2023

Workers' Compensation

Claims Seminar

THE INDUSTRIAL COMMISSION OF ARIZONA
NOVEMBER THIRD
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2023 Claims Adjusting Manual

New in ICA Claims Manual 2023

Small adjustments have been made throughout the manual for content and/or clarity.

Significant changes include the following.

Community FAQ

Community FAQ & Instructions have been updated and enhanced.

Average Monthly Wage

The average monthly wage chapter has been significantly enhanced to include greater detail and sample calculations of each line of the 108 Recommended Average Monthly wage.

ICA Community

Attorney, Carrier, Self-Insured, and TPA Guide

Community Introduction

Welcome to the ICA Community online portal. Engagement in the ICA Community is highly encouraged for real-time access of claim files, ALJ Case files, uploading documents and completing webforms. Please note that some documents require an ICA claim number to be associated. This number can be located on any notice from ICA and/or new claim notification. If not known, please call us at 602-542-4661 or email us at Claims@azica.gov with identifying information to obtain the number.

Community Features include:

- All Parties
  - View Claims & ALJ Hearing files in real time.
  - Upload Documents and submit Webforms.
  - Administrator access authorizes the user to update mailing address and change the preferred communication method.
- Payer (Carrier & Self-Insured Employer)
  - Subscribe to claims to receive daily digest when new documents are added to the claims file.
  - Submit 'Intent to File' for potential claims per ARS 23-1061(N)
  - Municipal Firefighter Cancer Reimbursement and Cancer Claim Reporting
- Attorney
  - Single step access: upload the retention document and the system will automatically request access to the claim (please allow up to 5 days for review).

Please visit our website for detailed instructions and videos on how to access Community and to complete webform and Upload documents: https://www.azica.gov/resources/resources-ica-community

Community FAQ

What is the difference between a Webform and an Upload Document?

Webform

A variety of forms are available online as individual webforms in Community. When completed in Community, a Webform is submitted directly into the claims file and an email confirmation is sent with copy of document. When webforms are submitted it generates appropriate workflows for the Claims Division and/or ALJ division when action is required on the document.

Please note, the completing party continues to be statutorily required to distribute copies of this document to the remaining interested parties (Injured Worker and Employer), as applicable. A webform only satisfies the ICA submission. It is not service upon the interested parties.

Upload Document

All claims documents that are not webforms may be uploaded directly to the claims file in Community through the 'Upload Document' tab. It is critical that you select the *correct* document type. Most documents will be immediately viewable in the claims file.

- Uploaded Document Types: "Return Solicit" and "Correspondence" will take 3-5 days for processing as they are separated and reviewed for workflows.

It is essential to select the appropriate Document Type from the list. If you don't see the document type you're looking for, in most cases, the document you are submitting is a webform and is not indented to be uploaded. In cases like this you should submit via US Mail and/or fax so that it generates appropriate workflows for the Claims Division and/or ALJ division when action is required on the document. Failure to follow this instruction will likely result in no action on the document.

Each upload will allow you to attach multiple documents in a single upload. Once uploaded successfully, you will receive an email confirmation.

Note: The completing party continues to be statutorily required to distribute copies of the webform/uploaded document to the remaining interested parties (The carrier, injured worker and employer), as applicable. A webform only satisfies the ICA submission. It is not service upon the interested parties.

Best Practice:

Important: *If you are unable to locate the document type you are searching for in 'Upload Document', it is either a Webform or you must mail/or fax the document to 602-542-3373.*

For example: If an Annual Report of Income (110) doc type is used to upload a Petition for Rearrangement, the Petition will not be processed because it will not generate a workflow for Awards to make a determination and will be scanned to the claims file with no further action indicated (ICA does not audit 110's). Circumventing the document typing on the upload will not assist in expediting the processes and may result in no action taken.

When do I use the upload a Returned Solicit or Correspondence?

A correspondence is to be used when a general letter or request from the claims division is to be included in the claims file. This letter will be routed for indexing to create the correct workflow for the correct department.

A 'returned solicit' is to be selected when uploading the response to a solicitation from the claims division. This can include the entire packet of notices and supporting documentation. The submitted documents will be routed for indexing and reenter into the system as the individual document types.

When I 'Upload Documents' in Claims, does the document go to the same place as 'Upload Documents' in ALJ?

While claims and ALJ are related, they are separate Divisions of the ICA and ALJ documents related to an active case may not be shared to the claims file until the ALJ case is closed. If a document intended for Claims is uploaded to an ALJ case, it may be delayed. For example, a bad faith withdrawal submitted to an ALJ case may not halt the claims investigation process and result in a bad faith finding as the two do not share documents while the ALJ case is active.

Why do I need an ALJ number?

If a document is being submitted to an active ALJ case, the case has an ALJ number assigned. Requiring an ALJ number on the submission ensures that the document is routed to the correct file and the assigned ALJ is notified of the submission. Failure to include the ALJ number will result in a delay in the submission being added to the ALJ case.

What are Direct Filings to Chief ALJ?

The upload function allows a direct filing with the Chief ALJ. When filed the system generates an ALJ number and notifies the Chief ALJ of the filing so that the matter can be appropriately assigned or processed. Direct filings are limited to Unassigned Settlements, Stipulations, Compromise and Settlement Agreements, Full and Final Settlements; Final Settlement of Undisputed Supportive Care; Vexatious Litigant Motions; Motions for Protective Order and 1026/1027 Motions if the matter is not currently assigned to an ALJ for litigation.

My Webform will not submit. What do I do?

First, check to see if a required field with a red line was missed or if the ICA# is correctly listed. If so, go back and fix the field and redo the submission process by clicking the check box "I agree" and "I'm not a robot" and submit after completing the missing field. If there is an error, your attached document may become unattached. Check the attachments or upload separately after the webform is submitted. If all fields are complete and still receiving an error, please call 602-542-4661 for assistance.

How do I know my document uploaded?

When an upload is successful the user will receive an email detailing the success. Each webform and most documents submitted through 'Upload Document' can be viewed almost immediately in the claims file. The exceptions are Correspondence and Returned Solicits, these documents go through additional processing where they are introduced back into the file approximately 3 days as the "correct" doc types.

The form fields are overlapping, and the layout is strange.

Each webform will resize based on the size of the browser window. Maximize the window for best display.

I am or have a claims assistant who submits all of the notices or documents for another person at the company. Do I/they have to have access to the claim in View Workers' Compensation Claim Files to upload documents?

No, you do not have to have access to the claims in View Workers' Compensation claim files. Each webform completed requires that the submitter certify that the party submitting the form is an authorized representative of the interested party.

If I have to submit all the documents separately, how does ICA know everything required was submitted?

ICA has built in intelligent processes to streamline claim reviews. For example, when a claim is closed with permanent disability, the system is looking for a medical report to be submitted within a certain period.

How do I submit a return solicitation into Upload Document?

To file your response, upload a copy of the solicitation letter and your response. We recommend you DO NOT resubmit the original error and ensure you select Returned Solicit as the document type.

What documents are not available in Community that I must fax/mail into ICA?

As of the publishing of this document, the following must be mailed or faxed into ICA.

- Request for 1061(M) benefits
- Request for 1061(K) benefits
- Request to reset a hearing from an Abeyance, however, the request should be completed as request for hearing via webform.

CLAIMS ADJUSTING

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Best Practice Legal Disclaimer

This manual will contain Best Practice recommendations based on industry standards. These recommendations are not to be construed as legal advice or direction.

This manual is not a complete guide to handling Arizona Workers' Compensation Claims and cannot cover every possible situation. Do not delay action or decisions for lack of documented procedure within this manual.

Please consult the Arizona Revised Statutes or Workers' Compensation Practice and Procedures or consult with your legal representative as indicated. ICA Claims Division can be reached at 602-542-4661 or Claims@azica.gov for assistance. ICA Claims Division cannot provide legal advice.

New Claim Reporting Requirements

Injured Worker

When a work-related accident occurs, the employee shall **forthwith** report the accident to the employer. [A.R.S. § 23-908(E)] Submission of a *Worker's and Physician's Report of Injury* (Form 102) or a *Worker's Report of Injury* (Form 407) to the Industrial Commission of Arizona (The Commission) constitutes the legal filing of a workers' compensation claim in the State of Arizona.

Employer

The employer must complete the *Employer's Report of Industrial Injury* (Form 101) within ten days after notification of an accident and send copies to the applicable insurance carrier/self-insured employer and the ICA.[A.R.S. § 23-908(G)] An employer must also notify the ICA's Claims Division of any work-related fatality within one business day following the death. [A.A.C § R20-5-110]

An employer also has additional reporting requirements from the Arizona Division of Occupational Safety & Health (ADOSH). Within eight hours after the occurrence of a work-related fatality, the employer must notify ADOSH. Likewise, all work-related inpatient hospitalizations, amputations, or loss of an eye(s), must also be reported to ADOSH within twenty-four hours after the accident. For more information concerning ADOSH, please visit www.azica.gov/divisions/adosh or call (855) 268-5251.

Physician

A physician who treats an employee for a work injury must report the claim to the Commission by mailing a completed *Worker's and Physician's Report of Industrial Injury* (Form 102) within eight days after providing initial treatment. [A.R.S. § 23-908(E) and A.A.C. R20-5-112]

Payers: Insurance Carriers, Self-Insured Employers, or Third-Party Administrators

- Upon receipt of a notification of a potential claim, the payer is to forward the communication immediately to the Commission [A.R.S. § 23-1061(N)], see Payer Reporting of a Claim article for more detail.
- Shall send a copy of all notices issued on a claim to all ***interested parties.***
    - Per A.R.S. § 23-901(10) an "interested party" includes:
        - Injured Worker or Representative
        - Employer
        - Insurance Carrier
        - The ICA
        - If the worker is deceased, the employee's estate, the surviving spouse, and any legal dependents.

Third Party Administrators

With a signed TPA agreement, a TPA can have electronic access to the ICA Community, priors, claim records, ALJ records, and all other Community features. The Commission, however, does not address or direct Claims and/or ALJ communications to TPA's, unless a payer has elected to direct their communications to a TPA by designating the TPA's mailing address, fax number, or SFTP destination.

Management of TPA's is the responsibility of payers. Payers may direct their communications to a TPA by designating the TPA's mailing address, fax number, or SFTP destination. Payers who choose to direct communications to a TPA will be solely responsible for updating the preferred communication method and the designated destination if/when a TPA relationship changes. Payers that utilize multiple TPA's will be responsible for managing the distribution of communications to TPA's for claim handling functions.

Please visit ICA Community Resources for full FAQ's regarding communication preferences https://www.azica.gov/resources/resources-ica-community. For more information, a new resource guide is posted on the Claims Division Website. Contact the ICA's Claims Division at (602)-542-4661.

Best Practice:
The medical provider is not an interested party in the State of Arizona, but it may be provided a copy of any notices.

Payer Reporting of a Claim A.R.S § 23-1061(N)

Payer Reporting of a Claim

As of September 24, 2022 pursuant to A.R.S. § 23-1061(N), when a payer receives written notification from an employee who was injured and intends to file a claim for compensation, the payer must forward the written notification to the Commission within seven business days and inform the employee of the employees requirement to file a claim with the Commission.

- The payer's failure to comply may result in relieving the injured worker's requirement of the one-year filing under A.R.S. § 23-1061(A) and may result in any other applicable bad faith/unfair claims processing allegations.

Payer Process

Upon receipt of a written notification of a potential claim from the injured worker, the payer is to forward the communication immediately to the Commission. Submission options include.

- Fax to 602-542-3373 including personally identifying information so the ICA can satisfy the statute by US Mail or email to the injured worker.
- New Community Process:
  The Commission has a new webform to satisfy the reporting of the claim online in advance of the effective date of the statute. Please visit https://www.azica.gov/divisions/claims-division for more information.

FAQ:

Q: What does "intends to file a claim for compensation" mean?

A: Intent to file for compensation is not defined by the statute. It is reasonable to assume that if the worker is seeking or has received medical and/or time loss benefits compliance is required.

Q: Does this statute apply to existing claims that have not been legally filed by the injured worker (no 102/407)?

A: Yes, if the injured employee intended "to file a claim for compensation" the payers must comply with the new statute.

Possible Scenarios:

Example 1:

The injured worker is communicating with the payer's adjuster about benefits (medical or indemnity). This would constitute a notice of injury and intention to file for benefits. The payer should use the XXXX webform to forward the information to the Commission and provide the injured worker a link to the Commission's website and include the 407 Form.

Example 2:

The injured worker calls the payer stating they have an injury and need to file for benefits. While the new statute only applies to written notification, the payer still has an obligation to not mislead the "claimant to applicable statutes of limitation, benefits, or remedies available under the Act." (*See* A.A.C. R20-5-163

(A) (5)). The payer should direct the injured worker to the appropriate resources to file a claim, such as their employer and the 407 Form on the Commission's website. There is no requirement to file with ICA.

Example 3:
The injured worker communicates to the payer that they have sought medical treatment over email, text, or other written forms of communication. This constitutes a notice of injury and the intent "to file a claim for compensation". The payer should advance the written communication using the webform to the Commission and provide the injured worker a link to the Commission's website and include the 407 Form.

This is not legal advice.

Notification to Accept or Deny a Claim

New Claim Notification

- When either a fully completed Form 102 or 407 is received by the ICA, the Commission will notify the payer, pursuant to A.R.S. § 23-1061(A) and (M), to either accept or deny the claim via a *Notice of Claim Status (*Form *104)* within **twenty one (21) days** from the mailing date on the notification.
- Failure to respond:
  - Failure to issue a 104 accepting or denying a claim may result in an allegation of bad faith by the Commission or the injured worker.
  - Failure to deny a claim within the 21-day notification period may result in penalty benefits pursuant to A.R.S § 23-1061(M).

Notification for a Claim Handled in Another State

- As noted above, the Commission will notify the payer, pursuant to A.R.S. § 23-1061(A) and (M), to either accept or deny the claim via a Notice of Claim Status (Form 104) within twenty-one (21) days from the mailing date on the notification. The Commission does not have the authority to make a compensability decision, including the ability to decide if the claim was filed in the incorrect state.
- Arizona has a robust tourism industry and sometimes an injured worker with an established claim in another state will seek treatment and complete the 102 while visiting which will result in a new claim notification. It is the responsibility of the Payer to ensure that an Arizona authorized adjuster completes their investigation and issues the Notice of Claim Status within the 21-day period.

Notification: Requesting Delete, Combine, or Change

- If the payer has been incorrectly notified, a separate written request to delete the notification must be sent to the ICA's Claims Division.
  - This request must contain all of the following:
    - ICA claim number
    - Payer claim number
    - Name of the injured worker
    - Date of injury
    - Date of notification
    - The reason for the request for a deletion

Best Practice:
The ICA will not consider a request to delete, combine, or change if submitted on a returned notification list.

  - Other Considerations when requesting a delete of a new claim notification.
    - A delete request is to be completed timely by the payer.
    - A letter will be issued either approving the request to combine the claims or denying the request.
    - A combine request is a request only and it is the payers responsibility to monitor and respond to the 21-day notification timely
    - When received by the commission later than 21 days or the Commission has denied the request, the notified payer is responsible for any penalty benefits and must still issue a notice accepting or denying the claim as appropriate... and the payer must issue a 104 either accepting or denying each claim as indicated by the investigation.

Combine

- The payer may submit a request to the claims division to combine claim notifications when notified multiple times on the same date of injury. The request must contain the following:
    - All ICA case numbers
    - All payer claim numbers
    - Name of the injured worker
    - Date or dates of injury
    - All dates of notification
    - Other Considerations when requesting a Combine of two claims.
        i. A second claim that causes an exacerbation to a previous claim may not be combined because it is a distinctly separate incident.
        ii. A delete request is to be completed timely by the payer.
        iii. A letter will be issued either approving the request to combine the claims or denying the request.
        iv. A combine request is a request only and it is the payer's responsibility to monitor and respond to the 21-day notification timely
        v. When received by the commission later than 21 days or the Commission has denied the request, the notified payer is responsible for any penalty benefits and must still issue a notice accepting or denying the claim as appropriate... and the payer must issue a 104 either accepting or denying each claim as indicated by the investigation.

Correction

- The payer may submit a request to the ICA to correct the claim record regarding the name of the injured worker, date of injury, and/or social security number. This request for **correction** must contain the following:
    - The ICA case number
    - Payer claim number
    - Name of the injured worker
    - Date of injury
    - Date of notification
    - An indication of what is to be corrected
    - Supporting documentation, as indicated.

If you have questions regarding a notification, please call the Claims Division for assistance at (602)-542-4661 and select New Claim Notifications from the phone tree or email us at Claims@azica.gov.

Best Practice:
See our YouTube Video: Claims Adjusting 1 to supplement new claim notifications and request to change/combine/delete

Accepting or Denying a Claim

How to Issue a Notice of Claim Status for Claim Compensability

Dear Reader, this chapter will guide you through the correct notices to file. The Commission is unable to provide guidance on the compensability process. Please consult your insurance company and legal resources.

Acceptance of a claim is permitted without legal filing of a claim by the injured worker; however, a claim cannot be denied by the carrier/self-insured employer unless the claim has been legally filed. The commission will issue a New Claim Notification when the 102 (workers and physicians report of injury) or a 407 (workers report of injury) is received and the claim has not already been properly accepted for benefits on a 104 (see notification section of the manual.

At the time of claim acceptance, the claim will typically be in one of the following statuses:

- Medical Only – no indemnity compensation owed, but the claimant has sought medical treatment related to a work injury.
- Temporary Total Disability (TTD) – a physician has placed the injured worker on a *no work status.*
- Temporary Partial Disability (TPD)- Doctor has placed the injured worker on a *light duty work status*.
- Fatality - (will be discussed in its own section)

Accepting a Medical Only Claim

How to Accept a Medical Only Claim

Compensable medical only claims are those wherein the worker has or continues to receive medical treatment, but no temporary compensation owed and no anticipated permanent disability. To accept a medical only claim, the payer is to issue a Form 104 checking #'s One (1) and Three (3). The payer may also accept and close a medical only claim on a single notice by issuing a Form 104 checking #'s One (1), Three (3), Six (6), and Seven (7). Five (5), regarding release to light/regular duty, is not necessary on no time loss or medical only claims.

