

## **Title 11. Labor and Industrial Relations**

### **Chapter IV. Workers' Compensation Commission, Department of Labor and Licensing**

#### **Subchapter A. Generally**

#### **Part 25. Workers' Compensation Commission Rules**

**Codification Notes.** This part as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"RULE 099.14 TESTIMONY AND REPORTS OF PHYSICIANS#099.14

The text of this Rule was incorporated verbatim into Section 27 of the Act [Ark. Stat. Ann. § 81-1327(c)] by Act 290 of 1981. [\*] To avoid confusion, this provision will no longer appear as a Rule. (Effective March 1, 1982)

\* See Ark. Code Ann. § 11-9-705(c)"

#### **Subpart 1. Generally**

##### **11 CAR § 25-101. Commission location and sessions.**

(a) The office of the Workers' Compensation Commission is in Little Rock.

(b) The commission shall:

(1) Remain in continuous session; and

(2) In addition, meet as a body at the call of the Chair of the Workers'

Compensation Commission for the purpose of transacting such business as may come before it.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

**11 CAR § 25-102. Carrier reporting requirement.**

(a) Every carrier that writes workers' compensation insurance in the State of Arkansas shall report to the National Council on Compensation Insurance (NCCI) all policy information in accordance with the NCCI reporting guidelines.

(b) Proof of coverage must be filed no later than twenty (20) days after the effective date of coverage.

(c)(1) The exact name of each Arkansas business operation and a complete Arkansas address shall be reported.

(2) Multiple Arkansas locations cannot use the same address.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective October 21, 1993, revised effective January 1, 2006)"

**11 CAR § 25-103. Termination of coverage by insurance carrier — Employer to obtain new coverage.**

(a)(1) Cancellation or termination by a carrier prior to the expiration date of any policy shall follow the statutory guidelines for cancellation as prescribed in Arkansas Code § 11-9-408(b).

(2) Cancellation of policies shall be reported to the National Council on Compensation Insurance in accordance with its reporting guidelines.

(b)(1) The employer whose policy has been canceled or terminated shall, on or before the thirtieth day after receiving notice of cancellation or termination, obtain other coverage in accordance with the law.

(2) Failure on the part of the employer to file such evidence within thirty (30)

days shall:

(A) Be considered by the Workers' Compensation Commission as prima facie evidence of violation of Arkansas Code § 11-9-401; and

(B) Subject the employer to the penalties prescribed under Arkansas Code § 11-9-406.

**Authority.** Arkansas Code §§ 11-9-207, 11-9-406.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective October 21, 1993, revised effective January 1, 2006)"

**11 CAR § 25-104. Self-insurance program.**

(a) **General — All self-insurers.**

(1) **Definitions.** When used in this part, the following words or terms shall have the meaning as described in this section:

(A) "Certified audit" means an audit upon which the auditor expresses his or her professional opinion that the accompanying statements present fairly the financial position of the self-insurer or fund in conformity with generally accepted accounting principles consistently applied, and accordingly including such tests of the accounting records and other auditing procedures as considered necessary in the circumstances;

(B) "Common claim fund" means a fund maintained by a group self-insurer for the sole purpose of paying claims imposed by the provisions of the Workers' Compensation Law, Arkansas Code § 11-9-101 et seq.;

(C) "Common self-insurer" means employers who are members of the same trade or professional association entering into agreement to pool their liabilities;

(D) "Conditional reserves" means acceptable assets equal to the security deposit requirement plus any additional contingent reserves established by the trustees

or required by the Workers' Compensation Commission;

(E)(i) "Contingent liability" means the amount that a self-insurer's fund may be obliged to pay in excess of a given fund year's standard premium collected or on hand.

(ii) This liability is considered funded if a security deposit equal to the total amount of the contingent liability has been posted.

(iii) This liability is considered unfunded if a surety bond has been posted equal to all or a portion of the total amount of the contingent liability;

(F) "Current ratio" means the ratio of current assets to current liabilities as shown in the most recent financial statement;

(G) "Group" means common self-insurer or homogeneous self-insurer;

(H) "Homogeneous self-insurer" means employers who are engaged in the same type of business activity or pursuit entering into agreement to pool their liabilities;

(I) "Loss" means the change in incurred loss from one point in time to another;

(J)(i) "Loss fund" means the retention of liability for a self-insurer, either individual self-insurer or group self-insurer, under the terms of an aggregate excess contract.

(ii) In the absence of an aggregate excess policy, it is the amount of money allocated to pay claims;

(K) "Net safety factor" means any amount needed in a given fund year in addition to current loss reserves to fund future loss development;

(L) "Surplus" means all other assets a fund may have on hand in excess of all loss reserves, actual and contingent liabilities, and net safety factors in all fund years;

(M)(i) "Third-party administrator" means a business which has:

(a) Met all the requirements of the Workers' Compensation Commission, 11 CAR § 25-133; and

(b) Received authorization from the Workers' Compensation Commission to act as a third-party administrator.

(ii) The term "service agent" is synonymous with the term "third-party administrator" as used in the workers' compensation laws and the rules of the Workers' Compensation Commission;

(N)(i) "Trustees" means a group of members elected by a group self-insurer for stated terms of office:

(a) To direct the administration of a group self-insurer; and

(b) Whose duties shall include responsibility for approving applications for new members in such group.

(ii) The majority of such trustees must be members of the group, but a trustee shall not be an owner, officer, or employee of the service agent.

(iii) They may delegate ministerial authority for membership approval to such person as they select, provided that person is not an owner, officer, or employee of the service agent;

(O) "Trustee's fund" means any fund under the control of the board of trustees of a group self-insurer which is not part of the loss fund or which is not required to pay claims;

(P) "Working capital" or "net current assets" means current assets less current liabilities; and

(Q)(i) "Written manual premium" means as defined by Arkansas Code § 11-9-303(b).

(ii) The rates used for the experience period shall be those published by the Workers' Compensation Commission.

**(2) Acceptable securities.**

(A)(i) The securities acceptable to the Workers' Compensation Commission as a security deposit shall be certificates of deposit issued by a state-chartered bank or a national-chartered bank in the State of Arkansas.

(ii) The securities acceptable to the commission as a security deposit shall include surety bonds in a form prescribed by the commission which are issued by any corporate surety which meets the qualifications prescribed in subdivision (a)(2)(B) of this section.

(iii) The securities acceptable to the commission as a security deposit shall also include letters of credit in a form prescribed and approved by the commission.

(iv) These three (3) approved methods of posting security must follow strict compliance with this section.

(B)(i) Any corporate surety, to be eligible for writing self-insurers' bonds in the State of Arkansas, shall be an admitted or approved carrier by the Insurance Commissioner of the State of Arkansas to transact such a business in the state, and its latest financial statement on file with the commissioner shall at all times show assets, including surplus to policyholders, at least equal to the latest commissioner requirement for admission of a new company to do business in the state.

(ii) Any securities held by the commission may be exchanged or replaced by the depositor with other securities of like nature and amount.

(iii) Any surety bond may be exchanged or replaced with another surety bond provided the required sixty-day notice of termination of liability is given to the commission.

(iv) Whenever an employer discontinues business in the state or desires to terminate his or her status as a self-insurer, or desires to replace securities with a surety bond, he or she:

(a) Shall so notify the commission; and

(b) May recover the securities deposited with the commission upon posting in lieu thereof a special release bond issued by a corporate surety in an amount equal to the total value of such securities.

(v) The special release bond shall cover all existing liabilities under the laws and shall remain in force for a period in accordance with the statute of limitations as specified in the Act, and until such time, to be determined by the commission, as all obligations under the Act have been fully discharged.

(vi) The commission shall be authorized to bring suit upon any surety bond so posted, to procure prompt payment of compensation liabilities.

(C)(i) Self-insurers shall make all funded securities payable to the commission, in trust for (name of depositor) as per commission requirements.

(ii) All such securities shall be filed with the commission for deposit with the Treasurer of State under custody receipt.

(iii) No other depository is acceptable.

(iv) The commission shall be authorized to sell and/or collect the securities in whole or in part, in the case of actual or imminent default of the employer or group, to pay compensation liabilities.

(v) Interest accruing on any negotiable securities so deposited shall be collected and transmitted to the depositor, provided he or she is not in default in payment of compensation benefits or the annual premium tax.

(vi) All prefunded deposits shall remain in the custody of the commission for a period of time as the statute of limitations provided in the laws may dictate, and until such time as all obligations of the employer or group have been fully discharged, such time to be determined by the commission.

(D)(i) The commission permits deposit of an irrevocable standby letter of credit as an alternative security deposit.

(ii) The commission will furnish upon request the prescribed and approved forms for use in utilizing this alternative.

(iii) The commission requires that an irrevocable standby letter of credit be accepted only from state-chartered banks or national-chartered banks with offices in the State of Arkansas.

(iv) Banks eligible for use must be:

(a) Covered under the Federal Deposit Insurance Corporation (FDIC); and

(b) Acceptable to the commission.

(v) Letters of credit issued by a bank that do not meet the standard as mandated by this section may be accepted by the commission with a confirming letter of credit issued by a bank meeting the prescribed criteria.

(vi) The commission shall be authorized to make demand and collect on the posted letter of credit in whole or in part, in the case of actual or imminent default of the employer or group to pay compensation liabilities.

(vii) All irrevocable standby letters of credit shall remain in the custody of the commission for a period of time:

*(a)* As the statute of limitations provided in the laws may dictate;

and

*(b)* Until such time as all obligations of the employer or group have been fully discharged, such time to be determined by the commission.

**(3) Filings of reports — Penalties.**

(A)(i) Each individual self-insurer or group shall file premium tax reports, financial statements, summary loss data, and such other reports and statements at such time and in such manner as the commission shall require.

(ii) This section places this responsibility on the employers, groups, and service companies to perform their prescribed duties and responsibilities without prompting from the commission.

(iii) Failure or refusal of any self-insurer or group to file the prescribed reports with the commission within the prescribed time period shall:

*(a)* Subject the mentioned self-insurer to a civil penalty in such amount as the commission may prescribe, not to exceed one hundred dollars (\$100) per infraction per day; and

*(b)* Be sufficient cause for the revocation of the self-insurer privilege.

(iv) Failure to pay such penalty within thirty (30) days of notification shall be considered good cause for revocation of the self-insurer privilege.

(B)(i) The commission shall require annual or otherwise periodic payroll audits from each employer, or group of employers, self-insured under the laws to determine the proper assessment for tax purposes.

(ii) The amount of tax shall be based upon the written manual premium for the calendar year in question.

(iii) The tax is limited by law at three percent (3%) of the tabulated written manual premium for each self-insurer.

(iv) Each individual self-insurer or group shall maintain a true and

accurate payroll record, which shall be made available during reasonable business hours, upon demand, to the commission and its authorized representatives.

(v) Unless payroll records are maintained in such manner that a true and accurate division by workers' compensation classification codes can readily be determined for proper rating, the entire payroll shall be presumed to be within the classification to which the highest insurance rate is applicable.

(vi) If such audits reveal a deficiency in the amounts reported to the commission or amounts paid to the commission, the commission may assess the cost of such audit against such self-insurer.

(vii) This audit report and payment of the proper tax is due on or before April 1 of each year.

(C)(i) Each individual self-insurer and group shall file annual statements of financial condition with the commission in a form acceptable to the commission.

(ii) Individual self-insurers must maintain a level of financial strength, financial position, and financial ratios that would be required of any new applicant.

(iii) These statements must be prepared by a certified public accountant and must be certified audits, except that an individual self-insurer may be allowed to submit another type of statement acceptable to the commission.

(iv) Public employers entering the individual self-insurance program may satisfy these requirements by furnishing independent certified audits or by furnishing the most current audit report as prepared by the Legislative Joint Auditing Committee.

(v) Any less requirements of these annual statements will be at the discretion of the commission.

(vi) An additional security deposit or surety bond may be required in the absence of a certified audit.

(vii) Interim financial reports may be required in addition to these annual financial statements at the discretion of the commission.

(viii) This report is due on or before April 1 of each year.

(D)(i) Summary loss data will be filed with the commission by each

individual self-insurer or group self-insurer under the laws.

(ii) This report shall be filed with the commission on:

*(a)* An annual basis;

*(b)* A quarterly basis; or

*(c)* Any interim basis as prescribed by the commission.

(iii) This report will be due:

*(a)* Within thirty (30) days after each prescribed evaluation

period; and

*(b)* Unless otherwise directed, not later than February 1 of each

year.

(iv) This self-insurers' statement on this report will be on a form prescribed by the commission, and any substitute form must contain all the requested data.

(v) This report will include but not be limited to the:

*(a)* Name of the employer;

*(b)* Name of the injured employee;

*(c)* Claim number;

*(d)* Date of accident;

*(e)* Nature of injury; and

*(f)* Amounts paid on the claim for indemnity, medical, expenses, and outstanding reserves, if any.

(vi) This report will cover all incurred losses of the evaluation period as well as any pending claims where any type payment is made or reserve is pending.

(vii) This report will require reasonable reserves on all open pending claims.

#### **(4) Contracts for excess insurance.**

(A) Aggregate and specific excess insurance with liability limits and retention amounts acceptable to the commission may be required as a condition of approval of any individual self-insurer or group self-insurer as hereinafter provided, except qualifying public employer self-insurer groups are entitled to statutory options

and limitations.

(B) Any casualty insurance company to be eligible to write excess liability coverage for individual self-insurers or group self-insurers in the State of Arkansas, shall at all times meet the same standard as required of any corporate surety as outlined in subdivision (a)(2)(B) of this section.

(C) No contract or policy of excess insurance shall be recognized by the commission in considering the ability of an applicant to fulfill its financial obligation under the workers' compensation laws unless such contract or policy:

(i) Is issued by a recognized, admitted, or approved casualty insurance company with the minimum qualifications established by this part;

(ii) May not be cancelled except upon thirty (30) days written notice by registered or certified mail to the other party to the policy and the commission;

(iii) Is renewable at the expiration of the policy period unless written notice by registered or certified mail is given to the other party to the policy and the commission, thirty (30) days prior to such expiration, by the party desiring to cancel or not to renew the policy;

(iv) If it contains any type of commutation clause, provided that:

(a) Any commutation effected thereunder shall not relieve the underwriter or underwriters of further liability as respects claims and expenses unknown at the time of such commutation or in regard to claims apparently closed but which may be subsequently revived by or through a competent authority; and

(b) In the event the underwriter proposes to redeem any future payments payable as compensation for accidents occurring during the term of the policy by the payment of a lump sum to be fixed as provided in the commutation clause of the policy, provided not less than thirty (30) days prior notice of such commutation shall be given to the commission by registered or certified mail by the underwriter or underwriters or their agent;

(v) In the event any commutation is permitted and effected, the commission shall have the right to direct that such sum either be:

(a) Placed in trust for the benefit of the injured employee or

employees entitled to such future payments of compensation; or

(b) Invested in approved securities and deposited with the commission to assure such future payments of compensation to the employee or employees entitled thereto; and

(vi) Contains the provision that obligations due under the terms of the policy shall be made to a party other than the employer, such party to be designated by the commission if it is deemed to be in the best interest of the employees covered by these laws.

**(5) Servicing for self-insurers — Qualifications.**

(A) Each individual self-insurer or group, as a condition of approval to self-insure, shall be required to provide proof of compliance with the provisions of this section regarding servicing requirements.

(B)(i) It shall be the sole responsibility of each individual self-insurer or group to provide for qualified persons to service its program in the areas of claims adjusting, underwriting, safety engineering, and loss control.

(ii) Should the individual self-insurer or group be unable or unwilling to provide any or all of these services through the use of its own employees, then it shall contract with outside agencies with established qualifications to provide these services.

(C) Individual self-insurers and groups may contract for claims adjusting with only those third-party administrators approved as such by the commission.

(D)(i) In the case where an individual self-insurer or group elects to contract with an approved third-party administrator, the commission may, at its discretion, choose to use the third-party administrator as an intermediary in its dealings with the employer.

(ii) In the case where no third-party administrator is used, the commission will deal with the employer only.

(E) In the case where an individual self-insurer or group elects to contract with an approved third-party administrator, the self-insurer or group shall notify the commission in writing prior to the effective date of said contract.

(F) In order to represent a group self-insurer client, the third-party administrator must:

(i) Maintain an Arkansas claims office; and

(ii) Have at least one (1) resident adjuster with check authority.

(G)(i) Each individual self-insurer or group shall designate a claims office in accordance with 11 CAR § 25-124.

(ii) Notice shall be provided to the commission prior to any changes in the designated claim office.

**(6) Revocation or termination of the self-insurer privilege.**

(A)(i) Failure to comply with any of the rules or with any order of the commission within the time prescribed shall be considered good cause for revocation or termination of self-insurer privilege, within the meaning of Arkansas Code § 11-9-404.

(ii) Noncompliance with any of the provisions of the workers' compensation laws, particularly those relating to time and method of compensation payments, the furnishing of medical treatment, and filing of accident and compensation reports and failure to pay any assessment, shall likewise be deemed good cause.

(iii) The commission shall give written notice of such revocation or termination to the employer and/or his or her agents.

(iv) The employer shall have fifteen (15) days from the date of mailing of the notice to request a hearing on the revocation or termination.

(v) Failure to request a hearing within the time prescribed shall result in the revocation or termination becoming effective thirty (30) days from the date of mailing of the original notice.

(vi) In no event shall any revocation or termination become effective prior to the date that a hearing on the question is scheduled.

(vii) Such notice shall be served personally or by certified or registered mail upon all interested parties.

(viii) This review and appeal process will also be applied to application issues.

(B)(i) It will be necessary for a self-insurer to notify the commission if the

status of the self-insurer is materially changed (individual ownership to partnership or to corporation, merger, etc.) at which time the new entity shall be required to qualify.

(ii) In the event there is a change in majority ownership of a self-insurer, the self-insurer privilege granted to an individual self-insurer shall be at the discretion of the commission.

**(7) Enforcement by commission of order of compliance, order of denial, or order of termination of self-insured status.** If the commission has probable cause to believe that an order denying or terminating self-insurer status is being violated or that an employer who is approved or has been previously approved as a self-insurer is liquidating or may be about to liquidate and distribute its assets to its stockholders or to its members without providing for its obligation as a self-insurer to pay or arrange for the payment of compensation and benefits as prescribed for in the law, the commission may cause an action to be filed in the:

(A) Pulaski County Circuit Court; or

(B) County in which such person does business to enjoin and restrain such person from engaging in such:

(i) Method;

(ii) Act; or

(iii) Practice.

**(8) Tenure of authority.**

(A) Certificates of authority granting the privilege of being a self-insurer for workers' compensation purposes shall expire on May 1 of each year.

(B) To effect the renewal of the certificate, the self-insurer must furnish or have on file with the commission an acceptable financial statement for its current fiscal year and must fully comply with the laws and the rules of this commission.

(C) Certificates of approval for service companies must be renewed on an annual basis.

(D) Any information submitted by an employer in its application to become a self-insurer or in its request for renewal of that authority will be treated with strict confidence by the commission.

(E) Any information submitted by a third-party administrator in its application for approval or in its request for renewal of that approval will be treated with strict confidence by the commission.

**(b) Individual self-insurer.**

(1)(A) Each employer desiring to become an individual self-insurer, as contemplated by Arkansas Code § 11-9-404, shall make application to the commission for such privilege on a form prescribed by the commission, and this application shall be filed with the commission sixty (60) days prior to the desired effective date.

(B) The application shall:

- (i) Contain answers to all questions propounded; and
- (ii) Be under oath.

(2) Before considering the application, the commission will require:

(A)(i) Financial statement of a current date showing a net worth of not less than two hundred fifty thousand dollars (\$250,000) and a current ratio of more than one to one (1:1) and a working capital of an amount establishing financial strength and liquidity of the business to pay normal compensation claims promptly.

(ii) The requirement for a more than one to one (1:1) current ratio may be waived in the case of a public utility or in those instances where generally recognized accounting principles peculiar to a particular industry make this requirement unreasonable.

(iii) In no event shall the net worth be less than three (3) times the annual loss fund, or in the event that aggregate excess insurance is not maintained, then the net worth shall be at least three (3) times the self-insurer's annual standard premium.

(iv) Financial statements dated six (6) months or more prior to the date of application may be required to be accompanied by an affidavit stating that there has been no material lessening of net worth nor significant deterioration of current ratio since the date of the statement;

(B) In considering the financial strength and liquidity of the business to pay normal compensation claims, the commission will take into consideration contracts

or policies of excess insurance in accordance with subdivision (a)(4) of this section;

(C) Each employer shall execute and file with the commission an agreement, which shall be part of their application, whereby he or she agrees to:

(i) Fully discharge by cash payment all amounts required to be paid by the provisions of the Act; and

(ii) Deposit with the commission acceptable securities or corporate surety bond to secure guarantee of payment of compensation liabilities unless waived by the commission;

(D)(i) Each individual self-insurer shall satisfy the commission that it has complied with the provisions of subdivision (a)(5)(A) of this section before approval for self-insurer status may be granted by the commission.

(ii) In addition, the commission may require periodic proof that the self-insurer is complying with these standards on a continuing basis;

(E)(i) The application for the privilege of being a self-insurer shall be accompanied by a remittance in the amount of one hundred dollars (\$100), payable to the Arkansas Workers' Compensation Commission.

(ii) This fee will not be refunded, regardless of the disposition of the application;

(F) Each individual self-insurer shall satisfy the commission that it has complied with the requirements of the self-insurer guaranty fund; and

(G)(i) An investigation and study of the financial and other capabilities of the individual applicant to meet its obligation under the laws will be conducted by the Self-Insurance Division of the commission.

(ii) The Self-Insurance Division of the commission will submit an evaluation report to the commission, after which formal approval for self-insurer status may be granted by the commission.

(3) Pursuant to Arkansas Code § 11-9-404, each individually self-insured employer shall deposit with the commission acceptable securities or post a surety bond issued by a corporate surety authorized to do business in the State of Arkansas except that the commission may waive the posting of any securities or surety bond by public

employers all in accordance with the following rules:

(A)(i) In every case where an application is favorably considered, the commission will then decide the amount of acceptable securities or surety bond which will be required, provided, however, that in no case will the amount of securities or surety bond be less than one hundred thousand dollars (\$100,000) except that the commission may waive the posting of any securities or surety bond by public employers.

(ii) A majority-owned subsidiary of a parent company, duly admitted as a self-insurer, may not be required to post securities or surety bond, provided the parent company, by resolution, guarantees payment of the liabilities of the subsidiary; and

(B) The minimum excess insurance requirements that an individually self-insured employer shall maintain shall be determined by the commission.

**(c) Group self-insurer — Application.**

(1)(A) In the case of group coverage as contemplated by Arkansas Code § 11-9-404, for the express purpose of establishing a group self-insurer, to be administered under the direction of an elected board of trustees, and to provide workers' compensation coverage for a group of employers classified as a common self-insurer group or a homogeneous self-insurer group and who are eligible for membership in accordance with the terms of the indemnity agreement, application shall be made to the commission at least sixty (60) days prior to the desired effective date of self-insurer status.

(B) Any application submitted with less than thirty (30) days remaining before the desired effective date may be rejected without further consideration.

(C) The application shall:

- (i) Be made on forms prescribed by the commission;
- (ii) Contain answers to all questions propounded; and
- (iii) Be under oath.

(D) The application as submitted by the trustees of the self-insurer group shall be accompanied by:

(i)(a) An indemnity agreement jointly and severally binding the group and each member thereof to comply with the provisions of the workers' compensation laws and rules of the commission.

(b) The indemnity agreement requirement mentioned here and elsewhere in this section is not applicable to public employer groups;

(ii) Individual application of each member of the group applying for membership in the self-insurer group on the inception date of the group;

(iii)(a) Current financial statements supported by a certified audit of at least two (2) members showing:

(1) The combined net worth of these members applying for self-insurer status on the inception date of the group self-insurer to be not less than one million dollars (\$1,000,000);

(2) A combined current ratio of more than one to one (1:1);

(3) A working capital of an amount establishing financial strength and liquidity of the business to pay normal compensation claims promptly; and

(4) Evidence of the financial ability of the group to meet its obligation under the laws.

(b) For members joining the group self-insurer after inception date or any time after initial qualification of the group, a certified audited financial statement shall not be required of any member of a group either for initial membership or as a condition for continued membership, however, such certified audited financial statement will be accepted.

(c) For members joining an established private employer self-insurer group, they may provide in lieu of a certified audited financial statement, a statement, certified by the president and treasurer of the member in the case of a corporation, and by the owner and general partners, respectively, in the case of an individual proprietorship or partnership, to the effect that such financial statement is true and correct to the best of the knowledge and belief of the signing authorities.

(d)(1) However, the commission may at its discretion grant a waiver to the requirement that financial statements be submitted as part of the

application process for new members.

(2) The waivers will be issued on a group-by-group basis depending on the financial stability of the group and the group's consistent adherence to the laws and rules of the commission.

(e) For members joining an established public employer self-insurer group, they may provide in lieu of a certified audited financial statement, a statement prepared by the Legislative Joint Auditing Committee or a financial statement certified by the member entity executive head and the member entity treasurer in the same manner as required of private employer members;

(iv) A set of bylaws governing the operation of the group self-insurer shall conform to the conditions specified in subdivision (c)(4)(A) of this section;

(v)(a) The application for the privilege of being a group self-insurer shall be accompanied by a remittance in the amount of one hundred dollars (\$100), payable to the Arkansas Workers' Compensation Commission.

(b) This fee will not be refunded, regardless of the disposition of the application; and

(vi) Each group self-insurer shall satisfy the commission that it has complied with the requirements of the appropriate guaranty fund.

(E)(i) Each group self-insurer shall satisfy the commission that it has complied with the provisions of subdivision (a)(5)(A) of this section before approval for self-insurer status may be granted by the commission.

(ii) In addition, the commission may require periodic proof that the self-insurer is complying with these standards on a continuing basis.

(F)(i) An investigation and study of the financial and other capabilities of the group applicant to meet its obligation under the law will be conducted by the Self-Insurance Division of the commission.

(ii) The Self-Insurance Division of the commission will submit an evaluation report to the commission, after which formal approval for self-insurer status may be granted by the commission.

(G)(i) Subsequent to the inception date of the group self-insurer,

prospective new members of the group self-insurer shall submit an application on a form prescribed by the commission for membership to the board of trustees.

(ii) The trustees must approve the application for membership in accordance with this part and the terms of the indemnity agreement for the application to be binding upon the group self-insurer and prospective members.

(iii) The application for membership shall then be filed with the commission thirty (30) days prior to the desired effective date of self-insurer status.

(iv) The commission may authorize groups to issue binders whereby the trustees may bind coverage for an individual member for a period of thirty (30) days.

(v) If such a binder has been issued, the trustees must file a copy of the binder with the commission within five (5) days of issuance and submit a completed application with supporting documents to the commission, Self-Insurance Division, within fifteen (15) days of the effective date of coverage.

(vi) At no time shall coverage be extended, by means of a binder, whereby the effective date of coverage precedes the issue date by more than ten (10) days.

(vii) Failure of a group to meet the requirements regarding the issuance of binders and/or the submission of applications may subject the group to the loss of authority to issue binders and shall be sufficient grounds for denying an application.

(viii) The commission retains the right to reject the admission of any new member.

**(2) Minimum security deposit for group self-insurer.**

(A) Each group self-insurer, pursuant to Arkansas Code § 11-9-404, shall deposit and maintain with the commission acceptable securities or post a surety bond issued by a corporate surety duly authorized to do business in the State of Arkansas in an amount determined by the commission, but not less than two hundred thousand dollars (\$200,000).

(B) The amount of the security deposit or bond shall be determined at

least annually based on net safety factors, contingent liabilities, growth of the group, and other data as submitted by the group self-insurers to the commission.

(C) The amount of the security deposit or bond requirement mentioned here and elsewhere in this section is not applicable to public employer groups.

**(3) Group self-insurers' funds and surplus.**

(A)(i) Each group self-insurer shall consist of two (2) separate funds, that is, the trustee fund and a common claim fund.

(ii) All premiums and assessments charged to the member are paid into the trustee fund.

(iii) The trustee fund shall be used to pay the operational expenses of the group self-insurer.

(B)(i) From the trustee fund there shall be created a separate common claim fund.

(ii) The common claim fund:

*(a)* Shall be placed in a designated depository; and

*(b)* Will be maintained at all times by the authorized service organization or the designated adjuster or individual charged with the handling and payment of claims.

(iii) This fund shall be adequate to cover any current incurred and contingent liabilities as imposed by the laws.

(C)(i) Employers participating in a group self-insurer shall pay the standard premium or percent thereof as designated by the group and approved by the commission, with exceptions being when at the discretion of the group manager or fiscal agent of the group it becomes necessary to surcharge or assess all members because of the loss experience of the group.

(ii) Members of a group self-insurer may elect to participate in the experience rating plan established by the National Council on Compensation Insurance or any other acceptable rating plan as approved by the commission.

(iii) In this event, an experience modification shall be determined for each member by the service agent.

(iv) Any discounts or deviations from written manual premium approved by the commission shall apply to all members of the group.

(D) Surplus funds for a fund year in excess of the amount necessary to fulfill all obligations under the laws for that fund year may be declared refundable by the trustees, provided that such amount shall not be paid to the members until approved by the commission.

