

NEBRASKA WORKERS' COMPENSATION COURT



AMENDED RULES
PROPOSED AS OF
NOVEMBER 10, 2016

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RULE 5

INTERPRETERS

- A. The court shall appoint an interpreter in any legal proceeding in order to assist a person who cannot readily understand or communicate the English or spoken language.
- B. Any party needing an interpreter for a party or witness at any ~~hearing or trial~~ legal proceeding shall allege such need for an interpreter as a separate allegation in a pleading titled “Request for Interpreter” by identifying the party or witness expected to give testimony at the ~~hearing or trial~~ legal proceeding and affirmatively stating that such individual cannot readily understand or communicate the English or spoken language and the language spoken by the party or witness. If an interpreter is required, the Request for Interpreter shall be filed within 30 days after the filing of a petition, or as soon as the parties become aware of the need for an interpreter.
- C. The employer in the case shall arrange for the interpreter. ~~At the time of~~ at least seven days prior to the legal proceeding, the employer shall file an affidavit affirming that the interpreter has been selected in accordance with the priorities for use of an interpreter as established in the Nebraska Supreme Court rules relating to court interpreters, Neb. Ct. R. § 6-703. The affidavit shall state the name of the interpreter selected and the date of the legal proceeding. The affidavit shall further state that the requested interpreter is (a) a certified or provisionally certified court interpreter pursuant to Neb. Ct. R. § 6-703(A), or (b) a registered, noncertified court interpreter pursuant to Neb. Ct. R. § 6-703(B), or (c) a nonregistered, noncertified interpreter who is otherwise competent to interpret in the courts. If the requested interpreter is a registered, noncertified court interpreter, the affidavit shall also state that the requesting party has made diligent efforts to obtain a certified or provisionally certified court interpreter and found none to be reasonably available. If the requested interpreter is a nonregistered, noncertified court interpreter, the affidavit shall state that the requesting party has made diligent efforts to obtain a certified, provisionally certified, or registered interpreter and found none to be reasonably available. Provided, however, in proceedings in which a Spanish interpreter is utilized, only a certified or registered interpreter shall be allowed. In proceedings in which a sign interpreter is utilized, only an interpreter awarded a Level I or Level II classification by the Nebraska Commission for the Deaf and Hard of Hearing shall be allowed.
- D. For any single proceeding scheduled for 3 hours or more, two language interpreters shall be arranged for and appointed. For any single proceeding scheduled for more than 1 hour, two sign interpreters shall be arranged for and appointed. For any single proceeding lasting more than 2 hours, if two interpreters are not reasonably available, the interpreter must be given not less than a 10-minute break every 30 minutes.
- E. Prior to appointment and before entering into his or her official duties, an interpreter shall take and subscribe to the oath for interpreters, which is included in Appendix 1, Neb. Ct. R. §§ 6-701 to 6-709.

F. The fees and expenses of an interpreter appointed by the court shall be authorized by the judge before whom the proceeding takes place, in accordance with the Nebraska Supreme Court Interpreter Fee Schedule and Payment Policy. The interpreter shall complete the appropriate Statement for Payment of Interpreters form approved by the State Court Administrator, and shall submit the completed form to the judge before whom the proceeding takes place for authorization.

RULE 12

APPEALS

WITHDRAWAL OF COUNSEL

Repealed effective January 21, 2016.

Upon motion for withdrawal and notice to all counsel and the client involved, an attorney who has appeared of record in a case may be given leave to withdraw by order of the court, for good cause shown, after filing with the clerk the motion, notice of hearing, and proof of service upon counsel and the client involved. If substitute counsel has entered an appearance, no hearing will be required.

RULE 26

**SCHEDULES OF FEES FOR
MEDICAL, SURGICAL, AND HOSPITAL SERVICES**

A. The following Nebraska Workers' Compensation Court fee schedules, including the instructions, ground rules, unit values, and conversion factors set out in such schedules, are hereby adopted pursuant to § 48-120(1)(b) of the Nebraska Workers' Compensation Act. Reimbursement for medical, surgical, and hospital services provided pursuant to § 48-120 shall be in accordance with such schedules, except for services covered by the inpatient hospital fee schedules established in § 48-120.04, and except for services covered by contract pursuant to § 48-120(1)(d).