The first installment of compensation is to be paid no later than the 21st day after notification A.R.S. § 23-1062(D). Thereafter, compensation is paid every 30 days during the period of Temporary Partial Disability. *See Bell v. Industrial Comm'n*, 236 Ariz. 478, 341 P.3d 1149 (2015); *see also* A.R.S. § 23-1062(D). *Please refer to Average Monthly Wage section for details on completing the Form 108.*

Denying a Claim for Benefits

How to Issue a Legal Claim Denial

If the payer intends to deny a claim:

- A Form 104 with #2 checked must be issued within 21 days after the notification date pursuant to A.R.S. § 23-1061(F) and (M).

- *A payer cannot deny a claim unless it has been legally filed with the ICA on a completed Workers Report of Injury (407) or Workers and Physicians Report of Injury (102)*. If the payer's claim file contains the 102 or 407, please send a copy with the denial notice. If it does not have this completed form, the denial must be held until the properly completed 102/407 form is received by either the payer or commission.

- If the denial is issued after 21 days from notification and temporary disability is indicated, penalty payments shall be made as provided by law from the date of notification until the date a 104 is issued. *See* A.R.S. § 23-1061 (M).
    - In this scenario,104 #2 is checked
    - #4B for Average Monthly Wage
    - #11 noting penalty benefits owed pursuant to A.R.S. § 23-1061(M).

Deny and Later Accept after Investigation:

If further investigation by the payer decides that the claim should have been accepted, and the notice is not final, the payer may:

- Issue a 104 rescinding the previous notice of denial by checking the following:
    - #1 indicating that the claim is accepted.
    - The payer should also check either #3 or #4a or 4b, indicating whether the claim is a medical only claim or a temporary disability claim (*see* next section for how to accept a claim with compensation due).
    - #11 indicating that the previous notice denying the claim is rescinded.

Accepting a Temporary Total or Temporary Partial Disability Claim

Accepting a Temporary Disability Claim

Temporary Total Disability

The payer is to issue a notice when first compensation is paid, establish the recommended AMW within 30 days, and issue subsequent notices each time the eligibility for compensation changes (i.e. light duty, regular work, MMI) *see* A.R.S. § 23-1061(F). At latest, the first installment of compensation is to be paid no later than the 21st day after notification *see* A.R.S. § 23-1062(D). Thereafter, compensation is paid every 14 days during the period of Temporary Total Disability. *See Bell v. Industrial Comm'n*, 236 Ariz. 478, 341 P.3d 1149 (2015); *see also* A.R.S. § 23-1062(D);

The payer must issue Form 104 checking the following:

- #1 Claim is Accepted
- #4 Details of the initial payment of compensation shall be included
    - Check Either A or B:
        - A: Minimum/Estimated Wage or
        - B: Include Form 108 calculations.
- When applicable, #5 including date of release to light/regular duty work.
- Attach supporting medical to the 104 to support the release to work.

Below is a guide to use to determine when the initial temporary benefit is payable.

**Light duty counts towards the 7-day waiting period.*

Days off work	Benefit status
0-7	No Indemnity payable
8-13	deduct the 1st 7 days and pay remaining days
14	Indemnity from 1st day of disability

Temporary Partial Disability

The payer must issue Form 104 checking the following:

- #1 Claim is Accepted
- #4 Details of the initial payment of compensation shall be included
    - Check Either A or B:
    - A: Minimum/Estimated Wage or
    - B: Include 108 Recommended Average Monthly Wage.
- #5 Details regarding release to light/regular duty work (when applicable).
- Attach any supporting medical documentation (as applicable)

The first installment of compensation is to be paid no later than the 21st day after notification A.R.S. § 23-1062(D). Thereafter, compensation is paid every 30 days during the period of Temporary Partial Disability. The payer may take credit for unemployment and also for reasonable accommodations provided by the employer. *See Bell v. Industrial Comm'n*, 236 Ariz. 478, 341 P.3d 1149 (2015); *see also* A.R.S. § 23-1062(D); A.R.S. § 23-1044(A); A.R.S. § 23-1048. *Please refer to Average Monthly Wage section for details on completing the Form 108.*

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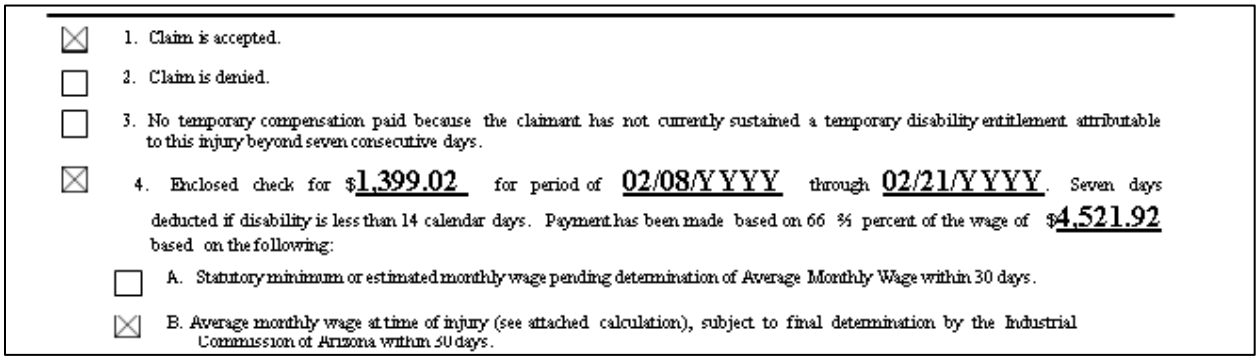
Recommended Average Monthly Wage Sample

- Check #4B on Form 104 and attach a *Recommended Average Monthly Wage Calculation of Carrier* (Form 108).
  SAMPLE:



☒ 1. Claim is accepted.

☐ 2. Claim is denied.

☐ 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.

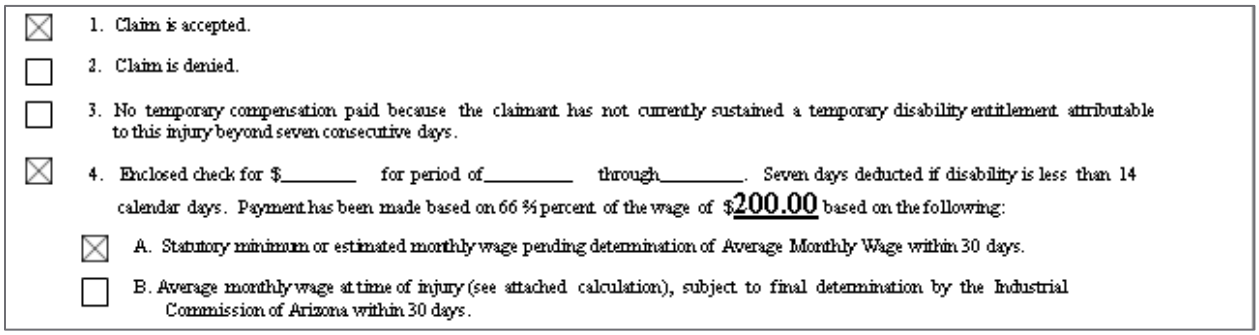
☒ 4. Enclosed check for $1,399.02 for period of 02/08/YYYY through 02/21/YYYY. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of $4,521.92 based on the following:

☐ A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.

☒ B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.

Estimated Average Monthly Wage Sample

- Check #4A on Form 104 pending a determination of the wage. Section 4A is used when estimating the wage if sufficient wage data is not available at the time the first payment is made.



☒ 1. Claim is accepted.

☐ 2. Claim is denied.

☐ 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.

☒ 4. Enclosed check for $_____ for period of_____ through_____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of $200.00 based on the following:

☒ A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.

☐ B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.

Best Practice:
The Commission and injured worker must both receive supporting medical documentation in the form of a physician's report for work status changes.
A.A.C. R20-5-118(B)

Best Practice:
A 104 checking and completing line #4B is required to be issued with a copy of the 108 to all interested parties when the Average Monthly Wage is established or amended for corrections.

Managing Active Claim Benefits

First Payment of Compensation

A.R.S. § 23-1062(D) The first installment of compensation is to be paid no later than the twenty-first day after written notification by the Commission to the payer of the filing of a claim unless the right to compensation is denied.

Best Practice

When possible, issue checks outside of the State of Arizona a few days early for mailing time.

Below is a guide to use to determine when the initial temporary benefit is payable. *Light Duty applies to the waiting period.

Days off work	Benefit status
0-7	No Indemnity payable
8-13	Deduct the 1st 7 days and pay remaining days
14	Indemnity from 1st day of disability

See the previous chapter, **Accepting or Denying a Claim** for instructions on how to accept the claim.

Temporary Total Disability (TTD)

AKA No work status, unable to work in any capacity.

Temporary total compensation is to be paid at least once every two weeks. To determine the amount of temporary total compensation due the injured worker, first determine the daily rate by using the following formula:

Calculations of **Temporary Total (TTD)** compensation using the daily rate:

- Step 1:
  - Multiply the **Average Monthly Wage (AMW)** by the factor .021918.
- Step 2:
  - If the injured worker has any dependents or is married, he is entitled to a dependent allowance of an additional $25.00* per month or .8219 dollars per day added to the daily rate of comp. *For dates of injury prior to 01-01-91, Dependents allowance was $10.00 per month. $10.00. ÷ 30.416 = $.3287 per day*
- *Step 3: Add Step 1 + Step 2 together for daily rate owed.*

TTD

Formula	Example
AMW	$4521.92
x Daily Factor	x .021918
Daily Amount	$99.1114
+ Dep Benefits	+ .8219
Daily Rate	$99.93 (rounded)

$99.93 x 14 days = $1,399.02 payable every 14 days while on TTD.

Equation for TTD calculation

Temporary Partial Disability (TPD)

AKA Release to work with restrictions, light duty and released to return to regular work.

When an injured worker is released to return to light duty or regular work (from no work or light duty work) by the treating physician but remains under medical care, the following steps are to be taken:

- Issue Form 104 – Notice of Claim Status
  - #5 indicate the date the claimant was released to modified duty or regular work.
  - Attach supporting medical documentation.
  - Reminder: The dates given in #5 on a Form 104 cannot be more than 30 days prior to the "mailed on" date indicated on the Form 104, per A.A.C R20-5-118(A)

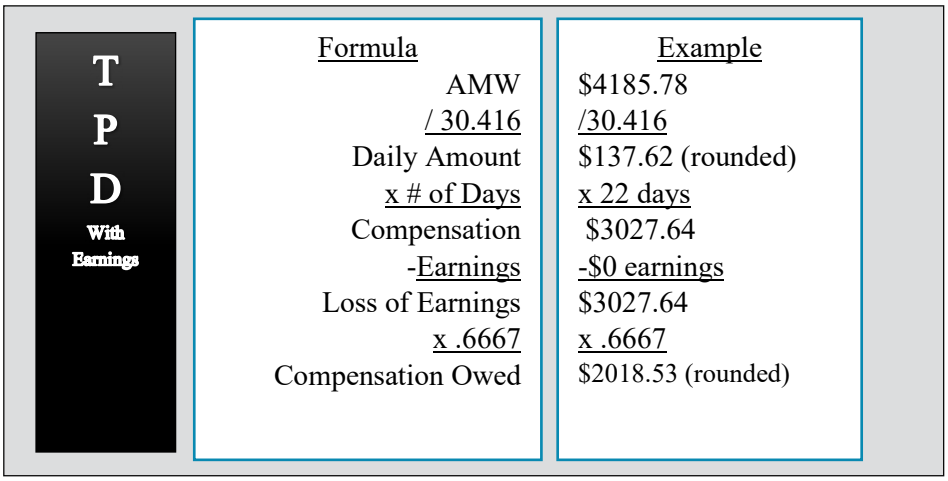
The first installment of compensation is to be paid no later than the 21st day after notification pursuant to A.R.S. § 23-1062(D). Thereafter, compensation is paid every 30 days during the period of temporary partial disability. *See Bell v. Industrial Comm'n*, 236 Ariz. 478, 341 P.3d 1149 (2015) and A.R.S. § 23-1062 (D).

- An injured worker who is released to light duty work may be entitled to Temporary Partial Disability (TPD) compensation if there is a loss of earnings capacity. The benefit is paid based upon 66 2/3% (.6667) of the difference between the Average Monthly Wage and the amount the injured worker is able to earn upon return to work A.R.S. § 23-1044(A).
  - If the injured worker was on light duty, but had no earnings, the compensation would be the same as the daily rate for Temporary Total Disability (TTD), less any applicable dependent allowance.
- TPD Example with Earnings:
  - In this scenario, the injured worker was on TPD status for 22 calendar days, earned $2,073.39 over that period, and was then released to regular work by the treating physician. Therefore, the computation would be as follows:

TPD With Earnings

Formula	Example
AMW	$4185.78
/ 30.416	/30.416
Daily Amount	$137.62 (rounded)
x # of Days	x 22 days
Compensation	$3027.64
-Earnings	-$2073.39 earnings
Loss of Earnings	$954.25
x .6667	x .6667
Compensation Owed	$636.20 (rounded)

- TPD Example Without Earnings:
  - In this scenario, the injured worker was on TPD status for 22 calendar days and the employer was not able to accommodate light duty during that time period and was then released to regular work by the treating physician. Therefore, the computation would be as follows:



- Note: Do not use the TTD formula because the TPD calculation is a higher benefit (without Dependents). For example: AMW 4185.78 x TTD Daily Rate.021918 = Daily Rate 91.74 x 22 days = 2018.28 is less than $2018.53 in the TPD example above).

Best Practice:
See our YouTube Video: Claims Adjusting 2 to supplement Accepting and Managing Claims

Issuing Claim Closure

AKA Medically Stationary, Maximum Medical Improvement, Permanent & Stationary, Discharge from Active Care, etc.

Permanent & Stationary Status

Prior Industrial Claims

All prior claims must be closed prior to closing the most recent date of injury. A request for all prior claims can be requested from the Claims Division through the ICA Community or a request can be faxed to 602-542-3373.

- If prior claims are still open, in lieu of a closure, the payer is to issue a 104 Notice checking #11 with statement that the closure is being held in abeyance until the prior claim closes.

Closure Process

When the injured worker is deemed medically stationary, the following steps are taken:

- Issue Notice of Claim Status – Form 104 marking Six (#6) and indicating the date of discharge from treatment. Along with indicating whether the claim resulted in no permanent disability (Seven #7) or resulted in a permanent disability (Eight #8). This may be selected along with the acceptance of the claim, when appropriate, i.e., Medical only claims.

Without Permanent Disability

- **Without permanent disability** mark #7 on Form 104.
- Supporting physician's report indicating the date of discharge.
  - A medical report is not required on a medical only claim.
  - If the injury is severe enough that it may have resulted in a permanent impairment, the doctor must clearly state whether there is or is not permanent impairment. The Commission will review the severity of injury and may solicit if the doctor fails to comment.

With Permanent Disability

- See the *'Permanent Awards'* section of this manual for further information regarding permanent disability

Best Practice Alert:
R20-5-118
A Notice of Claim Status shall not have a retroactive effect for more than 30 days from its 'mailed on' date.

Applicable for notices when: Returning to Work, Discharge from Active Care, Suspending Benefits & more.

This subsection does not apply to a subsequent notice that affects death benefits, and the Commission can relieve a carrier or self-insured employer from a strict application of this subsection for good cause.

See rule for full details or consult with legal counsel for more information.

Supportive Care

Notice of Supportive Medical Maintenance Benefits (103)

Supportive care is medical treatment that is recommended by a medical professional after an injured worker has been found medically stationary (AKA maximum medical improvement). The goal is to help the injured worker maintain his or her level of functionality. It is different from *active treatment* which is care designed to improve a worker's condition.

Notice of Supportive Medical Maintenance Benefits – Form 103

After an injured worker's condition becomes medically stationary, if supportive medical maintenance is recommended by the physician, the payer shall:

- Issue a Notice of Supportive Medical Maintenance Benefits, (hereinafter referred to as Form 103), setting forth the supportive care.
    - This form is to be used only after temporary benefits have been terminated, *and this procedure is applicable only to injuries sustained on or after August 8, 1973.*

Payment for the medical benefits is paid directly to the medical provider of service. A request for supportive care for a date of injury prior to August 8, 1973, should be referred to the ICA Special Fund

Unlike other Notices, a 103 does not contain a 90-day protest period. The only protest rights are via 1061(J).

Request to Change Treating Physician

Change of Physicians

This subsection pertains to a change of physicians for all further care, not for an Independent Medical Examination. *See* A.R.S. § 23- 1071(B)

A table of Authorized Self-Insured employers allowed to direct care is available on the ICA Claims Division Website under Claims Resources. Unless the Employer is identified on this list, a payer may only direct care one time. Injured workers establish their treating physician after two office visits. Change of an attending physician can be accomplished as follows:

- **The attending physician, by writing to the payer**, may transfer the injured worker to another physician for all further care. Unless the payer or injured worker objects to the transfer, the ICA need not be involved.

- **The payer and the injured worker, by mutual consent, may agree on a change of doctors**. This should be implemented by a letter to all concerned persons, including the physician being replaced. Upon request, the ICA will issue an award granting the change.

- **Any of the interested parties or their authorized representatives may petition the ICA in writing for a change of doctors**, giving the reason for the request. The ICA will conduct an administrative investigation, and an ICA award will be issued approving or denying the request based on the investigation.