**(4) Solvency of group self-insurer and trustee responsibility.**

(A)(i) The trustees of each authorized group self-insurer shall cause to be adopted a set of bylaws which shall govern the operation of the fund.

(ii) These bylaws shall contain, but not be limited to, the following subjects:

(a) Qualifications for group self-insurer membership, including underwriting considerations;

(b) The method for selecting the trustees, including the term of office; and

(c) The method for amending the bylaws.

(B) In addition to the above bylaws, the trustees shall adopt regulations on the following subjects which shall be binding on the group manager and third-party administrator:

(i) Investment of surplus funds and claim reserves;

(ii) Frequency and extent of loss control and safety engineering services to members;

(iii) The size of the common claim fund;

(iv) A schedule for payment and collection of premium including a definition of delinquent premium;

(v) Membership admission and expulsion procedures;

(vi) Delineation of authority granted to the trustees;

(vii) Delineation of authority granted to the group manager;

(viii) Delineation of authority granted to the third-party administrator;

(ix) Procedures for obtaining projected payroll information for initial

premium billing and actual payroll information for final premium adjustments after the close of the policy period to determine the actual premium to be collected for the policy period; and

(x) Procedures for handling disputes regarding premium paid by members.

(C)(i) In order to ensure the financial stability of the operations of each and every group self-insurer, the board of trustees of each group shall be responsible for all operations of the group.

(ii) The board of trustees of each group shall take all necessary precautions to safeguard the assets of the group, including:

*(a)(1)* The designation of a fiscal agent and/or group manager to administer the financial affairs of the group, who shall furnish a fidelity bond with the trustees as obligee, in an amount sufficient to protect the group against the misappropriation or misuse of any funds or securities.

*(2)* The amount of the bond shall be determined by the trustees, and evidence of such bond shall be filed with the commission, said bond being one (1) of the conditions required for approval of the establishment and continued operation of the group self-insurer.

*(3)* Such fiscal agent or group manager shall not be an owner, officer, or employee of the service organization;

*(b)(1)* All loss funds or funds of any type shall remain in the custody of the trustees or the authorized group manager, provided, however, that a common claim fund for payment of compensation benefits due and other related expenses may be established for the use of the authorized service organization.

*(2)* The service organization or the designated adjuster or individual or individuals charged with the handling and payment of claims shall furnish a fidelity bond covering its employees, with the trustees as obligee, in an amount sufficient to protect all funds placed in such common claim fund;

*(c)(1)* Requiring of the accounts and records of the group to be audited annually or at any time as may be required by the commission, such audits to

be made by certified public accountants or by authorized representatives of the commission, with the commission reserving the right to prescribe a uniform accounting system to be used by group self-insurers and/or service organizations, and the type of audits to be made, in order that it may determine the solvency of the group self-insurer.

(2) Copies of audits prepared by those other than commission personnel shall be filed with the Self-Insurance Division of the commission within three (3) months after the close of the fiscal year;

(d)(1) The trustee or fiscal agent or group manager shall not utilize any of the funds collected as premium for any purpose unrelated to workers' compensation.

(2) Further, they shall be prohibited from borrowing any money from the group self-insurer or in the name of the group self-insurer without advising the commission of the nature and purpose of the loan and obtaining commission approval;

(e) The trustees shall be authorized to invest trustees' funds, claims reserves, and surplus funds, subject to the Group Surplus Investment Policy as approved by the commission; and

(f)(1) The trustees shall provide annually, as part of the statement of financial condition of the group self-insurer, a schedule showing all investments, by type of investment, reflecting the amount invested, length of maturity, duration, annual percentage rate of interest, annual percentage yield, and income earned during the fiscal year just ended.

(2) A current schedule shall also be provided at other times as requested by the commission.

(D) The trustees shall review at least annually the following items for the purpose of determining whether these areas of concern are being adequately provided for:

- (i) Third-party administrator performance;
- (ii) Loss control and safety engineering;

- (iii) Investment policies;
- (iv) Collection of bad debt;
- (v) Admission and expulsion procedures; and
- (vi) Group manager performance.

(E)(i) Any changes in the bylaws or written regulations shall be filed with the commission no later than ten (10) days after their taking effect.

(ii) The commission reserves the right to declare any bylaw or regulation null and void if it is in violation of this part or the law.

(F) The indemnity agreement required pursuant to subdivision (c)(1)(D)(i) of this section shall conform to the form of the indemnity agreement as prescribed by the commission, and shall contain all its provisions, but may also contain other provisions not inconsistent with this section or with the required provisions, and wherever the term "service agent" appears therein, the term "group manager" or "fiscal agent" may be substituted as may be necessary to reflect the respective authority, responsibility, and duties of these agents, consistent with this section.

(G) The minimum excess insurance requirements that a group self-insurer shall maintain shall be determined by the commission, except qualifying public employer self-insurer groups that are entitled to statutory options and limitations.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective date April 1, 1989; revised August 8, 1995, effective August 29, 1995; revised effective September 20, 2001; revised effective January 1, 2006; revised effective January 1, 2008)"

**11 CAR § 25-105. Reporting injuries or deaths.**

(a) Employers shall report all on-the-job deaths of their employees to the Workers'

Compensation Commission within ten (10) days, as provided for in Section 34 of the Arkansas Workers' Compensation Act (Arkansas Statutes § 81-1334), and on forms prescribed by the commission.

(b) Injuries causing loss of time in excess of seven (7) days and those where compensation is due for permanent disability shall likewise be reported within the ten-day period.

(c) All injuries other than deaths, those causing loss of time in excess of seven (7) days, and those where compensation is due for permanent disability shall be reported monthly on forms prescribed by the commission, listing the number of injuries received, time loss, amount of medical, and nature of injury (totals).

(d) Self-insurers shall report directly to the commission.

(e) Other employers shall report only through their carrier.

(f) As required by Section 33 of the Act (Arkansas Statutes § 81-1333), it will be the responsibility of the employer to keep a record of all injuries, regardless of their nature, which will be available to the commission upon request.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

This section as promulgated prior to codification into the Code of Arkansas Rules contained a footnote to 11 CAR § 25-105(a) following the phrase "Section 34 of the Arkansas Workers' Compensation Act, (Arkansas Statutes § 81-1334)" as follows:

"\* See Ark. Code Ann. § 11-9-529(a)"

This section as promulgated prior to codification into the Code of Arkansas Rules

contained a footnote to 11 CAR § 25-105(c) following the phrase "reported monthly on forms" as follows:

"\*\* WCC Form M"

This section as promulgated prior to codification into the Code of Arkansas Rules contained a footnote to 11 CAR § 25-105(c) following the phrase "by Section 33 of the Act (Arkansas Statutes § 81-1333)" as follows:

"\*\*\* See Ark. Code Ann. § 11-9-528"

**11 CAR § 25-106. Weekly benefit waiting period.**

The waiting period provided for in Section 10, (Arkansas Statutes § 81-1310) shall:

- (1) Commence on the day after the date of injury; and
- (2) Be construed to continue for seven (7) calendar days.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

This section as promulgated prior to codification into the Code of Arkansas Rules contained a footnote to 11 CAR § 25-106 following the phrase "in Section 10 (Arkansas Statutes § 81-1310)" as follows:

"\* See Ark. Code Ann. § 11-9-501(a)"

**11 CAR § 25-107. Payment of attorneys' fees by separate check.**

In all cases where the petition for a fee is presented by attorneys or representatives of a claimant and a fee is granted, the fee shall be paid by separate check.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

**11 CAR § 25-108. Remands and mandates from courts of superior jurisdiction.**

Upon rendition by any court of superior jurisdiction of an order or opinion affecting any case over which the Workers' Compensation Commission has jurisdiction, the parties to the case shall file a copy of the opinion with the commission within thirty (30) days of the date of rendition.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

**11 CAR § 25-109. Compensation for amputation of fingers.**

(a) To achieve uniformity in administration of Initiated Act No. 4 of 1948, § 13(c), (Arkansas Statutes § 81-1313(c)), the following standards shall be applied in computing compensation due for amputation of fingers:

(1) Loss by amputation of one-half (1/2) or less than one-half (1/2) of the

terminal phalange of a member shall be:

(A) One-half (1/2) of the loss of the phalange; or

(B) One-fourth (1/4) of the digit;

(2) Loss of more than one-half (1/2) of the terminal phalange of a member shall constitute loss of:

(A) The phalange; or

(B) One-half (1/2) of the finger; and

(3) Loss of more than one (1) phalange by amputation shall constitute loss of:

(A) The digit; or

(B) All the finger.

(b)(1) More than one (1) phalange means any bony loss in excess of the first phalange by reason of amputation but not the surgical rounding of the joint, or the smoothing of the articular surfaces, done for the convenience of the injured employee.

(2) Ordinarily, the base of the nail may be used as a gauge of one-half (1/2) of the phalange.

(3) In disputed cases, more accurate measurement may be made by use of x-rays.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

This section as promulgated prior to codification into the Code of Arkansas Rules contained a footnote to 11 CAR § 25-109 following the phrase "Initiated Act No. 4 of 1948, § 13(c), (Arkansas Statutes § 81- 1313(c))" as follows:

"\* See Ark. Code Ann. § 11-9-521"

**11 CAR § 25-110. Hearings before commission and administrative law judges.**

(a) The Workers' Compensation Commission may, in its discretion, postpone or recess hearings at the instance of either party or on its own motion.

(b) No case set for hearing shall be postponed except by approval of the commission or administrative law judge.

(c) In the event neither party appears at the initial hearing, the case may be dismissed by the commission or administrative law judge, and such dismissal order will become final unless an appeal is timely taken therefrom or a proper motion to reopen is filed with the commission within thirty (30) days from receipt of the order.

(d) Upon meritorious application to the commission from either party in an action pending before the commission requesting that the claim be dismissed for want of prosecution, the commission may, upon reasonable notice to all parties, enter an order dismissing the claim for want of prosecution.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

**11 CAR § 25-111. Pretrial conferences.**

The Workers' Compensation Commission or an administrative law judge may direct the parties to appear before it for a pretrial conference.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of

Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

**11 CAR § 25-112. Depositions.**

(a) Depositions may be taken and discovery had by any party after the claim has been controverted in accordance with the statutory provisions and rule of civil procedure relating to civil actions in the chancery and circuit courts of this state, unless the parties agree otherwise.

(b) Prior to the time a case has been controverted, for good cause and upon application of either party, the Workers' Compensation Commission may order the depositions of any party or witness to be taken and any other discovery procedure.

(c) The commission may, at any time after a case has been heard by an administrative law judge or the commission, order the taking of evidence by deposition or otherwise, especially when this procedure will expedite the submission of the case for decision by the commission.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

**11 CAR § 25-113. Oral argument.**

(a) Oral argument may be granted by the Workers' Compensation Commission if requested in writing within a reasonable time after an appeal is filed.

(b) Whether or not requested, oral argument may be required if the commission thinks it necessary or advisable.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

**11 CAR § 25-114. Filings with the commission or appellate courts.**

(a) **Briefs to the commission.** Any party filing briefs with the Workers' Compensation Commission in connection with any case pending before it for review on appeal shall file an original and two (2) copies thereof.

(b) **All filings.**

(1)(A) Briefs, depositions, transcripts, and all other legal material to be filed with the commission will not be accepted after January 1, 1990, unless printed or typewritten, double-spaced on eight-and-one-half-inch by eleven-inch (8 1/2" x 11") paper.

(B) All briefs, letters, and other papers or documents shall:

- (i) Be served upon all other known parties; and
- (ii) Bear an appropriate certificate of service.

(2) Except for briefs filed in connection with cases on appeal to the full commission, multiple filings are discouraged, and only one (1) copy of any filing will be retained in the commission file.

(c) **Discovery documents.** Discovery depositions, interrogatories, requests for production or inspection, and responses thereto shall not be filed with the commission, except when permitted on a case-by-case basis, or when relevant to a motion, to which they or the relevant portions thereof shall be attached as an exhibit.

(d) **Appeals.**

(1) Any party who files an appeal from a compensation order or award made by the full commission shall be assessed a fifteen-dollar processing fee.

(2) Such fee shall be paid by appellant and/or cross appellant with the filing of

appeal.

(3) The record shall not be compiled and certified until such time as the processing fee has been received and acknowledged by the Clerk of the Commission.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1991 and amended September 20, 2001.)"

**11 CAR § 25-115. Joint petition settlements.**

(a) The joint petition must set forth in detail the reasons its approval will be in the claimant's best interest as required by Arkansas Code § 11-9-805(b).

(b) Joint petition settlements under Arkansas Code § 11-9-805(a) will be heard by an administrative law judge in the county in which the accident occurred or at a location convenient to the parties involved.

(c) No joint petition will be heard by an administrative law judge until five (5) days after the petition or a copy of the petition has been filed with the Workers' Compensation Commission.

(d) It shall be necessary for the claimant to appear and testify at a joint petition hearing.

(e) Petitions shall be signed by all parties, including the claimant, and must be verified.

(f) Under certain circumstances, the commission may designate or direct the parties to take claimant's testimony by deposition or interrogatories.

(g)(1) In all joint petitions where the claimant is represented by an attorney, the amount of agreed attorney's fees shall be set out in the petition.

(2) No attorney's fee shall be approved if it exceeds the limitations provided for in Arkansas Code § 11-9-715.

(3) If costs are claimed by a claimant's attorney, the:

- (A) Amount of the costs must be set forth in the joint petition; and
- (B) Reasonableness and necessity of the costs must be proved at the hearing.

(h) An administrative law judge who declines to approve a proposed settlement by joint petition may disqualify himself or herself from further action in that docket and related dockets.

**Authority.** Arkansas Code §§ 11-9-207, 11-9-715.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective date April 1, 1989)"

**11 CAR § 25-116. Reporting costs, transcription costs, and witness fees.**

**(a) Hearings and transcriptions.**

(1) The expense of taking and transcribing a hearing, including expenses incurred as a result of providing a non-English language interpreter where necessary before the Workers' Compensation Commission or administrative law judge (ALJ) shall be borne by the respondents.

(2) Provided, however, that no such expense shall be assessed against the Death and Permanent Total Disability Trust Fund or the Second Injury Trust Fund unless the commission or an ALJ determines that such expense is justified and directs the Death and Permanent Total Disability Trust Fund or the Second Injury Trust Fund to pay such expense or some portion thereof.

**(b) Depositions.**

(1) The expense or cost of reporting and transcribing depositions, including expenses incurred as a result of providing a non-English language interpreter where necessary, shall be borne by the respondents, except as indicated herein below.

(2) The expense or cost of reporting and transcribing depositions, including expenses incurred as a result of providing a non-English language interpreter where necessary, taken prior to the time a case is controverted shall be borne by the party requesting authorization to take said deposition.

(3) The cost of reporting and transcribing depositions, including expenses incurred as a result of providing a non-English language interpreter where necessary, taken after a case has been controverted, and where said depositions are to be made a part of the record, shall be borne by the respondents.

(c) **Witnesses.** The charge or fee made by the attending witness at depositions or hearings shall be paid as follows:

(1) The party who seeks to introduce or is relying upon the testimony of a witness shall be liable for the attendance fee of said witness; and

(2) All other witnesses shall be paid by the party which is responsible as set out in subsequent paragraphs.

(d) **Providers.**

(1) In the event a written report of a physician, osteopath, chiropractor, or other provider is offered in evidence and the right of cross-examination is requested, it will be granted.

(2) The party offering the report must produce the author of the report for cross-examination, but the attendance fee or charge of the witness is the liability of the party requesting cross-examination.

(3) In other types of written reports or evidence, the party offering the report shall, at his or her expense, produce the author of the report for cross-examination.

(4) If the commission or ALJ sends a claimant to a physician, osteopath, chiropractor, or other provider for examination or treatment, the cost of the examination or treatment is the liability of the respondents.

(5) If a written report of a doctor selected by the commission or ALJ is offered in evidence and cross-examination is requested, it will be granted, however, the party requesting cross-examination shall be liable for payment of the doctor's witness fee.

(e) **Uninsured employers.** The foregoing subsections do not apply in the case of

an uninsured employer where it is found he or she is not subject to the workers' compensation laws.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982; amended March 26, 1982; amended September 20, 2001.)"

**11 CAR § 25-117. Treatment at Veterans Affairs Hospital.**

(a) In the event an injured workman enters a United States Department of Veterans Affairs hospital for treatment of an on-the-job injury, the hospital, as soon as it ascertains from the injured employee that he or she is suffering from an alleged compensable injury, shall promptly notify the employer and its insurance carrier, as well as the Workers' Compensation Commission that the injured employee is under its care.

(b)(1) Upon receipt of such notice, the employer or its insurance carrier shall immediately offer in writing to provide the employee care in a private hospital under the care of a private physician qualified to treat the particular difficulty.

(2) The treating physician shall be chosen by respondents, but the right of the employee to change physicians under Section 11, Arkansas Statutes § 81-1311, shall not be abrogated.

(c) A copy of the offer shall be furnished to the hospital.

(d) In the event the offer is declined by the employee, then the employer and its insurance carrier shall not be liable for the expense of the treatment rendered by the hospital.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of

Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

This section as promulgated prior to codification into the Code of Arkansas Rules contained a footnote to 11 CAR § 25-117(b)(2) following the phrase "under Section 11, Arkansas Statutes § 81-1311" as follows:

"\* See Ark. Code Ann. § 11-9-514."

**11 CAR § 25-118. Replacement of prosthesis.**

Where a prosthesis (glasses, dentures, artificial limbs, etc.) is damaged or destroyed as a result of an on-the-job accident, the employer or insurance carrier shall bear the expense of repair or replacement of the prosthesis, even though the employee does not receive a physical injury in the accident.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

**11 CAR § 25-119. Deviation from this part.**

For good cause shown, the Workers' Compensation Commission or an administrative law judge may permit deviation from this part insofar as compliance is impossible or impracticable.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

**11 CAR § 25-120. Scope of review on appeal.**

(a) Parties appealing or cross-appealing to the full Workers' Compensation Commission from an order or award of an administrative law judge or a single commissioner shall specify in the notice of appeal or cross-appeal all issues to be presented.

(b)(1) All legal and factual issues should be developed at the hearing before the administrative law judge or single commissioner.

(2) The commission may refuse to consider issues not raised below.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective March 1, 1982)"

**11 CAR § 25-121. Conferences with legal advisor.**

(a)(1) Pursuant to Arkansas Code § 11-9-703 and legislative mandate, the Legal Advisor Division is directed to set and to conduct preliminary conferences, called mediation conferences, with the goal of mediating disputed issues between claimants and respondents.

(2) A mediation conference shall be held in all cases in which the amount in dispute is two thousand five hundred dollars (\$2,500) or less.

(b)(1) Upon written request by either party for a formal hearing, the mediator shall determine whether the dispute between the parties exceeds an amount of two

thousand five hundred dollars (\$2,500).

(2) If the mediator determines it does not, a mediation conference order shall be issued scheduling a mediation conference within thirty (30) days of the date of said determination.

(c)(1) The mediation conference shall be informal, nonbinding, and strictly confidential.

(2) The mediator is authorized to compel attendance at the conference but is not authorized to compel settlement.

(3) The mediator is not authorized to disclose any conference proceedings or communications.

(d)(1) Attendance by the parties, and/or a representative of each party having full authority to settle all issues, is required.

(2) Sanctions may be imposed upon any party willfully failing to attend a mediation conference without good cause.

(3) Sanctions may include dismissal, default, and/or fines as provided in Arkansas Code § 11-9-706.

(e) Mediation conferences may be conducted by telephone conference call or in person, in the county where the accident occurred, if the accident occurred in Arkansas, unless otherwise agreed to by the parties, or otherwise directed by the Workers' Compensation Commission.

(f)(1) Following the conference, the Report of Mediation Conference (Form R) shall be placed in the file and copies sent to the parties.

(2) The file shall then be returned to the Clerk of the Commission for further disposition prior to being returned to open general files.

(g) The mediation conferences shall be conducted according to policies and procedures approved and published by the commission.

(h) If all parties agree to voluntary mediation, the commission will provide mediation services regardless of the amount in dispute.

**Authority.** Arkansas Code §§ 11-9-207, 11-9-706.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Approved September 9, 1997, effective January 1, 1998; amended September 20, 2001.)"

**11 CAR § 25-122. Medical reports.**

(a)(1) Medical reports are to be:

(A) Requested by the insurance carrier/self-insured in a timely manner;

and

(B) Filed with the Workers' Compensation Commission upon receipt.

(2) Medical report filings should be limited to only those reports which provide information relative to:

(A) Diagnosis;

(B) Prognosis;

(C) Impairment ratings; and

(D) Return to work information.

(b) The commission may, at its discretion, request other medical information.

(c) In the event an insurance carrier/self-insured cannot obtain a medical report from the medical provider, then the insurance carrier/self-insured will not be responsible for the payment of the bill of the medical provider until such time as the insurance carrier/self-insured is provided a medical report outlining the services rendered.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective date April 1, 1989; Revised effective October 5, 2007; effective date January 1, 2008.)"

**11 CAR § 25-123. Death and permanent total disability.**

**(a) Trust fund claims — Death claims.**

(1) Employers or their designees shall report all work-related deaths by filing forms AR-D and AR-W with the Death and Permanent Total Disability Trust Fund within thirty (30) days of the death.

(2) Employers or their designees shall update the AR-D form in subdivision (a)(1) of this section within ten (10) days of receipt of additional information or claims.

(3) Employers or their designees shall provide notice to the trust fund within fifteen (15) days of controverting a claim for dependent benefits.

**(b) Trust fund claims — Permanent total disability claims.**

(1)(A) Employers or their designees shall file an AR-D form with the trust fund within thirty (30) days of acknowledging permanent total disability liability.

(B) Thereafter, an AR-D form shall be filed with the trust fund January 31 of each year benefits are paid except in claims in which the trust fund has issued a certificate of acceptance.

(2)(A) Any party desiring to join the trust fund in a controverted claim for permanent and total disability benefits shall notify the Workers' Compensation Commission Special Funds Administrator and all other parties by written notice and a form of mail requiring a signed receipt, no later than sixty (60) days prior to the hearing.

(B) The notice provided in subdivision (b)(2)(A) of this section must include all documentary and other evidence the party intends to rely upon to support the claim of liability.

(3) Failure to provide notice as set out in subdivision (b)(2) of this section shall constitute a waiver of a claim of trust fund liability until such time as the notice requirements are met.

**(c) Trust fund claims — Delinquent claims.**

(1) Failure to comply with the notice requirements of subdivisions (a)(1) and (b)(1) of this section, above, shall result in a penalty of fifteen dollars (\$15.00) per day for each day an employer or its designee fails to comply, up to a maximum penalty of ten thousand dollars (\$10,000), unless, after a showing of good cause, failure to provide notice is excused by the commission.

(2) Employers or their designees who violate subdivision (c)(1) of this section shall continue to make payments for appropriate death and permanent total disability benefits in addition to the statutory maximum provided in Arkansas Code § 11-9-502(b)(1) for ninety (90) days after the AR-D form is filed with the trust fund.

(d) **Trust fund claims — Due process rights.** The trust fund has an absolute right to investigate, challenge, and defend any claim made against it within ninety (90) days of receipt of notice of the claim, or a longer period for good cause shown.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective originally on April 1, 1989; Revision approved December 1, 2003, effective January 1, 2004)"

**11 CAR § 25-124. Designated claim office — Administrator — Underwriter.**

(a) **Carrier/self-insurer responsibilities.** Each insurance carrier or approved self-insurer shall:

(1) Designate to the Workers' Compensation Commission in the form and manner prescribed by the commission:

(A)(i) A claim office which shall:

(a)(1) Be approved by the commission to handle Arkansas workers' compensation claims.

(2) Should the claim office be that of a third-party administrator (hereafter TPA), the TPA shall also be approved, as well as the claim office location; and

(b) Be responsible to the commission for the receiving, processing, adjusting, and submission of forms, or otherwise handling of any Arkansas workers' compensation claim.

(ii) A carrier or self-insurer may not utilize the services of any claim office until that office has been approved by the commission.

(iii) Should an insurance carrier's designated claim office be a TPA, it shall be the responsibility of the carrier to provide the designated TPA an information system whereby that TPA can make immediate referrals to any other claim facility servicing accounts for the carrier;

(B) An administrator who shall:

(i) Be an employee of the carrier, self-insurer, or of the carrier's or self-insurer's parent company;

(ii) Serve as the commission's contact person and have sufficient authority to take action and/or implement procedural changes to maintain compliance with:

(a) Arkansas law;

(b) Commission rules and/or commission advisories;

(c) Any order of an administrative law judge, the full commission, Court of Appeals, and/or the Supreme Court; and

(d) Any other workers' compensation matter; and

(iii)(a) Be someone other than the designated claim office contact person.

(b) Exceptions to this may be allowed, subject to approval by the commission on a case-by-case basis; and

(C)(i) An underwriting contact person (applies to carriers only).

(ii) This person shall be the contact point for insurance policy questions regarding coverage, such as, but not limited to:

- (a) Policy numbers;
- (b) Entities covered; and
- (c) Coverage dates;

(2) Be responsible to the commission for the actions or inactions of the designated claim office or any other office in which claims are being handled;

(3) Work promptly and cooperatively with the commission to resolve any questions, issues, requests, or complaints; and

(4) Maintain current information for the claim office location, administrator, and underwriter information.

(b) **Designated claim office responsibilities.** The designated claim office, regardless of the location at which any specific claim is adjusted, shall:

(1) Serve as the sole contact point for the commission regarding claim-specific issues;

(2) Have a designated claims officer with sufficient knowledge and authority to answer inquiries from the commission;

(3) Be able to access claim information for all Arkansas claims for the carrier/self-insurer whether adjusted within that office or adjusted by another claim office or company;

(4) Be the office responsible to the commission for the proper filing of all commission forms for the carrier/self-insurer; and

(5) Work promptly and cooperatively with the commission to resolve any questions, issues, requests, or complaints.

(c) **Commission approval of claim office.**

(1) The commission retains the right to approve or deny a particular claim office from serving or being selected as the designated claim office.

(2) **Claim office approval.** In approving a designated claim office, the commission may require submission of evidence demonstrating knowledge, experience, and/or licensing of adjusters to satisfy the commission of the claim office's ability to handle Arkansas workers' compensation claims.

(3) **Claim office probation.**

(A) The commission may place a specific claim office on probation in the event of:

(i) Improper completion of forms;  
(ii) Failure to file forms or notices with the commission in a timely manner;

(iii) Failure to respond to commission requests for information or additional documentation; and/or

(iv) Any other grounds that prevent the timely, efficient, accurate handling of workers' compensation claims.

(B) Any claim office placed on probation shall be given notice:

(i) Indicating the reason or reasons for probation; and  
(ii) Establishing the terms and conditions by which probation may be removed.

**(4) Claim office approval revocation.**

(A) The commission may immediately revoke approval for any claim office to handle Arkansas workers' compensation claims for any carrier or self-insured employer.

(B) If approval is revoked, notice shall be sent to:

(i) The claim office providing at least thirty (30) days' notice to cease operations involving the handling of Arkansas workers' compensation claims at that location; and

(ii) Any carrier or self-insured employer for which that claim office handles Arkansas workers' compensation claims indicating that claim office's approval to handle claims has been revoked and providing the carrier or self-insured at least thirty (30) days in which to secure the services of, and designate to the commission, another claim office.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of

Arkansas Rules provided as follows:

"(Revised October 5, 2007; effective date January 1, 2008.)"

**11 CAR § 25-125. Medical cost containment program.**

**(a) General provisions.**

**(1) Scope.**

(A) This section does all of the following:

(i)(a) Establishes procedures by which the employer shall furnish, or cause to be furnished, to an employee who receives a personal injury arising out of and in the course of employment, reasonable and necessary medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of the state as legal, when needed.

(b) The employer shall also supply to the injured employee dental services, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably and necessarily possible, and relieve from the effects of the injury;

(ii) Establishes schedules of maximum fees by a health facility or healthcare provider for such:

(a) Treatment or attendance;

(b) Service;

(c) Device;

(d) Apparatus; or

(e) Medicine;

(iii) Establishes procedures by which a healthcare provider shall be paid the lesser of the:

(a) Provider's usual charge;

(b) Maximum fee established under this section; or

(c) MCO/PPO contracted price, where applicable;

(iv) Provides for:

(a) The identification of utilization of health care and health services above the usual range of utilization for such services, based on medically accepted standards; and

(b) Acquiring by a carrier and by the Medical Cost Containment Division (MCCD) of the necessary records, medical bills, and other information concerning any health care or health service under review;

(v) Establishes a system for the evaluation by a carrier of the appropriateness in terms of both the level of and the quality of health care and health services provided to injured employees, based upon medically accepted standards;

(vi) Authorizes carriers to withhold payment from or recover payment from, health facilities or healthcare providers which have:

(a) Made excessive charges; or

(b) Required unjustified and/or unnecessary:

(1) Treatment;

(2) Hospitalization; or

(3) Visits;

(vii) Provides for the review by the Workers' Compensation Commission of the records and medical bills of any health facility or healthcare provider which has been determined not to be in compliance with this section or to be requiring unjustified and/or unnecessary:

(a) Treatment;

(b) Hospitalization; or

(c) Office visits;

(viii) Establishes that when a healthcare facility or healthcare provider provides health care or healthcare service that is not usually associated with, is longer in duration than, is more frequent than, or extends over a greater number of days than that health care or service usually does with the diagnosis or condition for which the patient is being treated, the healthcare provider may be required by the carrier to explain the necessity in writing;

(ix)(a) Provides for the implementation of the MCCD review and

decision responsibility.