1. Schedule of Fees for Medical Services, effective ~~January 1, 2016~~ January 1, 2017.
2. Schedule of Fees for Hospitals and Ambulatory Surgical Centers, effective January 1, 2012.
3. Schedule of Fees for Implantable Medical Devices, effective January 1, 2012.

Such schedules and the inpatient hospital fee schedules established in § 48-120.04 shall be available free of charge on the court's web site at <http://www.wcc.ne.gov>.

B. Schedule of Fees for Medical Services.

1. The Schedule of Fees for Medical Services shall apply to medical and surgical services provided by physicians and other licensed health care providers within the scope of their respective licenses.
2. Effective January 1, 2016, the Schedule of Fees for Medical Services shall be established as follows. Adjustments to the schedule shall be made annually thereafter as provided herein, with such adjustments to become effective each January 1.
 - a. The schedule shall include the Medicare Resource-Based Relative Value Scale (RBRVS) applicable to Nebraska, as reflected in the applicable tables established and published by the federal Centers for Medicare and Medicaid Services (CMS) for the federal Medicare program and geographically adjusted for Nebraska.
 - b. The schedule shall include the Current Procedural Terminology (CPT) codes in the CMS tables and the relative value units established by CMS for each CPT code in the tables.
 - c. The schedule shall be adjusted annually to incorporate the CPT codes and relative value units in the then current CMS tables applicable to Nebraska.
 - d. The schedule may be supplemented with additional CPT codes, relative value units, follow-up days, base values, instructions, ground rules, or other components or factors as determined by the court.

- e. The conversion factors and service categories of the schedule shall be as follows:
 - i. For calendar year 2016, sixty-three dollars and fifty-nine cents (\$63.59) for emergency department services, fifty dollars and one cent (\$50.01) for all other evaluation and management services, fifty dollars and seventy-seven cents (\$50.77) for anesthesia services, one hundred and six dollars and seven cents (\$106.07) for orthopedic surgery services, seventy-two dollars and twenty-two cents (\$72.22) for all other surgery services, eighty-six dollars and ninety-two cents (\$86.92) for radiology services, seventy-six dollars and thirty-two cents (\$76.32) for pathology and laboratory services, fifty-four dollars and thirty-six cents (\$54.36) for medicine services, and forty-eight dollars and twenty-three cents (\$48.23) for physical medicine services. The specific services and related CPT codes to be included in each service category shall be determined by the court.
 - ii. For calendar years after 2016, the conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factor for each service category identified in Rule 26,B,2,e,i. For purposes of this rule, the MEI means the input price index used by CMS to measure changes in the costs of providing physician services paid under the RBRVS.
3. Services subject to the Schedule of Fees for Medical Services shall be reimbursed at the lower of the fee schedule amount or the provider's billed charge. The fee schedule amount for a particular service shall be determined by first multiplying the relative value unit for the CPT code applicable to the service provided by the dollar conversion factor for the service category in which the code is located. The resulting amount may then be modified by instructions or ground rules for the service category in which the code is located to arrive at the final fee schedule amount. Medical or surgical services not covered under the schedule shall be paid in full unless the payor has evidence that the provider's charge exceeds the regular charge for such service by Nebraska providers.
4. Coding for services subject to the Schedule of Fees for Medical Services shall be in accordance with the CPT manual published by the American Medical Association, and in accordance with the National Correct Coding Initiative (NCCI) established by CMS. A provider shall not fragment or unbundle charges imposed for a service except as consistent with the CPT manual and the NCCI. Coding by a provider may be changed by a workers' compensation insurer, risk management pool, or self-insured employer, or any adjustor, third-party administrator, or other agent acting on behalf of any such workers' compensation insurer, risk management pool, or self-insured employer, only as consistent with the CPT manual and the NCCI and following consultation with the provider.
5. The Schedule of Fees for Medical Services shall not apply to costs and expenses incurred by or on behalf of any party for the purpose of proving or disproving a contested claim, except that X-rays, laboratory services, and other diagnostic tests provided in connection with a medical-legal evaluation shall be subject to the schedule.