Self-Insured Employer- Able to Direct Care

- An injured worker may request to change of doctors when injured working for an employer who is able to direct care, however, the standard for approval is higher. See A.R.S. § 23- 1070(E) If the medical, surgical or hospital aid or treatment being furnished by an employer is such that there is reasonable ground to believe that the health, life or recovery of any employee is endangered or impaired thereby, the commission, upon application of the employee or upon its own motion, may order a change of physicians or other conditions…

Best Practice:

The Claims Division will contact the carrier or most recent adjuster on the file for their opinion by phone or email (if known). If there is no reply, the decision will be made on the information available in the file the following day.

Approval to Leave the State

Leaving the State of Arizona A.R.S. §23-1071(A)

An injured worker may not leave the state for a period exceeding two weeks (15 days or more) while the need for active medical treatment continues, without the written approval of the ICA. (*See* A.R.S. § 23-1071(A) and A.A.C. R20-5-115.)

The effective date which grants permission for the injured worker to leave the state is the date the written request was filed.

Payer Actions

Payers should refer inquiries of this nature directly to the Commission. The request form is available on https://www.azica.gov/divisions/claims-division under claim forms.

The payer may also accommodate the injured worker. As such, the payer may do the following:

- Obtain and refer immediately to the Commission a statement from the injured worker setting forth where the injured worker wishes to go, the reason for and dates of such absence, and the address where the worker may be reached while out of state.

Commission Actions

The Commission will review the request and issue an award either approving or disapproving the leave of state request.

- During the Commission's review, the Commission may:
  - Solicit the payer's comments.
  - Obtain written or verbal authorization from the attending physician to ascertain whether the injured worker's condition would be endangered by such an absence.
  - In cases where the move is going to be permanent, request the attending physician's opinion to determine the type of medical treatment required, and if a referral to a specialist is indicated.

Best Practice:
See our YouTube Video: Claims Adjusting 3 to supplement Request to Change Doctors, Leave the State and more

Solicitation from the Claims Division

The Claims Division serves as the regulatory entity tasked with ensuring that the state's workers' compensation claims are adjudicated properly and in accordance with the applicable law.

As part of this responsibility, the Commission sends solicitations to payers or employers when inaccurate Notices are issued and when either vital supporting documentation or Notices were not received by the Commission.

> ***Best Practice:***
> Please remember to include the ICA Claim Number on all communications to ensure there are no delays in matching the document to the ICA claims file.

The payer or employer **must** respond to every ICA issued solicitation within the number of days noted on the form, generally 14 days, with a correction or the requested information. Delays in responding to the solicitation may unfairly delay the injured worker's entitled benefits, as well as slow the claim's progress toward an appropriate resolution.

If there is no reply or a pattern of unreasonable delays or non-responsiveness established, the payer could be liable for "unfair claim processing practices" under A.A.C. R20-5-163 and A.R.S. 23-930 (A-F), wherein the statute allows for the assessment of monetary penalties for each infraction. For all of the aforementioned reasons, it is vitally important that claim adjusters, supervisors, and managers focus on responding to ICA solicitations in a timely and thorough fashion.

If the reason for the solicitation is unclear, please call 602-542-4661 or email claims@azica.gov for assistance.

> *Best Practice Alert:*
> *If you are receiving a second follow up from the Claims Division, but you had previously replied to the first solicit, do not assume it is resolved.*
> *The response may not have been received in the claims file, it may not have satisfied the inquiry, it was missing the ICA Claim # to match it to the appropriate claims file, or many other reasons. Please check the claims file in Community to verify the response is in ICA's possession. If it is unclear why the solicitations is escalating, call the person on the solicitations, or us at 602-542-4661, or email claims@azica.com to verify it is resolved before it escalates to a Bad Faith Allegation.*

Replying to a Solicitation

A payer or employer may reply to a solicitation by fax, US mail, or through the ICA Community. Upload into Community is the preferred method to ensure receipt of the document. When uploading, the correction can be uploaded as either a Returned Solicitation or Returned Wage Solicitation, as indicated. Do not upload the document that resulted in the solicitation, it may result in additional solicitations. More information is available in the Community chapter.

When sending by fax or US mail, it is critical that the ICA claim number be listed on the cover letter and/or notice to ensure all documents are routed correctly. If the ICA claim number is not listed, it will be separated into a manual match queue and may not have enough information to allow the Commission to identify the claim correctly resulting in further escalation.

Amend or Rescind a Notice of Claim Status

Notice of Claim Status issued needing to be corrected or voided.

Correcting an existing notice

- When a correction to an existing notice that is not yet final is indicated, the adjuster may issue a 104 checking #11 and listing the correction. This action effectively changes the original notice to reflect a correction. Both the original notice and new notice are enforceable as if they are one correct notice.
    - The new notice does create a new protest period as noted on the new notice of claim status.
    - The comment must list both the original notice with the error and a clear comment explaining the change. For example, the comment may state 'Notice of Claim Status dated MM/DD/YYYY is amended to change line #6 to date MM/DD/YYYY for compliance with rule 20-5-118.'
    - As with all notices, this amending notice is to be issued to all interested parties.

Rescinding an existing notice.

- When a notice of claim status that is not yet final needs to be rescinded, the adjuster may issue a 104 checking #11 and listing the date of the notice that is no longer in effect.
- This action voids the notice, and it is no longer enforceable.
    - For example, the comment may state 'Notice of Claim Status dated MM/DD/YYYY is hereby rescinded. The claim is open for active benefits.'

Correcting a notice that is final, (90-day protest period has expired).

- At times, a correction may be indicated after the notice is final. This is possible but case law instructs if the notice is void. Consulting with an attorney is recommended.
- One example of a void notice after the 90-day protest period has exhausted is where the notice was issued and it's not supported by the medical records (i.e., a closure was issued but medical record did not issue the correct discharge, or the claim is scheduled and should be unscheduled, etc.).

Suspension of Benefits

Suspension of Benefits – Form 105

Unilateral Suspension

There are four (4) statutory provisions by which the payer may unilaterally suspend compensation benefits. They are identified on the Notice of Suspension of Benefits, (hereinafter referred to as Form 105), and are as follows:

Left the State of Arizona without the written approval of the ICA

- Under the provisions of A.R.S. § 23-1071(A), an injured worker may leave the State of Arizona for a period not to exceed **two (2) weeks** while the necessity of having medical treatment continues without the written approval of the ICA. Therefore, if the injured worker is absent from the State in excess of two weeks without ICA approval, and the payer intends to suspend benefits, the effective date for such suspension would be the 15th day after departure from the State. See Leave the State article for information on the ICA approval process.

  If a request to leave the state occurs when the suspension is not final, the Commission will process the request.

Refused to submit to, or obstructed, an Independent Medical Examination or an examination pursuant to A.R.S. § 23-1026(A)

- Payers may unilaterally suspend benefits pursuant to A.R.S. § 23-1026(C) if the injured worker refuses to submit to or obstructs an independent medical examination or an examination authorized under A.R.S. § 23-1026(A-B) see *Velez v. Industrial Comm'n*, 174 Ariz. 307, 848 P.2d 886 (App. 1993).

Failed to submit a required Annual Report of Income

- Payer may suspend indemnity benefits for failure to return the *Annual Report of Income*. *See* Permanent Awards -Annual Report of Income for full details.

Incarcerated

- Compensation benefits* are suspended during incarceration if the injured worker has been convicted of a crime or has been adjudicated delinquent and is incarcerated in any state, federal, county, city jail or correctional facility. Medical benefits continue and are not suspended.
    - *Compensation may be suspended except for the following.
        i. Scheduled permanent impairment benefits are to be paid in full.
        ii. Any court-ordered child support payments are to be paid. [A.R.S. § 23-1031]
        iii. Medical benefits will continue.

Application for Suspension

Unsanitary or Injurious Practices

- The ICA may reduce or suspend compensation benefits of an injured worker who "persists in unsanitary or injurious practices tending to imperil or retard his recovery or who refuses to submit to medical or surgical treatment reasonably necessary to promote his recovery". A.R.S. § 23-1026(E).

Furthermore, no compensation shall be payable for the death or disability of an injured worker if his unreasonable refusal or neglect to submit to or follow any competent or reasonable surgical treatment or medical aid caused his death or aggravated, caused or continued his disability. A.R.S. § 23-1027. To Apply for Suspension under 1026(E) or 1027, the Payer must assign a legal representative to file a Motion with the ALJ Division.

Best Practice:
A suspension is not a claim closure. Following suspension for any of the above reasons, the claim must be monitored for future issuance of a Notice of Claim Status (Form 104) to either reinstate the benefits or to terminate benefits.

Appointing a Guardian Ad Litem

Guardian Ad Litem - A.R.S. § 23-1066
MINOR OR INCOMPETENT PERSON: GUARDIAN AD LITEM - A.R.S. § 23-1066

Statute Change Alert:
The language of A.R.S. § 23-1066 has been updated in the 2023 legislative session.

Minors or Incapacitated claimant

A.R.S. § 23-1066(A-B) provides for the appointment by the ICA of a guardian ad litem for an incompetent person or minor. On any minor's claim involving litigation, a guardian must be appointed prior to a formal hearing.

Appointment of a *guardian ad litem* is necessary if an injured worker is under 18 years of age and sustains an injury of sufficient severity as to result in temporary disability and/or permanent impairment.

A party requesting a guardian ad litem should be directed to the Commission for the application. Upon application, the claim will be assigned an Administrative Law Judge to make the final determination and appointment.

Minor Employee Penalty Payment

An injured minor who is working in an occupation not legally permitted is entitled to additional compensation in an amount equal to 50% of the compensation the injured minor would otherwise receive. *See* A.R.S. § 23-905(B) Minor Employee

The ICA Labor Division investigates the circumstances of the claim to determine if the injured minor was illegally employed:
If the investigation reveals a violation, the Labor Division shall issue a Cease-and-Desist Order. When awarded, all compensation paid on the claim is payable at the 150% rate.
When the Order becomes final, the ICA Claims Division will provide the payer with a copy of the Cease-and-Desist Order along with a letter advising additional compensation may be due to the minor injured worker. *If the claim is a temporary disability claim, the payer shall return a copy of the ICA's letter*, confirming that the additional compensation has been paid and the period for which it was paid. The payer may subrogate and recover from the employer and penalty amounts paid.

Minor Penalty Sample	If the minor was to receive $500.00 in compensation, the minor would be entitled to an additional 50% or $250.00 for a total of $750.00

Minor investigation will generally be completed within 60 days from the Commission's notification to the report of the claim. Do not withhold or delay normal compensation payments during the period the Commission is investigating the legality of the occupation

Incompetent Persons

- Evidence of the person's incompetency must be submitted to the ICA prior to the entry of the guardian award.
- Such proof may be copies of commitment papers or a physician's statement.

Petition to Reopen

Reopening Procedures

Process to Reopen a Claim for Active Benefits

An injured worker may **petition to reopen** a previously closed, compensable claim to secure additional benefits upon the basis of *new, additional, or previously undiscovered* temporary or permanent condition by filing a *petition* with the ICA. Unless a full and final settlement of a claim has been effectuated under A.R.S. § 23-1061(H), wherein the future right to reopen has been waived. The injured worker may file one or more petitions over their entire lifetime.

Requirements and Conditions

- The *Petition to Reopen* must be accompanied by a statement from a physician setting forth the physical condition which serves the basis for reopening and its relationship to the industrial injury. A.R.S. § 23-1061(H). (*See* A.2. below.)
- A closed claim should not be reopened solely for additional diagnostic or investigative tests. Expenses for any reasonable and necessary diagnostic or investigative medical tests that are causally related to the industrial injury must be paid by the payer without the necessity of reopening. [A.R.S. § 23-1061(H)]
- A claim cannot be reopened if it was previously denied by a Notice of Claim Status or a determination by the ICA and the notice or determination became final unless an exception applies under A.R.S.§ 23-947 excusing a late request for hearing.

Upon request, the Commission will provide a *Petition to Reopen* form to an injured worker for completion.

If the Commission receives a medical report which may meet the statutory criteria for reopening, without the *Petition to Reopen* Form, it may send the injured worker the form. A copy of the letter is also sent to the payer for informational purposes.

Action Taken by the Commission upon Receipt of a Petition to Reopen

- For a claim on which a Form 104 closing the claim has never been issued, the ICA will send a letter to the injured worker indicating that ICA records show the claim is currently open for benefits and recommend that the injured worker contact the payer.
- For a claim where a closing Form 104 has been issued but the *Petition to Reopen* is filed prior to the expiration of the 104's ninety-day protest period, the ICA will process the *Petition* as if the claimant had filed a *Request for Hearing* and refer the matter to the Administrative Law Judge Division for the scheduling of a hearing date.
- For a claim where the *Petition to Reopen* is complete and accompanied by supporting medical documentation, a copy of the *Petition to Reopen* and medical documentation is sent to the payer along

with the ***Notice of Petition to Reopen*** letter advising the payer to either accept or deny the *Petition* within 21 days as set forth in A.R.S. § 23-1061(I). (*See* sample below.)

NOTIFICATION OF PETITION TO REOPEN

Re:
Claimant:
ICA Claim No:
Date of Injury:
Employer:
Carrier Claim No:

Attached is a copy of the Petition to Reopen filed on

You are required to inform this Commission and the injured worker of your acceptance or denial of the petition within TWENTY-ONE DAYS from the date of this notification in accordance with A.R.S. 23-1061-I.

The Claims Division

THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT CLAIMS AT (602) 542-4661.

Enclosures: Copy of Petition to Reopen
Copy of medical report

Best Practice:

The Commission will not review the content of the medical record submitted to determine if it meets the PTR criteria before notification.

This decision is reserved for the Payer when investigating to accept or deny the Petition to Reopen.

If the *Petition to Reopen* is filed without supporting medical documentation, the ICA will solicit this information from the injured worker.

- The *Petition to Reopen* will be held for a period of 14 days pending the receipt of supporting medical documentation (*See* A.A.C. R20-5-133).
- If supporting medical documentation is not received within 14 days, the ICA will send a form letter to the injured worker, with a copy to the carrier, advising that no action by the payer is required.
- If supporting medical documentation is submitted to the ICA within a reasonable period, the ICA will formally notify the payer that it is now required to act on the P*etition to reopen* within 21 days from the date of the Notification.
- If issues regarding benefits cannot be resolved, the ICA will further recommend that the injured worker file a request for hearing pursuant to A.R.S. § 23-1061(J).

Action Taken by the Payer

Upon receipt of the formal *Notice of Petition to Reopen*, the payer must notify the ICA and injured worker in writing of its acceptance or denial of the *Petition to Reopen* within 21 days from the notification date. [*See* A.R.S. § 23-1061(I)].

Accepting the Petition to Reopen

- *Form 104 must be issued checking #9*
- *Compensation Benefits Owed*
    - Verify Average Monthly Wage has been established (109).
        - When the Average Monthly Wage has been previously established, do not re-set it. **The Average Monthly Wage previously determined remains in effect.**
        - Wage is not established

- Check #4B and include Form 108 attached showing the Average Monthly Wage calculation (*see* Average Monthly Wage section for detailed instructions).

  - Check #4 relative to the first payment and indicate on #11 that the Average Monthly Wage was previously established. *See* A.R.S. § 23-1061(F).

- *Medical Only Claim*
  - If the claim continues to be a medical only claim, check #9 and #3.

Deny the Petition to Reopen

- Form 104 must be issued checking #10,
- Item#11, "other" may be checked, giving an explanation, but this is discretionary

A response to this notification is required within **21days** from the mailing date on the *Notice of Petition to Reopen* [A.R.S. § 23-1061(M)]. Failure to respond to the ICA's notification may result in the ICA pursuing an allegation of bad faith.

Best Practice:
See our YouTube Video: Petition to Reopen to supplement this chapter

AVERAGE MONTHLY WAGE

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Average Monthly Wage

Establishing the Average Monthly Wage

In all cases where compensation is payable due to temporary disability and/or permanent impairment, the payer must promptly calculate the injured worker's average monthly wage (AMW) by submitting a Form 108 – *Recommended Average Monthly Wage Calculation of Carrier and Form 104- Notice of Claim Status selecting 4(B).*

- The form 108 calculation is not final; the payer submits to the Commission for an independent determination. [A.R.S. § 23-1041 and A.R.S. § 23- 1061(F)]. The method used to calculate an injured worker's average monthly wage may vary. *An injured worker's earnings in the **30 days during and over the month of the accident will be the presumptive wage base** and will become the average monthly wage unless these earnings fail to accurately measure the injured worker's preinjury earning capacity*.
- The selected wage should fairly reflect the injured worker's pre-injury wage.
    - Justification for using an expanded wage base (greater than 30 days) may include, but is not limited to, any of the following:
        - The 30-day calculation appears too high or low compared with other calculations,
        - Intermittent employment,
        - Seasonal employment,
        - Earnings from other employers,
        - Concurrent employment, and
        - Inflated wages received during the month before the injury.
- When setting the wage, the adjuster's investigation is to include a thorough review of the injured workers' complete earnings from the year prior to the injury including employment from other covered employment during that time period.
    - Covered employment includes all earnings made while working for a company who covered the employee with workers compensation insurance. Independent contractors are generally excluded.
    - The employer not participating in the investigation is not a good faith reason to delay setting the wage. The injured workers' proof of payment may also be considered, such as paycheck stubs and tax forms.
    - If all efforts have been exhausted and no further information is available, this is to be indicated on the bottom of the 108. See example.

Statutory Minimum

If the payer is unable to calculate the injured worker's average monthly wage by the date the first payment is due, compensation must be paid using at least the minimum average monthly wage of $200.00 for employees 18 years or older. A.R.S. § 23-1041(F).

This is a temporary average monthly wage – the statutory minimum wage to start compensation and must be adjusted as soon as sufficient wage information is obtained.

- The payer must issue Form 104, checking #4A. The Average Monthly Wage Calculation sheet (hereinafter referred to as Form 108) is not required when setting a temporary wage.
- The recommended average monthly wage is to be set within ***30 days*** of the payment of the first installment of compensation, the carrier or self-insured employer must **notify the Commission and the injured worker of its average monthly wage calculation and the basis for the calculation using Forms 104 and 108.** [A.R.S. § 23-1061(F)]

Best Practice:

The Minimum AMW is legally acceptable, however, it is best practice to use a reasonable estimation of the actual AMW.

