Rule 099.05 SELF- INSURANCE PROGRAM #099.05

PART I GENERAL - ALL SELF-INSURERS

A. Definitions. When used in these rules, the following words or terms shall have the meaning as described in this section.

1. Certified Audit - an audit upon which the auditor expresses his 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.

2. Common Claim Fund - a fund maintained by a Group Self-Insurer for the sole purpose of paying claims imposed by the provisions of the Arkansas Workers' Compensation Law.

3. Common Self-Insurer - employers who are members of the same trade or professional association entering into agreement to pool their liabilities.

4. Conditional Reserves - acceptable assets equal to the security deposit requirement plus any additional contingent reserves established by the trustees or required by the Commission.

5. Contingent Liability - 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. This liability is considered funded if a security deposit equal to the total amount of the contingent liability has been posted. 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.

6. Current Ratio - the ratio of current assets to current liabilities as shown in the most recent financial statement.

7. Group - Common Self-Insurer or Homogeneous Self-Insurer.

8. Homogeneous Self-Insurer - employers who are engaged in the same type of business activity or pursuit entering into agreement to pool their liabilities.

9. Loss Development - the change in incurred loss from one point in time to another.

10. Loss Fund - the retention of liability for a self-insurer, either individual self-insurer or group self-insurer, under the terms of an aggregate excess contract. In the absence of an aggregate excess policy, it is the amount of money allocated to pay claims.

11. Net Safety Factor - any amount needed in a given fund year in addition to current loss reserves to fund future loss development.

12. Third Party Administrator - a business which has met all the requirements of Commission Rule 099.38 and has received authorization from the Commission to act as a third party administrator. The term "Service Agent" is synonymous with the term "third party administrator" as used in the workers' compensation laws and the rules of the Commission.

13. Surplus - 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.

14. Trustees - a group of members elected by a group self-insurer for stated terms of office, to direct the administration of a group self-insurer, and whose duties shall include responsibility for approving applications for new members in such group. 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. 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.

15. Trustee's Fund - 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.

16. Working Capital or Net Current Assets - current assets less current liabilities.

17. Written Manual Premium - As defined by Ark.Code.Ann. 11-9-303(b). The rates used for the experience period shall be those published by the Arkansas Workers' Compensation Commission.

B. Acceptable Securities

1. The securities acceptable to the 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. 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 Part I, B, 2 of this rule. 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. These three approved methods of posting security must follow strict compliance with this rule.

2. 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 Insurance Commissioner shall at all times show assets, including surplus to policyholders, at least equal to the latest Insurance Commissioner requirement for admission of a new company to do business in the State. Any securities held by the Commission may be exchanged or replaced by the depositor with other securities of like nature and amount. Any surety bond may be exchanged or replaced with another surety bond provided the required thirty (30) day notice of termination of liability is given to the Commission. Whenever an employer discontinues business in the state or desires to terminate his status as a self-insurer, or desires to replace securities with a Surety Bond, he shall so notify the Commission and 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. 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 obligation under the Act have been fully discharged. The Commission shall be authorized to bring suit upon any surety bond so posted, to procure prompt payment of compensation liabilities.

3. Self-insurers shall make all funded securities payable to the Arkansas Workers' Compensation Commission, in trust for (name of depositor) as per Commission requirements. All such securities shall be filed with the Workers' Compensation Commission for deposit with the Treasurer of the State of Arkansas under custody receipt. No other depository is acceptable. 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. Interest accruing on any negotiable securities so deposited shall be collected and transmitted to the depositor, provided he is not in default in payment of compensation benefits or the annual premium tax. 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.

4. The Commission permits deposit of an "Irrevocable Standby Letter of Credit" as an alternative security deposit. The Commission will furnish upon request the prescribed and approved forms for use in utilizing this alternative. 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. Banks eligible for use must be covered under the Federal Deposit Insurance Corporation (FDIC) and must be acceptable to the Commission. Letters of credit issued by a bank that do not meet the standard as mandated by this rule may be accepted by the Commission with a confirming letter of credit issued by a bank meeting the prescribed criteria. 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. All "Irrevocable Standby Letters of Credit" 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.

C. Filings of Reports - Penalties

1. 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. This rule places this responsibility on the employers, groups and service companies to

perform their prescribed duties and responsibilities without prompting from the Commission. Failure or refusal of any self-insurer or group to file the prescribed reports with the Commission within the prescribed time period shall subject the mentioned self-insurer to a civil penalty in such amount as the Commission may prescribe, not to exceed one hundred ($100) per infraction per day, and shall be sufficient cause for the revocation of the self-insurer privilege. Failure to pay such penalty within thirty (30) days of notification shall be considered good cause for revocation of the self-insurer privilege.

2. 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. The amount of tax shall be based upon the written manual premium for the calendar year in question. The tax is limited by law at three (3) percent of the tabulated written manual premium for each self-insurer. 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. 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. 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. This audit report and payment of the proper tax is due on or before April 1 of each year.

3. Each individual self-insurer and group shall file annual statements of financial condition with the Commission in a form acceptable to the Commission. Individual Self-Insurers must maintain a level of financial strength, financial position, and financial ratios that would be required of any new applicant. 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. 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. Any less requirements of these annual statements will be at the discretion of the Commission. An additional security deposit or surety bond may be required in the absence of a certified

audit. Interim financial reports may be required in addition to these annual financial statements at the discretion of the Commission. This report is due on or before April 1 of each year.

4. Summary Loss Data will be filed with the Commission by each individual self-insurer or group self-insurer under the laws. This report shall be filed with the Commission on an annual basis, or on a quarterly basis, or on any interim basis as prescribed by the Commission. This report will be due within thirty (30) days after each prescribed evaluation period, and unless otherwise directed, this report will be due not later than February 1 of each year. 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. This report will include but not be limited to the name of the employer, name of the injured employee, claim number, date of accident, nature of injury, amounts paid on the claim for indemnity, or medical, expenses, and outstanding reserves, if any. 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. This report will require reasonable reserves on all open pending claims.

D. Contracts for Excess Insurance

1. 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.

2. 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 Part I, B 2.

3. 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:

a. Is issued by a recognized, admitted or approved casualty insurance company with the minimum qualifications established by these rules.

b. 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 Arkansas Workers' Compensation Commission.

c. 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 Arkansas Workers' Compensation Commission, thirty (30) days prior to such expiration, by the party desiring to cancel or not to renew the policy.

d. If it contains any type of commutation clause, provided (1) that any commutation effected thereunder shall not relieve the underwriter(s) 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 (2) that 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 Arkansas Workers' Compensation Commission by registered or certified mail by the underwriter(s) or their agent.

e. In the event any commutation is permitted and effected, the Commission shall have the right to direct that such sum either (1) be placed in trust for the benefit of the injured employee(s) entitled to such future payments of compensation, or (2) be invested in approved securities and deposited with the Commission to assure such future payments of compensation to the employee(s) entitled thereto.

f. 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.

E. Servicing for Self-Insurers - Qualifications

1. 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.

a. 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. 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.

b. Individual self-insurers and groups may contract for claims adjusting with only those third party administrators approved as such by the Commission.

c. 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. In the case where no third party administrator is used, the Commission will deal with the employer only.

d. 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.

e. In order to represent a group self-insurer client, the third party administrator must maintain an Arkansas claims office and have at lease one resident adjuster with check authority.

f. Each individual self-insurer or group shall designate a claim office in accordance with Commission Rule 099.29. Notice shall be provided to the Commission prior to any changes in the designated claim office.

F. Revocation or Termination of the Self-Insurer Privilege

1. 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 A.C.A. 11-9-404. 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. The Commission shall give written notice of such revocation or termination to the employer and/or his agent(s). The employer shall have fifteen (15) days from the date of mailing of the notice to request a hearing on the revocation or termination. 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. In no event shall any revocation or termination become effective prior to the date that a hearing on the question is scheduled. Such notice shall be served personally or by certified or registered mail upon all interested parties. This review and appeal process will also be applied to application issues.

2. 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. 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.

G. 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 Circuit Court of Pulaski County or in the county in which such person does business to enjoin and restrain such person from engaging in such method, act, or practice.

H. Tenure of Authority

Certificates of Authority granting the privilege of being a self-Insurer for workers' compensation purposes shall expire on May 1 of each year. 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. Certificates of Approval for service companies must be renewed on an annual basis. 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. 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.

PART II INDIVIDUAL SELF-INSURER - APPLICATION

A. Each employer desiring to become an individual self-insurer, as contemplated by A.C.A. 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. The application shall contain answers to all questions propounded and shall be under oath.

B. Before considering the application, the Commission will require:

1. 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 1 to 1 (1:1) and a working capital of an amount establishing financial strength and liquidity of the business to pay normal compensation claims promptly. The requirement for a more than 1 to 1 (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. 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. 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.

2. 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 Part I, D.

3. Each employer shall execute and file with the Commission an agreement, which shall be part of their application, whereby he agrees (1) to fully discharge by cash payment all amounts required to be paid by the provisions of the Act and (2) to deposit with the Commission acceptable securities or

corporate surety bond to secure guarantee of payment of compensation liabilities unless waived by the Commission.

4. Each individual self-insurer shall satisfy the Commission that it has complied with the provisions of Part I, E 1, ~~and Rule 29 where applicable~~ before approval for self-insurer status may be granted by the Commission. In addition, the Commission may require periodic proof that the self-insurer is complying with these standards on a continuing basis.

5. 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. This fee will not be refunded, regardless of the disposition of the application.

6. Each Individual self-insurer shall satisfy the Commission that it has complied with the requirements of the Arkansas Self-Insurer Guaranty Fund.

7. 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. 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.

C. Pursuant to A.C.A. 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:

1. 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. 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.

2. The minimum excess insurance requirements that an Individually Self-Insured employer shall maintain shall be determined by the Commission.

PART III GROUP SELF-INSURER - APPLICATION

A. In the case of group coverage as contemplated by A.C.A. 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 Workers' Compensation Commission at least sixty (60) days prior to the desired effective date of self-insurer status. Any application submitted with less than thirty (30) days remaining before the desired effective date may be rejected without further consideration. The application shall be made on forms prescribed by the Commission and shall contain answers to all questions propounded and shall be under oath.

1. The application as submitted by the trustees of the self-insurer group shall be accompanied by:

   a. An indemnity agreement jointly and severally binding the group and each member thereof to comply with the provisions of the Arkansas Workers' Compensation laws and Rules and Regulations of the Commission. The indemnity agreement requirement mentioned here and elsewhere in this rule is not applicable to public employer groups.

   b. Individual application of each member of the group applying for membership in the self-insurer group on the inception date of the Group.

   c. Current financial statements supported by a certified audit of at least two (2) members showing 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), a combined current ratio of more than 1 to 1 (1:1) and a working capital of an amount establishing financial strength and liquidity of the business to pay normal compensation claims promptly and

showing evidence of the financial ability of the group to meet its obligation under the laws. 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. 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. 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. 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. 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.

d. A set of by-laws governing the operation of the group self-Insurer shall conform to the conditions specified in Part III, D 1.

e. 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. This fee will not be refunded, regardless of the disposition of the application.

f. Each group self-insurer shall satisfy the Commission that it has complied with the requirements of the appropriate guaranty fund.

2. Each group self-insurer shall satisfy the Commission that it has complied with the provisions of Part I, E 1 before approval for self-insurer status may be granted by the Commission. In addition, the Commission may require

periodic proof that the self-insurer is complying with these standards on a continuing basis.

3. 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. 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.

4. 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. The trustees must approve the application for membership in accordance with these rules and the terms of the indemnity agreement for the application to be binding upon the group self-insurer and prospective members. The application for membership shall then be filed with the Commission thirty (30) days prior to the desired effective date of self-insurer status. 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. 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 Workers' Compensation Commission, Self-Insurance Division within fifteen(15) days of the effective date of coverage. 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. 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. The Commission retains the right to reject the admission of any new member.

B. Minimum Security Deposit For Group Self-Insurer

Each group self-insurer, pursuant to A.C.A. 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 ($200,000.00). 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. The amount of the security deposit or bond requirement mentioned here and elsewhere in this rule is not applicable to public employer groups.

C. Group Self-Insurers' Funds and Surplus

1. Each group self-insurer shall consist of two (2)separate funds, that is, the trustee fund and a common claim fund. All premiums and assessments charged to the member are paid into the trustee fund. The trustee fund shall be used to pay the operational expenses of the group self-insurer.

2. From the trustee fund there shall be created a separate common claim fund. The common claim fund shall be placed in a designated depository, and this fund will be maintained at all times by the authorized service organization or the designated adjuster or individual(s) charged with the handling and payment of claims. This fund shall be adequate to cover any current incurred and contingent liabilities as imposed by the laws.

3. 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. 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. In this event an experience modification shall be determined for each member by the service agent. Any discounts or deviations from written manual premium approved by the Commission shall apply to all members of the group.

4. 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.

D. Solvency of Group Self-Insurer and Trustee Responsibility

1. The trustees of each authorized group self-insurer shall cause to be adopted a set of by-laws which shall govern the operation of the fund. These by-laws 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.

c. The method for amending the by-laws.

