Rules of
Department of Labor and Industrial Relations
Division 50—Workers' Compensation
Chapter 2—Procedure

Title 8—DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
Division 50—Workers' Compensation
Chapter 2—Procedure

8 CSR 50-2.010 Procedures for Non-contested and Contested Workers' Compensation Cases

PURPOSE: This rule sets forth the procedures relating to workers' compensation injuries in noncontested and contested cases.

(1) Any injury which requires medical aid, other than immediate first aid with no lost time from the employment, shall be fully reported to the division, by the insurer or third-party administrator, as a Report of Injury (in accordance with section 287.380.1, RSMo). The employer, if self-administered and self-insured, shall submit the Report of Injury. The Report of Injury may also be filed electronically with the approval of the division.

(A) Employers shall report injuries, other than immediate first aid with no lost time from the employment, to their insurance carrier, or third-party administrator, if applicable, within five (5) days of the date of the injury or within five (5) days of the date on which the injury was reported to the employer by the employee, whichever is later.

(B) Where the division has not received a Report of Injury and receives other notice of a work-related injury, the case may be referred for a dispute management meeting under section (4) of this rule. When a Claim for Compensation is filed, a party may not request a dispute management meeting.

(2) A report of medical costs and temporary benefits paid pursuant to sections 287.170 and 287.180, RSMo, shall be filed within thirty (30) days of the date of original notification of the injury. If medical treatment or temporary benefits will continue past thirty (30) days, a status report including estimated dates of completion of medical treatment and temporary benefits, shall be provided to the division at that time. A final report shall be filed on conclusion or termination of medical treatment and temporary benefits. A final medical report shall be filed with the final report.

(3) The employer/insurer shall notify the employee of the termination of benefits pursuant to section 287.203, RSMo, within ten (10) days of when such benefits were due, and shall provide the division with a copy of the notice.

(4) Any party may request a dispute management meeting with a mediator on issues of medical or temporary benefits. Any such meeting is voluntary and will be conducted according to section 435.104, RSMo 1994. Any agreement regarding medical or temporary benefits shall be reduced to writing and signed by the parties. Any such agreement is to memorialize the understanding of the parties and is not binding as settlement of the benefits or rights of the employee. Venue for a dispute management meeting shall be in Jefferson City, or as may be determined by the division. When a Claim for Compensation is filed, a party may not request a dispute management meeting.

(5) Unless the parties otherwise agree, all hearings shall be held in the county, or in a city not part of any county, where the accident occurred, or in any county, or such city adjacent thereto, or if the accident occurred outside of the state, then the hearing shall be held in the county or city where the contract of employment was made.

(6) Any party, subject to the written procedures of the local adjudication office, may request a conference in any case filed with the division pursuant to section (1) of this rule. The division may also set a case for a conference. The parties shall be notified of the time and place of the setting at least ten (10) days prior to the setting.

(7) The employee or the employee's dependents may file a Claim for Compensation. In order that the place of setting may be determined, the county in which the accident occurred must be stated on the claim, and if the injury occurred outside of the state of Missouri, the name of the county in which the contract of employment was made must be stated. The claim shall be filed with sufficient copies for the division and each employer and insurer named, and the attorney general in case of a Second Injury Fund claim. The claim must be filed within the time prescribed by sections 287.430 or 287.440, RSMo, for accidental injuries, or section 287.063.3, RSMo, for occupational disease. A claim against the Second Injury Fund must be asserted affirmatively by the claimant and cannot be made by any other party to the claim, on motion or otherwise. Naming the state treasurer as a party is not, in itself, sufficient to make a claim against the fund. Injuries which are claimed to create fund liability must be specifically set forth in the Claim for Compensation.

(A) The filing of a claim initiates a contested case.

(B) A claim against an employer/insurer and the Second Injury Fund are against two (2) separate parties and the assertion of a claim against one is not an assertion of a claim against the other.

(8) Upon receipt of a Claim for Compensation, the division shall forward a copy of the claim to the employer and its insurer, or third-party administrator, if applicable, or Second Injury Fund, if applicable, and within thirty (30) days from the date of the division's acknowledgment of the claim, the employer or its insurer, or third-party administrator, if applicable, or the Second Injury Fund, if applicable, shall file an Answer to Claim for Compensation, with sufficient copies for the division, the claimant(s) and each of his/her attorneys.

(A) Extensions of time to file an Answer to Claim for Compensation will be granted only upon a showing of good cause. Applications for an extension of time to answer the claim shall be made to the chief administrative law judge of the local office with venue of the case.

(B) Unless the Answer to Claim for Compensation is filed within thirty (30) days from the date the division acknowledges receipt of the claim or any extension previously granted, the statements of fact in the Claim for Compensation shall be deemed admitted for any further proceedings.

(9) When an Answer to Claim for Compensation has been filed, or the time to answer, including any extensions, has run, any party may request a setting according to the written procedures of the local adjudication office. The division may also set a contested case for a prehearing. At the prehearing conference, a contested case may be reset for a prehearing conference, or set for a mediation or a hearing according to the written procedures of the local adjudication office.

(A) The local adjudication offices may, by written local procedures, require a mediation setting before a hearing will be set in a contested case. This mediation shall not be construed as the dispute management meeting held pursuant to section (4) of this rule.

(B) Any mediation in a contested case shall be conducted according to 8 CSR 50-2.050.

(C) The parties shall be notified of the date, time and place of any setting at least ten (10) days prior to the setting.

(D) Attendance at any setting is mandatory. Continuance of a case may be allowed for a prehearing conference at the discretion of the administrative law judge or legal advisor. A continuance from a mediation or hearing setting, or a dismissal docket, if established by written procedures for a local adjudication office, shall be allowed only for good cause shown.

