ARKANSAS REGISTER

Transmittal Sheet

Sharon Priest
Secretary of State
State Capitol Rm. 01
Little Rock, Arkansas 72201-1094

For Office Use Only: Effective Date 9/14/98 Code Number 099.00.98--001

Name of Agency Workers' Compensation Commission

Department Support Services

Contact Person Richard Lucy Phone 682-3930

Statutory Authority for Promulgating Rules Ark. Code Ann. § 11-9-106(b)

		Date
Intended Effective Date	Legal Notice Published	N. A.
☐ Emergency	Final Date for Public Comment	N. A.
☐ 10 Days After Filing	Filed With Legislative Council	
☑ Other	Reviewed by Legislative Council	
8-1-1998	Adopted by State Agency	

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

Julie Benafield Brannan
Signature

682-3930
Phone Number

Chief Executive Officer
Title

9-9-1998
Date

FILED
AR. REGISTER DIV.
98 SEP 14 AM 10:14
SECRETARY OF STATE
STATE OF ARKANSAS

FORT SMITH DIVISION
616 GARRISON - ROOM 207
FORT SMITH, AR 72901
TELEPHONE 501-783-7970
TOLL FREE 1-800-354-2711

SPRINGDALE DIVISION
244 SOUTH 40th
SPRINGDALE, AR 72762-3845
TELEPHONE 501-751-2790
TOLL FREE 1-800-852-5376

State of Arkansas
WORKERS' COMPENSATION COMMISSION

4th & Spring Streets
P.O. Box 950
Little Rock, Arkansas 72203-0950
Telephone 501-682-3930 / 1-800-622-4472
Arkansas Relay System TDD 1-800-285-1131

August 19, 1998

Tonya Springer
Secretary of State Office
Room 01 Capitol Building
State Capitol Grounds
Little Rock, Ar 72201

Dear Ms. Springer:

To comply with the portions of the Administrative Procedure Act that affect the Workers' Compensation Commission, enclosed are two copies each of:

--Revised Forms 2, 4, C and N;
--Transmittal Sheet;
--Financial Impact Statement for this regulation.

If there are any questions, please contact me at once.

Sincerely,

Richard Lucy

Richard Lucy, Information Officer

DEPARTMENT Arkansas Workers' Compensation Commission
DIVISION Administrative
PERSON COMPLETING THIS STATEMENT Stephen Williams, Fiscal Officer
TELEPHONE NUMBER: 501-682-3930 FAX NUMBER: 501-682-1791

FINANCIAL IMPACT STATEMENT

To comply with Act 884 of 1995, please complete the following Financial Impact Statement and file with the questionnaire and proposed rules.

SHORT TITLE OF THESE FORMS C (Claim), N (Notice), 2 (Intent), 4 (Closure)

1. **Does this proposed, amended, or repealed rule or regulation have a financial impact?** Yes x No ___

2. **If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.** Costs will be minimal. They are small for this Commission, and costs to the public should be comparable. In addition, companies affected are being allowed to use existing supplies, so objections to converting the new versions of the forms should be almost nil.

3. **If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.** Not applicable.

1998-99 Fiscal Year		1999-2000 Fiscal Year	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other		Other	

4. **What is the total estimated cost by Fiscal Year to any party subject to the proposed, amended, or repealed rule or regulation?**

1998-99 Fiscal Year	1999-2000 Fiscal Year
$80; $10 per side for 4 2-sided forms; this is cost to prepare Master Copies; in addition, existing supplies can be used	$0 except for printing new supplies as needed

5. **What is the total estimated cost by Fiscal Year to the agency to implement this regulation?**

1998-99 Fiscal Year	1999-2000 Fiscal Year
$80 to prepare new Master Copies, then usual budgeted costs of paper, printing and distribution, but no new costs	Ongoing reprint costs for supplies as needed as in former years

July 28, 1995

FORT SMITH DIVISION
616 GARRISON - ROOM 207
FORT SMITH, AR 72901
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August 1, 1998

**TO: Workers' Compensation Insurance Carriers,
Self-Insured Employers,
Third-Party Administrators**

RE: WCC Forms C, N, 2, and 4

To comply with Arkansas Code Annotated § 11-9-106(b), additional language is required "on all forms prescribed by the commission for ...employees claiming benefits and for...employers responding to such...claims..."