Setting the AMW

- When applicable, the payer is to calculate the injured worker's average monthly wage, by checking #4B on Form 104 and attach Form 108.
    - When completing the 108, numbers 1 through 9 and number 14 must be completed if the average monthly wage is not established at the maximum average monthly wage.
    - When there is no time loss and wage is established only for potential permanent impairment, establish the Average Monthly Wage is to be established with a completed 104 checking 4B and #11 with a comment that the wage is established for anticipated permanent disability and 108.

Best Practice:

Unemployment insurance benefits are NOT considered earnings in establishing the average monthly wage. However, they are considered wages able to be earned when calculating temporary partial disability benefits.

[A.R.S. § 23-1044(A)]

How to Complete the 108 – Recommended Average Monthly Wage

Fields/Lines labeled 1-9 and 14 are required.

- #1 Claimant: List Claimant Name
- #2 Occupation: List the Injured Workers Occupation. This field serves the claim in multiple ways, such as supporting special wage circumstances like contract or seasonal work. It also will be used if the claim is closed with an unscheduled permanent for loss of earning capacity evaluation.
- #3 Date of Hire: Required field and will be used to determine if calculations are correct.
- #4 Dependent: Dependents can be considered legally married spouse or children.
- #5 Employment Status: Required field and will be used to determine if calculations are correct. It also will be used if the claim is closed with an unscheduled permanent for loss of earning capacity evaluation.
- #6 Formula Examples
    - *These examples do not cover all possible scenarios, but they do provide the standardized process and calculations to follow. Please contact us with any questions.

How to Calculate Line 6

Line 6 Formula:
Base Rate of Pay X Number of Hours X Weeks = Line #6 AMW
*See Factors of Compensation for other factors that can be used in Weeks

Hourly Example
1. $24.76 X 40 = $990.40 weekly pay
2. $990.40 X 4.333 = $4291.4032
3. Round at 2nd Decimal: $4291.40

Daily Example
1. $235 X 5 = $1175 weekly pay
2. $1175 X 4.333 = $5091.275
3. Round at 2nd Decimal: $5091.28

Weekly Example
1. $1575 X 1 = $1575 weekly pay
2. $1575 X 4.333 = $6824.475
3. Round at 2nd Decimal: $6824.48

Monthly & Piece Rate do not require calculations.
Monthly amount is entered at = Sign
Piece Rate is indicated with the check box and no other information required.

- #7 - List Actual Earnings in 30 days prior to date of injury
- #8 - Earnings with Insured Employer

Watch for these Common Errors when setting wage

- *DO NOT: Include wages on or after date of injury*
- *DO: Include the Date of Hire*
- *DO: Check your dates include starting and end date (but not the date of injury)*
- *DO: Check where the number is rounded. Round up at the 3rd decimal at 5 and over, not down.*
- *DO: Check for concurrent/nonconcurrent employment when investigating, wages include all covered employment the year prior to the injury. That includes other covered employers.*
    - *DO NOT: Do not include wages worked for uncovered employers (do not pay into workers compensation i.e., independent contractor 'gig economy' work.*

- #8 Calculations Example: Full Year Available

How to Calculate Line 8 Full Year Available

Line 8 Formula, full year available:

1. 365 days prior to Date of Injury or 366 on leap year
2. Amount of Earnings from that date span / Number of Days from 1st Step = Daily Rate (round to 2nd digit)
3. Daily Rate x 30.416 = Recommended AMW (round to 2nd digit)

Line 8 Formula, full year available
Date of Hire:5/10/2019 Date of Injury:6/22/2023

1. 6/21/2022 – 6/21/2023 = 365 Days
2. $45,372 / 365 = 124.306849. Rounded: 124.31 daily rate
3. 124.31 X 30.416 = 3781.01296. Rounded 3781.01 Recommended AMW

- *#8 Example: Less than Full Year Available*

How to Calculate Line 8 DOH Less than 1 year

Line 8 Formula, DOH Less than 1 year.:

1. Date of Hire through Day Before Date of Injury
2. Amount of Earnings from that date span / Number of Days from 1st Step = Daily Rate (round to 2nd digit)
3. Daily Rate x 30.416 = Recommended AMW (round to 2nd digit)

Line 8 Formula, DOH Less than 1 year
Date of Hire:01/20/2023 Date of Injury:6/22/2023

1. 1/20/2023 – 6/22/2023 = 163 Days
2. $22,543 / 163 = 138.300613. Rounded: 138.30 daily rate
3. 138.30 X 30.416 = 4206.5328. Rounded 4206.53 Recommended AMW

- #9 - Date of Last Pay Increase
  - If this was not within the last year, enter N/A (not applicable)
  - If it is applicable, complete 9A using the same formula as Line #8 above.
- #10 – Wage Patterns of Other Employees of Insured Employer
  - This is to be used when the employment duration is less than one year, and the employer has at least two employees with similar jobs for the same time period.
  - Do Not List Names, use Employee A and Employee B for privacy between all parties.

- *#10: Wage Patterns Example, same job and pay*

Line 10 – Wage Pattern Example

Line 10, Wage Pattern, same Job/Rate of Pay as the Injured Worker

1. A (# of Days). From Start Date Through End Date =$ Total Earnings
2. B (# of Days). From Start Date Through End Date =$ Total Earnings
3. Total of A+B Earnings / Total of A+B Days =Daily Rate
   Daily Rate X 30.416 = Recommended AMW

Line 10, Wage Pattern, same Job/Rate of Pay as the Injured Worker
Date of Hire:8/1/2023 Date of Injury:8/11/2023

1. A (365). From 08/11/2022 Through 08/10/2023 =$42,273.25
2. B (365). From 08/11/2022 Through 08/10/2023 =$45,600.15
3. 87,873.40/ 730=120.3745 (round) = 120.37
   120.37 X 30.416 = 3661.17392 (round)

- *#10: Wage Patterns Example, prorated, similar job with different pay*

Line 10 – Pro-rated Wage Pattern

Line 10, Wage Pattern, similar job with different pay

1. A (# of Days). From Start Date Through End Date =$ Total Earnings (hourly rate)
2. B (# of Days). From Start Date Through End Date =$ Total Earnings (hourly rate)
3. Employee A Total Earnings / Hourly rate = Total # Hours (round)
4. Employee B Total earnings / Hourly Rate = Total # Hours (round)
5. Employee A # of Days + Employee B # of Days = Total Days
6. Employee A # of hours + Employee B # of Hours = Total Hours
7. Total Hours/Total Days = Average Daily Hours, round at 2nd decimal. (This may seem low however, it is calendar days including weekends/days off)
8. Average Daily Hours x IW's Base Rate of Pay = Daily Rate
9. Daily Rate X 30.416 = Recommended Average Monthly Wage

Line 10, Wage Pattern, similar job with different pay
Date of Hire:8/1/2023 Date of Injury:8/11/2023 Based Rate of Pay:21.75

1. A (365). From 08/11/2022 Through 08/10/2023 =$42,273.25 (21.02/hour)
2. B (365). From 08/11/2022 Through 08/10/2023 =$45,600.15 (21.90/hour)
3. 42273.25/21.02 = 2011.09657 (round at 2nd decimal) = 2011.10
4. 45600.15/21.90 = 2082.198630 (round at 2nd decimal) = 2082.20
5. 365 + 365 = 730
6. 2011.10 + 2082.20 = 4093.30
7. 4093.30/730 = 5.60726 (round at 2nd decimal) = 5.61
8. 5.61 X 21.75 = 122.0175 (round at 2nd decimal) = 122.02
9. 122.02 X 30.416 = 3711.36032 (round at 2nd decimal) = 3711.36

Seasonal Example

- If the injured worker did not perform any other work during the year and his occupation on the date of injury is not available throughout the year, average his gross earnings then multiply times (x) months (the number of months in the season) and divide by 12 months to determine his average monthly wage.
- It is important to remember that seasonal employment is generally defined by the occupation of the injured worker, not the availability of work with a particular employer. While the employer may only be in business at certain times of the year, the occupation of the worker may be available year-round and, therefore, the occupation would not be considered seasonal.

Seasonal

Line 8 - Seasonal

1. Date of Hire (start of season) through Day before Date of Injury= # of days
2. Earnings from Step 1 / # of Days = Daily Rate (rounded)
3. Daily Rate X 30.416 = Monthly Average
4. Monthly Average X # of Months in the Season = Average Per Month
5. Average per Month / 12 Months = Recommended Average Monthly Wage

Line 8 - Seasonal

Date of Hire:11/01/2022 Date of Injury:01/15/2023 Season: 3 mo's

1. 11/01/2022 – 01/14/2023 = 75 Days
2. 9350.32 / 75 = 124.6709. Rounded: 124.67
3. 124.67 X 30.416 = 3791.96272 Rounded: 3791.96
4. 3791.96 X 3 months = 11375.88
5. 11375.88/12 = 947.99

Wage Solicitation

- The Commission may send the payer a solicitation letter requesting either a correction or clarification of Form 108.
    - The payer should respond to the solicitation letter within **14 days**, providing the information requested.
- If the payer determines that a change to its average monthly wage calculation is indicated after further review, it should:
    - Issue an amended Form 104 setting out the new recommended average monthly wage, marking #4B and #11, and stating that the notice amends the average monthly wage; attach a revised Form 108; and send the two forms to all interested parties.
- Upon receipt of revisions, the Commission will review and then make its own independent determination and approve or disapprove the payer's recommended average monthly wage calculation.

Approval

If the Commission approves the payer's average monthly wage calculation, it will

- Issue a Notice of Average Monthly Wage (referred to as Form 109) to all interested parties.

Best Practice:

If the employer does not participate in providing wage, the payer should contact the injured worker for information including paycheck stubs. If that is not available or complete, the payer can, note on the bottom of the 108 that no other information is available.

Disapproval

If the Commission disapproves the payer's average monthly wage calculation, it will follow one of the two procedures below:

Error(s) in Calculations

- The Commission will issue Form 109, along with a completed Form 108 setting forth the basis for its determination. Both notices will be mailed to all interested parties.

Establishing from Payer Calculations

- The Commission will issue Form 109 disapproving the Payer's recommendation and selecting a different calculation from the Payer's Form 108.

Protest Rights

- Any party believing the ICA's Average Monthly Wage Determination (Form 109) is incorrect may protest it. The matter will be referred to the Administrative Law Judge Division for further disposition. (See A.R.S. § 23-941 and A.R.S. § 23-947.)
    - All benefits must be paid based upon the Commission's average monthly wage determination during the pendency of the protest.
    - The Commission's average monthly wage determination is retroactive to the injured worker's first date of entitlement to compensation benefits. [A.R.S. § 23-1061(F)]

Best Practice:
See our YouTube Videos:
Average Monthly Wage Basic &
Average Monthly Wage – Advanced
to supplement this chapter

Maximum Average Monthly Wage

By statute, the Commission reviews and establishes the maximum average monthly wage on a yearly basis. Here is the list of maximum wages pursuant to A.R.S. § 23-1041 on which compensation must be computed:

HISTORY OF AVERAGE MONTHLY MAXIMUMS		
MAX AMW	FOR INJURIES ON OR AFTER	
$5,663.04	01-01-2024	12-31-2024
$5,393.37	01-01-2023	12-31-2023
$5,161.12	01-01-2022	12-31-2022
$5,030.33	01-01-2021	12-31-2021
$4,888.56	01-01-2020	12-31-2020
$4,741.57	01-01-2019	12-31-2019
$4,625.92	01-01-2018	12-31-2018
$4,521.92	01-01-2017	12-31-2017
$4,428.91	01-01-2016	12-31-2016
$4,337.82	01-01-2015	12-31-2015
$4,256.94	01-01-2014	12-31-2014
$4,185.78	01-01-2013	12-31-2013
$4,062.29	01-01-2012	12-31-2012
$3,920.75	01-01-2011	12-31-2011
$3,763.44	01-01-2010	12-31-2010
$3,600.00	01-01-2009	12-31-2009
$3,000.00	01-01-2008	12-31-2008
$2,400.00	08-07-1999	12-31-2007
$2,100.00	07-01-1991	08-06-1999
$1,800.00	07-01-1989	06-30-1991
$1,650.00	01-01-1988	06-30-1989
$1,325.00	07-31-1980	12-31-1987
$1,250.00	08-27-1977	07-30-1980
$1,000.00	11-22-1948	08-26-1977

Factors to Determine Compensation

30.416	Number of days in an average month. (365 divided by 12 months)
4.333	Number of weeks in an average month. (52 weeks divided by 12 months)
2.167	Number of biweekly pay periods in an average month. (4.333 divided by 2)
60.832	Number of days in two months. Used for maximum benefits under hernia statute. A.R.S. § 23- 1043.
.02137	Used to obtain daily compensation rate on those injuries sustained prior to August 8, 1973. (65% divided by 30.416 = 2.13% or a factor of .02137)
.021918	Used to obtain daily compensation rate on those injuries sustained on or after August 08, 1973. (66 2/3% divided by 30.416 = 2.1918% or a factor of .021918)
.8219	Daily allowance for dependents ($25.00 divided by 30.416). Rate is the same regardless of the number of dependents. *Effective January 1, 1991, A.R.S. § 23-1045 subsection A paragraphs 1 and 2 were amended. The amendment to subsection A paragraph 2 increased the dependent allowance per family to $25.00 per month. The amendment to subsection A paragraph 2 also removed the term "totally", thereby allowing for income from more than one wage earner.*
.01151	Daily compensation rate of widows or widowers. 35% divided by 30.416 = 1.1507% or a factor of .01151. *If payment is being made at 66 2/3% use factor .021918.*
.6667	66 2/3%

Quick Reference - Payment of Compensation

- First installment of compensation: A.R.S. § 23-1062(D)
- Subsequent payment of compensation: A.R.S. § 23-1062(D): "*compensation shall be paid at least once each two weeks during the period of temporary total disability and at least monthly thereafter.*"
- Basis for computing compensation: A.R.S. § 23-1041
- Dependents allowance, calculated using a factor of .8219, is paid in addition to the daily rate even if the average monthly wage is established at maximum. A.R.S. § 23-1045(A)(2)

Carrier or Self-Insured Name and Address
Carrier Name
Carrier Address1

Phoenix, AZ 85006

Authorized Third Party Administrator (TPA) Name and Address
Awesome TPA
TPA Street 1

Phoenix, AZ 85006

Claimant's Name and Address
Wick John
123 Awesome St

Phoenix, AZ 85006

ICA Claim No. ADD THE ICA CLAIM #

Soc. Sec. No.

SSN not required if correct ICA claim number is provided

Carrier Claim No. WC101

Employer The Continental

Address 123 Awesome St

Phoenix, AZ 85006

Date of Injury 02/26/2019

Example: Accepting claim with Minimum Wage.
Actual 104 with 4B & 108 is due within 30 days

- [x] 1. Claim is accepted.
- [ ] 2. Claim is denied.
- [ ] 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.
- [x] 4. Enclosed check for _____ for period of _____ through _____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of $200.00 based on the following:
  - [x] A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
  - [ ] B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.
- [ ] 5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly. Return to regular duty effective _____.
- [ ] 6. Temporary compensation and active medical treatment terminated on _____ because claimant was discharged.
- [ ] 7. Injury resulted in no permanent disability.
- [ ] 8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, if any, will be authorized by separate Notice.
- [ ] 9. Petition to Reopen accepted.
- [ ] 10. Petition to Reopen denied.
- [ ] 11. Other:

Mailed on: 07/10/2019 By: Best Claims Adjuster

(Authorized Representative) Tel. #: (602) 542-4661

Copy to: Industrial Commission of Arizona

The insurance carrier/employer will, upon request, provide claimant a copy of the medical report to support Findings 5, 6, 7 or 8.

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

AVISO AL RECLAMANTE: Si usted no esta de acuerdo con este AVISO, y desea una audiencia en este caso, su peticion por escrito pidlendo una audiencia debera ser recibida en cualquira de las oficinas de la Comision Industrial a las direcciones abajo indicadas dentro de NOVENTA (90) DIAS despues de la fecha de este AVISO, de acuerdo con las leyes A.R.S. 23-941 y 23-947. SI DICHA PETICION NO ESTA RECIBIDA DENTRO DEL PERIODO DE NOVENTA (90) DIAS, ESTE AVISO SERA CONSIDERADO FINAL.

Phoenix Office: Industrial Commission of Arizona
800 W Washington Street
Phoenix, Arizona 85007-2922

PO Box 19070
Phoenix, AZ 85005-9070

Tucson Office: Industrial Commission of Arizona
2675 E Broadway
Tucson, Arizona 85716-5342

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 0104 - Rev 6/2019

NOTICE OF CLAIM STATUS

Carrier or Self-Insured Name and Address
Carrier Name
Carrier Address1

Phoenix, AZ 85006

Authorized Third Party Administrator (TPA) Name and Address
Awesome TPA
TPA Street 1

Phoenix, AZ 85006

Claimant's Name and Address
Wick John
123 Awesome St

Phoenix, AZ 85006

ICA Claim No. ADD THE ICA CLAIM #

Soc. Sec. No.

SSN not required if correct ICA claim number is provided

Carrier Claim No. WC101

Employer The Continental

Address 123 Awesome St

Phoenix, AZ 85006

Date of Injury 02/26/2019

Example: Accepting claim with Actual Monthly Wage

- [x] 1. Claim is accepted.
- [ ] 2. Claim is denied.
- [ ] 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.
- [x] 4. Enclosed check for $1,466.50 for period of 02/08/2019 through 02/21/2019. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of $4,741.57 based on the following:
  - [ ] A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
  - [x] B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.
- [ ] 5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly. Return to regular duty effective _____.
- [ ] 6. Temporary compensation and active medical treatment terminated on _____ because claimant was discharged.
- [ ] 7. Injury resulted in no permanent disability.
- [ ] 8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, if any, will be authorized by separate Notice.
- [ ] 9. Petition to Reopen accepted.
- [ ] 10. Petition to Reopen denied.
- [ ] 11. Other:

If establishing for Perm Only or Future potential Compensation, state this in box #11.