(10) When any party estimates that the hearing of a case will last longer than four (4) hours, the division shall be notified prior to setting the case for hearing and given an estimate of the length of time that will be required for the hearing. The division shall schedule the hearing according to written procedures of local adjudicative offices.

(11) All parties shall be prepared to introduce all relevant evidence when the case is heard. Continuances to file additional evidence will only be granted for good cause shown, when the administrative law judge who conducted the hearing decides that the additional evidence is necessary for a full and complete hearing.

(12) A Claim for Compensation may be dismissed or a default award issued, upon proper notice by the division.

(A) A Claim for Compensation may be voluntarily dismissed with or without prejudice at any time prior to the introduction of evidence at a hearing. The claim for compensation may be refiled by claimant so long as the statute of limitations has not run.

(B) A default award may be entered against an employer/insurer, upon proper notice, for failure to appear or defend the claim.

(C) Notice to the party or parties shall be sent by certified mail according to the provisions of Chapter 287, RSMo. Notice of hearing or dismissal to a party's attorney, at the attorney's last known address, which shall be sent by ordinary mail and need not be certified, shall meet the requirement of this section. All other notices, unless required by this rule or determined by the division, shall be sent by ordinary mail. The records of the division shall constitute *prima facie* evidence of the date of mailing of any notice, determination, award or other paper mailed pursuant to Chapter 287, RSMo.

(13) A party may request that a case be set for hearing on the grounds of undue hardship or pursuant to section 287.203, RSMo. The party making the request shall file a written copy of the request with the division and mail copies to all parties to the contested case. If the request for a hardship hearing is granted, it shall be set according to the written procedures of the local adjudication office which has venue over the contested case. The division will not set a hearing under this section unless a request is filed by a party.

(14) Hearings before the division shall be simple, informal proceedings. The rules of evidence for civil cases in the state of Missouri shall apply. Prior to hearing, the parties shall stipulate uncontested facts and present evidence only on contested issues.

(A) The administrative law judge shall have the power to exclude witnesses from the hearing room or close a hearing in the interest of a fair and impartial hearing.

(B) When the final award is rendered by the administrative law judge, the division will retain all exhibits offered or placed in evidence for three (3) months, except as required for review of the decision pursuant to section (16) of this rule. The parties shall be notified at the time of the award. After that time, or three (3) months after final review, exhibits not claimed by the parties and that are otherwise preserved by the division will be destroyed. This provision shall not apply to cases in which permanent total, future medical, or dependent death benefits are awarded.

(C) On the request of any party and on order of the administrative law judge, a brief may be submitted, which must be filed within the time set by the administrative law judge, which in no event shall be later than thirty (30) days after the submission of the case. The parties shall have equal time to prepare briefs, unless otherwise agreed by the judge and the parties.

(D) Within sixty (60) days after the submission of the case or the filing of briefs, whichever is later, the administrative law judge shall issue the award, together with a statement of findings of fact, but in no event longer than ninety (90) days from the last date of the hearing rulings of law and any other matters pertinent to the questions at issue. Signed copies of the award shall be sent to all parties by certified mail.

(15) If the services of an attorney are found to be necessary in proceedings for compensation, the administrative law judge shall set a reasonable fee considering relevant factors which may include, but are not limited to, the nature, character and amount of services rendered, the amount in dispute, and the complexity of the case and may allow a lien on the compensation due to the claimant.

(16) A request for review of an award must be postmarked within twenty (20) days of the date of the award. The form of application for review and filing for review and practice before the Labor and Industrial Relations Commission is governed by the provisions of 8 CSR 20-3.030.

(17) When request for a lump sum payment is made on behalf of a minor, commutation of compensation will not be ordered until there is filed with the division a certified copy of the order of the probate division of the circuit court for the county where the dependent resides, naming a legal guardian or conservator of the minor dependent, unless payment can be made to the parent or other person as natural guardian or conservator of the dependent.

(18) Statutory prerequisites for approval of a compromise settlement are set forth in sections 287.390 and 287.616, RSMo.

(A) The compromise settlement agreement shall set forth the workers' compensation issues compromised, the total amount of medical costs incurred and previously paid, the total amount of medical costs paid under the agreement, the total amount of temporary benefits previously paid, the total amount of temporary benefits paid under the agreement, the total amount of any permanency benefits previously paid, the total amount of permanency benefits paid under the agreement, the total amount of all benefits paid under the agreement, the total amount or the percentage of the employee's attorney's fees and expenses, and the total compensation paid in the case. A provision which prorates the amount of settlement over the life expectancy of the injured employee may be included.

(B) Before a compromise settlement will be approved, the employee must appear before the division and be advised of his or her rights under Chapter 287, RSMo, except as provided in subsection (D) of this section.

(C) A compromise settlement will be approved pursuant to sections 287.390 and 287.616, RSMo, unless in the opinion of the administrative law judge or legal advisor the settlement is not in accordance with the rights of the parties.

(D) If the employee does not live in the state of Missouri, has been inducted into the

armed forces of the United States, has previously appeared before the division and been advised of his or her rights under Chapter 287, RSMo, is represented by an attorney, or shows other extenuating circumstances, the compromise settlement may be submitted without the appearance of the employee or dependent. Upon agreement of the parties, the conference may be held by telephone. A representative of the employer/insurer is responsible for scheduling a telephone conference subject to the availability of an administrative law judge or legal advisor. Where the employee is not represented by counsel and does not appear at the time of approval of settlement, his or her signature shall be acknowledged by a notary public. Any compromise settlement submitted pursuant to this subsection shall be approved according to the provision of this section of the rule and sections 287.390 and 287.616, RSMo.