C. The Diagnostic Related Group inpatient hospital fee schedule established in § 48-120.04 shall include the following Medicare Diagnostic Related Groups, effective ~~January 1, 2016~~ January 1, 2017:

3	85	166	251	379	465	488	513	563	699	906	959
4	86	167	287	388	467	489	514	565	801	907	963
23	87	175	300	390	468	492	516	570	802	908	964
25	88	176	301	392	469	493	517	572	853	909	981
27	89	177	310	395	470	494	518	573	854	914	982
29	90	183	312	419	471	496	519	578	855	918	988
30	93	184	313	442	472	497	520	579	857	920	989
39	100	189	329	453	473	501	536	580	858	923	
41	101	191	330	454	475	502	549	581	863	927	
42	102	194	337	455	476	504	551	603	870	928	
65	103	200	343	457	480	505	552	605	871	935	
66	131	203	352	458	481	506	556	607	872	941	
70	152	204	354	459	482	507	558	638	885	948	
71	156	206	355	460	483	510	560	640	902	956	
83	158	208	358	463	486	511	561	641	903	957	
84	159	246	378	464	487	512	562	683	904	958	

<u>3</u>	<u>72</u>	<u>164</u>	<u>202</u>	<u>330</u>	<u>465</u>	<u>489</u>	<u>514</u>	<u>561</u>	<u>653</u>	<u>905</u>	<u>940</u>
<u>23</u>	<u>83</u>	<u>165</u>	<u>204</u>	<u>336</u>	<u>467</u>	<u>492</u>	<u>516</u>	<u>562</u>	<u>668</u>	<u>906</u>	<u>948</u>
<u>24</u>	<u>84</u>	<u>166</u>	<u>206</u>	<u>351</u>	<u>468</u>	<u>493</u>	<u>517</u>	<u>563</u>	<u>689</u>	<u>907</u>	<u>949</u>
<u>25</u>	<u>86</u>	<u>175</u>	<u>207</u>	<u>354</u>	<u>469</u>	<u>494</u>	<u>518</u>	<u>565</u>	<u>690</u>	<u>908</u>	<u>950</u>
<u>26</u>	<u>87</u>	<u>176</u>	<u>240</u>	<u>355</u>	<u>470</u>	<u>496</u>	<u>519</u>	<u>571</u>	<u>698</u>	<u>909</u>	<u>955</u>
<u>27</u>	<u>88</u>	<u>177</u>	<u>253</u>	<u>373</u>	<u>471</u>	<u>497</u>	<u>520</u>	<u>572</u>	<u>854</u>	<u>914</u>	<u>956</u>
<u>28</u>	<u>89</u>	<u>183</u>	<u>254</u>	<u>394</u>	<u>472</u>	<u>500</u>	<u>535</u>	<u>573</u>	<u>856</u>	<u>917</u>	<u>957</u>
<u>29</u>	<u>90</u>	<u>184</u>	<u>257</u>	<u>395</u>	<u>473</u>	<u>501</u>	<u>536</u>	<u>578</u>	<u>857</u>	<u>918</u>	<u>958</u>
<u>30</u>	<u>93</u>	<u>185</u>	<u>271</u>	<u>405</u>	<u>478</u>	<u>502</u>	<u>537</u>	<u>579</u>	<u>858</u>	<u>921</u>	<u>959</u>
<u>40</u>	<u>103</u>	<u>188</u>	<u>274</u>	<u>419</u>	<u>479</u>	<u>503</u>	<u>540</u>	<u>580</u>	<u>863</u>	<u>922</u>	<u>963</u>
<u>41</u>	<u>125</u>	<u>189</u>	<u>300</u>	<u>454</u>	<u>480</u>	<u>504</u>	<u>552</u>	<u>581</u>	<u>871</u>	<u>927</u>	<u>964</u>
<u>42</u>	<u>131</u>	<u>193</u>	<u>301</u>	<u>455</u>	<u>481</u>	<u>505</u>	<u>554</u>	<u>603</u>	<u>872</u>	<u>928</u>	<u>965</u>
<u>55</u>	<u>132</u>	<u>194</u>	<u>313</u>	<u>457</u>	<u>482</u>	<u>506</u>	<u>556</u>	<u>605</u>	<u>884</u>	<u>929</u>	<u>981</u>
<u>65</u>	<u>149</u>	<u>195</u>	<u>314</u>	<u>459</u>	<u>483</u>	<u>511</u>	<u>558</u>	<u>607</u>	<u>902</u>	<u>934</u>	<u>982</u>
<u>66</u>	<u>155</u>	<u>199</u>	<u>315</u>	<u>460</u>	<u>487</u>	<u>512</u>	<u>559</u>	<u>641</u>	<u>903</u>	<u>935</u>	<u>983</u>
<u>70</u>	<u>158</u>	<u>200</u>	<u>328</u>	<u>464</u>	<u>488</u>	<u>513</u>	<u>560</u>	<u>645</u>	<u>904</u>	<u>939</u>	<u>987</u>

