

RULES OF PROCEDURE

REVISED DECEMBER 2015



**NEBRASKA WORKERS'
COMPENSATION COURT**

CONTENTS

RULE	TITLE	PAGE
1	Office of the Court.....	1
2	Filings.....	1
3	Pleadings.....	6
4	Discovery.....	10
5	Interpreters.....	10
6	Pretrial Conferences.....	12
7	Allotted Time for Trial.....	12
8	Continuances.....	13
9	Reporting or Recording the Proceedings.....	13
10	Evidence.....	14
11	Decisions.....	15
12	Appeals (Repealed).....	15
13	Transcript of Pleadings (Repealed).....	15
14	Bill of Exceptions (Repealed).....	16
15	Records Checked Out (Repealed).....	16
16	Briefs (Repealed).....	16
17	Scheduling, Argument, and Submission (Repealed).....	16
18	Summary Dispositions (Repealed).....	16
19	Opinions (Repealed).....	16
20	Dismissal of Appeal (Repealed).....	17
21	Costs (Repealed).....	17
22	Appeal After Review (Repealed).....	17
23	Dismissal Docket.....	17
24	Meetings of the Court.....	17
25	Compliance with Rules.....	18
26	Schedules of Fees for Medical, Surgical, and Hospital Services.....	18
27	Insurance and Self Insurance (Repealed).....	23
28	Corporate Executive Officer Waiver (Repealed).....	23
29	First Report of Alleged Occupational Injury or Illness.....	23
30	Subsequent Report	26
31	Periodic Report of Continuing Compensation (Repealed).....	29
32	Reporting of Compensation Insurance.....	29
33	First Treatment Medical Reports.....	33
34	30-Day Medical Report (Repealed).....	33
35	Blank Forms.....	33
36	Eligibility and Approval of Vocational Rehabilitation Services.....	34
37	Vocational Rehabilitation—Reporting.....	35
38	Vocational Rehabilitation — Costs.....	36

CONTENTS

RULE	TITLE	PAGE
39	Vocational Rehabilitation — Certification of Vocational Rehabilitation Service Providers.....	37
40	Vocational Rehabilitation — Certification of Counselors.....	38
41	Vocational Rehabilitation — Certification of Job Placement Specialists.....	42
42	Vocational Rehabilitation — Choice of Counselor.....	45
43	Vocational Rehabilitation — Change of Counselor.....	48
44	Vocational Rehabilitation — Plan Development and Implementation.....	49
45	Loss of Earning Power Evaluation.....	51
46	Settlement Agreements (Repealed).....	52
47	Lump Sum Settlement.....	52
48	Informal Dispute Resolution.....	56
49	Definitions.....	57
50	Choice of Physician.....	60
51	Managed Care — Purpose.....	63
52	Managed Care — Application for Certification.....	64
53	Managed Care — Requirements for Certification.....	67
54	Managed Care — Coverage.....	72
55	Managed Care — Notice to Employee.....	74
56	Managed Care — Physicians Who Are Not Participating Physicians.....	76
57	Managed Care — Reporting Requirements.....	78
58	Managed Care — Dispute Resolution.....	80
59	Managed Care — Peer Review and Utilization Review.....	80
60	Managed Care — Medical Case Management.....	81
61	Managed Care — Suspension; Revocation.....	82
62	Independent Medical Examiners — Appointment.....	84
63	Independent Medical Examiners — Selection.....	85
64	Independent Medical Examiners — Procedures Before the Independent Medical Examiner.....	88
65	Independent Medical Examiners — Fees and Costs.....	90
66	Independent Medical Examiners — Removal.....	91
67	Independent Medical Examiners — Selected by Agreement of the Parties.....	92
68	Rules and Regulations.....	93
69	Insurance and Self Insurance.....	94
70	Self Insurance — Purpose.....	95

CONTENTS

RULE	TITLE	PAGE
71	Self Insurance — Application for Approval.....	95
72	Self Insurance — Requirements for Approval.....	96
73	Self Insurance — Security.....	98
74	Self Insurance — Excess Insurance.....	103
75	Self Insurance — Reporting Requirements.....	104
76	Self Insurance — Renewal, Termination.....	104

ADDENDA

ADDENDUM	TITLE	PAGE
1	Present Value Table.....	A3
2	U.S. Life Table: 2010.....	A9
3	Personal and Financial Account Information.....	A10

RULE 1

OFFICE OF THE COURT

The office of the Nebraska Workers' Compensation Court shall be deemed to be at 1010 Lincoln Mall, Lincoln, Nebraska.

Hearings in compensation cases may be held at any other place within the State as provided by statute, but no such other place shall be deemed to be an office or branch office of the court.

Sections 48-163, 48-186, R.R.S. 2010, and 48-177, 48-179, R.S. Supp., 2014.

Dolner vs. Peter Kiewit & Sons Co., 143 Neb. 384; 9 N.W. 2nd 483 (1943).

Effective date: August 31, 2011.

RULE 2

FILINGS

- A.** No pleading or other document regarding a proceeding of the Nebraska Workers' Compensation Court shall be deemed to be filed with the court until the same has been received and recorded by the clerk of said court at the office of the court in Lincoln, Nebraska. Upon filing of a petition or initial pleading in a case that has not yet been assigned a docket number, such petition or pleading shall include the date and location of injury or alleged injury.
- B.** All pleadings or other documents filed with, or correspondence received by, the court shall be stamped or imprinted by the court with the date of receipt. Time limits prescribed by law or these rules shall be calculated from the date of filing as reflected by the receipt date recorded on or with the document or correspondence.
- C.** The following privacy rules shall apply to all pleadings or other documents filed with, or correspondence received by, the court.
 - 1. These rules seek to prevent birth dates, Social Security numbers, and financial account numbers of all persons, including minor children, from being included in court records generally available to the public.
 - 2. Upon filing of a petition or initial pleading in a case that has not been assigned a docket number, the Social Security account number of the claimant shall be provided to the court in a separate document as set forth in Addendum 3 to these rules. Other personal and financial account information

identified in Rule 2,C,1 may, if applicable, be provided to the court prior to the issuance of any order, judgment, or award, and shall also be set forth in a separate Addendum 3 document. Such separate document shall be submitted in either electronic form or paper form and shall not be accessible or viewable by the public. The document shall contain, at the top of the first page, the following language, in bold type: **This document is confidential and shall not be made part of the court file or provided to the public pursuant to Workers' Comp. Ct. R. of Proc. 2.** The clerk of the court shall keep the document separate from the case file but accessible to judges and court staff. If the document is submitted in electronic form, or converted from paper form to electronic form, the electronic document or the data contained therein may be reproduced or stored in the Nebraska Workers' Compensation Court case management system. If the document is submitted in electronic form, the paper form shall not be submitted.

3. The personal and financial account information identified in Rule 2,C,1 shall not be included in any pleading or document submitted by a party or counsel for filing with the court, except by reference to a separate Addendum 3 document. An Addendum 3 document shall be separately submitted with any such pleading or other document. The Addendum 3 document is mandatory with respect to the information identified in Rule 2,C,1, but a party, attorney, or the court may include in the Addendum 3 document additional personal or financial account information sought to be protected.
4. The personal and financial account information identified in Rule 2,C,1 shall not be included in any court order, judgment, or award, except by reference to a separate Addendum 3 document. Where the court finds that an order, judgment, or award must contain Social Security numbers or other personal or financial account information identified in Rule 2,C,1, the court shall have the original order sealed and provide in the case file a redacted version of the order for public view.
5. No exhibit used at trial shall contain a complete account number for any financial accounts or debts of any party. The same shall be redacted by the person offering the exhibit to the extent necessary to protect the information from misuse. By agreement of the parties, or as directed by the court, financial account information shall be identified in all pleadings, other documents and court orders, judgments, or awards in such a manner as the parties, counsel, and the court may be able to distinguish information between similar accounts or debts, or as may be necessary to establish relevance to the matter being litigated.

6. The responsibility for redacting personal and financial account information set forth in Rule 2,C,1 rests solely with counsel and the parties. The clerk of the court shall not be required to review documents for compliance with this rule. If the clerk of the court identifies a violation of this rule, the clerk may, at his or her option, provide a redacted document for public access. However, the clerk electing to provide a redacted copy for public access shall maintain the original document without any alterations thereof, which document shall only be available to the court and the parties or the parties' counsel.

D. Electronic Filing and Service System.

1. Definitions.

- a. **Electronic Filing System.** Electronic filing system (E-Filing System) approved by the Nebraska Workers' Compensation Court for filing of pleadings or other documents via the Internet.
- b. **Electronic Filing.** Electronic filing (E-Filing) is the transmission of pleadings or other documents to and from the court via the E-Filing System.
- c. **Electronic Service.** Electronic service (E-Service) is the transmission of pleadings or other documents to any party in a case via the E-Filing System. E-Service by a party or attorney is not currently available via the E-Filing System.
- d. **Durable Medium.** Durable medium shall be any information storage medium that is created by a durable process. A process shall be the combination of hardware, software, storage media, techniques, and procedures used to manage, create, store, retrieve, and delete information belonging to the party required to maintain the record. A process shall be durable if it meets the following criteria:
 - i. The process is capable of creating and storing information for the required records retention period.
 - ii. The process can be migrated to a successor process when necessary and will retain all information available in the original process after migration to the successor process.
 - iii. The process maintains the integrity of information in a readily accessible manner, makes it retrievable, makes it processable through an established usual or routine set of procedures using available

hardware and software, and makes it accurately reproducible in a human-readable form.

- iv. The process provides for disaster recovery backups, which are periodically, depending on a retention schedule, verified for restorability and readability, and can be stored in a separate geographical location from the original information.
 - v. The process is demonstrated to create and maintain information for the retention period as specified, in an accurate, reliable, trustworthy, dependable, and incorruptible manner.
 - vi. The process allows the removal of information when it reaches the end of its required retention period.
 - vii. The process is documented so as to demonstrate to a reasonable person compliance with these criteria.
- e. Electronic Notice. Electronic notice (E-Notice) is the electronic transmission of notices, opinions, court entries, and any other dispositional order or information from the court to all persons who have registered for E-Notice. E-Notice is not currently available via the E-Filing System. Until such time as E-Notice becomes available, the court shall distribute notices and signed orders via regular mail and file-stamped copies of pleadings via e-mail, fax, or regular mail.
2. E-Filing is authorized for any pleadings or other documents filed in the Nebraska Workers' Compensation Court except appeal documents and exhibits to be offered at a hearing or trial.
 3. Only attorneys licensed to practice law in Nebraska may register to use the E-Filing System.
 4. The electronic filing of a petition or initial pleading from which printed copies can be made shall comply with the requirements of Rule 3,A. The court clerk shall print sufficient copies for service with the summons. The summons and any required attachments to the summons shall be provided in printed form by the court clerk and shall be served in accordance with Neb. Rev. Stat. §§ 48-175 and 48-175.01 as applicable.
 5. Pleadings filed via the E-Filing System shall be submitted in searchable non-editable PDF format. Proposed orders shall be submitted in either editable Microsoft Word format (*.doc or *.docx) or Rich-Text Format (*.RTF) format. Attachments to pleadings may be submitted in any noned-

itable PDF format. Pleadings or other documents filed via the E-Filing System shall not be secured with a password or encrypted in any fashion.

6. Pleadings or other documents in compliance with applicable filing requirements and electronically received by the court clerk by 11:59:59 p.m. local time shall be deemed to have been filed on that date. The clerk shall notify the filing party of any document that fails to comply with applicable filing requirements.
7. Use of the E-Filing System by an attorney shall constitute compliance with the Rule 3,G signature requirement, and the attorney using the E-Filing System shall be subject to all other requirements of Rule 3,G and Rule 3,H. Signatures of attorneys, parties, witnesses, and notaries and notary stamps may be typed using the signature format “/s/ [typed name],” and using the stamp format “seal, notary public, State of [state name],” and commission expiration date to satisfy signature and certification requirements. If the notarial commission of the particular notary public whose seal is being depicted is limited by county, the filing party shall use the stamp format “seal, notary public, State of [state name], County of [county name].” Other seals or stamps, such as those of courts, public bodies, agencies, or officials, or corporations, may be typed using the stamp format “seal, [alphanumeric content of seal].”
8. Possession of printed documents.
 - a. Except as provided in Rule 2,D,7,b, no pleading or other document may be filed via the E-Filing System unless the filing party first has possession of a printed document or documents bearing original signatures, stamps, and seals as applicable. Such printed documents:
 - i. shall be made available by the filing party for inspection by other parties or the court upon request, but shall not be filed with the court; and
 - ii. shall be maintained by the filing party for a period of two years after the final resolution of the action, including the final resolution of all appeals; and
 - iii. may be maintained by the filing party in either paper form or electronic form. Pleadings or other documents maintained in electronic form shall be stored using a durable medium as defined in Rule 2,D,1,d.

- b. Where an E-Filed pleading or other document is signed by only the filing attorney in accordance with Rule 2,D,6, the attorney shall not be required to have possession of or maintain a printed document or documents bearing an original signature.
9. An E-Filed pleading or other document shall not be transmitted to the clerk of the court by any other means unless the court requests a printed document bearing original signatures, stamps, and seals.
10. Upon satisfactory proof that E-Filing of a pleading or other document is not completed because of (1) an error in the transmission of the document to the court via the E-Filing System which was unknown to the sending party or (2) a failure to process the electronic filing when received by the court clerk or (3) technical failure in the State Data Communications Network, the court may enter an order permitting the pleading or other document to be filed as of the date it was first attempted to be sent electronically. Notwithstanding the foregoing, no order may be entered under this rule which expands the statutory time period for commencing an action or perfecting an appeal unless there is an affirmative showing that the failure to make a timely filing was due solely to an E-Filing System internal transmission error or a processing error by the court clerk.
11. Upon a showing of substantial good faith compliance with Rule 2,D, the court may waive nonjurisdictional defects in an E-Filing if it finds that no harm has occurred to any party as a result of the defective E-Filing.

Sections 48-157, 48-163, R.R.S. 2010.

Dolner vs. Peter Kiewit & Sons Co., 143 Neb. 384; 9 N.W. 2nd 483 (1943).

Effective date: January 21, 2016.

RULE 3

PLEADINGS

- A. All petitions, answers, motions, forms, proposed orders, and other pleadings and filings shall be printed or typewritten using nothing smaller than 12-point type in 8½- by 11-inch format. No reductions of print or type will be accepted. Double-spacing is allowed, but 1½ spacing is encouraged. All pages shall have 1-inch margins, except for the top margin of the first page, which shall have at least a 1½-inch margin. Facsimile copies are acceptable as provided in Neb. Ct. R. § 6-601 to 6-615.

Whenever a motion or stipulation is filed, a proposed order shall accompany such motion or stipulation. Proposed orders shall be submitted by separate document.

- B.** Every pleading subsequent to the petition, every written motion, every document relating to discovery or disclosure, and every written notice, appearance, designation of record on appeal, and similar document shall be served upon each of the parties by the initiating party. Except as provided in Rule 3,E, such party shall file proof of service with the court. Service and proof of service shall be made as follows:
1. Service upon an attorney or upon a party not represented by an attorney shall be made by:
 - a. delivering the document to the person to be served;
 - b. mailing it to the person to be served by first-class mail at the address designated pursuant to Rule 3,G, or if none is so designated, to the last-known address of the person;
 - c. leaving it at the person's office with the person's clerk or other person in charge thereof; or, if the office is closed or the person to be served has no office, leaving it at the person's dwelling house or usual place of abode with some person of suitable age and discretion then residing therein;
 - d. transmitting it by facsimile to the person, if the person has designated a fax number pursuant to Rule 3,G;
 - e. sending it to the person by electronic means if the person being served has designated an e-mail address pursuant to Rule 3,G; or
 - f. delivering it by electronic or other means consented to in writing by the party being served.
 2. Proof of service may be made by certificate of the attorney causing the service to be made or by certificate of the party not represented by an attorney. A certificate of service shall state the manner in which service was made on each person served.
 3. Service by mail is complete upon mailing. Service by facsimile or electronic means is complete upon transmission, but it is not effective if the person attempting to make service learns that the attempted service did not reach the person to be served.

4. Any requirement that a document or notice be written or in writing is satisfied if the document or notice is served by electronic means pursuant to Rule 3,B,1.
 5. Whenever a party has the right or is required to take some action within a prescribed period after the service of a notice or other document upon the party and the notice or document is served under Rule 3,B,1,b,d,e, or f, three days shall be added to the prescribed period.
- C.** In all proceedings involving approval or modification of a vocational rehabilitation plan, the moving party shall cause service of summons to be had on the Attorney General. Service on the Attorney General shall be made not less than 10 days prior to hearing, so that the Attorney General may have an opportunity to plead if requested by the court administrator.
- D.** The following shall apply to any motion or similar filing in which a hearing is required:
1. Except as otherwise provided by law, any motion or similar filing in which a hearing is requested shall be in writing and filed with the clerk of the court not less than five days prior to hearing except by permission of the trial judge.
 2. Counsel at the time of filing shall obtain a date for hearing from the judge to whom the case is assigned or the judge's secretary and file a notice of hearing with the filing. Unless approved by the judge, a hearing date must be obtained for each motion, even if motions in the same case are already scheduled.
 3. Notice of hearing shall be delivered to opposing counsel or party, if unrepresented, in accordance with Rule 3,B,1 three full days prior to hearing.
 4. To avoid delays in the progression of a case, the court shall refuse to consider any and all motions, including motions to compel, unless moving counsel, as part of the motion makes a showing that, after personal consultation with counsel for opposing party(ies) and reasonable efforts to resolve differences, counsel are unable to reach an accord. This showing shall recite, additionally, the date, time and place of such conference and the names of all participants. The term "counsel" shall include parties acting pro se.
- E.** Discovery materials that do not require action by the court shall not be filed with the court. All such materials, including notices of deposition, depositions,

certificates of filing a deposition, interrogatories, answers and objections to interrogatories, requests for documents or to permit entry upon land and responses or objections to such requests, requests for admissions and responses or objections to such requests, subpoenas for depositions or other discovery and returns of service of subpoenas, and related notices shall be maintained by the parties. Discovery materials shall be filed with the court only when ordered by the court or when required by law.

- F.** Copies of all correspondence sent to the court shall be given by the party originating the correspondence to all other parties of record in the case in accordance with Rule 3,B,1.
- G.** Any pleading or other document filed with, or correspondence received by, the court shall bear the typed or printed name and the signature of the preparer, the firm name if applicable, the complete address including the zip code, the telephone number, including the area code and the court's docket and page number if one has been assigned to the claim. If the document or correspondence has been prepared by legal counsel, the counsel's Nebraska Bar Association number shall also be listed. The signature block on any document may designate a fax number to which documents addressed to the signer may be sent by facsimile. The signature block on any document submitted for the pending case may designate an e-mail address to which documents addressed to the signer may be sent electronically.
- H.** The signature of an attorney or party constitutes the following:
 - 1. a certification by him or her that he or she has read the document;
 - 2. that it is not interposed for any improper purpose such as to harass or to cause unnecessary delay or needless increase in the cost of litigation;
 - 3. that to the best of his or her knowledge, information and belief formed after reasonable inquiry, it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification or reversal of existing law; and
 - 4. that any allegations or denials of facts have evidentiary support or, if specifically so identified, are likely to have evidentiary support after a reasonable opportunity for further investigation or discovery.
- I.** When a lawyer is not an attorney of record, such lawyer may prepare pleadings, briefs, and other documents to be filed with the court so long as such filings clearly indicate thereon that said filings are "Prepared By" along with the

name, business address, and bar number of the lawyer preparing the same, and that preparing such filings shall not be deemed an appearance by the lawyer in the case.

Sections 48-162.01, 48-163, R.R.S. 2010, and 48-162.03, R.S. Supp., 2014.

Effective date: January 21, 2016.

RULE 4

DISCOVERY

Discovery in the Workers' Compensation Court shall be pursuant to Neb. Ct. R. Disc. §§ 6-301 to 6-337. A pretrial conference may be scheduled and a pretrial order may be entered. If a pretrial order is entered, it will control the subsequent proceedings unless modified at trial to prevent manifest injustice.

Sections 48-163, 48-164, R.R.S. 2010.

Effective date: January 22, 2009.

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 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 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.
- C.** The employer in the case shall arrange for the interpreter. At the time of 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 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 pur-

suant 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.

Section 48-163, R.R.S. 2010.

Effective date: January 21, 2016.

RULE 6

PRETRIAL CONFERENCES

- A.** The court may in its discretion direct the attorneys for the parties and any unrepresented parties to appear before it for a conference or conferences before trial for such purposes as:
1. expediting the disposition of the action;
 2. establishing early and continuing control so that the case will not be protracted because of lack of management;
 3. discouraging wasteful pretrial activities;
 4. improving the quality of the trial through more thorough preparation, and;
 5. facilitating the settlement of the case.

A pretrial order may be entered, and if entered it will control the subsequent proceedings unless modified at trial to prevent manifest injustice.

- B.** Failure to appear at a conference, appearance at a conference substantially unprepared or failure to participate in good faith may result in any of the following sanctions:
1. an order entered by default;
 2. assessment of expenses and fees (either against a party or the attorney individually); or
 3. such other order as the court may deem just and appropriate.
- C.** The court may in its discretion schedule a pretrial mediation conference to be facilitated by a staff member of the court in accordance with Rule 48, for the purpose of facilitating settlement of the case.

Sections 48-163, 48-164, R.R.S. 2010.

Effective date: December 24, 1997.

RULE 7

ALLOTTED TIME FOR TRIAL

Cases set for trial shall be set by the court for an allotted time period of one-half day unless at least 45 days prior to trial, the court is notified by a party or the parties

that more or less time will be needed and the length of time that will be needed for trial of the case.

Section 48-163, R.R.S. 2010.

Effective date: August 31, 2011.

RULE 8

CONTINUANCES

No continuance will be granted because of a conflict in another court unless the case in the other court is set prior to the setting in this court nor because of any other conflict unless it predates the setting in this court and unless this court receives notification of such conflict immediately upon receipt of notice of hearing.

No continuance will be granted if a request for assignment of a vocational rehabilitation counselor pursuant to Rules 42 and 45, a request for informal dispute resolution pursuant to Rule 48, or a request for assignment of an independent medical examiner pursuant to Rule 63 is made less than 60 days prior to the date set for hearing.

A continuance may be granted at the discretion of the trial judge if good cause is shown.

Section 48-163, R.R.S. 2010.

Effective date: August 31, 2011.

RULE 9

REPORTING OR RECORDING THE PROCEEDINGS

The employer or, if insured, the employer's insurance carrier shall furnish a court reporter to be present and report or, by adequate mechanical means, to record and, if necessary, transcribe proceedings of any hearing. The reporter's charges for attendance shall be paid initially to the reporter by the employer or, if insured, by the employer's insurance carrier. The reporter shall faithfully and accurately report or record the proceedings. If the State of Nebraska, Workers' Compensation Trust Fund, is the only defendant, it shall furnish and pay initially the reporter's charges.

Sections 48-163, R.R.S. 2010, and 48-178, R.S. Supp., 2014.

Effective date: December 19, 2000.

RULE 10

EVIDENCE

A. Medical and Vocational Rehabilitation. The Nebraska Workers' Compensation Court is not bound by the usual common law or statutory rules of evidence; and accordingly, with respect to medical evidence on hearings before a judge of said court, written reports by a physician or surgeon duly signed by him, her or them and itemized bills may, at the discretion of the court, be received in evidence in lieu of or in addition to the personal testimony of such physician or surgeon; with respect to evidence produced by vocational rehabilitation experts, physical therapists, and psychologists on hearings before a judge of said court, written reports by a vocational rehabilitation expert, physical therapist, or psychologist duly signed by him, her or them and itemized bills may, at the discretion of the court, be received in evidence in lieu of or in addition to the personal testimony of such vocational rehabilitation expert, physical therapist, or psychologist. A sworn statement or deposition transcribed by a person authorized to take depositions is a signed, written report for purposes of this rule.

A signed narrative report by a physician or surgeon, vocational rehabilitation expert, or psychologist setting forth the history, diagnosis, findings and conclusions of the physician or surgeon, vocational rehabilitation expert, or psychologist and which is relevant to the case shall be considered evidence on which a reasonably prudent person is accustomed to rely in the conduct of serious affairs. The Nebraska Workers' Compensation Court recognizes that such narrative reports are used daily by the insurance industry, attorneys, physicians and surgeons and other practitioners, and by the court itself in decision making concerning injuries under the jurisdiction of the court.

Any party against whom the report may be used shall have the right, at the party's own initial expense, of cross examination of the physician or surgeon, vocational rehabilitation expert, or psychologist either by deposition or by arranging the appearance of the physician or surgeon, vocational rehabilitation expert, or psychologist at the hearing. Nothing in this rule shall prevent deposition or live testimony of the physician or surgeon, vocational rehabilitation expert, or psychologist. Unless exceptional cause is shown and extremely unusual circumstances exist, all evidence shall be submitted at the time of hearing.

If the original of a deposition is not in the possession of a party who intends to offer it in evidence at a hearing, that party shall give notice to the party in possession of it that the deposition will be needed at the hearing. Upon receiving

such notice, the party in possession of the deposition shall either make it available to the party who intends to offer it or produce it at the hearing.

- B. Motions for Summary Judgment or other Motions for Judgment on the Pleadings.** With respect to hearings on motions for summary judgment or other motions for judgment on the pleadings under section 48-162.03, the proceedings shall be governed by Neb. Rev. Stat. §§ 25-1330 et seq.

Sections 48-162, 48-163, 48-164, 48-168, R.R.S. 2010.