(E) The employer/insurer shall submit any required forms that have not previously been submitted with the compromise settlement before the close of the case.

(19) As the basis for arriving at the amount of compensation due for loss of teeth and resultant disfigurement provided for in section 287.190, RSMo, 8 CSR 50-5.010 Compensation for Loss of Teeth shall be used.

(20) As the basis for arriving at the amount of compensation due for visual loss provided for in section 287.190, RSMo, 8 CSR 50-5.020 Evaluation of Visual Disabilities shall be used.

(21) As the basis for arriving at the amount of compensation due for hearing impairment provided for in sections 287.190 and 287.197, RSMo, 8 CSR 50-5.060 Evaluation of Hearing Loss shall be used.

(22) As the basis for arriving at commutation amounts authorized by section 287.530.1, RSMo, 8 CSR 50-5.030 Present Worth Table shall be used for permanent partial and death benefits payable to those employees or dependents, except where death benefits are payable only to the surviving spouse.

(23) As the basis for arriving at commutation amounts authorized by section 287.530.1, 8 CSR 50-5.030 Present Value Table for Widows, which contains remarriage and widow-death experience factors, shall be used in cases of death benefits payable only to the surviving spouse.

AUTHORITY: section 287.650, RSMo Supp. 1997. Original rule filed Dec. 23, 1953, effective Jan. 3, 1954. Amended: Filed Jan. 15, 1960, effective Jan. 26, 1960. Amended: Filed Sept. 4, 1963, effective Sept. 15, 1963. Amended: Filed Aug. 26, 1975, effective Sept. 5, 1975. Amended: Filed Jan. 26, 1977, effective June 11, 1977. Amended: Filed Dec. 14, 1977, effective April 13, 1978. Emergency amendment filed Jan. 16, 1996, effective Jan. 26, 1996, expired July 23, 1996. Amended: Filed Feb. 15, 1996, effective Aug. 30, 1996. Rescinded and readopted: Filed May 29, 1998, effective Feb. 28, 1999.*

**Original authority 1939, amended 1949, 1961, 1980, 1993, 1995.*

***State ex rel River Cement Co. v. Pepple** 585 SW2d 122 (Mo. App. 1979). In workers' compensation case, the right to inspect inheres in the powers authorized by section 287.560, RSMo, since without this right claimant's ability to prove his/her case would be greatly diminished.*

***Hendricks v. Motor Freight Corp**. 570 SW2d 702 (Mo. App. 1978). Injured truck driver filed a claim for compensation incorrectly giving the date of accident as June 12, 1972. Since appellant's employer and insurer failed to file an answer to the claim in the time permitted under 8 CSR 50-2.010(13), the fact of the accident was taken as admitted.*

***Liechty v. Kansas City Bridge Company** 155 SW2d 297, affirmed 162 SW2d 275 (1942). The Missouri Workers' Compensation Commission is a ministerial and administrative body, with incidental quasi-judicial powers, exercised by the consent of those elected to be governed by the act, and is not vested with powers or duties in violation of constitutional limitations. The commission cannot usurp judicial functions contrary to the constitutional inhibition; however it has those powers which are incidental and necessary to the proper discharge of its duties in administering the Workers' Compensation Act.*

8 CSR 50-2.020 Administration

PURPOSE: This rule sets forth the requirements for administrative functions of the division, including acceptance and withdrawal from Chapter 287, RSMo, filing of documents, storage of documents, requests for documents, and maintenance of division records.

(1) Any employer exempted by section 287.090, RSMo, or any employer who is not covered by the provisions of Chapter 287, RSMo, because of section 287.030, RSMo, who desires to operate under the provisions of Chapter 287, RSMo, may do so by the purchase of a workers' compensation insurance policy evidenced by the carrier filing a proof of coverage form with the division or its designee.

(A) An employer who has elected to be covered under the provisions of Chapter 287, RSMo, may elect to withdraw that election by filing with the division, or its designee, on a form prescribed by the division.

(B) Employers that meet the statutory exception for two (2) owner corporations set out in section 287.090.5, RSMo, may elect to withdraw from coverage under Chapter 287, RSMo, by filing an election to withdraw with the division, or its designee, on a form prescribed by the division.

(2) Any forms filed with the division under any statutory provision or rule that do not meet division standards for filing based on completeness or legibility for imaging will be returned.

(3) Transcripts for cases on appeal and other division duties performed by court reporters shall have priority over requests for transcripts in cases not on appeal. Requests for transcripts not on appeal will be prepared by the court reporter that recorded the hearing after all other duties are performed. Requests for parts of transcripts already prepared will not be accepted and in such cases the entire transcript must be purchased at the rate set out in this section.

(4) All requests for copies of documents or other records must be in writing. The following standards will be used to determine if documents can be produced.

(A) The Claim for Compensation, Answer to Claim for Compensation, Compromise Settlement, Award and Minute Sheet forms may be obtained by written request. These documents are considered open records.

(B) The Report of Injury and subsequent medical reports are considered closed records pursuant to section 287.380.4, RSMo. To obtain closed records the requesting person must be a party to the workers' compensation case or an attorney who has filed an entry of appearance representing a party. The requesting person may receive copies of records of prior cases in which the requesting person was also a party to the prior case.

(C) Written requests must state the requesting party's relationship to the case as employee, employer, insurer, or attorney for the employee, employer/insurer or the Second

Injury Fund. The request must state specifically which documents are being requested. The following information must be provided when available:

1. Employee's name;
2. Employee's Social Security number;
3. Missouri Division of Workers' Compensation injury number;
4. Date of injury; and
5. Employer's name.