Mailed on: 07/10/2019 By: Even Better Claims Adjuster

(Authorized Representative) Tel. #: (602) 542-4661

Copy to: Industrial Commission of Arizona

The insurance carrier/employer will, upon request, provide claimant a copy of the medical report to support Findings 5, 6, 7 or 8.

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

AVISO AL RECLAMANTE: Si usted no esta de acuerdo con este AVISO, y desea una audiencia en este caso, su peticion por escrito pidiendo una audiencia debera ser recibida en cualquira de las oficinas de la Comision Industrial a las direcciones abajo indicadas dentro de NOVENTA (90) DIAS despues de la fecha de este AVISO, de acuerdo con las leyes A.R.S. 23-941 y 23-947. SI DICHA PETICION NO ESTA RECIBIDA DENTRO DEL PERIODO DE NOVENTA (90) DIAS, ESTE AVISO SERA CONSIDERADO FINAL.

Phoenix Office: Industrial Commission of Arizona
800 W Washington Street
Phoenix, Arizona 85007-2922

PO Box 19070
Phoenix, AZ 85005-9070

Tucson Office: Industrial Commission of Arizona
2675 E Broadway
Tucson, Arizona 85716-5342

Table of Contents

AMW Samples

Samples which demonstrate the methods used to calculate the average monthly wage are included at the end of this section for the following situations:

- Standard average monthly wage
- Standard average monthly wage (statutory maximum)
- Increase in effect less than 30 days
- Increase in effect more than 30 days
- Part-time
- Wage patterns available
- No wage patterns available
- Pro-rating wage patterns
- Temporary
- Seasonal
- Not seasonal (Injured worker has other earnings during remainder of year)
- Minor student
- Teacher contract
- Concurrent employment (existing at the time of the injury)
- More than one employer, not concurrent
- Deducting periods of time
- Board and lodging

STANDARD AVERAGE MONTHLY WAGE

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED (IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **3-10-23**
ICA Case No.: **20030-000011**
Soc. Sec. No.: **600-62-1976**
Carrier Claim No.: **WC100059369**
Employer: **Hobby & Crafts**
Date Injured: **3-1-23**

1. CLAIMANT: **Harry Smith** 2. OCCUPATION: **Cashier**

3. DATE OF HIRE: **1-6-19** 4. DEPENDENTS? [X] YES [ ] NO

5. EMPLOYMENT STATUS: [X] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **19.50** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **19.50** x **40 = $780.00** x **4.333** = $ **3,379.74** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ **3,950.50**

8. EARNINGS WITH INSURED EMPLOYER: FROM: **3-1-22** THRU: **2-28-23**

AMOUNT: $ **48,544.32** ÷ **365** (DAYS) = $ **133.00** x **30.416*** = $ **4,045.33** AVG.

9. DATE OF LAST PAY INCREASE: **N/A** IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM _____ THRU _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

10. WAGE PATTERNS OF OTHER EMPLOYEES OF INSURED EMPLOYER:

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

12. COMBINED EARNINGS FROM ITEMS: _____ + _____ + _____ + _____

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ _____ OTHER: $ _____ = $ _____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + _____ + **8** = $ **4,045.33**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

STANDARD AVERAGE MONTHLY WAGE (STATUTORY MAXIMUM)

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED (IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **3-10-23**
ICA Case No.: **20031-000023**
Soc. Sec. No.: **544-62-1976**
Carrier Claim No.: **545469-01**
Employer: **Kitchen Supply Company**
Date Injured: **1-27-23**

1. CLAIMANT: **Harriet Smith** 2. OCCUPATION: **Inventory Manger**

3. DATE OF HIRE: **2-10-13** 4. DEPENDENTS? [X] YES [ ] NO

5. EMPLOYMENT STATUS: [X] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **33.00** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **33.00** x **40 = $1,320** x **4.333** = $ **5719.56** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ _____

8. EARNINGS WITH INSURED EMPLOYER: FROM: _____ THRU: _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

9. DATE OF LAST PAY INCREASE: _____ IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM _____ THRU _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

10. WAGE PATTERNS OF OTHER EMPLOYEES OF INSURED EMPLOYER:

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

12. COMBINED EARNINGS FROM ITEMS: _____ + _____ + _____ + _____

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ _____ OTHER: $ _____ = $ _____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + _____ + **6** = $ **5,393.37**

Maximum allowable pursuant to AR.S. §23-1041

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

INCREASE IN EFFECT LESS THAN 30 DAYS

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED (IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **5-1-23**
ICA Case No.: **20180-010013**
Soc. Sec. No.: **711-22-2525**
Carrier Claim No.: **W/C-B010**
Employer: **The Shoe Depot**
Date Injured: **3-1-23**

1. CLAIMANT: **Howard Smith** 2. OCCUPATION: **Back Stock Lead**

3. DATE OF HIRE: **3-5-14** 4. DEPENDENTS? [ ] YES [X] NO

5. EMPLOYMENT STATUS: [X] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **14.40** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **14.40** x **40 = $576.00** x **4.333** = $ **2,495.81** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ **2,589.65**

8. EARNINGS WITH INSURED EMPLOYER: FROM: **3-1-22** THRU: **2-28-23**

AMOUNT: $ **30,084.21** ÷ **365** (DAYS) = $ **82.42** x **30.416*** = $ **2,506.89** AVG.

9. DATE OF LAST PAY INCREASE: **2-14-23** IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM _____ THRU _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

Use earnings for the 30 days prior to the industrial injury even if the injured worker receives a raise during this time period as long as the raise is a routine hourly wage increase. Davis v. Industrial Comm'n, 134 Ariz. 293, 655 P.2d 1345 (App. 1982).

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

12. COMBINED EARNINGS FROM ITEMS: _____ + _____ + _____ + _____

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ _____ OTHER: $ _____ = $ _____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + _____ + **7** = $ **2,589.65**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

INCREASE IN EFFECT MORE THAN 30 DAYS

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED
(IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **3-30-23**
ICA Case No.: **22003-222222**
Soc. Sec. No.: **723-74-1962**
Carrier Claim No.: **W/C-B03**
Employer: **TriStar Construction**
Date Injured: **3-1-23**

1. CLAIMANT: **Howard Smith** 2. OCCUPATION: **Carpenter**

3. DATE OF HIRE: **12-5-15** 4. DEPENDENTS? [X] YES [ ] NO

5. EMPLOYMENT STATUS: [X] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **17.50** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **17.50** x **40 = $700.00** x **4.333** = $ **3,033.10** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ **3,086.60**

8. EARNINGS WITH INSURED EMPLOYER: FROM: **3-1-22** THRU: **2-28-23**

AMOUNT: $ **36,265.40** ÷ **365** (DAYS) = $ **99.36** x **30.416*** = $ **3,022.13** AVG.

9. DATE OF LAST PAY INCREASE: **1-14-23** IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM **1-14-23** THRU **2-28-23**

AMOUNT: $ **4,731.95** ÷ **46** (DAYS) = $ **102.87** x **30.416*** = $ **3,128.89** AVG.

10. WAGE PATTERNS OF OTHER EMPLOYEES OF INSURED EMPLOYER:

____ FROM ____ THRU ____ $ ____ AMT.

____ FROM ____ THRU ____ $ ____ AMT.

TOTAL OF ABOVE: $ ____ ÷ ____ (DAYS) = $ ____ X **30.416*** = $ ____ AVG.

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

____ FROM ____ THRU ____ $ ____ AMT.

____ FROM ____ THRU ____ $ ____ AMT.

TOTAL OF ABOVE: $ ____ ÷ ____ (DAYS) = $ ____ X **30.416*** = $ ____ AVG.

12. COMBINED EARNINGS FROM ITEMS: ____ + ____ + ____ + ____

TOTAL OF ABOVE: $ ____ ÷ ____ (DAYS) = $ ____ X **30.416*** = $ ____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ ____ OTHER: $ ____ = $ ____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: ____ + ____ + **9(A)** = $ **3.128.89**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

PART-TIME

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED (IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **3-22-23**
ICA Case No.: **20122-403403**
Soc. Sec. No.: **710-29-1955**
Carrier Claim No.: **W/C-A-04**
Employer: **Paradise Dress To Impress**
Date Injured: **3-1-23**

1. CLAIMANT: **Harriet Smith** 2. OCCUPATION: **Stocker**

3. DATE OF HIRE: **4-10-15** 4. DEPENDENTS? [ ] YES [X] NO

5. EMPLOYMENT STATUS: [ ] STEADY [ ] INTERMITTENT [ ] SEASONAL [X] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **13.85** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **13.85** x **20 = $277.00** x **4.333** = $ **1,200.24** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ **1,011.80**

8. EARNINGS WITH INSURED EMPLOYER: FROM: **3-1-22** THRU: **2-28-23**

AMOUNT: $ **13,200.00** ÷ **365** (DAYS) = $ **36.16** x **30.416*** = $ **1099.84** AVG.

9. DATE OF LAST PAY INCREASE: **N/A** IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM _____ THRU _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

The number of hours actually worked may differ from the number of hours hired to work. If this is the case, complete line #8 and use the gross earnings.

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

12. COMBINED EARNINGS FROM ITEMS: _____ + _____ + _____ + _____

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ _____ OTHER: $ _____ = $ _____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + _____ + **8** = $ **1099.84**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

WAGE PATTERNS AVAILABLE

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED
(IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **7-2-23**
ICA Case No.: **20161-600690**
Soc. Sec. No.: **112-54-0022**
Carrier Claim No.: **WC-000012B05**
Employer: **AZ Desert Planting Co.**
Date Injured: **6-3-23**

1. CLAIMANT: **Howard Smith**
2. OCCUPATION: **Nursery Caretaker**
3. DATE OF HIRE: **5-31-23**
4. DEPENDENTS? [ ] YES [X] NO
5. EMPLOYMENT STATUS: [X] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **13.85** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **13.85** x **40 = $554.00** x **4.333** = $ **2,400.48** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $

8. EARNINGS WITH INSURED EMPLOYER: FROM: THRU:

AMOUNT: $ ÷ (DAYS) = $ x **30.416*** = $ AVG.

9. DATE OF LAST PAY INCREASE: IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM THRU

AMOUNT: $ ÷ (DAYS) = $ x **30.416*** = $ AVG.

10. WAGE PATTERNS OF OTHER EMPLOYEES OF INSURED EMPLOYER:

A(150 Days) FROM **1-4-23** THRU **6-2-23** $ **11,231.34** AMT.

B(120 Days) FROM **2-3-23** THRU **6-2-23** $ **9,207.76** AMT.

TOTAL OF ABOVE: $ **20,439.10** ÷ **270** (DAYS) = $ **75.70** X **30.416*** = $ **2,302.49** AVG.

Use wage patterns for situations where the injured worker worked less than 30 days prior to the injury and the employer has 2 identical wage patterns available. The wage patterns used must be the same rate of pay as the injured worker.

12. COMBINED EARNINGS FROM ITEMS: + + +

TOTAL OF ABOVE: $ ÷ (DAYS) = $ X **30.416*** = $ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ OTHER: $ = $

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: + + **10** = $ **2,302.49**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

NO WAGE PATTERNS AVAILABLE

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED (IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **2-12-23**
ICA Case No.: **21005-000016**
Soc. Sec. No.: **712-39-1012**
Carrier Claim No.: **125556900006**
Employer: **Valleywide Garage**
Date Injured: **1-14-23**

1. CLAIMANT: **Howard Smith** 2. OCCUPATION: **Mechanic**

3. DATE OF HIRE: **12-24-22** 4. DEPENDENTS? [X] YES [ ] NO

5. EMPLOYMENT STATUS: [X] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **17.20** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **17.20** x **40 = $688.00** x **4.333** = $ **2,981.10** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ _____

8. EARNINGS WITH INSURED EMPLOYER: FROM: _____ THRU: _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

9. DATE OF LAST PAY INCREASE: _____ IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM _____ THRU _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

10. WAGE PATTERNS OF OTHER EMPLOYEES OF INSURED EMPLOYER:

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

12. COMBINED EARNINGS FROM ITEMS: _____ + _____ + _____ + _____

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ _____ OTHER: $ _____ = $ _____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + _____ + **6** = $ **2,981.10**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

PRO-RATING WAGE PATTERNS

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED
(IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **3-3-23**
ICA Case No.: **20056-701017**
Soc. Sec. No.: **100-31-1963**
Carrier Claim No.: **AZ100002355893-0001**
Employer: **24 Hour Mechanical Garage**
Date Injured: **2-10-23**

1. CLAIMANT: **Howard Smith** 2. OCCUPATION: **Tire Repair Tech**

3. DATE OF HIRE: **2-1-23** 4. DEPENDENTS? [ ] YES [X] NO

5. EMPLOYMENT STATUS: [X] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **13.85** PER: HOUR [x] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **13.85** x **40 = $554.00** x **4.333** = $ **2,400.48** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $

8. EARNINGS WITH INSURED EMPLOYER: FROM: THRU:

AMOUNT: $ ÷ (DAYS) = $ x **30.416*** = $ AVG.

9. DATE OF LAST PAY INCREASE: IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM THRU

AMOUNT: $ ÷ (DAYS) = $ x **30.416*** = $ AVG.

10. WAGE PATTERNS OF OTHER EMPLOYEES OF INSURED EMPLOYER:

A (101 Days) FROM **11-01-22** THRU **2-9-23** $ **5,539.15 ($13.90/hour)** AMT.

B (102 Days) FROM **10-31-22** THRU **2-9-23** $ **5,405.83 ($13.85/hour)** AMT.

$5,539.15 ÷ $13.90 (A) = 398.50 hours

= 788.81 hours

$5,405.83 ÷ $13.85 (B) = 390.31 hours

788.81 hours ÷ 203 days (A & B) = 3.89 hours

3.89 (hours) x $13.85 (base rate of pay) = $53.88 (daily) x 30.416 = $1,638.81

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: + + **10** = $ **1,638.81**

Prorated wage patterns can be used to determine the number of hours the injured worker would have been expected to work had he worked for insured employer more than 30 days before the injury.

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

TEMPORARY

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED (IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **3-14-23**
ICA Case No.: **21607-357018**
Soc. Sec. No.: **739-46-1836**
Carrier Claim No.: **W/C-A04**
Employer: **Research Marketing L.A.**
Date Injured: **2-16-23**

1. CLAIMANT: **Harriet Smith** 2. OCCUPATION: **Information Clerk**

3. DATE OF HIRE: **12-16-17** 4. DEPENDENTS? [ ] YES [X] NO

5. EMPLOYMENT STATUS: [ ] STEADY [X] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **16.00** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **16.00** x **32 = $512.00** x **4.333** = $ **2,218.50** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ **2,252.00**

8. EARNINGS WITH INSURED EMPLOYER: FROM: **12-16-22** THRU: **2-15-23**

AMOUNT: $ **5,000.00** ÷ **62** (DAYS) = $ **80.65** x **30.416*** = $ **2,453.05** AVG.

9. DATE OF LAST PAY INCREASE: **N/A** IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM _____ THRU _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

10. WAGE PATTERNS OF OTHER EMPLOYEES OF INSURED EMPLOYER:

******Appears reasonable that injured worker could have performed this type of work an average of 32 hours per week on a yearly basis.***

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

12. COMBINED EARNINGS FROM ITEMS: _____ + _____ + _____ + _____

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ _____ OTHER: $ _____ = $ _____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + _____ + **8** = $ **2,453.05**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

SEASONAL

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED
(IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **2-17-23**
ICA Case No.: **22098-055109**
Soc. Sec. No.: **719-54-1960**
Carrier Claim No.: **W/C-B05**
Employer: **Snow Mountain Resort**
Date Injured: **1-22-23**

1. CLAIMANT: **Howard Smith** 2. OCCUPATION: **Ski Instructor**

3. DATE OF HIRE: **12-3-17** 4. DEPENDENTS? [ ] YES [X] NO

5. EMPLOYMENT STATUS: [ ] STEADY [ ] INTERMITTENT [X] SEASONAL [ ] PART-TIME [2] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **30.35** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **HOURS VARY** x ____ x ____ = $ ____ AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ ____

8. EARNINGS WITH INSURED EMPLOYER: FROM: **12-3-22** THRU: **1-21-23**

AMOUNT: $ **11,392.88** ÷ **50** (DAYS) = $ **227.86** x **30.416*** = $ **6,930.59** AVG.

($6,930.59 x 2 months (number of months in the season) = $13,861.18 ÷ 12 months = $1,155.10)

9. DATE OF LAST PAY INCREASE: **N/A** IF WITHIN LAST YEAR, COMPLETE #9A

If the injured worker did not perform any other work during the year and his occupation on the date of injury is not available throughout the year, average his gross earnings then multiply times (x) 2 months (the number of months in the season) and divide (÷) by 12 months to determine his average monthly wage.

It is important to remember that seasonal employment is generally defined by the occupation of the injured worker, not the availability of work with a particular employer. While the employer may only be in business certain times of the year, the occupation of the worker may be available year round and, therefore, the occupation would not be considered seasonal.

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

____ FROM ____ THRU ____ $ ____ AMT.

____ FROM ____ THRU ____ $ ____ AMT.

TOTAL OF ABOVE: $ ____ ÷ ____ (DAYS) = $ ____ X **30.416*** = $ ____ AVG.