2. In addition to the above by-laws, the trustees shall adopt regulations on the following subjects which shall be binding on the group manager and third party administrator:

a. Investment of surplus funds and claim reserves.

b. Frequency and extent of loss control and safety engineering services to members.

c. The size of the common claim fund.

d. A schedule for payment and collection of premium including a definition of delinquent premium.

e. Membership admission and expulsion procedures.

f. Delineation of authority granted to the trustees.

g. Delineation of authority granted to the group manager.

h. Delineation of authority granted to the third party administrator.

i. 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.

j. Procedures for handling disputes regarding premium paid by members.

3. In order to insure 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. The board of trustees of each group shall take all necessary precautions to safeguard the assets of the group, including:

a. 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. 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 of the conditions required for approval of the establishment and continued operation of the group self-insurer. Such fiscal agent or group manager shall not be an owner, officer, or employee of the service organization.

b. 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. The service organization or the designated adjuster or individual(s) 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. 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. 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. 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. 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. ~~provided the Trustees shall not invest more than twenty-five (25%) percent of such funds (as determined by market value at the time of initial purchase) for a given fund year in corporate or municipal bonds. The following are the only acceptable types of investments:~~

~~(1) Savings accounts, certificates of deposit, or similar accounts in a duly chartered commercial bank whose deposits are federally insured.~~

~~(2) Savings accounts, savings certificates, or similar accounts in a duly chartered savings and loan association whose deposits are federally insured.~~

~~(3) Direct obligations of the State of Arkansas.~~

~~(4) Direct and indirect obligations of the United States, such as notes, bonds, mortgages or bills which are backed by the full faith and credit of the United States Government.~~

~~(5) Corporate or general obligation municipal bonds, of Arkansas cities only, that are publicly traded provided that such bonds have:~~

~~(a) a rating equal to or higher than "A-" as rated by Standard & Poor's or "A3" as rated by Moody's at the time of initial purchase.~~

~~(b) no more than a five (5) year maturity from original purchase date.~~

~~In the event of downgrades in a bond's rating after initial purchase, the total amount invested shall not exceed thirty (30%) percent of all funds for a given fund year, and at no time shall any funds be invested in any bond whose rating has dropped below a rating of "BBB+" (as rated by Standard & Poor's) or "BBB1" (as rated by Moody's).~~

f. The trustees shall ~~report~~ 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 vested, length of maturity, duration, annual percentage rate of interest, annual percentage yield, and income earned during the fiscal year just ended. A current schedule shall also b provided at other times as requested by the Commission.

4. 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:

a. Third party administrator performance

b. Loss control and safety engineering

c. Investment policies

d. Collection of bad debt

e. Admission and expulsion procedures

f. Group Manager performance

5. Any changes in the by-laws or written regulations shall be filed with the Commission no later than ten (10) days after their taking effect. The Commission reserves the right to declare any by-law or regulation null and void if it is in violation of these rules or the law.

6. The indemnity agreement required pursuant to Part III, A.1.a. 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 these rules 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 these rules.

7. 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 are entitled to statutory options and

limitations. **(Effective date April 1, 1989; revised August 8, 1995, effective August 29, 1995; revised effective September 20, 2001; revised effective January 1, 2006; revised July 28, 2007.)**

FINAL DRAFT - RULE 099.27
Revised July 13, 2007

RULE 099.27 MEDICAL REPORTS

Medical reports are to be requested by the insurance carrier/self-insured in a timely manner and are to filed with the Commission upon receipt. Medical report filings should be limited to only those reports which provide information relative to diagnosis, prognosis, impairment ratings, and return to work information. The Commission may, at its discretion, request other medical information.

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. (Effective date April 1, 1989; Revised effective July 28, 2007.)

~~**RULE 099.29 REQUIREMENT OF MAINTAINING AN ARKANSAS CLAIMS OFFICE AND REPORT CARDS #099.29**~~

~~**TABLE OF CONTENTS**~~

I. ~~ARKANSAS CLAIMS OFFICE~~ Carrier/Self-Insurer Responsibilities

~~**A.**~~ Each ~~i~~insurance ~~C~~carrier, ~~Commission-~~ or approved ~~S~~self-~~Insured~~insurer ~~Employer~~ ~~("Insurer")~~ shall: ~~maintain a workers' compensation claims office within the borders of the State of Arkansas, subject to the waiver provisions below.~~

A. Designate to the Commission in the form and manner prescribed by the Commission:

1. ~~This claims office shall maintain workers' compensation claims files and shall be the office responsible to the Arkansas Workers' Compensation Commission ("Commission") for the proper filing of all Commission forms for Insurer.~~ A Claim Office which shall:

a. Be approved by the Commission to handle Arkansas workers' compensation claims. 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;

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

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

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

2. ~~The claims office shall file at least 66 2/3% of all forms and notices required by the Act, Commission Rules and Advisories timely; and the claims office shall make at least 80% of First Payments timely to claimants in uncontroverted cases. Failure to comply with this provision shall subject the Insurer to the sanctions set out in Section IV.~~ An Administrator who shall:

a. Be an employee of the carrier, self-insurer, or of the carrier's or self-insurer's parent company;

b. Serve as the Commission's contact person and have sufficient authority to take action and/or implement procedural changes to maintain compliance with:

(1) Arkansas law;

(2) Commission Rules and/or Commission Advisories;
(3) Any order of an Administrative Law Judge, the Full Commission, Arkansas Court of Appeals, or Arkansas Supreme Court;
(4) Any other Arkansas workers' compensation matter.

c. Be someone other than the designated claim office contact person. Exceptions to this may be allowed, subject to approval by the Commission on a case-by-case basis.

3. ~~This office shall be the sole contact for the Commission~~. An underwriting "Contact Person" (applies to carriers only). This person shall be the contact point for insurance policy questions regarding coverage, such as, but not limited to: policy numbers, entities covered, coverage dates.

B. Be responsible to the Commission for the actions, or inactions, of the designated claim office or any other office in which claims are handled;

C. Work promptly and cooperatively with the Commission to resolve any questions, issues, requests, or complaints;

D. Maintain current information for the claim office location, Administrator, and Underwriter information.

~~**4.** Authority to issue checks and to pay claims shall be vested in personnel located within the Sate of Arkansas.~~

~~**5.** The Insurer shall notify the Commission of the address of its claims office and shall report any subsequent address changes.~~

~~**6.** Should the claims office be a Third Party Administrator (TPA), it shall be the responsibility of the Insurer to provide the designated TPA an Information System whereby that TPA can make immediate referrals to any other claims facility serving accounts for the insurer.~~

~~**B.** No processing or payment of workers' compensation claims shall occur outside the State of Arkansas without the specific written waiver by the Commission.~~

II. ~~WAIVERS~~ Designated Claim Office Responsibilities

The designated claim office, regardless of location at which any specific claim is adjusted, shall:

A. ~~Requests for waivers from Section I of this Rule must be submitted to the Commission in writing and shall not be approved unless the applicant has exercised claims management and filing practices which illustrate proper compliance with the Law and other Commission regulations.~~ Serve as the sole contact point for the Commission regarding claim specific issues;

B. ~~No waiver request by an Insurer shall be approved unless the Insurer demonstrates compliance with the following requirements pertaining to:~~ Have a designated Claims Officer with sufficient knowledge and authority to answer inquiries form the Commission;

C. 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;

D. Be the office responsible to the Commission for the proper filing of all Commission forms for the carrier/self-insurer;

E. Work promptly and cooperatively with the Commission to resolve any questions, issues, requests, or complaints.

~~**1.** Report Cards.~~

~~**(a)** At least 66 2/3% of all forms and notices required by the Act, Commission Rules and Advisories are filed timely; and~~

~~**(b)** At least 80% of First Payments are made timely to claimants in uncontroverted cases; and~~

~~**2.** Resolution of complaints regarding:~~

~~**(a)** Compliance with the Arkansas Workers' Compensation Laws; and~~

~~**(b)** Compliance with Orders of Administrative Law Judges, the Workers' Compensation Commission, Arkansas Court of Appeals, or Arkansas Supreme Court; and~~

~~**(c)** Reporting requirements for all Commission Forms; and~~

~~**(d)** Compliance with the Rules and Advisories of the Commission.~~

~~**C.** Timeliness shall be determined by grades on Report Cards issued by the Commission.~~

~~**D.** Waivers may be reviewed annually at the discretion of the Commission, based on the final cumulative Report Card grade for the prior year.~~

~~**E.** If an Insurer fails to qualify for the continuance of a waiver, upon extreme or unusual circumstances, the Commission may, in its discretion, place the Insurer on probation.~~

~~If, after the probationary period, the Insurer fails to meet this Rule's requirements, any waivers in place shall be revoked, subjecting the Insurer to the requirement of maintaining an Arkansas claims office.~~

~~**F.** Eligibility for reapplication of an Insurer whose waiver has been revoked, shall be at the Commission's discretion.~~

III. ~~REPORT CARDS~~ Commission Approval of Claim Office

The Commission retains the right to approve or deny a particular claim office from serving or being selected as the designated claim office.

~~**A.** The Commission, through its Chief Executive Officer, or a designee, shall report, at least twice each year to all Insurers their performance as to:~~ 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.

~~**1.** Filings of forms; and~~

~~**2.** First payment of benefits; and~~

~~**3.** Problems resolution~~.

B. ~~Insurers must object within thirty (30) days of receipt of each report; otherwise, such report shall be considered conclusive as to timeliness. Failure to object may be excused by the Commission on the grounds that, for some satisfactory reason, objection could not be given within thirty (30) days.~~ Claim Office Probation - The Commission may place a specific claim office on "probation" in the event of improper completion of forms, failure to file forms or notices with the Commission in a timely manner, failure to respond to Commission requests for information or additional documentation, and/or on any other grounds that prevent the timely, efficient, accurate handling of workers' compensation claims. Any claim office on probation shall be given notice indicating the reason(s) for probation and establishing the terms and conditions by which probation may be removed.

C. ~~"Timely" grades are given if Insurers file forms and make First Payments as required by:~~

~~**1.** Ark. Code Ann. § 11-9-529; and~~ Claim Office Approval Revocation - The Commission may immediately revoke approval form any claim office to handle Arkansas workers' compensation claims for any carrier or self-insured employer. If approval is revoked:

~~**2.** 1. Ark. Code Ann. § 11-9-802; and~~ Notice shall be sent to the claim office providing at least thirty (30) days notice to cease operations involving the handling of Arkansas workers' compensation clams at that location.

~~**3.** 2. Ark. Code Ann. § 11-9-803; and~~ Notice shall be sent to any carrier or self-insured employer for which that claim office handles Arkansas workers' compensation claims indicating that claim offices' approval to handle claims has been revoked and providing the carrier or self-insured employer at least thirty (30) days in which to secure the services of, and designate to the Commission, another claim office.

~~**4.** Commission Rule 30; and~~

~~**5.** Any other rule or advisory with time limitations.~~

~~**D.** For Report Card purposes only, and not for adjudication purposes, timeliness is calculated as commencing from the latest occurrence of the following events:~~

~~**1.** Date of employer's receipt of notice or knowledge of injury; or~~

~~**2.** Date of injury; or~~

~~**3.** Date of disability. This may include cases where a claimant receives Permanent Partial Disability benefits in a no lost time claim.~~

E. For Report Card purposes only, and not for adjudication purposes, timeliness is calculated as concluding at the earliest receipt of any required responses, including the filing of reports with the Commission via the following methods:

1. United States Mail, as described in Ark. Code Ann. § 11-9-529(d):

The Mailing of any report in a stamped envelope, properly addressed, within the time prescribed in subsection (a) or (b) of this section, shall be in compliance with this section[; or]

2. Electronic Data Interchange (EDI) mailbox transmissions which meet all EDI requirements and are accepted by the Commission, as indicated by the Transaction Set Date; or

3. Any other mode of delivery of documents to the Commission, including but not limited to, hand-delivery, facsimile, or overnight mail, as indicated by the date stamp placed upon the response by the Commission.

F. EDI TRANSMISSIONS

1. EDI Transmissions must meet all Technical Edit and mandatory Data requirements set forth in the Insurer's Trading partner Agreement with the Commission and Rule 35 in order to be accepted by the Commission.

2. Commission acceptance of a First Report of Injury or Illness (Form 1) establishes a file, regardless of amount of time lost by a claimant. The acceptance of Form 1 obligates the insurer to file all additional required forms, which will be monitored for Report Card purposes.

3. EDI Transmissions which do not meet all Technical Edit and Mandatory Data requirements will be rejected and returned to the Insurer for refiling.

4. For Report Card purposes only, and not for adjudication purposes, rejected forms will not be considered filed as timely.

G. The Commission takes into consideration, when grading Report Cards, circumstances such as:

1. Closing of state offices on certain days; and

2. Non-delivery of United States mail on federal holidays and weekends; and

3. EDI Trading Partner Agreements and Rule 35 requirements.

IV. SANCTIONS

Any failure to comply with the provisions of this Rule shall subject any Insurer to the full extent of sanctions provided under Arkansas Workers' Compensation Law and Arkansas Insurance Law, including the possibility of revocation of the ability to write workers' compensation insurance in the State of Arkansas. (Effective date April 1, 1989, Revised October 18, 1995, effective January 1, 1996)

(Revised July 28, 2007.)

RULE 31

Table of Contents

Section

RULE 31

ACCIDENT PREVENTION SERVICES

I. Purpose and Scope

A. The purpose of this rule 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 Ark. Code Ann. § 11-9-409(d).

B. All insurance companies licensed to write or seeking license to write workers' compensation insurance policies in Arkansas are subject to the provisions of this rule.