The required language is found in ACA § 11-9-106(a)(1). It has been added to **Form C** (Claim for Compensation), **Form N** (Notice to Employer/Notice to Employee), **Form 2** (Employer's Intent) and **Form 4** (Closing Report).

Included here are samples of all four forms. Be sure this notice is distributed to all who need to be aware of the statute-mandated language.

You may continue to use you existing supplies of these forms if the correct language is added to them with a gummed label or other device that accurately reflects the law for fraud in workers' compensation matters.

Arrange with a printer of your choice to have the updated language added to future supplies of these forms.

If you have questions, contact the Workers' Compensation Commission Legal Advisor Division or the WCC Support Services Division.

Form AR-C
Authority: 11-9-205, 702
Revised 8/1/1998

ARKANSAS WORKERS' COMPENSATION COMMISSION
4th & Spring Streets, P.O. Box 950
Little Rock, Arkansas 72203-0950
CLAIM FOR COMPENSATION
1-800-622-4472 (Little Rock Office)
1-800-852-5376 (Springdale Office)
1-800-354-2711 (Fort Smith Office)

A.C.A. 11-9-106(a)(1): Any person or entity who willfully and knowingly makes any material false statement or representation, or who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme or artifice, for the purpose of obtaining any benefit or payment, or for the purpose of 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 subdivision or subdivision a(2) of 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.

EMPLOYEE INFORMATION (Please Print in Ink)

					❑501 ❑870 – –
Employee's Last Name	First Name	Middle Initial	Social Security Number	Date of Birth	Home Phone No.
Street Address or P.O. Box	City			State	Zip Code

EMPLOYER INFORMATION (Please Print)

			❑501 ❑870 – –
Employer's Name (given name under which doing business)			Employer's Telephone No.
Employer s Street Address/P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

Employer s Workers' Compensation Insurance Carrier (if known)	Place of Accident (City, State)	Date of Accident

Briefly describe the cause of injury and the part of body injured: _____

CLAIM INFORMATION (Please Print)

If this claim is for **initial** benefits (no benefits, either medical or indemnity, have been received), what compensation benefits are you claiming?

_____ Temporary Total Disability _____ Permanent Partial Disability _____ Permanent Total Disability _____ Rehabilitation
_____ Attorney Fees _____ Medical Expenses _____ Other (Explain):

If this claim is for **additional** benefits, what specific benefits are you claiming?

_____ Additional Temporary Total _____ Additional Permanent Partial _____ Additional Medical Expenses
_____ Rehabilitation _____ Attorney Fees _____ Other (Explain):

If employee is deceased and claim is for death benefits, list name and address of all persons claiming death benefits:

_____

List any person or entity (with address and phone number) which has paid any benefits under a group health, disability or loss of income policy for the injury you are reporting on this form: _____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, including but not limited to copies of medical records, concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician and psychotherapist patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original.

Date _____ Signature _____

If claimant is represented by an attorney, that legal representative must sign below pursuant to Ark. Code Ann. 11-9-717.

_____ _____

Name and Address of Attorney Signature

WCC Form C
(Claim for Compensation)

Arkansas Code Annotated 11-9-702 allows employees or their dependents to file claims for compensation and sets time limits for those filings.

This is the WCC's prescribed form for this action. It is filed directly with the WCC, usually by claimants or their attorneys.

Care must be taken on **Form C:**

1. Type or print in ink. Do not use pencil.

2. Information must be complete.

3. Employer's business name is needed, not the name of the foreman or supervisor.

4. Date of injury is essential. If specific date is unavailable, as in the case of diseases, list date employee knew of the condition.