- D.** For inpatient hospital discharges prior to October 1, 2015, a claim for inpatient trauma services shall mean a claim which has at least one of the following ICD-9-CM diagnosis codes in UB-04 Form Locator 67: Injury codes in the range of 800-959.9, 994.1, 994.7, or 994.8; and either:
1. The patient was admitted to the hospital from the emergency department (UB-04 Form Locator 14 with Priority (Type) of Visit as: 1-Emergency, or 5-Trauma), or
 2. The patient was transferred out of the hospital (UB-04 Form Locator 17 with Patient Discharge Status 02-Discharged/transferred to a Short Term General Hospital for Inpatient Care), or
 3. The patient was admitted directly to the hospital, bypassing the emergency department (UB-04 Form Locator 14 with Priority (Type) of Visit as: 1-Emergency, or 5-Trauma), or
 4. The patient died in the emergency department (UB-04 Form Locator 17 with Patient Discharge Status 20-Expired), or
 5. The patient was dead on arrival in the emergency department (UB-04 Form Locator 17 with Patient Discharge Status 20-Expired).
- E.** For inpatient hospital discharges on or after October 1, 2015, a claim for inpatient trauma services shall mean a claim which has at least one of the following ICD-10-CM diagnosis codes in UB-04 Form Locator 67: Injury codes in the range of M80, M84, S00-S99, T07-T34, T51-T79; and either:
1. The patient was admitted to the hospital from the emergency department (UB-04 Form Locator 14 with Priority (Type) of Visit as: 1-Emergency, or 5-Trauma), or
 2. The patient was transferred out of the hospital (UB-04 Form Locator 17 with Patient Discharge Status 02-Discharged/transferred to a Short Term General Hospital for Inpatient Care), or
 3. The patient was admitted directly to the hospital, bypassing the emergency department (UB-04 Form Locator 14 with Priority (Type) of Visit as: 1-Emergency, or 5-Trauma), or
 4. The patient died in the emergency department (UB-04 Form Locator 17 with Patient Discharge Status 20-Expired), or
 5. The patient was dead on arrival in the emergency department (UB-04 Form Locator 17 with Patient Discharge Status 20-Expired).

RULE 63
INDEPENDENT MEDICAL EXAMINERS
SELECTION

Words in italics are defined in Rule 49.