Effective date: August 31, 2011.

RULE 11

DECISIONS

- A. Meaningful Review.** Decisions of the court shall provide the basis for a meaningful appellate review. The judge shall specify the evidence upon which the judge relies.
- B. Official Version.** The official order, award, or judgment of the court shall be the original, signed version which is on file with the clerk of the court.
- C. Copies Mailed.** A copy of each order, award, or judgment will be mailed to all attorneys and self-represented parties.

Sections 48-163, R.R.S. 2010, and 48-178, R.S. Supp., 2014.

Effective date: August 31, 2011.

RULE 12

APPEALS

Repealed effective January 21, 2016.

RULE 13

TRANSCRIPT OF PLEADINGS

Repealed effective January 21, 2016.

RULE 14

BILL OF EXCEPTIONS

Repealed effective January 21, 2016.

RULE 15

RECORDS CHECKED OUT

Repealed effective January 21, 2016.

RULE 16

BRIEFS

Repealed effective January 21, 2016.

RULE 17

SCHEDULING, ARGUMENT, AND SUBMISSION

Repealed effective January 21, 2016.

RULE 18

SUMMARY DISPOSITIONS

Repealed effective January 21, 2016.

RULE 19

OPINIONS

Repealed effective January 21, 2016.

RULE 20

DISMISSAL OF APPEAL

Repealed effective January 21, 2016.

RULE 21

COSTS

Repealed effective January 21, 2016.

RULE 22

APPEAL AFTER REVIEW

Repealed effective August 31, 2011.

RULE 23

DISMISSAL DOCKET

As soon as practical after the 1st of January of each year and the 1st of July of each year, the clerk shall prepare a list of all pending cases in which no action has been taken for at least six months prior thereto. The court shall examine the list and, in those cases in which it is deemed proper, shall enter an order to show cause why such cases should not be dismissed for want of prosecution. A written response to the order to show cause must be filed in the action and a copy of the same provided to other counsel and the court within 30 days, or said action shall be dismissed.

Section 48-163, R.R.S. 2010.

Effective date: July 1, 1997.

RULE 24

MEETINGS OF THE COURT

In addition to the biennial meeting required by section 48-155, Revised Statutes of Nebraska, the court may hold other meetings at any time on call of the presiding

judge or upon request of a majority of the court. At such meetings any business of the court not at variance with statutory provisions may be transacted.

Sections 48-162, R.R.S. 2010, and 48-155, R.S. Supp., 2014.

Effective date: July 1, 1997.

RULE 25

COMPLIANCE WITH RULES

Wherever in these rules any requirement is made of the employer in a compensation case, compliance therewith by the employer's insurer or, if the employer is a member of a risk management pool, compliance therewith by such pool, will be deemed to be compliance by the employer.

Sections 48-144, 48-163, R.R.S. 2010.

Effective date: July 1, 1997.

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.
 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:

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

- 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).

Sections 48-120.04, R.S. Supp., 2014, and 48-120, R.S. Supp., 2015.

Effective date: December 9, 2015.

RULE 27

INSURANCE AND SELF INSURANCE

Repealed effective July 1, 2000.

RULE 28

CORPORATE EXECUTIVE OFFICER WAIVER

Repealed effective January 1, 2003.

RULE 29

FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY OR ILLNESS

- A.** In every case of reportable injury arising out of and in the course of employment, whether resulting from accident or from diagnosed occupational disease, the employer or its insurer or risk management pool shall file a report thereof with the compensation court, specifically stating the nature and extent of the injury. Such first report of alleged occupational injury or illness shall be filed within 10 days after the employer or insurer or risk management pool has been given notice or has knowledge of such injury.
- B.** Except as otherwise approved by the administrator of the compensation court, all first reports of alleged occupational injury or illness shall be filed electronically in the form and manner and to include the content prescribed by the administrator. With approval of the administrator, such reports may be filed by means of the paper First Report of Alleged Occupational Injury or Illness (Form 1), an exact copy of which appears on the two pages following this rule. The mandatory fields identified on the back of the Form 1 must be completed before the report will be deemed filed with the court. Blank forms for paper reports are furnished by the administrator upon request.
- C.** No report of alleged occupational injury or illness shall be deemed filed with the court until the report has been received and accepted by the court.

Sections 48-144, 48-144.01, 48-163, 48-165, R.R.S. 2010.

Effective date: December 15, 2011.

Nebraska Workers' Compensation Court

First Report of Alleged Occupational Injury or Illness

NWCC Form 1
Revised 12/2011

Employer							
Employer FEIN _____		SIC Code _____		Report Purpose _____		OSHA Log Case # _____	
Employer Name(s) _____ Address _____ City _____ State _____ Zip Code _____ Phone _____				Insured Name <i>(If different from employer name)</i> _____ Insured Address <i>(If different)</i> _____ Location _____			
Insurance Carrier							
Carrier FEIN _____				Administrator FEIN _____			
Name _____ Address _____ City _____ State _____ Zip Code _____ Phone _____				Claim Administrator <i>(Name, address & phone number)</i> _____ Self Insured <input type="checkbox"/> Claim Administrator Claim # _____ <i>Check if</i> Jurisdiction Claim # _____ <i>Appropriate</i>			
Policy Number _____ Policy Period: From _____ To _____				Insured Report # _____ Jurisdiction _____			
Insurance Carrier/Self-Insured Code # _____							
Employee							
Name <i>(Last, First, Middle)</i> _____ Address _____ City _____ State _____ Zip Code _____ Phone _____				Full Pay for DOI Yes <input type="checkbox"/> No <input type="checkbox"/> Salary Continued Yes <input type="checkbox"/> No <input type="checkbox"/>		Number of Days Worked/PerWeek _____	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth _____ Social Security Number _____ Date Hired _____				Number of Dependents _____		Occupational Job Title _____	
				Marital Status Married <input type="checkbox"/> Separated <input type="checkbox"/> Unmarried <input type="checkbox"/> Unknown <input type="checkbox"/>	Wage \$ _____ Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/>	Occupational Code _____ NCCI Class Code _____ Date Employee Began Work-Related Duties _____ Employment Status FT <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/>	
Occurrence/Treatment							
Date of Injury/Illness _____		Time Employee Began Work _____ AM <input type="checkbox"/> PM <input type="checkbox"/>		Time of Occurrence _____ AM <input type="checkbox"/> (Cannot be determined <input type="checkbox"/> PM <input type="checkbox"/>		Last Work Date _____	
Where Did Injury/Illness Occur? County _____ State _____ Zip _____				Did Injury/Illness Occur On Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Date Employer Notified _____		Date Disability Began _____		Date Returned to Work _____		If Fatal, Give Date of Death _____	
Type of Injury/Illness <i>(Briefly describe the nature of the injury or illness; e.g. lacerations to forearm)</i> _____						Nature of Injury Code _____	
Part of Body Affected <i>(Indicate the part of the body affected by the injury/illness; e.g. right forearm, lowerback; and how it was affected)</i> _____						Part of Body Code _____	
How Injury/Illness Occurred <i>(Describe activity and tools, materials, equipment the employee was using; how injury occurred)</i> _____						Cause of Injury Code _____	
Initial Treatment: No medical treatment <input type="checkbox"/> Emergency Room <input type="checkbox"/> Future major First aid by employer <input type="checkbox"/> Hospitalized overnight <input type="checkbox"/> medical/lost Minor clinic/hospital <input type="checkbox"/> Hospitalized > 24 hours <input type="checkbox"/> time <input type="checkbox"/>				Name of physician or other health care provider: _____			
Date Administrator Notified _____		Form Preparer's Name, Title and Phone _____				Date Prepared _____	

-REDUCED IN SIZE-

General Instructions

Underlined items are mandatory fields. A first report of injury or illness submitted without this information will be returned unfiled.

Employer:

- Employer FEIN — the employer/insured's Federal Employer's Identification Number.
- SIC Code — Standard Identification Classification code which represents the nature of the employer's business.
- Report Purpose — defines the specific purpose of the transaction (examples: original = 00; cancel = 01; change = 02; denial = 04; correction = CO).
- OSHA Log Case # — the Log Case number required for reporting to OSHA.
- Employer Name — include all business names/doing business as (dba).
- Address (including city, state, and zip code) — the address of the employer's actual location where the employee was employed at the time of the injury.
- Phone — phone number at the employer's facility.
- Insured Name (if different from employee) — the named insured on the policy or the financially responsible self-insured employer.
- Insured Address (if different from employer) — mailing address of the insured.
- Location — a code defined by the insured/employer which is used to identify the employer's location.

Insurance Carrier:

- Carrier FEIN — carrier's Federal Employer's Identification Number.
- Administrator FEIN — administrator's Federal Employer's Identification Number.
- Name — the workers' compensation insurer, approved self insured, or intergovernmental risk management pool.
- Address — address, city, state and zip code of insurer.
- Phone — phone number of insurer.
- Claim Administrator (name, address, & phone) — enter the name, address and phone number of the carrier, third party administrator, risk management pool, or self-insurer responsible for administering the claims, if different from carrier information.
- Policy # — the number assigned to the contract/policy for that employer.
- Policy Period — the effective and expiration dates of the contract/policy.
- Insurance Carrier/Self Insured Code # — for insurance carriers, the number assigned by the Nat'l Assn. of Insurance Commissioners. For self-insured employers, the code number assigned by the court.
- Self Insured — check if appropriate.
- Claim Administrator Claim # — identifies a specific claim within a claim administrator's claims processing system.
- Jurisdiction Claim # — number assigned by the court when the initial First Report is accepted.
- Insured Report # — a number used by the insured to identify a specific claim.
- Jurisdiction — the governing body or territory whose statutes apply (NE).

Employee:

- Name — give full name as shown on payroll (avoid initials if possible).
- Address — address, city, state and zip code of employee.
- Social Security Number. The social security number must be provided. This is mandatory pursuant to Neb Rev Stat. §48-144, Rule 29 of the Workers' Compensation Court Rules of Procedure, and Section 7(a)(2)(B) of the Privacy Act of 1974. The social security number is used by the Nebraska Workers' Compensation Court for purposes of verifying the identity of the employee and administering the Nebraska Workers' Compensation Act. It is a unique identifier and is needed because of the number of persons who have similar names and birth dates, and whose identities can only be distinguished by social security number. The social security number may also be shared with claims handling entities for purposes of processing a claim for workers' compensation benefits and verifying the identity of the claimant.
- Date of Birth — the date the injured worker was born.
- Date Hired — the date the injured worker began his/her employment with the employer.
- Full Pay for DOI (date of injury) — check one.
- Salary Continued — check one.
- Number of Days Worked Per Week — the number of the employee's regularly scheduled work days per week.
- Sex — check one.
- Number of Dependents — the number of dependents as defined by the Nebraska Workers' Compensation Act.
- Marital Status — check one.
- Wage — check one and state wage.
- Occupational Job Title — the primary occupation of the claimant at the time of the accident.
- Occupational Code — Standard Occupational Classification code used to identify the primary occupation of the employee at the time of the accident.
- NCCI Code — The identifying number for an occupational classification.
- Date Employee Began Work-Related Duties — date pertaining to employee's present occupation.
- Employment Status — check one.

Occurrence/Treatment

- Date of Injury/Illness — date on which the accident occurred (only one date of injury per form).
- Time Employee Began Work — time employee began work for that date.
- Time of Occurrence — time of day the injury occurred.
- Last Work Date — the last paid work day prior to the initial date of disability.
- Where Did Injury/Illness Occur — complete county, state, and zip code.
- Did Injury/Illness Occur On Employer's Premises — check one.
- Date Employer Notified — the date that the injury was reported to a representative of the employer.
- Date Disability Began — if not disabled answer none and skip questions.
- Date Returned to Work — if injured has returned to work, complete this question.
- If Fatal, Give Date of Death, (date employee died as a result of the work-related injury.)
- Type of Injury/Illness — describe the nature of injury.
- Nature of Injury Code — the code which corresponds to the nature of the injury sustained by the employee.
- Part of Body Affected — the part of the body to which the employee sustained injury.
- Part of Body Code — the code which corresponds to the Part of the body to which the employee sustained injury.
- How Injury/Illness Occurred — a free-form description of how the accident occurred and the resulting injuries.
- Cause of Injury Code — the code that corresponds to the cause of injury.
- Initial Treatment — check one.
- Name of physician or other health care provider — provide name of physician or other health care provider that treated employee for injury.
- Date Administrator Notified — the date the claim administrator who is processing the claim received notice of the loss or occurrence.
- Form Preparer's Name, Title and Phone.

—REDUCED IN SIZE—

RULE 30

SUBSEQUENT REPORT

- A.** In every case in which benefit payments have been made a subsequent report shall be filed with the court by the employer or its insurer or risk management pool. All such reports shall include cumulative weekly, medical, hospital, vocational rehabilitation and other benefit payments, and shall be filed within the timeframe prescribed by the administrator of the compensation court. A subsequent report must be filed even for cases in which only medical or other non-income benefit payments have been made. For cases in which the employer has continued to pay full salary, any portion of the full salary payment that was intended to apply to workers' compensation benefits shall be reported.
- B.** Except as otherwise approved by the administrator of the compensation court, all subsequent reports shall be filed electronically in the form and manner, and to include the content prescribed by the administrator. With approval of the administrator, such reports may be filed by means of the paper Subsequent Report (Form 4), an exact copy of which appears on the two pages following this rule. The mandatory fields identified on the back of the Form 4 must be completed before the report will be deemed filed with the court. Blank forms for paper reports are furnished by the administrator upon request.
- C.** No subsequent report shall be deemed filed with the court until the report has been received and accepted by the court.

Sections 48-144, 48-163, 48-165, R.R.S. 2010.

Effective date: April 24, 2008.

General Instructions

Items in bold are mandatory fields. Subsequent Report of Injury (SROI) without this information will be returned.

Item—Definitions

- Employee Name—the injured worker's legally recognized name.
 - **Social Security Number**—a number assigned by the Social Security Administration used to identify the employee.
 - **Date of Injury**—date on which the accident occurred (*only one date of injury per form*).
 - Report Effective Date—The date the payment which causes the form to be filed was made.
 - **Jurisdiction—the governing body or territory whose statutes apply (NE).**
 - Date Disability Began—the first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by the jurisdiction.
 - Pre-Existing Disability—identifies the existence of a disability that existed prior to the injury.
 - Date of Representation—the date the claim administrator became aware that the claimant had secured legal representation.
 - Date of Death—the date the injured worker died.
 - Report Purpose—The MTC (maintenance type code) that corresponds to the reason the form is being filed.
 - Released/Returned to Work (RTW) Date—the date, following the most recent disability period, on which the employee actually returned to work, or was released to return to work, as identified by the return to work qualifier.
 - Released/RTW Qualifier—a code identifying the employee's return to work status, with or without physical restrictions.
 - Agency Claim Number—the number assigned by the Nebraska Workers' Compensation Court to identify a specific claim.
 - Number of Dependents—the number of dependents as defined by the Nebraska Workers' Compensation Act.
 - Death Dependent/Payee Relationship—the relationship of the dependent(s)/payee(s) to the deceased employee; to which relationship and benefit entitlement may be determined by an adjudicator's decision for distribution of the death benefit.
 - Date of Maximum Medical Improvement—the date after which further recovery from or lasting improvement to an injury or disease can no longer be anticipated based upon reasonable medical probability.
 - Permanent Impairment Body Part Code—a code referencing the part(s) of body permanently impaired.
 - Permanent Impairment Percentage—report the amount of part(s) of body or functional abnormality or loss which results from the injury and exists after the date of maximum medical improvements.
 - Employer Name—the name of the business entity of the insured where the employee was employed at the time of the injury.
 - **Employer FEIN—the Federal Employer's Identification Number of the employer where the employee was employed at the time of the injury.**
 - Insured Report Number—a number used by the insured to identify a specific claim.
- Wage**
- Wage Period—a code indicating the time period during which the wage was earned.
 - Average Weekly Wage—the average wage of the employee at the time of injury as calculated by the claims administrator or jurisdictional authority for the wage period.
 - Number of Days Worked Per Week—the number of the employee's regularly scheduled work days per week.
 - Salary Continued In Lieu of Comp—the employer has paid or is paying the employee's salary in lieu of compensation during an absence caused by a work-related injury.
- Payments**
- Payment Type—a code that identifies the payment being made.
 - Payment From Date—the first start date of a benefit period for which benefits were paid.
 - Payment Through Date—the last date of a benefit period for which benefits were paid.
 - Payment Weeks Paid—the number of whole weeks for a specific payment code.
 - Payment Days Paid—the number of days paid for a specific payment code.
 - Payment Weekly Amount—the net weekly rate for the payment code being paid.
 - Payment Paid to Date—the cumulative amount paid for the payment code being paid.
- Benefit Adjustments**
- Benefit Adjustment Type— DO NOT USE. Reserved for future use.
 - Benefit Adjustment Weekly Amount— DO NOT USE. Reserved for future use.
 - Benefit Adjustment Start Date— DO NOT USE. Reserved for future use.
- Paid-To-Date**
- Paid to Date Type—a code that identifies the type of paid to date/reduced earnings/recoveries made.
 - Paid to Date Amount—the amount defined by the paid to date/reduced earnings/recoveries code.
- Claim Administrator**
- Insurer Name—the name of the insurer or self insured assuming the employer's financial responsibility for workers' compensation claim(s).
 - **Insurer FEIN—insurer's Federal Employer's Identification Number.**
 - Third Party Administrator Name—the name of the Third Party Administrator contracted to adjust the claim on behalf of the carrier or self insured.
 - Third Party Administrator FEIN—the Federal Employer's Identification Number of the third party administrator's independent adjuster, contracted to adjust the claim on behalf of the insurer or self insured.
 - **Claim Administrator Claim Number—identifies a specific claim within a claim administrator's claims processing system.**
 - Claim Administrator Address—the address, including zip code, and telephone number of the claim administrator.
 - Form Preparer's Name—the name of the person completing the form.
- Claim Status**
- **Claim Status—a code representing the current status of the claim.**
 - Claim Type—a code representing the current benefit classification of the claim as interpreted by the jurisdiction
 - Agreement to Compensate—a code used to identify the condition under which compensation benefits are being paid.
 - Late Reason—a code which identifies the reasons payment/report was not made within a jurisdiction's requirements.
 - Date Prepared—the date the form preparer completed the form.
 - Preparer's Phone—the phone number of the person completing the form.

Type or print neatly your response in ink.

—REDUCED IN SIZE—

RULE 31
PERIODIC REPORT OF
CONTINUING COMPENSATION

Repealed effective July 1, 1995.

RULE 32
REPORTING OF COMPENSATION INSURANCE

- A.** The insurer shall file a report as required by section 48-144.02 with the court within 10 days after a workers' compensation insurance policy is written, renewed, extended, or reinstated. The insurer shall give notice to the court of cancellation or nonrenewal of a workers' compensation insurance policy as required by section 48-144.03.
- B.** Any such report or notice shall be provided in writing or by electronic means, if such electronic means is approved by the administrator of the court. If such report or notice is filed by electronic means pursuant to such an approval, it shall be deemed given upon receipt and acceptance by the court. Written reports or notices filed with the court shall be made by means of the Record of Compensation Insurance (Form 12), and shall be deemed given upon the mailing of such report or notice by certified mail.
- C.** If an endorsement changes neither the insured's name, address, the effective date nor the expiration date, and does not affect the policy number, then it is not necessary to file another report with the court.
- D.** For multiple entities with the same policy number, each different name and address shall be reported to the court. If there are multiple locations, the locations shall be listed separately.
- E.** The Form 12P shall be filed by the risk management pool with the court within 10 days after the pool is organized showing the name and local addresses of its members. Within 10 days after any new member is accepted or whenever any member of a pool voluntarily terminates membership or is involuntarily terminated, the Form 12P shall be filed with the court showing the name, local address and effective date of termination or joinder of any single member. For multiple entities within the jurisdiction of a single member, each different name and address shall be listed on the Form 12P or on an attached sheet. If

there are multiple locations in Nebraska, the locations shall be listed on the Form 12P or on an attached sheet.

- F.** Exact copies of the Record of Compensation Insurance (Form 12) and the Record of Compensation Insurance – Form 12P appear on the two pages following this rule.

Sections 48-144.02, 48-144.03, 48-144.04, 48-146.01, 48-146.03, R.R.S. 2010.

Effective date: June 6, 2006.



Nebraska Record of Compensation Insurance — Form 12P Intergovernmental Risk Management Pool

To be used to provide information on each pool member involved in the event of organization, joinder, or termination, within 10 days of the event. Only one member of a pool may be reported on a Form 12P.

1. Name and Address of Member of Risk Management Pool:

Phone: _____ Dept. of Insurance Code: _____

2. Name of Member: _____

3. Event Reported (check one and give the effective date):

Initial Organization of Pool Effective Date: _____
 New Member Effective Date: _____
 Termination of Member Effective Date: _____

4. For workers' compensation purposes, list any separately named entities under the jurisdiction of this member from which employees work and the location. (If additional space is needed, attach a separate sheet.)

Name	Address	FEIN
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Name of Pool Administrator: _____

Address: _____

6. Prepared by (please type): _____

Phone: _____

7. Mail to: **Nebraska Workers' Compensation Court**
PO Box 98908
Lincoln NE 68509-8908
402-471-6468 or 800-599-5155

RULE 33

FIRST TREATMENT MEDICAL REPORTS

Words in italics are defined in Rule 49.

In all cases involving medical treatment, a report by the treating *physician* shall be furnished to the employer within 14 days following the first treatment specifically setting forth the nature and extent of the injury or disease. The current Form CMS – 1500 shall be used to meet the requirements of this rule.

Sections 48-165, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: November 14, 2007.

RULE 34

30-DAY MEDICAL REPORT

Repealed effective October 27, 1998.

RULE 35

BLANK FORMS

Upon request, copies of blank forms required or used by the court will be furnished to employees, employers, insurers, risk management pools, or other persons having need thereof, in any quantity needed, to the extent that such supplies are available. The court may charge a fee sufficient to pay the costs incurred in the preparation and delivery of the forms. Employers, insurers, risk management pools, or others may furnish and use their own forms providing such forms are first approved by the court.

Sections 48-163, 48-165, R.R.S. 2010.

Effective date: December 1, 1999.

RULE 36

ELIGIBILITY AND APPROVAL OF VOCATIONAL REHABILITATION SERVICES

- A.** Vocational rehabilitation services shall be made available as soon as it has been medically determined that the employee is capable of undertaking such activity and that he or she is unable to perform suitable work for which he or she has had previous training or experience.
- B.** All proposed vocational rehabilitation plans shall be evaluated by a vocational rehabilitation specialist of the court and approved or disapproved by such specialist. Any party who refuses to accept the decision of the specialist may request a hearing before a judge of the court.
 - 1. Notice of all plans approved or disapproved by a specialist of the court shall be sent to the employee, and either the employer, its workers' compensation insurer or risk management pool, and the vocational rehabilitation counselor.
 - 2. If a plan is approved by a specialist of the court, such employer or workers' compensation insurer or risk management pool shall inform the specialist within 14 days of the date such notice is sent whether or not it will accept the plan and shall concurrently with such acceptance agree to the payment of temporary disability to the employee while he or she is participating in the plan and making satisfactory progress.
 - 3. Failure of an employee to participate or make satisfactory progress in a plan approved by a specialist of the court and voluntarily agreed to by the employer may result in cancellation of the plan by the specialist or termination of funding by the administrator of the court. Any party who refuses to accept the decision of the specialist or administrator may request a hearing before a judge of the court.

Sections 48-121, 48-162.01, 48-163, 48-165, R.R.S. 2010.

Effective date: December 18, 2008.

RULE 37
VOCATIONAL REHABILITATION
REPORTING

Words in italics are defined in Rule 49.

- A.** When a vocational rehabilitation counselor is agreed to or appointed pursuant to Rule 42, any reports provided to any party that are prepared by such vocational rehabilitation counselor or job placement specialist acting under the supervision of such vocational rehabilitation counselor shall be provided to all parties, with an additional copy sent directly to the employee. An additional copy shall also be sent to the court, except that reports relating to a loss of earning power evaluation shall be sent to the court only if the counselor is also agreed to or appointed to provide vocational rehabilitation services.
- B.** In all cases involving an approved training plan, the vocational rehabilitation counselor shall provide the court with the employee's grade report or transcript which includes the term and cumulative grade point averages and a copy of the employee's class schedule for the next training period, including the days of the week. These shall be provided on or before the first class day of the next training period. The employee shall provide the counselor with a signed release form authorizing the training provider to release the employee's grade report, transcript, and class schedule to the counselor. Failure of the vocational rehabilitation counselor to provide a copy of the class schedule, grade transcript or a training progress report, or any other data requested by the court when due may result in a loss of funding or cancellation of the employee's vocational rehabilitation plan.
- C.** When an employee fails to make satisfactory progress or discontinues participating in an approved vocational rehabilitation plan, the court shall be immediately notified by the vocational rehabilitation counselor. The vocational rehabilitation counselor shall also promptly notify the employer or his or her insurer, in writing, when an employee has discontinued participating in an approved vocational rehabilitation plan.
- D.** The vocational rehabilitation counselor shall notify the court within five working days of termination of vocational rehabilitation services using a form developed by the court for such purpose.

- E. Failure of a vocational rehabilitation counselor to comply with the reporting requirements of this rule may cause the certification of such counselor to be denied, *revoked*, or placed in a *probationary status*.

Sections 48-162.01, 48-163, 48-165, R.R.S. 2010.

Effective date: December 12, 2013.