5. Address of employer must be exact to avoid the WCC's contacting a wrong employer with the same or similar name.

6. Employee's signature at bottom is important. It is the only part of **Form C** that is to be written.

Questions on a specific **Form C** go to the Legal Advisor Division. General information is available from the Support Services Division.

ARKANSAS WORKERS' COMPENSATION COMMISSION
WCC FORM N

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	Middle Initial	Social Security Number	Home Phone No.	
Street Address or P.O. Box		City		State	Zip Code

EMPLOYER INFORMATION (Please Print)

Employer's Name	Supervisor's Name		
Employer's Street Address or P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

Place of Accident	Date of Accident	Time of Accident	Date /Time Employer Notified of Accident

What part of your body was injured?_____

_____

_____

_____

Briefly discuss the cause of injury:_____

_____

_____

WITNESS

Name and address of witness(es), if any:_____

_____

_____

_____

_____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, including but not limited to copies of medical records, concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician and psychotherapist patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change of physician.

Date_____ Signature_____(See additional information on reverse side of form).

Help with WCC Form N is available from the WCC Legal Advisor Division (1-800-622-4472). Information is supplied by the Support Services Division.

Form AR-N
A.C.A. §§ 11-9-701, 508,514,106
Revised 8\1\1998

ARKANSAS WORKERS' COMPENSATION COMMISSION
WCC FORM N
EMPLOYEE'S NOTICE OF INJURY

NOTICE OF INJURY, NOTICE TO EMPLOYEE

A.C.A. § 11-9-701. Notice of injury or death.

(a)(1) Unless an injury either renders the employee physically or mentally unable to do so, or is made known to the employer immediately after it occurs, the employee shall report the injury to the employer on a form prescribed or approved by the Workers' Compensation Commission and to a person or at a place specified by the employer, and the employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's report of injury.

(2) All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements.

(3) The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

(b)(1) Failure to give the notice shall not bar any claim:

(A) If the employer had knowledge of the injury or death;

(B) If the employee had no knowledge that the condition or disease arose out of and in the course of the employment; or

(C) If the commission excuses the failure on the grounds that for some satisfactory reason the notice could not be given.

(2) Objection to failure to give notice must be made at or before the first hearing on the claim.

CHOICE\CHANGE OF PHYSICIAN

A.C.A. § 11-9-508. Medical services and supplies.

(e) . . . 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.

A.C.A. § 11-9-514. Change of physician.

EXCEPT FOR EMERGENCY TREATMENT, if your employer or its insurance company has contracted with a certified Managed Care Organization (MCO) or is certified as an Internal Managed Care System (IMCS) you must follow these rules:

1. Your employer has the right to select your initial primary care physician. The employer may select the initial primary care physician from among those associated with certified managed care entities.
2. You may request a change of physician. You should initially request a change of physician from the insurance carrier, employer, or self-insured employer. Within five business days of your initial request for a change of physician, the insurance carrier, employer, or self-insured employer should notify you of its decision to grant or deny the change of physician.
3. You may petition the Commission one (1) time only for a change of physician who must also either be associated with a certified MCO or IMCS or who is your regular treating physician. (Your "Regular Treating Physician" is one who maintains your medical records and with whom you have a history of regular treatment before the onset of your compensable injury.) The health care provider to whom you change must agree to refer you to a certified managed care entity for any specialized treatment, including physical therapy, and to comply with all the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by your employer.
4. **Treatment or services by any physician other than ones selected according to the foregoing, except emergency treatment, shall be at the employee's expense.**

If the employer or insurance carrier is **NOT** in an MCO or IMCS arrangement, change-of-physician laws are different. **Except for emergency treatment, after you receive this Notice, any unauthorized medical expense incurred shall not be the responsibility of your employer unless you have followed these rules:**

1. If your employer chooses the Initial Treating Physician, you have the right to ask, one time only, the WCC to approve a change. If the WCC approves a change, the WCC shall determine the second physician and not be bound by recommendations of you, the employer, or the insurance company.
2. However, if the desired change is to a chiropractic physician, optometrist, or podiatrist, you may make the change after giving written advance notification to your employer or the employer's insurance company.
3. If you selected the first physician, the WCC will not approve a change unless there is a compelling reason or circumstance justifying the change.