(D) Other documents and information may be obtained by a written request. Each request will be evaluated to determine if any requested documents or information are confidential. The division will supply information for all nonconfidential requests.

(E) Documents and other records will be provided in response to a Subpoena Duces Tecum or Release of Information form signed by the employee.

(F) The division will charge for copies of documents and any specific or general statistical information and certification of documents according to a policy statement establishing fees for these services published by the division. The division shall review this on an annual basis.

(5) The following documents can be submitted for electronic processing: any form required by the division; medical reports that are relevant to the case; and correspondence and notices relevant to the case. Depositions and medical records cannot be submitted for processing. Any document submitted as an exhibit at a hearing will be included in the record.

(A) Division forms must be submitted as an original document. Other documents submitted must be the original or where the original is unavailable, a clear, legible photocopy will be accepted. Handwritten documents will only be accepted if clearly written in black ink. Facsimiles will not be accepted for electronic processing. A minimum font size of ten (10) points is required for any computer generated form.

(B) Any required division form for which any party creates a computer generated form must be approved by the division before such documents may be used or filed.

(C) The division will accept required information by electronic filing. Any party who desires to file information electronically must receive approval from the division and must comply with all division standards for the electronic filing of information. To obtain approval for electronic filing, a party must contact the division and meet all current standards.

(D) The division and the Labor and Industrial Relations Commission will accept up to and including five (5) pages by facsimile. This provision does not affect subsection (A) of this section prohibiting facsimiles of documents for electronic processing.

(E) Any document stored electronically by the division shall be considered an original document and when reproduced in paper form shall be acceptable for all legal purposes. All documents submitted on or after January 1, 1994, for injuries occurring after that date, will be processed and stored electronically.

(F) The division shall have the discretion after five (5) years to destroy Reports of Injuries filed in which no compensation, exclusive of medical costs, was due or paid, together with the papers attendant to the filing of such reports. The division shall have the discretion after ten (10) years from the date of the termination of compensation to destroy records in compensable cases.

AUTHORITY: section 287.650, RSMo Supp. 1997. Original rule filed Dec. 23, 1953, effective Jan. 3, 1954. Amended: Filed Jan. 15, 1960, effective Jan. 26, 1960. Amended: Filed Sept. 4, 1963, effective Sept. 15, 1963. Amended: Filed Aug. 26, 1975, effective Sept. 5, 1975. Rescinded and readopted: Filed May 29, 1998, effective Feb. 28, 1999.*

**Original authority 1939, amended 1949, 1961, 1980, 1993, 1995.*

8 CSR 50-2.030 Resolution of Medical Fee Disputes

PURPOSE: This rule sets forth the Division of Workers' Compensation administrative procedures available to employers, insurance carriers and health care providers to resolve disputes concerning charges, services or aids in accordance with section 287.140, RSMo.

(1) If an employer or insurer disputes the reasonableness of a medical fee or charge, that employer or insurer shall notify the health care provider in writing that the medical bill is being disputed and shall explain the basis for the dispute. The employer or insurer may tender partial payment and the health care provider may accept payment of the amount tendered by the employer or insurer without prejudice to the filing of an application for payment of additional reimbursements of medical fees. Upon receiving the written notice of dispute, the health care provider shall contact the insurer or employer to attempt to resolve the dispute. If the negotiation is unsuccessful and more than ninety (90) days have elapsed since the date of first billing, the health care provider may file an application for payment of additional reimbursement of medical fees.

(2) The application for payment of additional reimbursements of medical fees shall contain the following information:

(A) The name, address and telephone number of the health care provider and, if different, the address where the service was rendered;

(B) Name, address and telephone number of the employer and insurer against whom the claim is being filed;

(C) Name, address and Social Security number of the patient (employee) for whom health care services were rendered, together with the date of injury, for all disputes;

(D) An explanation as to why the health care provider believes the medical fee charged is fair and reasonable, taking into consideration the usual and customary fees charged in the community for similar treatment of other similarly injured persons; and

(E) The relief requested.

(3) If the application does not include all the information required by section (2) of the rule, it will be returned for the additional information. If there is no report of injury or claim for compensation filed with the division for the alleged injury for which the health care was provided, the application will be returned for lack of jurisdiction of the division for the injury for which medical treatment was provided.

(4) The division, without a hearing, may reject an application for payment of additional reimbursements of medical fees without prejudice if the application does not contain a brief explanation of the dispute relating to the reasonableness of the bill.

(5) Upon the filing of an application for payment of additional reimbursements of medical fees, the health care provider shall file with the division an original and two (2) copies of the application, with a self-addressed stamped envelope. The division shall create and assign a medical fee dispute number to a file, and return to the health care provider two (2) file stamped copies. Thereafter, the health care provider shall serve through personal service or by certified mail, return receipt requested, a file stamped copy of the

application upon the person or corporation against whom the application has been filed.

(6) The parties shall again attempt to resolve their dispute without the assistance of the division.

(7) If the parties are unable to resolve their dispute, either party may file a written application for evidentiary hearing of the medical fee dispute. An evidentiary hearing shall be scheduled in front of an administrative law judge or legal advisor. The employer or insurer shall file an answer to the application within twenty (20) days of the date of notice for setting of evidentiary hearing. If the employer or insurer fails to file a timely answer, the health care provider's allegations are deemed admitted unless good cause is found by the division to extend the filing date of the answer. An application cannot be dismissed without prejudice after an evidentiary hearing has been scheduled without approval of the administrative law judge or legal advisor.

(8) Either party may engage in discovery to the extent authorized by Chapter 287, RSMo, upon approval by the administrative law judge or legal advisor.