(b) This section and its definitions are not intended to supersede or modify:

(1) The workers' compensation laws;

(2) The administrative rules of the commission; or

(3) Court decisions interpreting the laws or the commission's administrative rules;

(x) Provides for the certification of carriers determined to be in compliance with the criteria and standards established by this section in their utilization review of services and charges by healthcare facilities and healthcare providers;

(xi) Establishes maximum fees for depositions/witnesses;

(xii) Establishes maximum fees for medical reports;

(xiii) Provides for uniformity of billing for provider services;

(xiv) Establishes the effective date for implementation of this section;

(xv) Adopts by reference as part of this section the medical fee schedule and any amendments to that fee schedule;

(xvi) Establishes procedures for balance billing;

(xvii) Establishes procedures for reporting of medical claims;

(xviii) Establishes procedures for obtaining medical services by out-of-state providers; and

(xix)(a) Establishes procedures for preauthorization of nonemergency hospitalizations, transfers between facilities, and outpatient services expected to exceed one thousand dollars (\$1,000) in billed charges for a single date of service by a provider.

(b) See Arkansas Workers' Compensation Commission Inpatient Hospital Fee Schedule Part III.

(B) An independent medical examination performed to evaluate legal liability of a case, or for purposes of litigation of a case, shall be exempt from this section.

**(2) Procedure codes.**

(A)(i) Services must be coded with valid procedure or supply codes of the Health Care Financing Administration Common Procedure Coding System (HCPCS).

(ii) Procedure codes used in this section were developed and copyrighted by the American Medical Association.

(B) The most current edition of the Current Procedural Terminology (CPT) should be used for this section.

**(3) Procedures for which codes are not listed.**

(A)(i) If a procedure is performed which is not listed in the Medicare Resource Based Relative Value Scale (RBRVS), the healthcare provider must use an appropriate CPT procedure code.

(ii) The provider must submit:

*(a)* An explanation, such as copies of:

*(1)* Operative reports;

*(2)* Consultation reports;

*(3)* Progress notes;

*(4)* Office notes; or

*(5)* Other applicable documentation; or

*(b)* A description of equipment or supply (when that is the charge).

(B)(i) The CPT contains procedure codes for unlisted procedures.

(ii) These codes should only be used when there is no procedure code which accurately describes the service rendered.

(iii) A special report is required as these services are reimbursed BR (by report).

(C) Reimbursement by the carrier for BR procedures should be based upon the carrier's review of the submitted documentation, the recommendations from the carrier's medical consultant, and the carrier's review of the prevailing charges for similar services as identified by the carrier based on data which is representative of Arkansas charges.

**(4) Modifier codes.**

(A) Modifiers listed in the CPT shall be added to the procedure code when the service or procedure has been altered from the basic procedure described by the descriptor.

(B)(i) The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed.

(ii) Reimbursement for modified services or procedures must be:

(a) Based on documentation of reasonableness and necessity;  
and

(b) Determined on a case-by-case basis.

(C)(i) When Modifier 21, 22, or 25 is used, a report explaining the medical necessity of the situation must be submitted to the carrier.

(ii) It is not appropriate to use Modifier 21, 22, or 25 for routine billing.

**(5) Total procedures billed separately.**

(A)(i) Certain diagnostic procedures (neurologic testing, radiology and pathology procedures, etc.) may be performed by two (2) separate entities who also bill separately for the professional and technical components.

(ii) When this occurs, the total reimbursement must not exceed the maximum medical fee schedule allowable for the five-digit procedure code listed.

(B) When billing for the professional component only, Modifier 26 must be added to the appropriate five-digit procedure code.

(C) When billing for the technical component only, Modifier TC (technical component) must be added to the appropriate five-digit code.

**(6) Definitions.** As used in this section:

(A) "Act" means the Workers' Compensation Law, Arkansas Code § 11-9-101 et seq.;

(B) "Adjust" means that a carrier or a carrier's agent reduces a healthcare provider's request for payment such as:

(i) Applies the commission maximum fee;

(ii) Applies an agreed-upon discount to the provider's usual charge;

(iii) Adjusts to a reasonable amount when the maximum fee is by report;

(iv) Recodes a procedure; or

(v) Reduces payment as a result of utilization review;

(C) "Appropriate care" means health care that is suitable for a particular:

(i) Person;

(ii) Condition;

(iii) Occasion; or

(iv) Place;

(D) "Bill" means a request by a provider submitted to a carrier for payment for healthcare services provided in connection with a covered injury or illness;

(E) "Bill adjustment" means a reduction of a fee on a provider's bill;

(F)(i) "BR (by report)" means that the procedure is not assigned a maximum fee and requires a written description.

(ii) The description shall be included on the bill or attached to the bill and shall include the following information, as appropriate:

(a) Copies of operative reports;

(b) Consultation reports;

(c) Progress notes;

(d) Office notes or other applicable documentation; and

(e) Description of equipment or supply (when that is the charge);

(G)(i) "Carrier" means any stock company, mutual company, or reciprocal or interinsurance exchange or self-insured employer authorized to write or carry on the business of workers' compensation insurance in this state.

(ii) Whenever required by the context, the term "carrier" shall be deemed to include duly qualified self-insureds or self-insured groups;

(H) "Case" means a covered injury or illness occurring on a specific date and identified by the worker's name and date of injury or illness;

(I) "Case record" means the complete healthcare record maintained by the carrier pertaining to a covered injury or illness occurring on a specific date, and

includes:

(i) The circumstances or reasons for seeking health care;  
(ii) The supporting facts and justification for initial and continual receipt of health care;  
(iii) All bills filed by a healthcare service provider; and  
(iv) Actions of the carrier which relate to the payment of bills filed in connection with a covered injury or illness;

(J) "Commission" means the Workers' Compensation Commission;

(K) "Complete procedure" means a procedure containing a series of steps which are not to be billed separately;

(L)(i) "Consultant service" means, in regard to the health care of a covered injury and illness, an examination, evaluation, and opinion rendered by a specialist when requested by the authorized treating practitioner or by the employee, and which includes:

(a) A history;

(b) An examination;

(c) An evaluation of treatment; and

(d) A written report.

(ii) If the consulting practitioner assumes responsibility for the continuing care of the patient, subsequent service ceases to be a consultant service;

(M) "Covered injury or illness" means an injury or illness for which treatment is mandated;

(N) "Critical care" is defined in the most current CPT;

(O) "Day" means calendar day;

(P) "Diagnostic procedure" means a service which aids in determining the nature and cause of a disease or injury;

(Q) "Dispute" means a disagreement between a carrier or a carrier's agent and a healthcare provider on the application of this section;

(R) "DRG (diagnosis related group)" means one (1) of the classifications of diagnoses in which patients demonstrate similar resource consumption and length-of-

stay patterns;

(S) "Durable medical equipment" is equipment which:

(i) Can withstand repeated use;

(ii) Is primarily and customarily used to serve a medical purpose;

(iii) Generally is not useful to a person in the absence of illness or

injury; and

(iv) Is appropriate for use in the home;

(T) "Established patient" is defined in the most current CPT;

(U) "Expendable medical supply" means a disposable article which is needed in quantity on a daily or monthly basis;

(V) "Focused review" means the evaluation of a specific healthcare service or provider to establish patterns of use and dollar expenditures;

(W) "Follow-up care" means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum allowable payment, but does not include care for complications;

(X) "Follow-up visits" means the number of office visits following a surgical procedure which are included in the procedure's maximum allowable payment, but does not include care for complications;

(Y) "Follow-up visits" means the number of office visits following a surgical procedure which are included in the procedure's maximum allowable payment, but does not include care for complications;

(Z) "Healthcare organization" means a group of practitioners or individuals joined together to provide healthcare services and includes, but is not limited to:

(i) A freestanding surgical outpatient facility;

(ii) A health maintenance organization;

(iii) An industrial or other clinic;

(iv) An occupational healthcare center;

(v) A home health agency;

(vi) A visiting nurse association;

(vii) A laboratory;

(viii) A medical supply company; or

(ix) A community mental health center;

(AA) "Healthcare review" means the review of a healthcare case or bill, or both, by a carrier or the carrier's agent;

(BB) "Inappropriate health care" means health care that is not suitable for a particular person, condition, occasion, or place;

(CC) "Incidental surgery" means a surgery:

(i) Performed through the same incision;

(ii) On the same day;

(iii) By the same doctor; and

(iv) Not related to the diagnosis;

(DD) "Independent medical examination" means an examination and evaluation conducted by a practitioner different from the practitioner providing care;

(EE) "Independent procedure" means a procedure which may be carried out by itself, separate, and apart from the total service that usually accompanies it;

(FF) "Inpatient services" means services rendered to a person who is formally admitted to a hospital or whose length of stay exceeds twenty-three (23) hours;

(GG) "Institutional services" means all nonphysician services rendered within the institution by an agent of the institution;

(HH) "Maximum allowable payment" means the maximum fee for a procedure established by this section or the provider's usual and customary charge, whichever is less, except as otherwise might be specified;

(II) "Maximum fee" means the maximum allowable fee for a procedure established by this section;

(JJ) "Medical admission" means any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature;

(KK) "Medical only case" means a case which does not involve lost work time;

(LL) "Medically accepted standard" means a measure which is set by a

competent authority as the rule for evaluating quantity or quality of health care or healthcare services and which may be defined in relation to any of the following:

- (i) Professional performance;
- (ii) Professional credentials;
- (iii) The actual or predicted effects of care; and
- (iv) The range of variation from the norm;

(MM) "Medically appropriate care" means health care that is suitable for a particular:

- (i) Person;
- (ii) Condition;
- (iii) Occasion; or
- (iv) Place;

(NN) "Medical supply" means either a piece of durable medical equipment or an expendable medical supply;

(OO) "Modifier code" means a two-digit number used in conjunction with the procedure code to describe unusual circumstances which arise in the treatment of an injured or ill employee;

(PP) "New patient" means a patient who is new to the provider for a particular covered injury or illness and who needs to have medical and administrative records established;

(QQ) "Operative report" means the practitioner's written description of the surgery and includes all of the following:

- (i) A preoperative diagnosis;
- (ii) A postoperative diagnosis;
- (iii) A step-by-step description of the surgery;
- (iv) An identification of problems which occurred during surgery; and
- (v) The condition of the patient when leaving the operating room, the practitioner's office, or the healthcare organization;

(RR) "Optometrist" means an individual licensed to practice optometry;

(SS) "Optometry" shall be defined according to Arkansas Code § 17-90-

101;

(TT) "Orthotic equipment" means an orthopedic apparatus designed to support, align, prevent, correct deformities, or improve the function of a movable body part;

(UU) "Orthotist" means a person skilled in the construction and application of orthotic equipment;

(VV) "Outpatient service" means a service provided by the following, but not limited to, types of facilities:

- (i) Physicians' offices and clinics;
- (ii) Hospital emergency rooms;
- (iii) Hospital outpatient facilities;
- (iv) Community mental health centers;
- (v) Outpatient psychiatric hospitals;
- (vi) Outpatient psychiatric units; and
- (vii) Freestanding surgical outpatient facilities;

(WW)(i) "Package" means a surgical procedure that includes, but is not limited to, all of the following components:

- (a) The operation itself;
- (b) Local infiltration;
- (c) Topical anesthesia when used; and
- (d) The normal, uncomplicated follow-up care/visits.

(ii) This includes a standard postoperative period of thirty (30) days, except CPT-starred procedures;

(XX) "Pharmacy" means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced;

(YY) "Practitioner" means a person licensed, registered, or certified as:

- (i) An audiologist;
- (ii) A doctor of chiropractic;
- (iii) A doctor of dental surgery;

- (iv) A doctor of medicine;
- (v) A doctor of osteopathy;
- (vi) A doctor of podiatry;
- (vii) A doctor of optometry;
- (viii) A nurse;
- (ix) A nurse anesthetist;
- (x) A nurse practitioner;
- (xi) An occupational therapist;
- (xii) An orthotist;
- (xiii) A pharmacist;
- (xiv) A physical therapist;
- (xv) A physician's assistant;
- (xvi) A prosthetist;
- (xvii) A psychologist; or
- (xviii) Any other person licensed, registered, or certified as a

healthcare professional;

(ZZ) "Primary procedure" means the therapeutic procedure most closely related to the principle diagnosis;

(AAA) "Procedure" means a unit of health service;

(BBB) "Procedure code" means a five-digit numerical sequence or a sequence containing an alpha or alphas and followed by three (3) or four (4) digits, which identifies the service performed and billed;

(CCC)(i) "Properly submitted bill" means a request by a provider for payment of healthcare services submitted to a carrier on the appropriate forms which are completed pursuant to this section.

(ii) "Properly submitted bills" shall include appropriate documentation as required by this section;

(DDD) "Prosthesis" means an artificial substitute for a missing body part;

(EEE) "Prosthetist" means a person skilled in the construction and application of a prosthesis;

(FFF) "Provider" means a facility, healthcare organization, or a practitioner;

(GGG) "Reasonable amount" means a payment based upon the amount generally paid in the state for a particular procedure code using data available from but not limited to the provider, the carrier, or the Workers' Compensation Commission;

(HHH) "Reject" means that a carrier or a carrier's agent denies payment to a provider or denies a provider's request for reconsideration;

(III) "Secondary procedure" means a surgical procedure which is:

(i) Performed to ameliorate conditions that are found to exist during the performance of a primary surgery; and

(ii) Considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition;

(JJJ) "Specialist" means a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a particular field of healthcare service by virtue of education, training, and experience generally accepted by practitioners in that particular field of healthcare service;

(KKK) "Specialist service" means, in regard to the health care of a covered injury and illness, the treatment by a specialist, when requested by the treating practitioner, carrier, or by the employee, and includes:

(i) A history;

(ii) An examination;

(iii) An evaluation of medical data;

(iv) Treatment; and

(v) A written report;

(LLL) "Stop-loss payment (SLP)" means an independent method of payment for an unusually costly or lengthy stay;

(MMM) "Stop-loss reimbursement factor (SLRF)" means a factor established by the Workers' Compensation Commission to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds;

(NNN) "Stop-loss threshold (SLT)" means a threshold of charges established by the Workers' Compensation Commission, beyond which reimbursement is calculated by multiplying the applicable stop-loss reimbursement factor times the total charges identifying that particular threshold;

(OOO) "Surgical admission" means any hospital admission where the primary services rendered are not medical, psychiatric, or rehabilitative in nature;

(PPP)(i) "Transfer between facilities" means to move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care.

(ii) It may or may not involve a change in the admittance status of the patient, i.e., patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in the facility in which the patient has been admitted.

(iii) This includes costs related to transportation of patient to obtain medical care;

(QQQ) "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges previously billed separately which are included in the package for that procedure as defined by this section;

(RRR) "Wage loss" case means a case that involves the payment of wage loss compensation; and

(SSS) "Workers' compensation standard per diem amount (SPDA)" means a standardized per diem amount established for the reimbursement for hospitals for services rendered.

**(7) Information program regarding section.**

(A) The Medical Cost Containment Division shall institute an ongoing information program regarding this section for providers, carriers, and employers.

(B) The program shall include, at a minimum, information sessions throughout the state, as well as the distribution of appropriate information materials.

**(8) Independent medical examination to evaluate medical aspects of**

**case.**

(A)(i) An independent medical examination shall include a study of previous history and medical care information, diagnostic studies, diagnostic x-rays, and laboratory studies, as well as an examination and evaluation.

(ii) This service may be necessary in order to:

(a) Make a judgment regarding the current status of the injured or ill worker; or

(b) Determine the need for further health care.

(B)(i) An independent medical examination, performed to evaluate the medical aspects of a case, shall be billed using the independent medical examination procedure code 99199 (BR), and shall include the practitioner's time only.

(ii) The office visit charge is included with the code 99199 and may not be billed separately.

(C) Any laboratory procedure, x-ray procedure, and any other test which is needed to establish the worker's ability to return to work shall be identified by the appropriate procedure code established by this section.

**(9) Payment.**

(A)(i) Reimbursement for healthcare services shall be the lesser of the:

(a) Provider's usual charge;

(b) Maximum fee calculated according to the Workers' Compensation Commission Official Fee Schedule, and/or any amendments to that fee schedule; or

(c) MCO/PPO contracted price, where applicable.

(ii) A licensed provider shall receive no more than the maximum allowable payment, in accordance with this section, for appropriate healthcare services rendered to a person who is entitled to healthcare service.

(C)(i) The Medicare RBRVS is adopted by reference as part of this section.

(ii) The Medicare RBRVS is distributed by the Office of the Federal Register and is also available on the internet.

(D)(i) When extraordinary services resulting from severe head injuries,

major burns, and severe neurologic injuries or any injury requiring an extended period of intensive care are required, a greater fee may be allowed up to one hundred fifty percent (150%) of the fee schedule.

(ii) Such cases should be billed with Modifier 21 or 22 (for CPT-coded procedures) and should contain a detailed written description of the extraordinary service rendered and the need therefor.

(E) Billing for provider services shall be submitted on the forms approved by the commission, UB-92 and HFCA-1500.

(F) A carrier shall not make a payment for a service unless all required review activities pertaining to that service are completed.

(G)(i) A carrier's payment shall reflect any adjustments in the bill made through the carriers' utilization review program.

(ii) A carrier must provide an explanation of medical benefits to a healthcare provider whenever the carrier's reimbursement differs from the amount billed by the provider.

(iii) A provider shall not attempt to collect from the injured employee, employer, or carrier any amounts reduced by the carrier pursuant to this section.

(H)(i) A carrier shall date-stamp medical bills and reports upon receipt and shall pay an undisputed and properly submitted bill within thirty (30) days of receipt.

(ii) Any carrier not paying an undisputed and properly submitted bill within thirty (30) days of receipt shall be assessed a penalty of eighteen percent (18%), upon a determination by MCCD.

(I)(i) When a carrier disputes a bill or portion thereof, the carrier shall pay the undisputed portion of the bill within thirty (30) days of receipt of a properly submitted bill.

(ii) Any carrier not paying an undisputed portion of the bill within thirty (30) days of receipt can be assessed a penalty of eighteen percent (18%) on the undisputed portion of the bill, upon a determination by MCCD.

(J)(i) Any penalty for late payment will be assessed by the division after an administrative review has been conducted.

(ii) The penalty is payable to the medical provider.

(K)(i) Billings not submitted on the proper form may be returned to the provider for correction and resubmission.

(ii) If a carrier returns such billings, it must do so within twenty (20) days of receipt of the bill.

(iii) The number of days between the date the carrier returns the billing to the provider and the date the carrier receives the corrected billing shall not apply toward the thirty (30) days within which the carrier is required to make payment.

(10) **Reimbursement for employee-paid services.** Notwithstanding any other provision of this section, if an employee has personally paid for a healthcare service and at a later date a carrier is determined to be responsible for the payment, then the employee shall be fully reimbursed by the carrier.

(11) **Recovery of payment.**

(A)(i) Nothing in this section shall preclude the recovery of payment for services and bills which may later be found to have been medically paid at an amount which exceeds the maximum allowable payment.

(ii) This also includes payments reimbursed to an employee pursuant to subdivision (a)(10) above.

(B) A carrier may recover a payment to a provider, whether by an employee or a carrier, if the carrier requests the provider for the recovery of the payment, with a statement of reasons for the request, within one (1) year of the date of payment.

(C) Within thirty (30) days of receipt of the carrier's request for recovery of the payment, the provider shall do either of the following:

(i) If in agreement with the request, refund the payment to the carrier; or

(ii) If not in agreement with the request, supply the carrier with a written detailed statement of the reasons for its disagreement, along with a refund of the portion, if any, of the payment that the provider agrees should be refunded.

(D)(i) If the carrier does not accept the reason for disagreement supplied

by the provider, the carrier may file a request for administrative review within thirty (30) days of receipt of the provider's statement of disagreement.

(ii) The request for review shall be filed with the Administrator of the Medical Cost Containment Division and the carrier shall supply a copy to the provider.

(E) If, within sixty (60) days of the carrier's request for recovery of a payment, the carrier does not receive either a full refund of the payment or a statement of disagreement, then, at the option of the carrier, the carrier may do either or both of the following:

(i) File a request for administrative review, of which the carrier shall supply a copy to the provider; or

(ii) Reduce the payable amount on the provider's subsequent bills (in the case in question or any other case) to the extent of the request for recovery of payment.

(F) If, within thirty (30) days of a final order of any decision of the commission a provider does not pay in full any refund ordered, the carrier may reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment plus an additional eighteen percent (18%).

(12) **Amounts in excess of fees.** The provider shall not bill the employee, employer, or carrier for any amount for healthcare services provided for the treatment of a covered injury or illness when that amount exceeds the maximum allowable payment established by this section.

(13) **Missed appointment.**

(A) A provider shall not receive payment for a missed appointment unless the appointment was arranged by the carrier or the employer.

(B) If the carrier or employer fails to cancel the appointment not less than twenty-four (24) hours prior to the time of the appointment and the provider is unable to arrange for a substitute appointment for that time, the provider may bill the carrier for the missed appointment using procedure code 99199 with a maximum fee of BR.

(14) **Medical report of initial visit and progress reports for other than inpatient hospital care.**

(A) Except for inpatient hospital care, a provider shall furnish the carrier with a narrative medical report for the initial visit, all information pertinent to the covered injury or illness if requested at reasonable intervals, and a progress report for every sixty (60) days of continuous treatment for the same covered injury or illness.

(B) If the provider continues to treat an injured or ill employee for the same covered injury or illness at intervals which exceed sixty (60) days, then the provider shall provide a progress report following each treatment that is at intervals exceeding sixty (60) days.

(C) The narrative medical report of the initial visit and the progress report shall include all of the following information:

(i) Subjective complaints and objective findings, including interpretation of diagnostic tests;

(ii) For the narrative medical report of the initial visit, the history of the injury, and for the progress report or reports, significant history since the last submission of a progress report;

(iii) The diagnosis;

(iv) As of the date of the narrative medical report or progress report, the projected treatment plan, including the type, frequency, and estimated length of treatment;

(v) Physical limitations; and

(vi) Expected work restrictions and length of time if applicable.

(D)(i) Cost of the narrative medical reports required by subdivision (a)(14)(A) of this section shall be reimbursed at the following rates:

(a) Initial report, forty dollars (\$40.00);

(b) Subsequent reports, eleven dollars (\$11.00); and

(c) Final report, twenty-eight dollars (\$28.00).

(ii) Under no circumstances may a provider bill for more than one (1) report per visit.

(iii) Initial reports should be billed using procedure code WC101, subsequent reports should be billed using procedure code WC102, and final reports

should be billed using procedure code WC103.

(E) A medical provider may not charge any fee for completing a medical report form required by the commission.

(15) **Additional reports.** Nothing in this section shall preclude a carrier or an employee from requesting reports from a provider in addition to those specified in the preceding section.

(16) **Deposition/witness fee limitation.**

(A) Any provider who gives a deposition shall be allowed a witness fee.

(B) Procedure code 99075 must be used to bill for a deposition.

(C) Reimbursement for a deposition is limited to twenty-eight dollars (\$28.00) per quarter hour, including preparation time.

(D) This limitation does not apply to an expert witness who has never provided direct professional services to a party or who has provided only direct professional services which were unrelated to the workers' compensation case.

(17) **Joint petition cases.** See 11 CAR § 25-115.

(18) **Out-of-state providers.**

(A) All services and requests for change-of-physician to out-of-state providers must be made to providers who agree to abide by the commission medical fee schedule.

(B) Providers shall sign an agreement stating they shall comply with this section.

(C) Carriers/self-insured employers which are not contracted with a certified managed care organization shall be responsible for obtaining this agreement.

(19) **Preauthorization.**

(A) Preauthorization is required for all nonemergency hospitalizations, transfers between facilities, and outpatient services expected to exceed one thousand dollars (\$1,000) in billed charges for a single date of service by a provider.

(B) A denial decision for payment for any type of healthcare services and/or treatment resulting from a utilization review, as opposed to a determination of whether such service or treatment is related to a compensable injury, shall only be

made by an Arkansas certified private review agent.

(C) The Department of Health utilization review certification number is required upon request.

(D) See Arkansas Workers' Compensation Hospital Inpatient Fee Schedule Part III for procedures for requesting preauthorization.

(E) Upon emergency admission, notice must be given to the carrier within twenty-four (24) hours or for the next business day.

**(b) Process for resolving differences between carrier and provider regarding bill.**

**(1) Carrier's dispute of a bill.**

(A) When a carrier adjusts and/or disputes a bill or portion thereof, the carrier shall notify the provider:

(i) Within thirty (30) days of the receipt of the bill of the specific reasons for adjusting and/or disputing the bill or portion thereof; and

(ii) Of its right to provide additional information and to request reconsideration of the carrier's action.

(B) If the provider sends a bill to a carrier and the carrier does not respond in thirty (30) days, and if a provider sends a second bill and receives no response within sixty (60) days from the date the provider supplied the first bill, the provider may then file a request for administrative review with the administrator, with a copy to the carrier.

(C)(i) The carrier shall notify the employer, employee, and the provider that this part prohibits a provider from billing an employee, employer, or carrier for any amount for healthcare services provided for the treatment of a covered work-related injury or illness when that amount:

(a) Is disputed by the carrier pursuant to its utilization review program; or

(b) Exceeds the maximum allowable payment established by the fee schedule.

(ii) The carrier shall request the employee to notify the carrier if the

provider so bills the employee or employer.

(D)(i) The carrier shall notify the division when a provider attempts to balance bill or attempts to bill when a dispute exists between a carrier and a provider regarding services.

(ii) A desk audit shall be conducted by the division on all notices regarding balance billing.

(iii) The provider and carrier shall be notified of the results of the desk audit.

(iv) Providers found guilty of balance billing shall be counseled (first offense) and may be referred to the appropriate authority (second offense).

(v) Providers found guilty of balance billing may ask for a review of the decision before referral by the division to the appropriate authority.

**(2) Provider's request for reconsideration of bill.**

(A) A provider may request reconsideration of its adjusted and/or disputed bill by a carrier within thirty (30) days of receipt of a notice of an adjusted and/or disputed bill or portion thereof.

(B) The provider's request to the carrier for reconsideration of the adjusted and/or disputed bill shall include a statement in detail of the reasons for disagreement with the carrier's adjustment and/or dispute of a bill or portion thereof.

**(3) Carrier's response to provider's request for reconsideration of bill — Provider's right to appeal.**

(A)(i) Within thirty (30) days of receipt of a provider's request for reconsideration, the carrier shall notify the provider of the actions taken and a detailed statement of the reasons.

(ii) The carrier's notification shall include an explanation of the appeal process provided under this section.

(B) If a provider is in disagreement with the action taken by the carrier on its request for reconsideration, the provider may file a request for administrative review within thirty (30) days from the date of receipt of a carrier's denial of the provider's request for reconsideration, and the provider shall supply a copy to the carrier.

(C) If within sixty (60) days of the provider's request for reconsideration, the provider does not receive payment for the adjusted and/or disputed bill or portion thereof, or a written detailed statement of the reasons for the actions taken by the carrier, then the provider may make application for administrative review.

**(4) Disputes.**

(A)(i) Unresolved disputes between a carrier and provider due to conflicting interpretation of this section and/or the official medical fee schedule may be appealed to, and resolved by, the administrator.

(ii) A request for administrative review may be submitted to:

Administrator of the Medical Cost Containment Division  
Arkansas Workers' Compensation Commission  
P.O. Box 950  
Little Rock, AR 72203-0950

(B) Valid requests for administrative review do not require a particular form but must be legible and contain copies of the following:

(i) Copies of the original and resubmitted bills in dispute which include:

(a) Dates of service;

(b) Procedure codes;

(c) Charges for services rendered and any payment received;

and

(d) An explanation of unusual services or circumstances;

(ii) Copies of the specific reimbursement;

(iii) Supporting documentation and correspondence, if any;

(iv) Specific information regarding contact with the carriers;

(v) A verified or declared written medical report signed by the physician; and

(vi) A specific written request for administrative review.

(C) The party requesting administrative review must send a copy of the request and all documentation accompanying the request to the opposing party.

**(c) Hearings.**

**(1) Administrative review procedure.**

(A)(i) When the request for administrative review is received by the administrator and it is determined that the commission has jurisdiction over the cause of action, all parties shall be notified by certified mail return receipt requested.

(ii) All parties shall have thirty (30) days from the date of receipt of notification to submit further evidence, documentation, or clarifications to the administrator.

(iii) After thirty (30) days, a decision will be determined by the administrator and an order will be issued to the parties.

(iv) Prior to this determination, the administrator may request all parties to attend a hearing on the matter.

(v) The hearing shall be recorded verbatim.

(vi) Failure to appear at such hearing may result in dismissal of request for administrative review.

(B)(i) Any party feeling aggrieved by the order of the administrator shall have ten (10) days from the date of notification to request a rehearing.

(ii) A request for rehearing shall:

*(a)* Be in writing; and

*(b)* State the grounds upon which the moving party relies.

(iii) Upon a finding that the record is not complete or that error was made in the hearing process, the administrator may order a rehearing.