RULE 38
VOCATIONAL REHABILITATION
COSTS

- A. Costs of tuition, books, tools, and such other fees and costs as are deemed appropriate by the court shall be paid directly to the service provider or payor from the Workers' Compensation Trust Fund upon receipt of a training progress report, as required, and proper billing or other appropriate documentation.
- B. When residence is required at or near the facility or institution away from the employee's customary residence and board and/or lodging is available at the training facility, such costs shall be paid directly to the training facility from the Workers' Compensation Trust Fund upon receipt of proper billing.
- C. When residence is required at or near the facility or institution away from the employee's customary residence and board and lodging are available at the training facility or institution and the employee elects to utilize local housing in lieu of that available at the training facility or institution, the equivalent of the published cost of the training facility's or institution's board and lodging, but not local travel, may be paid directly to the employee from the Workers' Compensation Trust Fund. Such costs shall be established and approved by the court.
- D. When residence is required at or near the facility or institution, away from the employee's customary residence and board and/or lodging is not available at the training facility, the reasonable cost of board, lodging and travel will be paid directly to the employee from the Workers' Compensation Trust Fund. Such costs shall be established and approved by the court.
- E. When it is in the best interests of the employee to commute to and from the facility or institution rather than to reside at or near the facility or institution the reasonable cost of travel or the equivalent of the reasonable cost of room and

board, whichever is lower, may be paid directly to the employee from the Workers' Compensation Trust Fund. Such costs shall be established and approved by the court.

Sections 48-162.01, 48-162.02, 48-163, R.R.S. 2010.

Effective date: December 19, 2000.

RULE 39

VOCATIONAL REHABILITATION CERTIFICATION OF VOCATIONAL REHABILITATION SERVICE PROVIDERS

Words in italics are defined in Rule 49.

- A.** The court will certify vocational rehabilitation service providers in the following areas: vocational rehabilitation counselor and job placement specialist.
- B.** No vocational rehabilitation service provider shall provide vocational rehabilitation services unless he or she has satisfied the standards for certification established by the court and has been certified by the court.
- C.** Any loss of earning power evaluation performed by a vocational rehabilitation counselor shall be performed by a vocational rehabilitation counselor who has satisfied the standards for certification established by the court and has been certified by the court.
- D.** Certification may be denied, *revoked*, or placed in a *probationary status* if the court determines that the vocational rehabilitation service provider is not capable of rendering competent vocational rehabilitation services or for any of the following reasons:
 - 1. Failure to comply with the ethical standards and responsibilities established by the court or the generally accepted standards of conduct in the vocational rehabilitation profession, including but not limited to the Code of Professional Ethics for Rehabilitation Counselors adopted by the Commission on Rehabilitation Counselor Certification.
 - 2. Conviction of a crime that is reasonably related to professional activities performed in providing vocational rehabilitation services.
 - 3. Deliberately withholding pertinent information from or submitting false or misleading information to any of the parties, another vocational rehabilitation service provider, or the court.

4. Failure to provide sufficient supporting documentation or deliberately presenting false or misleading information or omitting relevant facts in the application for certification under Rules 40 and 41.
 5. Failure to comply with the reporting requirements of Rule 37.
 6. Failure to comply with the requirements of the Nebraska Workers' Compensation Act or the court's Rules of Procedure.
- E.** Certification of a vocational rehabilitation service provider shall not be denied, *revoked*, or placed in a *probationary status* pursuant to Rules 37, 39, 40, or 41 until after he or she has had notice and an opportunity to be heard by a judge of the court. A request by a vocational rehabilitation service provider to be heard by a judge of the court shall not stay operation of the denial, *revocation*, or *probationary status* unless such a stay is ordered by the judge.

Sections 48-162.01, 48-163, R.R.S. 2010.

Effective date: November 16, 2006.

RULE 40

VOCATIONAL REHABILITATION CERTIFICATION OF COUNSELORS

Words in italics are defined in Rule 49.

- A.** The vocational rehabilitation counselor certification process is designed to ensure individuals working in this specialized area of rehabilitation have attained an acceptable level of education, knowledge, and experience necessary to provide all relevant vocational rehabilitation services to the employee, and are otherwise capable of rendering competent vocational rehabilitation services to the employee.
- B.** For the purpose of the Nebraska Workers' Compensation Act, the vocational rehabilitation counselor, to be eligible for certification, shall meet the required education and/or experience. All education and/or experience claimed and used as a basis for certification shall have been attained at the time of application. Acceptable experience shall be:
1. Paid employment performing five or more of the following duties:
 - a. Client Assessment;
 - b. Transferable Skills Analysis;

- c. Labor Market Research and Analysis;
 - d. Vocational Counseling;
 - e. Job Placement;
 - f. Loss of Earning Power Evaluation;
 - g. Application of Medical Information to Vocational Rehabilitation;
 - h. Vocational Plan Development and Implementation;
 - i. Case Management.
2. Professionally supervised internships, preceptorships, or practica performing five or more of the duties listed in Rule 40,B,1, whether paid or unpaid.
- C. Certification shall be for a period of two years. To be eligible for certification, the applicant shall present documentary evidence that he/she has attained:
- 1. A master's or doctoral degree in rehabilitation counseling or rehabilitation administration from an accredited college or university, or;
 - 2. A master's or doctoral degree in a counseling discipline from an accredited college or university, and 1,000 hours acceptable experience or;
 - 3. A master's or doctoral degree in a human services field and 2,000 hours acceptable experience or;
 - 4. Designation of Certified Rehabilitation Counselor (CRC) from the Certification of Rehabilitation Counselor Commission (CRCC), or;
 - 5. Certification as a Fellow or Diplomate by the American Board of Vocational Experts (ABVE), or;
 - 6. Designation of Certified Vocational Evaluator (CVE) from the Commission on the Certification of Work Adjustment and Vocational Evaluation Specialists (CCWAVES), and 2,000 hours acceptable experience or;
 - 7. A bachelor's degree in a human services related field and at least 4,000 hours acceptable experience or;
 - 8. A bachelor's degree in any field (other than human services), at least 4,000 hours acceptable experience and completion of at least nine credit hours of training or course work from an accredited college or university or 110 contact hours of CCMC/ CDMSC/ CRCC/ CCWAVES/ IARPS/ NBCC/ ABVE approved continuing education units in any of the following subject areas:

- a. Medical (and/or psychological) aspects of disability;
- b. Counseling theories;
- c. Vocational evaluation and testing;
- d. Occupational and labor market information;
- e. Rehabilitation plan development and implementation;
- f. Job placement process in rehabilitation;
- g. Introduction to/overview of rehabilitation;
- h. Loss of earning power evaluations.

D. An individual desiring certification as a vocational rehabilitation counselor shall submit to the court:

1. A completed application for certification. A form developed by the court shall be used for this purpose.
2. An official college transcript or, if applicable, proof of national certification by CRCC, CCWAVES, or ABVE.
3. A detailed employment history including at a minimum: names, addresses, and telephone numbers of the applicant's employers and immediate supervisors; inclusive dates of employment; and copies of official job descriptions or detailed summaries of job responsibilities for positions intended to meet the required employment experience.
4. Any other information, including supporting documentation, as requested by the court.

E. Individuals shall apply for renewal of certification within 60 days prior to the expiration date of their current certification period. Upon receipt of a written request, the court at its discretion, may grant the vocational rehabilitation counselor additional time to apply for renewal. If certification is not renewed, either at the normal expiration date or within the time prescribed by the court, the individual will be notified that his or her certification has not been renewed. The individual's name shall be removed from the directory of certified vocational rehabilitation counselors maintained by the court, and the counselor shall provide no further services in cases subject to the Act. The counselor shall notify the court of all employees for whom services are currently being provided, and a new counselor will be agreed to or appointed pursuant to Rule 42.

- F.** An individual desiring renewal of certification as vocational rehabilitation counselor shall submit to the court:
1. A completed application for certification. A form developed by the court shall be used for this purpose.
 2. Documentary evidence that he or she has completed 24 contact hours of continuing education. A minimum of two hours shall be in ethics. Continuing education contact hours shall be approved by CCMC/ CDMSC/ CRCC/ CCWAVES/ IARPS/ NBCC/ ABVE or the court's vocational rehabilitation section. Hours not approved by one of the certifying boards listed shall be in the areas identified in Rule 40,C,8. The dates of completion of continuing education hours must fall within the current certification period.
 3. Any other information, including supporting documentation, as requested by the court.
- G.** A counselor whose certification has not been renewed shall reapply for certification in order to provide services under the Act. In order to be eligible for certification after nonrenewal the applicant shall submit to the court:
1. A completed application for certification. A form developed by the court shall be used for this purpose.
 2. Documentary evidence that he or she has completed at least 24 contact hours of continuing education. A minimum of two hours shall be in ethics. Continuing education contact hours shall be approved by CCMC/ CDMSC/ CRCC/ CCWAVES/ IARPS/ NBCC/ ABVE or the court's vocational rehabilitation section. Hours not approved by one of the certifying boards listed shall be in the areas identified in Rule 40,C,8. The dates of completion of continuing education hours must fall within the 24 months immediately preceding the application for certification.
 3. Any other information, including supporting documentation, as requested by the court.
- H.** Failure to provide sufficient supporting documentation or deliberately presenting false or misleading information or omitting relevant facts in the application may cause certification to be denied, *revoked*, or placed in *probationary status*.

Sections 48-162.01, 48-163, 48-165, R.R.S. 2010.

Effective date: November 16, 2006.

RULE 41

VOCATIONAL REHABILITATION CERTIFICATION OF JOB PLACEMENT SPECIALISTS

Words in italics are defined in Rule 49.

- A.** The job placement specialist certification process is designed to ensure individuals working in this specialized area of rehabilitation have attained an acceptable level of education and experience necessary to provide all relevant services to the employee, and are otherwise capable of rendering competent job placement services to the employee.
- B.** The job placement specialist, under the supervision of the vocational rehabilitation counselor, shall be responsible for assisting the employee in returning to gainful employment within the individual's capabilities. In conjunction with the vocational rehabilitation counselor, the job placement specialist shall confirm the employee's job readiness and overall preparation to seek employment.
- C.** The job placement specialist shall work closely with the employee to identify appropriate potential positions and/or vacancies for which the individual should apply. These positions shall be consistent with the employee's skills, interests, aptitudes, physical limitations and restrictions, and the specific vocational goal(s) listed on the approved vocational rehabilitation plan written by a vocational rehabilitation counselor.
- D.** A vocational rehabilitation counselor or job placement specialist employed by a state agency providing vocational rehabilitation services and not working as a private vocational rehabilitation service provider shall be exempt from meeting job placement specialist certification or renewal of certification requirements for so long as he or she remains employed by such agency and shall be considered qualified and certified to provide job placement services.
- E.** To be eligible for job placement specialist certification, the applicant shall meet the required education and/or experience. All education and/or experience claimed and used as a basis for certification shall have been attained at the time of application. Acceptable experience shall be:
 - 1. Paid employment performing all of the following duties:
 - a. Job development;
 - b. Resume writing;

- c. Interview assistance;
 - d. Job lead identification;
 - e. On-the-job-training development;
 - f. Employee and employer follow up.
2. Professionally supervised internships, preceptorships, or practica performing all of the duties listed in Rule 41,E,1, whether paid or unpaid.
- F.** Certification shall be for a period of two years. To be eligible for certification, the applicant shall present documentary evidence that he/she has attained:
1. A master's degree or higher in a counseling discipline from an accredited college or university, or;
 2. Designation of Certified Rehabilitation Counselor (CRC) from the Certification of Rehabilitation Counselor Commission, or; Rehabilitation Counselor Commission (CRCC), or;
 3. Certification as a Fellow or Diplomate by the American Board of Vocational Experts (ABVE), or;
 4. Designation of Certified Vocational Evaluator (CVE) from the Commission on the Certification of Work Adjustment and Vocational Evaluation Specialists (CCWAVES), and 2,000 hours acceptable experience or;
 5. A bachelor's degree in a human services field from an accredited postsecondary institution and 1,000 hours acceptable experience, or;
 6. An associate degree or higher from an accredited postsecondary institution, and 2,000 hours acceptable experience, or;
 7. A minimum of 6,000 hours acceptable experience.
- G.** An individual desiring certification as a job placement specialist shall submit to the court:
1. A completed application for certification. A form developed by the court shall be used for this purpose.
 2. An official transcript from the postsecondary institution or, if applicable, proof of national certification.
 3. A detailed employment history including at a minimum: names, addresses, and telephone numbers of the applicant's employers and immediate supervisors; inclusive dates of employment; and copies of official job descrip-

tions or detailed summaries of job responsibilities for positions intended to meet the required employment experience.

4. Any other information, including supporting documentation, as requested by the court.

H. Individuals shall apply for renewal of certification within 60 days prior to the expiration date of their current certification period. Upon written request the court, at its discretion, may grant the job placement specialist additional time to apply for renewal. If certification is not renewed, either at the normal expiration date or within the time prescribed by the court, the individual will be notified that his or her certification has not been renewed. The individual's name shall be removed from the directory of certified job placement specialists maintained by the court, and the job placement specialist shall provide no further services in cases subject to the Nebraska Workers' Compensation Act. The job placement specialist shall notify the court of all employees for whom services are currently being provided.

I. An individual desiring renewal of certification as a job placement specialist shall submit to the court:

1. A completed application for certification. A form developed by the court shall be used for this purpose.
2. Documentary evidence that he or she has completed at least 24 contact hours of continuing education. A minimum of two hours shall be in ethics. Continuing education contact hours shall be approved by CCMC/ CDM-SC/ CRCC/ CCWAVES/ IARPS/ NBCC/ ABVE or the court's vocational rehabilitation section. Hours not approved by one of the certifying boards listed shall be in the areas identified in Rule 41,E,1. The dates of completion of continuing education hours must fall within the current certification period.
3. Any other information, including supporting documentation, as requested by the court.

J. A job placement specialist whose certification has not been renewed shall re-apply for certification in order to provide services under the Act. In order to be eligible for certification after nonrenewal the applicant shall submit to the court:

1. A completed application for certification. A form developed by the court shall be used for this purpose.
2. Documentary evidence that he or she has completed at least 24 contact hours of continuing education. A minimum of two hours shall be in ethics.

Continuing education contact hours shall be approved by CCMC/ CDM-SC/ CRCC/ CCWAVES/ IARPS/ NBCC/ ABVE or the court's vocational rehabilitation section. Hours not approved by one of the certifying boards listed shall be in the areas identified in Rule 41,E,1. The dates of completion of continuing education hours must fall within the 24 months immediately preceding the application for certification.

3. Any other information, including supporting documentation, as requested by the court.
- K.** Failure to provide sufficient supporting documentation or deliberately presenting false or misleading information or omitting relevant facts in the application may cause certification to be denied, *revoked*, or placed in *probationary status*.

Sections 48-162.01, 48-163, 48-165, R.R.S. 2010.

Effective date: November 16, 2006.

RULE 42

VOCATIONAL REHABILITATION CHOICE OF COUNSELOR

- A.** If entitlement to vocational rehabilitation services is claimed by the employee, or a loss of earning power evaluation is desired by any party, the selection requirements of section 48-162.01(3) shall apply. The parties shall make a good faith attempt to agree on the choice of a vocational rehabilitation counselor from the directory of vocational rehabilitation counselors.
1. Any party may propose the selection of a vocational rehabilitation counselor from the directory.
 2. The proposed vocational rehabilitation counselor shall obtain written agreement of his or her selection from each of the parties. The vocational rehabilitation counselor may contact the parties directly for this purpose. If agreement of all parties is obtained, the vocational rehabilitation counselor shall notify the court of his or her selection within five working days, using a form developed by the court.

Before agreement is obtained from the employee, the vocational rehabilitation counselor must provide written notice to the employee of his or her rights regarding the selection of the vocational rehabilitation counselor. The written notice shall include:

- a. The employee's right to agree to the proposed vocational rehabilitation counselor to provide vocational rehabilitation services and/or perform a loss of earning power evaluation;
- b. The employee's right not to agree to the proposed vocational rehabilitation counselor;
- c. The employee's right to propose a vocational rehabilitation counselor of his or her own choosing from the directory of vocational rehabilitation counselors;
- d. The employee's right to request the court to appoint a vocational rehabilitation counselor at no cost to the employee, if the parties are unable to agree on a vocational rehabilitation counselor.

A form developed by the court may be used to provide the required notice to the employee.

3. If, after a good faith attempt, the parties are unable to agree on the selection of a vocational rehabilitation counselor, a party shall request that the court appoint a vocational rehabilitation counselor from the directory. This request shall be made using a form developed by the court with the requestor providing copies to all other parties.
4. Within 15 working days following receipt of a form requesting appointment of a vocational rehabilitation counselor, a rehabilitation specialist of the court shall appoint a vocational rehabilitation counselor from the directory and advise the parties of the name of the court appointed vocational rehabilitation counselor.

B. When appointing a vocational rehabilitation counselor, a rehabilitation specialist of the court shall contact the individual whose name appears at the top or first position of the directory to ascertain if that vocational rehabilitation counselor agrees to accept the appointment, taking into consideration, but not limited to, such factors as geographic location of the employee and counselor, availability of the counselor to provide the requested services, ability of the counselor to provide timely services, and whether the counselor or another counselor associated with the same firm has provided or will provide medical case management services in the same claim.

1. If the vocational rehabilitation counselor accepts the appointment, his or her name shall be placed at the end of the directory. The next vocational rehabilitation counselor's name on the directory shall then be moved to the top of the directory.

2. In the event that the vocational rehabilitation counselor does not accept the appointment, the vocational rehabilitation counselor whose name appears next on the directory shall be contacted to determine if he or she will accept the appointment. This process shall continue until the appointment is finally accepted.
 3. Refusal without good cause to accept an appointment shall result in the vocational rehabilitation counselor's name being placed at the end of the directory.
- C. All contact between the vocational rehabilitation counselor and the parties, other than the employee, shall be in writing with copies provided to all other parties, with an additional copy sent directly to the employee, except that the vocational rehabilitation counselor may have direct contact:
1. As provided in Rule 42,A,2;
 2. With the employer to assess the likelihood of the employee being able to return to the previous job with the same employer, or being able to return to the previous job with modifications, or to obtain a new job with the same employer. For purposes of this paragraph "employer" shall not include attorneys, claims representatives, risk management personnel, or similar representatives of the employer, but shall only include the person or persons required to explain what the applicable job entails, and what may be necessary to modify the job;
 3. With all parties when they agree to jointly meet or to conduct a jointly held conference call with the vocational rehabilitation counselor to discuss the case;
 4. For the purpose of taking a deposition;
 5. With the employer or its insurer or risk management pool to assist the employee in obtaining special or adaptive equipment necessary for the employee to accomplish an approved vocational rehabilitation plan, or necessary for the employee to return to a job with the same employer as described in Rule 42,C,2;
 6. With the employer or its insurer or risk management pool to assist the employee in determining the status of temporary disability benefit payments while undergoing an approved vocational rehabilitation plan;
 7. With the employer or its insurer or risk management pool to assist the employee in arranging for necessary specialized or acute medical care while the employee is participating in an approved vocational rehabilitation plan.

- D. The vocational rehabilitation counselor agreed to or appointed pursuant to this rule shall be the sole vocational rehabilitation counselor to provide vocational rehabilitation services at any one time.
- E. The parties, other than the employee, shall not attempt to influence or to control the meeting place, the outcome of the evaluation, or the recommendations of the vocational rehabilitation counselor. The meetings shall be held at a neutral site, except as provided in Rule 42,C.

Sections 48-162.01, 48-163, R.R.S. 2010.

Effective date: November 16, 2006.

RULE 43

VOCATIONAL REHABILITATION CHANGE OF COUNSELOR

- A. A change in the vocational rehabilitation counselor providing vocational rehabilitation services or performing a loss of earning power evaluation may be requested by the employee, the employer or its insurer or risk management pool, or the vocational rehabilitation counselor. This change shall only be made after approval has been obtained from the court.
 - 1. The party or the vocational rehabilitation counselor desiring a change in vocational rehabilitation counselor must submit the request in writing to the court, using a form developed by the court with copies to all other parties and the counselor.
 - 2. The request shall identify the specific reasons for the requested change.
 - 3. A vocational rehabilitation specialist of the court will review the request and either approve or deny the request within 15 working days.
 - a. If the specialist of the court does not concur with the requested change, the specialist will notify all parties and the counselor of the denial and the reasons for rejecting the requested change. When a change request is not approved, vocational rehabilitation services must be continued with the previously agreed upon or appointed vocational rehabilitation counselor.
 - b. If the specialist of the court determines that the requested change should be approved, the specialist will notify all parties and the current counselor of the approval and the reasons for approving the requested change.

- B. Following receipt of notification from the court that the request for change in vocational rehabilitation counselor has been approved, the procedures and requirements of Rules 42,A and 42,B shall apply.
- C. Once a change of vocational rehabilitation counselor has been accomplished, the previous vocational rehabilitation counselor shall provide any and all pertinent information in the previous vocational rehabilitation counselor's possession to the newly appointed vocational rehabilitation counselor except for such information that may be legally considered proprietary in nature.

Sections 48-162.01, 48-163, R.R.S. 2010.

Effective date: November 16, 2006.

RULE 44

VOCATIONAL REHABILITATION PLAN DEVELOPMENT AND IMPLEMENTATION

- A. The vocational rehabilitation counselor voluntarily chosen or appointed shall perform the unbiased and accurate evaluation, development, submission, and implementation of the employee's vocational rehabilitation plan.
 - 1. When required, the vocational rehabilitation counselor shall evaluate the employee's vocational interests, aptitudes, skills, and physical, psychological, and psychosocial abilities. In addition to reviewing medical data or consulting with medical and/or mental health professionals, the vocational rehabilitation counselor may obtain the data via interviews, review of medical, diagnostic, psychometric, and related information describing the individual's injury and functional capabilities.
 - 2. When required, the vocational rehabilitation counselor or other qualified personnel under the supervision of the vocational rehabilitation counselor shall perform transferable skills analyses, labor market surveys, utilization of occupational and employment information, and on-the-job evaluations (including real or simulated work activity determinations), administering and/or interpreting psychometric and/or vocational testing (to include standardized interest, aptitude, achievement, and specific skills tests).
- B. The vocational rehabilitation counselor voluntarily agreed to or appointed shall evaluate the employee to determine what vocational rehabilitation services, if any, may be needed to assist the employee to return to suitable employment.

1. The vocational rehabilitation counselor shall follow the priorities pursuant to section 48-162.01 in evaluating the employee and developing a rehabilitation plan. No formal retraining plan shall be submitted to the court unless the vocational rehabilitation counselor certifies that all lower priorities have been determined to be unlikely to result in a suitable job placement or return to work opportunity for the injured employee.
 2. No higher priority may be utilized unless the vocational rehabilitation counselor has determined that all lower priorities would unlikely result in the job placement or return to work of the injured employee. If a lower priority is clearly inappropriate for the employee, the next higher priority shall be utilized.
 3. The following priorities are listed in order from lower to higher priority.
 - a. Return to the previous job with the same employer;
 - b. Modification of the previous job with the same employer;
 - c. A new job with the same employer;
 - d. A job with a new employer;
 - e. A period of formal training which is designed to lead to employment in another career field. This is designed to prepare the employee for suitable employment in another occupation. Formal training shall be applicable to the specific vocational goal listed on the proposed vocational rehabilitation plan and shall be appropriate and necessary to enable the employee to meet the vocational goal.
- C.** Only certified vocational rehabilitation counselors shall develop vocational rehabilitation plans. When the vocational rehabilitation counselor determines the injured employee will be unable to return to suitable employment without the provision of vocational rehabilitation services, the vocational rehabilitation counselor shall develop a vocational rehabilitation plan and submit it directly to the court. The plan shall list the specific vocational goal, the specific types of services and estimated costs necessary to meet the specific vocational goal.
- D.** All proposed rehabilitation plans shall be submitted on a vocational rehabilitation plan form developed by the court and shall be completed in accordance with the instructions provided on the form.
- E.** The fee of the vocational rehabilitation counselor for the evaluation and for the development and implementation of the vocational rehabilitation plan shall be paid for by the employer or his or her insurer within 30 days of receipt of a

statement of charges. Such fee shall include expenses for job placement services provided by the vocational rehabilitation counselor as well as expenses for a certified job placement specialist or an interpreter when necessary to assist the vocational rehabilitation counselor in the performance of his or her duties. Any such job placement specialist or interpreter shall be selected by the vocational rehabilitation counselor.

Sections 48-162.01, 48-163, 48-165, R.R.S. 2010.

Effective date: December 18, 2008.

RULE 45

LOSS OF EARNING POWER EVALUATION

- A.** Loss of earning power evaluations shall be performed by private vocational rehabilitation counselors whose names appear on the approved directory established by the court.
- B.** If the parties cannot agree on the choice of a vocational rehabilitation counselor from the directory to perform the loss of earning power evaluation, the parties shall request the court to assign a vocational rehabilitation counselor from the directory of vocational rehabilitation counselors pursuant to the procedures outlined in Rule 42.
- C.** The fee of the vocational rehabilitation counselor for the loss of earning power evaluation shall be paid by the employer or his or her insurer within 30 days of receipt of a statement of charges. Such fee shall include expenses for an interpreter when necessary to assist the vocational rehabilitation counselor in the performance of his or her duties. Any such interpreter shall be selected by the vocational rehabilitation counselor.

Sections 48-162.01, 48-163, R.R.S. 2010.

Effective date: December 18, 2008.

RULE 46

SETTLEMENT AGREEMENTS

Repealed effective December 15, 2009.