(9) The parties shall notify the division of the date and amount of any settlement of the application for payment of additional reimbursements of medical fees.

(10) The division shall notify all parties as to the time and place of any hearing and at the hearing all parties shall be entitled to be heard and to introduce evidence. The administrative law judge or legal advisor shall conduct the hearing and shall issue an award deciding the dispute. The award should be completed within thirty (30) days of submission of the case.

(11) Either party may file an application for review with the Labor and Industrial Relations Commission within twenty (20) days from the date of the ruling or order of the administrative law judge or legal advisor. This review shall be subject to review and appeal in the same manner as provided for other awards in Chapter 287, RSMo.

(12) Except as otherwise provided in this rule, each party filing any document with the division shall mail or deliver to the opposing party a true and accurate copy of the document filed with the division and shall certify or state on the document being filed that such mailing or delivery has occurred.

(13) Venue for the proceedings established in sections (1)–(12) shall be in Jefferson City, except that proceedings on the application may be held in other locations as determined by the division.

(14) If an employer or insurer fails to make payment for authorized services provided to an employee by a health care provider due to an injury covered under the Missouri Workers' Compensation Law, and more than ninety (90) days have elapsed since date of first billing, the health care provider may file with the division an application for payment and request for direct payment, and shall serve through personal service or by certified mail, return receipt requested, a copy of the application on the person or corporation against whom the application has been filed. The health care provider shall file a proof of service with the division.

(15) The notice of services provided and request for direct payment shall contain the following information:

(A) Name, address, signature and telephone number of the health care provider and, if different, the address where the service was rendered;

(B) Name, address and telephone number of the employer and insurer against whom the claim is being filed;

(C) Name, address and Social Security number of the patient (employee) for whom health care services were rendered, together with the date of injury and, if known, the Division Injury Number; and

(D) A brief description of the disputed services rendered; the date the services were provided; the amount of money claimed owed; and the name and title of the person giving authorization (if known).

(16) If the application does not include all the information required by section (15), it will be returned for the additional information. If there is no report of injury or claim for compensation filed with the division for the alleged injury for which the health care was provided, the application will be returned for lack of jurisdiction of the division for the injury for which medical treatment was provided.

(17) The division, without a hearing, may reject an application for payment and request for direct payment without prejudice, if the application does not pertain to a dispute relating to authorized services.

(18) Upon the filing of the application, the division shall cause the notice to be made part of the underlying workers' compensation case and shall notify the health care provider of all proceedings relating to the underlying workers' compensation case. The division shall notify all parties to the case that the application has been made part of the underlying workers' compensation case. The health care provider shall be granted standing to appear as a party in the underlying workers' compensation case for the limited purpose of establishing that the services were authorized by the employer or insurer, and that the health care provider is entitled to payment for services rendered. The health care provider shall have all rights accorded a party under Chapter 287, RSMo, and rule 8 CSR 50-2.010 as to these limited issues.

(19) In any dispute between a health care provider and a managed care organization regarding medical care services or payment for such services, the decision of the managed care organization is subject to review by the division according to section 287.135.5, RSMo.

AUTHORITY: section 287.650, RSMo 1994. Emergency rule filed Feb. 3, 1993, effective Feb. 19, 1993, expired June 18, 1993. Emergency rule filed June 29, 1993, effective July 9, 1993, expired Nov. 5, 1993. Emergency rule filed Nov. 16, 1993, effective Nov. 26, 1993, expired March 25, 1994. Emergency rule filed June 28, 1994, effective July 8, 1994, expired Nov. 4, 1994. Emergency rule filed Oct. 20, 1994, effective Nov. 5, 1994, expired March 4, 1995. Emergency rule filed Aug. 18, 1995, effective Aug. 28, 1995, expired Feb. 23, 1996. Original rule filed Aug. 18, 1995, effective Feb. 24, 1996.*

**Original authority 1939, amended 1949, 1961, 1980, 1993.*

DIVISION OF WORKERS' COMPENSATION

NOTICE OF SERVICES PROVIDED & REQUEST FOR DIRECT PAYMENT

W.C. Injury Number	
Medical Fee Dispute Number	

Use only if services were authorized in advance by the employer/insurer, but payment has not been made, and 90 days or more have lapsed since first billing.

Employee (Patient's) Name	Address (Street, City & County)	State	Zip Code	Date of Injury / Patient's Social Security Number

1. Application is made for direct payment of health care services rendered to the employee in the underlying workers' compensation case. The services rendered were authorized in advance by the employer/insurer, but the medical or health care bill has not been paid.

2. Name of Health Care Provider	Address (Street, City & County)	State	Zip Code	Telephone Number
2 a. Location of services rendered (If different than above.)	Address (Street, City & County)	State	Zip Code	Telephone Number
3. Name of Employer	Address (Street, City & County)	State	Zip Code	Telephone Number
4. Name of Insurer	Address (Street, City & County)	State	Zip Code	Telephone Number

5.	Brief Description of Disputed Services Rendered	Date Services Provided	Name and Title of Person Giving Authorization	Amount Claimed
A.				$
B.				$
C.				$
D.				$
E.				$
F.				$

(If additional space is required, please attach additional page.)

6. Signature of Health Care Provider	Name/Title/Address of Requesting Party (Print/type)	Date / Telephone Number

7. Health Care Provider's Attorney & Address (Print/type)	Attorney's Signature / Bar Number:	Date / Telephone Number

CERTIFICATE:

The undersigned applicant certifies that the foregoing information is true and correct to the best of his/her knowledge, information and belief; and that the said applicant has attempted to resolve this dispute with the employer/insurer.