C. This rule does not apply to self-insured employers.

II. Definitions

A. "Accident Prevention Services Plan" (APSP) – A document describing the policies and procedures used by the insurance company to provide accident prevention services to its policyholders in accordance with Rule 31.

B. "Approved Professional Safety Source" (APSS) – Occupational health and safety consultant approved by the Arkansas Workers' Compensation Commission Health and Safety Division to service employers defined in AWCC Rule 32.

C. "Commission" – Arkansas Workers' Compensation Commission.

D. "Days" – Calendar days.

E. "Direct Premium Written" – The amount charged to the policyholder for the workers' compensation policy which shall include the expense constant, any allowable deviated discounts, any experience rating modification, any premium discount or debit, any reinsurance or deductible arrangement as common with fronting carriers, any dividend consideration, or other trade discount.

F. "Division" – AWCC Health and Safety Division.

G. "Employee" – Any person in service of an employer as defined by Ark. Code Ann. § 11-9-102(9).

H. "Employer" – Any individual, partnership, association, or corporation as defined by Ark. Code Ann. § 11-9-102(10).

I. "Field Safety Representative" (FSR) – Occupational health and safety consultant approved by the division to service workers' compensation accounts.

J. "Loss analysis" – An in-depth examination of root causes of losses, which may include a loss run as one, but not the sole component.

K. "Loss Ratio" – Losses incurred during the ~~previous full~~ policy year, both paid and expected/reserved, divided by the written manual premium. In the context of this rule "loss ratio" is used as an indicator of whether accident prevention services must include an annual on-site visit or other appropriate services.

L. "Policyholder" – The person or entity owning the policy of insurance.

M. "Rule 32 Program" – The program established by Ark. Code Ann. § 11-9-409(c) with criteria established by the Amended Rule 32.

N. "Workplace" – Each business operation, facility, or location of an employer where employees are present during part of or for the entire work shift.

O. "Written Manual Premium" – 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. Further, "written manual premium" means premium before any allowable deviated discounts, any experience rating modification, any premium discount, any reinsurance or deductible arrangement as common with fronting carriers, any dividend consideration, or other trade discount.

III. Accident Prevention Services

A. An insurance company desiring to write workers' compensation insurance in Arkansas shall have the ability to provide accident prevention services described in Section III. B. - E., subject to inspection by the commission, as a prerequisite to obtaining or maintaining a license to write such insurance.

B. 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. If these fees have already been paid, an APSP must be on file with the commission.

C. An insurance company shall provide or make available basic accident prevention services to policyholders at no additional charge or change in premium. These may include visits to each policyholder workplace. Accident prevention services required under Rule 32 must be provided or made available at no additional charge to each policyholder workplace identified under that rule.

D. The insurance company, using only commission approved FSRs/APSSs, shall:

1. Provide appropriate accident prevention services to its clients as listed below. For services to be appropriate, the insurance company must demonstrate that it actively evaluated the insured's performance and loss potential stated in Section III. D. and then offered to provide services to correct or alleviate hazards recognizable by an occupational health and safety professional;

2. 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;

3. Provide appropriate services to each Arkansas policyholder. At a minimum, appropriate services shall include:

a. Annual on-site workplace visit(s) or other appropriate services to each policyholder with a direct premium written of $25,000 or greater.

b. Annual workplace visit(s) or other appropriate services to each policyholder with a direct premium written of $5,000 up to $24,999 whose loss ratio is equal to or greater than 100%.

c. Annual workplace visit(s) or other appropriate services to each policyholder with a direct premium written of less than $5000, whose loss ratio is equal or greater than 150%.

d. Contacting all policyholders not serviced under the guidelines of Section III. D. 1. – 3. at least once during the policy year <u>within 60 days of policy inception or renewal date, separate from the actual workers' compensation insurance policy</u> to determine their need for assistance and to advise them accident prevention services are available at no additional cost. The insurance company may determine the method of contact (e.g., visit, letter, telephone call, e-mail, etc.).

E. The insurance company shall provide accident prevention services which meet the standards of the division as required by Arkansas Code Ann. § 11-9-409(d). The program shall provide at a minimum:

1. 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 rule, experience modifiers, frequency rates, and severity rates;

c. Total number of employees, number of workplaces, and number of employees per workplace;

2. Procedures for determining the appropriate accident prevention services to be provided to a policyholder and to each policyholder's workplace;

3. Procedures indicating the time frame and manner in which the requested accident prevention services as stated in Section III. C. will be provided;

4. Records, reports, and evidence of all accident prevention services provided to each policyholder and each workplace;

5. Procedures for providing safety training and safety material for each policyholder;

6. At a minimum of once a year, written notification to policyholders and policyholder workplaces of their actual claims experience <u>including reserves</u> and, if the policyholder meets the criteria of Section III. D. 3. or if the policyholder is identified under Rule 32, a loss analysis;

7. 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

8. Evidence that the notice required by Section V. is provided to policyholders.

F. The insurance company shall provide the following to the division's Accident Prevention Services staff:

1. An APSP, updated as necessary. The plan shall describe how the company will meet all the requirements relating to the provision of accident prevention services presented in this rule and Ark. Code Ann. § 11-9-409(d). The plan must meet the requirements of the division before it is accepted;

2. Annual reports as required by Section VI.; and

3. Other information as requested by the division.

IV. Accident Prevention Services Required Inspection

A. Each insurance company's accident prevention services program will be inspected in accordance with Ark. Code Ann. § 11-9-409(d) and may be inspected more frequently at the division director's discretion. 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. 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 the Ark. Code Ann. § 11-9-409(d).

B. The division shall notify the insurance company in writing of the date, time, and location of the inspection at least ~~ninety (90)~~ one-hundred-twenty (120) days prior to the inspection.

C. ~~At least sixty days prior to the inspection~~ Within thirty (30) days after Notification of Inspection, the insurance company or company group shall provide the division, in the format requested, the following:

1. A list of policyholders with Arkansas exposures, separated by insurance company, with physical addresses of all Arkansas workplaces as defined in AWCC Rule 3, direct premium written and written manual premium for Arkansas based on the insurance company's most current records.

a. The insurance company shall list the policyholders by written manual premium in descending order for each year or portion of year requested.

b. For policyholders with corporate headquarters outside the state of Arkansas, the insurance company shall list the corporate location.

c. The insurance company may send the list(s) electronically in a format agreed upon by the division.

d. The commission will keep the list of policyholder accounts confidential.

2. A list of the names, whether employee or contractor, and AWCC FSR/APSS identification number for each person acting as an FSR/APSS for the insurance company.

D. The division shall select the specific accounts to be evaluated and return the selected policyholder list to the insurance company no later than fifteen (15) days after receipt of the policyholder list. For the policyholders identified, the insurance company shall provide the following to the division to arrive no later than ~~fifteen (15) days prior to the inspection date~~ thirty (30) days after receipt of the selected policyholder list:

1. Loss control files of the policyholders identified to include any survey reports and correspondence, in the manner and format specified by the division;

2. Documentation of all accident prevention services provided;

3. Copy of loss runs for each account;

4. A sample of training materials, and other material as requested; and

5. An Accident Prevention Services Worksheet, Form AWCC-HS-31D, for each policyholder selected by the division.

E. An insurance company's failure to meet one or more of the specified requirements of Rule 31 may be construed as a failure to provide appropriate accident prevention services to policyholders. The division may reschedule the inspection, impose fines, and/or ask the Arkansas Insurance Department to take action. The 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.

F. The division shall determine the depth and scope of the inspection.

G. The division's staff and the insurance company's representative(s) shall review:

1. The results and recommendations of any previous inspections of the company by the commission;

2. The insurance company's APSP, including quality control and quality analysis provisions;

3. The insurance company's accident prevention services provided to policyholders and policyholders' workplaces;

4. Any changes completed in response to recommendations made during previous inspections;

5. Any written complaints from policyholders relating to accident prevention services; and

6. Policyholder worksheets, questionnaires, and results of site visits by commission staff, including information obtained through Rules 32 and 36 activities.

H. The 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.

I. The division staff shall prepare and file a written report of the inspection within thirty (30) days of the close of the inspection. The report shall contain.

1. Results of the inspection including a list of deficiencies, if any, and
2. Required corrective actions, if any.

J. The division shall provide a copy of the report to the insurance company and the Arkansas Insurance Department.

K. Insurance companies that meet the requirements of Rule 31 will receive a Certificate of Inspection from the commission.

L. Insurance companies with accident prevention services that do not meet the standards of Rule 31 will be notified of the specific deficiencies. The commission shall determine the appropriate amount of time for the insurance company to address the identified problems. The insurance company shall respond in writing with the corrective actions to be taken. When the division director determines that the insurance company has taken appropriate measures to correct the deficiencies, the division shall issue the Certificate of Inspection. A request for review of the decision may be made to the director of the division and, if desired, the Chief Executive Officer of the commission.

M. The commission may require another complete inspection of accident prevention services before issuing a Certificate of Inspection.

V. Accident Prevention Services Notification Requirements

A. 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 a least 10 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 Rule 32. 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 Health and Safety Division, Arkansas Workers' Compensation Commission at 1-800-622-4472.**

B. Certain accident prevention services are basic services as described in Ark. Code Ann. § 11-9-409(d).

C. Extensive sampling of environmental conditions and exposures, writing detailed safety plans (with the exception of Rule 32 activities), and on-site management of specific safety programs, e.g., respirator, hearing conservation, etc., are beyond the scope of basic services. The division will determine the scope of basic services on an issue-by-issue basis if necessary.

VI. Annual Report Requirements

A. Each insurance company licensed to write workers' compensation insurance in Arkansas shall submit to the division an annual report quantifying the accident prevention services it provided to its policyholders in Arkansas over the previous year. AWCC Form HS 31-C, or an alternate form as approved by the division, shall be used.

B. The division director shall send the annual report notification to each insurance company licensed to write workers' compensation insurance in Arkansas.

C. The insurance company shall send the report so that it is received no later than April 1 of each year.

D. The report shall not include the expenses of underwriting visits to policyholders' premises unless accident prevention services are provided during the visit. In such case, the costs of the accident prevention services shall be included in the report.

VII. Field Safety Representative (FSR)

A. An individual seeking to become an FSR shall apply to the division using application AWCC Form HS-31-A.

B. To be approved as an FSR, an individual must have at least two (2) years experience in the occupational health and safety profession during the past ten (10) years and must meet at least one of the following qualifications:

1. An associate's degree in safety, industrial hygiene, or related field. The college or university must submit a certified transcript directly to the division.

2. A current certification by the Board of Certified Safety Professionals as a Certified Safety Professional or Associate Safety Professional;

3. A current certification by the American Board of Industrial Hygiene as a Certified Industrial Hygienist or Industrial Hygienist in Training; or

4. A current certification by the World Safety Organization as a Certified Safety Manager, or Certified Safety Specialist.

C. 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.

D. If applicants meet the education requirements listed in Subsection B. above, but do not have the required occupational health and safety experience, they may be approved as an FSR in training. The following is required to be approved as an FSR in Training:

1. A copy of AWCC From HS-31-A completed and submitted to the division;

2. 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;

E. When two (2) years of occupational health and safety experience have been obtained, the FSR in Training may resubmit an AWCC Form HS-31-A requesting approval as an FSR.

F. If an applicant is not approved, the division shall notify the applicant in writing and state the reason(s) for the denial. Any applications not approved shall be destroyed after ninety (90) days.

G. All FSR performances are subject to review by the division. The division may rescind FSR approval for cause. A request for review of the decision may be made to the director of the division and, if desired, the Chief Executive Officer of the commission.

VIII. Approval of Professional Safety Sources

A. An individual seeking to become an APSS pursuant to the AWCC Rule 32 Program shall apply to the division using application AWCC Form HS-31-A.

B. To be approved as an APSS, an individual must meet the FSR requirements and provide verification of at least three (3) additional years of occupational health and safety experience and must attend the commission's APSS Seminar.

C. If an applicant is not approved, the division director shall notify the applicant in writing and state the reason for the denial. Any applications not approved will be destroyed after ninety (90) days.

D. All APSS performances are subject to review by the division staff. The division may rescind APSS approval for cause. A request for review of the decision may be made to the director of the division and, if desired, the Chief Executive Officer of the commission.

E. 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 Rule 32 program.

IX. Penalties

The commission may assess a civil penalty in an amount up to one thousand dollars ($1,000.00) per day of violation against an insurance company that does not maintain or provide the accident prevention services required by Ark. Code Ann. § 11-9-409, payable to the Death and Permanent Total Disability Trust Fund. Furthermore, the insurance company shall be subject to suspension or revocation of license to do business in this state by the Insurance Commissioner.

X. Severability

If any provision of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

(Effective December 30, 1993; revised June 10, 2003, effective July 1, 2003; revised xx xx, 2007, effective xx xx, 2007.)

Form HS-31-A	ARKANSAS WORKERS" COMPENSATION COMMISSION **HEALTH & SAFETY DIVISION** 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	**HS-31-A**
Ark. Code Ann. "11-9-409 & AWCC Rule 31 Rev. ~~1-1-2001~~ 7-28-2007		

Application for (check all that apply)

"Approved Professional Safety Source (APSS) **"Field Safety Representative (FSR)**

(Note: Attendance at an on-site AWCC class is mandatory for APSS certification)

Section 1. Personal Information

1) Name~~:~~: Last: _____ First: _____MI: _____	2) Telephone no.: Primary: (_____) _____ Secondary: (_____) _____	3) Social Security no.:
		4) Total no. of years occupational health and safety experience :_____
5) ~~Street~~ Mailing address:	6) City:	7) State: ~~, Zip:~~ 8: Zip:

~~8~~9) ~~Mail address (if different from street address)~~E-Mail address:

~~9) City:~~

~~10) State, Zip:~~

Section 2. Professional Certifications

Check all that apply. Enclose copy of current membership card. Information will be verified.