RULE 47

LUMP SUM SETTLEMENT

- A.** Before any application for an order approving a lump sum settlement in a compensation case shall be approved or otherwise acted upon by this court, an application, signed and verified by all parties, must first be filed with the compensation court and entered of record by the clerk thereof.
1. Each time that an application for an order approving a lump sum settlement is submitted or resubmitted after being withdrawn or disapproved, it must be accompanied by the statutory filing fee of \$15.00.
 2. At least one medical report by an attending or examining physician, substantiating the disability for which compensation is to be paid, shall accompany the application for approval. Copies of all medical reports to be submitted with the application shall be provided to the claimant prior to claimant's signing and verifying the application.
 3. Sufficient evidence must be submitted with the application to establish that the settlement is for the best interests of the claimant and that the application is in conformity with the workers' compensation schedule and law.
 4. An application will not be considered for approval without a proposed order of approval. A standard order developed by the court shall be used for this purpose.
- B.** The following information shall be included in or submitted with the application for an order approving lump sum settlement. A standard form or forms developed by the court may be used to meet these requirements.
1. The application is to be venued "In The Nebraska Workers' Compensation Court" and the title must clearly identify it as an application for approval of lump sum settlement.
 2. The salary paid, and whether it is on an hourly, daily, weekly, monthly, or other basis must be shown.

3. The number of weeks and dates of temporary total and temporary partial disability sustained and the number of weeks which have been paid and/or are being paid under the settlement must be clearly stated.
4. The percentage of permanent impairment and/or loss of earning power sustained, the number of weeks paid and to be paid and the amount of compensation per week must be clearly stated.
5. An itemized list of all medical, hospital and miscellaneous expenses incurred and whether paid or to be paid and by whom paid or to be paid must be clearly stated. This shall include payments made by Medicaid. Any payments which have been reduced by operation of the Diagnostic Related Group inpatient hospital fee schedule established in section 48-120.04 or a fee schedule adopted by the court pursuant to Rule 26 must be clearly identified. If the application provides for payment of future medical expenses incurred by the employee, there must be a statement in the application that in the event that a dispute arises as to payment of a medical expense, the parties may submit the matter to a judge of the compensation court for a determination.
6. In those cases in which there is subrogation, the full liability under the compensation law and the amount being subrogated must be set out. In addition, the extent of each party's participation in achieving any third party recovery must be set forth.
7. The computation must always be shown on the application.
8. The application must state whether or not the claimant has returned to work and if so, the date, the type of work, and wage.
9. In every case there must be a statement in the application that the claimant understands his or her rights regarding vocational rehabilitation, and there must be a waiver by the claimant of any further rights to vocational rehabilitation benefits. This is required even if the claimant has returned to work. The reason for the waiver must be given. Waivers will be closely scrutinized by the court, and in most cases will not be approved if the claimant has not returned to suitable employment. Attempts to "buy out" vocational rehabilitation will not be approved.
10. When an annuity or structured settlement is used to effectuate a lump sum settlement, the terms of said annuity or structured settlement together with the name of the annuity carrier must be included in the application, although the cost of the annuity or structured settlement need not be set forth; however, the cost of any annuity must be separately provided in writing to

the court with the submission of the application. Any such application shall recite that the workers' compensation insurer, risk management pool, or self-insured employer shall be responsible for all payments in the application in case the annuity carrier or any entity to which the annuity has been assigned fails to fulfill any of its obligations. The application shall also state that the owner of the annuity or structured settlement shall be someone other than the employee or other beneficiary, and that the employee or other beneficiary shall have no control over or right to transfer the annuity or structured settlement.

11. The Social Security account number of the claimant must be on file with the court or submitted with the application in accordance with Rule 2.
12. The application must state whether, at the time the settlement is executed, the claimant is eligible for Medicare, is a Medicare beneficiary, or has a reasonable expectation of becoming eligible for Medicare within 30 months after the date the settlement is executed. If the claimant has a reasonable expectation of becoming eligible for Medicare within 30 months of the date the settlement is executed, the date of expected Medicare eligibility should be provided.

If the claimant is a Medicare beneficiary at the time the settlement is executed, the application must state whether a conditional payment investigation through the Centers for Medicare and Medicaid Services has been completed. The application shall provide that the employer will reimburse Medicare for conditional payments made by Medicare, or that the employer will reimburse Medicare an amount agreed to by Medicare in satisfaction of its interests regarding such payments.

- C. If the court requests additional information from the parties prior to the approval of the application, the deadline for submission of the information shall be 10 calendar days from the date of the court's request. An extension of up to seven days may be granted upon good cause shown, if either party, on their own initiative, contacts the court to request the extension. At the expiration of the 10 day deadline or a court granted extension, an Order of Disapproval shall be entered if the requested information has not been submitted.
- D. After approval in compensation court and payment of the settlement has been made, the employer, insurer, or risk management pool must file with the compensation court a subsequent report showing all amounts paid in the case. The subsequent report shall be filed in accordance with Rule 30.

- E.** Sums being paid under the lump sum settlement are to be paid directly to those entitled to said sums, not into court. Payment must be made within 30 days after approval in compensation court.
- F.** Compromise settlements will not be approved unless there is evidence submitted with the application which satisfies the court that the matter is doubtful and disputed. A lump sum settlement will not be approved if all of the compensation payable under such settlement is due and no reasonable controversy exists, unless a reasonable additional amount is paid as consideration for such lump sum settlement. All requirements of the compensation court must be satisfied before any lump sum settlement will be approved.
- G.** A hearing will be scheduled when the court, in its discretion, deems it necessary.
- H.** For cases involving life expectancies the U.S. Life Table, 2010, shall be the minimum life expectancy table used. A copy of this table may be found in the addenda to these rules.
- I.** For cases in which the employer has continued to pay full salary, credit will be allowed only for that portion of the full salary payment that was intended to apply to workers' compensation benefits, not to exceed the weekly income benefit owed pursuant to the Nebraska Workers' Compensation Act.
- J.** For cases in which an order of dismissal is required pursuant to § 48-139(4), upon making payment owed by the employer as set forth in the release, the parties shall file a receipt, satisfaction, or joint stipulation for dismissal setting forth the amount(s) received by the employee from the employer. The parties shall also submit a proposed order of dismissal to be signed by the judge together with certificate of service of mailing to be signed by the clerk of the court via e-mail attachment sent to wcc.proposedordersonly@nebraska.gov or via e-filing. The e-mail attachment shall be in either editable Microsoft Word format (*.doc or *.docx) or Rich-Text Format (*.RTF) file formats. The subject line of the e-mail shall include the case name and number.

Sections 48-138, 48-144, 48-163, 48-165, R.R.S. 2010, and 48-139, R.S. Supp., 2014.
Effective date: December 9, 2015.

RULE 48

INFORMAL DISPUTE RESOLUTION

- A.** Resolution of any workers' compensation dispute or controversy is available on an informal basis. Any party may contact the court to request resolution by informal means, or a judge of the court may, on his or her own motion, refer the parties to informal dispute resolution.
- B.** Any dispute regarding medical, surgical, or hospital services furnished or to be furnished under section 48-120 may be submitted by the provider of such services.
 - 1. Such dispute may include the reasonableness and necessity of any medical treatment provided or to be provided to the injured employee.
 - 2. Such dispute may include the application of the medical and hospital fee schedules or payment for services rendered by an independent medical examiner.
- C.** Any dispute regarding services provided by a certified vocational rehabilitation counselor under section 48-162.01 may be submitted by a party or the vocational rehabilitation counselor providing such services.
- D.** Before any dispute involving medical treatment or medical issues related to managed care may be submitted to the court for informal dispute resolution, the internal dispute resolution procedure of the managed care plan shall first be exhausted.
- E.** The court shall identify all parties to the dispute and notify all parties and any other participants of the proposed informal means of resolving the dispute. The court staff shall by informal means, which may include telephone contact, determine the nature and extent of the dispute or controversy and attempt to resolve it. The court staff may request the parties and any other participants to identify, in writing, the issues that are disputed and to be submitted for resolution by informal means. The court staff may require that the parties and any other participants appear and submit relevant information. At the conclusion of the informal resolution process, a written statement shall be issued to all parties and any other participants by the court that documents the results of the informal resolution process.
 - 1. Any party who requests such informal dispute resolution shall not be precluded from filing a petition pursuant to section 48-173.

2. Any settlement reached as the result of informal dispute resolution shall be final and not subject to readjustment only if the settlement is in conformity with the Nebraska Workers' Compensation Act.

Sections 48-163, 48-168, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: December 15, 2009.

RULE 49

DEFINITIONS

The following words and terms, when used in the Rules of Procedure of the Nebraska Workers' Compensation Court shall have the following meanings, unless the context of the particular rule clearly indicates otherwise.

- A. Compensability.** "Compensability" or "compensable" when used with reference to injuries or diseases means personal injuries for which an employee is entitled to compensation from his or her employer pursuant to section 48-101.
- B. Complex Case.** "Complex case" when used with reference to fees for services performed by an independent medical examiner means a case requiring two or more of the following in order to render medical findings on the questions and issues submitted:
 1. two or more hours of face-to-face time by the physician with the patient;
 2. two or more hours of record review by the physician;
 3. two or more hours of medical research by the physician;
 4. addressing the issue of medical causation;
 5. addressing the issue of apportionment between any preexisting impairment or disability and the impairment or disability contributed by the injury in question.
- C. Denial of Compensability.** "Denial of compensability" or "compensability is denied" means a denial that the employee is entitled to compensation for personal injury from his or her employer pursuant to section 48-101.
- D. Emergency Medical Treatment.** "Emergency medical treatment" means those medical services that are required for the immediate diagnosis and treatment of conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain. "Emergency medical treatment" includes treatment de-

livered in response to symptoms that may or may not represent an actual emergency, but is necessary to determine whether an emergency exists.

- E. Family Physician.** “Family physician” when used with reference to an employee’s right to choose a primary treating physician, means a physician who has maintained the medical records of and has a documented history of treatment with the employee or an employee’s immediate family member prior to an injury.
- F. Health Care Providers.** “Health care providers” means providers or suppliers of health care services.
- G. Health Care Services.** “Health care services” means medical, surgical, or hospital services, including specialized medical services, for which the employer is liable pursuant to section 48-120.
- H. Immediate Family Member.** “Immediate family member” when used with reference to the selection of a physician pursuant to section 48-120(2)(a) means the employee’s spouse, children, parents, stepchildren, and stepparents.
- I. Independent Medical Examiner.** “Independent Medical Examiner” means either a physician appointed and assigned by the court or a physician agreed to by the parties pursuant to section 48-134.01. In either case the physician shall render medical findings on the medical condition of an employee and related issues pursuant to section 48-134.01.
- J. Major Surgical Operation.** “Major surgical operation” means any invasive procedure that requires the penetration of the body or removal of human tissues and requires the administration in any concentration of anesthesia or sedation which renders an individual incapable of taking action for self-preservation under emergency conditions without the assistance of another individual.
- K. Managed Care Plan.** “Managed care plan” means a plan certified by the court that provides for the delivery and management of treatment to injured employees.
- L. Nonparticipating Physician.** “Nonparticipating Physician” when used with reference to a managed care plan means a physician who is not a participating physician, but who may provide services pursuant to Rule 56 to an employee subject to a managed care plan contract.
- M. Participating Physician.** “Participating Physician” means a physician with which a managed care plan has a contract or other arrangement for the delivery of health care services to injured employees.

- N. Participating Health Care Provider.** “Participating health care provider” means any person or entity with which the managed care plan has a contract or other arrangement for the delivery of health care services to injured employees.
- O. Physician.** “Physician” means any person licensed to practice medicine and surgery, osteopathic medicine, chiropractic, podiatry, or dentistry in the State of Nebraska or in the state in which the physician is practicing.
- P. Primary Treating Physician.** “Primary treating physician” means a physician who is responsible for providing primary medical care to the employee, maintaining the continuity of the employee’s medical care and initiating referrals to other health care providers.
- Q. Probation.** “Probation” or “probationary status” when used with reference to vocational rehabilitation means the limitation for a specified period of time and under such conditions as determined by the court of a vocational rehabilitation provider’s certification to provide vocational rehabilitation services under Rules 37 through 44, or to perform a loss of earning power evaluation under Rule 45.
- R. Revocation.** “Revocation” or “revoked” when used with reference to vocational rehabilitation means the termination, prior to the normal expiration date, of a vocational rehabilitation provider’s certification to provide vocational rehabilitation services under Rules 37 through 44, or to perform a loss of earning power evaluation under Rule 45. “Revocation” or “revoked” when used with reference to a managed care plan means the termination of a managed care plan’s certification to provide services under Rules 51 through 61.
- S. Specialized Medical Services.** “Specialized medical services” means health-care services other than those provided by a primary treating physician.
- T. Suspension.** “Suspension” or “suspended” when used with reference to a managed care plan means that a managed care plan’s authority to enter into new or amended contracts with insurers, risk management pools, or self insured employers has been suspended by the court for a period of time.

Sections 48-120.02, 48-134.01, 48-163, R.R.S. 2010, and 48-120, R.S. Supp., 2015.
Effective date: November 16, 2006.

RULE 50

CHOICE OF PHYSICIAN

Words in italics are defined in Rule 49.

A. Employee's Choice.

1. If the employer does not give the employee notice, as described in Rule 50,B,2, of the right to choose a *family physician* as the *primary treating physician*, the employee is free to choose any *physician* qualified to treat the injury as the *primary treating physician*.
2. If the employer gives the employee notice, as described in Rule 50,B,2, the employee has the right to choose a *family physician* as the *primary treating physician*. As soon as possible after getting the notice, the employee must give the employer the name of the *family physician* chosen. The employee must do this before receiving any treatment, unless it is *emergency medical treatment*. If the employee does not do this, the employer has the right to choose the *primary treating physician*.
3. The employer may ask the *family physician* chosen by the employee for a letter to verify prior treatment. If an authorization is needed, the employee or *immediate family member* must give it. If it is not given, the employer has the right to choose the *primary treating physician*.
4. The employee may not change the *primary treating physician* chosen according to Rule 50,A,2 unless the employer agrees or the compensation court orders the change. A referral by the *primary treating physician* is not a change.
5. The employee may choose the *physician* to do surgery when the injury involves dismemberment or a *major surgical operation*.
6. The employee may choose a *physician* if *compensability* is *denied* and the employer will pay for medical, surgical, or hospital services later found to be *compensable*.
7. If the *primary treating physician* chosen by the employer refuses to provide certain medical services and those services are later ordered by the compensation court, the employee can choose a *physician* to furnish further services.

B. Employer's Choice.

1. The employer may have the right to choose an injured employee's *primary treating physician*. If the employer wishes to choose, the employer must first give the employee notice, following an injury, of the right to choose a *family physician* as the *primary treating physician*.
2. The court has a form the employer may use to give notice to the employee. In all cases, the notice:
 - a. must be given to the employee as soon as possible after the employer knows about the injury;
 - b. must tell the employee of the right to choose a *family physician* as the *primary treating physician*;
 - c. must tell the employee to give the employer the name of the *family physician* chosen as the *primary treating physician* as soon as possible after getting notice from the employer, and before any treatment, unless it is *emergency medical treatment*;
 - d. must tell the employee the employer gets to choose the *primary treating physician* if the employer is not given the name of the *family physician* as soon as possible after the employee receives the notice;
 - e. must tell the employee the employer gets to choose the *primary treating physician* if an authorization is needed to verify prior treatment and is not given; and
 - f. must tell the employee the *primary treating physician* may not be changed once the employer has been given the name, unless the change is agreed to by the employer or is ordered by the compensation court. A referral by the *primary treating physician* is not a change.
3. The employer may ask the *family physician* for a letter to verify prior treatment. If an authorization is needed, the employee or *immediate family member* must give it.
4. The employer can choose the *primary treating physician* following notice to the employee if:
 - a. the employee has no *family physician*; or
 - b. there is a *family physician* but the employee does not tell the employer the name of the *family physician* as soon as possible after getting notice from the employer; or

c. if authorization to verify treatment by the *family physician* is not given.

5. If the employee lives or works in a city of 5,000 or more, the *primary treating physician* chosen by the employer must be within 30 miles of where the employee lives or works. If the employee lives and works outside a city of 5,000 or more, the *physician* must be within 60 miles of where the employee lives or works. If there is no *physician* qualified to treat the injury within these mileage limits, they do not apply.
6. The employer may not change the choice of the *primary treating physician* made according to Rule 50,B,4, unless the employee agrees or the compensation court orders a change. A referral by the *primary treating physician is not a change*.
7. The employer does not have to give the employee notice of the right to choose a *family physician* as the *primary treating physician*. If the employer does not give notice, the employee is free to choose any *physician* qualified to treat the injury as the *primary treating physician*.

C. Change of *Physician*. Following notice as described in Rule 50,B,2 if the *primary treating physician* has been chosen by the employee according to Rule 50,A,2 or by the employer according to Rule 50, B,4, there can be no change in the *primary treating physician* unless the employee and employer agree or the compensation court orders a change.

D. Referrals. The *primary treating physician* may arrange for *specialized medical services* the employee needs. A referral by the *primary treating physician* is not a change. A *physician* may not send an employee to a facility in which the *physician* has an ownership or similar financial or investment interest, unless the services are not available within 60 miles of where the employee lives or works. The rules of the *managed care plan* will apply to referrals made by a *participating or nonparticipating physician* under a *managed care plan*.

E. Inability to Follow Rule 50 for Choice of *Primary Treating Physician*. An employer and/or employee may be unable to follow Rule 50 to choose the *primary treating physician*. This may happen if the injury takes place away from the employer's place of business or because of the type of injury. Rule 50 will not apply to choosing the *primary treating physician* as long as this inability lasts.

F. Travel Expenses. If the employee chooses a *physician* from a community other than where the employee lives or works, and if a *physician* is available in a closer community, the employer does not have to pay travel expenses.

- G. Effective Date.** If the employer received notice of the injury before January 1, 1994, the employee may continue to receive services for that injury from a *physician* selected prior to that date.

Sections 48-120.02, 48-163, 48-164, 48-165, 48-173, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: December 15, 2009.

RULE 51

MANAGED CARE PURPOSE

- A.** The purpose of Rule 51 through Rule 61 is to establish procedures and requirements for certification of a managed care plan relating to the management and delivery of medical, surgical, and hospital services to injured employees under the Nebraska Workers' Compensation Act, and for contracting between a certified managed care plan and an insurer, risk management pool, or self insured employer.
- B.** No health care provider, network of providers, employer, insurer, risk management pool or any other person may make any representation or state in any name, contract, or literature that an entity constitutes workers' compensation managed care for the provision of services under the Nebraska Workers' Compensation Act unless the entity is a certified managed care plan under these rules.
- C.** No employee may be required to receive services under a managed care plan, including but not limited to a preferred provider organization, point of service plan, health maintenance organization, or similar entity, unless the plan has been certified by the court.

Sections 48-120.02, 48-163, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: July 1, 1997.

RULE 52
MANAGED CARE
APPLICATION FOR CERTIFICATION

Words in italics are defined in Rule 49.

- A. Application.** Any person or entity may make written application for certification by the court of a plan to provide management of quality treatment to injured employees for injuries and diseases *compensable* under the Nebraska Workers' Compensation Act. Any such application shall be submitted to the court, together with one identical copy, and shall include the following information.
1. The Application must describe the manner in which the plan will meet the requirements of Rule 51 to Rule 61 and section 48-120.02, including a description of the times, places, and manner of providing *health care services* under the plan, and a statement describing how the plan will ensure an adequate number of each category of *health care providers* listed in Rule 53,C is available to give employees convenient geographic accessibility to all categories of *health care providers* and adequate flexibility to choose the *primary treating physician* pursuant to Rule 53,E,3.
 2. The Application must identify the following (an individual may act in more than one capacity):
 - a. the names of all directors and officers of the *managed care plan*;
 - b. the title and name of the person to be the day-to-day administrator of the *managed care plan*;
 - c. the title and name of the person to be the administrator of the financial affairs of the *managed care plan*;
 - d. the name and medical specialty, if any, of the medical director; and
 - e. the name, address, and telephone number of a communication liaison for the court, insurer, risk management pool, employer, and the employee.
 3. The Application must provide a copy of any standard contract used with *health care providers* who will deliver services under the *managed care plan*, and a description of any other relationships with *health care providers* who may deliver services to a covered employee, together with a copy of any related contract. The *managed care plan* must provide a list

of names, clinics, addresses, telephone numbers, types of license, certification or registration, and specialties for the *health care providers* subject to the contracts. The *managed care plan* must also submit a statement that all licensing, certification or registration requirements for the *health care providers* are current and in good standing in Nebraska or the state in which the *health care provider* is practicing.

4. The Application must identify any entity, other than *health care providers*, with whom the *managed care plan* has a joint venture or other agreement to perform any of the functions of the *managed care plan*, together with a description of the specific functions to be performed by each such entity. Copies of the related contracts must also be provided.
5. The Application must disclose to the court the existence of any of the following factors and any equivalent interest the *managed care plan* has in an insurer, risk management pool or employer. The court may consider these factors and any other relevant information in determining whether a *managed care plan* shall be certified. If an insurer, risk management pool, or employer, or any member of the staff of such entity:
 - a. directly participates in the formation or certification of the plan; or
 - b. occupies a position as a director, or other governing member, officer, agent, or employee of the plan; or
 - c. has any ownership interest or similar financial or investment interest in the *managed care plan*; or
 - d. enters into any contract with the plan that limits the ability of the plan to accept business from any other source; or
 - e. has any relationship not listed above with a *managed care plan*, other than a contract for the provision of medical, surgical, and hospital services under the Nebraska Workers' Compensation Act.

Rule 52,A,5 is not intended to prohibit an insurer, risk management pool, or employer, from forming, owning, or operating a *managed care plan*, so long as the plan includes adequate safeguards to insure fairness and equity in the operation of the plan and in the provision of medical, surgical, or hospital services under the plan.

6. The Application must include satisfactory evidence of ability to meet the financial requirements necessary to ensure delivery of service in accordance with the plan.

7. The Application must include 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 bylaws or similar document, if any.
8. The Application must identify one place of business in this state where the plan is administered and membership records and other records are kept, or if the plan is located outside the state of Nebraska, the Application must identify one such place of business in such other state and must also include a statement that the plan agrees and stipulates to the jurisdiction of Nebraska courts for all purposes.

B. Fees. Each application for original certification or application for certification following revocation must be accompanied by a nonrefundable fee of \$1,500. The fee for the annual report is established in Rule 57.

C. Notification; approval or denial.

1. An application received by the court shall be approved if such application meets all the requirements as set out in Rules 51 through 61. The court may request of the applicant further information or clarification of information submitted pursuant to Rule 52,A,1 through Rule 52,A,8. Failure to respond to a request from the court 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 working days of the decision by the court to deny the application.
2. An applicant denied certification pursuant to Rule 52,C,1 shall be permitted to reapply no earlier than 30 days after receipt of the notice of denial of certification. Such reapplication shall be accompanied by a nonrefundable fee of \$750. In no event shall an entity be allowed to reapply for one year after having been denied certification three consecutive times.

Sections 48-120.02, 48-163, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: October 27, 1998.

RULE 53
MANAGED CARE
REQUIREMENTS FOR CERTIFICATION

Words in italics are defined in Rule 49.

- A.** In order to become and remain certified under these rules, a *managed care plan* must meet all the requirements of Rule 51 through Rule 61 as well as those listed in section 48-120.02.
- B.** The *managed care plan* must ensure provision of quality *health care services* that meet all uniform treatment standards adopted by the plan or which may be prescribed by the court, and all *health care services* that may be required under the Nebraska Workers' Compensation Act in a manner that is timely, effective and convenient for the employee. The employer shall remain liable for any *health care service* required under the Act that the *managed care plan* does not provide.
- C.** The *managed care plan* must have contracted for, at a minimum, the following types of *health care services and providers*, unless the *managed care plan* is unable to contract for a particular service or type of provider. If the *managed care plan* is unable to contract for a particular service or provider, then the *managed care plan* shall provide an explanation. The *managed care plan* must provide to an employee at a minimum, when necessary, the following types of *health care services and providers*:
1. medical doctors in at least one of the following specialized fields: family practice, internal medicine, occupational medicine, physiatry or emergency medicine;
 2. orthopedic surgeons;
 3. specialists in hand and upper extremity surgery;
 4. neurologists;
 5. neurosurgeons;
 6. general surgeons;
 7. chiropractors;
 8. podiatrists;
 9. osteopaths;

10. dentists;
11. dermatologists;
12. ophthalmologists;
13. optometrists;
14. physical therapists;
15. occupational therapists;
16. psychologists;
17. psychiatrists;
18. diagnostic pathology and laboratory services;
19. radiology services;
20. hospital services;
21. outpatient surgery; and
22. urgent care services.

D. The *managed care plan* must provide for referral for any services that are not specified above in Rule 53,C that are required under the Nebraska Workers' Compensation Act.

E. The *managed care plan* must include procedures to ensure that employees will receive *health care services* in accordance with the following:

1. Employees must receive initial evaluation by a *participating* licensed *physician* in one of the disciplines listed below in Rule 53,E,3 within 24 hours of the employee's request to the *managed care plan* for treatment following an injury. The *managed care plan* may select the *physician* to do the evaluation.
2. In cases where the employee has received treatment for the work injury by a *physician* outside the *managed care plan* under Rule 56,A,1 or Rule 56,A,6 the employee must receive initial evaluation or treatment by a *participating* licensed *physician* within five working days of the employee's request for a change of doctor, or referral to the *managed care plan*. The *managed care plan* may select the *physician* to do the evaluation.
3. Following the initial evaluation and upon request, the employee must be allowed to choose to receive ongoing treatment from any one *participat-*

ing physician in one of the disciplines listed below as the *primary treating physician*, if the *physician* is available within the mileage limitations established in Rule 53,E,7, if the treatment is required under the Nebraska Workers' Compensation Act, if the treatment is within the provider's scope of practice, and if the treatment is appropriate under the standards of treatment adopted by the *managed care plan*:

- a. medical doctors;
- b. chiropractors;
- c. podiatrists;
- d. osteopaths; or
- e. dentists.