The undersigned applicant further certifies that a true and accurate copy of this Notice of Services Provided & Request for Direct Payment, together with a copy of all supporting documentation, as identified herein, have been mailed by first-class mail, postage prepaid, or hand delivered to the above referenced employer, insurer, and employee on this _____ day of _____, 19 _____.

_____
Applicant or Applicant's Attorney

WC-MD-01 (6-94)

DIVISION OF WORKERS' COMPENSATION

APPLICATION FOR PAYMENT OF ADDITIONAL REIMBURSEMENTS OF MEDICAL FEES

W.C. Injury Number
Medical Fee Dispute Number

Use only if partial payment has been made and the amount of the fee billed is in dispute.
See instructions on reverse side..

Employee (Patient's) Name	Address (Street, City & County)	State	Zip Code	Date of Injury / Patient's Social Security Number

1. Application is made for additional payment of health care services rendered to the employee above the amount already paid in the underlying workers' compensation case. The medical or health care bill is being disputed by the employer/insurer. (NOTE: The employee is not a party to the medical fee dispute and should not be made a part of or otherwise notified of such proceedings.)

2. Name of Health Care Provider	Address (Street, City & County)	State	Zip Code	Telephone Number
2 a. Location of services rendered (If different than above.)	Address (Street, City & County)	State	Zip Code	Telephone Number
3. Name of Employer	Address (Street, City & County)	State	Zip Code	Telephone Number
4. Name of Insurer	Address (Street, City & County)	State	Zip Code	Telephone Number

5.	Brief Description of Disputed Services Rendered	Date Services Provided	Amount Billed	Amount Paid	Amount Claimed
A.	_____	_____	$_____	$_____	$_____
B.	_____	_____	$_____	$_____	$_____
C.	_____	_____	$_____	$_____	$_____
D.	_____	_____	$_____	$_____	$_____
E.	_____	_____	$_____	$_____	$_____

(If additional space is required, please attach additional page.)

6. Explanation of Reasonableness for each disputed service: (Please attach additional page and supporting documentation.)

7. Signature of Applicant	Name Title Address of Applicant (Print/type)	Date / Telephone Number

8. Applicant's Attorney & Address (Print/type)	Attorney's Signature / Bar Number:	Date / Telephone Number

CERTIFICATE OF SERVICE:

The undersigned applicant certifies that the foregoing information is true and correct to the best of his/her knowledge, information and belief. The undersigned applicant further certifies that she/he has discussed this dispute with an authorized representative of the employer/insurer and has attempted to resolve this dispute.

_____
Applicant or Applicant's Attorney

WC-MD-02 (6-94)

INSTRUCTIONS

This form (WC-MD-02) is to be used in medical fee disputes involving the "Reasonableness of the Amount of Fee Charged." Be sure you understand the different types of medical fee disputes, and choose the applicable procedure and form to avoid delay or confusion in the handling of your claim. (See, "Medical Care/Fee Disputes" general information material.)

A dispute involving the "Reasonableness of the Amount of Fee Charged" is between the employer/insurer and the health care provider as to whether the fee charged by the health care provider is fair and reasonable.

In these instances, the employer/insurer recognizes that the underlying workers' compensation claim is compensable, and has authorized the health care provider to provide treatment to the injured employee. The issue in dispute is limited to the amount of the fee charged by the health care provider. The employee is not a party to this dispute, and his/her right to workers' compensation benefits may not be jeopardized by such dispute.

The administrative procedures involved in this dispute are as follows:

STEP ONE: The health care provider is notified by the employer/insurer that the amount of the medical fee charged is in dispute. The health care provider and the employer/insurer make an earnest attempt to resolve the dispute.

STEP TWO: If the parties are unable to resolve their dispute as to the reasonableness of the medical fee charged by the health care provider, the health care provider files with the Division of Workers' Compensation in Jefferson City, Missouri (3315 West Truman Boulevard, P.O. Box 58, Jefferson City, Missouri 65102) an original and two copies of an Application for Payment of Additional Reimbursements of Medical Fees, along with a self addressed stamped envelope.

STEP THREE: The Division of Workers' Compensation creates and assigns a medical fee dispute number to a file, and returns to the health care provider the two file stamped copies.

STEP FOUR: The health care provider shall serve through personal service or by certified mail, return receipt requested, a file stamped copy of the application upon the person or corporation against whom the application has been filed.

STEP FIVE: The parties are encouraged to resolve their dispute without the assistance of the Division of Workers' Compensation. If the parties have attempted in good faith to resolve their dispute, but have been unsuccessful, either party may request or the division may schedule an evidentiary hearing. Alternatively, both parties may request an administrative ruling. The employer/insurer must file with the division an Answer to the Application For Payment of Additional Reimbursements of Medical Fees within twenty (20) days of the date of the Notice of Evidentiary Hearing. The parties have the right of appeal to the Labor & Industrial Relations Commission, See, 8 CSR 50-2.030 (17).

8 CSR 50-2.040 Notice and Acknowledgment of Right to Workers' Compensation Benefits

PURPOSE: This rule sets forth the notice requirements that an employer must provide to an employee who has suffered an injury or illness for which compensation is payable under the Missouri Workers' Compensation Law and the accident involves less than five hundred dollars in total medical costs and no lost time from the employment. It is necessary that this rule become effective in order to comply with the requirements of section 287.380.2. of Senate Bill No. 251, as truly agreed to and finally passed in the first regular session of the 87th General Assembly.

(1) Upon being notified that an employee has suffered an injury or illness for which compensation is payable under the Missouri Workers' Compensation Law, and the accident involves less than five hundred dollars ($500) in total medical costs and no lost time from the employment, the employer shall notify the employee, in writing, of his/her rights under the Missouri Workers' Compensation Law.