A.C.A. § 11-9-106(a)(1). Penalties for misrepresentation. Any person or entity who willfully and knowingly makes any material false statement or representation, or who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme or artifice, for the purpose of obtaining any benefit or payment or for the purpose of 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 subdivision or subdivision a(2) of 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.

Form AR-2
Authority: ACA 11-9-803
and ACA 11-9-810
Revised 8/1/1998

ARKANSAS WORKERS' COMPENSATION COMMISSION
4th & Spring Streets, P.O. Box 950
Little Rock, Arkansas 72203-0950
EMPLOYER'S REPORT OF INITIAL PAYMENT OF COMPENSATION OR INTENTION TO CONTROVERT

☐ **Initial Filing**

☐ **Amended Filing**

A.C.A. 11-9-106(a)(1): Any person or entity who willfully and knowingly makes any material false statement or representation, or who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme or artifice, for the purpose of obtaining any benefit or payment, or for the purpose of 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 subdivision or subdivision a(2) of 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.

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number

Employer Name	Fed. Employer I.D. No.	City	State	Zip Code

Carrier Or Self-Insured Name	NAIC or Self-Insured Fed. Employer I.D. No.	Claims Office Location (City, State)

COMPENSATION (if not applicable, skip to next section)

Date of Injury	City, State of Injury	Dates Covered by First Check	Body Part Injured	First Date Indemnity Triggered (Disability Date)

Date of First Comp. Check	Average Weekly Wage	Weekly Comp. Rate	Check condition applicable:
			___ Medical Only Claim (no indemnity due) ___ PPD Only Case

CONTROVERSION SECTION

DATE OF INJURY OR DEATH: _____
REASON FOR CONTROVERTING CLAIM: _____
_____

DEATH CASE DATA

List all Dependents below: If no Dependents, check here:_____

Attach Death Certificate and Birth Certificates for Dependent Children

NAME OF DEPENDENT	DATE OF BIRTH	RELATIONSHIP TO DECEASED	WEEKLY BENEFIT AMOUNT

(If more space is needed, attach supplemental sheet)

CERTIFICATION

I certify that the foregoing is a complete and accurate report according to the records of the insurer pertaining to first payment, controversion and beneficiary information. I further certify that a copy of this report or equivalent information has been provided to the employee or his beneficiaries.

Signature	Printed or Typewritten Name	Title	Date

If insurer is represented by an attorney, that legal representative must sign below pursuant to Ark. Code Ann. 11-9-717.

Name and Address of Attorney	Signature

WCC Form 2
(Employer's Intent)

A form to accept a case and report payment or to controvert. **WCC Form 2** also is used to amend positions taken earlier.

Help With WCC Form 2:

1. The first payment to the employee is due by the 15th day after the employer knows of the injury or death **(Arkansas Code Annotated 11-9-802).**

2. The WCC is notified "upon making the first payment" **(ACA 11-9-810).**

3. A controversion notice is due on or before the 15th day following notice of the death or alleged injury **(ACA 11-9-803).**

4. Therefore, **WCC Form 2** is required in all cases by the 15th day from (a) the day of disability or (b) the day the employer is aware of the alleged incident, whichever date is later.

Be sure to include on **WCC Form 2:**

5. A mark in either the Initial Filing Box or Amended Filing Box.

6. The WCC File Number (obtained from **WCC Form A-110)** and your company's file number for this case.

Be sure to bear in mind:

7. Form 2 is NOT interchangeable with the required written response to the 15-day letter for **Form C.**

8. If respondents need additional time for investigation, an extension request must be sent in before the **Form 2** deadline. Using **Form 2** to say the respondent is investigating or needs more time is invalid. If anything is written in the Controversion Section ("We are investigating"), the WCC will consider the case controverted.