(iv) A rehearing shall follow the same procedure as subdivision (c)(1)(A) of this section, above.

(C)(i) Any party feeling aggrieved by the rehearing order of the administrator shall have ten (10) days from the date of notification to appeal the ruling to an administrative law judge of the commission.

(ii) Notice of appeal shall be filed with the Clerk of the Commission.

(iii) The notice of appeal shall contain the following:

(a) A copy of the administrative review order appeal form;

(b) Copies of all materials submitted to the administrator in the administrative review proceedings;

(c) A statement identifying each portion of the administrator's order claimed to be in error; and

(d) An explanation of how each portion of the administrator's order conflicts with the schedule of medical fees or this section.

(D)(i) The appealing party shall mail a copy of all materials which are filed in the appeal to each opposing party.

(ii) No response to the appeal of the administrator's order is required.

(iii) A decision must be entered by the administrator before any appeal may be brought.

(iv) A judge of the commission may affirm the decision of the administrator, or reverse or modify said decision only if it is found to be contrary to the medical fee schedule and rules existing at the time the said medical care or treatment was provided.

(E) If any bill for services rendered under Arkansas Code § 11-9-508 by a provider of health care is not paid within thirty (30) days after it has been approved by the commission and returned to the responsible party by certified mail return receipt requested, there shall be added to such unpaid bill an amount equal to eighteen percent (18%) thereof, which shall be paid at the same time as, but in addition to, such medical bill unless such late payment is excused by the commission.

**(2) Computation of time periods.**

(A) In computing a period of time prescribed or allowed by this section, the day of the act, event, or default from which the designated period of time begins to run shall not be included.

(B) The last day on which a compliance therewith is required shall be included.

(C)(i) If the last day within which an act shall be performed or an appeal

filed is a Saturday, Sunday, or a legal holiday:

(a) The day shall be excluded; and

(b) The period shall run until the end of the next day which is not a Saturday, Sunday, or legal holiday.

(ii) "Legal holiday" means those days designated as a holiday by the President of the United States or United States Congress or so designated by the laws of this state.

**(3) Extension of time — Request — Waiver.**

(A) A request for an extension of time for the filing of any document shall be filed with the administrator in advance of the day on which the document is due to be filed.

(B) This requirement may be waived for good cause shown.

**(d) Utilization review.**

**(1) Scope.**

(A) Requirements contained in this section shall pertain to utilization review activity as defined by Arkansas Code § 20-9-901 et seq., with respect to all bills (except repriced bills) submitted for payment by a provider for health care or health-related services furnished as a result of a covered injury or illness arising out of and in the course of employment.

(B) A private review agent who approves or denies payment or who recommends approval or denial of payment for hospital or medical services or whose review results in approval or denial of payment for hospital or medical services on a case-by-case basis, may not conduct utilization review in this state unless the State Board of Health has granted the private review agent a certificate.

(C) Merely repricing (matching CPT codes to the fee schedule) patient bills against the Arkansas Fee Schedule will not be required to certify with the board as a private review agent.

(D) Denying, recommending denial, or negotiating inpatient or outpatient bill payment or BRs requires certification by the board as a private review agent.

**(2) Carrier's utilization review program.**

(A) The carrier shall have a utilization review program.

(B) Utilization review shall be conducted in a reasonable manner and in accordance with this section.

(C) Under the utilization review program, the carrier shall do all of the following:

(i) Perform ongoing utilization review of medical bills to identify overutilization of services and improper billing;

(ii)(a) Determine the accuracy of the procedure coding.

(b) If the carrier determines, based upon review of the bill and any related material which describes the procedure performed, that the procedure is incorrectly or incompletely coded, the carrier may recode the procedure, but shall notify the provider of the reasons for the recoding within thirty (30) days of receipt of the bill;

(iii) Reduce the bill to the maximum allowable payment for that procedure;

(iv) Refer to the commission providers whose billing practices indicate overutilization; and

(v) A carrier may have another certified entity perform utilization review activities on its behalf.

(D)(i) The utilization review program, whether operated by the carrier or an entity on behalf of the carrier, shall be certified by the board.

(ii) For information regarding certification, parties should contact the Department of Health.

(E) The carrier shall provide the division with the name, address, and license number, and a copy of the contract agreement between the carrier and other entity, if applicable, of the entity responsible for conducting the carrier's utilization review program.

(F) The carrier is responsible for notifying the division when changing reviewing entities.

(G) For purposes of this section, a carrier which has another entity perform utilization review activities on its behalf maintains full responsibility for

compliance with this section.

(H) Under the carrier's utilization review program, the carrier shall make determinations concerning a covered injury or illness through one (1) of the following approaches:

(i) Review by licensed, registered, or certified healthcare professionals;

(ii) The application of criteria developed by licensed, registered, or certified healthcare professionals; or

(iii) A combination of approaches in subdivisions (d)(2)(H)(i) and (ii) of this section according to the type of covered injury or illness.

(I) Licensed, registered, or certified healthcare professionals shall be involved in determining the carrier's response to a request by a provider for reconsideration of its bill.

(J) These licensed, registered, or certified healthcare professionals shall have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided.

**(3) Commission utilization review and monitoring responsibilities.**

(A) The commission shall monitor the carriers to:

(i) Ensure they have a utilization review plan that complies with commission requirements and Arkansas Code § 20-9-201 et seq.; and

(ii) Monitor their claims handling and reimbursement practices.

(B) The commission shall perform utilization review of healthcare providers who have been identified to have trends or patterns of overutilization or inappropriate billing, as well as to investigate patterns of abuse.

(C) The commission is responsible for the review process and the implementation of penalties and/or sanctions for findings of overutilization and/or violations by carriers and/or providers.

**(4) Commission investigative process.**

(A) The commission shall perform two (2) types of utilization review regarding carriers and/or providers:

(i)(a) Individual claimant review.

(b) The review of an individual case with all applicable documentation; and

(ii)(a) Random sample review.

(b) The review of a random sample of a healthcare provider's workers' compensation cases for a given time based on a valid referral from a carrier, claimant, or governmental source or based on commission reports which indicate provider patterns which deviate from the norm.

(B) The division may recommend corrective actions, such as provider or carrier education, referrals to professional organizations, referrals to the State Insurance Department and other appropriate authorities, for providers or carriers whose practices are determined to be questionable.

(C) Monitoring activities by the commission can result in penalties imposed upon:

(i) A provider for findings of improper practice patterns; or

(ii) A carrier for inappropriate claims handling practices.

**(e) Rule review.**

(1) The commission encourages participation in the development of and changes to the medical cost containment program and fee schedules by:

(A) All groups;

(B) Associations; and

(C) The public.

(2)(A) Any such group, association, or other party desiring input into or changes made to this section and associated schedules must make their recommendations in writing to the administrator.

(B) After analysis, the commission may incorporate such recommended changes into this section after appropriate public comment pursuant to Arkansas Code § 11-9-205.

(3) The medical fee schedule shall be reviewed July, 2001, and every two (2) years thereafter.

**(f) Provider and facility fees for copies of medical records.**

(1)(A) Healthcare providers and facilities are entitled to recover a reasonable amount to cover the cost of copying documents which have been requested by the carrier, self-insured employer, employee, attorneys, etc.

(B)(i) Certain procedure code descriptors and this section's guidelines require the submission of records and/or reports.

(ii) The amount of reimbursement is designated in this section for these.

(C) Documentation which is submitted by the provider and/or facility, but was not specifically requested by the carrier, is not allowed a copy charge.

(2)(A) Healthcare providers and facilities must furnish an injured employee or his or her attorney and carriers/self-insureds or their attorneys copies of his or her records and reports upon request.

(B) The charge shall be the same as set out in Arkansas Code § 16-46-106(a)(2).

(3) Healthcare providers and facilities may charge the actual direct cost of copying x-rays, microfilm, or other nonpaper records.

(4) The copying charge shall be paid by the party who requests the records.

(5) An itemized invoice shall accompany the copy.

**(g) Medical fee schedule.**

**(1) Services rendered under worker's compensation laws.**

(A) The official medical fee schedule of the commission shall be based upon the Health Care Financing Administration's Medicare Resource Based Relative Value Scale (RBRVS), utilizing the Health Care Financing Administration's national relative value units and Arkansas specific conversion factors adopted by the commission.

(B) Parties using this schedule should also be familiar with this section, the most current CPT, the Health Care Financing Administration Common Procedure Coding System (HCPCS), and the ASA Relative Value Guide.

**(2) Effective date and coding references.**

(A) This fee schedule shall replace the current commission fee schedule on May 15, 2000, and the most current versions of CPT and the Medicare RBRVS shall automatically be applicable upon their effective dates.

(B)(i) Due to the length of the medical fee schedule, it is not being reproduced herein.

(ii) Anyone desiring a copy of the medical fee schedule can obtain same by contacting the commission (800-622-4472).

**(3) Commission inpatient hospital fee schedule.**

(A) Due to the length of the inpatient hospital fee schedule, it is not being reproduced herein.

(B) Anyone desiring a copy of the inpatient hospital fee schedule can obtain same by contacting the commission (800-622-4472).

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** "ASA" means American Society of Anesthesiologists.

"MCO/PPO" means managed care organization/preferred provider organization.

This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"Pursuant to Ark. Code Ann. § 11-9-517 (Repl. 1996) the following rule is hereby established in order to implement a medical cost containment program."

Subdivision (f)(5) of this section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Adopted September 15, 1992; Revised Effective September 1, 1994; Revised effective May 15, 2000 for services rendered on and subsequent to this date.)"

**11 CAR § 25-126. Accident prevention services.**

**(a) Purpose and scope.**

(1) The purpose of this section is to promote safer Arkansas workplaces by ensuring that Arkansas employers are provided adequate accident prevention services from their workers' compensation insurance companies as provided for in Arkansas Code § 11-9-409(d).

(2) All insurance companies licensed to write or seeking license to write workers' compensation insurance policies in Arkansas are subject to the provisions of this section.

(3) This section does not apply to self-insured employers.

**(b) Definitions.** As used in this section:

(1) "Accident prevention services plan (APSP)" means a document describing the policies and procedures used by the insurance company to provide accident prevention services to its policyholders in accordance with this section;

(2) "Approved professional safety source (APSS)" means an occupational health and safety consultant approved by the Workers' Compensation Commission Workers' Health and Safety Division to service employers defined in 11 CAR § 25-127;

(3) "Commission" means Workers' Compensation Commission;

(4) "Days" means calendar days;

(5) "Direct premium written" means the amount charged to the policyholder for the workers' compensation policy which shall include:

(A) The expense constant;

(B) Any allowable deviated discounts;

(C) Any experience rating modification;

(D) Any premium discount or debit;

(E) Any reinsurance or deductible arrangement as common with fronting carriers;

(F) Any dividend consideration; or

(G) Any other trade discount;

(6) "Division" means Workers' Compensation Commission Workers' Health and Safety Division;

(7) "Employee" means any person in service of an employer as defined by Arkansas Code § 11-9-102(9);

(8) "Employer" means any individual, partnership, association, or corporation as defined by Arkansas Code § 11-9-102(10);

(9) "Extra-Hazardous Employer Program" means the program established by Arkansas Code § 11-9-409(c) with criteria established by 11 CAR § 25-127;

(10) "Field safety representative (FSR)" means an occupational health and safety consultant approved by the Workers' Health and Safety Division to service workers' compensation accounts;

(11) "Loss analysis" means an in-depth examination of root causes of losses, which may include a loss run as one (1), but not the sole component;

(12)(A) "Loss ratio" means losses incurred during the policy year, both paid and expected/reserved, divided by the written manual premium.

(B) In the context of this section, "loss ratio" is used as an indicator of whether accident prevention services must include an annual on-site visit or other appropriate services;

(13) "Policyholder" means the person or entity owning the policy of insurance;

(14) "Workplace" means each business operation, facility, or location of an employer where employees are present during part of or for the entire work shift; and

(15)(A) "Written manual premium" means a premium produced in a given year by the manual rates in effect during the experience period which shall exclude the premium produced by the expense constant.

(B) Further, "written manual premium" means premium before:

(i) Allowable deviated discounts;

(ii) Experience-rating modification;

(iii) Premium discount;

(iv) Reinsurance or deductible arrangement as common with fronting carriers;

- (v) Dividend consideration; or
- (vi) Other trade discount.

**(c) Accident prevention services.**

(1) An insurance company desiring to write workers' compensation insurance in Arkansas shall have the ability to provide accident prevention services described in subdivisions (c)(2) – (5) of this section, subject to inspection by the Workers' Compensation Commission, as a prerequisite to obtaining or maintaining a license to write such insurance.

(2)(A) An APSP must be filed with the commission at the time an insurance company pays its filing fees prior to writing workers' compensation policies in Arkansas.

(B) If these fees have already been paid, an APSP must be on file with the commission.

(3)(A) An insurance company shall provide or make available basic accident prevention services to policyholders at no additional charge or change in premium.

(B) These may include visits to each policyholder workplace.

(C) Accident prevention services required under 11 CAR § 25-127 must be provided or made available at no additional charge to each policyholder workplace identified under that section.

(4) The insurance company, using only commission-approved FSRs/APSSs, shall:

(A)(i) Provide appropriate accident prevention services to its clients as listed below.

(ii) For services to be appropriate, the insurance company must demonstrate that it actively evaluated the insured's performance and loss potential stated in this subdivision (c)(4) and then offered to provide services to correct or alleviate hazards recognizable by an occupational health and safety professional;

(B) Respond to requests from policyholder for services within fifteen (15) days of the date services were first requested and provide the actual services within sixty (60) days; and

(C)(i) Provide appropriate services to each Arkansas policyholder.

(ii) At a minimum, appropriate services shall include:

(a) Annual on-site workplace visit or visits or other appropriate services to each policyholder with a direct premium written of twenty-five thousand dollars (\$25,000) or greater;

(b) Annual workplace visit or visits or other appropriate services to each policyholder with a direct premium written of five thousand dollars (\$5,000) up to twenty-four thousand nine hundred ninety-nine dollars (\$24,999) whose loss ratio is equal to or greater than one hundred percent (100%);

(c) Annual workplace visit or visits or other appropriate services to each policyholder with a direct premium written of less than five thousand dollars (\$5,000), whose loss ratio is equal or greater than one hundred fifty percent (150%); and

(d)(1) Contacting all policyholders not serviced under the guidelines of this subdivision (c)(4) at least once during the policy year within sixty (60) days of policy inception or renewal date, separate from the actual workers' compensation insurance policy to determine their need for assistance and to advise them that accident prevention services are available at no additional cost.

(2) The insurance company may determine the method of contact (e.g., visit, letter, telephone call, email, etc.).

(5)(A) The insurance company shall provide accident prevention services which meet the standards of the Workers' Health and Safety Division as required by Arkansas Code § 11-9-409(d).

(B) The program shall provide at a minimum:

(i) An annual evaluation of accident prevention services for policyholders and their workplaces, based on the following criteria:

(a) Hazard, probability of serious accidents, probability of catastrophic accidents, accident frequency, and probability of occupational illnesses or diseases;

(b) Loss experience, including loss ratio as defined by this section, experience modifiers, frequency rates, and severity rates; and

(c) Total number of employees, number of workplaces, and number of employees per workplace;

(ii) Procedures for determining the appropriate accident prevention services to be provided to a policyholder and to each policyholder's workplace;

(iii) Procedures indicating the time frame and manner in which the requested accident prevention services as stated in subdivision (c)(3) of this section will be provided;

(iv) Records, reports, and evidence of all accident prevention services provided to each policyholder and each workplace;

(v) Procedures for providing safety training and safety material for each policyholder;

(vi) At a minimum of once a year, written notification to policyholders and policyholder workplaces of their actual claims experience including reserves and, if the policyholder meets the criteria of subdivision (c)(4)(C) of this section or if the policyholder is identified under 11 CAR § 25-127, a loss analysis;

(vii) Procedures for providing internal documentation and written reports to the policyholders and policyholders' workplaces when the FSR/APSS has identified hazardous conditions and work practices; and

(viii) Evidence that the notice required by subsection (e) of this section is provided to policyholders.

(6) The insurance company shall provide the following to the Workers' Health and Safety Division's Accident Prevention Services staff:

(A)(i) An APSP, updated as necessary.

(ii) The plan shall describe how the company will meet all the requirements relating to the provision of accident prevention services presented in this section and Arkansas Code § 11-9-409(d).

(iii) The plan must meet the requirements of the Workers' Health and Safety Division before it is accepted;

(B) Annual reports as required by subsection (f) of this section; and

(C) Other information as requested by the Workers' Health and Safety

Division.

**(d) Accident prevention services required inspection.**

(1)(A) Each insurance company's accident prevention services program will be inspected in accordance with Arkansas Code § 11-9-409(d) and may be inspected more frequently at the Workers' Health and Safety Division director's discretion.

(B) For insurance companies licensed to write workers' compensation insurance in the State of Arkansas, but not actively writing workers' compensation insurance, the inspection shall consist of a review of their APSP.

(C) Once an insurance company starts actively writing workers' compensation insurance in the State of Arkansas, it is subject to an inspection of its accident prevention services in accordance with Arkansas Code § 11-9-409(d).

(2) The Workers' Health and Safety Division shall notify the insurance company in writing of the date, time, and location of the inspection at least one hundred twenty (120) days prior to the inspection.

(3) Within thirty (30) days after notification of inspection, the insurance company or company group shall provide the Workers' Health and Safety Division, in the format requested, the following:

(A)(i) A list of policyholders with Arkansas exposures, separated by insurance company, with physical addresses of all Arkansas workplaces as defined Rule 3, direct premium written and written manual premium for Arkansas based on the insurance company's most current records.

(ii) The insurance company shall list the policyholders by written manual premium in descending order for each year or portion of year requested.

(iii) For policyholders with corporate headquarters outside the State of Arkansas, the insurance company shall list the corporate location.

(iv) The insurance company may send the list or lists electronically in a format agreed upon by the Workers' Health and Safety Division.

(v) The commission will keep the list of policyholder accounts confidential; and

(B) A list of the names, whether employee or contractor, and commission

FSR/APSS identification number for each person acting as an FSR/APSS for the insurance company.

(4)(A) The Workers' Health and Safety Division shall:

(i) Select the specific accounts to be evaluated; and

(ii) Return the selected policyholder list to the insurance company no later than fifteen (15) days after receipt of the policyholder list.

(B) For the policyholders identified, the insurance company shall provide the following to the Workers' Health and Safety Division to arrive no later than thirty (30) days after receipt of the selected policyholder list:

(i) Loss control files of the policyholders identified to include any survey reports and correspondence, in the manner and format specified by the Workers' Health and Safety Division;

(ii) Documentation of all accident prevention services provided;

(iii) Copy of loss runs for each account;

(iv) A sample of training materials and other material as requested;

and

(v) An Accident Prevention Services Worksheet, Form AW CC-HS-31D, for each policyholder selected by the Workers' Health and Safety Division.

(5)(A) An insurance company's failure to meet one (1) or more of the specified requirements of this section may be construed as a failure to provide appropriate accident prevention services to policyholders.

(B) The Workers' Health and Safety Division may reschedule the inspection, impose fines, and/or ask the State Insurance Department to take action.

(C) The Workers' Health and Safety Division director shall report the insurance company's failure to provide the information in the format and in the time specified to other divisions within the commission for appropriate action.

(6) The Workers' Health and Safety Division shall determine the depth and scope of the inspection.

(7) The Workers' Health and Safety Division's staff and the insurance company's representative or representatives shall review:

(A) The results and recommendations of any previous inspections of the company by the commission;

(B) The insurance company's APSP, including quality control and quality analysis provisions;

(C) The insurance company's accident prevention services provided to policyholders and policyholders' workplaces;

(D) Any changes completed in response to recommendations made during previous inspections;

(E) Any written complaints from policyholders relating to accident prevention services; and

(F) Policyholder worksheets, questionnaires, and results of site visits by commission staff, including information obtained through 11 CAR §§ 25-127 and 25-131 activities.

(8) The Workers' Health and Safety Division's staff may make scheduled or unscheduled inspections of the policyholder's workplace during normal work hours to obtain additional information regarding the insurance company's accident prevention services.

(9)(A) The Workers' Health and Safety Division staff shall prepare and file a written report of the inspection within thirty (30) days of the close of the inspection.

(B) The report shall contain:

(i) Results of the inspection including a list of deficiencies, if any; and

(ii) Required corrective actions, if any.

(10) The Workers' Health and Safety Division shall provide a copy of the report to the insurance company and the department.

(11) Insurance companies that meet the requirements of this section will receive a Certificate of Inspection from the commission.

(12)(A) Insurance companies with accident prevention services that do not meet the standards of this section will be notified of the specific deficiencies.

(B) The commission shall determine the appropriate amount of time for the insurance company to address the identified problems.

(C) The insurance company shall respond in writing with the corrective actions to be taken.

(D) When the Workers' Health and Safety Division director determines that the insurance company has taken appropriate measures to correct the deficiencies, the Workers' Health and Safety Division shall issue the Certificate of Inspection.

(E) A request for review of the decision may be made to the director of the Workers' Health and Safety Division and, if desired, the chief executive officer of the commission.

(13) The commission may require another complete inspection of accident prevention services before issuing a Certificate of Inspection.

**(e) Accident prevention services notification requirements.**

(1) Each workers' compensation insurance policy delivered or issued for delivery in Arkansas shall contain the following notice on the front of the insurance policy eminently visible to policyholder or, if the format does not permit, on a separate page placed in front of or on the declaration page, in at least ten-point bold type:

[Name of company] is required to provide its policyholders with certain accident prevention services at no additional cost as required by Ark. Code Ann. § 11-9-409(d) and AWCC 11 CAR § 25-127. If you would like more information, call [company's loss control division or provider's telephone number]. If you have any questions about this requirement, call the Workers' Health and Safety Division, Workers' Compensation Commission at 1-800-622-4472.

(2) Certain accident prevention services are basic services as described in Arkansas Code § 11-9-409(d).

(3)(A) Extensive sampling of environmental conditions and exposures, writing detailed safety plans (with the exception of 11 CAR § 25-127 activities), and on-site management of specific safety programs, e.g., respirator, hearing conservation, etc., are beyond the scope of basic services.

(B) The Workers' Health and Safety Division will determine the scope of basic services on an issue-by-issue basis if necessary.

**(f) Annual report requirements.**

(1)(A) Each insurance company licensed to write workers' compensation insurance in Arkansas shall submit to the Workers' Health and Safety Division an annual report quantifying the accident prevention services it provided to its policyholders in Arkansas over the previous year.

(B) Commission Form HS 31-C, or an alternate form as approved by the Workers' Health and Safety Division, shall be used.

(2) The Workers' Health and Safety Division director shall send the annual report notification to each insurance company licensed to write workers' compensation insurance in Arkansas.

(3) The insurance company shall send the report so that it is received no later than April 1 of each year.

(4)(A) The report shall not include the expenses of underwriting visits to policyholders' premises unless accident prevention services are provided during the visit.

(B) In such case, the costs of the accident prevention services shall be included in the report.

**(g) Field safety representative (FSR).**

(1) An individual seeking to become an FSR shall apply to the Workers' Health and Safety Division using application commission Form HS-31-A.

(2) To be approved as an FSR, an individual must:

(A) Have at least two (2) years' experience in the occupational health and safety profession during the past ten (10) years; and

(B) Meet at least one (1) of the following qualifications:

(i)(a) An associate's degree in safety, industrial hygiene, or related field.

(b) The college or university must submit a certified transcript directly to the Workers' Health and Safety Division;

(ii) A current certification by the Board of Certified Safety Professionals as a certified safety professional or associate safety professional;

(iii) A current certification by the American Board of Industrial Hygiene as a certified industrial hygienist or industrial hygienist in training; or

(iv) A current certification by the World Safety Organization as a certified safety manager or certified safety specialist.

(3) If applicants do not meet these requirements, they may still be eligible for approval as an FSR if, out of the previous ten (10) years, they have worked at least seven (7) years as an occupational health and safety professional with a minimum of fifty percent (50%) of their time devoted to workplace health and safety.

(4)(A) If applicants meet the education requirements listed in subdivision (g)(2) of this section, above, but do not have the required occupational health and safety experience, they may be approved as an FSR in training.

(B) The following is required to be approved as an FSR in training:

(i) A copy of commission Form HS-31-A completed and submitted to the Workers' Health and Safety Division; and

(ii) The FSR in training shall work under the direct supervision of an approved FSR with all accident prevention services work documents (reports, recommendations, etc.) signed by the approved FSR as well as the FSR in training.

(5) When two (2) years of occupational health and safety experience have been obtained, the FSR in training may resubmit a commission Form HS-31-A requesting approval as an FSR.

(6)(A) If an applicant is not approved, the Workers' Health and Safety Division shall notify the applicant in writing and state the reason or reasons for the denial.

(B) Any applications not approved shall be destroyed after ninety (90) days.

(7)(A) All FSR performances are subject to review by the Workers' Health and Safety Division.

(B) The Workers' Health and Safety Division may rescind FSR approval for cause.

(C) A request for review of the decision may be made to the director of the Workers' Health and Safety Division and, if desired, the chief executive officer of the commission.

**(h) Approval of professional safety sources.**

(1) An individual seeking to become an APSS pursuant to the commission Hazardous Employer Program, 11 CAR § 25-127, shall apply to the Workers' Health and Safety Division using application commission Form HS-31-A.

(2) To be approved as an APSS, an individual must:

(A) Meet the FSR requirements and provide verification of at least three (3) additional years of occupational health and safety experience; and

(B) Attend the commission's APSS seminar.

(3)(A) If an applicant is not approved, the Workers' Health and Safety Division director shall notify the applicant in writing and state the reason for the denial.

(B) Any applications not approved will be destroyed after ninety (90) days.

(4)(A) All APSS performances are subject to review by the Workers' Health and Safety Division staff.

(B) The Workers' Health and Safety Division may rescind APSS approval for cause.

(C) A request for review of the decision may be made to the director of the Workers' Health and Safety Division and, if desired, the chief executive officer of the commission.

(5) APSSs who have been inactive in the State of Arkansas for a period of more than five (5) years shall attend the commission's APSS seminar again before providing APSS services to employers in the Extra-Hazardous Employer Program, 11 CAR § 25-127.

**(i) Penalties.**

(1) The commission may assess a civil penalty in an amount up to one thousand dollars (\$1,000) per day of violation against an insurance company that does not maintain or provide the accident prevention services required by Arkansas Code § 11-9-409, payable to the Death and Permanent Total Disability Trust Fund.

(2) Furthermore, the insurance company shall be subject to suspension or revocation of license to do business in this state by the Insurance Commissioner.

(j) **Severability.** If any provision of this section or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the provisions of this section are declared to be severable.

**Authority.** Arkansas Code §§ 11-9-207, 11-9-409.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective December 30, 1993; revised June 10, 2003, effective July 1, 2003; revised October 5, 2007, effective January 1, 2008.)"

**11 CAR § 25-127. Extra-Hazardous Employer Program.**

**(a) Criteria for identifying extra-hazardous employers.**

(1)(A) The Workers' Health and Safety Division of the Workers' Compensation Commission pursuant to Arkansas Code § 11-9-409(c) shall identify extra-hazardous employers based on criteria established by the commission in this section.

(B) Each employer identified, continued, or monitored shall have the right to:

(i) Verify employment, illness, and injury data used by the Workers' Health and Safety Division;

(ii) Obtain a review of the findings of the Workers' Health and Safety Division by the chief executive officer (CEO) of the commission; and

(iii) Request a hearing before the full commission to contest the findings of the CEO.

(C) A request for review by the CEO or hearing before the full commission shall be:

- (i) In writing, setting out the grounds therefore; and
- (ii) Shall be filed within fifteen (15) days of the action from which the request is made.

(D) The CEO or the full commission, as applicable, shall decide the issues within fifteen (15) days of receipt of the request for review or hearing.

(2) **Definitions.** As used in this section:

(A)(i) "Employer incidence rate" means the rate derived for each employer according to the following formula:

$$\frac{\text{(Number of Incidents/Number of Employees)} \times 100}{\text{Employer Incidence Rate}} =$$

(ii) Site-specific computations will be made only if data is reported to the Workers' Compensation Commission by individual location;

(B)(i) "Expected incidence rate" means the benchmark illness and injury rate for each North American Industry Classification System (NAICS) code.

(ii) The "expected incidence rate" is obtained from data compiled from national statistics as reported to the United States Occupational Safety and Health Administration and published by the United States Bureau of Labor Statistics.

(iii) Lost workday cases are defined by United States Occupational Safety and Health Administration/United States Bureau of Labor Statistics as those illness and injury cases which result in one (1) or more days away from work.

(iv) Lost workday cases do not include cases where the employee works in restricted or light duty.

(v) If data is not available from the United States Bureau of Labor Statistics publication, other suitable sources are used to determine the expected incidence rate;

(C)(i) "Extra-hazardous employer" means any employer whose hazard index is one (1.0) or greater may be identified as an extra-hazardous employer.

(ii) A hazard index of one (1.0) or greater indicates an employer

incidence rate which substantially exceeds the expected incidence rate since employer incidence rates are based on cases which result in eight (8) or more days away from work while expected incidence rates are based on cases which result in one (1) or more days away from work;

(D)(i) "Hazard index" means the index derived annually and based on the preceding year's incidence rates for each employer according to the following formula:

$$\text{Employer Incidence Rate/Expected Incidence Rate} = \text{Hazard Index}$$

(ii) Site-specific computations will be made only if data is reported to the Workers' Compensation Commission by individual location;

(E)(i) "Incident" means a work-related illness or injury for which compensation is paid, as set out in Arkansas Code § 11-9-501.