12. COMBINED EARNINGS FROM ITEMS: ____ + ____ + ____ + ____

TOTAL OF ABOVE: $ ____ ÷ ____ (DAYS) = $ ____ X **30.416*** = $ ____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ ____ OTHER: $ ____ = $ ____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: ____ + ____ + **8** = $ **1,155.10**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

NOT SEASONAL

(Injured worker has other earnings during remainder of year)

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED
(IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **6-24-23**
ICA Case No.: **23745-077109**
Soc. Sec. No.: **719-54-1960**
Carrier Claim No.: **W/C-B06**
Employer: **Dee Dee's Farm**
Date Injured: **6-2-23**

1. CLAIMANT: **Howard Smith** 2. OCCUPATION: **Watermelon Picker**

3. DATE OF HIRE: **2-2-18** 4. DEPENDENTS? [ ] YES [X] NO

5. EMPLOYMENT STATUS: [ ] STEADY [ ] INTERMITTENT [X] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **13.85** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **HOURS VARY** x ____ x ____ = $ ____ AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ **1,669.53**

8. EARNINGS WITH INSURED EMPLOYER: FROM: **2-1-23** THRU: **6-1-23**

AMOUNT: $ **7,299.26** ÷ **121** (DAYS) = $ **60.32** x **30.416*** = $ **1,834.69** AVG.

9. DATE OF LAST PAY INCREASE: **N/A** IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM ____ THRU ____

AMOUNT: $ ____ ÷ ____ (DAYS) = $ ____ x **30.416*** = $ ____ AVG.

If the injured worker performed other work during the year, complete line #11. Note: In this example the injured worker was not performing both jobs at the time he was injured.

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

Don's Farms FROM **8-31-22** THRU **1-31-23** $ **7,183.25** AMT.

____ FROM ____ THRU ____ $ ____ AMT.

TOTAL OF ABOVE: $ ____ ÷ ____ (DAYS) = $ ____ X **30.416*** = $ ____ AVG.

12. COMBINED EARNINGS FROM ITEMS: **8** + **11** + ____ + ____

TOTAL OF ABOVE: $ **14,482.51** ÷ **275** (DAYS) = $ **52.66** X **30.416*** = $ **1,601.71** AVG.

($7,299.26 + $7,183.25 = $14,482.51)

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ ____ OTHER: $ ____ = $ ____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: ____ + ____ + **12** = $ **1601.71**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

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MINOR STUDENT

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED
(IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **8-2-23**
ICA Case No.: **21586-114002**
Soc. Sec. No.: **707-43-9858**
Carrier Claim No.: **W/C-A06**
Employer: **Barn's Market Store**
Date Injured: **7-18-23**

1. CLAIMANT: **Harriet Smith** 2. OCCUPATION: **Bagger**

3. DATE OF HIRE: **5-27-23** 4. DEPENDENTS? [ ] YES [X] NO

5. EMPLOYMENT STATUS: [ ] STEADY [ ] INTERMITTENT [ ] SEASONAL [X] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **13.85** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **13.85** x **25 = $346.25** x **4.333** = $ **1,500.30** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ **1,375.00**

8. EARNINGS WITH INSURED EMPLOYER: FROM: **5-27-23** THRU: **7-17-23**

AMOUNT: $ **2,600.00** ÷ **52** (DAYS) = $ **50.00** x **30.416*** = $ **1,520.80** AVG.

9. DATE OF LAST PAY INCREASE: **N/A** IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM _____ THRU _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

If the injured worker goes to school full time, works part-time during the summer months in an occupation available throughout the year, and is injured during the temporary summer employment, this sample would apply.

It would be incorrect to multiple times 3 months and divide by 12 months because the temporary employment is available throughout the year. Stanton v. Industrial Comm'n, 116 Ariz. 1, 567 P.2d 317 (1977).

If the injury results in permanent disability, the average monthly wage must be re-established based upon earnings the injured worker could have earned at age 18. A.R.S. § 23-1042.

12. COMBINED EARNINGS FROM ITEMS: _____ + _____ + _____ + _____

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ _____ OTHER: $ _____ = $ _____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + _____ + **8** = $ **1,520.80**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

TEACHER -CONTRACT

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED
(IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **3-30-23**
ICA Case No.: **23009-000021**
Soc. Sec. No.: **708-63-7543**
Carrier Claim No.: **W/C-A09**
Employer: **Daniel Webster Elem. School**
Date Injured: **3-2-23**

1. CLAIMANT: **Harriet Smith**
2. OCCUPATION: **Teacher**
3. DATE OF HIRE: **08-12-21**
4. DEPENDENTS? [ ] YES [X] NO
5. EMPLOYMENT STATUS: [ ] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR
5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**
6. BASE RATE OF PAY: $ **38,100.00** **(Per Contract)** PER: [ ] HOUR [ ] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE
PER ABOVE: $ _____ x _____ x _____ = $ _____ AVG.
7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ _____
8. EARNINGS WITH INSURED EMPLOYER: FROM: **8-12-22** THRU: **5-30-23**
AMOUNT: $ **38,100.00** ÷ **292** (DAYS) = $ **130.48** x **30.416*** = $ **3,968.67** AVG.
9. DATE OF LAST PAY INCREASE: **N/A** IF WITHIN LAST YEAR, COMPLETE #9A
9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM _____ THRU _____
AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.
10. WAGE PATTERNS OF OTHER EMPLOYEES OF INSURED EMPLOYER:

Calculate the average monthly wage by using only the number of days in the contract period. Powell v. Industrial Comm'n, 104 Ariz. 257, 451 P.2d 37 (1969).

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)
_____ FROM _____ THRU _____ $ _____ AMT.
_____ FROM _____ THRU _____ $ _____ AMT.
TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.
12. COMBINED EARNINGS FROM ITEMS: _____ + _____ + _____ + _____
TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.
13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:
BOARD & LODGING: $ _____ OTHER: $ _____ = $ _____
14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + _____ + **8** = $ **3,968.67**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

CONCURRENT EMPLOYMENT

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED
(IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **3-29-23**
ICA Case No.: **22922-980056**
Soc. Sec. No.: **773-54-0123**
Carrier Claim No.: **W/C-B17**
Employer: **Rich's Fine Dining**
Date Injured: **3-1-23**

1. CLAIMANT: **Howard Smith** 2. OCCUPATION: **Cook**

3. DATE OF HIRE: **11-30-16** 4. DEPENDENTS? [ ] YES [X] NO

5. EMPLOYMENT STATUS: [X] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [X] YES [ ] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **15.00** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **15.00** x **40 = $600.00** x **4.333** = $ **2,599.80** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ **2,572.92**

8. EARNINGS WITH INSURED EMPLOYER: FROM: **3-1-22** THRU: **2-28-23**

AMOUNT: $ **31,258.60** ÷ **365** (DAYS) = $ **85.64** x **30.416*** = $ **2,604.83** AVG.

9. DATE OF LAST PAY INCREASE: **N/A** IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM _____ THRU _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

Use earnings from multiple concurrent employments, similar or dissimilar, when calculating the average monthly wage as long as the earnings are from covered employment. Wiley v. Industrial Comm'n, 174 Ariz. 94, 847 P.2d 595 (1993). Do not exceed maximum average monthly wage.

Always place concurrent earnings on Line 11. Do not place on Line 12 as this would not be fair to the injured worker.

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

Harry's Place FROM **12-8-22** THRU **2-28-23** $ **2,595.65** AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ **2,595.65** ÷ **83** (DAYS) = $ **31.27** X **30.416*** = $ **951.11** AVG.

12. COMBINED EARNINGS FROM ITEMS: _____ + _____ + _____ + _____

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ _____ OTHER: $ _____ = $ _____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + **8** + **11** = $ **3,555.94**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

MORE THAN ONE EMPLOYER, NOT CONCURRENT EMPLOYMENT

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED (IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **3-17-23**
ICA Case No.: **20951-456022**
Soc. Sec. No.: **713-26-1946**
Carrier Claim No.: **W/C-136**
Employer: **Hard Rock Construction**
Date Injured: **3-1-23**

1. CLAIMANT: **Howard Smith** 2. OCCUPATION: **Laborer**

3. DATE OF HIRE: **10-6-16** 4. DEPENDENTS? [ ] YES [X] NO

5. EMPLOYMENT STATUS: [X] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **20.00** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **HOURS VARY** x ____ x ____ = $ ____ AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ **5,050.00**

8. EARNINGS WITH INSURED EMPLOYER: FROM: **3-1-22** THRU: **2-28-23**

AMOUNT: $ **45,000** ÷ **365** (DAYS) = $ **123.29** x **30.416*** = $ **3,749.99** AVG.

9. DATE OF LAST PAY INCREASE: **NA** IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM ____ THRU ____

AMOUNT: $ ____ ÷ ____ (DAYS) = $ ____ x **30.416*** = $ ____ AVG.

10. WAGE PATTERNS OF OTHER EMPLOYEES OF INSURED EMPLOYER:

____ FROM ____ THRU ____ $ ____ AMT.

____ FROM ____ THRU ____ $ ____ AMT.

TOTAL OF ABOVE: $ ____ ÷ ____ (DAYS) = $ ____ X **30.416*** = $ ____ AVG.

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

A (106 Days) FROM **8-27-22** THRU **12-10-22** $ **4,441.56** AMT.

B (38 Days) FROM **1-4-23** THRU **2-10-23** $ **2,904.22** AMT.

TOTAL OF ABOVE: $ ____ ÷ ____ (DAYS) = $ ____ X **30.416*** = $ ____ AVG.

12. COMBINED EARNINGS FROM ITEMS: **8** + **11** + ____ + ____

TOTAL OF ABOVE: $ **52,345.78** ÷ **365** (DAYS) = $ **143.41** X **30.416*** = $ **4361.96** AVG.

($45,000 + $4,441.56 + $2,904.22 = $52,345.78)

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ ____ OTHER: $ ____ = $ ____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: ____ + ____ + **12** = $ **4361.96**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

DEDUCTING PERIODS OF TIME

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED (IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **4-16-23**
ICA Case No.: **23123-058241**
Soc. Sec. No.: **733-54-0022**
Carrier Claim No.: **W/C-18**
Employer: **Bob's Construction Co.**
Date Injured: **3-1-23**

1. CLAIMANT: **Harriet Smith** 2. OCCUPATION: **Driver**

3. DATE OF HIRE: **4-22-16** 4. DEPENDENTS? [ ] YES [X] NO

5. EMPLOYMENT STATUS: [X] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **16.45** PER: HOUR [X] DAY [ ] WEEK [ ] MONTH [ ] PIECE RATE [ ]

PER ABOVE: $ **16.45** x **40 = $658.00** x **4.333** = $ **2,851.11** AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ **2,889.25**

8. EARNINGS WITH INSURED EMPLOYER: FROM: **3-1-22** THRU: **2-28-23**

AMOUNT: $ **32,225.10** ÷ **323** (DAYS) = $ **99.77** x **30.416*** = $ **3,034.60** AVG.

9. DATE OF LAST PAY INCREASE: **N/A** IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM _____ THRU _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

Deducting period 6-7-22 - 7-18-22 due to personal medical

Omit periods of time during which the injured worker did not work for reasons over which he or she had no control, and where the loss of time was not a common and ordinary incident to the particular employment. Pettis v. Industrial Comm'n, 91 Ariz. 298, 372 P.2d 72 (1962).

For example, days off during a strike period are subtracted. Time off due to layoffs or slack periods, voluntary removal from the labor market or time taken off by personal choice is not subtracted. Time off due to personal illness, industrial or non-industrial injuries may be subtracted.

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

12. COMBINED EARNINGS FROM ITEMS: _____ + _____ + _____ + _____

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ _____ OTHER: $ _____ = $ _____

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + _____ + **8** = $ **3,034.60**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

BOARD & LODGING

INDUSTRIAL COMMISSION OF ARIZONA

AVERAGE MONTHLY WAGE CALCULATION

(Subject to Final Determination By The Industrial Commission Upon Issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU #9 AND #14 SHALL BE COMPLETED
(IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: **3-7-23**
ICA Case No.: **23124-036901**
Soc. Sec. No.: **625-88-9735**
Carrier Claim No.: **W/C-19**
Employer: **D's Crops**
Date Injured: **2-3-23**

1. CLAIMANT: **Howard Smith**
2. OCCUPATION: **Farm Manager**
3. DATE OF HIRE: **5-11-15**
4. DEPENDENTS? [X] YES [ ] NO
5. EMPLOYMENT STATUS: [X] STEADY [ ] INTERMITTENT [ ] SEASONAL [ ] PART-TIME [ ] MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? [ ] YES [X] NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ **2,450.00** PER: HOUR [ ] DAY [ ] WEEK [ ] MONTH [X] PIECE RATE [ ]

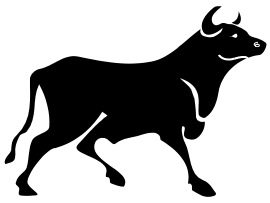
PER ABOVE: $ _____ x _____ x _____ = $ _____ AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ _____

8. EARNINGS WITH INSURED EMPLOYER: FROM: _____ THRU: _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

Horse: 4 x $400.00 = $1,600.00 value



Bull: 4 x $500.00 = $2,000.00 value

Vehicle: 12 x $500.00 = $6,000.00 value

Board & Lodging: $700.00

$1,600.00 + $2,000.00 + $6,000.00 = $9,600.00 ÷ 12 = $800.00

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ **700.00** OTHER: $ **800.00** = $ **1,500**

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + **6** + **13** = $ **3,950.00**

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the Commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

FATALITIES

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Fatality Claims

Fatality

Reporting Requirements

When an accident occurs resulting in a fatality, the employer shall notify the ICA no later than the next business day following the death. See A.A.C. R20-5-110, A.R.S. § 23-1046, A.R.S.§ 23-1061(A) and A,R,S,§ 23-1064. Arizona Department of Occupational Safety and Health (ADOSH) must be notified within (8) eight hours, *see* 29 CFR 1904.39(a)(1).

- After receiving a report of a fatality, the Claims Division will mail a *Claim for Dependents Benefits – Fatality* form to the estate of the deceased worker. (*See* sample within this section.)

Addressing communications to the deceased injured worker

- Payer and Commission communications not being issued directly to a dependent are to be addressed as follows,
    - First Name Last Name, Decedent.

Claim for Dependent Benefits

Surviving dependents of the deceased worker must file a *Claim for Dependent's Benefits – Fatality (120)* form with the Commission to secure benefits. The ICA will notify the payer of the filing of the claim upon receipt. [A.R.S.§ 23-1061(A)]

Compensability of all fatality claims must be determined by the payer's issuance of a Form 104 no later than the 21st day after ICA notification.

- When a claim for dependent benefits has been filed, the payer may require copies of the following documents to investigate the claim:
    - Marriage certificate,
    - Divorce decrees of any prior marriages
    - Birth certificates of any dependent children
    - Death certificate of the deceased worker.

Best Practice:

More than one notification on a fatality may be received as a result of multiple claims filed by the dependents. If this is the case, issue separate notices to each person who filed a claim for benefits.

Samples for Dependent Payment

Sample:	Example
Single Dependent	$4521.92 AMW x .6667 $3014.764 (rounded) 3014.76

Payable Monthly

Sample:	Example
Widow(er) + Dependent Single Household i.e., Widow is guardian of Dependent	$4521.92 AMW x .6667 $3014.764 (rounded) 3014.76

Payable Monthly

Sample:	Example
Widow(er) + 2 dependents, ***2 separate households.*** Max Benefits 66 2/3% of AMW 35% Widow 31 2/3% Share and Share Alike 2 dependents 31 2/3% = .3167 / 2 = .15835 of the AMW	***Household 1:*** ***Widow +1 dependent*** *Widow* $4521.92 AMW x 35% (rounded) 1582.67 *Dependent 1* $4521.92 AMW x.15835 716.05 (rounded) 1582.67 + 716.05 =2298.72 monthly **Household 2:** **1 dependent** $4521.92 AMW x.15835 716.05 (rounded) Monthly

Payable Monthly

Accepting a Fatality Claim

If the claim is accepted, the payer must take the following actions:

- Form 104 - Accepting Claim for Benefits use line #11 when accepting a fatality claim.
- Form 108 - Calculate the deceased worker's average monthly wage
- Form 106 – Fatality establishing the benefits to which the dependents are entitled, as applicable.

Multiple Dependents in Different Households

The Commission will notify the payer of each dependent as the filing for Dependent Benefits are received. In the case of multiple households, the carrier is responsible to respond to each notification with a separate notice accepting or denying each individual dependent, when they are in different households. The 104 and 106 are to list the dependent (in care of any guardian) listed in the Injured Worker area. If they are in the same household, the claim may be accepted on the same 104 and 106. See the examples below for the wording provided for sample scenarios.

Burial Expenses

The payer is responsible for burial expenses, not to exceed $5,000.00, along with all industrial medical expenses incurred prior to the worker's death. The amount payable for burial expenses is determined as of the date of death, not the date of the injury. *See Kisco, Inc. v. Industrial Comm'n, 190 Ariz. 389, 949 P.2d 49 (App. 1997).* When the claim is for burial benefits alone with no dependents, the 104 can be addressed to the deceased injured worker with "To the Personal Representative of" before their name.

Dependent Benefits

In the event there are surviving dependents, benefits are payable under A.R.S. § 23-1046(A) (1) and (2). *See* samples below for payment details.

- On January 06, 1994, the Arizona Supreme Court issued opinions regarding the interpretation of A.R.S. § 23-1064(B). Dependency will be determined as of the date of death, not the date of the initial injury. *Rico v. Industrial Comm'n*, 177 Ariz. 197, 866 P.2d 865 (1994) and *Dunn v. Industrial Comm'n*, 177 Ariz. 190, 866 P.2d 858 (1994).
- For dates of injury occurring on or after September 27, 1990, A.R.S. § 23-1046 extends dependent death benefits from age 18 to age 22 if the surviving child is enrolled as a full-time student in any accredited educational institution.
- *For partial dependency claims*, the payer should forward **Form 107** #3 or #4 to the ICA with all available information regarding the extent of the dependency, *see* A.R.S. § 23-1046(B).
- Effective September 19, 2007, benefits payable to a single surviving child and no surviving spouse were increased and benefits payable to multiple surviving children and no surviving spouse are to be divided equally.