An evaluating *physician* may also be offered as a *primary treating physician*.

The *primary treating physician* may arrange for any consultation, referral, or extraordinary or other *specialized medical services* as the nature of the injury shall require, as permitted under the *managed care plan*.

4. Employees must receive any required treatment, diagnostic tests, or *specialized medical services* in a manner that is timely, effective, and convenient for the employee.
5. Employees must be allowed to change *primary treating physicians* within the *managed care plan* at least once by making application for such change to the plan without proceeding through the *managed care plan's* dispute resolution process. A change of *physician* from the evaluating *physician* to a *primary treating physician* for ongoing treatment is not considered a change of *physician*, unless the employee has received treatment from the evaluating *physician* more than once for the injury.
6. Employees must be able to receive information at no cost on a 24-hour basis regarding the availability of *health care services* under the *managed care plan*. The information may be provided through recorded telephone messages after normal working hours. The message must include information on how the employee can obtain emergency services or other urgently needed care, and how the employee can receive an evaluation.
7. Employees must have access to the evaluating and *primary treating physician* within 30 miles of either the employee's place of employment or res-

idence if either the residence or place of employment is within a city with a population of 5,000 or more. If both the employee's residence and place of employment are outside a city with a population of 5,000 or more, the allowable distance is 60 miles. If the *primary treating physician* is not available within the stated mileage restrictions then a *nonparticipating physician* may be selected pursuant to Rule 56,A,5.

- F. The *managed care plan* must designate the procedures for approval of services from a *physician* outside the *managed care plan* as permitted in Rule 56,A,1 through Rule 56,A,6, and how such *physician* will be informed of the rules, terms, and conditions of the *managed care plan*, and the procedures for referring an employee to the *managed care plan* for any other treatment that the employee may require.
- G. The *managed care plan* must include a procedure for peer review and utilization review as specified in Rule 59.
- H. The *managed care plan* must include a procedure for internal dispute resolution as specified in Rule 58.
- I. The *managed care plan* must describe how employers, insurers, and risk management pools will be provided with information that will inform employees of all choices of *physician* under the plan and how employees can gain access to those *physicians*. The plan must submit a proposed notice to employees, which may be customized according to the needs of the employer, but which must include the information required by Rule 55.
- J. The *managed care plan* must describe how aggressive medical case management will be provided as specified in Rule 60, and how a program for early return to work and cooperative efforts to promote workplace health and safety consultative services will be provided.
- K. The *managed care plan* must describe a procedure or program through which *health care providers* may obtain information on the following topics:
 - 1. treatment parameters adopted by the plan;
 - 2. maximum medical improvement;
 - 3. permanent partial impairment rating;
 - 4. return to work and disability management;
 - 5. *health care provider* obligations in the workers' compensation system; and

6. other topics the *managed care plan* deems necessary to obtain cost effective, quality medical treatment and appropriate return to work for an injured employee.

The medical director or designee must be available as a consultant on the topics listed above in Rule 53,K,1 through Rule 53,K,6 to any *health care provider* delivering services under the *managed care plan*.

- L. The *managed care plan* must describe the treatment standards it has adopted or developed, if any, for *health care services* that are to be used in the treatment of workers' compensation injuries. All participating *health care providers* and those nonparticipating providers subject to the rules, terms and conditions of the *managed care plan* shall be governed by such treatment standards. This paragraph does not, however, require ongoing treatment in individual cases if the treatment is not medically necessary, even though the maximum amount of treatment permitted under any standard has not been given.
- M. The *managed care plan* may contract for payment of medical, surgical, and hospital services under the plan at fees different from those established by the Diagnostic Related Group inpatient hospital fee schedule established in section 48-120.04 or a fee schedule adopted by the court pursuant to Rule 26.
- N. The *managed care plan* must maintain a standardized claimant medical record-keeping system designed to facilitate entry of information into computerized databases.
- O. The *managed care plan* must provide a timely and accurate method of reporting to the court necessary and useable information regarding medical, surgical, and hospital service cost and utilization to enable the court to determine the effectiveness of the plan.
- P. The *managed care plan* must maintain and provide to the court on request any other information or data as the court considers necessary.

Sections 48-120.02, 48-163, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: December 18, 2008.

RULE 54
MANAGED CARE
COVERAGE

A. Contracts.

1. In order to provide management of treatment for injuries and diseases compensable under the Nebraska Workers' Compensation Act a managed care plan must contract with:
 - a. an insurer licensed by the Nebraska Department of Insurance to write workers' compensation insurance in this state that has issued a current workers' compensation insurance policy or policies; or
 - b. a risk management pool formed pursuant to the Intergovernmental Risk Management Act that provides group self insurance to member employers; or
 - c. an individual employer approved for self insurance by the court.
2. All contracts pursuant to Rule 54,A,1 shall specify the billing and payment procedures that will be utilized, and how the aggressive case management, early return to work, and cooperative efforts to promote workplace health and safety consultative services will be provided.
3. All contracts pursuant to Rule 54,A,1 shall specify that any contractual obligations of an insurer, risk management pool, or self insured employer to allow a managed care plan to provide medical, surgical, or hospital services for employees pursuant to the Nebraska Workers' Compensation Act shall be null and void upon revocation of the certification of the managed care plan.
4. Once compensability has been accepted or determined, the employer may require that employees subject to the contract shall receive medical, surgical, and hospital services in the manner prescribed in the contract.
5. The employer shall remain liable for any health care services required under the Nebraska Workers' Compensation Act that the managed care plan does not provide.

B. Multiple Plans. An insurer, risk management pool, or self insured employer may contract with multiple managed care plans to provide coverage for employers. When an insurer, risk management pool, or self insured employer con-

tracts with multiple managed care plans to provide coverage for the same employer, and more than one such plan has participating physicians within the mileage restrictions established pursuant to Rule 53,E,7 whose scope of practice is appropriate for treatment of the injury in question, the employee shall have the right to select the managed care plan that will manage the employee's care; except that if any such certified managed care plan also provides group health insurance for the employer and the employee is obligated to receive services under the group health insurance plan, then that plan, if the employer so elects, shall also manage the employee's care for workers' compensation purposes.

C. Coverage.

1. If an employee gives notice of injury to an employer under the Nebraska Workers' Compensation Act on or after the effective date of the managed care plan contract with the insurer, risk management pool, or self insured employer, and if compensability has been accepted or determined, then the employee may be required to receive services under the managed care plan; except that an employee may not be required to receive services under the managed care plan until the notice required by Rule 55 has been given to the employee.
2. If the employer received notice of the injury before the effective date of the managed care plan contract, the employee may not be required to receive services under the managed care plan until the employee requests a change of physician. At that time the employee may be required to receive further services under the managed care plan.
3. Prior to acceptance or determination of compensability, or subsequent to the denial of compensability, the employee may not be required to receive services under a managed care plan.
4. If compensability is denied by the insurer, risk management pool, or self insured employer, the employee may leave the managed care plan and the employer shall be liable for medical, surgical, and hospital services previously provided.

D. Termination of Coverage.

1. To ensure continuity of care, the managed care plan contract shall specify the manner in which an employee will receive health care services when a managed care plan contract or a contract with a health care provider terminates.

2. When a contract with a participating primary treating physician terminates, the employee may continue to treat with such physician if the physician remains in good standing in Nebraska or the state in which he or she practices, and if the physician agrees to refer the employee to the managed care plan for any other treatment that the employee may require with respect to the injury in question, and if the physician agrees to comply with all of the rules, terms, and conditions of the managed care plan with respect to treatment of the injury in question.
3. When managed care plan coverage for an employee is transferred from one managed care plan to another, the employee may continue to treat with the primary treating physician selected under the old plan if such physician agrees to refer the employee to the new managed care plan for any other treatment that the employee may require with respect to the injury in question, and if the physician agrees to comply with all of the rules, terms, and conditions of the new managed care plan with respect to treatment of the injury in question. If the employee requests a change in the primary treating physician, further services will be provided under the new managed care plan.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: July 1, 1997.

RULE 55
MANAGED CARE
NOTICE TO EMPLOYEE

Words in italics are defined in Rule 49.

An employee is not required to receive services under a *managed care plan* until the insurer, risk management pool, or self insured employer gives the employee notice of the information listed below in this rule. Individual notice of such information must be given at the time the employee becomes subject to the contract (see Rule 53,I). The notice must include the following information:

- A. The employer is covered by the named *managed care plan* to provide all required treatment for work related injuries after a specified date. An employee sustaining an injury prior to the specified date is required to receive services under the plan only if the employee changes *physicians*.

- B. The toll free telephone number of the *managed care plan* where the employee can receive answers to questions about managed care.
- C. The employee may receive treatment from a medical doctor, chiropractor, podiatrist, osteopath, or dentist under the plan, if the treatment is available within the community and the scope of practice of the *physician* is appropriate for the treatment of the injury in question.
- D. How the employee can access care under the *managed care plan*, how the employee can identify eligible *physicians*, and the toll free 24 hour telephone number of the *managed care plan* that informs employees of available services.
- E. The employee may be required to receive services from a *participating physician* under the *managed care plan* except in the following circumstances:
 - 1. if the employee or an *immediate family member* has treated with a *physician* prior to the date of injury who can provide treatment appropriate for the injury in question, if the employee selects such *physician* according to rules established by the court, if such *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require, and if such *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*; or
 - 2. if the employer fails to notify the employee of the right to select a *family physician* according to the rules established by the court;
 - 3. for *emergency medical treatment*; or
 - 4. in cases of injury requiring dismemberment or injuries involving *major surgical operation*, if the employee selects the *physician* to perform the operation and such *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require, and if such *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*; or
 - 5. after *compensability* has been denied by the insurer, risk management pool, or self insured employer; or
 - 6. if there is no *participating primary treating physician* available within the mileage restrictions established in Rule 53,E,7 of the Rules of Procedure of the Nebraska Workers' Compensation Court.

Sections 48-120.02, 48-163, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: October 27, 1998.

RULE 56
MANAGED CARE
PHYSICIANS WHO ARE NOT
PARTICIPATING PHYSICIANS

Words in italics are defined in Rule 49.

A. Authorized Services. For provisions relating to choice of *physician* generally, see Rule 50. A *physician* who is not a *participating physician* under the *managed care plan* may provide services to an employee in any of the circumstances listed below under this rule if the scope of practice of the *nonparticipating physician* is appropriate for treatment of the injury in question.

1. A *nonparticipating physician* may be selected as the *primary treating physician* by the employee if:
 - a. the *physician* is a *family physician*;
 - b. the *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require;
 - c. the *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*; and
 - d. the employee selects the *physician* as required in Rule 50,A following notice by the employer as required in Rule 50,B.

If the *physician* selected by the employee does not agree to refer the employee to the *managed care plan* for any other treatment that the employee may require or to comply with all of the rules, terms, and conditions of the *managed care plan*, the *physician* may not provide services to the employee and the employee may select another *nonparticipating physician* pursuant to Rule 56,A,1.

2. A *nonparticipating physician* may be selected as the *primary treating physician* by the employee if the employer does not give the employee notice, as described in Rule 50,B,2, of the right to choose a *family physician* as the *primary treating physician*.
3. A *nonparticipating physician* may provide services to an employee for *emergency medical treatment*.
4. A *nonparticipating physician* may deliver services to an employee when the employee is referred to such *physician* by the *managed care plan*.

5. A *nonparticipating primary treating physician* may be selected by the employee to provide services if there is no *participating physician* available within the mileage restrictions established in Rule 53,E,7, or if there is an insufficient number of *participating physicians* within the mileage restrictions to permit the employee to change *primary treating physicians* as permitted under the plan (see Rule 53,E,5); except that a *nonparticipating physician* may be selected in such circumstances only if no *participating physician* is available closer to either the residence or place of employment of the employee whose scope of practice is appropriate for treatment of the injury in question.
 6. A *nonparticipating physician* may be selected by the employee in cases of injury requiring dismemberment or injuries involving *major surgical operation* to perform the operation if:
 - a. the *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require; and
 - b. the *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*.
 7. If *compensability* is denied by the insurer, risk management pool, or self insured employer, the employee may leave the *managed care plan* and the employer shall be liable for medical, surgical, and hospital services previously provided. Under such circumstances a *nonparticipating physician* may be selected by the employee to provide services.
- B. Change of *Physician*.** If the employee requests a change of *nonparticipating primary treating physician*, further services shall be provided in accordance with Rules 53,E.
- C. Disputes.** Any dispute relating to the selection of a *nonparticipating physician* pursuant to Rule 56,A,1 through 56,A,6, as well as any dispute relating to the obligation of any *nonparticipating physician* to make referrals into the *managed care plan* or to comply with the other rules, terms, and conditions of the *managed care plan* shall be resolved according to the dispute resolution procedures of the *managed care plan*. Any *nonparticipating physician* who has an obligation to make referrals into the *managed care plan* or to comply with the other rules, terms, and conditions of the *managed care plan* and who fails to refer or comply, is subject to denial of payment for the related services.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: October 27, 1998.

RULE 57
MANAGED CARE
REPORTING REQUIREMENTS

- A. Contracts.** A managed care plan shall provide the court with copies of the following contracts:
1. Contracts between the managed care plan and any insurer, risk management pool, or self-insured employer, signed by the parties, within 30 days of execution of such contracts. Such contracts must include a listing of all employers covered by each contract, including the employer's name, address, telephone number, unemployment insurance identification number, and estimated number of employees and location of the employees covered by the managed care plan contract.
 2. Contracts between the managed care plan and any entity other than health care providers that perform any of the functions of the managed care plan, which have not previously been provided with the application for certification. These must be signed by the parties and submitted within 30 days of execution of such contracts.
 3. New standard contracts between the managed care plan and health care providers who will deliver services under the plan, if such contracts have not previously been provided with the application for certification. These must be submitted within 30 days of adoption. Such new contracts must meet the requirements set out in Rule 52,A,3.
- B. Amendments; Changes.** Within 30 days of execution or adoption, a managed care plan shall provide to the court the following amendments or changes.
1. Amendments to any of the contracts listed in Rule 57,A as well as amendments to any contracts previously provided with the application for certification.
 2. Changes in the managed care plan's ownership or organizational status, or the affiliation of the managed care plan with an insurer, risk management pool, or employer other than through a contract to provide management of treatment for injuries and diseases compensable under the Nebraska Workers' Compensation Act.
 3. Any other amendments to the certified managed care plan.

- C. Annual reporting.** In order to maintain certification, each managed care plan shall, with a nonrefundable fee of \$400, provide to the court within 30 days following each anniversary of certification the following information:
1. A current listing of participating health care providers, including names, clinics, addresses, telephone numbers, types of license, certification or registration, and specialties. The managed care plan must also submit a statement that all licensing, certification or registration requirements for the providers are current and in good standing in Nebraska or the state in which the provider is practicing.
 2. A summary of any sanctions or punitive actions taken by the managed care plan against any of its participating providers.
 3. A summary of any peer review, utilization review, reported complaints and dispute resolution proceedings showing cases reviewed, issues involved, and action taken.
 4. Any other information requested by the court.
- D. Data, Requested or Required.** The managed care plan must report to the insurer, risk management pool, or self insured employer any data regarding medical, surgical, and hospital services related to a workers' compensation claim requested by the insurer, risk management pool, or self insured employer to determine compensability under the Nebraska Workers' Compensation Act and any other data required by statute or rule.
- E. Monitoring.** The court may monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements. All records of the managed care plan and its participating health care providers relevant to determining compliance with Rule 51 through Rule 61, and sections 48-120 and 48-120.02, shall be disclosed within a reasonable time after request by the court. Records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: July 1, 1997.

RULE 58

MANAGED CARE DISPUTE RESOLUTION

- A.** Disputes that arise between the employee, health care provider, managed care plan, insurer, risk management pool, or employer, involving the question of inappropriate, excessive, or not medically necessary treatment, medical disputes, and those disputes listed under Rule 56,C shall first be processed without charge to the employee or health care provider through the dispute resolution procedure of the managed care plan. The managed care plan dispute resolution procedure must be completed within 30 days of receipt of a written request.
- B.** Under section 48-120.02, an employee shall exhaust the dispute resolution procedure of the certified managed care plan prior to filing a petition or otherwise seeking relief from the court on an issue related to managed care. If an employee has exhausted the dispute resolution procedure of the managed care plan, the employee may submit the dispute to the court for informal dispute resolution or may seek a medical finding by an independent medical examiner. No petition may be filed with the court pursuant to section 48-173 solely on the issue of the reasonableness and necessity of medical treatment unless a medical finding on such issue has been rendered by an independent medical examiner, but such finding shall not thereafter preclude the filing of a petition. A petition may be filed with the court for the purpose of avoiding the running of the applicable statute of limitations in which case the petition shall be deemed filed with the court for purposes of the statute of limitations and will be held in abeyance until the medical finding on the issue has been received from the independent medical examiner.

Sections 48-120.02, 48-134.01, 48-173, R.R.S. 2010, and 48-120, R.S. Supp., 2015.
Effective date: July 1, 1997.

RULE 59

MANAGED CARE PEER REVIEW AND UTILIZATION REVIEW

- A. Peer review.** The managed care plan shall implement a system for peer review to prevent inappropriate, excessive, or not medically necessary treatment and to improve the quality of patient care and cost effectiveness of treatment. Peer review must include at least one health care provider of the same discipline be-

ing reviewed. The peer review must be designed to evaluate the quality of care given by a health care provider to a patient or patients. The plan must describe in its application for certification how the providers will be selected for review, the nature of the review, and how the results will be used.

- B. Utilization review.** The managed care plan shall implement a program for utilization review to prevent inappropriate, excessive, or not medically necessary treatment and to improve the quality of patient care and cost effectiveness of treatment. The program must include the collection, review, and analysis of group data to improve overall quality of care and efficient use of resources. In its application for certification, the managed care plan must specify the data that will be collected, how the data will be analyzed, and how the results will be applied to improve patient care and increase cost effectiveness of treatment.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: July 1, 1997.

RULE 60

MANAGED CARE

MEDICAL CASE MANAGEMENT

- A. Role of case manager.** A medical case manager in a managed care plan shall monitor, evaluate, and coordinate the delivery of quality, cost effective medical treatment and other health care services needed by an injured employee to assist him or her in reaching maximum medical improvement, and shall promote an appropriate, prompt return to work. Medical case managers shall facilitate communication between the employee, employer, insurer, risk management pool, health care provider, managed care plan, and any assigned vocational rehabilitation counselor to achieve these goals. The managed care plan must describe in its application for certification how injured employees will be selected for medical case management, the services to be provided, and who will provide the services.
- B. Qualifications of medical case manager.** A medical case manager, for purposes of a managed care plan, shall have attained the educational and/or employment experience set forth below in this rule. Acceptable case management experience must be full-time paid employment. Acceptable clinical experience involves full-time, paid employment either in a professional clinical setting (e.g., hospital/clinic, home health care, physician's private practice, etc.) or with a private rehabilitation firm. Additionally, professionally supervised intern-

ships, preceptorships, practica—whether paid or unpaid—may be counted toward meeting the full-time employment and clinical experiences. Volunteer work experience activities, however, may not be counted toward meeting the full-time employment or clinical experience requirements.

1. Designation of Certified Case Manager (CCM) by the Certification of Insurance Rehabilitation Specialists Commission for Case Manager Certification, or;
2. Designation of Certified Insurance Rehabilitation Specialist (CIRS) by the Certification of Insurance Rehabilitation Specialists Commission, or;
3. Current licensure as a Registered Nurse (RN), or;
4. Current licensure as a Licensed Practical Nurse (LPN) and 18 months supervised clinical experience and six months acceptable case management experience, or;
5. A baccalaureate degree (in a field other than nursing), current professional licensure or national certification in a health and human services profession, and at least 24 months employment experience, of which six months must be acceptable case management experience and 18 months must be supervised clinical experience.
6. Extensive experience in medical case management may be substituted for any of the foregoing.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: July 1, 1997.

RULE 61

MANAGED CARE

SUSPENSION; REVOCATION

- A. Criteria.** The certification of a managed care plan may be suspended or revoked by the court if:
1. the plan for providing services or a contract with the insurer, risk management pool, self insured employer, or health care provider fails to meet the requirements of Rule 51 through Rule 61 or sections 48-120 and 48-120.02 or;

2. service under the plan is not being provided according to the terms of the plan; or
3. any false or misleading information is submitted by the managed care plan or participating provider; or
4. the managed care plan continues to use the services of a health care provider whose license, registration, or certification has been suspended or revoked.

B. Complaints; investigation. Complaints pertaining to violations of Rule 51 through 61 or sections 48-120 and 48-120.02 by the managed care plan shall be directed in writing to the court. On receipt of a written complaint, or after monitoring the managed care plan operations, the court may investigate the alleged violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the investigation reveals reasonable cause to believe that there has been a violation, the certification may be suspended or revoked.

C. Immediate Revocation. Notwithstanding Rules 61,A and 61,B above, in any case where the court finds a serious danger to the public health or safety the court may immediately revoke the certification of the managed care plan.

D. Effects.

1. An employee is no longer required to receive services under a managed care plan if the managed care plan's certification is revoked.
2. Any contractual obligations of an insurer, risk management pool, or self insured employer to allow a managed care plan to provide medical, surgical, or hospital services for employees pursuant to the Nebraska Workers' Compensation Act shall be null and void upon revocation of the certification of the managed care plan.
3. Any contractual obligations of a health care provider or other entity to deliver medical, surgical, or hospital services pursuant to the Nebraska Workers' Compensation Act, or to comply with any rules, terms, and conditions of the managed care plan or to make referrals into the managed care plan shall be null and void upon revocation of the certification of the managed care plan.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: July 1, 1997.

RULE 62
INDEPENDENT MEDICAL EXAMINERS
APPOINTMENT

Words in italics are defined in Rule 49.

A. Qualifications. To be eligible for appointment by the court to the list of qualified *independent medical examiners* the *physician* must:

1. be licensed and in good standing in Nebraska or the state in which he or she practices;
2. be highly experienced and competent in his or her specific field of expertise and in the treatment of work-related injuries; and
3. be knowledgeable of workers' compensation principles and the workers' compensation system in Nebraska, as demonstrated by prior experience and/or education.

B. Appointment. Appointment of *physicians* to the list of qualified *independent medical examiners*, and maintenance and periodic validation of such list shall be by a majority vote of the judges of the court.

C. Application for Appointment. To request appointment to the list of qualified *independent medical examiners* a *physician* shall complete and forward to court an application form provided by the court, and shall also verify that the *physician*, if appointed, will:

1. provide independent, impartial and objective medical findings in all cases that come before him or her;
2. decline a request to serve as an *independent medical examiner* only for good cause shown;
3. conduct an examination, if necessary, in order to render findings on the questions and issues submitted, within the time frame established in Rule 64,C;
4. submit a written report to the parties and the court within the time frame established in Rule 64,E;
5. accept as payment in full for services rendered as an *independent medical examiner* the fees established pursuant to Rule 65;
6. submit to a review pursuant to Rule 62,E; and

7. comply with all of the other provisions of Rule 62 through Rule 67 and section 48-134.01.

D. Disclosure. As part of the application the *physician* shall identify any employer, insurer, attorney, employee group, *managed care plan*, or representatives of any of the above to whom the *physician* is under contract or who regularly uses the services of the *physician*.

E. Review. The court may at its discretion review the performance of any *physician* appointed to the list of qualified *independent medical examiners*. Such review may include, but not be limited to, the timeliness of submission of medical findings, the quality of the reports submitted, and any other aspects of the performance of the examiner as determined by the court.

Sections 48-120.02, 48-134.01, 48-173, R.R.S. 2010, and 48-120, R.S. Supp., 2015.
Effective date: December 1, 1999.

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.

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*.

Sections 48-120.02, 48-134.01, 48-173, R.R.S. 2010, and 48-120, R.S. Supp., 2015.
Effective date: April 24, 2008.

RULE 64

INDEPENDENT MEDICAL EXAMINERS PROCEDURES BEFORE THE INDEPENDENT MEDICAL EXAMINER

Words in italics are defined in Rule 49.

- A.** An *independent medical examiner* shall render medical findings in any dispute submitted to the examiner on the medical condition of the employee and related issues, including, but not limited to:
1. whether the employee is able to perform any gainful employment temporarily or permanently;
 2. what physical restrictions, if any, would be imposed on the employee's employment;
 3. whether the employee has reached maximum medical improvement;
 4. the existence and extent of any permanent physical impairment;
 5. the reasonableness and necessity of any medical treatment previously provided or to be provided to the employee; and
 6. any other medical question(s) as may pertain to the causality and relatedness of the medical condition to the employment.
- B.** In addition to the review of records and information, the *independent medical examiner* may examine the employee as often as the examiner determines necessary in order to render medical findings on the questions and issues submitted. The examiner may also perform any necessary tests and may also arrange for any necessary tests, evaluations and examinations to be performed by other *health care providers*, but shall not refer the employee to any facility in which the examiner has an ownership or similar financial or investment interest, unless the type of facility or services are not otherwise available within 60 miles of the residence or place of employment of the employee.