Certification	Certificate No.	State (if applicable)
" Certified Safety Professional (CSP)		
" Certified Industrial Hygienist (CIH)		
" WSO Certification (~~specify type~~ specify Certified Safety Manager or Certified Safety Specialist)		
" ~~Other certification~~ (provide explaination)		

Section 3. Education and Professional Training Note: A certified transcript must be sent **directly from the granting institution** to the Arkansas Workers" Compensation Commission, Health and Safety Division, P.O. Box 950, Little Rock, AR 72203-0950, ATTN: FSR/APSS.

College or University	*City, State*	*Attendance Dates (From/To)*	*Sem. Hrs. Completed*	*Major*	*Degree Earned*

Section 4. Occupational Safety and Health Professional Experience Using Attachment 1, list each occupational health and safety work assignment in chronological order, beginning with present position.

Section 5. Signature

I certify that the preceding statements, including attachments, are accurate to the best of my knowledge, and authorize the Arkansas Workers" Compensation Commission to verify the information. I understand that any falsification of information is this application, including attachments, may be cause for rejection or withdrawal of the Field Safety Representative and/or Approved Professional Safety Source designation.

Applicant Signature: _____ Date:_____

(please use ink)

HS-31-A Attachment 1

Occupational Safety and Health Work Experience

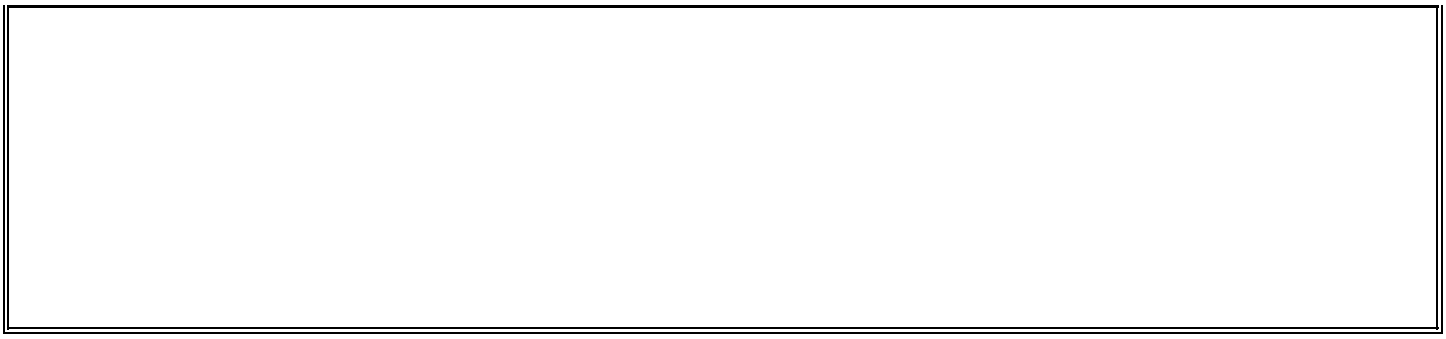
Use a separate copy of Attachment 1 for each change in position, regardless of whether or not there was a change in employers.

1) Name during employment:	2) Position with this employer::
3) Employer: Name Address: City:	Telephone no.: ( ) State: Zip:
4) Employment dates (Mo/Yr.): From:____/_____ To:____/_____	5) Major product or service of this company:
6) Immediate supervisor: Name	Telephone No.: ( )

7) Description of occupational health and safety work experience. Indicate the percentage of your time spent in the following areas:

_____ Hazard identification	_____ Safety & health program design	_____ Safety training & education
_____ Hazard evaluation	_____ Safety & health program evaluation	_____ Supervision of other health & safety professionals
_____ Hazard control design	_____ Safety & health communication	_____ Neither health & safety or environmental
_____ Environmental	_____ Incident investigation	_____ Hazard control verification

For the three (3) areas above where you spent the **most** time, provide a brief description of your work in those areas:



Form HS-31-C	ARKANSAS WORKERS' COMPENSATION COMMISSION **HEALTH & SAFETY DIVISION** 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	**HS-31-C**
Ark. Code Ann. §11-9-409 & AWCC Rule 31 Rev. ~~1, 1, 2001~~ 7-28-2007		

ACCIDENT PREVENTION SERVICES ANNUAL REPORT

1) Insurance Company:	3) Mailing Address:	4) City, State, Zip:
2) Telephone no.: ( )		5a) NAIC Company no.: _____ 5b) NAIC Group no.: _____

6) Total amount spent for accident prevention services during the current calendar year (salaries, travel): $_____

7a) Total amount of workers' compensation insurance **written manual premium** in AR for year: $_____
7b) Total amount of workers' compensation insurance **direct premium written** in AR for year: $_____
7c) Premium information provided by: Name: _____ Office: _____

	Employee	Contract
8a) Number of Field Safety Representatives(FSRs) used by the insurance company:		
8b) Number of Approved Professional Safety Sources (APSSs) used by the insurance company:		
9) Number of on-site inspections performed by FSRs:		

10) Identify the number of AR workers' compensation insurance policyholders for the most recent calendar year for the premium groups listed:
_____ $0 - $24,999 _____ $25,000 - $49,999 _____ $50,000 - $74,999 _____ $75,000 - $100,000 _____ Above $100,000

Evidence of accident prevention effectiveness will be measured by an analysis of the following loss data:	Current Year	Previous Year
11a) Total number of medical-only workers' compensation claims opened:		
11b) Total amount paid on medical-only claims:		
11c) Total number of indemnity claims opened:		
11d) Total amount paid on indemnity claims:		

I certify that the above information is correct to the best of my knowledge and I have read and understand the provisions set by Arkansas Code Ann. §11-9-409.

_____ _____ _____

Designated Insurance Company Representative (Print Name) Position or Title
Date

_____

Designated Insurance Company Representative (Signature)

Instructions for Completing Form AWCC HS-31-C
Accident Prevention Services Annual Report

This form must be filed with the Accident Prevention Services Section no later than ~~March~~ April 1 of each year.

Calendar year is defined as January 1 - December 31. This form may be obtained from the Accident Prevention Services Section of the Health and Safety Division, Arkansas Workers' Compensation Commission.

Note: Complete one form for each company or sister company in the insurance group. Return the original (copies are not acceptable). A separate report must be submitted for each sister company.

Complete all blanks. Do not use "N/A" or "not applicable."

Items 1-5: List name, address, telephone number, NAIC insurance company number and the NAIC group number for the insurance group of which the insurance company is a member

Item 6: This includes amounts spent for contract field service representatives, company field safety representatives, salaries and any related expenses, to include clerical-related expenses. Expenses or costs for underwriting visits to policyholders' premises shall not be included.

Item 7a: Enter the total amount of workers' compensation insurance written manual premium, less expense constant, for calendar year. See Ark. Code Ann. §11-9-303. Check with your carrier's tax department for help.

Item 7b: Enter the total amount of workers' compensation insurance direct premium written for calendar year. If the amount on line 7b is larger than that on line 7a, or lines 7a and 7b are identical, attach an explanation.

Item 7c: Enter the name and office of the person supplying the information for Items 7a and 7b.

Item 8: Enter the total number of Field Safety Representatives (FSRs) and Approved Professional Safety Sources (APSSs) utilized by the insurance company and indicate if they are employees of the insurance company or their services are under contract.

Item 9: "On-site" surveys do not include underwriting surveys for prospective accounts.

Item 10: Enter the number of Arkansas workers' compensation insurance policyholders in each category; based on written manual premium.

Item 11a: Enter the total number of medical-only workers' compensation claims opened during the current year and the previous year in Arkansas.

Item 11b: Enter the total amount paid on medical-only workers' compensation claims paid during the current year and the previous year in Arkansas.

Item 11c: Enter the total number of indemnity workers' compensation claims opened during the current year and the previous year in Arkansas.

Item 11d: Enter the total amount paid on indemnity workers' compensation claims paid during the current year and the previous year in Arkansas.

Authorized signature of insurance company's designated representative. Insert date the report was completed by the designated representative.

Form HS-31-C	ARKANSAS WORKERS' COMPENSATION COMMISSION **HEALTH & SAFETY DIVISION** 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	**HS-31-C**
Ark. Code Ann. §11-9-409 & AWCC Rule 31 Rev. ~~1, 1, 2001~~ 7-28-2007		

ACCIDENT PREVENTION SERVICES ANNUAL REPORT

1) Insurance Company:	3) Mailing Address:	4) City, State, Zip:
2) Telephone no.: ( )		5a) NAIC Company no.: _____ 5b) NAIC Group no.: _____

6) Total amount spent for accident prevention services during the current calendar year (salaries, travel): $_____

7a) Total amount of workers' compensation insurance **written manual premium** in AR for year: $_____
7b) Total amount of workers' compensation insurance **direct premium written** in AR for year: $_____
7c) Premium information provided by: Name: _____ Office: _____

	Employee	Contract
8a) Number of Field Safety Representatives(FSRs) used by the insurance company:		
8b) Number of Approved Professional Safety Sources (APSSs) used by the insurance company:		
9) Number of on-site inspections performed by FSRs:		

10) Identify the number of AR workers' compensation insurance policyholders for the most recent calendar year for the premium groups listed:
_____ $0 - $24,999 _____ $25,000 - $49,999 _____ $50,000 - $74,999 _____ $75,000 - $100,000 _____ Above $100,000

Evidence of accident prevention effectiveness will be measured by an analysis of the following loss data:	Current Year	Previous Year
11a) Total number of medical-only workers' compensation claims opened:		
11b) Total amount paid on medical-only claims:		
11c) Total number of indemnity claims opened:		
11d) Total amount paid on indemnity claims:		

I certify that the above information is correct to the best of my knowledge and I have read and understand the provisions set by Arkansas Code Ann. §11-9-409.

_____ _____ _____

Designated Insurance Company Representative (Print Name) Position or Title
Date

_____

Designated Insurance Company Representative (Signature)

Instructions for Completing Form AWCC HS-31-C
Accident Prevention Services Annual Report

This form must be filed with the Accident Prevention Services Section no later than ~~March~~ April 1 of each year.

Calendar year is defined as January 1 - December 31. This form may be obtained from the Accident Prevention Services Section of the Health and Safety Division, Arkansas Workers' Compensation Commission.

Note: Complete one form for each company or sister company in the insurance group. Return the original (copies are not acceptable). A separate report must be submitted for each sister company.

Complete all blanks. Do not use "N/A" or "not applicable."

Items 1-5: List name, address, telephone number, NAIC insurance company number and the NAIC group number for the insurance group of which the insurance company is a member

Item 6: This includes amounts spent for contract field service representatives, company field safety representatives, salaries and any related expenses, to include clerical-related expenses. Expenses or costs for underwriting visits to policyholders' premises shall not be included.

Item 7a: Enter the total amount of workers' compensation insurance written manual premium, less expense constant, for calendar year. See Ark. Code Ann. §11-9-303. Check with your carrier's tax department for help.

Item 7b: Enter the total amount of workers' compensation insurance direct premium written for calendar year. If the amount on line 7b is larger than that on line 7a, or lines 7a and 7b are identical, attach an explanation.

Item 7c: Enter the name and office of the person supplying the information for Items 7a and 7b.

Item 8: Enter the total number of Field Safety Representatives (FSRs) and Approved Professional Safety Sources (APSSs) utilized by the insurance company and indicate if they are employees of the insurance company or their services are under contract.

Item 9: "On-site" surveys do not include underwriting surveys for prospective accounts.

Item 10: Enter the number of Arkansas workers' compensation insurance policyholders in each category; based on written manual premium.

Item 11a: Enter the total number of medical-only workers' compensation claims opened during the current year and the previous year in Arkansas.

Item 11b: Enter the total amount paid on medical-only workers' compensation claims paid during the current year and the previous year in Arkansas.

Item 11c: Enter the total number of indemnity workers' compensation claims opened during the current year and the previous year in Arkansas.

Item 11d: Enter the total amount paid on indemnity workers' compensation claims paid during the current year and the previous year in Arkansas.

Authorized signature of insurance company's designated representative. Insert date the report was completed by the designated representative.