Denying a Fatality Claim

If the claim is non-compensable and the claim has been legally filed by the dependents/injured worker., the payer must take the following actions:

- Form 104 – Checking #2 Denying the claims for benefits. Box #11 can be used to outline any/all dependents as indicated (see below).

Both Accepting and Denying Fatality Benefits

In some cases, a fatality claim may be compensable but some or all of the dependent benefits are not compensable. Follow the prior instructions for accepting/denying the claim ensuring that each dependent (from different households) receives a 104 clearly defining which portions of the claim are accepted and which are denied.

Remarriage of Surviving Spouse

In the event and at the time of remarriage the surviving spouse is *due two years of the monthly entitlement* (35% of the AMW if there is a dependent child, 66 2/3% of the AMW if the child is no longer receiving benefits) payable in one lump sum.

In the event of the death or subsequent remarriage of the surviving spouse, the benefits payable to the surviving children must be considered independent and recalculated immediately as of the date of death or remarriage. *See Self v. Industrial Comm'n*, 192 Ariz. 399, 966 P.2d 1003 (App. 1998)

Best Practice:
See our YouTube Video: Fatality Process to supplement this chapter

BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA

CLAIM FOR DEPENDENT'S BENEFITS – FATALITY

CHECK APPROPRIATE BOX:

- ☐ SPOUSE
- ☐ SPOUSE WITH DEPENDENT CHILDREN
- ☐ DEPENDENT CHILDREN *(Must be filed by guardian)*
- ☐ PARENTS
- ☐ OTHER DEPENDENTS
- ☐ BURIAL EXPENSE ONLY

INFORMATION REGARDING DECEASED:

1. Name of Deceased: _____ Soc. Sec. # *: _____
2. Date of Birth: _____ Date of Death: _____
3. Date of Injury: (If different from date of death): _____
4. Deceased's Address: _____
5. Employer at time of death: _____
   Employer's address: _____
6. Briefly state cause of death: _____
7. List name and address of health care providers that treated deceased in the last two years and state condition treated:

CLAIM FOR SPOUSAL BENEFITS: *(Provide certified copy of marriage certificate.)*

1. Your Full Name: _____ Date of Birth: _____
2. Your Address: _____
3. Date of Marriage to Deceased: _____
   Place of Marriage: _____
4. Were You or Deceased Married Previously? ☐ Yes ☐ No If yes, state details and provide copies of divorce decrees. _____

(Rev. 1/02)

5. Did you reside with deceased at time of death? ☐ Yes ☐ No If living apart provide reason, such as divorced, divorce pending, annulment, abandonment. _____

_____

_____

CLAIM FOR DEPENDENT CHILDREN: *(Provide certified copies of birth certificates.)*

1. List *dependent* children:

NAME	DATE OF BIRTH	RELATIONSHIP TO DECEASED	ADDRESS AT TIME OF DEATH

2. Which of these children are still in your care and custody? _____

_____

3 Is a posthumous (unborn) child expected? ☐ Yes ☐ No If yes provide anticipated date of delivery:

_____

OTHER DEPENDENTS:

1. Name: _____
2. Address: _____

_____

3. Relationship to Deceased: _____
4. Extent of Dependency: ☐ Full ☐ Partial Please give details: _____

_____

_____

_____ _____

DATE SIGNATURE OF/OR ON BEHALF OF DEPENDENT

_____

TELEPHONE NUMBER

To be filed at either office of the Industrial Commission:

Phoenix Office: Industrial Commission of Arizona
800 W. Washington Street
Phoenix, Arizona 85007-2922

P. O. Box 19070
Phoenix, Arizona 85005-9070

Tucson Office: Industrial Commission of Arizona
2675 E. Broadway
Tucson, Arizona 85716-5342

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT CLAIMS AT (602) 542-4661.

NOTICE OF PERMANENT DISABILITY OR DEATH BENEFITS

Carrier or Self-Insured Name and Address	ICA Claim No. _____
	Soc. Sec. No. _____
Authorized Third Party Administrator Name and Address	Carrier Claim No. _____
	Employer: _____
Claimant's Name and Address	Address: _____
	Date Injured: _____

You are hereby notified that the above-named insurance carrier has determined that you are entitled to the following Permanent Disability or Death Benefits:

1. Statute under which compensation is payable: A.R.S. 23 - 1046
2. Percentage and type of disability: Fatality
3. Amount of compensation and method of payment:

Mailed On: By:

Copy to: Industrial Commission of Arizona (Authorized Representative) Tel. #:

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

AVISO AL RECLAMANTE: Si usted no esta de acuerdo con este AVISO, y desea una audiencia en este caso, su peticion por escrito pidiendo una audiencia debera ser recibida en cualquira de las oficinas de la Comision Industrial a las direcciones abajo indicadas dentro de NOVENTA (90) DIAS despues de la fecha de este AVISO, de acuerdo con las leyes A.R.S. 23-941 y 23-947. SI DICHA PETICION NO ESTA RECIBIDA DENTRO DEL PERIODO DE NOVENTA (90) DIAS, ESTE AVISO SERA CONSIDERADO FINAL.

Phoenix Office:
Industrial Commission of Arizona
800 W Washington Street
Phoenix, Arizona 85007-2922

PO Box 19070
Phoenix, AZ 85005-9070

Tucson Office
Industrial Commission of Arizona
2675 E Broadway
Tucson, Arizona 85716-5342

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 0106 - Rev 6/2019

Sample 106 Fatality Language

Fatality Samples

Spouse Only, No Children
Dependent upon the deceased at the time of death were the following:

(Surviving Spouse's Name)

The sum of $_____ monthly (66 2/3% of the AMW), the first payment effective as of the day after the death of deceased to continue until the death or remarriage of (name of spouse), and the payment in one sum of $_____ (2 years of 66 2/3% of AMW) in the event and at the time of remarriage. A.R.S. § 23-1046(A)(3).

Surviving Spouse, One Child
Dependent upon the deceased at the time of death were the following:

_____
(Surviving Spouse's Name)

_____
(Child + Date of Birth)
The sum of $_____ monthly (35% of the AMW) for the surviving spouse and the further sum of $_ (31 2/3% of the AMW) for the child until the child reaches the age of 18 years or until the age of 22 years if the child is enrolled as a full-time student in any accredited educational institution or if over 18 years and incapable of self-support until the child becomes capable of self-support. The first payment effective as of the day after the death of the deceased. A.R.S. § 23-1046(A)(2).

If a guardian has been appointed, in the above paragraph insert the following: The further sum of $_____ for the minor child, payable to (name of guardian), guardian of said minor child, the first payment effective _____

In the event and at the time of remarriage the surviving spouse is due two years of the monthly entitlement (35% of the AMW if there is a dependent child, 66 2/3% of the AMW if the child is no longer receiving benefits) payable in one lump sum.

In the event of remarriage or death of a surviving spouse the monthly entitlement for the dependent child will increase from 31 2/3% of the AMW to 66 2/3% of the AMW. A.R.S. § 23-1046(A)(3).

Surviving Spouse, Two Children
Dependent upon the deceased at the time of death were the following:

_____
(Surviving Spouse's Name)

_____
(First Child + Date of Birth)

_____
(Second Child + Date of Birth)

If a guardian has been appointed, in the above paragraph insert the following: The further sum of $_____for the minor children, payable to (name of guardian), guardian of said minor children, the first payment effective_____

In the event and at the time of remarriage the surviving spouse is due two years of the monthly entitlement (35% of the AMW if there are dependent children, 66 2/3% of the AMW if the children are no longer receiving benefits) payable in one lump sum.

In the event of remarriage or death of a surviving spouse the monthly entitlement for dependent children will increase from 31 2/3% of the AMW to 66 2/3% of the AMW. A.R.S. § 23-1046(A)(3).

Surviving Spouse, Three or More Children

Dependent upon the deceased at the time of death were the following:

_____
(Surviving Spouse's Name)

_____
(First Child + Date of Birth)

_____
(Second Child + Date of Birth)

_____
(Third Child + Date of Birth)

The sum of $_____monthly (35% of the AMW) for the surviving spouse and the further sum of $ _____ (31 2/3% of the AMW) for the children on a share and share alike basis until the last child reaches the age of 18 years or until the age of 22 years if the child is enrolled as a full-time student in any accredited educational institution or if over 18 years and incapable of self-support until the child becomes capable of self-support. The first payment effective as of the day after the death of the deceased. A.R.S. § 23-1046(A)(2).

If a guardian has been appointed, in the above paragraph insert the following: The further sum of $_____for the minor children, payable to (name of guardian), guardian of said minor children, the first payment effective _____.

In the event and at the time of remarriage the surviving spouse is due two years of the monthly entitlement (35% of the AMW if there are dependent children, 66 2/3% of the AMW if the children are no longer receiving benefits) payable in one lump sum.

In the event of remarriage or death of a surviving spouse the monthly entitlement for dependent children will increase from 31 2/3% of the AMW to 66 2/3% of the AMW. A.R.S. § 23-1046(A)(3).

Surviving Children, No Surviving Spouse or
Surviving Spouse Subsequently Dies or Remarries
*(Effective Date of Death 9-19-07 going forward***)**
***If there is more than one child, the amount is on a share and share alike basis*.**

Dependent upon the deceased at the time of death are the following:

_____ 66 2/3% of the AMW
(One child)

The above stated amount until each child reaches the age of 18 years or until the age of 22 years if the child is enrolled as a full-time student in any accredited educational institution or if over 18 years and incapable of self-support until the child becomes capable of self- support until the last remaining child is receiving the amount of 66 2/3% of the AMW. A.R.S. § 23-1046(A)(3).

Compensation to any child shall also stop upon death or marriage of child prior to normal termination date.

If a guardian has been appointed, in the above paragraph insert the following: The further sum of $_____ for the minor children, payable to (name of guardian), guardian of said minor children, the first payment effective _____

Surviving Children Only with No Surviving Spouse or Surviving Spouse Dies or Remarries. *Version of A.R.S. § 23-1046 (1999), prior to its amendment by A.R.S. § 23-1046 (2007)

The total amount payable cannot exceed 66 2/3% of the AMW and the amount is on a share and share alike basis.

Dependent upon the deceased at the time of death are the following:
_____25% of the AMW
(One child)
_____ An additional 15% of the AMW
(Second child)
_____ An additional 15% of the AMW
(Third child)
_____ An additional 11 2/3% of the AMW
(Fourth child)

The above stated amounts are reduced as each child reaches the age of 18 year or until the age of 22 years if the child is enrolled as a full-time student in any accredited educational institution or if over 18 years and incapable of self-support until the child becomes capable of self-support with the amount being reduced until the last remaining child is receiving the amount of 25% of the AMW. A.R.S. § 23-1046(A)(2).

Compensation to any child shall also stop upon death or marriage prior to normal termination date.

If a guardian has been appointed, in the above paragraph insert the following: The further sum of $_____ for the minor children, payable to (name of guardian), guardian of said minor children, the first payment effective_____

Survivors Intend to Pursue a Cause of Action Against a Third Party

The surviving dependents may pursue a cause of action against a third party pursuant to A.R.S. § 23-1023(A-E). In this situation, the payer or the Special Fund Division/No Insurance Section has a lien on the amount collectible from the third party equal to the benefits already awarded and paid. Thereafter, the payer or the Special Fund Division/No Insurance Section is only liable to contribute the deficiency between the remaining amount collectible and benefits payable.

PERMANENT AWARDS

Table of Contents

Permanent Disability Awards

Closing with Permanent Impairment

Determining Scheduled or Unscheduled Closure

Closing with Permanent Impairment
A doctor may determine there is permanent impairment when discharging from care. This impairment must be decided on the most recent version of AMA Guides to the Evaluation of Permanent Impairment R20-5-113. The following instructions may be used to determine if the claim is scheduled or unscheduled.

Scheduled Definition
Scheduled permanent disabilities are outlined in A.R.S. § 23-1044(B) (1-22) and determined when the injured worker is deemed medically stationary (AKA at maximum medical improvement).

Unscheduled Definition
A.R.S. § 23-1044(C) provides for disabilities not enumerated in A.R.S. § 23-1044(B), such as injuries resulting in permanent impairment to the shoulder, spine, or back.

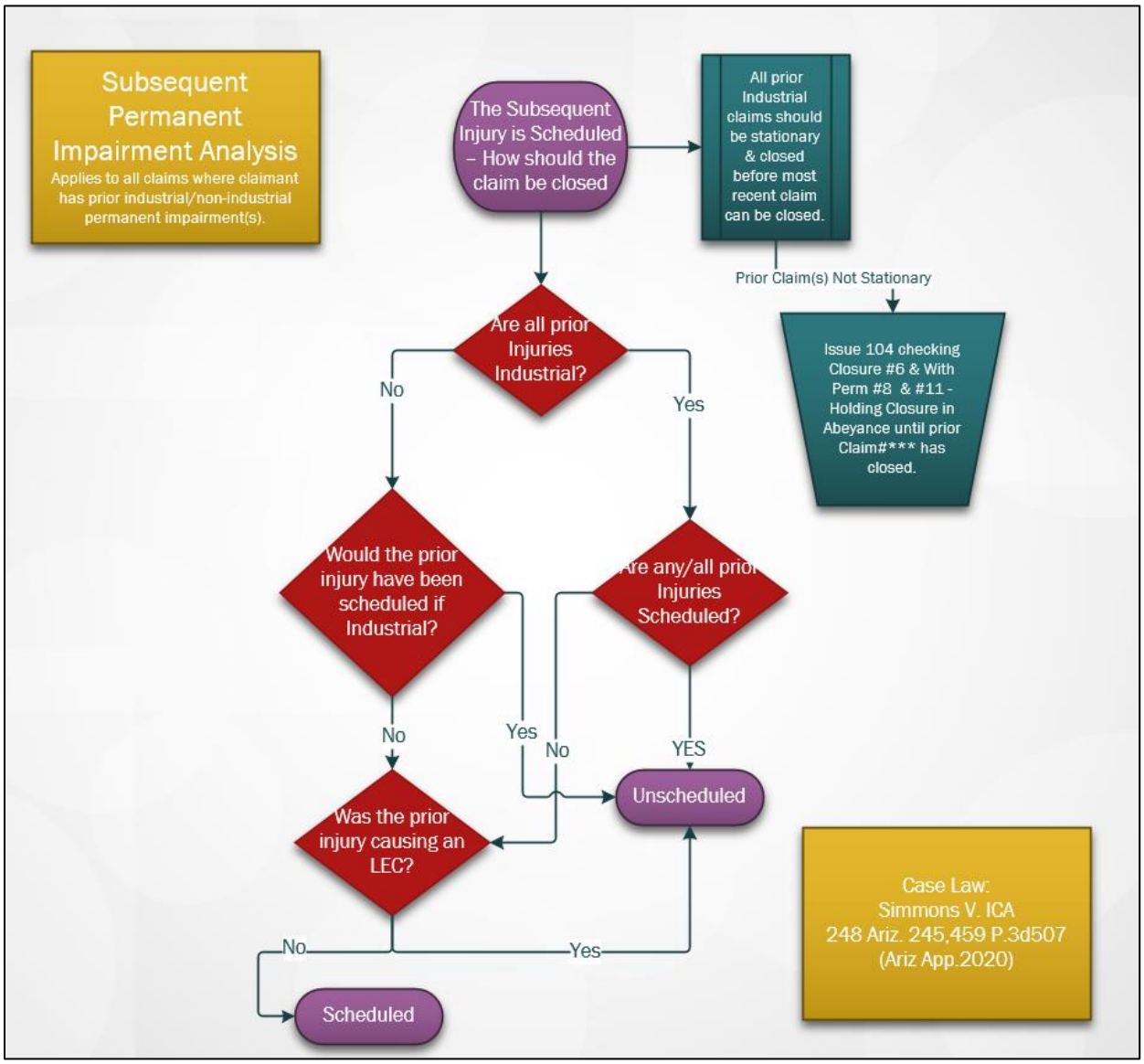
Prior claims with permanent impairment can cause a scheduled type of permanent impairment to result in unscheduled disabilities.

Applicable Case Laws that can convert a Scheduled type of injury to an Unscheduled injury.

- If a physician assigns an impairment rating to two or more body parts not of the same extremity, the claim converts to an unscheduled injury. *Ossic v. Verde Central Mines*, 46 Ariz. 176, 49 P.2d 396 (1935).
- …"the combined effects of the original injury on all portions of the body should be considered. Pain, swelling, or any other impairment to an unscheduled portion of the body, if it affects function at all, transforms a scheduled injury into an unscheduled injury." *Dye v. Industrial Comm'n of Arizona*, 153 Ariz. 292, 736 P.2d 376 (1987).
- A worker has a previously scheduled injury with permanent impairment and subsequently suffers another industrial injury to a scheduled body part that results in additional impairment, then the permanent partial disability (PPD) for the second injury will be determined on an unscheduled basis. (*Ronquillo v. Industrial Comm'n* 107 Ariz. 542). This is true even if the first and second industrial claims pertain to the same extremity, as long as the second injury results in additional impairment. (*Rodgers v. Industrial Comm'n* 109 Ariz. 216)
- Prior, out-of-state industrial injuries can also potentially "unschedule" a normally scheduled injury. If the prior injury in another state was a scheduled-type injury and subject to a final award or judgement. The subsequent scheduled Arizona injury is automatically unscheduled for the determination of PPD benefits because the same conclusive presumption under *Ronquillo* applies to the first injury. (*Young v Industrial Comm'n, 204 Ariz.267)*
  - This may not apply if the prior industrial injury was not subject to a final award or judgment by the respective state's workers' compensation administrative entity or a higher court. (*PFS v. Indus. Comm'n* 191 Ariz. 274)

- If there is a prior Unscheduled claim with a Loss of Earning Capacity, then the subsequent scheduled injury becomes unscheduled. If the prior Unscheduled claim has no LEC, then the subsequent stays scheduled. If the prior injury is non-industrial there are two possibilities - if the injury would have been scheduled in AZ if it were an industrial injury, then it is presumed to be an earning capacity disability, and the subsequent injury becomes unscheduled. If the prior nonindustrial injury would not have been a scheduled injury the applicant must show an actual loss of earning capacity from the prior injury at the time of the second injury. (*Simmons v Industrial Comm'n,* 248 Ariz. 245,459 P.3d507 (Ariz App.2020)*)*

To determine if the subsequent permanent impairment closure should be scheduled or unscheduled, please follow flowchart noted below.