(2) The notice shall be signed by the employee; and the employer shall retain a copy of this notice. The employer shall file with the Division of Workers' Compensation the notice, as signed by the employee and accompanied by or affixed to the Report of Injury.

(3) The notice provided for under this rule shall be made available by the division upon request.

(4) If, at any time, the total medical costs exceed five hundred dollars ($500) or an incident of lost time from the employment occurs, the employer shall notify the division, in writing, of the change in circumstances.

AUTHORITY: section 287.650, RSMo Supp. 1993. Emergency rule filed Sept. 15, 1993, effective Sept. 25, 1993, expired Jan. 13, 1994. Emergency rule filed Jan. 12, 1994, effective Jan 22, 1994, expired May 21, 1994. Original rule filed Jan. 31, 1994, effective July 30, 1994.*

**Original authority 1939, amended 1949, 1961, 1980, 1993.*

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

NOTICE AND ACKNOWLEDGEMENT OF RIGHT TO WORKERS' COMPENSATION BENEFITS

INJURY NUMBER

USE FOR ACCIDENTS INVOLVING LESS THAN $500 IN TOTAL MEDICAL COSTS AND NO LOST TIME FROM THE EMPLOYMENT, UPON RECEIPT OF THE NOTICE REQUIRED BY SECTION 287.380, RSMo.

1. Name of Employee	Address (Street, City & County)	State	Zip Code	Telephone number
2. Name of Employer	Address (Street, City & County)	State	Zip Code	Telephone number
3. Name of Insurer	Address (Street, City & County)	State	Zip Code	Telephone number
4. Date of Accident/Injury	Location of Accident/Injury (Street/City/County)	State	Zip Code	Employee's Social Security

I, _____ (print/type name of employee), understand that on the _____ day of _____, 19___, while engaged in employment at _____ (location of accident), I suffered an injury or illness for which compensation is payable under the Missouri Workers' Compensation Law, and as an injured employee I am entitled to workers' compensation benefits. These benefits include:

(1) MEDICAL CARE TO CURE THE INJURY. The employer/insurer must provide all reasonable and necessary medical care to cure the injury/illness. There is no deductible, and all costs are paid directly by the employer/insurer (i.e. doctor bills, medicines, hospital costs, lab test fees, x-rays, crutches, etc. plus mileage). The employer/insurer, however, has the right to choose the doctor, medical facilities, etc., and is not required to pay for the cost of any treatment not authorized by them.

(2) CASH PAYMENT FOR LOST WAGES. If an employee is unable to work more than three regularly scheduled work days because of a work-related injury/illness, the employer/insurer must provide the employee with "temporary disability" payments until the doctor says the employee is able to return to work. (This benefit does not apply to employees who have not missed any time from work.)

(3) ADDITIONAL CASH PAYMENTS. Once medical treatment is completed and a determination has been made that the injury has resulted in permanent disability, the employer/insurer is responsible for "permanent disability" payments, with the amount of compensation being computed according to the disability schedule, as provided by law.

Also, I understand that if I do not act to secure the benefits in a timely manner I may forfeit my right to such benefits. An employee must file a claim for compensation within two (2) years of the date of the injury or the date of the last payment for medical treatment provided on account of the injury. (However, the two (2) year period is extended to three (3) years if the employer/insurer does not timely file the Report of Injury with the Division of Workers' Compensation.)

I solemnly swear or affirm under the penalty of perjury that I have read and understand the Notice and Acknowledgment of Right to Workers' Compensation Benefits; or, through an alternative format, I have been advised of and understand the Notice and Acknowledgment of Right to Workers' Compensation Benefits.

Employee:	Date:	Signature:

CERTIFICATE:

The undersigned employer representative without admitting liability or the compensability of the alleged injury, certifies that a true and accurate copy of this notice has been hand-delivered to the above-referenced employee on this _____ day of _____, 19 ___, and is being mailed to the Division of Workers' Compensation accompanied by or affixed to the Report of Injury.

_____
Employer Representative

WC-1-A

8 CSR 50-2.050 Mediation Services

PURPOSE: This rule sets forth the administrative procedures for initiating mediation services whereby parties are afforded an opportunity to resolve disputes prior to proceeding to the hearing process.

(1) As the division deems appropriate, or upon application filed by either party, mediation services will be provided by a representative of the division for the purposes of ascertaining the issues, identifying the areas of dispute and attempting to facilitate a resolution of the dispute.

(2) The written request for mediation services should include the injury number assigned to the case, the names of each party to the dispute, if known, and an explanation of the dispute.

(3) Mediation services shall be informal and may be used at any time prior to commencement of an evidentiary hearing. The individual conducting the mediation proceeding may note in the case file that an attempt at mediation was unsuccessful and may also note the areas of dispute. However, no notation shall be made in the case file with respect to any settlement offer that may have been proposed which was not accepted, except to list any disputed issues that were not resolved.

(4) In the event the person conducting the mediation service also has authority to preside over an evidentiary hearing should mediation prove unsuccessful, that person shall be disqualified from conducting an evidentiary hearing relating to that particular case without limiting the rights conferred by section 287.810, RSMo, unless the parties to the case agree to permit that person to conduct an evidentiary hearing.