(ii) For an illness or injury to be compensable, the affected employee must miss eight (8) or more calendar days of work.

(iii) Each illness or injury which results in permanent partial disability without lost time shall also be deemed an incident for purposes of this section.

(iv) Illness or injuries to volunteers, elected officials, or board members of public entities shall not be counted;

(F)(i) "Number of employees" means number of employees reported to the Division of Workforce Services.

(ii) Volunteers, elected officials, and board members of public entities shall not be counted; and

(G)(i) "Number of incidents" means the total number of incidents reported per employer during a calendar year.

(ii) The number of incidents will be tabulated on a site-specific basis unless reported by the employer in a different manner.

(3) The following criteria shall be used to evaluate employers and identify extra-hazardous employers:

(A) Employer incidence rates and hazard indexes will be calculated annually, based on the preceding year's incidence rates;

(B)(i) When possible, employers with multiple locations in the state shall be evaluated by individual sites or locations and a hazard index will be determined for each individual site or location.

(ii) Site-specific evaluation is possible only if data is reported to the Workers' Compensation Commission by individual site location;

(C)(i) No employer who has only one (1) incident in any single calendar year will be identified as an extra-hazardous employer.

(ii) However, if two (2) or more incidents occur in any single calendar year, all incidents occurring during that year will be used to calculate the employer incidence rate and hazard index;

(D) A hazard index of one (1.0) or greater indicates an employer whose illness and injury frequencies during the period evaluated substantially exceeded those that may reasonably be expected in that employer's business or industry, since employer incidence rates are based only on those cases which result in eight (8) or more days away from work while expected incidence rates are based on cases which result in one (1) or more days away from work; and

(E) Employers identified as extra-hazardous employers will be ranked in descending order (from highest to lowest) based on their hazard index, with priority attention given to the higher hazard indexes.

(4)(A) Employers with a hazard index of less than nine-tenths (0.9) will not receive official notification from the Workers' Health and Safety Division of their status.

(B) They may request this information by contacting the Workers' Health and Safety Division by telephone, letter, or fax.

(5)(A) Employers with a hazard index of nine-tenths (0.9) to ninety-nine hundredths (0.99) will receive a courtesy letter from the Workers' Health and Safety Division notifying them of their status.

(B) This letter will be sent to the employer only.

(C) The letter may contain the following information:

- (i) Notification that the employer is close to the one (1.0) hazard index for extra-hazardous employer designation; and
- (ii) Programs available from the commission and Department of Labor and Licensing, at no cost to the employer, designed to:
  - (a) Assist employers to improve their overall health and safety programs;
  - (b) Prevent illness and injuries; and
  - (c) Decrease their incident rate.

(6)(A) All employers with a hazard index of one (1.0) or higher will be issued a warning notice.

(B) Such notice shall be in writing and sent to the specific site of the employer's central/corporate headquarters, and the insurance carrier.

(C) The notice may include the following information:

- (i) Notification that the employer meets the criteria to be identified as an extra-hazardous employer and may be placed in the Extra-Hazardous Employer Program during the twelve (12) months following the notification;
- (ii) Data (including number of employees, number of incidents, and expected incidence rate) used to determine the hazard index; and
- (iii) Programs available from the commission and Department of Labor and Licensing, at no cost to the employer, designed to:
  - (a) Assist employers improve their overall safety programs;
  - (b) Prevent illness and injuries; and
  - (c) Decrease their incident rate.

**(b) Notice to extra-hazardous employers.**

(1)(A) Upon a determination by the Workers' Health and Safety Division that an employer should be classified as hazardous, the Workers' Health and Safety Division shall notify the employer and the employer's workers' compensation insurance carrier.

(B) The notice shall be sent to:

- (i) The employer by certified mail at the employer's principal place of business; and

(ii) The loss control department or equivalent of the employer's workers' compensation insurance carrier or third-party administrator of record in the commission's files.

(2) The notice shall be in writing and shall inform the employer of the following provisions:

(A) State that the employer has been identified as an extra-hazardous employer;

(B) State the facts on which the identification of the extra-hazardous employer is based;

(C) Outline the steps the employer is required to take as an identified extra-hazardous employer; and

(D) Inform the employer of the penalties for failure to take steps required under the Extra-Hazardous Employer Program.

**(c) Health and safety consultation.**

(1)(A) An employer who receives notification under subsection (b)(1) of this section must obtain a health and safety consultation within thirty (30) days by an approved professional safety source (APSS) approved by the Workers' Health and Safety Division for that purpose.

(B) The APSS may be from:

(i) The Department of Labor and Licensing;

(ii) The employer's insurance carrier;

(iii) An employee of the employer; or

(iv) A private consultant.

(2) Upon request, the Workers' Health and Safety Division shall provide a list of available approved professional safety sources.

(3)(A) The APSS shall conduct a hazard survey at each appropriate job site and prepare a hazard survey report.

(B) The report shall:

(i) Be in writing in a format prescribed by the commission; and

(ii) Include a description of any potentially hazardous conditions or

practices identified, along with recommendations for controlling the identified potentially hazardous conditions or practices and projected dates of correction.

(4) The hazard survey report or reports and any attachments shall be filed by the APSS with the Clerk of the Commission.

(5)(A) If the initial consultation and report cannot be completed in the time allowed under this subsection, the employer may apply in writing to the Workers' Health and Safety Division for a waiver of the time requirements.

(B) In no case shall the initial consultation exceed sixty (60) days following the date of notification.

**(d) Formulation of health and safety plan.**

(1)(A) Employers who receive notification under subdivision (b)(1) of this section will develop a health and safety plan within thirty (30) days of the date of the APSS' initial report with the assistance of the same or other approved professional safety source as referred to in subsection (c) of this section.

(B) This plan must be consistent with accepted industry practices.

(C) The health and safety plan shall include, but need not be limited to, the following:

(i) Management component, including a written safety policy statement and assignment, by position or title, of health and safety responsibilities and authority;

(ii) Analysis component, including identified operational, health, and safety hazards;

(iii) Program record keeping system component;

(iv) Safety and health education and training component;

(v) Safety and health audit/inspection component, including identification, by title or position, of qualified person or persons to conduct the audits/inspections;

(vi) Incident investigation component, including procedures to identify factors contributing to near-misses and accidents and institute corrective measures; and

(vii) Periodic review and revision of the health and safety program and operational procedures component to determine effectiveness of abatement measures.

(2) An implementation timeline, not to exceed six (6) months after the formulation of the plan, shall be developed and included with the plan.

(3)(A) If the employer disagrees with any or all of the plan, the employer shall:

(i) Sign the plan; and

(ii) Attach a statement containing the specific reasons for disagreement with the plan and proposed alternative solutions to the health and safety issues cited.

(B) The Workers' Health and Safety Division will:

(i) Review the areas of disagreement; and

(ii) Notify the employer and the APSS of the decision on each area of disagreement.

(4) The employer's signature is understood to exclude those areas of the plan for which there is a stated disagreement, pending a final determination by the Workers' Health and Safety Division.

(5)(A) The employer will begin implementation of any or all parts of the plan that are not subject to the employer's disagreement.

(B) The timelines specified in the plan shall remain in effect for those parts of the plan the employer is directed to implement.

(C) During the review of the plan by the Workers' Health and Safety Division, the Workers' Health and Safety Division may direct the employer and the APSS to implement a procedure in lieu of the part of the plan that is in disagreement.

(6) The employer shall be responsible for filing the health and safety plan with the Workers' Health and Safety Division within thirty (30) days of the date of the consultant's initial report.

(7) Reference material for the development of a health and safety plan may be obtained from the Workers' Health and Safety Division.

**(e) Follow-up inspection by the Workers' Health and Safety Division.**

(1) Six (6) months after the formulation of the employer's health and safety plan, or earlier when requested by the employer with the concurrence of the APSS, the Workers' Health and Safety Division shall conduct a follow-up inspection to ensure compliance with, and the effectiveness of, the health and safety plan at the employer's premises.

(2) The inspection shall be conducted and completed during normal work hours.

(3) The employer shall allow the Workers' Health and Safety Division access to the employer's premises, including remote job sites, and employees during normal work hours to conduct the follow-up inspection.

(4) At the time of the inspection, the Workers' Health and Safety Division may consider as evidence of compliance, information which includes, but is not limited to:

(A) Visual verification;

(B) Written policies and procedures;

(C) Attendance rosters for training programs;

(D) Employee interviews; and

(E) Purchase orders or receipts for equipment or services necessary to support the accident prevention plan.

**(f) Report of follow-up inspection.**

(1) The employer, the APSS, and the employer's workers' compensation insurance carrier shall be provided copies of the report of the follow-up inspection by the Workers' Health and Safety Division.

(2) The report shall be in writing and shall specify whether the employer has, or has not, implemented the health and safety plan or other acceptable corrective measures approved by the Workers' Health and Safety Division.

(3) If the employer is found not to have implemented the health and safety plan, the report shall also contain:

(A) A notification that the employer's extra-hazardous employer status is being continued;

(B) A list of the specific areas of the health and safety plan which have not been implemented; and

(C) A list of the specific actions required of the employer to correct the identified deficiencies.

(g) **Removal from extra-hazardous employer status.** An employer shall be removed from extra-hazardous employer status if, upon inspection, the Workers' Health and Safety Division determines that the employer has complied with the terms of the health and safety plan.

(h) **Continuation of extra-hazardous employer status.**

(1) An employer shall remain on extra-hazardous employer status if the employer is found under subsection (e) of this section to have failed or refused to implement a health and safety plan or other suitable hazard abatement measures as approved by the Workers' Health and Safety Division.

(2) If an employer is not certified for removal from extra-hazardous employer status after the follow-up inspection, the employer shall take the actions specified in the follow-up inspection report, or other suitable hazard abatement measures as approved by the Workers' Health and Safety Division, as a condition for removal from extra-hazardous employer status.

(3)(A) An employer shall file a progress report with the Workers' Health and Safety Division every sixty (60) days until the employer has been removed from extra-hazardous employer status.

(B) The report shall include:

(i) For subdivision (h)(1) of this section only, the list of areas of the health and safety plan and/or hazard survey report which were identified as not being fully implemented or abated at the time of the follow-up inspection;

(ii) Additional areas identified in the follow-up inspection report; and

(iii) The steps which are being taken to address them.

(4)(A) After the required corrective actions have been taken, the employer shall notify the Workers' Health and Safety Division and request a reinspection.

(B) The request for reinspection shall be made no later than six (6)

months after the date of the follow-up inspection.

**(i) Penalties.**

(1) The commission may assess a civil penalty against an employer who, at any time in the process, fails or refuses to implement the recommended health and safety plan or other suitable hazard abatement procedures, in an amount up to one thousand dollars (\$1,000) per day of violation, payable to the Death and Permanent Total Disability Trust Fund.

(2) Further, the commission may petition the appropriate chancery court for an order enjoining the employer from engaging in further employment until such time as the employer implements the health and safety plan or abatement measure described above and/or makes payment of all civil penalties, Arkansas Code § 11-9-409(c).

**(j) Judicial proceedings.** The identification as an extra-hazardous employer under this section is not admissible in any judicial proceeding unless:

(1) The commission has determined that the employer is not in compliance with this section; and

(2) That determination has not been reversed or superseded at the time of the event giving rise to the judicial proceeding.

**(k) Rule review.**

(1) The commission encourages all interested parties to participate in promulgating changes to the rules governing the Extra-Hazardous Employer Program.

(2) Those who desire input into said changes should submit them in writing to the Workers' Health and Safety Division.

(3) After analysis, the commission may incorporate such changes to the rules following public comment pursuant to Arkansas Code § 11-9-205.

**Authority.** Arkansas Code §§ 11-9-207, 11-9-409.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Revised October 5, 2007, effective January 1, 2008.)"

**11 CAR § 25-128. Managed care.**

**(a) Generally.**

(1)(A) Pursuant to Arkansas Code § 11-9-508, the following section is hereby established in order to implement a voluntary managed care program.

(B) This section provides for certification, administration, evaluation, and enforcement of managed care organizations (MCOs) and internal managed care systems (IMCSs).

(2) Pursuant to Arkansas Code § 11-9-514(a)(3), an Arkansas managed care system shall be deemed to exist for a carrier, employer, and/or self-insured employer when more than one (1) approved MCO is available for contracting purposes to cover the insurance carrier/employer, and/or self-insured's employees.

(3) Managed care becomes effective when:

(A) The insurance carrier/employer or self-insured has either contracted with a certified MCO or the insurance carrier/self-insured or employer has obtained certification of its internal managed care system (IMCS); and

(B) Notice (Form H) has been posted in accordance with Workers' Compensation Commission Rule 7 [repealed].

(4)(A) The applicable MCO/IMCS plan will provide all treatment for work-related injuries occurring after notice is posted.

(B) Previous notice given to employees by a certified MCO shall fulfill the above notice requirements.

**(b) Definitions.** For the purpose of this section, unless the context requires otherwise:

(1) "Administrator" means the Administrator of the Medical Cost Containment Division of the Workers' Compensation Commission;

**(2) Healthcare providers.**

(A)(i) "Initial healthcare provider" means a physician/provider who is primarily responsible for the treatment of a workers' compensable injury or illness and

who is a medical doctor, osteopath, podiatrist, dentist, optometrist, ophthalmologist, chiropractor, or oral surgeon, practicing in and licensed under the laws of Arkansas, or under the laws of another state.

(ii) This definition shall apply to initial treating physician, regular treating physician, primary care physician, and initial primary care physician as referred to in Arkansas Code §§ 11-9-508(d)(5)(A) and 11-9-514(a)(3)(A)(ii).

(B) "Nonparticipating healthcare provider" means any person, provider, company, professional corporation, organization, or business entity which chooses not to contract with an MCO/IMCS for the delivery of medical services or supplies to injured employees.

(C) "Participating healthcare provider" means any person, provider, company, professional corporation, organization, or business entity with which the MCO/IMCS has contracts or other arrangements for the delivery of medical services or supplies to injured employees.

(D) "Regular treating physician" means the provider/physician who:

(i) Is the regular treating physician of the employee; and

(ii) Has maintained the medical records of and has a documented history of treatment with the employee prior to the date of injury.

**(E) Optometric or ophthalmologic provider.**

(i) The injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions.

(ii)(a) Such optometric or ophthalmologic medical service provider shall be considered a certified provider by the Workers' Compensation Commission.

(b) See Arkansas Code § 11-9-508(e);

(3) "Internal managed care system" (IMCS) means a certified in-house managed care system established and operated by:

(A) An insurance carrier;

(B) An employer; or

(C) A self-insured employer;

(4)(A) "Managed care entity" means a Workers' Compensation Commission approved MCO or IMCS.

(B) See Arkansas Code §§ 11-9-508(d)(1), 11-9-508(d)(5)(A), and 11-9-514(a)(3)(A)(i) and (ii);

(5) "Managed care organization" (MCO) means an entity certified by the Workers' Compensation Commission that provides for the delivery and management of treatment to injured employees and markets these services;

(6) "Probation" means that an MCO/IMCS has been given a specified length of time in which to remedy any problem or problems of which it has been notified pursuant to subsection (o) of this section;

(7) "Revocation" means the termination of certification of an MCO/IMCS to provide services;

(8) "Specialized medical services" means healthcare services other than those provided by an initial healthcare provider; and

(9) "Suspension" means that an MCO's authority to enter into new or amended contracts with insurance carriers, employers, or self-insured employers has been suspended by the Workers' Compensation Commission for a period of time.

**(c) Initial choice of physician.**

(1)(A) The employer shall have the right to select the initial primary care physician from among those associated with managed care entities certified by the Workers' Compensation Commission.

(B) See Arkansas Code §§ 11-9-508(d)(5)(A) and 11-9-514(a)(3)(A)(i).

(2) The Insurance Commissioner may allow a rate reduction for employers who use their carriers' contracted MCO or IMCS exclusively.

**(d) Referrals.**

(1) **Participating providers.** All referrals by participating healthcare providers or initial healthcare providers shall be to providers who agree to abide by the rules, terms, and conditions of the insurance carrier/employer/self-insured employer's

MCO/IMCS.

(2) **Nonparticipating providers.** Nonparticipating providers may provide services under the following circumstances:

(A) **Change of physician.** When approving a change of physician, the Workers' Compensation Commission may authorize a nonparticipating provider/physician to provide services to a worker if the provider/physician:

(i) Is the regular treating physician of the employee;

(ii) Agrees to refer the employee to the insurance

carrier/employer/self-insured employer's MCO/IMCS for any other treatment that the employee may require; and

(iii) Agrees to comply with all of the rules, terms, and conditions of the insurance carrier/employer/self-insured employer's MCO/IMCS pursuant to Arkansas Code § 11-9-508(d)(5);

(B) Emergency medical treatment; or

(C) When the employee is referred to such provider/physician by the MCO/IMCS.

(e) **Change of physician.**

(1) Employees should initially request a change of physician from the insurance carrier/employer/self-insured employer.

(2) Within five (5) business days of the employee's initial request for a change of physician, the insurance carrier/employer/self-insured employer shall notify the employee of its decision to grant or deny the change of physician.

(3) Pursuant to Arkansas Code § 11-9-514(a)(3), where the employer has contracted with a managed care organization certified by the Workers' Compensation Commission, the claimant employee, however, shall be allowed to change physicians by petitioning the Workers' Compensation Commission one (1) time only for a change of physician to a physician who must either be associated with the managed care entity chosen by the employer or be the regular treating physician of the employee who maintains the employee's medical records and with whom the employee has a bona fide doctor-patient relationship demonstrated by a history of regular treatment prior to the

onset of the compensable injury, but only if the primary care physician agrees to:

(A) Refer the employee to the managed care entity chosen by the employer for any specialized treatment, including physical therapy; and

(B) Comply with all the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer.

(4)(A) Where the employer does not have a contract with a managed care organization certified by the Workers' Compensation Commission, the claimant employee, however, shall be allowed to change physicians by petitioning the Workers' Compensation Commission one (1) time only for a change of physician to a physician who must either be associated with any managed care entity certified by the Workers' Compensation Commission or be the regular treating physician of the employee who maintains the employee's medical records and with whom the employee has a bona fide doctor-patient relationship demonstrated by a history of regular treatment prior to the onset of the compensable injury, but only if the primary care physician agrees to:

(i) Refer the employee to a physician associated with any managed care entity certified by the Workers' Compensation Commission for any specialized treatment, including physical therapy; and

(ii) Comply with all the rules, terms, and conditions regarding services performed by any managed care entity certified by the Workers' Compensation Commission.

(B) Treatment or services furnished or prescribed by any physician other than the ones selected according to the foregoing, except emergency treatment, shall be at the claimant's expense.

(5) The Medical Cost Containment Division may refer a person or party to an administrative law judge to conduct a contempt proceeding pursuant to Arkansas Code § 11-9-706 for failure to provide documentation to facilitate a request for change of physician.

(f) **Multiple MCOs.** When an insurance carrier, employer, or self-insured employer contracts with more than one (1) MCO, the insurance carrier/self-insured employer shall designate to the Workers' Compensation Commission one (1) MCO whose rules, terms,

and conditions will apply to services rendered by change of physician and referral providers.

(g) **Rules, terms, and conditions of MCO/IMCS.** Rules, terms, and conditions shall be made available upon request by the Workers' Compensation Commission.

(h) **MCO application for certification.**

(1) **MCO certification.**

(A) Any person or entity may make written application to the Administrator of the Medical Cost Containment Division for certification as an MCO.

(B)(i) Two (2) copies of the application must be submitted.

(ii) The application must include the following specific information to ensure the MCO will be able to meet the provisions of this section:

(a) The names of all directors and officers of the organization and the name, address, and telephone number of a communication liaison for the proposed plan;

(b) The names, addresses, and specialties of the individuals who will provide services under the MCO;

(c) A statement describing how the plan will ensure an adequate number of healthcare providers to give employees convenient accessibility to all categories of providers;

(d) The rules, terms, and conditions regarding the services the MCO will be providing;

(e)(1) All entities with whom the MCO has an agreement to perform any of the functions of the managed care plan, and a description of the specific functions to be performed by each such entity.

(2) A sample contract which complies with subdivision (h)(2)(D) of this section must be furnished;

(f) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, as well as the bylaws or similar document, if any; and

(g) A description of the MCO's quality assurance program which shall include, but is not limited to:

- (1) An internal dispute resolution program;
- (2) A medical peer review program;
- (3) Preadmission review program which complies with 11 CAR § 25-125;
- (4) Second surgical opinion program;
- (5)(A) Utilization review program which includes concurrent and retrospective review.

(B) The MCO utilization review program must meet the requirements of Arkansas Code § 20-9-901 et seq., the Rules for Utilization Review in Arkansas, 20 CAR pt. 50, and must be certified with the Department of Health Utilization Review Certification Program as a private review agent; and

(6) Technical and professional review programs which shall comply with 11 CAR § 25-125, and satisfy the requirements of Arkansas Code § 20-9-901 et seq.

(C)(i) The MCO must provide programs through which participating healthcare providers may obtain information on the following topics:

- (a) Treatment parameters adopted by the Workers' Compensation Commission;
- (b) End of healing period;
- (c) Permanent partial impairment rating;
- (d) Return to work and disability management;
- (e) Healthcare provider obligation in the workers' compensation system; and

(f) Other topics the MCO or Workers' Compensation Commission deems necessary to obtain cost-effective medical treatment and appropriate return to work for an injured employee.

(ii) The medical director of an MCO must document attendance for a minimum of six (6) hours of education during the first year, and three (3) hours each

year thereafter, covering any of the topics listed in subdivision (h)(1)(C)(i) of this section, above.

(iii) The documentation shall be submitted to the administrator upon request.

(iv) The medical director or designee must be available as a consultant on these topics to any healthcare provider delivering services under the MCO.

(D) The MCO must describe its program for medical case management which must at a minimum comply with the following rule requirements:

(i) A description of how medical case management will be provided;

(ii) **Retention of medical case manager.**

(a) A medical case manager shall monitor, evaluate, and coordinate the delivery of quality, cost-effective medical treatment, and other healthcare services needed by an injured employee.

(b) Medical case managers:

(1) Should ensure that the injured or disabled employee is following the prescribed medical care plan; and

(2) Shall promote an appropriate, prompt return to work.

(c) Medical case managers shall facilitate communication between the employee, employer, insurance carrier/self-insured, healthcare provider, managed care plan, and any assigned vocational rehabilitation counselor to achieve these goals; and

(iii) **Qualifications of medical case manager.** A medical case manager, for the purposes of this section, means an individual who provides or supervises the provision of medical case management services under the MCO and who is either:

(a) A physician licensed in Arkansas;

(b) A designated certified case manager (CCM) by the Certification of Insurance Rehabilitation Specialists Commission for Case Manager Certification;

- (c) Currently licensed as a registered nurse (RN);
- (d) Currently licensed as an occupational health nurse; or
- (e) Currently licensed as a licensed practical nurse (LPN) and

have eighteen (18) months supervised clinical experience and six (6) months acceptable case management experience.

(E) Each application for original certification, or application for certification following revocation, must be accompanied by a nonrefundable fee of five hundred dollars (\$500).

(F)(i) An application received by the Workers' Compensation Commission shall be approved within forty-five (45) days of receipt of all required information if such application meets all certification requirements.

(ii) Further information or clarification of submitted information may be requested from the applicant.

(iii) Failure to respond to a request from the Workers' Compensation Commission or failure to meet the requirements shall result in a denial of certification.

(iv) A letter detailing the reason or reasons for denial shall be sent to the applicant within five (5) working days of the decision by the Workers' Compensation Commission to deny the application.

(G)(i) An applicant denied certification shall be permitted to reapply no earlier than thirty (30) days after receipt of the notice of denial of certification.

(ii) Such application shall be accompanied by a nonrefundable fee of two hundred fifty dollars (\$250).

(iii) In no event shall an entity be allowed to reapply for one (1) year after having been denied certification three (3) consecutive times.

(H) MCOs shall be initially certified for two (2) years and must undergo certification review every two (2) years thereafter.

## (2) **Contracts.**

(A) In order to provide management of treatment for injuries and diseases compensable under the Workers' Compensation Act, an MCO may contract with:

- (i) An insurance carrier licensed by the State Insurance Department

to write workers' compensation insurance in this state that has provided the Workers' Compensation Commission with a current Form A-13;

(ii) An individual employer or group of employers approved for self-insurance by the Workers' Compensation Commission; or

(iii) An employer.

(B) An MCO shall provide comprehensive medical services in accordance with its certification to all injured workers covered by the insurance carrier/employer/self-insured contracts.

(C) Copies of all contract agreements shall be made available upon request from the Workers' Compensation Commission.

(D)(i) When an MCO contracts with an insurance carrier/employer/self-insured employer to provide services, the contract shall specify those employers governed by the contract.

(ii) The MCO contract must include the following terms and conditions when establishing who is governed by the contract:

(a) Insurance carriers/employers/self-insured employers may contract with more than one (1) MCO to provide services for employers, however, all workers at any specific employer's location with accepted compensable injuries shall be governed by the same MCO; and

(b)(1) To ensure continuity of care, the MCO contract shall specify the manner in which injured workers with compensable injuries will receive medical services when an MCO contract terminates.

(2) When MCO coverage for an injured worker is transferred from one (1) MCO to another, the worker may continue to treat with his or her attending physician until a change of physician occurs.

(E) Notwithstanding the requirements of this section, failure of the MCO to provide such medical services does not relieve the insurance carriers/employers/self-insured employers of their responsibility to ensure that medical benefits are provided to injured workers.

(i) **IMCS application for certification.**

(1) Any insurance carrier, employer, individual self-insured employer, or group self-insured employer may make application to the administrator for certification of its in-house managed care system.

(2) The application must include the following specific information to ensure the IMCS will be able to meet the provisions of this section:

(A) The name, address, and telephone number of a communication liaison for the IMCS;

(B)(i) A description of the IMCS.

(ii) The description of the IMCS must include the rules, terms, and conditions regarding the services the IMCS will be providing;

(C) A list of the names, addresses, and specialties of the individuals who will provide services for the IMCS;

(D) The names and qualifications of those individuals who will be providing case management services for the IMCS;

(E) The description of a program for medical case management which shall not be limited to, but which must at a minimum comply with subdivision (h)(1)(D) of this section; and

(F) The description of a program for quality assurance which shall not be limited to, but which must at a minimum comply with subdivision (h)(1)(B)(ii)(g) of this section.

(3) Each request for certification of an IMCS must be accompanied by a nonrefundable application fee of five hundred dollars (\$500).

(4) Approval of certification is dependent upon proof of compliance with the above.

(5) An approved IMCS may provide services only to their policyholders, employees, and/or group self-insured employers.

**(j) Reporting requirements.**

**(1) MCO reporting requirements.**

(A) In order to maintain certification, each MCO shall provide within thirty (30) days following each anniversary of certification the following information for the

previous calendar year:

- (i) A current membership listing by category of medical service providers, including provider names as required in subsection (i) of this section;
- (ii) A listing of all employers covered by each contract;
- (iii) A summary of any sanctions or punitive actions taken by the MCO against participating healthcare providers;
- (iv) A summary of actions taken by the MCO's peer review committee which shows the number of cases reviewed, issues involved, and action taken;
- (v) A list of entities other than healthcare providers that perform any of the functions of the MCO plan which were not previously provided with the application for certification; and
- (vi) Any other information requested by the Workers' Compensation Commission which is deemed reasonable/necessary to monitor the MCO's compliance with the requirements of this section.

(B) The MCO must report to the insurance carrier/employer/self-insured employer and Workers' Compensation Commission any data regarding medical, surgical, and hospital services related to a workers' compensation claim requested by the insurance carrier, employer, self-insured employer, or Workers' Compensation Commission.

(2) **IMCS reporting requirements.** In order to maintain certification, each IMCS shall provide within thirty (30) days following each anniversary of certification the following information:

- (A) A summary of any sanctions or punitive actions taken by the IMCS against participating providers;
- (B) A summary of actions taken by the IMCS's peer review committee which shows the number of cases reviewed, issues involved, and action taken;
- (C) Any other information requested by the Workers' Compensation Commission which is deemed reasonable/necessary to monitor the IMCS's compliance with the requirements of this section; and
- (D) Any significant changes in the certified plan or provider network.

**(k) Record maintenance.**

(1) Every MCO/IMCS that is certified to provide medical services as required by this section shall maintain records for three (3) full calendar years.

(2) If the insurance carrier's/employer's/self-insured employer's contract with the MCO is canceled for any reason, all MCO records relating to treatment provided to workers within the MCO must be forwarded to the insurance carrier/employer/self-insured employer upon request.

(3)(A) Individual MCO/IMCS participating providers must maintain claimant medical records.

(B) The records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided within each set of records.

(C) The records shall contain:

(i) Objective and subjective findings; and

(ii) Complete case history of the services rendered (diagnostic and therapeutic procedures employed) to each claimant, and the time involved if the procedure being billed is based upon time.