Form HS-31-D

ARKANSAS WORKERS' COMPENSATION COMMISSION

HEALTH & SAFETY DIVISION

324 Spring Street, Little Rock, AR 72201
Mail: P. O. Box 950, Little Rock, AR 72203-0950
501-682-3930 / 1-800-622-4472

HS-31-D

Ark. Code Ann. §11-9-409 & AWCC Rule 31
Rev. ~~1-1-2001~~7-28-2007

Accident Prevention Services Worksheet

1a) Policyholder's name:

1b) Arkansas location(s):

1c) Effective date (mm/dd/year):

~~2a) SIC Code:~~

~~2c~~2b) Number of employees:

~~2d~~2c) Best Hazard Index:

~~2b~~2a) NAICS Code:

3) Insurance Carrier :

	Current policy year	First prior year	Second prior year
~~3~~4) Number of claims			
~~4~~5) Frequency indicator			
~~5~~6) Loss ratio			
~~6~~7) Number of ~~visits~~contacts			

~~7a~~8a) Date of last ~~site visit~~ contact (mm/dd/yyyy):

~~7b) Written manual premium:~~
~~$~~

~~7c~~8b) Experience modifier:

~~8a~~ 9a) Written manual premium (unadjusted):

$) ~~Insurance carrier:~~

~~8b~~9b) ~~Completed by:~~ Direct premium written (adjusted):

$

Note: *May Attach Additional Sheets, if needed.*

~~9~~10) Description of operations:

~~10~~11) Attach trend analysis for the last three years, by year:

~~11~~12) Describe any planned, programmed or scheduled service for this policyholder:

~~12~~13) Describe training program review and provide a list of recommendations made:

~~13~~14) Were accident analysis services provided? ' Yes ' No 'Not Needed

~~14~~15) Were industrial hygiene/health service s provided? ' Yes ' No 'Not Needed

~~15~~16) Comments:

17a) Completed by (print name and title, sign):

17b) Date:

(Form instructions on back side)

Instructions for Completing Accident Prevention Services Worksheet

AWCC-HS-31-D (Rev. ~~1-1-2001~~ 7-28-2007)

This form may be obtained from the Accident Prevention Services Program of the Health and Safety Division.

1a. Name of policyholder (e.g., "ABC Company").
1b. Each Arkansas location (by city).
1c. Date of annual renewal. If account is a new policy, include policy inception date.
2a. ~~Standard Industrial Classification (SIC) code.~~
~~2b. National Association of Insurance Commissioners~~ North American Industrial Classification System ~~carrier~~ code. (NAICS Number - 5 digits, e.g. 21233)
~~2c~~2b. Number of covered employees.
~~2d~~2c. Hazard index according to A.M. Best Company.
3. Name of insurance company. If the insurance company is a subsidiary company, enter parent company.
4. Number of claims in the current policy year to date (See item ~~8c~~17b) followed by the total number of ~~visits~~ claims made each of the two prior policy years.

~~4~~5. Frequency indicator = $\frac{\text{Number of Claims X 100}}{\text{Number of Employees}}$

~~5~~6. Loss ratio = $\frac{\text{Incurred Losses}}{\text{~~Earned~~ Written Manual Premium}} \times 100$

~~6~~7. Number of ~~on-site visits to~~ contacts with the account made by the Field Safety Representative(s) in the current policy year to date (see item ~~8c~~17b) followed by the total number of ~~visits~~ contacts made each of the two prior policy years.
~~7a~~8a. Date of last ~~visit~~ contact ~~to~~ or direct communication with the account by the Field Safety Representative.
8b. Experience modifier.
~~7b~~9a. Written manual premium (unadjusted) for current policy year. If policy is a retrospective, cost-plus or self-rating plan, enter your best estimate of the annual premium. Contact your carrier's tax department for assistance.
9b. Direct premium written (adjusted) for current policy year.
~~7c. Experience modifier.~~
~~8a. Name of insurance company. If the insurance company is a subsidiary company, enter parent company.~~
~~8b. Name of person who completed the worksheet.~~
~~8c. Date worksheet was completed.~~
~~9~~10. Enter the policyholder's type of business. Include a description of the kinds of operations involved as well as their size (e.g., "Wire goods manufacturing. Bulk rolls of coiled wire and sheet metal are cut to size, welded and painted or plated. Insured has 3 locations and 12 vehicles.")
Attach a trend analysis/loss run for each of the last three years.
~~11~~12. Describe any programmed, planned or scheduled service that has been established for this policyholder, including type of service, frequency, etc.
~~12~~13. Describe the training programs employed by the policyholder. List training programs recommended by the Field Safety Representative(s). Tell whether they have been implemented by the policyholder and, if so, how.
14. State whether accidents were of sufficient number to warrant an analysis to identify trends. If yes, briefly describe analysis results provided to the policyholder.
15. State whether the policyholder's operations required industrial hygiene/health service. If yes, describe what services were provided by the insurance carrier.
16. Comment on response/receptiveness of policyholder to recommendation(s) by Field Safety Representative(s).
17a. Name and title (printed) and signature of person completing this worksheet.
17b. Date worksheet was completed.

RULE 099.32 HAZARDOUS EMPLOYER PROGRAM #099.32

TABLE OF CONTENTS

I. CRITERIA FOR IDENTIFYING HAZARDOUS EMPLOYERS

A. The Health and Safety Division (HSD) of the Arkansas Workers" Compensation Commission (the Commission) pursuant to Ark. Code Ann. Section 11-9-409(c) shall identify hazardous employers based on criteria established by the Commission in this rule. Each employer identified, continued, or monitored shall have the right to verify employment, illness, and injury data used by the HSD, obtain a review of the findings of the HSD by the Chief Executive Officer (C.E.O.) Of the Commission, and request a hearing before the Full Commission to contest the findings of the C.E.O.

A request for review by the C.E.O. or hearing before the Full Commission shall be in writing, setting out the grounds therefore, and shall be filed within fifteen (15) days of the action from which the request is made. The C.E.O. or the Full Commission, as applicable, shall decide the issues within fifteen (15) days of receipt of the request for review or hearing.

DEFINITIONS:

1. Number of Employees - Number of employees reported to the ~~Employment Security Department~~ Arkansas Department of Workforce Services. Volunteers, elected officials, and board members of public entities shall not be counted.

2. Incident - A work-related illness or injury for which compensation is paid, as set out in Ark. Code Ann. Section 11-9-501. For an illness or injury to be compensable, the affected employee must miss eight (8) or more calendar days of work. Each illness or injury which results in permanent partial disability without lost time, shall also be deemed an incident for purposes of this rule. Illness or injuries to volunteers, elected officials, or board members of public entities shall not be counted.

3. Number of Incidents - The total number of incidents reported per employer during a calendar year. The number of incidents will be tabulated on a site-specific basis unless reported by the employer in a different manner.

4. Expected Incidence Rate - The benchmark illness and injury rate for each ~~SIC~~ North American Industrial Classification System (NAICS) code. The Expected Incident Rate is obtained from data compiled from national statistics as reported to the Occupational Safety and

Health Administration (OSHA) and published by the Bureau of Labor Statistics (BLS). Lost work day cases are defined by OSHA/BLS as those illness and injury cases which result in one or more days away from work. Lost work day cases do not include cases where the employee works in restricted or light duty. If data is not available from the BLS publication, other suitable sources are used to determine the Expected Incident Rate.

5. Employer Incidence Rate - Derived for each employer according to the following formula:

(Number of Incidents/Number of Employees) x 100 = Employer Incidence Rate

Site-specific computations will be made only if data is reported to the Commission by individual location.

6. Hazard Index - Derived annually and based on the preceding year‟s incidence rates for each employer according to the following formula:

Employer Incidence Rate/Expected Incidence Rate = Hazard Index

Site-specific computations will be made only if data is reported to the Commission by individual location.

7. Hazardous Employer - Any employer whose Hazard Index is 1.0 or greater may be identified as a Hazardous Employer. A Hazard Index of 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 or more days away from work.

B. The following criteria shall be used to evaluate employers and identify Hazardous Employers:

1. Employer Incident Rates and Hazard Indexes will be calculated annually, based on the preceding year‟s incidence rates.

2. 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. Site-specific evaluation is possible only if data is reported to the Commission by individual site location.

3. No employer who has only one incident in any single calendar year will be identified as a Hazardous Employer. However, if two or more incidents occur in any single calendar year, all incidents occurring during that year will be used to calculate the Employer Incident Rate and Hazard Index.

4. A Hazard Index of 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 or more days away from work.

5. Employers identified as 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.

C. Employers with a Hazard Index of less than 0.9 will not receive official notification from the HSD of their status. They may request this information by contacting the HSD by telephone, letter or fax.

D. Employers with a Hazard Index of 0.9 to 0.99 will receive a courtesy letter from the HSD notifying them of their status. This letter will be sent to the employer only. The letter ~~will~~ may contain the following information:

1. Notification that the employer is close to the 1.0 Hazard Index for Hazardous Employer designation.

2. Programs available from the Arkansas Workers" Compensation Commission and Arkansas Department of Labor, at no cost to the employer, designed to assist employers to improve their overall health and safety programs, prevent illness and injuries, and decrease their incident rate.

E. All employers with a Hazard Index of 1.0 or higher will be issued a Warning Notice. Such notice shall be in writing and sent to the specific site the employer"s central/corporate headquarters, and the insurance carrier. The notice ~~shall~~ may include the following information:

1. Notification that the employer meets the criteria to be identified as a Hazardous Employer and may be placed in the Hazardous Employer Program during the twelve (12) months following the notification.

2. Data (including number of employees, number of incidents and Expected Incident Rate) used to determine the Hazard Index.

3. Programs available from the Arkansas Workers" Compensation Commission and Arkansas Department of Labor, at no cost to the employer, designed to assist employers improve their overall safety programs, prevent illness and injuries, and decrease their incident rate.

II. NOTICE TO HAZARDOUS EMPLOYERS

A. Upon a determination by the HSD that an employer should be classified as hazardous, the HSD shall notify the employer and the employer"s workers" compensation insurance carrier. The notice shall be sent to:

1. The employer by certified mail at the employer"s principal place of business; and

2. 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.

B. The notice shall be in writing and shall inform the employer of the following provisions:

1. State that the employer has been identified as a Hazardous Employer;

2. State the facts on which the identification of the Hazardous Employer is based;

3. Outline the steps the employer is required to take as an identified Hazardous Employer;

4. Inform the employer of the penalties for failure to take steps required under the Hazardous Employer Program.

III. HEALTH AND SAFETY CONSULTATION

A. An employer who receives notification under Subsection II.A. of this Rule must obtain a health and safety consultation within thirty (30) days by an Approved Professional Safety Source (APSS) approved by the HSD for that purpose. The APSS may be from the Arkansas Department of Labor, from the employer"s insurance carrier, an employee of the employer, or a private consultant.

B. Upon request, the HSD shall provide a list of available Approved Professional Safety Sources.

C. The APSS shall conduct a hazard survey at each appropriate job site and prepare a hazard survey report. The report shall be in writing in a format prescribed by the Commission and shall 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.

D. The hazard survey report(s) and any attachments shall be filed by the APSS with the Clerk of the Commission.

E. If the initial consultation and report cannot be completed in the time allowed under this section, the employer may apply in writing to the HSD for a waiver of the time requirements. In no case shall the initial consultation exceed 60 days following the date of notification.

IV. FORMULATION OF HEALTH AND SAFETY PLAN

A. Employers who receive notification under Subsection II.A. will develop a health and safety plan within 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 Section III. This plan must be consistent with accepted industry practices. The Health and Safety plan shall include, but need not be limited to, the following:

1. Management component - Including a written safety policy statement and assignment, by position or title, of health and safety responsibilities and authority;
2. Analysis component - Including identified operational, health and safety

hazards;

3. Program record keeping system component;

4. Safety and health education and training component;

5. Safety and health audit/inspection component - Including identification, by title or position, of a qualified person(s) to conduct the audits/inspections;

6. Incident investigation component - Including procedures to identify factors contributing to near-misses and accidents and institute corrective measures; and,

7. Periodic review and revision of the health and safety program and operational procedures component - to determine effectiveness of abatement measures.

B. An implementation time line, not to exceed 6 months after the formulation of the plan, shall be developed and included with the plan.

C. If the employer disagrees with any or all of the plan, the employer shall sign the plan and attach a statement containing the specific reasons for disagreement with the plan and proposed alternative solutions to the health and safety issues cited. The HSD will review the areas of disagreement and notify the employer and the APSS of the decision on each area of disagreement.

D. 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 HSD.

E. The employer will begin implementation of any or all parts of the plan that are not subject to the employer‟s disagreement. The time lines specified in the plan shall remain in effect for those parts of the plan the employer is directed to implement. During the review of the plan by the HSD, the HSD may direct the employer and the APSS to implement a procedure in lieu of the part of the plan that is in disagreement.

F. The employer shall be responsible for filing the health and safety plan with the HSD within 30 days of the date of the consultant‟s initial report.

G. Reference material for the development of a health and safety plan may be obtained from the HSD.

V. FOLLOW-UP INSPECTION BY THE HSD

A. Six 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 HSD shall conduct a follow-up inspection to ensure compliance with, and the effectiveness of, the health and safety plan at the employer‟s premises.

B. The inspection shall be conducted and completed during normal work hours.

C. The employer shall allow the HSD access to the employer‟s premises, including remote job sites, and employees during normal work hours to conduct the follow-up inspection.

D. At the time of the inspection, the HSD may consider as evidence of compliance, information which includes, but is not limited to, visual verification, written policies and procedures, attendance rosters for training programs, employee interviews, and purchase orders or receipts for equipment or services necessary to support the accident prevention plan.

VI. REPORT OF FOLLOW-UP INSPECTION

A. 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 HSD.

B. 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 HSD.

C. If the employer is found not to have implemented the health and safety plan, the report shall also contain:

1. A notification that the employer‟s Hazardous Employer status is being continued;

2. A list of the specific areas of the health and safety plan which have not been implemented;

3. A list of the specific actions required of the employer to correct the identified deficiencies.

VII. REMOVAL FROM HAZARDOUS EMPLOYER STATUS

An employer shall be removed from Hazardous Employer status if, upon inspection the HSD determines that the employer has complied with the terms of the health and safety plan.