9. If a case is opened at the WCC on **Form 1** or **Form C,** a WCC **Form 2** is required, even if the case, upon investigation, turns out to be a medical-only claim.

Questions about a specific **Form 2** can be answered by the WCC Office Services Support Staff, which processes this form. General information can be obtained from the WCC Support Services Division.

Form AR-4
Authority: ACA 11-9-810
Revised 8/1/1998

ARKANSAS WORKERS' COMPENSATION COMMISSION
4th & Spring Streets, P.O. Box 950
Little Rock, Arkansas 72203-0950
REPORT OF COMPENSATION PAID/SUSPENSION OF PAYMENTS

☐ **Update Report**
☐ **Report of Payment Suspension**
☐ **Closing Report**

A.C.A. 11-9-106(a)(1): Any person or entity who willfully and knowingly makes any material false statement or representation, or who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme or artifice, for the purpose of obtaining any benefit or payment, or for the purpose of 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 subdivision or subdivision a(2) of 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.

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number

Employer Name	Fed. Employer I.D. No.	City	State	Zip Code

Carrier Or Self-Insured Name	NAIC or Self-Insured Fed. Employer I.D. No.	Claims Office Address

DISABILITY INFORMATION: Check here if this report is for Medical Only Case and skip to Compensation Section: _____

Date of Injury	Last Day Employee Worked	Date Employee Able to RTW	Return to Work Date

Did Employee work between date of injury and last day of disability? _____ If so, give dates below:

COMPENSATION INFORMATION:

COMPENSATION PAYMENTS MADE:

(1) TTD Weeks _____ Days _____ $_____
(2) TPD Weeks _____ Days _____ _____
(3) PPD Weeks _____ Days _____ _____
(4) Weeks PTD _____ _____
(5) Weeks for Death _____ _____
(6) Lump Sum Settlement _____
(7) Joint Petition _____
(8) Claimant Attorney Fees _____

(9) Defense Attorney Fees $_____
(10) Other (Compensation Related) _____
(11) Hospital Expenses _____
(12) Medical Expenses _____
(13) Drugs, Medicine _____
(14) Funeral Expenses _____
(15) Rehabilitation _____
(16) Other (Expense Related) _____
(1-16) GRAND TOTAL _____

SUSPENSION OF PAYMENTS OF COMPENSATION

Date of Suspension of Compensation: _____/_____/_____ Reason for Suspension:
Compensation paid through _____/_____/_____ (date).

CERTIFICATION

I certify that the foregoing is a complete and accurate report according to the records of the insurer pertaining to payments of compensation and suspensions of payment information. I further certify that a copy of this report or equivalent information has been provided to the employee or his beneficiaries.

Signature	Printed or Typewritten Name	Title	Date

Form 4
(End of Payment)

A Final Report is due within 30 days of the last compensation payment **(Arkansas Code Annotated 11-9-810[b][1]).**

Every **Form 4** must have the WCC File Number. Those without the number will be returned to respondents. Also, respondents must list the Carrier NAIC and the Federal Employer Identification numbers.

Form 4 is for all end-of-payment reports, i.e.:

1. The suspension of benefits; reason for suspension must be given.

2. The closing of a medical-only case that was accidentally opened by the respondent on **Form 1** or by a claimant on **Form C.** A check mark on the medical-only line right before the **Disability Section** is necessary.

3. The Final Report of a compensable case, detailing all payments. **Forms 1, 2,** and **3** are required for these cases.

4. Maximum liability being reached in cases involving death or permanent and total disability (both the Payments Section and the Suspension of Benefits Section are to be completed).

Information on **Form 4** can be supplied by the Support Services Division. For a specific case, refer to the Office Services Support Staff, which processes **Form 4** and closes the case.