- C. If it is determined by the *independent medical examiner* that it is necessary to examine the employee in order to render medical findings on the disputed issues, then the examiner shall contact the employee to schedule the appointment. Such contact may be by telephone or in writing, and shall occur within 10 business days from receipt of records from all parties pursuant to Rule 63. The examiner shall immediately notify all parties and the court, in writing by regular mail, of the date, time, location, and purpose of the examination. If the employee fails to appear for a scheduled examination, or if an examination is cancelled within 48 hours of the scheduled time by the employee, then the examination shall not be rescheduled unless approved by the employer or insurance carrier or by order of the court.
- D. All contact between the examiner and the parties, other than for the scheduling of an appointment for an examination and the examination, shall be in writing with copies to all other parties and the court.
- E. After review of the records and information, and completion of any necessary examinations and/or additional tests, evaluations or examinations, the *independent medical examiner* shall submit a written report to the court and to all parties, stating the examiner's medical findings on the questions or issues raised and providing a description of the findings sufficient to explain the basis of those findings. Where only a review of records and information is required, such report shall be submitted within 10 business days of receipt of all necessary records and information. If an examination and/or additional tests, evaluations or examinations are required, such report shall be submitted within 10 business days of the completion of the examinations, additional tests or evaluations. The court may approve extension of time upon good cause shown by the examiner.
- F. Requests for clarification of the *independent medical examiner's* findings must be submitted to the court, not to the *independent medical examiner*. Clarification will be permitted only with approval of a medical services specialist of the court. No request for clarification will be permitted if it is determined by the specialist to be overly burdensome to the examiner. Any party may depose the examiner in accordance with the Nebraska Discovery Rules for all Civil Cases.
- G. The written report of the *independent medical examiner's* findings shall be admissible in a proceeding before the court, and may be received into evidence by the court on its own motion.
- H. Once the *independent medical examiner* has submitted a written report 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.

- I. No petition may be filed with the court solely on the issue of reasonableness and necessity of medical treatment unless a medical finding on such issue has been rendered by an *independent medical examiner*; but such finding shall not thereafter preclude the filing of a petition. A petition may be filed with the court for the purpose of avoiding the running of the applicable statute of limitations in which case the petition shall be deemed filed with the court for purposes of the statute of limitations but will be held in abeyance until the medical finding on the issue has been received from the *independent medical examiner*.
- J. Any *physician* acting without malice and within the scope of the provider's duties as an *independent medical examiner* shall be immune from civil liability for making any report or other information available to the court or for assisting in the origination, investigation, or preparation of the report or other information so provided.

Sections 48-134.01, 48-173, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: April 24, 2008.

RULE 65

INDEPENDENT MEDICAL EXAMINERS FEES AND COSTS

Words in italics are defined in Rule 49.

- A. All fees with respect to services performed by an *independent medical examiner* shall be paid by the employer according to the following schedule.
 - 1. The *independent medical examiner* shall bill his or her usual fees for services rendered as a medical examiner. Payment shall be the examiner's usual fee or the amount allowed under Rule 65,A,2, whichever is lower. The number of hours required shall be included with the bill, as well as a statement that the services were rendered as a court assigned or agreed to *independent medical examiner*.
 - 2. The *independent medical examiner* shall receive up to \$400 per hour up to a maximum of four hours for review of records and information, the performance of any necessary examinations, and the preparation of the written report. In a *complex case* an additional fee of up to \$400 per hour for up to two additional hours may be allowed.
 - 3. If additional diagnostic tests are required, payment for such tests whether performed by the *independent medical examiner* or by another *health care*

provider at the request of the examiner, shall be in accordance with the court's Schedule of Fees for Medical Services or Schedule of Fees for Hospitals and Ambulatory Surgical Centers, as applicable. If additional evaluations or examinations are required and performed by another *health care provider* at the request of the examiner, payment shall be in accordance with the above schedules.

4. An *independent medical examiner* may require prepayment from the employer of up to \$400 prior to submitting a report on the issues submitted. Any additional amounts owed to the examiner are payable upon submission of the examiner's written report.
 5. If an employee fails to appear for a scheduled examination, or if an examination is cancelled by the employee or the employer within 48 hours of the scheduled time, the *independent medical examiner* may charge and receive up to \$400, to be paid initially by the employer, subject to the right of the employer to be reimbursed by the employee if the failure to appear or the cancellation by the employee was without good cause.
- B.** Any dispute regarding payment for services rendered by an *independent medical examiner* that cannot otherwise be resolved by the examiner and the parties themselves shall be submitted for informal dispute resolution.
- C.** The employer shall pay all necessary and reasonable expenses of the employee incident to such examination, such as transportation, lodging, meals, and loss of wages, and when required, shall advance necessary costs. If the employee fails to appear for the scheduled examination, such expenses shall not be paid again if the examination is rescheduled.

Sections 48-134.01, 48-168, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: May 9, 2012.

RULE 66

INDEPENDENT MEDICAL EXAMINERS REMOVAL

- A.** Removal of physicians from the list of qualified independent medical examiners shall be by request of the physician or by a majority vote of the judges of the court.
- B.** Grounds for removal include, but are not limited to:

1. a material misrepresentation on the application for appointment to the list; or
 2. refusal or substantial failure to comply with the provisions of Rule 62 through Rule 66 or section 48-134.01.
- C. In arriving at a determination as to whether to remove a physician from the list, the court may consider the character of the alleged violation and all of the attendant circumstances, and may confer with public or private medical consultants.

Sections 48-134.01, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: July 1, 1997.

RULE 67

INDEPENDENT MEDICAL EXAMINERS SELECTED BY AGREEMENT OF THE PARTIES

Words in italics are defined in Rule 49.

- A. Nothing in Rule 62 through Rule 66 shall prohibit the parties from agreeing to the use of an *independent medical examiner* who is not on the list of qualified *independent medical examiners* established by the court. If the parties agree to the use of an *independent medical examiner*, whether from the list of qualified *independent medical examiners* established by the court or otherwise, Rules 63 through 65 shall apply. Written notice of any such agreement shall be provided by the parties to the examiner and to the court on a form developed by the court. If the agreed upon examiner is not on the list of qualified *independent medical examiners* established by the court, the parties shall also obtain written agreement from the examiner that he or she will comply with Rules 63 through 65, and shall provide a copy of such agreement to the court.
- B. Any agreement between the parties to the use of an *independent medical examiner* shall specify the questions and issues to be submitted to the examiner for a finding.
- C. If the parties agree to the use of a particular named *independent medical examiner* and the *independent medical examiner* has submitted a written report stating findings on the questions or issues raised, no party may request court assignment of an *independent medical examiner* on the same questions or issues.

Sections 48-134.01, 48-163, 48-164, R.R.S. 2010, and 48-120, R.S. Supp., 2015.

Effective date: July 1, 1997.

RULE 68

RULES AND REGULATIONS

- A.** The adoption, amendment, or repeal of the rules and regulations necessary to carry out the intent and purpose of the Nebraska Workers' Compensation Act shall be controlled by the procedures set out in this rule.
- B.** For purposes of this rule, quorum shall mean a majority of the judges of the Nebraska Workers' Compensation Court.
- C.** Adoption and promulgation of rules and regulations:
 - 1. No rule or regulation shall be adopted, amended, or repealed except after public hearing on the question of adopting, amending, or repealing such rule or regulation. Any such hearing shall be open to the public. A quorum of the judges of the court shall be present and conduct such hearing.
 - 2. Notice of any such public hearing shall be given at least 30 days prior to the date of the hearing.
 - a. Notice shall be given by publication in a newspaper having general circulation in the state.
 - b. Notice shall be given in the manner requested to those subscribers whose names are on a list maintained by the court.
 - c. Notice shall be given in the manner requested to the news media requesting notice of such hearings.
 - 3. Draft copies or working copies of all rules and regulations proposed to be adopted, amended, or repealed shall be available to the public in the office of the court at the time of giving notice of the public hearing.
 - 4. The adoption, amendment or repeal of any rule or regulation shall be accomplished at a public meeting held after a public hearing as provided in this rule, and after reasonable advance publicized notice of the time and place of such public meeting. No rule or regulation shall be adopted, amended, or repealed except upon the affirmative vote of a majority of the judges of the court and, with respect to rules or regulations relating to the court's adjudicatory function, only upon approval of the Supreme Court. A roll call vote is to be taken at such public meeting and the record shall state the vote of each judge or if a judge was absent or not voting. The effective date of the adoption, amendment, or repeal of any rule or regulation shall be established at the time of the public meeting, except that rules

or regulations relating to the court's adjudicatory function shall become effective upon approval of the Supreme Court.

5. The proceedings of any public hearing or public meeting held pursuant to this rule shall be recorded and made available within 10 working days after the hearing or meeting.

D. Publication and distribution of rules and regulations:

1. Copies of the rules and regulations in force and effect shall be published by the court and made available to the public, upon request, at a fee established by the court. Rules and regulations relating to the court's adjudicatory function shall be published in the Nebraska Advance Sheets upon approval of the Supreme Court, and copies of such rules and regulations shall be filed with the Clerk of the Supreme Court and Court of Appeals.
2. A current copy of the rules and regulations in force and effect and any updates to those rules and regulations, once adopted, shall be distributed, at no cost, by the court to the State Library and to each county law library or the largest public library in each county.

Sections 48-163, 48-164, R.R.S. 2010, 48-156, R.S. Supp., 2014, 84-1408, 84-1409, 84-1410, 84-1411, 84-1412, R.R.S. 2014, and 84-1413, R.S. Supp., 2015.

Effective date: October 15, 2008.

RULE 69

INSURANCE AND SELF INSURANCE

All employers subject to the Nebraska Workers' Compensation Act, except the State of Nebraska and any governmental agency created by the state, must either carry workers' compensation insurance, or, if eligible, may self-insure through a risk management pool, or, after application to and approval by the Nebraska Workers' Compensation Court, may self-insure their risk, or, in the case of an employer who is a lessor of one or more commercial vehicles leased to a self-insured motor carrier, may be a party to an effective agreement with the self-insured motor carrier under section 48-115.02. No employee may reject the provisions of the Act. No employer, including religious or charitable institutions, and governmental subdivisions, may reject the provisions of the Act.

Sections 44-4304, and 48-103, 48-106, 48-112, 48-114, 48-115.02, 48-131, R.R.S. 2010, and 48-145, R.S. Supp., 2015.

Effective date: April 25, 2002.

RULE 70
SELF-INSURANCE
PURPOSE

- A. The purpose of Rules 70 through 76 is to establish procedures and requirements for an employer seeking approval to self-insure its liability under the Nebraska Workers' Compensation Act, and for approval by the court to self-insure.
- B. No employer may self-insure its liability under the Act or make any representation that it self-insures its liability under the Act unless it has been approved by the court pursuant to these rules.
- C. All financial information required by the court of an employer seeking approval to self-insure or an employer approved to self-insure shall be confidential.
- D. An employer may request approval to self-insure a subsidiary, division, or other entity provided a majority interest is owned or controlled by such employer. Majority interest means more than 50% of voting stock, or more than 50% of members or directors if there is no voting stock.
- E. An employer approved to self-insure may not delegate the ultimate responsibility for complying with the Act or rules of the court to any other party.

Section 48-145, R.S. Supp., 2015.

Effective date: November 16, 2006.

RULE 71
SELF-INSURANCE
APPLICATION FOR APPROVAL

- A. An employer seeking approval to self-insure its liability under the Nebraska Workers' Compensation Act shall submit a written request for an application to the court. The written request for an application must be signed by a corporate officer and be on the employer's own letterhead. The employer requesting an application must:
 - 1. have 100 employees in Nebraska or reasonably expect to have 100 employees in Nebraska within one (1) year of beginning operations in Nebraska;
 - 2. have a minimum of five (5) years in business under the present organizational structure, and;

3. be a corporation or political subdivision.
- B.** All questions on the application for approval to self-insure must be fully and accurately answered. Such answers shall be given under oath by an authorized officer of the applicant. Each application for approval to self-insure must be accompanied by:
1. a nonrefundable fee which has been determined in accordance with section 48-145.04(1);
 2. copies of the applicant's certified financial statements for the last five years;
 3. a current payroll report broken down by job classification code plus payroll reports broken down by job classification code for the four previous consecutive years;
 4. incurred loss history for the last five years;
 5. evidence of authorization to transact business in Nebraska or status as a political subdivision, and;
 6. any other information, including supporting documentation, as requested by the court.

Sections 48-145.04, R.R.S. 2010, and 48-145, R.S. Supp., 2015.

Effective date: April 25, 2002.

RULE 72

SELF-INSURANCE REQUIREMENTS FOR APPROVAL

- A.** The following factors will be among those used in analyzing an application and determining whether an employer can be granted approval to self-insure:
1. standard financial ratio analysis and comparison to similar industry statistical data;
 2. historical operating results;
 3. evaluation of financial trends;
 4. organizational structure and management background;
 5. contingent liabilities;

6. pending litigation;
 7. general and specific industry economic conditions;
 8. number of employees;
 9. current and historical loss experience, reserves, and modification factor;
 10. safety program;
 11. nature of business;
 12. claim administration procedures, and;
 13. proposed retention and limits for excess insurance.
 14. claims record regarding delinquent payment of indemnity and medical expenses, as defined by section 48-125.
- B.** The court will approve employers to self-insure who meet the requirements of Rule 71,A and can provide:
1. satisfactory proof of financial strength and liquidity to meet all obligations under the Nebraska Workers' Compensation Act;
 2. a fully executed parental guarantee if the employer is a subsidiary;
 3. acceptable arrangements for claim administration and injury and payment reporting;
 4. security in accordance with Rule 73;
 5. excess insurance in accordance with Rule 74;
 6. evidence of a safety committee and an effective written injury prevention program in accordance with section 48-443, and;
 7. evidence of compliance with any other requirements under the Act and these rules.
- C.** After reviewing the application and all supporting documentation and other information the court will send written notice of approval, denial, or requirements for further consideration. If the court has additional requirements, the employer will have 30 days to comply. Upon receipt of a written request the court, at its discretion, may grant the employer additional time to comply. If all requirements are not met within the time prescribed, the application shall be considered withdrawn.

- D.** A certificate of approval to self-insure will be provided upon approval. The term of approval will be included on the certificate.

Sections 48-443, 48-444, 48-445, 48-446, R.R.S. 2010, and 48-145, R.S. Supp., 2015.
Effective date: November 16, 2006.

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 em-

ployer 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.

Section 48-145, R.S. Supp., 2015.

Effective date: December 17, 2002.

RULE 74

SELF-INSURANCE **EXCESS INSURANCE**

- A.** Specific excess workers' compensation insurance shall be required of each approved self-insurer. Aggregate excess insurance may be required as a condition of approval to self-insure, at the discretion of the court. Political subdivisions with either unlimited rate making authority or having taxing authority with a tax base of at least \$2,500,000,000 and with 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.** The specified upper limit of excess workers' compensation coverage must be "statutory" and the retention amounts must be approved by the court.
- C.** Each excess workers' compensation policy must be issued by a corporation, association, or organization authorized and licensed by the Nebraska Department of Insurance to transact the business of workers' compensation insurance in this state.
- D.** All excess workers' compensation policy forms and endorsements must be filed with and approved by the Nebraska Department of Insurance. The Nebraska Amendatory Endorsement is required for all excess workers' compensation policies.
- E.** Excess workers' compensation policies may not include deductible provisions or deductible endorsements.
- F.** An exact copy of each excess workers' compensation policy must be filed with the court, in its entirety, including any endorsements, amendments, and schedules.

Section 48-145, R.S. Supp., 2015.

Effective date: November 16, 2006.

RULE 75

SELF-INSURANCE REPORTING REQUIREMENTS

- A.** The court shall be notified promptly of contemplated mergers, consolidations, acquisitions, divesting or spinning off of current operations, and other major organizational changes.
- B.** The court shall be notified promptly when there is any change in third party administrator, address, court contact, Nebraska Registered Agent, security, or other information in the application.
- C.** The court shall be notified within 10 days by certified mail of any bankruptcy filing by the self-insurer or its parent, or any subsidiary of the self-insurer or its parent.
- D.** The self-insurer will furnish additional reports or other information the court may require on an annual or as needed basis.
- E.** The court may conduct periodic audits and special examinations of the self-insurer's payroll and other workers' compensation records, or the records of a third party administrator or other agent acting on behalf of the self-insurer, to ensure compliance with self-insurance requirements and other obligations under the Nebraska Workers' Compensation Act.

Section 48-145, R.S. Supp., 2015.

Effective date: April 25, 2002.

RULE 76

SELF-INSURANCE RENEWAL, TERMINATION

- A.** An employer desiring to renew approval to self-insure its liability under the Nebraska Workers' Compensation Act must submit an application to the court 30 days prior to the expiration date shown on the current certificate. Upon receipt of a written request the court, at its discretion, may grant the employer additional time to comply. If the application is not submitted within the time prescribed, approval to self-insure will expire on the date shown on the current certificate or other date specified by the court.

- B.** All questions on the application for renewal of approval to self-insure must be fully and accurately answered. Such answers shall be given under oath by an authorized officer of the applicant. Each application must be accompanied by:
 - 1. a nonrefundable fee which has been determined in accordance with section 48-145.04(1);
 - 2. a copy of the applicant's most recent certified financial statement, and;
 - 3. any other information, including supporting documentation, as requested by the court.
- C.** Upon receipt of the application and all fees, supporting documentation, and other information, approval to self-insure will be extended until the employer is provided a certificate evidencing renewal of approval to self-insure or until the employer is notified of nonrenewal and the date approval to self-insure will expire.
- D.** The application, supporting documentation, and other information will be analyzed and continued approval to self-insure will be in accordance with Rules 72,A and 72,B.
- E.** After reviewing the application and all supporting documentation and other information, the court will send written notice of renewal or nonrenewal of approval, or requirements for further consideration. If the court has additional requirements, the employer will have 30 days to comply. Upon receipt of a written request the court, at its discretion, may grant the employer additional time to comply. If all requirements are not met within the time prescribed, the application for renewal shall be considered denied and approval to self-insure will expire on the date specified by the court.
- F.** An applicant denied renewal of approval to self-insure may not reapply for one year after receipt of notice of denial.
- G.** An employer may voluntarily terminate approval to self-insure prior to the expiration date shown on the current certificate by providing the court with written notice of the reason for termination, the date and time of the intended termination, the name of the insurer assuming the risk after termination, and the policy number and effective date of the workers' compensation insurance policy.

Sections 48-145.04, R.R.S. 2010, and 48-145, R.S. Supp., 2015.

Effective date: April 25, 2002.

ADDENDA

ADDENDUM	TITLE	PAGE
1	Present Value Table.....	A3
2	U.S. Life Table: 2010.....	A9
3	Personal and Financial Account Information.....	A10

ADDENDUM 1

PRESENT VALUE TABLE **NEBRASKA WORKERS' COMPENSATION COURT**

Present value of annuity certain of \$1.00 per week. Interest at five percent per annum with annual rests. Payment at end of week 365.2425 days to a year.

TO USE TABLES:

Find present value of \$1.00 for number of weeks to be commuted; multiply the value so found by the weekly compensation rate.

EXAMPLE:

Weeks to be commuted, 215; weekly compensation rate, \$62.00; present value of \$1.00 for 215 weeks is \$194.2141; multiplying \$194.2141 by \$62.00 produces the commuted value of \$12,041.27.

EXAMPLE WHERE WEEKLY RATE CHANGES:

Weeks to be commuted, 1,100; first 175 weeks at \$62.00; following 925 weeks at \$47.00 (1,100 weeks at \$47.00 per week plus 175 weeks at \$15.00 per week running concurrently, beginning with the first week, produces the same result.) Present value of \$1.00 for 1,100 weeks is \$679.6809; multiplying \$679.6809 by \$47.00 produces \$31,945.00. Present value of \$1.00 for 175 weeks is \$161.0426; multiplying \$161.0426 by \$15 produces \$2,415.64. Adding \$31,945.00 to \$2,415.64 makes a total of \$34,360.64, being the present worth of 1,100 weeks at the rates stated.

Weeks	Present Value						
1	\$0.9990	56	\$54.4985	111	\$105.2527	166	\$153.4023
2	\$1.9971	57	\$55.4454	112	\$106.1509	167	\$154.2545
3	\$2.9943	58	\$56.3914	113	\$107.0484	168	\$155.1058
4	\$3.9904	59	\$57.3364	114	\$107.9449	169	\$155.9564
5	\$4.9857	60	\$58.2806	115	\$108.8406	170	\$156.8061
6	\$5.9799	61	\$59.2238	116	\$109.7355	171	\$157.6551
7	\$6.9732	62	\$60.1662	117	\$110.6295	172	\$158.5032
8	\$7.9656	63	\$61.1076	118	\$111.5226	173	\$159.3505
9	\$8.9570	64	\$62.0482	119	\$112.4149	174	\$160.1970
10	\$9.9475	65	\$62.9878	120	\$113.3063	175	\$161.0426
11	\$10.9370	66	\$63.9265	121	\$114.1969	176	\$161.8875
12	\$11.9256	67	\$64.8644	122	\$115.0866	177	\$162.7316
13	\$12.9132	68	\$65.8013	123	\$115.9754	178	\$163.5748
14	\$13.8999	69	\$66.7374	124	\$116.8635	179	\$164.4173
15	\$14.8856	70	\$67.6725	125	\$117.7506	180	\$165.2589
16	\$15.8704	71	\$68.6068	126	\$118.6369	181	\$166.0997
17	\$16.8543	72	\$69.5401	127	\$119.5224	182	\$166.9398
18	\$17.8372	73	\$70.4726	128	\$120.4070	183	\$167.7790
19	\$18.8191	74	\$71.4042	129	\$121.2908	184	\$168.6174
20	\$19.8002	75	\$72.3349	130	\$122.1737	185	\$169.4550
21	\$20.7803	76	\$73.2647	131	\$123.0558	186	\$170.2918
22	\$21.7594	77	\$74.1936	132	\$123.9370	187	\$171.1278
23	\$22.7376	78	\$75.1216	133	\$124.8174	188	\$171.9631
24	\$23.7149	79	\$76.0487	134	\$125.6970	189	\$172.7975
25	\$24.6912	80	\$76.9749	135	\$126.5757	190	\$173.6311
26	\$25.6666	81	\$77.9003	136	\$127.4535	191	\$174.4639
27	\$26.6411	82	\$78.8248	137	\$128.3306	192	\$175.2959
28	\$27.6146	83	\$79.7483	138	\$129.2067	193	\$176.1271
29	\$28.5872	84	\$80.6710	139	\$130.0821	194	\$176.9576
30	\$29.5589	85	\$81.5928	140	\$130.9566	195	\$177.7872
31	\$30.5297	86	\$82.5138	141	\$131.8303	196	\$178.6160
32	\$31.4995	87	\$83.4338	142	\$132.7031	197	\$179.4441
33	\$32.4684	88	\$84.3530	143	\$133.5751	198	\$180.2713
34	\$33.4363	89	\$85.2713	144	\$134.4463	199	\$181.0978
35	\$34.4034	90	\$86.1887	145	\$135.3166	200	\$181.9235
36	\$35.3695	91	\$87.1052	146	\$136.1861	201	\$182.7483
37	\$36.3347	92	\$88.0209	147	\$137.0548	202	\$183.5724
38	\$37.2989	93	\$88.9356	148	\$137.9226	203	\$184.3957
39	\$38.2622	94	\$89.8495	149	\$138.7896	204	\$185.2182
40	\$39.2247	95	\$90.7626	150	\$139.6558	205	\$186.0400
41	\$40.1861	96	\$91.6747	151	\$140.5211	206	\$186.8609
42	\$41.1467	97	\$92.5860	152	\$141.3856	207	\$187.6811
43	\$42.1064	98	\$93.4964	153	\$142.2493	208	\$188.5004
44	\$43.0651	99	\$94.4059	154	\$143.1122	209	\$189.3190
45	\$44.0229	100	\$95.3146	155	\$143.9742	210	\$190.1368
46	\$44.9798	101	\$96.2224	156	\$144.8354	211	\$190.9538
47	\$45.9358	102	\$97.1293	157	\$145.6958	212	\$191.7701
48	\$46.8909	103	\$98.0354	158	\$146.5554	213	\$192.5855
49	\$47.8450	104	\$98.9406	159	\$147.4141	214	\$193.4002
50	\$48.7982	105	\$99.8449	160	\$148.2720	215	\$194.2141
51	\$49.7506	106	\$100.7483	161	\$149.1291	216	\$195.0272
52	\$50.7020	107	\$101.6509	162	\$149.9854	217	\$195.8395
53	\$51.6525	108	\$102.5527	163	\$150.8408	218	\$196.6511
54	\$52.6021	109	\$103.4535	164	\$151.6955	219	\$197.4618
55	\$53.5508	110	\$104.3535	165	\$152.5493	220	\$198.2718