VIII. CONTINUATION OF HAZARDOUS EMPLOYER STATUS

A. An employer shall remain on Hazardous Employer status if the employer is found under Section V. of this Rule (Follow-Up Inspection by the HSD) to have failed or refused to implement a health and safety plan or other suitable hazard abatement measures as approved by the HSD.

B. If an employer is not certified for removal from 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 HSD, as a condition for removal from Hazardous Employer status.

C. An employer shall file a progress report with the HSD every 60 days until the employer has been removed from Hazardous Employer status. The report shall include:

1. For Subsection A. 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;

2. Additional areas identified in the follow-up inspection report; and

3. The steps which are being taken to address them.

D. After the required corrective actions have been taken, the employer shall notify the HSD and request a re-inspection. The request for re-inspection shall be made no later than six months after the date of the follow-up inspection.

IX. PENALTIES

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 ($1,000.00) per day of violation, payable to the Death and permanent Total Disability Trust Fund. 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. Ark. Code Ann. Section 11-9-409(c).

X. JUDICIAL PROCEEDINGS

The identification as a Hazardous Employer under this rule is not admissible in any judicial proceeding unless the Commission has determined that the employer is not in compliance with Rule 32 and that determination has not been reversed or superseded at the time of the event giving rise to the judicial proceeding.

XI. RULE REVIEW

The Arkansas Workers" Compensation Commission encourages all interested parties to participate in promulgating changes to the Rules governing the Hazardous Employer program. Those who desire input into said changes should submit them in writing to the HSD. After analysis, the Commission may incorporate such changes to the Rule, following public comment, pursuant to Ark. Code Ann. Section 11-9-205.

(Revised effective July 28, 2007.)

Form HS-32-A	ARKANSAS WORKERS' COMPENSATION COMMISSION **HEALTH & SAFETY DIVISION** 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	**HS-32-A**
Ark. Code Ann. §11-9-409 & AWCC Rule 32 ~~Rev. 1-1-2001~~ Rev. 6-1-2007		

AWCC File No. _____

Hazard Survey Report

Employer Information				
1) Company name:				
2) Mailing Address:		3) City:	4) State:	5)Zip:
6) Physical Address:		7) City:	8) State:	9) Zip:
10~~6~~) Employer Representative:		11~~7~~) Title:		
12~~8~~) Address:		13~~9~~) City:	14~~10~~) State:	15~~11~~) Zip:
16~~12~~) Telephone no.: ( )	17~~13~~) Fax no: ( )	18~~14~~) e-Mail:		
Consultant Information				
19~~15~~) Name:	20~~16~~) Address:			
21~~17~~) AWCC/APSS no.:	22~~18~~) City:	23) State:	24~~19~~) Zip:	
25~~20~~) Telephone no.: ( )	26~~21~~) Fax no.: ( )	27~~22~~) e-Mail:		

Identification of Hazards

28~~23~~) List hazards, reference, recommendations and anticipated correction date for deficiencies found during consultation (use additional sheets if necessary).

No.	Hazard	Reference	Recommendation(s)	Targeted Correction Date

29~~24~~) Employer Representative signature: Date:				30~~25~~) Consultant signature: Date:	

FORM HS-32-B	ARKANSAS WORKERS' COMPENSATION COMMISSION	HS-32-B
ARK. CODE ANN. §11-9-409 & AWCC RULE 32 ~~REV. 1-1-2001~~ REV. 6-1-2007	**HEALTH & SAFETY DIVISION** 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

AWCC File Number_____

Health and Safety Plan Cover Sheet

1) Company name:			
2) Address:	3) City:	4) State:	5)Zip:

Mandatory Safety Program Administration Components					
Components	**6) In Place**		**7) Effectiveness**		**8)Comments**
	Yes	No	Yes	No	
A. **Management**-includes written Safety Policy Statement, assignment (by position/title) of health and safety responsibilities and authority					
B. **Analysis**-includes identified ~~i~~ health and safety hazards					
C. **Safety program record keeping**					
D. **Safety and health education and training**					
E. **Audit/Inspection**-includes identification (title, position) of person(s) qualified to conduct audit/inspection.					
F. **Accident investigation**-includes methods to investigate, identify root causes, and corrective actions taken					
G. **Periodic review and revision**-includes methods to determine effectiveness of program and corrective actions					

Signature/Statement

9) Employer's Statement: ❑ Agree ❑Disagree ~~(Attach as Part V of Plan)~~ "Attach additional sheets if necessary"

10) Employer's Signature:	11) Consultant's Signature:
12) Date:	13) Date:

FINAL DRAFT - RULE 099.33

Revised July 12, 2007

RULE 099.33 MANAGED CARE **#099.33**

TABLE OF CONTENTS

MANAGED CARE

Pursuant to Ark. Code Ann. § 11-9-508 (Rpl. 1996), the following rule is hereby established in order to implement a voluntary managed care program.

Rule 33 provides for certification, administration, evaluation and enforcement of managed care organizations (MCO) and internal managed care systems (IMCS).

Pursuant to Ark. Code Ann. § 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 approved MCO is available for contracting purposes to cover the insurance carrier/employer, and/or self-insured's employees.

Managed care becomes effective when:

1. 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

2. Notice (Form H) has been posted in accordance with Commission Rule 7.

The applicable MCO/IMCS plan will provide all treatment for work related injuries occurring after notice is posted. Previous notice given to employees by a certified MCO shall fulfill the above notice requirements.

I. DEFINITIONS

For the purpose of this rule, unless the context requires otherwise:

1. Administrator. "Administrator" means the Administrator of the Medical Cost Containment Department of the Arkansas Workers' Compensation Commission.

2. Health Care Providers:

a. Initial Health Care Provider. "Initial health care 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. This definition shall apply to initial treating physician, regular treating physician, primary care physician, and initial primary care physician as referred to in Ark. Code Ann. § 11-9-508 (d)(5)(A) and § 11-9-514(a)(3)(A)(ii).

b. Nonparticipating Health Care Provider. "Nonparticipating health care 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 Health Care Provider. "Participating health care 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. "Regular treating physician" means the provider/physician who is the regular treating physician of the employee and 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. 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. Such optometric or ophthalmologic medical service provider shall be considered a certified provider by the commission. See Ark. Code Ann. § 11-9-508(e).

3. Internal Managed Care System. "Internal managed care system" (IMCS) means a

certified in-house managed care system established and operated by an insurance carrier, employer, or self-insured employer.

4. Managed Care Entity. "Managed care entity" means a Commission approved MCO or IMCS. See Ark. Code Ann. § 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. "Managed care organization" (MCO) means an entity certified by the Arkansas Workers' Compensation Commission that provides for the delivery and management of treatment to injured employees and markets these services.

6. Probation. "Probation" means that an MCO/IMCS has been given a specified length of time in which to remedy any problem(s) of which it has been notified pursuant to Section XIV of this rule.

7. Revocation. "Revocation" means the termination of certification of an MCO/IMCS to provide services.

8. Specialized Medical Services. "Specialized medical services" means health care services other than those provided by an initial health care provider.

9. Suspension. "Suspension" means that a MCO's authority to enter into new or amended contracts with insurance carriers, employers or self-insured employers has been suspended by the Arkansas Workers' Compensation Commission for a period of time.

II. INITIAL CHOICE OF PHYSICIAN

The employer shall have the right to select the initial primary care physician from among those associated with managed care entities certified by the Commission. See Ark. Code Ann. § 11-9-508(d)(5)(A) and § 11-9-514(a)(3)(A)(i). The Insurance Commissioner may allow a rate reduction for employers who use their carriers' contracted MCO or IMCS exclusively.

III. REFERRALS

1. Participating Providers

All referrals by participating health care providers or initial health care 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. Non-Participating Providers

a. Non-Participating providers may provide services under the following circumstances:

(1) Change of physician.

When approving a change of physician, the Commission may authorize a nonparticipating provider/physician to provide services to a worker if:

(a) the provider/physician is the regular treating physician of the employee; and

(b) the provider/physician 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

(c) the provider/physician agrees to comply with all of the rules, terms, and conditions of the insurance carrier/employer/self-insured employer's MCO/IMCS pursuant to Ark. Code Ann. § 11-9-508(d)(5).

(2) Emergency Medical Treatment.

(3) When the employee is referred to such provider/physician by the MCO/IMCS.

IV. CHANGE OF PHYSICIAN

Employees should initially request a change of physician from the insurance carrier/employer/self-insured employer. Within five 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.

Pursuant to Ark. Code Ann. § 11-9-514(a)(3) where the employer has contracted with a managed care organization certified by the commission, the claimant employee, however, shall be allowed to change physicians by petitioning the 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 refer the employee to the managed care entity chosen by the employer for any specialized treatment, including physical therapy, and only if such primary care physician agrees to comply with all the rules, terms and conditions regarding services performed by the managed care entity initially chosen by the employer.

Where the employer does not have a contract with a managed care organization, certified by the commission, the claimant employee, however, shall be allowed to change physicians by petitioning the 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 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 refer the employee to a physician associated with any managed care entity certified by the Commission for any specialized treatment, including physical therapy, and only if such primary care physician agrees to comply with all the rules, terms, and conditions regarding services performed

by any managed care entity certified by the Commission.

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.

Pursuant to Ark. Code Ann. §11-9-706, the Medical Cost Containment Division may hold a person or party in contempt for failure to provide documentation necessary to facilitate a request for Change of Physician.

V. MULTIPLE MCOs

When an insurance carrier, employer, or self-insured employer contracts with more than one MCO, the insurance carrier/self-insured employer shall designate to the Commission one MCO whose rules, terms and conditions will apply to services rendered by change of physician and referral providers.

VI. RULES, TERMS, AND CONDITIONS OF MCO/IMCS

Rules, terms, and conditions shall be made available upon request by the Arkansas Workers' Compensation Commission.

VII. MCO APPLICATION FOR CERTIFICATION

1. MCO Certification.

a. Any person or entity may make written application to the Administrator for certification as an MCO.

b. Two (2) copies of the application must be submitted. The application must include the following specific information to ensure the MCO will be able to meet the provisions of this rule:

(1) 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.

(2) The names, addresses, and specialties of the individuals who will provide services under the MCO.

(3) A statement describing how the plan will ensure an adequate number of health care providers to give employees convenient accessibility to all categories of providers.

(4) The rules, terms, and conditions regarding the services the MCO will be providing.

(5) 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. A sample contract which complies with Rule 33, Section VII.2.d. must be furnished.

(6) 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 by-laws or similar document, if any.

(7) A description of the MCO's Quality Assurance Program which shall include, but is not limited to:

(a) An internal dispute resolution program.

(b) A medical peer review program.

(c) Pre-admission review program which complies with Rule 30.

(d) Second surgical opinion program.

(e) Utilization Review Program which includes concurrent and retrospective review. The MCO utilization review program must meet the requirements of Ark. Code Ann. §§ 20-9-902, et seq. (1989), the Rules & Regulations for Utilization Review in Arkansas, and must be certified with the Arkansas Department of Health Utilization Review Certification Program as a Private Review Agent.

(f) Technical and professional review programs which shall comply with Rule 30, and satisfy the requirements of Ark. Code Ann. §§ 20-9-902, et seq. (1989).

c. The MCO must provide programs through which participating health care providers may obtain information on the following topics:

(1) treatment parameters adopted by the Commission;

(2) end of healing period;

(3) permanent partial impairment rating;

(4) return to work and disability management;

(5) health care provider obligation in the workers' compensation system; and

(6) other topics the MCO or Commission deems necessary to obtain cost effective medical treatment and appropriate return to work for an injured employee.

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 items (1) to (6) above. The documentation shall be submitted to the

Administrator upon request. The medical director or designee must be available as a consultant on these topics to any health care 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:

(1) A description of how medical case management will be provided.

(2) Retention of Medical Case Manager.

A medical case manager shall monitor, evaluate, and coordinate the delivery of quality, cost effective medical treatment and other health care services needed by an injured employee. Medical case managers should ensure that the injured or disabled employee is following the prescribed medical care plan, and shall promote an appropriate, prompt return to work. Medical case managers shall facilitate communication between the employee, employer, insurance carrier/self-insured, health care provider, managed care plan, and any assigned vocational rehabilitation counselor to achieve these goals.

(3) Qualifications of medical case manager.

A medical case manager for the purposes of this Rule 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; or

(b) a Designated Certified Case Manager (CCM) by the Certification of Insurance Rehabilitation Specialists Commission for Case Manager Certification; or,

(c) currently licensed as a Registered Nurse (RN); or,

(d) currently licensed as an Occupational Health Nurse; or,

(e) currently licensed as a Licensed Practical Nurse (LPN) and have 18 months supervised clinical experience and 6 months acceptable case management experience.

e. Each application for original certification, or application for certification following revocation, must be accompanied by a non-refundable fee of $500.

f. An application received by the Commission shall be approved within forty-five (45) days of receipt of all required information if such application meets all certification requirements. Further information or clarification of submitted information may be requested from the applicant. Failure to respond to a request from the Commission or failure to meet the requirements shall result in a denial of certification. A letter detailing the reason(s) for denial shall be sent to the applicant within five (5) working days of the decision by the Commission to deny the application.

g. An applicant denied certification shall be permitted to reapply no earlier than thirty (30) days after receipt of the notice of denial of certification. Such application shall be accompanied by a non-refundable fee of $250. 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 years and must undergo certification review every two years thereafter.

