation

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

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

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

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

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

(c) Proceedings related to revocation shall be governed by ~~810:2-5-50~~810:10-5-50 on show cause hearings and the contested hearings rules set forth in Subchapter 5 of Chapter ~~2~~10 of this Title.

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

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

810:15-9-5. 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~~810:10-5-16, or by mediation, as appropriate.

SUBCHAPTER 11. MEDICAL CASE MANAGEMENT

810:15-11-3. Revocation

(a) Removal of a case manager from the list of qualified independent medical case managers shall

be at the request of the case manager, or by the Commission after notice and opportunity for hearing.

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

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

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

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

(c) Proceedings related to revocation shall be governed by ~~810:2-5-50~~810:10-5-50 on show cause hearings and the contested hearings rules set forth in Subchapter 5 of Chapter ~~2~~10 of this Title.

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

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

810:15-11-4. Requests for assignment

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

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

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

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

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

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

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

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

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

(h) The respondent shall pay all reasonable and customary charges of a medical case manager appointed by the Commission. Failure to timely pay a Commission appointed independent medical case manager for services rendered pursuant to Commission order may result in the imposition of assessments and sanctions by the administrative law judge or Commission, including a fine for contempt

as provided in 85A O.S., § 73(B). Disputes regarding payment for services rendered by a Commission appointed independent medical case manager that cannot be resolved by the case manager and the parties themselves, may be addressed by filing a request for hearing before an administrative law judge of the Commission as provided in ~~810:2-5-16~~810:10-5-16, or by mediation, as appropriate.

SUBCHAPTER 15. MEDICAL DISPUTE RESOLUTION

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

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

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

(1) **MFDR Form 19.** A provider may initiate proceedings to address a medical fee dispute by filing a Commission prescribed MFDR Form 19 with the Commission. A copy of the form may be obtained from the Commission at its main offices, or from the Commission's website. ~~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~~810:10-1-9.

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

810:15-15-4. Other medical disputes

Medical disputes not otherwise addressed by this Subchapter, including, but not limited to, matters of medical necessity or appropriateness, requests by an injured employee for a refund or reimbursement for health care paid by the employee, and requests initiated by the employer or insurance carrier pursuant to 85A O.S., § 55 for a determination of the reasonableness of charges for appropriate and necessary medical services and supplies rendered to an injured employee with a compensable work-related injury, may be addressed by filing a request for hearing before an administrative law judge of the Commission as provided in ~~810:2-5-16~~810:10-5-16, by mediation, or by agreement of the parties, as appropriate.

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

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

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

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

(c) Contested hearings before the administrative law judge shall be conducted as provided in Subchapter 5 of Chapter ~~2~~10 of this Title.

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

SUBCHAPTER 1. GENERAL PROVISIONS

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

The Commission may deny an application, refuse to issue or renew, or revoke a permit for Individual Own Risk Employer (Subchapter 9 of this Chapter), Group Self-Insurance Association (Subchapter 11 of this Chapter) or Third-Party Administrator (Subchapter 13 of this Chapter) as provided in this Chapter. Proceedings related to such Commission actions shall be governed by ~~810:2-5-50~~810:10-5-50 on show cause hearings and the contested hearings rules set forth in Subchapter 5 of Chapter ~~2~~10 of this Title.

SUBCHAPTER 3. PROOF OF COVERAGE

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

(a) Any insurer issuing a policy to provide benefits pursuant to the AWCA, or group self-insurance association approved by the Commission, must report its statutorily required notices of insurance coverage and cancellation electronically with the Commission using the NCCI Proof of Coverage (POC) system. To do so, the insurer must elect with the NCCI to use the NCCI POC system, authorize the NCCI to make the required filings on behalf of the insurer, and report its policy information, including, but not limited to, new and renewal policies, binders, cancellations, reinstatements, and endorsements, with the NCCI in accordance with NCCI reporting requirements for the State of Oklahoma.

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

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

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

SUBCHAPTER 7. ENFORCEMENT OF WORKERS' COMPENSATION INSURANCE REQUIREMENTS

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

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

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

never be reduced to less than the amount in premiums saved by the employer's non-compliance.
(c) The consent agreement becomes void if the employer defaults on payment under the agreement or if the agreement was obtained by fraud or misrepresentation of a material fact.
(d) The Commission may institute collection proceedings independently or in District Court, including, but not limited to, an asset hearing, garnishment of income and wages, judgment lien against personal and/or business properties, upon any penalties becoming final under the provisions of 85A O.S.
§ 40.

SUBCHAPTER 9. INDIVIDUAL OWN RISK EMPLOYER PERMIT

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

An individual own risk employer must designate a service agent to receive service of notice. The designation must be on a form prescribed by the Commission and filed with the Commission as provided in ~~810:2-1-11~~810:10-1-11.

SUBCHAPTER 11. GROUP SELF-INSURANCE ASSOCIATION PERMIT

810:25-11-3. Approval of new members of the association

A new membership may not become effective without Commission approval. All applications for membership, in a form approved by the Commission, shall be filed with the Commission. The application shall include evidence of the execution of the indemnity agreement, power of attorney, and joint and several liability agreement, as required by 810:25-11-15, with signed approval of the applicant by the association, and shall be accompanied by a current balance sheet and income statement ~~.~~of the association and the applicant. The Commission shall approve new members upon finding that the applicant is solvent, that the applicant has the financial ability to meet its obligations as a member, and proof that the applicant is in compliance with the legal requirements specified in this subchapter.

810:25-11-17. Third-party administration

(a) The association must contract with a third party to provide claims adjusting, underwriting, industrial safety engineering, marketing and accounting functions. More than one organization can be contracted with to provide these services. The company providing the claims adjusting and marketing must be licensed by the Commission.
(b) All copies of contracts between the association and any organization providing services to association shall be filed with the Commission. Any change in contract must be filed with the Commission ten (10) days' before the effective date.
(c) Any contract with a TPA for claims adjusting must state the TPA agrees to handle all claims incurred to their conclusion, unless approval to transfer the claims is obtained from the Commission before such transfer.
(d) A company providing marketing services to a self-insurance program must be approved by the Commission's Insurance Division. The company requesting approval must submit to the Commission's Insurance Division all marketing material prior to being utilized by an association.