**(l) Dispute resolution.**

**(1) MCO/IMCS internal dispute resolution program.**

(A) Disputes, other than choice and change of physician, which arise on an issue related to managed care, such as the question of inappropriate, excessive, or not medically necessary treatment, medical disputes, disputes regarding nonparticipating providers, etc., between the employee, healthcare provider, managed care plan, insurance carrier/self-insured employer, or employer shall first be processed without charge to the employee or healthcare provider through the dispute resolution process of the MCO/IMCS.

(B) Disputes must be in writing and filed within thirty (30) days of the dispute.

(C) The MCO/IMCS dispute resolution process must be completed within thirty (30) days of receipt of a written request.

(D) If the dispute cannot be resolved, or one (1) of the parties so

requests in writing, the administrator shall assist in resolution pursuant to the administrative review process as set out below.

(E) For change of physician, see subsection (e) of this section.

(F) For choice of physician, see subsection (c) of this section.

**(2) Administrative review.**

(A) The process for administrative review of such matters shall be as follows:

(i)(a) The request for administrative review shall be made in writing to the administrator within ninety (90) days of the disputed action.

(b) No administrative review shall be granted unless the request is in writing and specifies the grounds upon which the action is contested and is received by the administrator within ninety (90) days of the contested action, unless the administrator or his or her designee determines that there was good cause for delay or that substantial injustice may otherwise result;

(ii)(a) When the request for administrative review is received by the administrator and it is determined that the Workers' Compensation Commission has jurisdiction over the cause of action, all parties shall be notified by certified mail return receipt requested.

(b) All parties shall have thirty (30) days from the date of receipt of notification to submit further evidence, documentation, or clarification to the administrator;

(iii)(a) The review may be conducted by the administrator or the administrator's designee.

(b) The review may include a hearing where all parties to the dispute will be required to attend.

(c) All hearings will be recorded.

(d) Failure to appear at such hearing may result in dismissal of the request for administrative review;

(iv) An order or award shall be issued within thirty (30) days;

(v)(a) Any party feeling aggrieved by the order of the administrator

shall have ten (10) days from the date of the notification to request a rehearing.

(b) A request for rehearing shall be in writing and shall state the grounds upon which the moving party relies.

(c) Upon a finding that the record is not complete or that error was made in the hearing process, the administrator may order a rehearing.

(d) A rehearing shall follow the same procedure as the initial administrative review; and

(vi)(a) Any party feeling aggrieved by the rehearing order of the administrator shall have ten (10) days from the date of the notification to appeal the ruling to an administrative law judge of the Workers' Compensation Commission.

(b) The notice of appeal shall be filed with the Clerk of the Commission.

(c) The notice of appeal shall contain the following:

(1) A copy of the administrative review order appealed;

(2) Copies of all materials submitted to the administrator in the administrative review proceedings;

(3) A statement identifying each portion of the administrator's order claimed to be in error; and

(4) An explanation of how each portion of the administrator's order conflicts with this section.

(d) The appealing party shall mail a copy of all materials which are filed in the appeal to each opposing party.

(e) No response to the appeal of the administrator's order is required.

(f) A decision must be entered by the administrator or administrator's designee before any appeal may be brought.

(B)(i) An order or award of an administrative law judge shall become final unless a party to the dispute shall, within thirty (30) days from the receipt by him or her of the order or award, petition in writing for a review by the full Workers' Compensation Commission of the order or award.

(ii) See Arkansas Code § 11-9-711(a)(1).

(C)(i) An order or award of the Workers' Compensation Commission shall become final unless a party to the dispute shall, within thirty (30) days from receipt of the order or award, file notice of appeal to the Court of Appeals.

(ii) See Arkansas Code § 11-9-711(b).

**(m) Monitoring/auditing.**

(1) The Workers' Compensation Commission for good cause may monitor and conduct periodic audits and special examinations of the MCO/IMCS as necessary to ensure compliance with the MCO/IMCS certification and performance requirements and any applicable 11 CAR § 25-125 requirements.

(2)(A) All records of the MCO/IMCS and their individual members shall be disclosed within a reasonable time upon request of the Workers' Compensation Commission.

(B) These records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided for the codes.

**(n) Charges and fees.**

(1)(A) Billings for medical services under an MCO/IMCS shall be submitted in the form and format as prescribed in 11 CAR § 25-125.

(B) The payment of medical services may be less than, but shall not exceed, the maximum amounts allowed pursuant to 11 CAR § 25-125.

(2) Fees paid to medical providers who are not subject to the terms of an agreement with an MCO/IMCS shall be governed by the provisions of 11 CAR § 25-125.

(3)(A) Balance billing as defined in 11 CAR § 25-125 by medical providers and/or facilities is specifically prohibited.

(B) The MCO/IMCS must have an effective plan for handling balance billing.

**(o) Complaints/investigations.**

(1)(A) Complaints pertaining to the operations of an MCO/IMCS shall be directed in writing to the administrator.

(B) Upon receipt of a written complaint, or after monitoring the

MCOs/IMCSs, the administrator may investigate the alleged violation.

(C) The investigation may include, but shall not be limited to:

- (i) Requests for and review of pertinent MCO/IMCS records;
- (ii) Interviews with the parties to the complaint; or
- (iii) Consultation with an appropriate committee of the medical

provider's peers.

(D) If the investigation reveals a violation, the certification may be suspended or revoked or the IMCS may be placed on probation.

(E) The administrator may return the complaint to the originating party for completion if the complaint does not satisfy the requirements of this section.

(F) The complaint must:

- (i) State the grounds for alleging a rule violation;
- (ii) Include the specific contentions of error;
- (iii) State the complainant's request for correction and relief; and
- (iv) Include sufficient documentation to support the complaint.

(2) Upon completion of the investigation, if the administrator determines there has been a violation, the administrator may issue sanctions and/or penalties pursuant to subsection (p) of this section.

(p) **Suspension/revocation.**

(1) The certification of an MCO/IMCS may be suspended, placed on probation, or revoked by the administrator if:

(A) The MCO/IMCS plan for providing services fails to meet the requirements of this section;

(B) Service under the plan is not being provided in accordance with the terms of the certified plan;

(C) Any false or misleading information is submitted by the MCO/IMCS or any participating providers of the organization;

(D) The MCO/IMCS continues to use the services of a healthcare provider whose license, registration, or certification has been suspended or revoked; or

(E) There is a change in legal entity of the MCO/IMCS which does not

conform to the requirements of this section.

(2) **Definitions.** For the purpose of this section:

(1) "Probation" means that an IMCS has been given a specified length of time in which to remedy any problem of which it has been notified pursuant to subsection (o) of this section;

(2) "Revocation" means a permanent revocation of an MCO's/IMCS's certification to provide services under this section; and

(3)(A) "Suspension" means an MCO may not enter into new contracts with insurance carriers/employers/self-insured employers for a specified period of time.

(B) The suspension period may be imposed for a period up to a maximum of one (1) year.

(3) A show cause hearing may be held at any time the administrator has reason to believe an MCO/IMCS has failed to comply with its obligations under the Workers' Compensation Act, Workers' Compensation Commission rules, or orders of the administrator, or when serious questions of operation of an MCO/IMCS warrant a hearing.

(4) Suspension, probation, or revocation under this section will not be made until the MCO/IMCS has been given notice and the opportunity to be heard at a hearing before the administrator to show cause why it should be permitted to continue to provide services under this section.

(5) The process for suspension/probation/revocation shall be as follows:

(A)(i) The administrator shall provide the MCO/IMCS written notice of an intent to suspend, place on probation, or revoke the MCO's/IMCS's certification and the grounds for such action.

(ii) The notice shall also advise the MCO/IMCS of its right to participate in a show cause hearing and the date, time, and place of the hearing.

(iii) The notice shall be sent by certified mail at least thirty (30) days prior to the scheduled date of the hearing;

(B) After the show cause hearing, the administrator may issue an order suspending, placing on probation, or revoking the MCO/IMCS;

(C)(i) Upon suspension or probation, the MCO/IMCS may continue to provide services in accordance with the contracts in effect at the time of the suspension/probation.

(ii) Prior to the end of the suspension/probation period, the administrator shall determine if the MCO/IMCS is in compliance.

(iii) If the MCO/IMCS is in compliance, the suspension/probation will terminate on its designated date.

(iv) If the MCO/IMCS is not in compliance, the suspension/probation may be extended without further hearing or revocation proceedings may be initiated.

(v) A suspension/probation may be set aside prior to the designated end of the suspension/probation period if the administrator is satisfied that the MCO/IMCS is in compliance with this section;

(D)(i) If the MCO/IMCS certificate is suspended, placed on probation, or revoked, the administrator shall allow for a rehearing and shall give the MCO/IMCS at least ten-days' notice of the time and place of the rehearing.

(ii) Within thirty (30) days after the hearing, the administrator shall:

(a) Either affirm or withdraw the revocation; and

(b) Give the MCO/IMCS written notice thereof by registered or certified mail.

(iii) If revocation is affirmed after rehearing by the administrator, the revocation is effective ten (10) days after the MCO/IMCS receives notice of the affirmance, unless the MCO/IMCS appeals to an administrative law judge; and

(E) If the revocation is affirmed following judicial review by an administrative law judge, the revocation is effective ten (10) days after entry of the final decree of affirmance.

(6) After revocation of an MCO's/IMCS's authority to provide services under this section has been in effect for one (1) year or longer, it may petition the administrator to restore its authority by submitting a plan and application in the form and format as required by subsections (h) or (i) of this section.

(7) Insurance carrier/employer/self-insured employer contractual obligations to

allow an MCO to provide medical services for injured workers shall be null and void upon revocation of the MCO/IMCS certification by the administrator.

(8) Any contractual obligations of a healthcare provider or other entity to deliver medical, surgical, or hospital services pursuant to the Workers' Compensation Act or to comply with any rules, terms, and conditions of the MCO/IMCS or to make referrals into the MCO/IMCS shall be null and void upon revocation of the certification of the MCO/IMCS.

(q) **Service of orders.**

(1) When the administrator suspends/places on probation or revokes certification of an MCO/IMCS or assesses a penalty, the order, including a notice of the party's appeal rights, shall be served upon the party.

(2) The order shall be served by delivering a copy to the party through certified mail return receipt requested or in any manner provided by the Arkansas Rules of Civil Procedure.

(r) **Amendment changes.** Any amendments and/or changes to the certified MCO/IMCS plan must be approved by the administrator before becoming effective.

(s) **Applicability of rules.**

(1) This revised section was adopted December 3, 1996, and shall govern all Workers' Compensation Commission managed care organizations and/or internal managed care systems from January 20, 1997, forward.

(2) The provisions of this section shall be applicable to all such managed care organizations and/or internal managed care systems and services rendered thereby, subsequent to the effective date of this section.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Adopted July 1, 1994; Revised Effective January 20, 1997; Revised effective

November 14, 1999; Revised October 5, 2007, effective January 1, 2008.)"

This section as promulgated prior to codification into the Code of Arkansas Rules contained a footnote to 11 CAR § 25-128(h)(2)(A)(i) following the phrase "with a current Form A-13" as follows:

"\* Form A-13 was replaced by WCC Form I (Insurance Coverage), a 6" x 4" card."

**11 CAR § 25-129. Impairment rating guide.**

(a) **General provisions.** Pursuant to Arkansas Code §§ 11-9-519(h) [removed], 11-9-521(h), and 11-9-522(g), the following section is hereby established in order to implement an impairment rating guide to be used in the assessment of anatomical impairment.

(b) **Purpose.**

(1) The purpose of this section is to establish an impairment rating guide to be used in the assessment of anatomical impairment.

(2) To accomplish this purpose, the Workers' Compensation Commission hereby adopts Guides to the Evaluation of Permanent Impairment (4th ed. 1993) published by the American Medical Association exclusive of any sections which refer to pain and exclusive of straight leg raising tests or range-of-motion tests when making physical or anatomical impairment ratings to the spine.

(3) This publication is also known as the AMA Guides, available from:

American Medical Association  
AMA Plaza  
330 N. Wabash Ave., Suite 39300  
Chicago, IL 60611-5885

(4) This publication is adopted until such time as the commission shall develop another impairment rating guide.

(c) **Definition.**

(1) "Objective findings" means those findings which cannot come under the voluntary control of the patient.

(2)(A) When determining physical or anatomical impairment, neither a physician (or any other medical provider) nor an administrative law judge, the Workers' Compensation Commission, or the courts may consider complaints of pain.

(B) For the purpose of making physical or anatomical impairment ratings to the spine, straight leg raising tests or range-of-motion tests shall not be considered objective findings.

(3) Medical opinions addressing compensability and permanent impairment must be stated within a reasonable degree of medical certainty, Arkansas Code § 11-9-102(16).

**Authority.** Arkansas Code § 11-9-207.

**11 CAR § 25-130. Electronic data interchange filings.**

(a) **Electronic data interchange — Definition and purpose.**

(1) **Definition.** The Workers' Compensation Commission (commission) accepts electronic data interchange (EDI) transmissions, which allow the filing of data via paperless forms, pursuant to a contractual arrangement with:

(A) An insurance carrier;

(B) A Workers' Compensation Commission-approved self-insured employer;

(C) A Workers' Compensation Commission-approved self-insured group;

(D) A third-party administrator; or

(E) A governmental entity (reporter).

(2)(A) **Purpose.** The intended purpose of accepting electronic transmissions is to allow for a faster and more efficient method of reporting claim information to the Workers' Compensation Commission.

(B) As a result, claims will be processed faster, allowing injured employees

benefits to be paid in a more timely fashion.

**(b) Transmission and retrieval of data.**

**(1) Specifications.**

(A)(i) Transmission and retrieval of data shall be accomplished via a method designated by the commission.

(ii) Such method may include:

*(a)* Magnetic tape;

*(b)* Direct connection;

*(c)* Electronic mailbox; or

*(d)* Another method agreed upon.

(B) Transmission by the reporter via the specified method is deemed by the commission to meet the commission's requirements for transmittal and receipt of document data on behalf of the reporter, including any requirement that the document be signed by the reporter or employer.

(C) Transmissions by the reporter and retrieval by the commission will be at a time and to a place designated by the commission.

(D) The commission agrees to:

(i) Access on a timely basis the information transmitted by the reporter; and

(ii) Timely acknowledge receipt of the transmission back to the reporter via:

*(a)* Telephone;

*(b)* Facsimile transmittal;

*(c)* Electronic acknowledgment; or

*(d)* Other method.

**(2) Applications.**

(A)(i) Reporters have precise, once-a-week transmission times to deposit forms via the designated method.

(ii) Transmission times are set forth in each reporter's contract with the commission and must be adhered to for efficient exchange of data.

(B) Transmission errors shall be timely identified by the commission and directed to the reporter.

(C) The commission will cooperate to find satisfactory resolutions should conflicts arise in EDI scheduling.

(D) If transmissions occur no more frequently than on a weekly basis, it is possible for a transmission deposited on Monday to be updated prior to its actual transmission to the commission.

**(c) EDI project specifications.**

**(1) Project stages.**

(A) The EDI project will occur in two (2) stages:

(i) Initial document stage, which will consist of EDI transmission of an agreed-upon version of a First Report of Injury; and

(ii) Subsequent document stage, which will consist of EDI transmissions of other documents used by the commission, or other data retained or sought.

(B) Both stages will consist of two (2) phases:

(i) Parallel production phase, or testing phase, during which the reporter will transmit data electronically to the commission, while concurrently filing the same information via paper reports; and

(ii)(a) Full production stage, which will begin upon the successful completion of the parallel production phase.

(b) During this phase, concurrent testing will discontinue, and the electronic transmission of the data will become standard.

(2) **Duration.** Any phase of the project shall begin on or after the date of the written agreement between the commission and the reporter, or on a mutually agreed-upon date, and shall continue until the reporter satisfies the success criteria set forth below.

(3) **Success criteria.** Any phase of the project shall be considered a success when the reporter has transmitted data, for a time designated by the commission, which meets the acceptance criteria stated below, and has been accepted by the

commission.

(4) **Acceptance criteria.** The commission's acceptance criteria is that the information transmitted:

(A) Meets the mandatory data elements set forth in the technical criteria format, subdivision (c)(6) of this section;

(B) Passes the edits as designated in the technical criteria format, subdivision (c)(6) of this section; and

(C) Matches or is more accurate than the paper forms filed by the reporter to the commission.

(5) **Completion of parallel production phase.** Upon successful completion of a parallel production phase, the commission shall notify the reporter in writing that the reporter is no longer required to send the corresponding report via paper document to the commission.

(6) **Technical criteria format.** The transmission of forms, as set forth in each contract, requires that all data conform with regard to:

(A) **Data elements.** All data elements pertaining to any document or report shall be set forth in a corresponding trading partner table, and shall specify whether the element is mandatory, conditional, or optional;

(B) **Technical edits.**

(i) All technical edits shall be applied to all documents received electronically to ensure that:

(a) Mandatory elements are always supplied;

(b) Conditional elements are supplied when appropriate; and

(c) All other data elements meet the prescribed formats and data relationship tests.

(ii) Documents that fail to pass these edits will be rejected and must be resubmitted once the appropriate changes have been made.

(7) EDI transmissions must meet all technical edit and mandatory data requirements in order to be accepted by the commission.

(8) Any forms received by the commission which do not meet all technical edit

and mandatory data requirements will be rejected and returned to the reporter for refileing.

**(d) Transmissions to the commission.**

(1)(A) In order for any form required by the Workers' Compensation Commission to be filed, the EDI transmission must first be accepted.

(B) In order for a transmission to be considered accepted, the transmission must meet the requirements set forth in subsection (b) of this section.

**(2) First Report of Injury or Illness.**

(A) Commission acceptance of a First Report of Injury or Illness (Form 1) establishes a file, regardless of amount of time lost by a claimant.

(B) The acceptance of Form 1 obligates the reporter to file all additional required forms.

**(e) Data retention, confidentiality, and database security.**

(1) All data shall be maintained in the reporter's database for the statutory requirements for retaining such information.

(2) Databases transmitted pursuant to an EDI agreement shall be kept privileged and confidential, and any information contained in any electronic record is subject to all existing and applicable laws, rules, and regulations regarding confidentiality.

(3) Reporters shall not enter any unauthorized data, make any unauthorized alterations to their own data, or access or alter the data of another reporter.

(4) The parties shall have the rights to make use of the information contained in any electronically submitted record as they would have had in the equivalent paper-based document.

**(f) Criminal penalties.**

(1) Destroying, damaging, or tampering with EDI transmissions or equipment may subject an individual to criminal penalties.

(2) Arkansas Code § 5-38-101(5) defines "property" to include "intangible personal property".

(3) Arkansas Code § 5-38-101(6) defines "property of another" as "any

property in which any person or government other than the actor has a possessory or proprietary interest”.

(4) Arkansas Code § 5-38-203(a)(1) states:

(a) A person commits the offense of criminal mischief in the first degree if he or she purposely and without legal justification destroys or causes damage to any:

(1) Property of another person;

(5) Criminal mischief in the first degree is a Class C felony or a Class A misdemeanor.

(6) Arkansas Code § 5-38-204(a) states:

(a) A person commits criminal mischief in the second degree if the person:

(1) Recklessly destroys or damages any property of another person; or

(2) Purposely tampers with any property of another person and by the tampering causes substantial inconvenience to the owner or another person.

(7) Criminal mischief in the second degree is a:

(A) Class D felony;

(B) Class A misdemeanor; or

(C) Class B misdemeanor.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective November 20, 1995)"

**11 CAR § 25-131. Voluntary program for drug-free workplaces.**

**(a) Purpose and scope.**

**(1) Purpose.**

(A) The purpose of this section is to promote voluntary drug-free workplaces in accordance with Acts 1999, No. 1552, in order that employers in this state may be afforded the opportunity to maximize their levels of productivity, enhance their competitive positions in the marketplace, and reach their desired levels of success without experiencing the costs, delays, and tragedies associated with work-related accidents resulting from drug or alcohol abuse by employees.

(B) It is also the purpose of this section that drug or alcohol abuse be discouraged and that employees who choose to engage in drug or alcohol abuse face the risk of unemployment and being precluded from receiving workers' compensation medical and indemnity benefits.

(2) If an employer implements a drug-free workplace program which includes notice, education, and procedural requirements for testing for drugs and alcohol, in accordance with this section, then the Rule 36 employer may require the employee or job applicant to submit to a test for the presence of drugs or alcohol.

(3) If a drug or alcohol is found to be present in the employee's system at a level prescribed by this section, or if an employee refuses to submit to a test for drugs or alcohol, the employee may be:

(A) Terminated; and

(B) Precluded from receiving workers' compensation medical and indemnity benefits.

(4) If a drug or alcohol is found to be present in the job applicant's system at a level prescribed by this section, or if a job applicant refuses to submit to a test for drugs or alcohol, the Rule 36 employer may refuse to hire the applicant.

(5) Employers who adopt a drug-free workplace program as prescribed herein

and are annually accepted by the Workers' Health and Safety Division as having such a program, shall qualify for a workers' compensation premium credit as described in subsection (o) of this section.

(6) **Scope.** The provisions of this section apply to all employers in the State of Arkansas subject to provisions of the workers' compensation laws who qualify for the drug-free workplace program.

(7) The application of the provisions of this section is subject to the provisions of any applicable collective bargaining agreement.

(b) **Policies.**

(1)(A) It is intended that any employer required to test its employees pursuant to the requirements of any federal statute or regulation shall be deemed to be in conformity with 11 CAR § 25-131 as to the employees it is required to test by those standards and procedures designated in that federal statute or regulation.

(B) All other employees of such employer shall be subject to testing as provided in this section in order for such employer to qualify as having a drug-free workplace.

(2) Nothing in this section is intended to authorize any employer to test any applicant or employee for alcohol or drugs in any manner inconsistent with federal constitutional or statutory requirements, including those imposed by the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq., and the National Labor Relations Act of 1935, 29 U.S.C. §§ 151 — 166.

(3) Nothing in this section shall be construed to require an employer to test or create a legal obligation upon an employer to request an employee or job applicant to undergo drug or alcohol testing.

(4) Nothing in this section shall be construed to prohibit an employer from affording an employee greater protection than provided herein.

(5) A Rule 36 employer is not barred from conducting more extensive testing (including random testing) provided the employee's/job applicant's constitutional rights are not infringed.

(6) No cause of action shall arise in favor of any person based upon the failure

of an employer to establish a program or policy for drug or alcohol testing.

(7) Nothing in this section shall be construed to amend or affect the employment-at-will doctrine.

(c) **Definitions.** As used in this section:

(1) "49 C.F.R. pt. 40" means the most current version of 49 C.F.R. pt. 40;

(2) "Alcohol" as used in this section shall have the same meaning as in the federal regulations describing procedures for the testing of alcohol by programs operating pursuant to the authority of the United States Department of Transportation as currently compiled in 49 C.F.R. pt. 40;

(3) "Alcohol test" means an analysis of breath or blood, or any other analysis which determines the presence and level or absence of alcohol as authorized by the United States Department of Transportation in its rules and guidelines concerning alcohol testing and drug testing;

(4) "Certified laboratory" means a laboratory licensed and approved as outlined in subsection (g) of this section;

(5) "Chain of custody" refers to the methodology of tracking specified materials or substances for the purpose of maintaining control and accountability from initial collection to final disposition for all such materials or substances, and providing for accountability at each stage in:

(A) Handling;

(B) Testing and storing specimens; and

(C) Reporting test results;

(6) "Confirmation test", "confirmed test", or "confirmed drug or alcohol test" means a second analytical procedure used to identify the presence of a specific drug or alcohol or metabolite in a specimen, which test must be:

(A) Different in scientific principle from that of the initial test procedure;

and

(B) Capable of providing requisite specificity, sensitivity, and quantitative accuracy;

(7)(A) "Rule 36 employer" means a person or entity that employs a person, is

covered by the workers' compensation laws, and maintains a drug-free workplace pursuant to this section.

(B) This section shall have no effect on employers who do not meet this definition;

(8) "Director" means the Director of the Workers' Health and Safety Division of the Workers' Compensation Commission;

(9) "Division" means the Workers' Health and Safety Division of the Workers' Compensation Commission;

(10)(A) "Drug" means any controlled substance subject to testing pursuant to drug testing regulations adopted by the United States Department of Transportation.

(B) A Rule 36 employer shall test an individual for all such drugs in accordance with the provisions of this section;

(11) "Drug or alcohol rehabilitation program" means a service provider that provides confidential, timely, and expert identification, assessment, and resolution of employee drug or alcohol abuse;

(12) "Drug test" or "test" means any chemical, biological, or physical instrumental analysis administered by a certified laboratory for the purpose of determining the presence or absence of a drug or its metabolites or alcohol pursuant to regulations governing drug or alcohol testing adopted by the United States Department of Transportation;

(13) "Employee" means any person who works for a salary, wage, or other remuneration for a covered employer;

(14)(A) "Employee assistance program (EAP)" means an established program of substance abuse professionals (SAP) capable of providing:

- (i) Expert assessment of employee personal concerns;
- (ii) Confidential and timely identification services with regard to employee drug or alcohol abuse;
- (iii) Referrals of employees for appropriate diagnosis, treatment, and assistance; and
- (iv) Follow-up services for employees who participate in the program

or require monitoring after returning to work.

(B) If, in addition to the above activities, an employee assistance program provides diagnostic and treatment services, these services shall in all cases be provided by the program;

(15) "Employer" means a person or entity that employs a person and is covered by the workers' compensation laws;

(16) "First-aid treatment" means treatment as defined by the United States Department of Labor, Occupational Safety and Health Administration in 29 C.F.R. pt. 1904;

(17) "Initial drug or alcohol test" means a procedure that qualifies as a "screening test" or "initial test" pursuant to regulations governing drug or alcohol testing adopted by the United States Department of Transportation;

(18) "Injury" means any work-related accident requiring more than first-aid treatment;

(19) "Job applicant" means a person who:

(A) Has applied for a position with a Rule 36 employer and has been offered employment conditioned upon successfully passing a drug or alcohol test; and

(B) May have begun work pending the results of the drug or alcohol test;

(20) "Medical review officer" or "MRO" means a licensed physician, pharmacist, pharmacologist, or similarly qualified individual, employed with or contracted with a Rule 36 employer, who:

(A) Has knowledge of substance abuse disorders, laboratory testing procedures, and chain-of-custody collection procedures;

(B) Verifies positive, confirmed test results; and

(C) Has the necessary medical training to interpret and evaluate an employee's positive test result in relation to the employee's medical history or any other relevant biomedical information;

(21) "Presence of drugs or alcohol" means levels of drugs, alcohol, or metabolites in the body at or above the cutoff levels established by the United States Department of Transportation as published in 49 C.F.R.pt. 40 and elsewhere;

(22) "Reasonable suspicion drug testing" means drug or alcohol testing based on a belief that an employee is using or has used drugs or alcohol in violation of the Rule 36 employers' policy drawn from specific objective and articulable facts and reasonable inferences drawn from those facts in light of experience;

(23)(A) "Safety-sensitive position" means a position involving a safety-sensitive function pursuant to regulations governing drug and alcohol testing adopted by the United States Department of Transportation.

(B) "Safety-sensitive position" means, with respect to any employer, a position in which a drug or alcohol impairment constitutes an immediate and direct threat to public health or safety, such as a position that requires the employee to:

(i) Carry a firearm;

(ii) Perform life-threatening procedures;

(iii) Work with confidential information or documents pertaining to criminal investigations or work with controlled substances; or

(iv) Work in a position in which momentary lapse in attention could result in injury or death to another person; and

(24) "Specimen" means tissue, fluid, or a product of the human body capable of revealing the presence of alcohol, drugs, or their metabolites.

**(d) Written policy statement — Notice to job applicants and employees.**

(1)(A) It is a requirement of the drug-free workplace program that, prior to testing, the employer give a one-time written policy statement to all employees and job applicants.

(B) A model notice and policy may be obtained from the division.

(C) This model notice and policy may be modified by the employer.

(D) However, any such notice must contain:

(i) A general statement of the Rule 36 employer's policy on employee drug and alcohol abuse, which must identify:

(a) That it is a condition of employment for an employee to refrain from reporting to work or working with the presence of drugs or alcohol in the employee's body;

(b) The types of drug or alcohol testing an employee or job applicant may be required to submit to; and

(c) The actions the Rule 36 employer may take against an employee or job applicant on the basis of a positive, confirmed, verified drug or alcohol test result;

(ii) A statement advising the employee or job applicant of the existence of this section;

(iii) A statement explaining the protections available to employees under this section as outlined in subsection (i) of this section;

(iv) A general statement concerning confidentiality;

(v) The consequences of refusing to submit to a drug or alcohol test;

(vi) A representative sampling of names, addresses, and telephone numbers of employee assistance programs and/or local drug and alcohol rehabilitation programs;

(vii) A statement informing the employee or job applicant of his or her responsibility to notify the laboratory of any administrative or civil action brought pursuant to this section;

(viii) A list of all classes of drugs for which the Rule 36 employer may test;

(ix) A statement regarding any applicable collective bargaining agreement or contract and the right to appeal to the applicable court; and

(x) That this notice complies with the requirements for notice under subsection (a) of this section.

(2) A Rule 36 employer shall ensure that at least sixty (60) days elapse between a general one-time notice to all employees that:

(A) A drug-free workplace program is being implemented; and

(B) The effective date of the program.