2. Contracts.

a. In order to provide management of treatment for injuries and diseases compensable under the Arkansas Workers' Compensation Act, an MCO may contract with:

(1) An insurance carrier licensed by the Arkansas Department of Insurance to write workers' compensation insurance in this state that has provided the Commission with a current A-13[*], or

(2) An individual employer or group of employers approved for self-insurance by the Commission.

(3) 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 agreement(s) shall be made available upon request from the Arkansas Workers' Compensation Commission.

d. When a MCO contracts with an insurance carrier/employer/ self-insured employer to provide services, the contract shall specify those employers governed by the contract. The MCO contract must include the following terms and conditions when establishing who is governed by the contract:

(1) Insurance carriers/employers/self-insured employers may contract with more than one 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(s).

(2) 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. When MCO coverage for an injured work is transferred from one MCO to another, the worker may continue to treat with his/her attending physician until a change of physician occurs.

e. Notwithstanding the requirements of this rule, 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.

FINAL DRAFT - RULE 099.33

Revised July 12, 2007

VIII. IMCS's 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 rule:

a. The name, address, and telephone number of a communication liaison for the IMCS.

b. A description of the IMCS. 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 name(s) 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 Section VII.1.d. of this rule.

f. The description of a program for quality assurance which shall not be limited to but which must at a minimum comply with Section VII.1.b.(7) of this rule.

3. Each request for certification of an IMCS must be accompanied by a non-refundable application fee of $500.00.

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.

IX. 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:

(1) a current membership listing by category of medical service providers, including provider names as required in Section VIII of this rule; and

(2) a listing of all employers covered by each contract.

(3) a summary of any sanctions or punitive actions taken by the MCO against participating health care providers;

(4) a summary of actions taken by the MCO's peer review committee which shows the number of cases reviewed, issues involved, and action taken;

(5) a list of entities other than health care providers that perform any of the functions of the MCO plan, which were not previously provided with the application for certification.

(6) any other information requested by the Commission which is deemed reasonable/necessary to monitor the MCO's compliance with the requirements of this rule.

b. The MCO must report to the insurance carrier/employer/self-insured employer, and Arkansas 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 Arkansas 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 Commission which is deemed reasonable/necessary to monitor the IMCS's compliance with the requirements of this rule.

d. any significant changes in the certified plan or provider network.

X. RECORD MAINTENANCE

1. Every MCO/IMCS that is certified to provide medical services as required by this rule shall maintain records for three (3) full calendar years.

2. If the insurance carrier's/employers/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. Individual MCO/IMCS participating providers must maintain claimant medical records. 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. The records shall contain:

a. objective and subjective findings; and

b. 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.

XI. DISPUTE RESOLUTION

1. MCO/IMCS Internal Dispute Resolution Program

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 non-participating providers, etc., between the employee, health care provider, managed care plan, insurance carrier/self-insured employer, or employer shall first be processed without charge to the employee or health care provider through the dispute resolution process of the MCO/IMCS. Disputes must be in writing and filed within thirty (30) days of the dispute. The MCO/IMCS dispute resolution process must be completed within thirty (30) days of receipt of a written request. If the dispute cannot be resolved, or one of the parties so requests in writing, the Administrator shall assist in resolution pursuant to the administrative review process as set out below. For change of physician see Section IV of this rule. For choice of physician see Section II of this rule.

2. Administrative Review.

The process for administrative review of such matters shall be as follows:

a. The request for administrative review shall be made in writing to the Administrator within ninety (90) days of the disputed action. 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/her designee determines that there was good cause for delay or that substantial injustice may otherwise result.

b. 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. All parties shall have thirty (30) days from the date of receipt of notification to submit further evidence, documentation, or clarification to the Administrator.

c. The review may be conducted by the Administrator or the Administrator's designee. The review may include a hearing where all parties to the dispute will be required to attend. All hearings will be recorded. Failure to appear at such hearing may result in dismissal of the request for administrative review.

d. An order or award shall be issued within thirty (30) days.

e. 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. A request for rehearing shall be in writing and shall state the grounds upon which the moving party relies. Upon a finding that the record is not complete or that error was made in the hearing process, the Administrator may order a rehearing. A rehearing shall follow the same procedure as the initial administrative review.

f. 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 Arkansas Workers' Compensation Commission. The notice of appeal shall be filed with the Clerk of the Commission. The notice of appeal shall contain the following:

(1) a copy of the Administrative Review Order appealed; and

(2) copies of all materials submitted to the Administrator in the administrative review proceedings; and

(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 Rule 33.

The appealing party shall mail a copy of all materials which are filed in the appeal to each opposing party. No response to the appeal of the Administrator's order is required. A decision must be entered by the Administrator or Administrator's designee before any appeal may be brought.

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 of the order or ward, petition in writing for a review by the Full Commission of the order or award. See Ark. Code Ann. § 11-9-711 (a)(1)(1987).

An order or award of the 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. See Ark. Code Ann. § 11-9-711(b)(1987).

XII. MONITORING/AUDITING

1. The 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 Rule 30 requirements.

2. All records of the MCO/IMCS and their individual members shall be disclosed within a reasonable time upon request of the Commission. These records must be legible and cannot be

kept in a coded or semi-coded manner unless a legend is provided for the codes.

XIII. CHARGES AND FEES

1. Billings for medical services under a MCO/IMCS shall be submitted in the form and format as prescribed in Rule 30. The payment of medical services may be less than, but shall not exceed, the maximum amounts allowed pursuant to Rule 30 of the Arkansas Workers' Compensation Commission.

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 Rule 30 of the Arkansas Workers' Compensation Commission.

3. Balance billing as defined in Rule 30 by medical providers and/or facilities is specifically prohibited. The MCO/IMCS must have an effective plan for handling balance billing.

XIV. COMPLAINTS/INVESTIGATION

1. Complaints pertaining to the operations of a MCO/IMCS shall be directed in writing to the Administrator. Upon receipt of a written complaint, or after monitoring the MCOs/IMCSs, the Administrator may investigate the alleged violation. The investigation may include, but shall not be limited to, requests for and review of pertinent MCO/IMCS records, interviews with the parties to the complaint, or consultation with an appropriate committee of the medical provider's peers. If the investigation reveals a violation, the certification may be suspended or revoked or the IMCS may be placed on probation. The Administrator may return the complaint to the originating party for completion if the complaint does not satisfy the requirements of this rule. The complaint must:

a. state the grounds for alleging a rule violation;

b. include the specific contentions of error;

c. state the complainant's request for correction and relief; and

d. 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 Section XV of this rule.

XV. 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 rule;

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 health care 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 rule;

2. For the purpose of this rule:

a. "Suspension" means an MCO may not enter into new contracts with insurance carrier/employers/self-insured employers for a specified period of time. The suspension period may be imposed for a period up to a maximum of one year.

b. "Probation" means that an IMCS has been given a specified length of time in which to remedy any problem(s) of which it has been notified pursuant to Section XIV of this rule.

c. "Revocation" means a permanent revocation of a MCO/IMCS's certification to provide services under this rule.

3. A show cause hearing may be held at any time the Administrator has reason to believe a MCO/IMCS has failed to comply with its obligations under the Arkansas Workers' Compensation Act, 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 rule 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 rule.

5. The process for suspension/probation/revocation shall be as follows:

a. The Administrator shall provide the MCO/IMCS written notice of an intent to suspend, place on probation, or revoke the MCO/IMCS's certification and the grounds for such action. 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. 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. 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. Prior to the end of the suspension/probation period the Administrator shall determine if the MCO/IMCS is in compliance. If the MCO/IMCS is in compliance, the suspension/probation will terminate on its designated date. If the MCO/IMCS is not in compliance, the suspension/probation may be extended without further hearing or revocation proceedings may be initiated. 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 Rule 33.

d. 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 (10) days notice of the time and place of the rehearing. Within thirty (30) days after the hearing, the Administrator shall either affirm or withdraw the revocation and give the MCO/IMCS written notice thereof by registered or certified mail. 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.

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 a MCO/IMCS's authority to provide services under these rules 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 Sections VII and VIII of this rule.

7. Insurance carrier/employer/self-insured employer contractual obligations to allow a 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 health care provider or other entity to deliver medical, surgical, or hospital services pursuant to the Arkansas 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.

XVI. 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.

XVII. AMENDMENT/CHANGES

Any amendments and/or changes to the certified MCO/IMCS plan must be approved by the Administrator before becoming effective.

FINAL DRAFT - RULE 099.33

Revised July 12, 2007

XVIII. APPLICABILITY OF RULES

1. This revised rule was adopted December 3, 1996 and shall govern all Arkansas Workers' Compensation managed care organizations and/or internal managed care systems from January 20, 1997 forward.

2. The provisions of these rules 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 rule.

*** Form A-13 was replace by WCC Form I (Insurance Coverage), a 6" x 4" card.**

(Adopted July 1, 1994; Revised Effective January 20, 1997; Revised effective November 14, 1999; Revised effective July 28, 2007.)

FINAL DRAFT - RULE 099.33

Revised July 12, 2007

Form HS-36-A	ARKANSAS WORKERS' COMPENSATION COMMISSION	HS-36-A
Ark. Code Ann. §11-14-101 & AWCC Rule 36 Rev. ~~1-1-2001~~x-x-2007	**HEALTH & SAFETY DIVISION** 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

Application for Voluntary Drug-Free Workplace Program

Application Type: ❑Initial/first time application ❑Renewal (Approval no._____) ❑ Termination of Participation

Company Information		
1) Company name:	2) Address:	
3) City:	4) State	5) Zip:
6) FEIN:	7) ~~SIC~~NAICS:	8) Effective date of drug-testing program:
9) Company contact:		10) Telephone no.: ( )
11) Title:		12) e-Mail:
13) Workers' compensation insurance (WCI) status: ❑Self-insured ❑Purchase (WCI)		
14) Insurance carrier or third party administrator (TPA):		
15) Average number of employees during the most recent calendar year:	15a) Full-time:	15b) Part-time:
~~16) Average number of leased or temporary employees during the most recent calendar year:~~		
~~17) List leasing companies or temporary agencies used (use a separate sheet if necessary):~~ ~~1.~~ _____ ~~2.~~ _____		

Drug Testing Program					
~~*Collection site:*~~ *Program Manager or Third Party Administrator* ~~18~~16) Name:					
~~19~~17) Address:					
~~20~~18) City:	~~21~~19) State:	~~22~~20) Zip:	~~23~~21)	~~24~~22)	~~25) Certification no.:~~
Testing Lab: ~~26~~23) Name:					
~~27~~24) Address:					
~~28~~25) City	~~29~~26) State:	~~30~~27) Zip:	~~31~~28) Telephone no.: ( )		
Certification	~~32~~29) SAMSHA	~~33~~30) CAP-FUDTAP	~~34~~31) Other (specify):		
MRO: ~~35~~32) Name:		~~36~~33) Address:			
~~37~~34) City:	~~38~~35) State:	~~39~~36) Zip:	~~40~~37) Telephone no.: ( )		
~~41~~38) MRO certification no.:	~~42~~39) Other qualifying certification (please attach explanation describing how this meets the Rule 36 requirements for an MRO):				

(40)Summary Statistics

~~*Please provide the following information for the most recently completed calendar year.*~~*Please attach the most recent year-end summary report from your testing laboratory or a letter certifying that no tests were required to be performed and who (no hires, no accidents, etc.).*

	~~Job Applicant~~	~~Reasonable Suspicion~~	~~Post Accident~~	~~Follow-Up~~	~~Routine Fitness for Duty~~	~~Other (please specify)~~
~~43) Total no. of drug tests~~						
~~44) Total no. of alcohol tests~~						
~~***Summary of positive tests*** *(give the total number of confirmed verified positive tests for each drug and each type of test)*~~						
~~45) Marijuana~~						
~~46) Opiates~~						
~~47) PCP~~						
~~48) Amphetamines~~						
~~49) Cocaine~~						
~~50) Alcohol~~						
~~51) Other~~						
~~52) Total no. of verified positive tests (including alcohol tests)~~						

Employer Certification *(complete for all applications)*

I certify the above information is, to my best knowledge, true and accurate. I further certify that I understand submitting false information on this application may constitute workers' compensation fraud (Ark. Code Ann. §11-9-106). I certify that at each of the above mentioned locations a drug-free workplace program has been put in place which is in full compliance with the requirements of AWCC Rule 36.

(~~53~~41)_____ _____

Signature of Owner/Officer and Title — Date

(~~54~~42)_____ _____

Notary/Date and State of Commission — Date

The completed and notarized application should be sent to:

Voluntary Drug-Free Workplace Program
Health and Safety Division
Arkansas Workers' Compensation Commission
P.O. Box 950
Little Rock, AR 72203-0950

Final Draft - Rule 099.39

Last Revised - June 18, 2007 (3:15 pm)

AWCC Rule 099.39 **#099.39**

FILING REQUIREMENTS / REPORT CARDS / SANCTIONS

I. FORM FILING / PAYMENT REQUIREMENTS

A. Form Filing

1. General

a. Claims to be filed with the Commission shall include, but not be limited to:

(1) Claims involving more than seven (7) days of disability;
(2) Controverted medical only claims;
(3) Claims involving Commission assisted change of physician;
(4) 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 Rule and/or Advisory shall be filed or paid in the form and manner, and within the time prescribed by the Commission.

d. 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.