- A.** Once a dispute regarding medical, surgical, or hospital services furnished or to be furnished under the Nebraska Workers' Compensation Act has arisen any party or the court on its own motion may submit the dispute for a medical finding by an *independent medical examiner*.
- B.** If the parties to a dispute cannot agree on an *independent medical examiner* of their own choosing, the court shall assign one from the list of qualified *independent medical examiners* maintained by the court. Assignments by the court from the list shall be made by means of a revolving selection process established by the court, and may take into account the specialty and location of the examiner. The requesting party may express a preference with regard to the specialty of the *physician* when submitting a request for assignment, but the court shall not be bound by such preference when making an assignment.
- C.** In order to be eligible for assignment, a qualified *independent medical examiner*:
1. shall not be the employee's treating *physician* with respect to the injury for which the claim is being made, and shall not have treated the employee with respect to such injury; and
 2. shall not have previously examined the employee at the request of any party with respect to the injury for which the claim is being made.
- D.** To request assignment of a qualified *independent medical examiner* the requesting party shall complete and forward to the court an application form developed by the court setting out any questions or issues that they wish to submit to the *independent medical examiner*. At the same time, the requesting party shall serve a copy of the application on all other parties and shall file proof of service with the court. Service shall be made by regular mail, and proof of service shall be made by certificate of the party causing the service to be made. Within 10 business days of being served the other parties shall submit to the court in writing any questions or issues that they wish to submit to the *independent medical examiner*. The court shall assign a qualified *independent medical examiner* within five business days thereafter, and shall issue a notification by regular mail to the examiner and the parties to include:
1. the name, address and telephone number of the assigned examiner;
 2. an identification of the disputed issues upon which the *independent medical examiner* shall render a finding;
 3. the obligation of the insurer, risk management pool, or self insured employer to provide copies of records and information pursuant to Rule 63,E;

4. the obligation of any party, other than the insurer, risk management pool, or self insured employer, to provide copies of records and information pursuant to Rule 63,F; and
5. any other information as determined by the court.

Once an independent medical examiner has been assigned, submission of additional questions by either party shall not be allowed without prior approval of the court.

- E. Following notice of assignment by the court, or notice of agreement by the parties pursuant to Rule 67,A, the insurer, risk management pool, or self insured employer shall send to the examiner copies of all records and information in its possession that are relevant to the disputed issues, and shall send to all other parties and to the court a description of all such records and information. Such copies, information and description shall be sent by regular mail within 10 business days of receipt of the notification of assignment or agreement, at no cost to the examiner, the court or any other party.
- F. Following receipt of the description of records and information from the insurer, risk management pool, or self insured employer, any other party shall send to the examiner copies of any relevant records and information in its possession that were not previously provided by the insurer, risk management pool, or self insured employer, and shall send to all other parties and to the court a description of all such records and information. Such copies, information and description shall be sent by regular mail within 10 business days of receipt of the description from the insurer, risk management pool, or self insured employer, at no cost to the examiner, the court or any other party.
- G. If no records or information are in the possession of the insurer, risk management pool, or self insured employer as provided in Rule 63,E or any other party as provided in Rule 63,F, then a letter to this effect shall be sent to the examiner with copies to all other parties and the court, together with information as to the location of any records or information of which they are aware but which are not in their possession. Necessary records not in the possession of any party, including any records requested by the examiner, shall be obtained by the party most able to do so, with the cost to be paid by the insurer, risk management pool, or self insured employer.
- H. All records and information provided pursuant to Rule 63,E and 63,F shall be in chronological order by provider, and shall be accompanied by an index to the submitted records and information.
- I. An *independent medical examiner* assigned by the court or agreed to by the parties pursuant to Rule 67 to render a medical finding shall not refer the employee for treatment, nor shall the examiner treat the employee with respect to the injury for which the claim is being made unless the examiner:
 1. has completed his or her duties as the *independent medical examiner*;
 2. agrees to treat the employee; and

3. either becomes the *primary treating physician* as agreed to by the employee and employer, or is selected by the employee to do surgery when the injury involves dismemberment or a *major surgical operation*.
- J.** An *independent medical examiner* may decline assignment by the court only for good cause shown.
- K.** If an *independent medical examiner* has submitted a written report pursuant to Rule 64,E stating findings on the questions or issues raised, no party may request court assignment of another *independent medical examiner* on the same questions or issues.
- L.** Disputes relating to treatment provided or to be provided through a *managed care plan* shall be processed through the internal dispute resolution procedures of the *managed care plan* prior to the filing with the court of a request for assignment of an *independent medical examiner*.

