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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.

The Medical Cost Containment Division may refer a person or party to an Administrative Law Judge to conduct a contempt proceeding pursuant to Ark. Code Ann. § 11-9-706 for failure to provide documentation 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.

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 award, 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/REVOCAION

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.

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 replaced 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 October 5, 2007, effective January 1, 2008.)