(3)(A) A Rule 36 employer shall include notice of drug and/or alcohol testing on vacancy announcements for positions for which drug and/or alcohol testing is required.

(B) A notice of the Rule 36 employer's drug and alcohol testing policy must also be posted in an appropriate and conspicuous location on the Rule 36 employer's premises, and copies of the policy must be made available for inspection by the employees or job applicants of the Rule 36 employer during regular business hours in the Rule 36 employer's personnel office or other suitable locations.

(4)(A) A Rule 36 employer may rescind its coverage under this section by posting a written and dated notice in an appropriate and conspicuous location on its premises.

(B) The notice shall state that the policy will no longer be conducted pursuant to this section.

(C)(i) The employer shall provide sixty (60) days' written notice of the rescission to the employer's workers' compensation insurer and the division.

(ii) Such notice shall be sent by certified mail.

(D) The rescission shall become effective no earlier than sixty (60) days after the date of the posted notice.

**(e) Types of testing.**

(1) This section does not preclude an employer from conducting any lawful testing, including random testing, of employees for drugs or alcohol that is in addition to the minimum testing required under this section.

(2) An employee who is not in a safety-sensitive position may be tested for alcohol only when the test is based upon reasonable suspicion.

(3) An employee in a safety-sensitive position may be tested for alcohol use at any occasion as described in this section.

(4)(A) To the extent permitted by law, a Rule 36 employer who voluntarily establishes a drug-free workplace is required to conduct the following types of drug and alcohol tests.

**(B) Job applicant drug and/or alcohol testing.** After a conditional offer of employment, a Rule 36 employer:

(i) Must require job applicants to submit to a drug test and may use a refusal to submit to a drug test or a positive, confirmed, verified drug test as a basis for

refusing to hire a job applicant;

(ii) May conduct limited testing of applicants, but only if it is based on a reasonable classification basis, in accordance with this section;

(iii) May, but is not required to, test job applicants for alcohol;

(iv) May test an employee for any drug as set out in subsection (g) of this section and at any time set out in this subsection; and

(v) Shall limit such testing for public employees to the extent permitted by the Arkansas Constitution and United States Constitution.

**(C) Reasonable suspicion drug or alcohol testing.**

(i) A Rule 36 employer must require an employee to submit to reasonable suspicion drug or alcohol testing.

(ii)(a) Specimen collection for reasonable suspicion testing must be done within a reasonable time after the precipitating incident.

(b) For alcohol, it must be done within eight (8) hours of the incident and, for drugs, it must be done within thirty-two (32) hours of the incident.

(iii) Among other things, reasonable suspicion shall include such facts and inferences as may be based upon:

(a) Observable phenomena while at work, such as direct observation of drug or alcohol use or of the physical symptoms or manifestations of being under the influence of a drug or alcohol;

(b) Abnormal conduct or erratic behavior while at work, or a significant deterioration in work performance;

(c) A report of drug or alcohol use, provided by a reliable and credible source;

(d) Evidence that an individual has tampered with a drug or alcohol test during employment with the current Rule 36 employer;

(e) Information that an employee has caused, contributed to, or been involved in an accident while at work; or

(f) Evidence that an employee has used, possessed, sold, solicited, or transferred drugs or used alcohol while working or while on the Rule 36

employer's premises or while operating the Rule 36 employer's vehicle, machinery, or equipment.

(iv)(a) Within twenty-four (24) hours of the observed behavior or before the results of the test are released, whichever is earlier, the Rule 36 employer must make a written record of the observations leading to a controlled substance or alcohol reasonable suspicion test.

(b) A copy of this documentation shall be given to the employee upon request, and the original documentation shall be kept confidential by the Rule 36 employer pursuant to subsection (l) of this section and shall be retained by the Rule 36 employer for at least one (1) year.

**(D) Routine fitness-for-duty drug or alcohol testing.**

(i) A Rule 36 employer must require an employee to submit to a drug or alcohol test if, as a part of the employer's written policy, the test is:

(a) Conducted as a routine part of a routinely scheduled employee fitness-for-duty medical examination; or

(b) Scheduled routinely for all members of an employment classification or group.

(ii) A public employer may require scheduled, periodic testing only of employees who:

(a) Are police or peace officers;

(b) Have drug interdiction responsibilities;

(c) Are authorized to carry firearms;

(d) Are engaged in activities which directly affect the safety of others;

(e) Work in direct contact with inmates in the custody of the Department of Corrections; or

(f) Work in direct contact with minors who have been adjudicated delinquent or who are in need of supervision in the custody of the Department of Human Services.

(iii)(a) This section does not require a drug or alcohol test if a Rule 36

employer's current personnel policy on July 1, 2000, does not include drug or alcohol testing as a part of a routine fitness-for-duty medical exam.

(b) If such testing is included, it must be done on a nondiscriminatory manner.

(iv) Routine fitness-for-duty drug or alcohol testing of employees does not apply to:

(a) Volunteer employee health screenings;

(b) Employee wellness programs;

(c) Programs mandated by governmental agencies; or

(d) Medical surveillance procedures that involve limited examinations targeted to a particular body part or function.

**(E) Follow-up drug testing.**

(i) If the employee in the course of employment enters an employee assistance program for drug or alcohol-related problems, or a drug or alcohol rehabilitation program, the Rule 36 employer must require the employee to submit to a drug or alcohol test, as appropriate, as a follow-up to such program, unless the employee voluntarily entered the program.

(ii) In those cases, the Rule 36 employer has the option to not require follow-up testing.

(iii) If follow-up testing is required, it must be conducted at least once a year for a two-year period after successful completion of the program.

(iv) Advance notice of a follow-up testing date must not be given to the employee to be tested.

**(F) Post-accident testing.**

(i) After an accident which results in an injury, the Rule 36 employer shall require the employee to submit to a drug or alcohol test in accordance with this section.

(ii) Post-accident specimen collection for alcohol testing shall be done within eight (8) hours of the accident.

(iii) Post-accident specimen collection for drugs shall be done within

thirty-two (32) hours of the accident.

**(f) Refusal to test.**

(1)(A) If an employee or job applicant refuses to submit to a drug or alcohol test, the Rule 36 employer is not barred from discharging or disciplining the employee or from refusing to hire the job applicant.

(B) However, this section does not abrogate the rights and remedies of the employee or job applicant as otherwise provided in this section.

(2) Attempting to defraud a drug test (substitution, adulteration, dilution, etc.) is a Class B misdemeanor under Arkansas law punishable by up to ninety (90) days in jail and/or five-hundred-dollar fine.

**(g) Testing procedures and laboratory requirements.**

(1) Pursuant to 49 C.F.R. pt. 40, a Rule 36 employer shall test as specified in this section for:

- (A) Amphetamines;
- (B) Marijuana (cannabinoids);
- (C) Cocaine (benzoylecgonine);
- (D) Opiates (codeine, morphine, heroin);
- (E) PCP (phencyclidine); and
- (F) Alcohol.

(2) The cutoffs established by the United States Department of Transportation and published in 49 C.F.R. pt. 40 or elsewhere shall be used for determination of presumptively positive tests and confirmation tests.

(3) The following shall be performed in accordance with the procedures provided for by the United States Department of Transportation rules for workplace drug and alcohol testing compiled in 49 C.F.R. pt. 40, Subpart B and Subpart C for drugs and alcohol, respectively:

- (A) Split-sample method of collection;
- (B) Security of the collection site;
- (C) Privacy of the individual;
- (D) Collection control;

(E) Chain-of-custody procedures, which include integrity, identity, and retention of the specimen;

(F) Transportation of the specimen;

(G) Testing; and

(H) Reporting.

(4) Except for subdivision (g)(5) of this section and subdivision (i)(2) of this section, the procedures for laboratory reporting and medical review officer and reporting of specimen test results shall be in accordance with those described in 49 C.F.R. §§ 40.29 and 40.33.

(5)(A) Any specimens with evidence of dilution, contamination, tampering, or any question normally requiring a medical review officer opinion shall be reported to the medical review officer for disposition.

(B) The medical review officer may determine the need to retest, recollect, order more extensive testing, or otherwise modify the collection or testing procedure to ensure adequate and appropriate testing.

(6) A laboratory may not analyze initial test specimens unless:

(A) The laboratory is:

(i) Licensed and approved by the Department of Health, using criteria established by the United States Department of Health and Human Services as guidelines for modeling the state drug-free testing program pursuant to this section; or

(ii) Certified by the United States Department of Health and Human Services or the College of American Pathologists; and

(B) The laboratory complies with:

(i) The procedures established by the United States Department of Transportation for a workplace drug test program; or

(ii) Such other recognized authority approved by the Director of the Workers' Health and Safety Division.

(7) Confirmation test may only be conducted by a laboratory that:

(A) Meets the requirements of subdivision (g)(6) of this section; and

(B) Is certified by either the Substance Abuse and Mental Health Services

Administration or the College of American Pathologists forensic urine testing programs.

(8)(A) The Department of Health may license and approve any new laboratory to analyze initial or confirmation test specimens under the provisions of this section and may charge a fee, not to exceed two thousand dollars (\$2,000), for the license and approval of the new laboratory.

(B) The fees set forth in this section shall be cash funds of the Department of Health and shall be deposited as provided in Arkansas Code §§ 19-4-801 – 19-4-816.

(h) **Cost of testing.**

(1) A Rule 36 employer shall pay the cost of all drug and alcohol tests, initial and confirmation, which the Rule 36 employer requires of employees.

(2) An employee or job applicant shall pay the costs of any additional drug or alcohol tests not required by the Rule 36 employer.

(i) **Employee protection.**

(1) The employer shall provide procedures for the employee or job applicant to confidentially report to the medical review officer the use of prescription or nonprescription medications after being tested, but only if the testing process has revealed a positive result for presence of drugs or alcohol.

(2)(A) An employee or job applicant who receives a positive confirmed test result may contest or explain the result to the medical review officer within five (5) working days after receiving written notification of the test result.

(B) If an employee's or job applicant's explanation or challenge is unsatisfactory to the medical review officer, the medical review officer shall then report the positive test result to the Rule 36 employer.

(C) An employee may then contest the drug test result pursuant to subdivision (i)(6) of this section.

(3) Employees and job applicants must be given a reasonable opportunity to consult with a medical review officer for technical information regarding prescription and nonprescription medicine.

(4) A Rule 36 employer may not discharge, discipline, refuse to hire,

discriminate against, or request or require rehabilitation of an employee or job applicant on the sole basis of a positive test result that has not been confirmed and verified by a medical review officer.

(5)(A) A Rule 36 employer shall not discharge, discipline, or discriminate against an employee solely upon the employee's voluntarily seeking treatment, while employed by the Rule 36 employer, for a drug-related or alcohol-related problem if the employee has:

- (i) Not previously tested positive for drug or alcohol use;
- (ii) Entered an employee assistance program for drug-related or alcohol-related problems; or
- (iii) Entered a drug or alcohol rehabilitation program.

(B) A Rule 36 employer may select the employee assistance program or drug or alcohol rehabilitation program if the Rule 36 employer pays the cost of the employee's participation in the program.

(C) However, nothing in this section is intended to require any employer to permit or provide such a rehabilitation program.

(6) Within thirty (30) days of termination, an employee shall be entitled to contest the test results before the Department of Labor and Licensing by filing written notice with the department.

**(j) Employer protection.**

(1) An employee or job applicant whose drug or alcohol test result is confirmed as positive in accordance with this section shall not, by virtue of the result alone, be deemed to have a handicap or disability as defined under federal, state, or local handicap and disability discrimination laws.

(2)(A) A Rule 36 employer who discharges or disciplines an employee or refuses to hire a job applicant in compliance with this section is considered to have discharged, disciplined, or refused to hire for cause.

(B) Nothing in this section shall be construed to amend or affect the employment-at-will doctrine.

(3)(A) No physician-patient relationship is created between an employee or job

applicant and a Rule 36 employer or any person performing or evaluating a drug or alcohol test, solely by the establishment, implementation, or administration of a drug or alcohol testing program.

(B) This subsection (j) in no way relieves the person performing the test from responsibility for acts of negligence in performing the tests.

(4) Nothing in this section shall be construed to prevent a Rule 36 employer from:

(A) Establishing reasonable work rules related to employee possession, use, sale, or solicitation of drugs or alcohol, including convictions for offenses relating to drugs or alcohol; and

(B) Taking action based upon a violation of any of those rules.

(5)(A) This section does not:

(i) Operate retroactively; and

(ii) Abrogate the right of an employer under state law to:

(a) Lawfully conduct drug or alcohol tests; or

(b) Implement lawful employee drug-testing programs.

(B) The provisions of this section shall not prohibit an employer from conducting any drug or alcohol testing of employees which is otherwise permitted by law.

(6)(A) If an employee or job applicant refuses to submit to a drug or alcohol test, the Rule 36 employer is not barred from:

(i) Discharging or disciplining the employee; or

(ii) Refusing to hire the job applicant.

(B) However, subdivision (j)(6)(A) of this section does not abrogate the rights and remedies of the employee or job applicant as otherwise provided in this section.

(7)(A) This section does not prohibit an employer from conducting medical screening or other tests required, permitted, or not disallowed by any statute, rule, or regulation for the purpose of monitoring exposure of employees to toxic or other unhealthy substances in the workplace or in the performance of job responsibilities.

(B) Such screening or testing is limited to the specific substances expressly identified in the applicable statute, rule, or regulation, unless prior written consent of the employee is obtained for other tests.

(C) Such screening or testing need not be in compliance with this section.

(D) If applicable, such drug or alcohol testing must be specified in a collective bargaining agreement as negotiated by the appropriate certified bargaining agent before such testing is implemented.

**(k) Substance abuse education/awareness.**

**(1) Employee education/awareness required for certification.**

(A)(i) Rule 36 employers are required to provide to all employees educational materials which explain the:

*(a)* Requirements of this section; and

*(b)* Employer's policies and procedures with respect to these requirements.

(ii) The employer shall ensure that a copy of this material is distributed to each employee:

*(a)* Prior to the start of the drug-free workplace program; and

*(b)* Hired or transferred into locations covered by the drug-free workplace program.

(iii) Each employer shall provide written notice to representatives of employee organizations of the availability of this information.

(B) **Required content.** The materials to be made available to employees shall include detailed discussion of at least the following:

(i) The identity of the person designated by the employer to answer employee questions about the materials;

(ii) Sufficient information about safety-sensitive functions performed by employees to make clear what period of the work day the employee is required to be in compliance with this section;

(iii) Specific information concerning employee conduct that is prohibited by this section;

(iv) The circumstances under which an employee will be tested for alcohol and/or drugs under this section;

(v) The procedures that will be used to test for the presence of alcohol and drugs, protect the employee and the integrity of the testing process, safeguard the validity of the test results, and ensure that those results are attributed to the correct employee, including post-accident information, procedures, and instructions required by this section;

(vi) The requirement that an employee submit to alcohol and drug tests administered in accordance with this section;

(vii) An explanation of what constitutes a refusal to submit to an alcohol or drug test and the attendant consequences;

(viii) The consequences for employees found to have violated the employer's drug-free workplace program, including the requirement that the employee be removed immediately from safety-sensitive functions;

(ix) The consequences for employees in safety-sensitive positions found to have an alcohol concentration above the cutoff limits defined by this section; and

(x) Information concerning the:

(a) Effects of alcohol and drug use on an individual's health, work, and personal life;

(b) Signs and symptoms of an alcohol or drug problem (the employee or a co-worker); and

(c) Available methods of intervening when an alcohol or drug problem is suspected, including confrontation, referral to an employee assistance program, and/or referral to management.

**(C) Optional provision.**

(i) The materials supplied to employees may also include information on additional employer policies with respect to the use of alcohol or drugs, including any consequences for an employee found to have a specified alcohol or drug level, that are based on the employer's authority independent of this section.

(ii) Any such additional policies or consequences must be clearly and obviously described as being based on independent authority.

**(D) Certificate of receipt.**

(i) Each employer shall ensure that each employee is required to sign a statement certifying that he or she has received a copy of these materials described in subsection (k) of this section.

(ii) Each employer shall maintain the original of the signed certificate and may provide a copy of the certificate to the employee.

**(2) Training for supervisors.**

(A) Each Rule 36 employer shall ensure that all persons designated to supervise employees receive at least:

(i) Sixty (60) minutes of training on alcohol misuse; and

(ii) An additional sixty (60) minutes of training on drug use.

(B) The training will be used by the supervisor to determine whether reasonable suspicion exists to require an employee to undergo testing under subsection (e) of this section.

(C) The training shall include the physical, behavioral, speech, and performance indicators of probable alcohol misuse and use of drugs.

**(I) Confidentiality.**

(1) All information, interviews, reports, statements, memoranda, and drug or alcohol test results, written or otherwise, received by the Rule 36 employer through a drug or alcohol testing program are confidential communications and may not be used or received in evidence, obtained in discovery, or disclosed in any public or private proceedings, except in accordance with this section in determining compensability under Arkansas Code § 11-14-109 or § 11-9-409.

(2)(A) Employers shall furnish the following information to both the Workers' Compensation Commission and their insurance carrier upon request:

(i) The name of the testing laboratory, third-party administrator, and MRO being used (including contact information); and

(ii) Summary reports indicating the total number, types, and results

of tests conducted during a specific period.

(B) The testing laboratory is authorized to verify these reports to the commission and insurer.

(3)(A) Rule 36 employers, laboratories, medical review officers, employee assistance programs, drug or alcohol rehabilitation programs, and their agents who receive or have access to information concerning drug or alcohol test results shall keep all information confidential.

(B) Release of such information under any other circumstance is authorized solely pursuant to written consent form signed voluntarily by the person tested, unless:

- (i) Such release is compelled by a hearing officer or a court of competent jurisdiction pursuant to an appeal taken under this section;
- (ii) Relevant to a legal claim asserted by the employee; or
- (iii) Is deemed appropriate by a professional or occupational licensing board in a related disciplinary proceeding.

(4) The consent form must contain, at a minimum the:

- (A) Name of the person who is authorized to obtain the information;
- (B) Purpose of the disclosure;
- (C) Precise information to be disclosed;
- (D) Duration of the consent; and
- (E) Signature of the person authorizing release of the information.

(5)(A) Information on drug or alcohol test results for tests administered pursuant to this section shall not be released or used in any criminal proceeding against the employee or job applicant.

(B) Information released contrary to this section is inadmissible as evidence in any such criminal proceeding.

(6)(A) This section does not prohibit a Rule 36 employer, agent of such employer, or laboratory conducting a drug or alcohol test from having access to employee drug or alcohol test information or using such information when:

- (i) Consulting with legal counsel in connection with actions brought

under or related to this section; or

(ii) When the information is relevant to its defense in a civil or administrative matter.

(B) Neither is this section intended to prohibit disclosure among management as is reasonably necessary for making disciplinary decisions relating to violations of drug or alcohol standards of conduct adopted by an employer.

(7) A person who discloses confidential medical records of an employee, except as provided in this section, shall be deemed guilty of a Class C misdemeanor, as provided by Acts 1999, No. 1552.

(m) **Drug-free program approval process.**

(1)(A) It is the sole responsibility of the employers applying for commission review of their drug-free workplace programs to submit accurate applications.

(B) Neither the commission nor the insurer is responsible for validating compliance with the program other than to assess whether the program components as submitted comply with this section.

(C) However, both the commission and the insurer have the right to assess actual compliance with the program.

(2)(A) Any employer wishing to acknowledge compliance with the provisions of this section shall annually complete and submit an application (on a form approved by the director) to the division.

(B) After review of the completed form, the division will notify the employer of acceptance or any deficiencies that must be corrected.

(3) Substantial compliance in completing and filing the form with the director shall create a rebuttable presumption that the employer has established a drug-free workplace program and is emitted to the protection and benefit of Arkansas Code §§ 11-14-104 – 11-14-112.

(4) Prior to receiving any premium credit from an insurer pursuant to Arkansas Code §§ 11-14-104 – 11-14-112, all employers requesting premium credits shall provide the commission acceptance form to their insurer.

(5) If a Rule 36 employer fails to maintain a drug-free workplace program in

accordance with the standards and procedures established in this section, the Rule 36 employer shall not be eligible for premium credits as specified in subsection (o) of this section.

(6) All Rule 36 employers qualifying for and receiving premium credits provided under this section must be reported annually by the insurer to the director on a form approved by the director.

(n) **Appeal process.**

(1) Each employer submitting a drug-free workplace program to the division for review but which program is not accepted by the division may obtain a review of the division staff's findings by the director.

(2) Each insurance company receiving notice that a client company has obtained acceptance of its drug-free workplace program by the division may obtain a review of the findings made by the director.

(3) The director shall cause a record to be made of all:

(A) Submissions by the party or parties; and

(B) Findings made by the director.

(4) An employer or insurance company may request a review by the Chief Executive Officer (CEO) of the commission of the findings made by the director.

(5) An employer or insurance company may request a review by the full commission of the findings made by the CEO.

(6)(A) A request for review by the director, the CEO, or the full commission shall be in writing, setting out the grounds for the review.

(B) A request for review of a decision of the director, the CEO, or the full commission shall be filed with the Clerk of the Commission within fifteen (15) days of receipt of such decision.

(C) The director, CEO, or the full commission, as applicable, shall decide the issues within fifteen (15) days of receipt of the request for review, based on the written record made with the director.

(7)(A) The State Insurance Department will be promptly notified by the Clerk of the Commission of requests for review by the full commission.

(B) The results of full commission reviews will be forwarded to the department for review and any appropriate action.

(o) **Rating plans.**

(1) The Insurance Commissioner shall approve rating plans for workers' compensation insurance that give a premium credit to employers that implement a drug-free workplace program pursuant to this section.

(2) The plans must:

(A) Take effect January 1, 2000;

(B) Be actuarially sound; and

(C) State the savings anticipated to result from such drug testing.

(3) The credit shall be at least five percent (5%) unless the commissioner determines that five percent (5%) is actuarially unsound.

(4) This premium credit shall not be available to employers who do not maintain their drug-free workplace program for the entire workers' compensation insurance policy period.

(p) **Severability.** If any provision of this section or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the provisions of this section are declared to be severable.

**Authority.** Arkansas Code §§ 11-14-111, 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"XVII. EFFECTIVE DATE

(This rule shall become effective November 1, 1999; revised effective September 20, 2001; revised October 5, 2007; effective January 1, 2008.)"

**11 CAR § 25-132. Occupational carpal tunnel syndrome.**

**(a) Authority and purpose.**

(1) Pursuant to Acts 2001, No. 1281, an additional section, Arkansas Code § 11-9-117, has been added to empower the Workers' Compensation Commission, in accordance with its rulemaking authority, to enact medical diagnostic and treatment guidelines regarding occupational carpal tunnel syndrome.

(2) These guidelines are based upon the joint recommendation of the Arkansas American Federation of Labor and Congress of Industrial Organization and the Arkansas State Chamber of Commerce.

**(b) Applicability and effective date.** This section and the guidelines set forth herein shall be applicable to all claims for workers' compensation benefits regarding occupational carpal tunnel syndrome filed with the commission on or after September 20, 2001.

**(c) Introduction.**

(1)(A) Carpal tunnel syndrome (CTS) is caused by compression of the median nerve at the wrist.

(B) Occupational CTS (OCTS) assumes a work-relatedness.

(2) Compared to nonoccupational CTS, OCTS patients are:

(A) Younger and have generally less severe changes on nerve conduction studies (NCS); and

(B) About equally male or female.

(3) Diabetes, pregnancy, hypothyroidism, and rheumatoid and other inflammatory arthritides are health problems occasionally associated with CTS.

**(d) Diagnosis.**

(1)(A) Initially, patients may have mild, intermittent symptoms usually of a few weeks duration without objective signs of median nerve dysfunction.

(B) The intermittent symptoms include numbness, tingling, or pain in the hand that occur with use of the hand and at night.

(C) Patients with persistent CTS have objective findings on examination or symptoms that fail to improve with conservative treatment, usually within four (4) weeks.

**(2) Clinical findings.**

**(A) Symptoms:**

(i)(a) Paresthesia in the hand, usually the first three (3) digits of the hand.

(b) However, patients often do not discriminate between some or all of the digits.

(c) Symptoms appropriate to the median nerve distribution are sensitive, ninety-three hundredths (0.93) or seven percent (7%) false negative, but also have low specificity, twenty-five hundredths (0.25) or seventy-five percent (75%) false positives;

(ii) Pain in the hand, forearm, upper arm;

(iii) A feeling of weakness or clumsiness of the hand.

**(B) Signs or objective findings:**

(i) Decreased sensation in the median nerve distribution (two-point discrimination has a sensitivity of twenty-three hundredths (0.23) but a specificity of eighty-two hundredths (0.82));

(ii)(a) Weakness is usually difficult to demonstrate in mild CTS.

(b) Thenar atrophy indicates more severe CTS;

(iii) Tinel's sign (sensitivity = sixty-two hundredths (0.62), specificity = sixty-six hundredths (0.66));

(iv) Phalen's sign (sensitivity = seventy-three hundredths (0.73), specificity = thirty-six hundredths (0.36));

(v) Abnormal nerve conduction studies;

(vi) Even in patients with NCS-established OCTS, the exam may be normal.

(C) If the NCS changes are mild to moderate, conservative management with splinting, medication, and job modification could be continued for four (4) to eight (8) weeks.

(D) Surgical decompression of the carpal tunnel (carpal tunnel release) is considered if there is:

(i) Failure to improve with conservative management and there are corroborative NCS findings;

(ii) Progression of symptoms during conservative management and there are corroborative NCS findings; or

(iii) Atrophy or significant NCS abnormality.

(E) In general, if a patient has symptoms that are thought to be from OCTS but has no objective verification of OCTS, including no abnormality on NCS, then that patient has likely reached maximum medical improvement at no longer than eight (8) weeks of conservative management under the care of a medical or osteopathic physician.

**(e) Nerve conduction studies.**

(1)(A)(i) Nerve conduction studies are the recognized standard for the diagnosis of CTS.

(ii) The following recommended criteria are adapted from those of the State of Washington Department of Labor & Industry.

(iii) Other criteria may be utilized as long as such criteria have a sound basis in the peer-reviewed literature.

(B)(i) Median palmar latencies (palm to wrist at eight centimeters (8 cm)).

(ii) Abnormal latency greater than two and two-tenths milliseconds (> 2.2 msec).

(iii) Median minus ulnar palmar latency abnormal greater than three-tenths milliseconds (> 0.3 msec).

(C)(i) Median motor latency (wrist to APB at eight centimeters (8 cm)).

(ii) Abnormal latency greater than four and five-tenths milliseconds (> 4.5 msec).

(iii) Median minus ulnar motor distal latency abnormal greater than one and eight-tenths milliseconds (> 1.8 msec).

(D)(i) Median sensory distal latency (wrist to digit at fourteen centimeters (14 cm)).

(ii) Abnormal latency greater than three and five-tenths milliseconds

(> 3.5 msec).

(E)(i) Fourth digit sensory distal latency (wrist to digit at fourteen centimeters (14 cm)).

(ii) Median minus ulnar sensory latency difference abnormal greater than five-tenths milliseconds (> 0.5 msec).

(2)(A)(i) In general, a complete study would include median and ulnar palmar latencies and median and ulnar motor nerve conduction studies, with hand skin temperature greater than thirty degrees (> 30° C).

(ii) No more than ten percent (10%) of CTS patients will have normal standard NCS.

(iii) These patients likely have mild median nerve impingement that may occur only with use of the hand.

(B) EMG is rarely needed for the diagnosis of CTS.

(C) If there is prominent concern for cervical radiculopathy, structural studies might be indicated.

(f) **Work relatedness.**

(1)(A) Carpal tunnel syndrome occurs both from intrinsic or patient factors (e.g., small carpal tunnel from arthritis or congenitally, metabolic derangement, etc.) and extrinsic factors, which for occupational CTS would be job activities.

(B) That is, if the predominant cause of the CTS is from job activity, then the CTS is work-related.

(2)(A) Job activity that regularly requires extensive use of the hands may be an appropriate exposure.

(B) Such activity involves repetitive hand use, especially:

(i) For prolonged periods;

(ii) Against force;

(iii) With strongly vibrating equipment;

(iv) With repeated wrist flexion, extension, deviation, forearm rotation, or constant firm gripping; or

(v) With awkward hand or wrist positions.

**(g) Management.**

**(1) Initial management.**

(A) Wrist splinting to maintain the wrist in a neutral position at night and when the hand is engaged in substantial activity.

(B) Medication, usually an NSAID.

(C) Job modification.

(D)(i) Steroid injection into the carpal tunnel may offer short-term improvement, but only twenty-two percent (22%) maintain the improvement (in a nonoccupational CTS setting).

(ii) A short, tapering course of oral corticosteroid has been shown to offer significant symptomatic improvement in patients with mild to moderate CTS.

(iii) Neurology, 1988, 51:390-393.

**(2) Progress.**

(A) If there is failure to improve with initial management, or if there is a more severe presentation of pain, swelling, weakness, or numbness, then more aggressive measures may be needed, including nerve conduction studies.

(B) Nerve conduction studies (NCS) or specialist referral are obtained when there is:

(i) Failure to have improvement of symptoms after four (4) weeks of conservative management;

(ii) Progression of symptoms during treatment;

(iii) Significant abnormality on examination, especially atrophy; or

(iv) Time loss on the job.