RULE 73

SELF-INSURANCE SECURITY

- A. Security Requirement.** As a condition for approval to self-insure and continue to self-insure, the employer shall deposit an acceptable security to secure the payment of compensation liabilities under the Nebraska Workers' Compensation Act as they are incurred. Political subdivisions with either unlimited rate making authority or having taxing authority with a tax base of at least \$2,500,000,000 and a general obligation bond rating from Standard & Poor or Moody's Investor Service of "A" or better may, at the discretion of the court, be excluded from this requirement.
- B. Form of Security.** Security shall be in the form of a surety bond or irrevocable workers' compensation trust agreement. Forms for bonds and trust agreements must be approved by the court.
- C. Amount of Security.**
1. The amount of security required, regardless of the method used for determining the amount, will be calculated using Nebraska specific payroll, paid losses, or reserve. The reserve is the actual and present value of the determined and estimated future compensation payments under the Act.
 2. One of two methods will be used by the court to calculate the amount of security required if the employer is able to provide paid loss totals for each of the last three complete calendar years. The formula method, as set out in Rule 73,D, will be used to determine the amount required unless the employer chooses to have the amount calculated based on an actuarial statement of reserve, as set out in Rule 73,F. If the employer is unable to provide paid loss totals for each of the last three complete calendar years, the court will determine the amount of security required based on actual and projected payroll by job classification code. The amount required may be periodically adjusted, at the court's discretion, until such time as the employer qualifies to have the amount of security determined by the formula or actuarial method.
 3. The amount of security required will be determined when the application to self-insure is reviewed and at other times at the court's discretion.
 4. Any change to the amount of security shall extend to all compensation liabilities of the employer as a self-insurer, including those liabilities already present, whether known or yet to be discovered.
 5. Except in accordance with Rule 73,G the amount of security shall, in no case, be less than \$500,000 or the reserve, whichever is greater.
- D. Formula Method.** The formula for determining the amount of security is the average of the employer's paid losses for the last three complete calendar years preceding the date the amount

of security is determined, multiplied by 2.5. The product is increased by 40% or \$500,000, whichever is greater. The result is the amount of the security required under the formula method.

E. Adjustments to the Formula Method. The amount of security required under the formula method may, at the discretion of the court, be adjusted based on the financial condition of the employer. For purposes of determining eligibility for such an adjustment self-insurers will be assigned to one of three classes. Assignment to a given class shall be in accordance with the criteria set forth in Rule 73,E,1 through Rule 73,E,3, based on the periodic review of financial and other records of the self-insured employer. The self-insurer and its parent, if applicable, must furnish annual audited financial statements to the court within a time frame established by the court. To ascertain continued eligibility for a Class II or Class III designation, the court may periodically request financial statements and other information. Failure to comply with court requests for financial statements and other information will result in assignment to Class I.

1. Class I: Employers in Class I shall be required to deposit security in the full amount calculated according to the formula method as set out in Rule 73,D. Employers assigned to Class I are:
 - a. Employers with a net worth of less than \$100,000,000, excluding goodwill and restricted assets, or;
 - b. Employers not showing a net profit in four out of the last five years, or;
 - c. Employers not showing a positive operational cash flow in four out of the last five years regardless of net worth, or;
 - d. Employers with a total reduction of net worth of 50% or more over the last five years, or;
 - e. Employers with a reduction in net worth of 25% or more in the most recent year, or;
 - f. Employers with a net worth between \$100,000,000 and \$250,000,000, excluding goodwill and restricted assets, and a net worth to asset ratio of less than 20% (i.e. net worth as a percent of assets) excluding goodwill and restricted assets from both net worth and assets, or;
 - g. Employers terminating self-insurance for any reason, without regard to eligibility for another class.
2. Class II: Employers in Class II may, at the discretion of the court, be eligible for a 25% reduction in the amount of security calculated according to the formula method as set out in Rule 73,D. In no case shall the amount of security be less than \$500,000 or the reserve, whichever is greater. Employers eligible for Class II are:
 - a. Employers with a net worth between \$100,000,000 and \$250,000,000, excluding goodwill and restricted assets, and;
 - i. Net profit in four out of the last five years, and;