Weeks	Present Value						
221	\$199.0811	276	\$242.4158	331	\$283.5268	386	\$322.5281
222	\$199.8895	277	\$243.1828	332	\$284.2544	387	\$323.2184
223	\$200.6972	278	\$243.9490	333	\$284.9813	388	\$323.9080
224	\$201.5041	279	\$244.7145	334	\$285.7075	389	\$324.5969
225	\$202.3102	280	\$245.4793	335	\$286.4330	390	\$325.2852
226	\$203.1156	281	\$246.2433	336	\$287.1579	391	\$325.9728
227	\$203.9202	282	\$247.0066	337	\$287.8820	392	\$326.6598
228	\$204.7240	283	\$247.7692	338	\$288.6054	393	\$327.3461
229	\$205.5271	284	\$248.5310	339	\$289.3282	394	\$328.0318
230	\$206.3293	285	\$249.2921	340	\$290.0502	395	\$328.7168
231	\$207.1309	286	\$250.0525	341	\$290.7716	396	\$329.4011
232	\$207.9316	287	\$250.8122	342	\$291.4923	397	\$330.0848
233	\$208.7316	288	\$251.5711	343	\$292.2122	398	\$330.7679
234	\$209.5308	289	\$252.3293	344	\$292.9315	399	\$331.4502
235	\$210.3292	290	\$253.0868	345	\$293.6501	400	\$332.1320
236	\$211.1269	291	\$253.8435	346	\$294.3681	401	\$332.8130
237	\$211.9238	292	\$254.5995	347	\$295.0853	402	\$333.4935
238	\$212.7200	293	\$255.3548	348	\$295.8018	403	\$334.1732
239	\$213.5154	294	\$256.1094	349	\$296.5177	404	\$334.8524
240	\$214.3100	295	\$256.8633	350	\$297.2329	405	\$335.5308
241	\$215.1039	296	\$257.6164	351	\$297.9473	406	\$336.2087
242	\$215.8970	297	\$258.3688	352	\$298.6612	407	\$336.8858
243	\$216.6894	298	\$259.1205	353	\$299.3743	408	\$337.5624
244	\$217.4810	299	\$259.8715	354	\$300.0867	409	\$338.2382
245	\$218.2718	300	\$260.6217	355	\$300.7985	410	\$338.9135
246	\$219.0619	301	\$261.3713	356	\$301.5095	411	\$339.5881
247	\$219.8512	302	\$262.1201	357	\$302.2199	412	\$340.2620
248	\$220.6398	303	\$262.8682	358	\$302.9296	413	\$340.9353
249	\$221.4276	304	\$263.6156	359	\$303.6387	414	\$341.6079
250	\$222.2147	305	\$264.3623	360	\$304.3470	415	\$342.2799
251	\$223.0010	306	\$265.1082	361	\$305.0547	416	\$342.9513
252	\$223.7865	307	\$265.8535	362	\$305.7617	417	\$343.6220
253	\$224.5713	308	\$266.5980	363	\$306.4680	418	\$344.2921
254	\$225.3554	309	\$267.3418	364	\$307.1737	419	\$344.9615
255	\$226.1387	310	\$268.0849	365	\$307.8786	420	\$345.6303
256	\$226.9212	311	\$268.8273	366	\$308.5829	421	\$346.2985
257	\$227.7030	312	\$269.5690	367	\$309.2866	422	\$346.9660
258	\$228.4841	313	\$270.3099	368	\$309.9895	423	\$347.6329
259	\$229.2644	314	\$271.0502	369	\$310.6918	424	\$348.2991
260	\$230.0439	315	\$271.7898	370	\$311.3934	425	\$348.9647
261	\$230.8227	316	\$272.5286	371	\$312.0943	426	\$349.6297
262	\$231.6008	317	\$273.2667	372	\$312.7946	427	\$350.2940
263	\$232.3781	318	\$274.0042	373	\$313.4942	428	\$350.9577
264	\$233.1547	319	\$274.7409	374	\$314.1931	429	\$351.6207
265	\$233.9305	320	\$275.4769	375	\$314.8913	430	\$352.2831
266	\$234.7056	321	\$276.2122	376	\$315.5889	431	\$352.9449
267	\$235.4800	322	\$276.9468	377	\$316.2858	432	\$353.6061
268	\$236.2536	323	\$277.6808	378	\$316.9821	433	\$354.2666
269	\$237.0264	324	\$278.4140	379	\$317.6776	434	\$354.9265
270	\$237.7986	325	\$279.1465	380	\$318.3726	435	\$355.5857
271	\$238.5699	326	\$279.8783	381	\$319.0668	436	\$356.2444
272	\$239.3406	327	\$280.6094	382	\$319.7604	437	\$356.9023
273	\$240.1105	328	\$281.3398	383	\$320.4533	438	\$357.5597
274	\$240.8797	329	\$282.0695	384	\$321.1456	439	\$358.2164
275	\$241.6481	330	\$282.7985	385	\$321.8372	440	\$358.8725

Weeks	Present Value						
441	\$359,5280	496	\$394,6293	551	\$427,9293	606	\$459,5204
442	\$360,1829	497	\$395,2505	552	\$428,5186	607	\$460,0795
443	\$360,8371	498	\$395,8712	553	\$429,1074	608	\$460,6381
444	\$361,4907	499	\$396,4912	554	\$429,6957	609	\$461,1962
445	\$362,1437	500	\$397,1107	555	\$430,2833	610	\$461,7537
446	\$362,7960	501	\$397,7295	556	\$430,8704	611	\$462,3107
447	\$363,4477	502	\$398,3478	557	\$431,4570	612	\$462,8671
448	\$364,0988	503	\$398,9655	558	\$432,0430	613	\$463,4230
449	\$364,7493	504	\$399,5826	559	\$432,6284	614	\$463,9784
450	\$365,3991	505	\$400,1991	560	\$433,2133	615	\$464,5333
451	\$366,0484	506	\$400,8150	561	\$433,7976	616	\$465,0876
452	\$366,6970	507	\$401,4303	562	\$434,3813	617	\$465,6414
453	\$367,3450	508	\$402,0451	563	\$434,9645	618	\$466,1947
454	\$367,9923	509	\$402,6592	564	\$435,5471	619	\$466,7474
455	\$368,6391	510	\$403,2728	565	\$436,1292	620	\$467,2996
456	\$369,2852	511	\$403,8857	566	\$436,7107	621	\$467,8513
457	\$369,9307	512	\$404,4981	567	\$437,2917	622	\$468,4024
458	\$370,5756	513	\$405,1099	568	\$437,8721	623	\$468,9530
459	\$371,2199	514	\$405,7211	569	\$438,4519	624	\$469,5031
460	\$371,8635	515	\$406,3318	570	\$439,0312	625	\$470,0527
461	\$372,5066	516	\$406,9418	571	\$439,6100	626	\$470,6017
462	\$373,1490	517	\$407,5513	572	\$440,1881	627	\$471,1502
463	\$373,7908	518	\$408,1601	573	\$440,7658	628	\$471,6982
464	\$374,4320	519	\$408,7684	574	\$441,3428	629	\$472,2457
465	\$375,0726	520	\$409,3761	575	\$441,9194	630	\$472,7926
466	\$375,7125	521	\$409,9833	576	\$442,4953	631	\$473,3390
467	\$376,3519	522	\$410,5898	577	\$443,0708	632	\$473,8849
468	\$376,9906	523	\$411,1958	578	\$443,6456	633	\$474,4303
469	\$377,6288	524	\$411,8011	579	\$444,2199	634	\$474,9751
470	\$378,2663	525	\$412,4060	580	\$444,7937	635	\$475,5195
471	\$378,9032	526	\$413,0102	581	\$445,3669	636	\$476,0633
472	\$379,5395	527	\$413,6138	582	\$445,9396	637	\$476,6066
473	\$380,1752	528	\$414,2169	583	\$446,5117	638	\$477,1493
474	\$380,8103	529	\$414,8194	584	\$447,0833	639	\$477,6916
475	\$381,4447	530	\$415,4213	585	\$447,6543	640	\$478,2333
476	\$382,0786	531	\$416,0226	586	\$448,2248	641	\$478,7745
477	\$382,7119	532	\$416,6234	587	\$448,7947	642	\$479,3152
478	\$383,3445	533	\$417,2236	588	\$449,3641	643	\$479,8553
479	\$383,9766	534	\$417,8232	589	\$449,9330	644	\$480,3950
480	\$384,6080	535	\$418,4222	590	\$450,5013	645	\$480,9341
481	\$385,2388	536	\$419,0207	591	\$451,0690	646	\$481,4728
482	\$385,8691	537	\$419,6186	592	\$451,6362	647	\$482,0109
483	\$386,4987	538	\$420,2159	593	\$452,2029	648	\$482,5485
484	\$387,1277	539	\$420,8127	594	\$452,7690	649	\$483,0855
485	\$387,7562	540	\$421,4089	595	\$453,3346	650	\$483,6221
486	\$388,3840	541	\$422,0045	596	\$453,8997	651	\$484,1581
487	\$389,0112	542	\$422,5995	597	\$454,4642	652	\$484,6937
488	\$389,6378	543	\$423,1940	598	\$455,0281	653	\$485,2287
489	\$390,2639	544	\$423,7879	599	\$455,5915	654	\$485,7632
490	\$390,8893	545	\$424,3812	600	\$456,1544	655	\$486,2972
491	\$391,5141	546	\$424,9740	601	\$456,7168	656	\$486,8307
492	\$392,1383	547	\$425,5661	602	\$457,2786	657	\$487,3637
493	\$392,7620	548	\$426,1578	603	\$457,8398	658	\$487,8961
494	\$393,3850	549	\$426,7488	604	\$458,4006	659	\$488,4281
495	\$394,0074	550	\$427,3393	605	\$458,9608	660	\$488,9595

Weeks	Present Value						
661	\$489.4905	716	\$517.9226	771	\$544.8956	826	\$570.4846
662	\$490.0209	717	\$518.4258	772	\$545.3730	827	\$570.9374
663	\$490.5508	718	\$518.9285	773	\$545.8499	828	\$571.3899
664	\$491.0802	719	\$519.4307	774	\$546.3264	829	\$571.8419
665	\$491.6091	720	\$519.9325	775	\$546.8024	830	\$572.2935
666	\$492.1375	721	\$520.4338	776	\$547.2780	831	\$572.7447
667	\$492.6654	722	\$520.9346	777	\$547.7531	832	\$573.1954
668	\$493.1928	723	\$521.4349	778	\$548.2278	833	\$573.6457
669	\$493.7197	724	\$521.9348	779	\$548.7020	834	\$574.0956
670	\$494.2461	725	\$522.4341	780	\$549.1757	835	\$574.5450
671	\$494.7720	726	\$522.9330	781	\$549.6490	836	\$574.9940
672	\$495.2973	727	\$523.4314	782	\$550.1218	837	\$575.4426
673	\$495.8222	728	\$523.9294	783	\$550.5942	838	\$575.8907
674	\$496.3466	729	\$524.4268	784	\$551.0661	839	\$576.3384
675	\$496.8704	730	\$524.9238	785	\$551.5376	840	\$576.7857
676	\$497.3938	731	\$525.4203	786	\$552.0086	841	\$577.2326
677	\$497.9167	732	\$525.9164	787	\$552.4792	842	\$577.6790
678	\$498.4390	733	\$526.4119	788	\$552.9493	843	\$578.1250
679	\$498.9609	734	\$526.9070	789	\$553.4190	844	\$578.5706
680	\$499.4822	735	\$527.4016	790	\$553.8883	845	\$579.0157
681	\$500.0031	736	\$527.8957	791	\$554.3570	846	\$579.4604
682	\$500.5235	737	\$528.3894	792	\$554.8254	847	\$579.9047
683	\$501.0433	738	\$528.8826	793	\$555.2932	848	\$580.3486
684	\$501.5627	739	\$529.3753	794	\$555.7607	849	\$580.7920
685	\$502.0816	740	\$529.8676	795	\$556.2277	850	\$581.2351
686	\$502.6000	741	\$530.3593	796	\$556.6942	851	\$581.6777
687	\$503.1178	742	\$530.8506	797	\$557.1603	852	\$582.1198
688	\$503.6352	743	\$531.3415	798	\$557.6259	853	\$582.5616
689	\$504.1521	744	\$531.8318	799	\$558.0911	854	\$583.0029
690	\$504.6685	745	\$532.3217	800	\$558.5559	855	\$583.4438
691	\$505.1844	746	\$532.8111	801	\$559.0202	856	\$583.8843
692	\$505.6998	747	\$533.3001	802	\$559.4841	857	\$584.3244
693	\$506.2147	748	\$533.7886	803	\$559.9475	858	\$584.7640
694	\$506.7291	749	\$534.2766	804	\$560.4105	859	\$585.2032
695	\$507.2431	750	\$534.7642	805	\$560.8730	860	\$585.6420
696	\$507.7565	751	\$535.2512	806	\$561.3351	861	\$586.0804
697	\$508.2694	752	\$535.7379	807	\$561.7967	862	\$586.5184
698	\$508.7819	753	\$536.2240	808	\$562.2579	863	\$586.9559
699	\$509.2938	754	\$536.7097	809	\$562.7187	864	\$587.3930
700	\$509.8053	755	\$537.1949	810	\$563.1790	865	\$587.8297
701	\$510.3163	756	\$537.6797	811	\$563.6389	866	\$588.2660
702	\$510.8268	757	\$538.1640	812	\$564.0984	867	\$588.7019
703	\$511.3368	758	\$538.6478	813	\$564.5574	868	\$589.1373
704	\$511.8463	759	\$539.1312	814	\$565.0159	869	\$589.5724
705	\$512.3553	760	\$539.6141	815	\$565.4740	870	\$590.0070
706	\$512.8639	761	\$540.0965	816	\$565.9317	871	\$590.4412
707	\$513.3719	762	\$540.5785	817	\$566.3890	872	\$590.8750
708	\$513.8795	763	\$541.0600	818	\$566.8458	873	\$591.3083
709	\$514.3866	764	\$541.5411	819	\$567.3022	874	\$591.7413
710	\$514.8932	765	\$542.0217	820	\$567.7581	875	\$592.1738
711	\$515.3993	766	\$542.5018	821	\$568.2136	876	\$592.6059
712	\$515.9049	767	\$542.9815	822	\$568.6687	877	\$593.0376
713	\$516.4100	768	\$543.4607	823	\$569.1233	878	\$593.4689
714	\$516.9147	769	\$543.9395	824	\$569.5775	879	\$593.8998
715	\$517.4189	770	\$544.4178	825	\$570.0312	880	\$594.3303

Weeks	Present Value	Weeks	Present Value	Weeks	Present Value	Weeks	Present Value
881	\$594.7604	926	\$613.6929	971	\$631.8267	1,160	\$700.0024
882	\$595.1900	927	\$614.1044	972	\$632.2209	1,170	\$703.2772
883	\$595.6193	928	\$614.5155	973	\$632.6147	1,180	\$706.5208
884	\$596.0481	929	\$614.9263	974	\$633.0081	1,190	\$709.7335
885	\$596.4765	930	\$615.3366	975	\$633.4011	1,200	\$712.9156
886	\$596.9045	931	\$615.7466	976	\$633.7938	1,210	\$716.0673
887	\$597.3321	932	\$616.1561	977	\$634.1860	1,220	\$719.1890
888	\$597.7593	933	\$616.5653	978	\$634.5779	1,230	\$722.2809
889	\$598.1861	934	\$616.9741	979	\$634.9695	1,240	\$725.3434
890	\$598.6124	935	\$617.3824	980	\$635.3606	1,250	\$728.3766
891	\$599.0384	936	\$617.7904	981	\$635.7514	1,260	\$731.3810
892	\$599.4639	937	\$618.1980	982	\$636.1418	1,270	\$734.3567
893	\$599.8891	938	\$618.6052	983	\$636.5318	1,280	\$737.3040
894	\$600.3138	939	\$619.0121	984	\$636.9215	1,290	\$740.2233
895	\$600.7382	940	\$619.4185	985	\$637.3108	1,300	\$743.1147
896	\$601.1621	941	\$619.8245	986	\$637.6997	1,350	\$757.1636
897	\$601.5856	942	\$620.2302	987	\$638.0882	1,400	\$770.5555
898	\$602.0087	943	\$620.6355	988	\$638.4764	1,450	\$783.3212
899	\$602.4314	944	\$621.0403	989	\$638.8642	1,500	\$795.4900
900	\$602.8537	945	\$621.4448	990	\$639.2516	1,600	\$818.1470
901	\$603.2756	946	\$621.8489	991	\$639.6387	1,700	\$838.7346
902	\$603.6971	947	\$622.2526	992	\$640.0254	1,800	\$857.4418
903	\$604.1182	948	\$622.6560	993	\$640.4117	1,900	\$874.4404
904	\$604.5389	949	\$623.0589	994	\$640.7976	2,000	\$889.8863
905	\$604.9592	950	\$623.4615	995	\$641.1832	2,200	\$916.6747
906	\$605.3791	951	\$623.8636	996	\$641.5684	2,400	\$938.7930
907	\$605.7986	952	\$624.2654	997	\$641.9533	2,600	\$957.0555
908	\$606.2177	953	\$624.6668	998	\$642.3377	2,800	\$972.1342
909	\$606.6363	954	\$625.0679	999	\$642.7218	3,000	\$984.5842
910	\$607.0546	955	\$625.4685	1,000	\$643.1056	3,300	\$999.3106
911	\$607.4725	956	\$625.8687	1,010	\$646.9227	3,600	\$1,010.3592
912	\$607.8900	957	\$626.2686	1,020	\$650.7035	4,000	\$1,020.9229
913	\$608.3070	958	\$626.6681	1,030	\$654.4483	4,500	\$1,029.5334
914	\$608.7237	959	\$627.0672	1,040	\$658.1573	5,000	\$1,034.8672
915	\$609.1400	960	\$627.4659	1,050	\$661.8311	6,000	\$1,040.2181
916	\$609.5559	961	\$627.8642	1,060	\$665.4697	7,000	\$1,042.2715
917	\$609.9714	962	\$628.2622	1,070	\$669.0737	8,000	\$1,043.0594
918	\$610.3865	963	\$628.6598	1,080	\$672.6434	10,000	\$1,043.4778
919	\$610.8012	964	\$629.0570	1,090	\$676.1790		
920	\$611.2154	965	\$629.4538	1,100	\$679.6809		
921	\$611.6293	966	\$629.8502	1,110	\$683.1494		
922	\$612.0428	967	\$630.2463	1,120	\$686.5849		
923	\$612.4559	968	\$630.6420	1,130	\$689.9876		
924	\$612.8687	969	\$631.0373	1,140	\$693.3579		
925	\$613.2810	970	\$631.4322	1,150	\$696.6961		

ADDENDUM 2

U.S. LIFE TABLE: 2010

Expectancy Expressed in Years

NEBRASKA WORKERS' COMPENSATION COURT

AGE	EXPECTANCY	AGE	EXPECTANCY	AGE	EXPECTANCY
10	69.3	40	40.5	70	15.5
11	68.3	41	39.6	71	14.8
12	67.3	42	38.7	72	14.1
13	66.3	43	37.7	73	13.4
14	65.3	44	36.8	74	12.7
15	64.3	45	35.9	75	12.1
16	63.3	46	35.0	76	11.4
17	62.4	47	34.1	77	10.8
18	61.4	48	33.2	78	10.2
19	60.4	49	32.3	79	9.6
20	59.5	50	31.4	80	9.1
21	58.5	51	30.6	81	8.5
22	57.6	52	29.7	82	8.0
23	56.6	53	28.9	83	7.5
24	55.7	54	28.0	84	7.0
25	54.7	55	27.2	85	6.5
26	53.8	56	26.3	86	6.1
27	52.8	57	25.5	87	5.7
28	51.9	58	24.7	88	5.3
29	50.9	59	23.9	89	4.9
30	50.0	60	23.1	90	4.6
31	49.0	61	22.3	91	4.3
32	48.1	62	21.5	92	4.0
33	47.1	63	20.7	93	3.7
34	46.2	64	19.9	94	3.4
35	45.2	65	19.1	95	3.2
36	44.3	66	18.4	96	3.0
37	43.3	67	17.6	97	2.8
38	42.4	68	16.9	98	2.6
39	41.5	69	16.2	99	2.5
				100	2.3

- 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.

Section 48-145, R.S. Supp., 2015.

Effective date: December 17, 2002.

RULE 74

SELF-INSURANCE **EXCESS INSURANCE**

- A.** Specific excess workers' compensation insurance shall be required of each approved self-insurer. Aggregate excess insurance may be required as a condition of approval to self-insure, at the discretion of the court. Political subdivisions with either unlimited rate making authority or having taxing authority with a tax base of at least \$2,500,000,000 and with 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.** The specified upper limit of excess workers' compensation coverage must be "statutory" and the retention amounts must be approved by the court.
- C.** Each excess workers' compensation policy must be issued by a corporation, association, or organization authorized and licensed by the Nebraska Department of Insurance to transact the business of workers' compensation insurance in this state.
- D.** All excess workers' compensation policy forms and endorsements must be filed with and approved by the Nebraska Department of Insurance. The Nebraska Amendatory Endorsement is required for all excess workers' compensation policies.
- E.** Excess workers' compensation policies may not include deductible provisions or deductible endorsements.
- F.** An exact copy of each excess workers' compensation policy must be filed with the court, in its entirety, including any endorsements, amendments, and schedules.

Section 48-145, R.S. Supp., 2015.

Effective date: November 16, 2006.

RULE 75

SELF-INSURANCE REPORTING REQUIREMENTS

- A.** The court shall be notified promptly of contemplated mergers, consolidations, acquisitions, divesting or spinning off of current operations, and other major organizational changes.
- B.** The court shall be notified promptly when there is any change in third party administrator, address, court contact, Nebraska Registered Agent, security, or other information in the application.
- C.** The court shall be notified within 10 days by certified mail of any bankruptcy filing by the self-insurer or its parent, or any subsidiary of the self-insurer or its parent.
- D.** The self-insurer will furnish additional reports or other information the court may require on an annual or as needed basis.
- E.** The court may conduct periodic audits and special examinations of the self-insurer's payroll and other workers' compensation records, or the records of a third party administrator or other agent acting on behalf of the self-insurer, to ensure compliance with self-insurance requirements and other obligations under the Nebraska Workers' Compensation Act.

Section 48-145, R.S. Supp., 2015.

Effective date: April 25, 2002.

RULE 76

SELF-INSURANCE RENEWAL, TERMINATION

- A.** An employer desiring to renew approval to self-insure its liability under the Nebraska Workers' Compensation Act must submit an application to the court 30 days prior to the expiration date shown on the current certificate. Upon receipt of a written request the court, at its discretion, may grant the employer additional time to comply. If the application is not submitted within the time prescribed, approval to self-insure will expire on the date shown on the current certificate or other date specified by the court.

- B.** All questions on the application for renewal of approval to self-insure must be fully and accurately answered. Such answers shall be given under oath by an authorized officer of the applicant. Each application must be accompanied by:
 - 1. a nonrefundable fee which has been determined in accordance with section 48-145.04(1);
 - 2. a copy of the applicant's most recent certified financial statement, and;
 - 3. any other information, including supporting documentation, as requested by the court.
- C.** Upon receipt of the application and all fees, supporting documentation, and other information, approval to self-insure will be extended until the employer is provided a certificate evidencing renewal of approval to self-insure or until the employer is notified of nonrenewal and the date approval to self-insure will expire.
- D.** The application, supporting documentation, and other information will be analyzed and continued approval to self-insure will be in accordance with Rules 72,A and 72,B.
- E.** After reviewing the application and all supporting documentation and other information, the court will send written notice of renewal or nonrenewal of approval, or requirements for further consideration. If the court has additional requirements, the employer will have 30 days to comply. Upon receipt of a written request the court, at its discretion, may grant the employer additional time to comply. If all requirements are not met within the time prescribed, the application for renewal shall be considered denied and approval to self-insure will expire on the date specified by the court.
- F.** An applicant denied renewal of approval to self-insure may not reapply for one year after receipt of notice of denial.
- G.** An employer may voluntarily terminate approval to self-insure prior to the expiration date shown on the current certificate by providing the court with written notice of the reason for termination, the date and time of the intended termination, the name of the insurer assuming the risk after termination, and the policy number and effective date of the workers' compensation insurance policy.

Sections 48-145.04, R.R.S. 2010, and 48-145, R.S. Supp., 2015.

Effective date: April 25, 2002.

ADDENDA

ADDENDUM	TITLE	PAGE
1	Present Value Table.....	A3
2	U.S. Life Table: 2010.....	A9
3	Personal and Financial Account Information.....	A10

ADDENDUM 1

PRESENT VALUE TABLE **NEBRASKA WORKERS' COMPENSATION COURT**

Present value of annuity certain of \$1.00 per week. Interest at five percent per annum with annual rests. Payment at end of week 365.2425 days to a year.

TO USE TABLES:

Find present value of \$1.00 for number of weeks to be commuted; multiply the value so found by the weekly compensation rate.

EXAMPLE:

Weeks to be commuted, 215; weekly compensation rate, \$62.00; present value of \$1.00 for 215 weeks is \$194.2141; multiplying \$194.2141 by \$62.00 produces the commuted value of \$12,041.27.

EXAMPLE WHERE WEEKLY RATE CHANGES:

Weeks to be commuted, 1,100; first 175 weeks at \$62.00; following 925 weeks at \$47.00 (1,100 weeks at \$47.00 per week plus 175 weeks at \$15.00 per week running concurrently, beginning with the first week, produces the same result.) Present value of \$1.00 for 1,100 weeks is \$679.6809; multiplying \$679.6809 by \$47.00 produces \$31,945.00. Present value of \$1.00 for 175 weeks is \$161.0426; multiplying \$161.0426 by \$15 produces \$2,415.64. Adding \$31,945.00 to \$2,415.64 makes a total of \$34,360.64, being the present worth of 1,100 weeks at the rates stated.