(3) The NCS are likely to be more sensitive if performed when the patient is still engaged in his or her usual occupation under normal working conditions.

**Authority.** Arkansas Code §§ 11-19-117, 11-9-207.

**Codification Notes.** "APB" means abductor pollicis brevis.

"EMG" means electromyography.

"NSAID" means nonsteroidal anti-inflammatory drug.

This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Approved August 29, 2001; effective September 20, 2001.)"

**11 CAR § 125-133. Third-party administrators.**

**(a) General.**

(1)(A) For purposes of this section, "third-party administrator" (hereafter TPA) means any person, firm, or partnership which:

- (i) Collects or charges premiums or fees;
- (ii) Receives remuneration in any form in exchange for adjusting or settling claims; or
- (iii) Otherwise providing administrative services concerning workers' compensation coverage in this state.

(B) The term does not include:

- (i) Companies which are licensed workers' compensation carriers, except to the extent that they engage in claims and administrative activities for which they or companies, including self-insurers, in their corporate family do not bear a direct risk;
- (ii) Self-insurers which self-administer their claims and administrative activities, except to the extent that they engage in claims and administrative activities for which they or companies, including licensed workers' compensation carriers, in their corporate family do not bear a direct risk; and
- (iii) Attorneys engaged in the representation of claimants or respondents in cases of controverted workers' compensation claims.

(2) Any TPA that has applied for or received authorization from the Workers'

Compensation Commission shall at all times meet the following conditions:

(A) The owners, partners, members, or officers of the TPA shall be persons of good moral character with reputations for honesty and fair dealings;

(B)(i) The TPA must have a sufficient number of experienced and qualified claims personnel.

(ii) In order to represent a group self-insurer client, the TPA must maintain an Arkansas claims office and have at least one (1) resident adjuster with check authority;

(C)(i) The TPA shall provide, at the commission's request, written proof of compliance with the conditions set forth in subdivisions (a)(2)(A) and (B) of this section, above.

(ii) When received by the commission, such documentation shall be considered of a confidential nature;

(D) The TPA shall continuously maintain with the commission a current listing of all claim office locations handling Arkansas workers' compensation claims as well as a contact person/information for such locations; and

(E)(i) The TPA shall, at the request of the commission, provide a list of clients for which Arkansas claims handling is offered.

(ii) When received by the commission, such documentation shall be considered as being of a confidential nature.

(b) **Applications.** Any firm desiring authorization to act as a TPA for workers' compensation purposes shall:

(1) Make application to the commission on such forms as may be prescribed;

(2)(A) Remit an application fee of one hundred dollars (\$100) payable to the Arkansas Workers' Compensation Commission.

(B) This fee will not be refunded, regardless of the disposition of the application; and

(3) Receive authorization from the commission prior to contracting with any client to provide claims handling services for Arkansas workers' compensation claims.

(c) **Renewals.**

(1) Certificates of authority to act as a TPA for workers' compensation purposes shall expire annually on September 30.

(2) Any firm desiring to continue its authorization to act as a TPA from the commission shall annually renew such authority.

(3) Such renewal shall consist of:

(A)(i) Remittance of a renewal fee in the amount of one hundred dollars (\$100) payable to the Arkansas Workers' Compensation Commission.

(ii) Any TPA having made application and receiving approval from the commission with an effective date from August 1 to September 30, may, at the commission's discretion, have the first renewal fee waived;

(B) Submission of a certified listing of:

(i) All locations;

(ii) Location contact persons;

(iii) Location contact information;

(iv) Company's renewal contact person; and

(v) Contact information; and

(C) Submission of the above items and any additional documentation required by the commission shall be submitted no later than September 1 of the year in question.

(d) **Termination or revocation of authority.**

(1) **Termination by the TPA.** Any TPA may surrender its authority by notifying the commission in writing of the effective date of such termination.

(2) **Revocation by the commission.**

(A)(i) Failure to comply with any of the foregoing rules or any order of the commission within the time prescribed shall be considered good cause for revocation of the TPA authority.

(ii) The commission shall give prior written notice of such revocation.

(B) The TPA shall have fifteen (15) days from the date of mailing to request a hearing.

(C) Failure to request a hearing within the time prescribed shall result in

the revocation becoming effective thirty (30) days from the date of mailing of the original notice.

(D) In no event shall the revocation of the certificate of authority be effective prior to the date that the hearing on the question is scheduled.

(E) Such notice shall be served personally or by certified or registered mail upon all interested parties.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Approved August 29, 2001; effective September 20, 2001. revised effective January 1, 2006)"

**11 CAR § 25-134. Filing requirements — Report cards — Sanctions.**

**(a) Form filing/payment requirements.**

**(1) Form filing — General.**

(A) Claims to be filed with the Workers' Compensation Commission shall include, but not be limited to:

- (i) Claims involving more than seven (7) days of disability;
- (ii) Controverted medical-only claims;
- (iii) Claims involving commission assisted change of physician; and
- (iv) Any other claim where filing with the commission is desired to

preserve any rights.

(B) All forms filed with the commission shall reference, if previously established, the commission file number.

(C) Any form, notice, or first payment of compensation required by the Act, commission rules, and/or advisory shall be filed or paid in the form and manner, and within the time prescribed by the commission.

(D)(i) Any claim filed with the commission and receiving a commission file number must include a Form 1, Form 2, Form 3 (where applicable), and a Form 4, filed in the form and manner prescribed by the commission.

(ii) Form 1 filings may be returned if, determined by the commission, the claim involves medical-only benefits, unless the Form 1 is clearly marked to indicate anticipated indemnity benefits or pending controversion.

(iii)(a)(1) All original claims filed with the commission require a response from the carrier or self-insurer as to the acceptance or controversion of the claim via a Form 2 filing.

(2) If the claim is controverted, the Form 2 shall clearly state the reason or reasons the claim is not accepted as compensable.

(3) If, after the initial indication as to acceptance or controversion of a claim, the position of the carrier or self-insurer changes, the claim office shall make an amended Form 2 filing reflecting its current position as to acceptance or controversion.

(b) All claims filed with the commission will be deemed to be temporary total disability (TTD) cases unless specifically marked otherwise via a Form 2 filing.

(iv) A Form 4 must be filed with the commission in order for a claim to be closed by a carrier or self-insurer.

**(2) Acceptability.**

(A) All applicable boxes/blanks are to be completed on all submitted commission forms.

(B) Any form filed with the commission with missing, incomplete, or inaccurate information or containing data that requires additional documentation:

(i) May be rejected; and

(ii) Shall be considered as not filed.

(C) Any carrier or self-insured having a form rejected by the commission may be subject to sanctions.

(D) Upon determination of a form as rejected, the commission shall

provide notice to the designated claim office of the:

- (i) Determination; and
- (ii) Specific reason or reasons for the rejection of the form.

**(3) Claims for compensation — Form C filings.**

(A) All claims established with the commission by a claimant (or claimant's attorney) utilizing commission Form C (Claim for Compensation) will be subject to the established report card standards for form filing timeliness.

(B)(i) Upon receipt of a Form C, the commission shall send notice to the designated claim office of the carrier or self-insurer (includes group self-insurers and individual self-insurers) on record as having coverage for the employer listed on the Form C as of the date of the injury or death.

(ii) The date of such notice shall:

*(a)* Serve as the date on which the employer was notified for report card purposes; and

*(b)* Not relieve the employer of its obligation to file a Form 1, Form 2, or any other form required within the time frames provided by law.

(C)(i) If a Form C is filed subsequent to the establishment of a claim, the designated claim office shall provide to the commission a narrative response indicating the current status of the claim and addressing the claim made in the Form C filing.

(ii) If a Form 2 has previously been filed, an amended Form 2 is only necessary if the position of acceptance or controversion has changed.

**(b) Timeliness standards — Reports.**

**(1) Timeliness standards.**

(A)(i) The commissioners have established minimum filing standards, including time frames by which the standard will be based, for the timely filing of a particular form or notice or for the timely making of any compensation payments.

(ii) Establishment of a minimum standard shall not be considered as condoning a late filing or payment or preclude the commission from assessing civil penalties (fines) as provided under Arkansas law.

(B) The established minimum, acceptable standards as to the timely filing

of specific forms and the timely making of compensation payments for all claims involving indemnity benefits, whether accepted or controverted, are as follows:

(i)(a) Form 1 (Workers' Compensation - First Report of Injury or Illness).

(b) A minimum seventy percent (70%) of Form 1 filings required by Arkansas law, commission rule, or commission advisory shall be filed in a timely manner;

(ii)(a) Form 2 (Employer's Intent to Accept or Controvert Claim).

(b) A minimum seventy percent (70%) of Form 2 filings required by Arkansas law, commission rule, or commission advisory shall be filed in a timely manner;

(iii)(a) First payment (first payment of compensation paid to the claimant).

(b) A minimum eighty percent (80%) of first payments are to be paid to claimants in uncontroverted cases as required by Arkansas law, commission rule, or commission advisory in a timely manner; and

(iv)(a) Form 4.

(b) Zero (0) claims appearing in the Unresolved section of the AR-4 Monitoring Report.

## (2) **Calculation of timeliness.**

(A) For report card purposes only, timeliness shall be calculated from the latter of:

(i) The date of employer's receipt of notice or knowledge of injury; or  
(ii) The first date of disability or date indemnity triggered to the earliest receipt of an acceptable version of the specific form.

(B) First payments shall be calculated to the date on which the first payment of compensation was issued to the claimant.

(C)(i) Date indemnity triggered applies only in those cases where disability is not continuous from the first day of disability to the eighth day of disability.

(ii) In the event of intermittent disability, the eighth day of disability

shall be used as the date indemnity triggered and indicated on the Form 2.

(D) Cases involving only permanent partial disability (PPD) benefits shall use the date on which medical documentation of the PPD rating was received by the employer, carrier, self-insurer, designated claim office, or any claim office handling the claim for the carrier as the date indemnity triggered (disability date) and indicated on the Form 2.

**(E) Form submissions via electronic data interchange (EDI).**

(i) Form transmissions via EDI that do not meet the technical edit and mandatory data requirements will be rejected and returned to the reporting entity.

(ii) EDI transmissions received on the transmission date indicated in the EDI trading partner agreement shall reflect the date the form was input into the reporting entities system as the date received by the commission.

(iii) EDI transmissions received after the transmission date indicated in the EDI trading partner agreement shall reflect the date of the transmission to the commission as the date received by the commission.

**(3) Reports.**

(A)(i) The commission shall issue, to each carrier and each self-insurer, reports reflecting the performance or status of the carrier or self-insurer in meeting any standard for any filing or payment for which a standard has been established.

(ii) No report shall be issued to a carrier or self-insurer when, for a specific standard, there are no cases for which performance or status can be rated.

(iii) Reports shall be issued with a frequency to coincide with any time frame established for such standard.

(iv) Reports shall be furnished to the designated administrator and designated claim office.

**(B) Report card.**

(i) The commission shall issue to each carrier and self-insurer a report card indicating:

*(a)* Its performance as to the timely filing of Form 1, Form 2; and

*(b)* The timely making of the first payment of compensation.

(ii) The report card shall:

*(a)* Indicate the percentage of timely filings or payments for that quarter; and

*(b)* Also provide a year-to-date (calendar year basis) percentage.

(iii) The report card will consist of two (2) parts:

*(a)* The Form 1 report card; and

*(b)* The Form 2 report card (which will include first payments).

(iv) The Form 1 report card shall list claims based on the receipt date of the Form 1.

(v) The Form 2 report card shall list claims based on the due date of the Form 2.

(vi) The due date of the first payment will always be the same as the due date of the Form 2.

(vii) For Form 1 and Form 2 grades, the report card shall list all claims reported to the commission during the previous quarter involving indemnity benefits (whether accepted or controverted).

(viii) For the first payment grade, claims involving controversion of benefits shall not be considered in grade determination.

**(C) Form AR-4 Monitoring Report.**

(i)*(a)* The commission shall issue to each carrier and self-insurer a report indicating those claims for which:

*(1)* A Form 4 has been rejected; and

*(2)* An acceptable Form 4 has not been received.

*(b)* This report will have two (2) sections:

*(1)* Rejected AR-4s; and

*(2)* Unresolved AR-4s.

(ii) The Rejected AR-4 section will list all claims for which a submitted AR-4 was rejected in the quarter immediately preceding the date of the report and the commission has not yet received an acceptable Form 4 (and/or required documentation).

(iii)(a) The Unresolved AR-4 section will list all claims appearing in the Rejected section of the previous quarter's Form AR-4 Monitoring Report for which the commission has not yet received an acceptable Form 4 (and/or required documentation).

(b) Any claim appearing in the Unresolved section will remain in unresolved status until an acceptable Form 4 (and supporting documentation) is received.

(iv) The Form AR-4 Monitoring Report shall be cumulative.

(v) Any claim listed shall continue to be listed until any deficiencies are corrected.

**(4) Correction requests.**

**(A) Report cards.**

(i) For any claim listed on either the Form 1 or Form 2 report cards which reflects incorrect data, a correction request may be made.

(ii) Correction requests may be made for only those claims listed in the quarter immediately preceding the issuance of the report card.

(iii) Such correction request shall:

(a) Be submitted to the commission only by the designated claim office (even if other claim offices are utilized) or by the administrator;

(b) Be made in writing, including contact information for the writer;

(c) Be received by the commission within thirty (30) days of the issuance of the report card;

(d) Identify the claim in question by commission file number, claimant's name, and date of injury;

(e) State the specific nature of the correction to be made;

(f) State why the correction should be made; and

(g)(1) Include any necessary documentation to support why the correction should be made.

(2) The commission may require a revised form.

(iv) All correction requests are subject to approval or rejection by the commission, on a case-by-case basis and for good cause.

(v) The commission may allow corrections to prior quarters at its discretion.

**(B) Form AR-4 Monitoring Report.**

(i) As this report is cumulative in nature and is based on the acceptability of the Form 4, corrections are not typically required or necessary, however, situations may arise that necessitate a review of a particular claim.

(ii)(a) Should a claim be listed for which proper documentation and/or a revised Form 4 has been previously submitted, a review request may be submitted.

(b) Such request shall:

(1) Identify the claim in question by commission file number and claimant's name;

(2) Indicate the reason for review (specify corrections and/or documentation submitted); and

(3) Indicate the date on which the revised Form 4 and/or documentation was provided (including the method of submission).

(iii) Should a claim be listed for which the claim has reopened, the claimant has resumed treatment, and/or additional indemnity benefits have been or are being paid, a review request shall be submitted along with documentation substantiating an open status of the claim.

(iv) The commission file will be reviewed and the claim removed from the Form 4 Monitoring Report if appropriate.

(v) If additional information is required, the commission will provide notice specifying the corrections/documentation needed.

**(c) Sanctions.**

**(1) Report cards.**

(A) **Imposition of sanctions.** If any two (2) consecutive quarterly report cards for any one (1) carrier or self-insurer reflect a performance level for either Form

1, Form 2, and/or first payment that falls below the minimum standards established, the commission shall impose sanctions.

(B) **Sanction levels.** Any carrier or self-insurer failing to meet any standards established by the commission shall be subject to sanctions in the form and manner the commission deems appropriate.

(2) **Form AR-4 Monitoring Report — Imposition of sanctions.** Any carrier or self-insurer having a claim or claims appearing in the Unresolved section of the report may have sanctions imposed.

(d) **Fines.**

(1) Any fines assessed shall be assessed against the carrier or self-insurer.

(2) Responsibility for the payment of any fine rests with the carrier or self-insurer, whether or not actually paid by a third-party administrator (TPA).

(3) All fines shall be payable to the Arkansas Workers' Compensation Commission.

(4) **Report card fines.**

(A)(i) At the close of the report card correction period and after the processing of correction requests received for that quarter, each carrier or self-insured employer to which fines are applicable will be issued a revised report card incorporating the approved corrections.

(ii) Fines shall then be administratively assessed on each late filing and on each late payment reflected in the revised report card in accordance with the sanction level applicable to that carrier or self-insurer.

(B)(i) An invoice for each carrier and self-insurer assessed with a fine or fines will be generated in sufficient detail to document the fine assessments by:

(a) Claim file number;

(b) Claimant name;

(c) Form on which the fine is assessed; and

(d) Amount.

(ii) The invoice, a copy of the recalculated report card, and/or a copy of the Form AR-4 Monitoring Report, and a cover letter shall be sent to the

administrator advising of the:

(a) Assessment of the fine or fines; and

(b) Due date by which the assessed fine or fines are to be paid.

(5) **Form AR-4 Monitoring Report fines.** A hearing for contempt may result from either of the following:

(A) The fine imposed is not paid and an acceptable Form 4 is not filed; or

(B) A request for a hearing is not received in the time frame specified.

(6) **Fine payment due date — Unpaid fines.**

(A) All fines assessed with regard to forms are to be paid within thirty (30) days of the cover letter date.

(B) Any unpaid fines may be subject to contempt proceedings and/or termination of authority as follows:

(i)(a) Carriers.

(b) Pursue revocation of carrier's authority to write workers' compensation coverage in Arkansas following the procedures of the State Insurance Department; and

(ii)(a) Self-insurers.

(b) Pursue revocation of authority to self-insure following the procedures of 11 CAR § 25-104.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Effective date January 1, 2008.)"

**11 CAR § 25-135. Carrier premium tax auditing.**

(a) Every carrier writing workers' compensation insurance in the State of Arkansas shall, upon request by the Workers' Compensation Commission, make available policy

information sufficient to allow auditing of premium calculations to verify accurate payment of workers' compensation premium tax in accordance with Arkansas Code § 11-9-303.

(b) Policy information shall:

(1) Include any information used by a carrier to determine written manual premium as defined in Arkansas Code § 11-9-303; and

(2) Be provided in a form and manner prescribed by the commission.

(c) A carrier's failure to comply with this section shall result in said carrier being referred to the Insurance Commissioner for appropriate administrative action against the Arkansas certificate of authority of the carrier.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"(Adopted February 13, 2013; Effective July 1, 2013)"

**11 CAR § 25-136. Workers' Compensation Commission drug formulary.**

(a) **General provisions.**

(1) Pursuant to Arkansas Code § 11-9-517 and Workers' Compensation Commission Rule 099.02 (Effective March 1, 1982) [repealed], the following section is hereby established in order to implement a workers' compensation drug formulary.

(2) This section is adopted for all prescriptions for workers' compensation claims with a date of injury on or after July 1, 2018, and applies to all United States Food and Drug Administration approved drugs that are prescribed and dispensed for outpatient use.

(3) **Scope.** This section does all of the following:

(A)(i) Adopts by reference as part of this section the Public Employee Claims Division Workers' Compensation Drug Formulary, which is maintained and

updated by:

(a) The College of Pharmacy of the University of Arkansas for Medical Sciences Evidence-Based Prescription Program; and

(b) Any amendments to that formulary.

(ii) The formulary will be reviewed and updated as needed;

(B)(i) Establishes that all initial prescriptions for opioids shall:

(a) Be limited to a five-day supply; and

(b) Not exceed fifty (50) MED per day without prior

authorization.

(ii) All subsequent opioid prescriptions shall:

(a) Be limited to a ninety-day maximum supply; and

(b) Not exceed a fifty-MED dosage limitation per day without

prior authorization.

(iii) With prior authorization, a subsequent prescription may be prescribed in excess of fifty (50) MED but shall not exceed ninety (90) MED;

(C) Establishes the effective date for implementation of this section;

(D) Establishes procedures by which all payors shall:

(i) Have on staff a pharmacist and physician or medical director; or

(ii) Contract with a PBM, who has:

(a) A pharmacist and a physician or medical director on staff; or

(b) Contracted with a pharmacist and a physician or medical

director;

(E) Establishes a procedure for pharmacists filling workers' compensation prescriptions;

(F)(i) Provides for the certification of all payors determined to be in compliance with the criteria and standards established by this section.

(ii) See Part II. A for certification requirements;

(G)(i) Provides for the implementation of Medical Cost Containment Division (MCCD) review and decision-making responsibility.

(ii) This section and definitions are not intended to supersede or

modify:

- (a) The workers' compensation laws;
- (b) The administrative rules of the commission; or
- (c) Court decisions interpreting the laws or the commission's

administrative rules;

(H) Provides for the right to appeal from the MCCD to an administrative law judge; and

(I) Provides requirements in order for payors to be held responsible for payment of United States Food and Drug Administration-approved opioid medications.

(4) **Definitions.** As used in this section:

(A) "Administrator" means the Administrator of the Medical Cost Containment Division of the Workers' Compensation Commission or his or her designee;

(B) "Day" means calendar day;

(C) "Dispute" means a disagreement between a payor, pharmacists, provider, or claimant regarding this section;

(D) "Filling pharmacist" is a pharmacist filling a prescription for medication;

(E)(i) "Initial prescription" means the beginning, starting, commencing, or first written order for a medication.

(ii) Changes in dosage, addition of or removal of previously prescribed medications either individually or in combination are not considered an initial prescription;

(F) "Medical director" means a physician that is on staff or is contracted with either a PBM or the payor of the worker's compensation claim;

(G) "Outpatient service" means a service provided by the following, but not limited to, types of facilities:

- (i) Physicians' offices and clinics;
- (ii) Hospital emergency rooms;
- (iii) Hospital outpatient facilities;
- (iv) Community health centers;

- (v) Outpatient psychiatric hospitals;
- (vi) Outpatient psychiatric units; and
- (vii) Free-standing surgical outpatient facilities;

(H) "Payor" means a self-insured entity, third-party administrator, or insurance carrier which pays workers' compensation benefits;

(I) "Reviewing pharmacist" is an individual with a doctorate in pharmacy or a bachelor's degree in pharmacy contracted with or on staff with a payor or pharmacy benefit manager;

(J) "Pharmacy benefit manager (PBM)" means a third-party administrator (TPA) of prescription drug programs;

(K) "Provider" means a facility, healthcare organization, or practitioner (as defined by 11 CAR § 25-125); and

(L) "MED" means morphine equivalent dose per day.

**(b) Process for requiring all payors to contract with a pharmacist and physician or medical director or PBM who has contracted with a pharmacist and physician or medical director.**

(1) All payors shall have on staff or shall contract with a:

(A) Pharmacist and physician or medical director; or

(B) PBM who has:

(i) Contracted with a pharmacist and physician or medical director; or

(ii) A pharmacist and physician or medical director on staff.

(2) Certification requires the payor to:

(A) Furnish the current name, license number, and address of their pharmacist, PBM, and physician or medical director to the Medical Cost Containment Division of the Workers' Compensation Commission; and

(B) Update this information when changes occur.

**(c) Opioid medications.**

(1)(A) For workers' compensation injuries or illnesses with an incident date on or after July 1, 2018, payors will not be held financially responsible for payment for United States Food and Drug Administration-approved opioid medications in excess of

fifty (50) MED per day or in excess of ninety (90) days without prior authorization.

(B) With prior authorization, a prescription may be prescribed in excess of fifty (50) MED but shall not exceed ninety (90) MED.

(C) The commission will adopt criteria for prior authorization for prescriptions in excess of fifty (50) MED but not exceeding ninety (90) MED and criteria for recertification every ninety (90) days.

(2) Prior to prescribing opioid medications or benzodiazepine, prescribers shall check the Prescription Drug Monitoring Program (PDMP) database in accordance with Arkansas Code § 20-7-604.

(3)(A) A payor shall not be required to pay for more than five (5) days of medication for the first prescription of an opioid medication without prior authorization.

(B) A payor shall not be required to pay for continuing an opioid medication beyond the first five-day prescription unless all of the following requirements are met:

(i) The medication is prescribed by an authorized treating prescriber;

(ii) The medication is reasonable, necessary, and related to the worker's compensation injury or illness;

(iii) The provider prescribing the medication examines the injured employee in a follow-up visit and documents to the payor that the medication taken so far is proving to be effective in controlling pain associated with the employee's work-related injury or illness; and

(iv) The provider prescribing the medication documents to the payor that continuing the opioid medication therapy is medically necessary.

(4) A payor shall not be required to pay for continuing an opioid medication beyond ninety (90) days without written certification to the payor of medical necessity which shall include the following:

(A) Follow-up visits with prescriber have been conducted;

(B) Documentation by prescriber of improved function under the medication;

(C) A plan for periodic urinary drug screening;

(D) A detailed plan for future weaning off the opioid medication;

(E) Documentation within patient's record showing conservative care rendered to the worker that focused on increased function and return to work; and

(F) A statement on what prior or alternative conservative measures were ineffective or contraindicated (including nonopioid pain medications).

**(d) Processing for filling workers' compensation prescriptions.**

(1) Pharmacists filling a workers' compensation prescription must verify that the prescribed drug or drugs are listed on the approved drug formulary.

(2) If the prescribed drug is not on the approved drug formulary, the pharmacist must:

(A) Contact the payor for approval of the prescribed drug; and

(B) Consult with the prescriber before switching the medication to a formulary medication.

(3)(i) The filling pharmacist must abide by the rule requirements for prescribed opioids for the payor to be required to pay for the medication.

(ii) Fifty (50) MED per day for five (5) days and a ninety-day duration without prior authorization.

(4) Compounded medications require preauthorization from the payor and medical certification of the patient's inability to tolerate treatment by other noncompounded medications.

**(e) Process for resolving disputes between provider and reviewing pharmacist or PBM.**

(1) When the payor denies the medication and the injured employee, filling pharmacist, or prescriber insists on the medication that has been denied, a reconsideration may be made to the reviewing pharmacist on staff or contracted with the payor or the payor's PBM by submitting a Reconsideration Form.

(2) The payor should promptly send a Reconsideration Form to the prescriber to complete and submit together with any supporting documentation to the reviewing pharmacist.

(3) The reviewing pharmacist shall have three (3) business days to:

- (A) Consult with the prescriber or medical director, if necessary; and
- (B) Respond to the reconsideration request.

(4) If the reviewing pharmacist does not respond within three (3) business days, the filling pharmacist may fill the prescription.

(5) If the reviewing pharmacist denies the reconsideration request, an appeal may be made within ten (10) business days to the Medical Cost Containment Division of the commission.

**(f) Hearings — Administrative review procedure.**

(1) An appeal may be made to the Administrator of the Medical Cost Containment Division by mail, fax, or email:

Administrator of the Medical Cost Containment Division  
P.O. Box 950  
Little Rock, AR 72203-0950  
501-682-1790 fax  
[awcc.info@arkansas.gov](mailto:awcc.info@arkansas.gov)

(2) Appeals will be reviewed by the Medical Cost Containment Division and a determination will be issued within three (3) business days of receipt of the appeal and supporting documentation.

(3) An appeal may be rejected if it does not contain the following information:

- (A) Injured employee name;
- (B) Date of birth of injured employee;
- (C) Social Security number of injured employee;
- (D) Commission file number;
- (E) Date of injury;
- (F) Prescriber's name;
- (G) Prescriber's DEA number;
- (H) Name of drug and dosage;
- (I) Requestor's name (pharmacy or prescriber);

(J) Requestor's contact information;

(K) A statement that the approval request for a prescribed drug has been denied by the insurance carrier, accompanied by the denial letter if available;

(L) A statement that the prior approval denial poses an unreasonable risk of a medical emergency and justification from a medical perspective such as withdrawal potential or other significant side effects or complications;

(M) A statement that the potential medical emergency has been documented in the prior approval process;

(N) A statement that the insurance carrier has been notified that a request for an expedited determination is being submitted to the commission; and

(O) The signature of the requestor and the following certification by the requestor for subdivisions (f)(3)(G) – (O) of this section, "I hereby certify under penalty of law that the previously listed conditions have been met."

(4)(A) An appeal determination shall be processed and approved or denied by the Administrator of the Medical Cost Containment Division in accordance with this subsection (f).

(B) At the discretion of the Administrator of the Medical Cost Containment Division, an incomplete appeal may be considered in accordance with this subsection (f).

(5) A determination by the Administrator of the Medical Cost Containment Division:

(A) Becomes final under the appeal process; and

(B) Shall be effective retroactively to the date of the original prescription.

(6)(A) Any party feeling aggrieved by the order of the Administrator of the Medical Cost Containment Division has the right to appeal the final decision of the Administrator of the Medical Cost Containment Division to an administrative law judge of the commission for an expedited hearing.

(B) The appeal must be made within ten (10) business days.

(C) The administrative law judge shall have two (2) weeks from receipt of the appeal to conduct an expedited hearing and render a decision.

(D) The notice of appeal shall contain the following:

(i) A copy of the Administrator of the Medical Cost Containment Division's order appealed from; and

(ii) Copies of all materials submitted to the administrator in the appeal proceedings.

(g) **Rule review.**

(1) The commission encourages participation in the development of and changes to this section by all groups, associations, and the public.

(2) Any such group, association, or other party desiring input or changes made to this section and associated schedules must make their recommendations in writing to the Administrator of the Medical Cost Containment Division.

(3) After yearly analysis, the commission may incorporate such recommended changes into this section.

**Authority.** Arkansas Code § 11-9-207.

**Codification Notes.** "MED" means morphine equivalent dose.

This section as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"Part VIII. Effective Date of Rule

This Rule is adopted for all prescriptions for workers' compensation claims with a date of injury on or after July 1, 2018, and applies to all FDA approved drugs that are prescribed and dispensed for outpatient use.

(Promulgated May 1, 2017, Filed with Secretary of State November 17, 2017, and Effective July 1, 2018)"