- ii. Positive operational cash flow in four out of the last five years, and;
- iii. No reduction of net worth of 25% or more in the most recent year, and;
- iv. No reduction of net worth of 50% or more over the last five years, and;
- v. A net worth to asset ratio of between 20% and 66.67% (i.e. net worth as a percent of assets) excluding goodwill and restricted assets from both net worth and assets;

OR

- b. Employers with a net worth of \$250,000,000 or more excluding goodwill and restricted assets, and;
 - i. Net profit in four out of the last five years, and;
 - ii. Positive operational cash flow in four out of the last five years, and;
 - iii. No reduction of net worth of 25% or more in the most recent year, and;
 - iv. No reduction of net worth of 50% or more over the last five years, and;
 - v. A net worth to asset ratio of less than 20% (i.e. net worth as a percent of assets) excluding goodwill and restricted assets from both net worth and assets.
- 3. Class III: Employers in Class III may, at the discretion of the court, be eligible for a 50% reduction in the amount of security calculated according to the formula method as set out in Rule 73,D. In no case shall the amount of security be less than \$500,000 or the reserve, whichever is greater. Employers eligible for Class III are:
 - a. Employers with a net worth between \$100,000,000 and \$250,000,000, excluding goodwill and restricted assets, and;
 - i. Net profit in four out of the last five years, and;
 - ii. Positive operational cash flow in four out of the last five years, and;
 - iii. No reduction of net worth of 25% or more in the most recent year and;
 - iv. No reduction of net worth of 50% or more over the last five years, and;
 - v. A net worth to asset ratio of 66.67% or more (i.e. net worth as a percentage of assets) excluding goodwill and restricted assets from both net worth and assets.

OR

- b. Employers with a net worth of \$250,000,000 or more excluding goodwill and restricted assets, and;
 - i. Net profit in four out of the last five years, and;
 - ii. Positive operational cash flow in four out of the last five years, and;
 - iii. No reduction of net worth of 25% or more in the most recent year, and;

- iv. No reduction of net worth of 50% or more over the last five years, and;
- v. A net worth to asset ratio of 20% or more (i.e. net worth as a percent of assets) excluding goodwill and restricted assets from both net worth and assets.

F. Actuarial Method. As an alternative to the formula method of determining the amount of security required, the court will calculate the amount required based on an actuarial estimate of compensation liabilities. In no case shall the amount of security be less than \$500,000.

1. A qualified independent actuary who is a member of the American Academy of Actuaries or Casualty Actuarial Society must perform an analysis of the self-insurer's workers' compensation liabilities and provide a certified statement of the reserve. The opinion must include a statement that there is no impediment to the actuary's ability to provide an unbiased and independent opinion as to the adequacy of the reserve. The report must also include a synopsis of the nature of the actuary's approach.
2. The self-insurer is responsible for any cost associated with obtaining the statement.
3. The amount of security required is equal to 66.67% of the actual reserve amount, increased by 40% or \$500,000 whichever is greater.
4. An actuarial statement of the reserve must be provided with the application to self-insure. Failure to provide an actuarial statement shall result in the security amount being calculated using the formula method as set out in Rules 73,D and 73,E.

G. Reduction or Release of Security after Termination of Self-Insurance. An employer whose approval to self-insure has been terminated for at least two years may submit a written request to the court to reduce the amount of security. At its discretion, with satisfactory proof of the actual amount of outstanding compensation liabilities, the court may approve a reduction in the amount of security required. Unless an employer provides the court with satisfactory proof of the transfer of all outstanding compensation liabilities, no security will be released for at least two years after approval to self-insure terminates the last payment to or on behalf of the claimant on any and all claims arising during the period the employer was approved for self-insurance.