AUTHORITY: section 287.650, RSMo 1994. Emergency rule filed March 7, 1994, effective March 17, 1994, expired July 14, 1994. Emergency rule filed July 18, 1994, effective July 28, 1994, expired Nov. 24, 1994. Emergency rule filed Oct. 28, 1994, effective Nov. 25, 1994, expired March 24, 1995. Emergency rule filed March 13, 1995, effective March 25, 1995, expired July 22, 1995. Original rule filed Oct. 28, 1994, effective May 28, 1995.*

**Original authority 1939, amended 1949, 1961, 1980, 1993.*

8 CSR 50-2.060 Performance Standards for Administrative Law Judges and Legal Advisors

PURPOSE: This rule establishes the conduct, performance and productivity standards for administrative law judges, associate administrative law judges and legal advisors as required by section 287.610.2, RSMo Supp. 1998.

PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) The director of the division shall perform an annual evaluation of all chief administrative law judges. The chief administrative law judge of each local office shall perform an annual evaluation of all administrative law judges, associate administrative law judges and legal advisors in the local office based on the standards established by this rule.

(2) The performance and productivity of administrative law judges, associate administrative law judges and legal advisors shall be based on an objective appropriate evaluation of individual standards, office standards and system (division)-wide standards. The performance and productivity standards will be based on the following individual, office and system-wide standards. When appropriate, these standards should be reviewed on a calendar or fiscal year. The standards reflect a collaborative effort among the department, division director and administrative law judges, associate administrative law judges and legal advisors.

(A) System-Wide Standards—

1. An appropriate number of docket settings held by the end of each year;

2. An appropriate disposition rate of cases closed to cases assigned;

3. An appropriate number of cases opened and closed;

4. An appropriate number of cases closed and their disposition at the end of the year;

5. An appropriate time period between the injury date, division notification of injury, and the date of disposition of the case;

6. An appropriate time period from the request for a docket setting to the date action is taken;

7. An appropriate time period between the date of the maximum medical improvement (rating) and the disposition of the case;

8. An appropriate time period between a party's request for a docket setting and the date the setting is held or other appropriate action is taken;

9. An appropriate time period from the date of the request for a hardship hearing to date of disposition; and

10. An appropriate number of cases concluded in statutory time frame.

(B) Office-Wide Standards—

1. An appropriate number of docket settings held by the end of each year;

2. An appropriate disposition rate of cases closed to cases assigned;

3. An appropriate number of cases opened and closed;

4. An appropriate number of cases closed and their disposition at the end of the year;

5. An appropriate time period between the injury date, division notification of injury, and the date of disposition of the case;

6. An appropriate time period from the request for a docket setting to the date action is taken;

7. An appropriate time period between the date of the maximum medical improvement (rating) and the disposition of the case;

8. An appropriate time period between a party's request for a docket setting and the date the setting is held or other appropriate action is taken;

9. An appropriate time period from the date of the request for a hardship hearing to date of disposition; and

10. An appropriate number of cases concluded in statutory time frame.

(C) Individual standards as determined at least annually by the chief administrative law judge in consultation with the administrative law judges in their respective offices.

1. For administrative law judges, associate law judges and legal advisors, the performance and productivity measures shall include:

A. An appropriate number of docket settings held by the end of each year;

B. An appropriate disposition rate of cases closed to cases assigned;

C. An appropriate number of cases closed;

D. An appropriate number of cases closed and their disposition at the end of the year;

E. An appropriate time period between the injury date, division notification of injury, and the date of disposition of the case;

F. An appropriate time period from the request for a docket setting to the date action is taken;

G. An appropriate time period between the date of the maximum medical improvement (rating) and the disposition of the case;

H. An appropriate time period between a party's request for a docket setting and the date the setting is held or other appropriate action is taken;

I. An appropriate time period from the date of the request for a hardship hearing to date of disposition;

J. An appropriate number of cases concluded in statutory time frame;

K. An appropriate time period between the date of the last hearing and the issuance of the written award; and

L. An appropriate time period from the date of the hardship hearing to the date that the written award is issued.

2. For all administrative law judges and associate administrative law judges, all hearings shall be concluded within the statutory time period.

(3) The division hereby adopts and incorporates by reference the *Code of Judicial Conduct for Missouri Workers' Compensation Administrative Law Judges and Legal Advisors*. This Code shall be used to evaluate the conduct of administrative law judges, associate administrative law judges and legal advisors. This Code shall be made available to all who request it.

(4) This rule shall in no way be construed to inhibit, restrain or restrict the ability of an administrative law judge, associate administrative law judge or legal advisor to decide any issue regarding a workers' compensation case that is before that individual for decision or approval. The review of these decisions shall be prohibited except as established in sections 287.470, 287.480, 287.490, and 287.495, RSMo, which provide for appellate review of the decision and award of an administrative law judge or associate administrative law judge.

(5) Any administrative law judge, associate administrative law judge or legal advisor who receives an unsatisfactory evaluation in any of the three (3) categories of conduct, performance, or productivity may appeal that evaluation to the Administrative Law Judge Review Committee.

(6) The division director may refer an unsatisfactory evaluation of any administrative law judge, associate administrative law judge, or legal advisor to the Administrative Law Judge Review Committee.

(7) When a written complaint is made against an administrative law judge, associate administrative law judge or legal advisor, it shall be referred to the director of the division. When the director finds the complaint alleges facts which if proved true would constitute a crime, habitual drunkenness, willful neglect of duties, the failure to meet reasonable conduct, performance or productivity standards, incompetency, corruption in office, or any offense involving oppression in office or moral turpitude, it shall be referred to the committee for investigation and review.

AUTHORITY: section 287.610.2, RSMo Supp. 1998. Emergency rule filed Dec. 21, 1998, effective Jan. 1, 1999, expired June 29, 1999. Original rule filed Dec. 21, 1998, effective June 30, 1999.*

**Original authority: 1939, amended 1945, 1951, 1955, 1957, 1959, 1961, 1977, 1980, 1987, 1992, 1993, 1998.*