(1) Form 1 filings may be returned if determined by the Commission the claim involves medical only benefits, unless the Form1 is clearly marked to indicate anticipated indemnity benefits or pending controversion.

(2)

(a) 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. If the claim is controverted, the Form 2 shall clearly state the reason(s) the claim is not accepted as compensable. 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.

(3) 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

All applicable boxes/blanks are to be completed on all submitted Commission forms. Any form filed with the Commission with missing, incomplete, or inaccurate information or containing data that requires additional documentation may be "rejected" and shall be considered as not filed. Any carrier or self-insured having a form rejected by the Commission may be subject to sanctions. Upon determination of a form as "rejected", the Commission shall provide notice to the designated claim office of the determination and the specific reason(s) 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. 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. The date of such notice shall serve as the date on which the employer was notified for Report Card purposes, and shall 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. 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(s) made in the Form C filing. If a Form 2 has previously been filed, an amended Form 2 is only necessary if the position of acceptance or controversion has changed.

II. TIMELINESS STANDARDS / REPORTS

A. Timeliness Standards

1. 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. 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.

2. 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:

a. **Form 1** - (Workers' Compensation - First Report of Injury or Illness) - A minimum 70.00% of Form 1 filings required by Arkansas law, Commission Rule, or Commission Advisory shall be filed in a timely manner.

b. **Form 2** - (Employer's Intent to Accept or Controvert Claim) **-** A minimum 70.00% of Form 2 filings required by Arkansas law, Commission Rule, or Commission Advisory shall be filed in a timely manner.

c. **First Payment -** (First payment of compensation paid to the claimant) - A minimum 80.00% 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.

d. **Form 4 -** Zero claims appearing in the "Unresolved" section of the "AR-4 Monitoring Report".

B. Calculation of Timeliness -

For Report Card purposes only, timeliness shall be calculated from the latter of, the date of employer's receipt of notice or knowledge of injury, or the first date of disability or date indemnity triggered to the earliest receipt of an acceptable version of the specific form. First Payments shall be calculated to the date on which the first payment of compensation was issued to the claimant.

1. Date indemnity triggered applies only in those cases where disability is not continuous from the first day of disability to the eighth (8th) day of disability. In the event of intermittent disability, the eighth (8^{th}) day of disability shall be used as the date indemnity triggered and indicated on the Form 2.

2. 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.

3. Form submissions via Electronic Data Interchange (EDI)

a. Form transmissions via EDI that do not meet the Technical Edit and Mandatory Data requirements will be rejected and returned to the reporting entity.

b. 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.

c. 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.

Final Draft - Rule 099.39

Last Revised - June 18, 2007 (3:15 pm)

C. Reports

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. 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. Reports shall be issued with a frequency to coincide with any time frame established for such standard. Reports shall be furnished to the designated Administrator and designated claim office.

1. Report Card

The Commission shall issue to each carrier and self-insurer a "Report Card" indicating its performance as to the timely filing of Form 1, Form 2 and the timely making of the First Payment of compensation. The Report Card shall indicate the percentage of timely filings or payments for that quarter and also provide a year to date (calendar year basis) percentage. The Report Card will consist of two (2) parts; The Form 1 Report Card and the Form 2 Report Card (which will include First Payments).

a. The Form 1 Report Card shall list claims based on the receipt date of the Form 1.

b. The Form 2 Report Card shall list claims based on the "due date" of the Form 2. The due date of the First Payment will always be the same as the due date of the Form 2.

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). For the First Payment grade, claims involving controversion of benefits shall not be considered in grade determination.

2. Form AR-4 Monitoring Report

The Commission shall issue to each carrier and self-insurer a report indicating those claims for which a Form 4 has been rejected, and an acceptable Form 4 has not been received. This report will have two (2) sections; "Rejected AR-4's" and "Unresolved AR-4's"

(1) 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).

(2) 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). Any claim appearing in the "Unresolved" section will remain in unresolved status until an acceptable Form 4 (and supporting documentation) is received.

The Form AR-4 Monitoring Report shall be cumulative. Any claim listed shall continue to be listed until any deficiencies are corrected.

D. Correction Requests

1. Report Cards - For any claim listed on either the Form 1 or Form 2 Report Cards which reflects incorrect data, a "correction request" may be made. Correction requests may be made for only those claims listed in the quarter immediately preceding the issuance of the Report Card. Such correction request shall:

   (1) Be submitted to the Commission only by the designated claim office (even if other claim offices are utilized) or by the Administrator.
   (2) Be made in writing, including contact information for the writer;
   (3) Be received by the Commission within thirty (30) days of the issuance of the Report Card;
   (4) Identify the claim in question by AWCC file number, claimant's name, and date of injury.
   (5) State the specific nature of the correction to be made;
   (6) State why the correction should be made;
   (7) Include any necessary documentation to support why the correction should be made; the Commission may require a revised form.

   All correction requests are subject to approval or rejection by the Commission, on a case by case basis and for good cause. The Commission may allow corrections to prior quarters at its discretion.

2. Form AR-4 Monitoring Report

   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.

   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. Such request shall:

      (1) Identify the claim in question by AWCC file number and claimant's name;
      (2) Indicate the reason for review (specify corrections and/or documentation submitted);
      (3) Indicate the date on which the revised Form 4 and/or documentation was provided (including the method of submission).

   b. 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.

   The Commission file will be reviewed and the claim removed from the Form 4 Monitoring

Report if appropriate. If additional information is required, the Commission will provide notice specifying the corrections/documentation needed.

III. SANCTIONS

A. Report Cards

1. Imposition of Sanctions

If any two (2) consecutive quarterly Report Cards for any one 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.

2. 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.

B. Form AR-4 Monitoring Report

1. 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.

IV. Fines

Any fines assessed shall be assessed against the carrier or self-insurer. 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). All fines shall be payable to the Arkansas Workers' Compensation Commission.

A. Report Card Fines

1. 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. 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.

2. An invoice for each carrier and self-insurer assessed with a fine(s) will be generated in sufficient detail to document the fine assessments by claim file number, claimant name, form on which the fine is assessed, and amount. The invoice, a copy of the re-calculated 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 assessment of the fine(s) and the due date by which the assessed fine(s) are to be paid.

Form AR-A

Ark. Code Ann. § 11-9-102(9)(D), 11-9-402 Revised 6-18-2007

ARKANSAS WORKERS' COMPENSATION COMMISSION

324 Spring Street, Little Rock, AR 72201
Mail: P.O. Box 950, Little Rock, AR 72203-0950
501-682-3930/1-800-622-4472

A

Be sure to include: Application
Notarized Certificate
Check or Money Order for $50 made payable to Arkansas Workers' Compensation Commission

APPLICATION FOR CERTIFICATE OF NON-COVERAGE

Please note prior to completing this Application:

1. Arkansas law generally requires workers' compensation insurance for every employment:
   (a) ~~in the state~~ in which three (3) or more employees are ~~regularly~~ employed by the same employer;
   (b) in which two (2) or more employees are ~~employed by any person~~ engaged in building or building repair work;
   (c) in which one (1) or more employee~~s are~~ is employed by a contractor who subcontracts any part of his contract;
   (d) in which one (1) or more employee~~s are~~ is employed by a subcontractor.
2. In order to arrive at the above number, employee is defined to include, but is not limited to, an owner, a sole proprietor, a partner or partners who devote full-time to the partnership, a full-time employee, a part-time employee, and a volunteer.
3. ~~Exclusion of business arrangements or professions from the definition of "employee" under law does not affect the coveragerights coverage rights of employees of the persons listed below~~.
4 3. ~~It is a felony for prime contractors to compel sole proprietors or partnerships to pay or contribute to workers' compensation in surance insurance coverage~~.
   It is a felony for any employer or contractor to compel any employee or sub-subcontractor to pay for, or contribute to, workers' compensation insurance coverage.
5.4 ~~It is a felony for prime contractorsor contractors or employers to compel sole proprietors, partnerships or "employees" to obtain a Certificate of Non-Coverage when the sole proprietor, partnership or employee does not desire to do so.~~
   It is a felony for any employer or contractor to compel any employee or sub-contractor to obtain a Certificate of Non-Coverage.
6. ~~Sole proprietors or partners of a partnership who devote full time to the proprietorship or partnership are presumed to be "employees" for workers' compensation purposes. and subject to coverage for themselves UNLESS they obtain a Certificate of Non-Coverage.~~
7.5 Address below must be the applicant's OWN business or home address, NOT address of company to whom the applicant is contracting or for whom the applicant is doing a project.
6. Any questions or comments may be referred to your workers' compensation insurance agent or the Arkansas Workers' Compensation Commission.

~~Name of PARTY Applying~~ Applicant Information (please print~~, attach additional sheets if necessary~~):

(Printed Name)	Social Security No.	Signature	Date
	- -		
~~(Printed Name)~~	~~Social Security No.~~	~~Signature~~	~~Date~~
	- -		

Company Name (list ALL names under which you yourself conduct business): _____

_____

~~Address of YOUR Company or Home~~ Business Address: _____

_____

_____

1. ☐ Yes ☐ No Does the business employ others in addition to the parties listed above?
2. ~~☐ Yes ☐ No Have any partners determined they wish to remain under workers' compensation coverage?~~
~~3~~. ☐ Yes ☐ No Is the company or companies incorporated?
~~4.~~ 3. If you or any of your employees are ~~co vered~~ covered under a workers' compensation policy, please list:

Insurance Company: _____ Policy No.: _____

If answers to any questions above are "yes," provide the application to your insurance agent for further processing during the writing of your workers' compensation insurance policy. The agent is to provide the following information, then forward the Application to the Arkansas Workers' Compensation Commission at the address below:

Agent's Name _____

Agent's Address _____

(City) _____ (State) _____ (Zip Code) _____

Agent's Signature _____

If answers to ALL questions above are "no", submit Form A to the Coverage/Compliance Section, Arkansas Workers' Compensation, P.O. Box 950, Little Rock, Arkansas 72203-0950 or deliver to 324 Spring St., Little Rock, Arkansas 72201. Your Application will be processed and action communicated back to you within ten (10) working days.

SEE IMPORTANT INFORMATION ON OTHER SIDE

AWCC Form A
(Application for Certificate of Non-Coverage)

Form A is not used for exclusion from a workers' compensation policy by corporations or corporate officers, sole proprietors, partners of a partnership, members of a limited liability company, members of a professional association, or a self-employed employer who is not a subcontractor and who owns and operates his or her own business. Exclusions ~~of corporate officers~~ from coverage is handled directly by the agent/carrier.

If the answer is yes to Question 1 on **Form A**, the application for non-coverage will be rejected unless:

~~1. The Arkansas Workers' Compensation Commission has From I (insurance coverage card) for the employment from a carrier;~~

~~2.~~ 1. The agent furnishes a copy of the declarations page or the National Council on Compensation Insurance application for proof of workers'compensation coverage; or

3. The applicant has furnished proof that coverage is not required.

~~**Questions about a specific Form 2 may be answered by the AWCC Office Services Division, which processes this form. General information may be obtained from the AWCC Support Services Division. (1-800-622-4472 or 501-682-2607)**~~

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willingly and knowingly employs any device, scheme, or artifice for the purpose of : obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under ... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

(Revised 6-18-2007)

Form O Eff 1/01/2008	ARKANSAS WORKERS' COMPENSATION COMMISSION	O
Rule 099.29	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-2783 / 1-800-622-4472	

CLAIM OFFICE / ADMINISTRATOR / UNDERWRITER
Designation Form

Commission Rule 099.29 requires the designation of certain contacts to facilitate compliance with Arkansas law, Commission Rules and the processing of claims. The designations below are to be made only by insurance carriers or self-insured employers. This form is not to be completed by third party administrators, insurance agents or brokers.

Insurance Carriers - Please complete the following	
NAIC Company Number	NAIC Group Number

This form is being filed for:

☐ An Insurance Carrier

☐ A Self-Insured Employer or Group

Company Name (full legal) _____ **FEIN** _____

Claim Office: This is to be the office responsible for all Arkansas workers' compensation claims.

Claims are: ☐ Self-Administered (i.e. handled in-house or by a company within the above company's corporate family)

☐ Handled by a Third Party Administrator (TPA). The TPA must be approved and authorized by the Commission.

Claim Office Company Name _____

Mailing Address _____

Complete the remainder of this section only if claims are self-administered.

Claims/Office Manager Name _____ E-Mail _____

Direct Phone _____ Fax _____ Toll Free _____

Administrator: This person is to be an employee of the carrier or self-insured employer who is responsible for all Arkansas workers' compensation issues. This person may be an employee of the carrier/self-insured company's parent company if desired.

Admin. Company Name _____

Mailing Address _____

Admin. Name _____ E-Mail _____

Direct Phone _____ Fax _____ Toll Free _____

Underwriting: (carriers only) This is the carrier contact person for employer coverage or questions.

Underwriter's Company Name _____

Mailing Address _____

Underwriter Name _____ E-Mail _____

Direct Phone _____ Fax _____ Toll Free _____

I, _____ (printed name), as an employee of the above carrier/self-insured employer (or it's parent company) make the above designations in compliance with Commission Rule 099.29. Further, we agree to promptly notify the Commission of any changes to the above designations by re-completing and submitting this form.

Phone _____

Signature _____ Title _____ Date _____