Weeks	Present Value						
1	\$0.9990	56	\$54.4985	111	\$105.2527	166	\$153.4023
2	\$1.9971	57	\$55.4454	112	\$106.1509	167	\$154.2545
3	\$2.9943	58	\$56.3914	113	\$107.0484	168	\$155.1058
4	\$3.9904	59	\$57.3364	114	\$107.9449	169	\$155.9564
5	\$4.9857	60	\$58.2806	115	\$108.8406	170	\$156.8061
6	\$5.9799	61	\$59.2238	116	\$109.7355	171	\$157.6551
7	\$6.9732	62	\$60.1662	117	\$110.6295	172	\$158.5032
8	\$7.9656	63	\$61.1076	118	\$111.5226	173	\$159.3505
9	\$8.9570	64	\$62.0482	119	\$112.4149	174	\$160.1970
10	\$9.9475	65	\$62.9878	120	\$113.3063	175	\$161.0426
11	\$10.9370	66	\$63.9265	121	\$114.1969	176	\$161.8875
12	\$11.9256	67	\$64.8644	122	\$115.0866	177	\$162.7316
13	\$12.9132	68	\$65.8013	123	\$115.9754	178	\$163.5748
14	\$13.8999	69	\$66.7374	124	\$116.8635	179	\$164.4173
15	\$14.8856	70	\$67.6725	125	\$117.7506	180	\$165.2589
16	\$15.8704	71	\$68.6068	126	\$118.6369	181	\$166.0997
17	\$16.8543	72	\$69.5401	127	\$119.5224	182	\$166.9398
18	\$17.8372	73	\$70.4726	128	\$120.4070	183	\$167.7790
19	\$18.8191	74	\$71.4042	129	\$121.2908	184	\$168.6174
20	\$19.8002	75	\$72.3349	130	\$122.1737	185	\$169.4550
21	\$20.7803	76	\$73.2647	131	\$123.0558	186	\$170.2918
22	\$21.7594	77	\$74.1936	132	\$123.9370	187	\$171.1278
23	\$22.7376	78	\$75.1216	133	\$124.8174	188	\$171.9631
24	\$23.7149	79	\$76.0487	134	\$125.6970	189	\$172.7975
25	\$24.6912	80	\$76.9749	135	\$126.5757	190	\$173.6311
26	\$25.6666	81	\$77.9003	136	\$127.4535	191	\$174.4639
27	\$26.6411	82	\$78.8248	137	\$128.3306	192	\$175.2959
28	\$27.6146	83	\$79.7483	138	\$129.2067	193	\$176.1271
29	\$28.5872	84	\$80.6710	139	\$130.0821	194	\$176.9576
30	\$29.5589	85	\$81.5928	140	\$130.9566	195	\$177.7872
31	\$30.5297	86	\$82.5138	141	\$131.8303	196	\$178.6160
32	\$31.4995	87	\$83.4338	142	\$132.7031	197	\$179.4441
33	\$32.4684	88	\$84.3530	143	\$133.5751	198	\$180.2713
34	\$33.4363	89	\$85.2713	144	\$134.4463	199	\$181.0978
35	\$34.4034	90	\$86.1887	145	\$135.3166	200	\$181.9235
36	\$35.3695	91	\$87.1052	146	\$136.1861	201	\$182.7483
37	\$36.3347	92	\$88.0209	147	\$137.0548	202	\$183.5724
38	\$37.2989	93	\$88.9356	148	\$137.9226	203	\$184.3957
39	\$38.2622	94	\$89.8495	149	\$138.7896	204	\$185.2182
40	\$39.2247	95	\$90.7626	150	\$139.6558	205	\$186.0400
41	\$40.1861	96	\$91.6747	151	\$140.5211	206	\$186.8609
42	\$41.1467	97	\$92.5860	152	\$141.3856	207	\$187.6811
43	\$42.1064	98	\$93.4964	153	\$142.2493	208	\$188.5004
44	\$43.0651	99	\$94.4059	154	\$143.1122	209	\$189.3190
45	\$44.0229	100	\$95.3146	155	\$143.9742	210	\$190.1368
46	\$44.9798	101	\$96.2224	156	\$144.8354	211	\$190.9538
47	\$45.9358	102	\$97.1293	157	\$145.6958	212	\$191.7701
48	\$46.8909	103	\$98.0354	158	\$146.5554	213	\$192.5855
49	\$47.8450	104	\$98.9406	159	\$147.4141	214	\$193.4002
50	\$48.7982	105	\$99.8449	160	\$148.2720	215	\$194.2141
51	\$49.7506	106	\$100.7483	161	\$149.1291	216	\$195.0272
52	\$50.7020	107	\$101.6509	162	\$149.9854	217	\$195.8395
53	\$51.6525	108	\$102.5527	163	\$150.8408	218	\$196.6511
54	\$52.6021	109	\$103.4535	164	\$151.6955	219	\$197.4618
55	\$53.5508	110	\$104.3535	165	\$152.5493	220	\$198.2718

Weeks	Present Value						
221	\$199.0811	276	\$242.4158	331	\$283.5268	386	\$322.5281
222	\$199.8895	277	\$243.1828	332	\$284.2544	387	\$323.2184
223	\$200.6972	278	\$243.9490	333	\$284.9813	388	\$323.9080
224	\$201.5041	279	\$244.7145	334	\$285.7075	389	\$324.5969
225	\$202.3102	280	\$245.4793	335	\$286.4330	390	\$325.2852
226	\$203.1156	281	\$246.2433	336	\$287.1579	391	\$325.9728
227	\$203.9202	282	\$247.0066	337	\$287.8820	392	\$326.6598
228	\$204.7240	283	\$247.7692	338	\$288.6054	393	\$327.3461
229	\$205.5271	284	\$248.5310	339	\$289.3282	394	\$328.0318
230	\$206.3293	285	\$249.2921	340	\$290.0502	395	\$328.7168
231	\$207.1309	286	\$250.0525	341	\$290.7716	396	\$329.4011
232	\$207.9316	287	\$250.8122	342	\$291.4923	397	\$330.0848
233	\$208.7316	288	\$251.5711	343	\$292.2122	398	\$330.7679
234	\$209.5308	289	\$252.3293	344	\$292.9315	399	\$331.4502
235	\$210.3292	290	\$253.0868	345	\$293.6501	400	\$332.1320
236	\$211.1269	291	\$253.8435	346	\$294.3681	401	\$332.8130
237	\$211.9238	292	\$254.5995	347	\$295.0853	402	\$333.4935
238	\$212.7200	293	\$255.3548	348	\$295.8018	403	\$334.1732
239	\$213.5154	294	\$256.1094	349	\$296.5177	404	\$334.8524
240	\$214.3100	295	\$256.8633	350	\$297.2329	405	\$335.5308
241	\$215.1039	296	\$257.6164	351	\$297.9473	406	\$336.2087
242	\$215.8970	297	\$258.3688	352	\$298.6612	407	\$336.8858
243	\$216.6894	298	\$259.1205	353	\$299.3743	408	\$337.5624
244	\$217.4810	299	\$259.8715	354	\$300.0867	409	\$338.2382
245	\$218.2718	300	\$260.6217	355	\$300.7985	410	\$338.9135
246	\$219.0619	301	\$261.3713	356	\$301.5095	411	\$339.5881
247	\$219.8512	302	\$262.1201	357	\$302.2199	412	\$340.2620
248	\$220.6398	303	\$262.8682	358	\$302.9296	413	\$340.9353
249	\$221.4276	304	\$263.6156	359	\$303.6387	414	\$341.6079
250	\$222.2147	305	\$264.3623	360	\$304.3470	415	\$342.2799
251	\$223.0010	306	\$265.1082	361	\$305.0547	416	\$342.9513
252	\$223.7865	307	\$265.8535	362	\$305.7617	417	\$343.6220
253	\$224.5713	308	\$266.5980	363	\$306.4680	418	\$344.2921
254	\$225.3554	309	\$267.3418	364	\$307.1737	419	\$344.9615
255	\$226.1387	310	\$268.0849	365	\$307.8786	420	\$345.6303
256	\$226.9212	311	\$268.8273	366	\$308.5829	421	\$346.2985
257	\$227.7030	312	\$269.5690	367	\$309.2866	422	\$346.9660
258	\$228.4841	313	\$270.3099	368	\$309.9895	423	\$347.6329
259	\$229.2644	314	\$271.0502	369	\$310.6918	424	\$348.2991
260	\$230.0439	315	\$271.7898	370	\$311.3934	425	\$348.9647
261	\$230.8227	316	\$272.5286	371	\$312.0943	426	\$349.6297
262	\$231.6008	317	\$273.2667	372	\$312.7946	427	\$350.2940
263	\$232.3781	318	\$274.0042	373	\$313.4942	428	\$350.9577
264	\$233.1547	319	\$274.7409	374	\$314.1931	429	\$351.6207
265	\$233.9305	320	\$275.4769	375	\$314.8913	430	\$352.2831
266	\$234.7056	321	\$276.2122	376	\$315.5889	431	\$352.9449
267	\$235.4800	322	\$276.9468	377	\$316.2858	432	\$353.6061
268	\$236.2536	323	\$277.6808	378	\$316.9821	433	\$354.2666
269	\$237.0264	324	\$278.4140	379	\$317.6776	434	\$354.9265
270	\$237.7986	325	\$279.1465	380	\$318.3726	435	\$355.5857
271	\$238.5699	326	\$279.8783	381	\$319.0668	436	\$356.2444
272	\$239.3406	327	\$280.6094	382	\$319.7604	437	\$356.9023
273	\$240.1105	328	\$281.3398	383	\$320.4533	438	\$357.5597
274	\$240.8797	329	\$282.0695	384	\$321.1456	439	\$358.2164
275	\$241.6481	330	\$282.7985	385	\$321.8372	440	\$358.8725

Weeks	Present Value						
441	\$359,5280	496	\$394,6293	551	\$427,9293	606	\$459,5204
442	\$360,1829	497	\$395,2505	552	\$428,5186	607	\$460,0795
443	\$360,8371	498	\$395,8712	553	\$429,1074	608	\$460,6381
444	\$361,4907	499	\$396,4912	554	\$429,6957	609	\$461,1962
445	\$362,1437	500	\$397,1107	555	\$430,2833	610	\$461,7537
446	\$362,7960	501	\$397,7295	556	\$430,8704	611	\$462,3107
447	\$363,4477	502	\$398,3478	557	\$431,4570	612	\$462,8671
448	\$364,0988	503	\$398,9655	558	\$432,0430	613	\$463,4230
449	\$364,7493	504	\$399,5826	559	\$432,6284	614	\$463,9784
450	\$365,3991	505	\$400,1991	560	\$433,2133	615	\$464,5333
451	\$366,0484	506	\$400,8150	561	\$433,7976	616	\$465,0876
452	\$366,6970	507	\$401,4303	562	\$434,3813	617	\$465,6414
453	\$367,3450	508	\$402,0451	563	\$434,9645	618	\$466,1947
454	\$367,9923	509	\$402,6592	564	\$435,5471	619	\$466,7474
455	\$368,6391	510	\$403,2728	565	\$436,1292	620	\$467,2996
456	\$369,2852	511	\$403,8857	566	\$436,7107	621	\$467,8513
457	\$369,9307	512	\$404,4981	567	\$437,2917	622	\$468,4024
458	\$370,5756	513	\$405,1099	568	\$437,8721	623	\$468,9530
459	\$371,2199	514	\$405,7211	569	\$438,4519	624	\$469,5031
460	\$371,8635	515	\$406,3318	570	\$439,0312	625	\$470,0527
461	\$372,5066	516	\$406,9418	571	\$439,6100	626	\$470,6017
462	\$373,1490	517	\$407,5513	572	\$440,1881	627	\$471,1502
463	\$373,7908	518	\$408,1601	573	\$440,7658	628	\$471,6982
464	\$374,4320	519	\$408,7684	574	\$441,3428	629	\$472,2457
465	\$375,0726	520	\$409,3761	575	\$441,9194	630	\$472,7926
466	\$375,7125	521	\$409,9833	576	\$442,4953	631	\$473,3390
467	\$376,3519	522	\$410,5898	577	\$443,0708	632	\$473,8849
468	\$376,9906	523	\$411,1958	578	\$443,6456	633	\$474,4303
469	\$377,6288	524	\$411,8011	579	\$444,2199	634	\$474,9751
470	\$378,2663	525	\$412,4060	580	\$444,7937	635	\$475,5195
471	\$378,9032	526	\$413,0102	581	\$445,3669	636	\$476,0633
472	\$379,5395	527	\$413,6138	582	\$445,9396	637	\$476,6066
473	\$380,1752	528	\$414,2169	583	\$446,5117	638	\$477,1493
474	\$380,8103	529	\$414,8194	584	\$447,0833	639	\$477,6916
475	\$381,4447	530	\$415,4213	585	\$447,6543	640	\$478,2333
476	\$382,0786	531	\$416,0226	586	\$448,2248	641	\$478,7745
477	\$382,7119	532	\$416,6234	587	\$448,7947	642	\$479,3152
478	\$383,3445	533	\$417,2236	588	\$449,3641	643	\$479,8553
479	\$383,9766	534	\$417,8232	589	\$449,9330	644	\$480,3950
480	\$384,6080	535	\$418,4222	590	\$450,5013	645	\$480,9341
481	\$385,2388	536	\$419,0207	591	\$451,0690	646	\$481,4728
482	\$385,8691	537	\$419,6186	592	\$451,6362	647	\$482,0109
483	\$386,4987	538	\$420,2159	593	\$452,2029	648	\$482,5485
484	\$387,1277	539	\$420,8127	594	\$452,7690	649	\$483,0855
485	\$387,7562	540	\$421,4089	595	\$453,3346	650	\$483,6221
486	\$388,3840	541	\$422,0045	596	\$453,8997	651	\$484,1581
487	\$389,0112	542	\$422,5995	597	\$454,4642	652	\$484,6937
488	\$389,6378	543	\$423,1940	598	\$455,0281	653	\$485,2287
489	\$390,2639	544	\$423,7879	599	\$455,5915	654	\$485,7632
490	\$390,8893	545	\$424,3812	600	\$456,1544	655	\$486,2972
491	\$391,5141	546	\$424,9740	601	\$456,7168	656	\$486,8307
492	\$392,1383	547	\$425,5661	602	\$457,2786	657	\$487,3637
493	\$392,7620	548	\$426,1578	603	\$457,8398	658	\$487,8961
494	\$393,3850	549	\$426,7488	604	\$458,4006	659	\$488,4281
495	\$394,0074	550	\$427,3393	605	\$458,9608	660	\$488,9595

Weeks	Present Value						
661	\$489.4905	716	\$517.9226	771	\$544.8956	826	\$570.4846
662	\$490.0209	717	\$518.4258	772	\$545.3730	827	\$570.9374
663	\$490.5508	718	\$518.9285	773	\$545.8499	828	\$571.3899
664	\$491.0802	719	\$519.4307	774	\$546.3264	829	\$571.8419
665	\$491.6091	720	\$519.9325	775	\$546.8024	830	\$572.2935
666	\$492.1375	721	\$520.4338	776	\$547.2780	831	\$572.7447
667	\$492.6654	722	\$520.9346	777	\$547.7531	832	\$573.1954
668	\$493.1928	723	\$521.4349	778	\$548.2278	833	\$573.6457
669	\$493.7197	724	\$521.9348	779	\$548.7020	834	\$574.0956
670	\$494.2461	725	\$522.4341	780	\$549.1757	835	\$574.5450
671	\$494.7720	726	\$522.9330	781	\$549.6490	836	\$574.9940
672	\$495.2973	727	\$523.4314	782	\$550.1218	837	\$575.4426
673	\$495.8222	728	\$523.9294	783	\$550.5942	838	\$575.8907
674	\$496.3466	729	\$524.4268	784	\$551.0661	839	\$576.3384
675	\$496.8704	730	\$524.9238	785	\$551.5376	840	\$576.7857
676	\$497.3938	731	\$525.4203	786	\$552.0086	841	\$577.2326
677	\$497.9167	732	\$525.9164	787	\$552.4792	842	\$577.6790
678	\$498.4390	733	\$526.4119	788	\$552.9493	843	\$578.1250
679	\$498.9609	734	\$526.9070	789	\$553.4190	844	\$578.5706
680	\$499.4822	735	\$527.4016	790	\$553.8883	845	\$579.0157
681	\$500.0031	736	\$527.8957	791	\$554.3570	846	\$579.4604
682	\$500.5235	737	\$528.3894	792	\$554.8254	847	\$579.9047
683	\$501.0433	738	\$528.8826	793	\$555.2932	848	\$580.3486
684	\$501.5627	739	\$529.3753	794	\$555.7607	849	\$580.7920
685	\$502.0816	740	\$529.8676	795	\$556.2277	850	\$581.2351
686	\$502.6000	741	\$530.3593	796	\$556.6942	851	\$581.6777
687	\$503.1178	742	\$530.8506	797	\$557.1603	852	\$582.1198
688	\$503.6352	743	\$531.3415	798	\$557.6259	853	\$582.5616
689	\$504.1521	744	\$531.8318	799	\$558.0911	854	\$583.0029
690	\$504.6685	745	\$532.3217	800	\$558.5559	855	\$583.4438
691	\$505.1844	746	\$532.8111	801	\$559.0202	856	\$583.8843
692	\$505.6998	747	\$533.3001	802	\$559.4841	857	\$584.3244
693	\$506.2147	748	\$533.7886	803	\$559.9475	858	\$584.7640
694	\$506.7291	749	\$534.2766	804	\$560.4105	859	\$585.2032
695	\$507.2431	750	\$534.7642	805	\$560.8730	860	\$585.6420
696	\$507.7565	751	\$535.2512	806	\$561.3351	861	\$586.0804
697	\$508.2694	752	\$535.7379	807	\$561.7967	862	\$586.5184
698	\$508.7819	753	\$536.2240	808	\$562.2579	863	\$586.9559
699	\$509.2938	754	\$536.7097	809	\$562.7187	864	\$587.3930
700	\$509.8053	755	\$537.1949	810	\$563.1790	865	\$587.8297
701	\$510.3163	756	\$537.6797	811	\$563.6389	866	\$588.2660
702	\$510.8268	757	\$538.1640	812	\$564.0984	867	\$588.7019
703	\$511.3368	758	\$538.6478	813	\$564.5574	868	\$589.1373
704	\$511.8463	759	\$539.1312	814	\$565.0159	869	\$589.5724
705	\$512.3553	760	\$539.6141	815	\$565.4740	870	\$590.0070
706	\$512.8639	761	\$540.0965	816	\$565.9317	871	\$590.4412
707	\$513.3719	762	\$540.5785	817	\$566.3890	872	\$590.8750
708	\$513.8795	763	\$541.0600	818	\$566.8458	873	\$591.3083
709	\$514.3866	764	\$541.5411	819	\$567.3022	874	\$591.7413
710	\$514.8932	765	\$542.0217	820	\$567.7581	875	\$592.1738
711	\$515.3993	766	\$542.5018	821	\$568.2136	876	\$592.6059
712	\$515.9049	767	\$542.9815	822	\$568.6687	877	\$593.0376
713	\$516.4100	768	\$543.4607	823	\$569.1233	878	\$593.4689
714	\$516.9147	769	\$543.9395	824	\$569.5775	879	\$593.8998
715	\$517.4189	770	\$544.4178	825	\$570.0312	880	\$594.3303

Weeks	Present Value	Weeks	Present Value	Weeks	Present Value	Weeks	Present Value
881	\$594.7604	926	\$613.6929	971	\$631.8267	1,160	\$700.0024
882	\$595.1900	927	\$614.1044	972	\$632.2209	1,170	\$703.2772
883	\$595.6193	928	\$614.5155	973	\$632.6147	1,180	\$706.5208
884	\$596.0481	929	\$614.9263	974	\$633.0081	1,190	\$709.7335
885	\$596.4765	930	\$615.3366	975	\$633.4011	1,200	\$712.9156
886	\$596.9045	931	\$615.7466	976	\$633.7938	1,210	\$716.0673
887	\$597.3321	932	\$616.1561	977	\$634.1860	1,220	\$719.1890
888	\$597.7593	933	\$616.5653	978	\$634.5779	1,230	\$722.2809
889	\$598.1861	934	\$616.9741	979	\$634.9695	1,240	\$725.3434
890	\$598.6124	935	\$617.3824	980	\$635.3606	1,250	\$728.3766
891	\$599.0384	936	\$617.7904	981	\$635.7514	1,260	\$731.3810
892	\$599.4639	937	\$618.1980	982	\$636.1418	1,270	\$734.3567
893	\$599.8891	938	\$618.6052	983	\$636.5318	1,280	\$737.3040
894	\$600.3138	939	\$619.0121	984	\$636.9215	1,290	\$740.2233
895	\$600.7382	940	\$619.4185	985	\$637.3108	1,300	\$743.1147
896	\$601.1621	941	\$619.8245	986	\$637.6997	1,350	\$757.1636
897	\$601.5856	942	\$620.2302	987	\$638.0882	1,400	\$770.5555
898	\$602.0087	943	\$620.6355	988	\$638.4764	1,450	\$783.3212
899	\$602.4314	944	\$621.0403	989	\$638.8642	1,500	\$795.4900
900	\$602.8537	945	\$621.4448	990	\$639.2516	1,600	\$818.1470
901	\$603.2756	946	\$621.8489	991	\$639.6387	1,700	\$838.7346
902	\$603.6971	947	\$622.2526	992	\$640.0254	1,800	\$857.4418
903	\$604.1182	948	\$622.6560	993	\$640.4117	1,900	\$874.4404
904	\$604.5389	949	\$623.0589	994	\$640.7976	2,000	\$889.8863
905	\$604.9592	950	\$623.4615	995	\$641.1832	2,200	\$916.6747
906	\$605.3791	951	\$623.8636	996	\$641.5684	2,400	\$938.7930
907	\$605.7986	952	\$624.2654	997	\$641.9533	2,600	\$957.0555
908	\$606.2177	953	\$624.6668	998	\$642.3377	2,800	\$972.1342
909	\$606.6363	954	\$625.0679	999	\$642.7218	3,000	\$984.5842
910	\$607.0546	955	\$625.4685	1,000	\$643.1056	3,300	\$999.3106
911	\$607.4725	956	\$625.8687	1,010	\$646.9227	3,600	\$1,010.3592
912	\$607.8900	957	\$626.2686	1,020	\$650.7035	4,000	\$1,020.9229
913	\$608.3070	958	\$626.6681	1,030	\$654.4483	4,500	\$1,029.5334
914	\$608.7237	959	\$627.0672	1,040	\$658.1573	5,000	\$1,034.8672
915	\$609.1400	960	\$627.4659	1,050	\$661.8311	6,000	\$1,040.2181
916	\$609.5559	961	\$627.8642	1,060	\$665.4697	7,000	\$1,042.2715
917	\$609.9714	962	\$628.2622	1,070	\$669.0737	8,000	\$1,043.0594
918	\$610.3865	963	\$628.6598	1,080	\$672.6434	10,000	\$1,043.4778
919	\$610.8012	964	\$629.0570	1,090	\$676.1790		
920	\$611.2154	965	\$629.4538	1,100	\$679.6809		
921	\$611.6293	966	\$629.8502	1,110	\$683.1494		
922	\$612.0428	967	\$630.2463	1,120	\$686.5849		
923	\$612.4559	968	\$630.6420	1,130	\$689.9876		
924	\$612.8687	969	\$631.0373	1,140	\$693.3579		
925	\$613.2810	970	\$631.4322	1,150	\$696.6961		

ADDENDUM 2

U.S. LIFE TABLE: 2010

Expectancy Expressed in Years

NEBRASKA WORKERS' COMPENSATION COURT

AGE	EXPECTANCY	AGE	EXPECTANCY	AGE	EXPECTANCY
10	69.3	40	40.5	70	15.5
11	68.3	41	39.6	71	14.8
12	67.3	42	38.7	72	14.1
13	66.3	43	37.7	73	13.4
14	65.3	44	36.8	74	12.7
15	64.3	45	35.9	75	12.1
16	63.3	46	35.0	76	11.4
17	62.4	47	34.1	77	10.8
18	61.4	48	33.2	78	10.2
19	60.4	49	32.3	79	9.6
20	59.5	50	31.4	80	9.1
21	58.5	51	30.6	81	8.5
22	57.6	52	29.7	82	8.0
23	56.6	53	28.9	83	7.5
24	55.7	54	28.0	84	7.0
25	54.7	55	27.2	85	6.5
26	53.8	56	26.3	86	6.1
27	52.8	57	25.5	87	5.7
28	51.9	58	24.7	88	5.3
29	50.9	59	23.9	89	4.9
30	50.0	60	23.1	90	4.6
31	49.0	61	22.3	91	4.3
32	48.1	62	21.5	92	4.0
33	47.1	63	20.7	93	3.7
34	46.2	64	19.9	94	3.4
35	45.2	65	19.1	95	3.2
36	44.3	66	18.4	96	3.0
37	43.3	67	17.6	97	2.8
38	42.4	68	16.9	98	2.6
39	41.5	69	16.2	99	2.5
				100	2.3

ADDENDUM 3

IN THE NEBRASKA WORKERS' COMPENSATION COURT

**THIS DOCUMENT IS CONFIDENTIAL AND SHALL NOT BE MADE PART OF
THE COURT FILE OR PROVIDED TO THE PUBLIC PURSUANT TO
WORKERS' COMP. CT. R. OF PROC. 2.**

_____)	Docket: _____	Page: _____
[your first name, middle initial, and last name])		
Plaintiff,)		
vs.)		
_____)		
_____)		
[name of employer or name of employer and insurance company])		
Defendant(s).)		
)		

**PERSONAL AND FINANCIAL
ACCOUNT INFORMATION**

Employee Social Security Number: _____

Employee Date of Birth (if applicable to this case): _____

Minor Children (if applicable to this case)

Name:	Social Security Number:	Date of Birth:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Protected financial account information (if applicable to this case)

Entity/Person:	Type of Account:	Account Number:
_____	_____	_____

(add additional pages as necessary)

Addendum 3