Scheduled vs. Unscheduled Flow Chart

Scheduled Permanent Impairment

Scheduled Injuries and Use of Form 106

Scheduled permanent disabilities are outlined in A.R.S. § 23-1044(B) (1-22) and determined when the injured worker is deemed medically stationary (AKA at maximum medical improvement).

The physician who rates the percentage of impairment is to use the standards for the evaluation of permanent impairment as published by *the most recent edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment*, if applicable. [A.A.C. R20-5-113(B)]

All scheduled awards must be calculated using the *established average monthly wage* for the claim. If the wage has not been established, this should be set now, and the Scheduled Award may be paid at the estimated rate from the 108 and adjusted later should the average monthly wage is approved at a different rate.

Scheduled awards are paid on a monthly basis. A scheduled award may be paid in full by the payer *if the balance of the award does not exceed 3.5 months*. If the balance exceeds 3.5 months and the injured worker wishes to commute the award to a lump sum, please refer to 'Lump Sum Commutations' section and the 'Life Tables' tab. The payer may also voluntarily elect to pay the balance without requiring the injured worker to apply for a commutation.

A scheduled disability award is payable in full to the personal representative of the estate upon the death of an injured worker; whether the award is issued before or after the injured worker's death. *Reed v. Industrial Comm'n, 104 Ariz. 412, 454 P .2d 157 (1969).*

When a notice is issued for an award of permanent compensation benefits under A.R.S. § 23-1044(B), the **benefits must be paid according to the notice and cannot be interrupted if there is a request for hearing or an ongoing appeal to a higher court.** Any resulting overpayment of these benefits shall be credited against any future liability for compensation benefits that may arise out of the same claim. (A.R.S. § 23-953)

Calculating Scheduled Impairment: Percentage of Average Monthly Wage
Under A.R.S.23-1044 (B)(1-22), scheduled permanent partial disability (PPD) is paid at various percentages of the claimant's Average Monthly Wage (AMW).

Best Practice:

When the physician assigns an impairment rating to two or more body parts not of the same extremity, the resulting disability becomes unscheduled. Ossic v. Verde Central Mines, 46 Ariz. 176, 49 P.2d 396 (1935)

When the physician discharges an injured worker and rates the impairment for two different parts of the same extremity (such as fingers, hand and arm) the injured worker is entitled to the award that provides the larger amount of compensation. Camis v. Industrial Comm'n, 4 Ariz. App. 312, 420 P.2d 35 (1966)

For injuries that result in the "partial loss of use" of a leg, foot, toe(s), arm, hand, or any finger(s), 50% of the AMW is used to determine the applicable monetary amount of PPD. However, if any of the scheduled-type body parts sustain a complete or partial amputation (must involve bone loss), then 55% of the AMW is utilized. Likewise, in situations involving hearing loss in one or both ears, loss of sight in one eye (with and without enucleation), facial scarring, and full or partial loss of teeth, 55% is used.

Significantly, if the injured worker's impairment medically precludes the injured worker from returning to the type of work performed at the time of injury, then 75% of the AMW is utilized. This is applicable whether the worker's impairment rating is based on a partial or complete loss of use or an amputation.

The following chart summarizes the correct use of the varying percentages:

% OF AMW	PER STATUTE	DEFINITION
50%	A.R.S. § 23-1044(B)(21)	Partial Loss of Use but Able to Return to Date of Injury Work
55%	A.R.S. § 23-1044(B) (1-20)	Total Loss of Use or Amputation but Able to Return to Date of Injury Work
75%	A.R.S. § 23-1044(B)(21)	Unable to Return to Date of Injury Work due to Medical Reasons Related to Loss of Use or Amputation
55%	A.R.S. § 23-1044(B)(22)	Total or Partial Tooth Loss and Facial Scarring

Closing a Claim with a Scheduled Permanent Impairment

- **Form 104** marking #'s 6 and 8, indicating on #6, the date of discharge from treatment.
    - This notice must be supported by a physician's report indicating the date of discharge and percentage of impairment.
- **Form 106** to establish the percentage of impairment and the amount payable for the number of months of entitlement. [A.R.S. § 23-1044]
- **Form 103** if any Supportive Medical Maintenance Benefits are recommended.

Best Practice:
See our YouTube Video: Scheduled Awards to supplement this chapter

Examples: Completing the 106 Calculations

Example 1

Functional Loss: partial loss of use under A.R.S. § 23-1044(B)(21)
15% functional loss of the index finger with an Average Monthly Wage of $4,000.00.

Functional Loss – Able to RTW

Formula:
Statute under which compensation is payable:
A.R.S. § 23-1044(B) (# Part of Body) (% of AMW Factor)
1. AMW x Functional Loss Factor per Statute = Monthly Value
2. Value of Injury x % of Impairment = Total Months of Benefits
3. Monthly Value x Total Months of Benefits = Total Award

Complete the following on the 106:
Statute under which compensation is payable:
A.R.S. § 23-1044(B) (2)

1. $4000 x 50% = $2000
2. 9 months (Index Finger) X 15% =1.35 months
3. 1.35 months x $2,000 = $2700

Example 1: Functional Loss – Able to Return to Work

Example 2

15% functional loss of the index finger with a wage of $4,000.00. Injured worker is unable to perform date of injury occupation because of partial loss of use of finger:

Functional Loss – Unable to RTW

Formula:
Statute under which compensation is payable:
A.R.S. § 23-1044(B) (# Part of Body) (% of AMW Factor)
1. AMW x Functional Loss Factor per Statute = Monthly Value
2. Value of Injury x % of Impairment = Total Months of Benefits
3. Monthly Value x Total Months of Benefits = Total Award

Complete the following on the 106:
Statute under which compensation is payable:
A.R.S. § 23-1044(B)(2)(21)
1. $4000 x 75% = $3000
2. 9 months X 15% =1.35 months
3. 1.35 months x $3000 = $4050

Example 2: Functional Loss - Unable to Return to Work

Example 3

100% functional loss of the index finger due to amputation with a wage of $4,000.00. Injured worker is able to perform date of injury occupation:

Total Functional Loss – Able to Return to Work

Formula:

Statute under which compensation is payable:
A.R.S. § 23-1044(B) (# Part of Body) (% of AMW Factor)

1. AMW x Functional Loss Factor per Statute = Monthly Value
2. Value of Injury x % of Impairment = Total Months of Benefits
3. Monthly Value x Total Months of Benefits = Total Award

Complete the following on the 106:

Statute under which compensation is payable:
A.R.S. § 23-1044(B) (2)

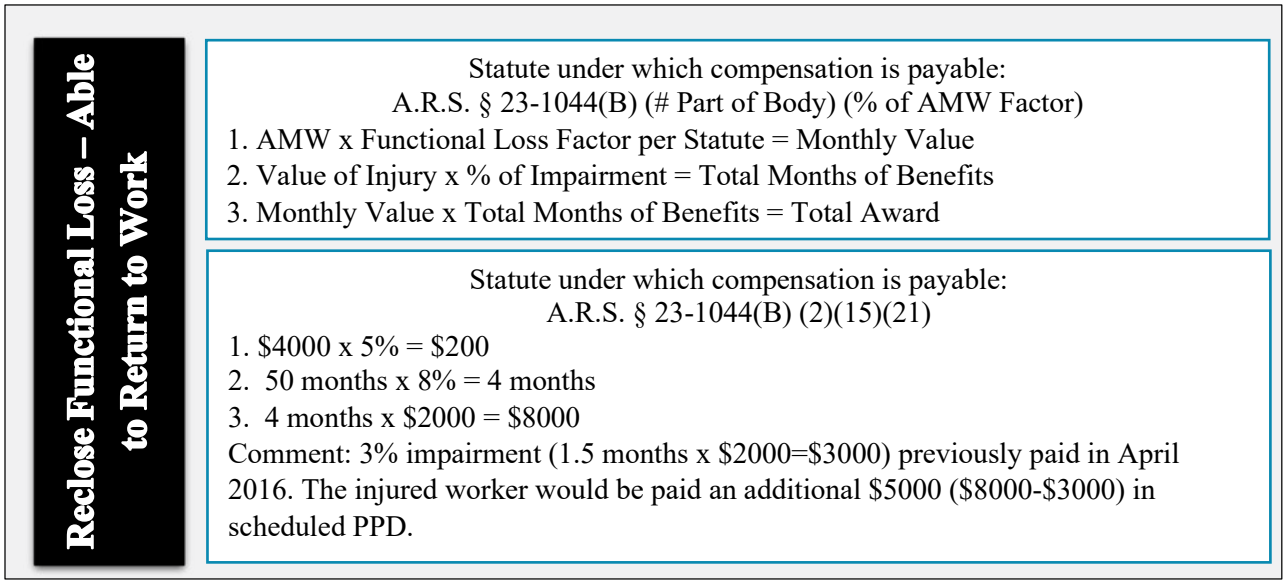
1. $4000 x 55% = $2200
2. 9 months X 100% =9 months
3. 9 months x $2200 = $19,800

Example 3 Amputation

Example 4

Closed Claim is Reopened and Additional Impairment is Applicable In this example, the claim is closing for a second time. When the claim was initially closed with a Form 104 issued on 04/02/16, the injured worker was paid a 3% functional loss for the right lower extremity and was able to return to work. A Petition to Reopen was later filed and accepted in 2018 for an additional surgery to the same leg, which ultimately resulted in an overall impairment rating of 8% to the right lower extremity, wherein the treating physician indicated in his discharge report that the additional 5 % in impairment related solely to the second surgery. The average monthly wage is $4,000. The injured worker is able to perform the date of injury occupation.

When a claim closes for the second time with permanent impairment, ensure the closing medical report detailing the permanent impairment is clear. The report should state the impairment is either additional to the prior impairment or includes the prior permanent impairment



Example 4: Reclosure with Additional Impairment

Example 5

Situations where a Closed Claim is Reopened and No Impairment is Applicable.

In this example, the claim is closing for a second time. When the claim was initially closed with a Form 104 issued on 08/02/20, the injured worker was paid a 3% functional loss for the right upper extremity and was able to return to work. A Petition to Reopen was later filed and accepted in 2021 for an additional surgery to the same elbow, which ultimately resulted in an overall impairment rating of the same 3% to the right upper extremity, wherein the treating physician indicated in his discharge report that there is no additional impairment due to the successful surgery.

The adjuster may:

- Close the claim using a 104 checking 6 & 8,
- Comment on line 11 stating that there is no additional permanent impairment
- Include medical records with the closure clearly stating no additional impairment.
- No 106 is required.

Example 6

Situations Where there are Multiple Ratings to a Single Extremity (*Camis v. Industrial Comm'n, 4 Ariz. App. 312, 420 P.2d 35 (1966))* This example claim involved multiple ratings to the same extremity. Per the Camis decision, the greater valued rating must be paid.

The injured worker had multiple amputations working on a machine. This person was able to return to date of injury work but and the doctor gave the following ratings: 25% amputation of the little finger, 75% of the ring finger, 70% of the middle finger, or 20% of the major hand, or 18% of the major extremity, or 2% of the whole person. *This feels like a trick question, always remember that a doctor may give a valid AMA rating but the application of the law regarding amputations should be applied, and greater award provided to the injured worker.* The ratings are calculated below based on the level of amputation and not the doctors rating.

Reclose Functional Loss - Able to Return to Work

In this case, the adjuster calculates ALL ratings to determine the greatest value before issuing the 106:

Fingers:
25% Little Finger, with bone loss at the distal phalanx
1. $4000 x 55% = $2200
2. 4 Months x 50% =2 months
3. $2200 x4 months = **$4,400**

75% of the Ring Finger, with bone loss at the middle phalanx
1. $4000 x 55% = $2200
2. 5 months x 100% = 5 months
3. $2200 x 3.75 = **$11,000**

70% of the Middle Finger, with bone loss at the middle phalanx.
1. $4000 x 55% = $2200
2. 7 months x 100% = 7 months
3. $2200 x 4.9 = **$15,400**

Add Fingers together: **$4400 + $11000 +$15400 = $30,800**

20% of Major Hand
1. $4000 x 50% = $2000
2. 50 months x 20% = 10 months
3. $2000 x 10 = **$20,000**

18% of Major Extremity
1. $4000 x 50% = $2000
2. 60 months x 18% = 10.8 months
3. $2000 x 10.8 = **$21,600**

The highest valued rating are the fingers, this is what should be paid and issued on the 106.

Example 6: Multiple Ratings to a Single Extremity

NOTICE OF PERMANENT DISABILITY OR DEATH BENEFITS

Carrier or Self-Insured Name and Address **CARRIER NAME** **CARRIER MAILING ADDRESS** **CITY, STATE. ZIPCODE**	ICA Claim No. SUBMIT WITH ICA#
	Soc. Sec. No. **XXX-XX-XXXX (or LAST 4 digits)**
Authorized Third Party Administrator Name and Address **TPA NAME** **TPA MAILING ADDRESS** **TPA CITY TPA STATE TPA ZIPCODE**	Carrier Claim No. **XXXXXXXXXX___**
	Employer: **YOUR EMPLOYER**
Claimant's Name and Address **CLAIMANT FIRST NAME CLAIMANT LAST NAME** **CLAIMANT MAILING ADDRESS** **CLAIMANT CITY, STATE, ZIPCODE**	Address: **YOUR EMPLOYER LOCAL ADDRESS**
	DOI (USUALLY FROM 101.102 OR 407)

You are hereby notified that the above-named insurance carrier has determined that you are entitled to the following Permanent Disability or Death Benefits:

1. Statute under which compensation is payable: **A.R.S. 23-1044(B) (15) (21)**

2. Percentage and type of disability **10% to LEG**

3. Amount of compensation and method of payment:

50 Months x 10% Impairment = 5 Months

AMW: $4000 x 50% = $2,000.00

TOTAL AWARD $10,000.00

Other Details:

The first payment is effective as of (date), Payable monthly

Mailed On: **MMM/DD/YYYY (or any format)** By: **(name is required)**
Copy to: Industrial Commission of Arizona (Authorized Representative) Tel. #: (xxx) xxx-xxxx

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

AVISO AL RECLAMANTE: Si usted no esta de acuerdo con este AVISO, y desea una audiencia en este caso, su peticion por escrito pidiendo una audiencia debera ser recibida en cualquira de las oficinas de la Comision Industrial a las direcciones abajo indicadas dentro de NOVENTA (90) DIAS despues de la fecha de este AVISO, de acuerdo con las leyes A.R.S. 23-941 y 23-947. SI DICHA PETICION NO ESTA RECIBIDA DENTRO DEL PERIODO DE NOVENTA (90) DIAS, ESTE AVISO SERA CONSIDERADO FINAL.

Phoenix Office: Industrial Commission of Arizona
800 W Washington Street
Phoenix, Arizona 85007-2922

PO Box 19070
Phoenix, AZ 85005-9070

Tucson Office: Industrial Commission of Arizona
2675 E Broadway
Tucson, Arizona 85716-5342

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

INDUSTRIAL COMMISSION OF ARIZONA

Form ICA 04-0106-80 (Rev. 94)

Facial Disfigurement and Loss of Teeth

Scheduled Awards- Facial & Loss of Teeth Under A.R.S. 23-1044(B)(22).

Per A.R.S. § 23-1044(B) (22) facial disfigurement and loss of teeth are both scheduled awards that require the Commission to independently determine the amount of compensation due the injured worker.

- The Commission will award compensation as it deems appropriate for a period not to exceed 18 months.
- Awards for facial disfigurement and loss of teeth must be paid based upon 55% of the injured worker's established average monthly wage.

Facial Disfigurements

This section does not apply to facial disfigurements that result in functional impairment. (S*ee section on Unscheduled Permanent Impairment.)*

Scars on the face, neck or ears are compensable if they are clearly visible when the injured worker is fully dressed, i.e., a scar must cause an observable marring or impairment of the natural appearance of the injured worker.

- Scars on other portions of the body are not compensated.
- In its discretion, the Commission may determine that a facial disfigurement is not ratable.

Accepting a Claim with a Facial Disfigurement

When initial reports are received, the payer should carefully review them to determine:

- If the injured worker has sustained a jagged or severe laceration, severe burns or soft tissue loss on or about the face, neck or ears.
- If this is the case, the payer should immediately process the claim for the establishment of the average monthly wage as follows:

Medical Only Claim:

- Form 104
  - Check #1 and #3, accepting the claim as a medical only claim without temporary disability for seven consecutive days. *See* A.R.S. § 1062(D); *Bell v. Industrial Comm'n*, 236 Ariz. 478, 341 P.3d 1149 (2015)
  - Check #4B adding the monthly wage in the proper space and leave blank the spaces provided for the amount of the check.
  - Mark #11 indicating that the average monthly wage is being established for a possible permanent impairment only,
- Form 108 – Average Monthly Wage for complete instructions.

Temporary Disability Claim:

- Follow normal processing, *see* Claims Adjusting Section.

Closing a Claim with a Facial Disfigurement

- Form 104
  - Check #6 indicating the date of discharge from treatment.
  - Check #8. This notice must be supported by a physician's report setting forth the date of discharge.

- Form 107
  - Check #2 indicating permanent facial disfigurement.
  - Attach a facial chart diagramming the scar, noting the color and the distance from which it can be detected and, if possible, include a photograph**.**
    - **See sample Facial Chart in this section**.

The Commission will make a determination and all parties of interest will be served with the Findings and Award for Scheduled Permanent Disability.

APPLICANT'S NAME _____

ICA CASE NO. _____ DOI _____

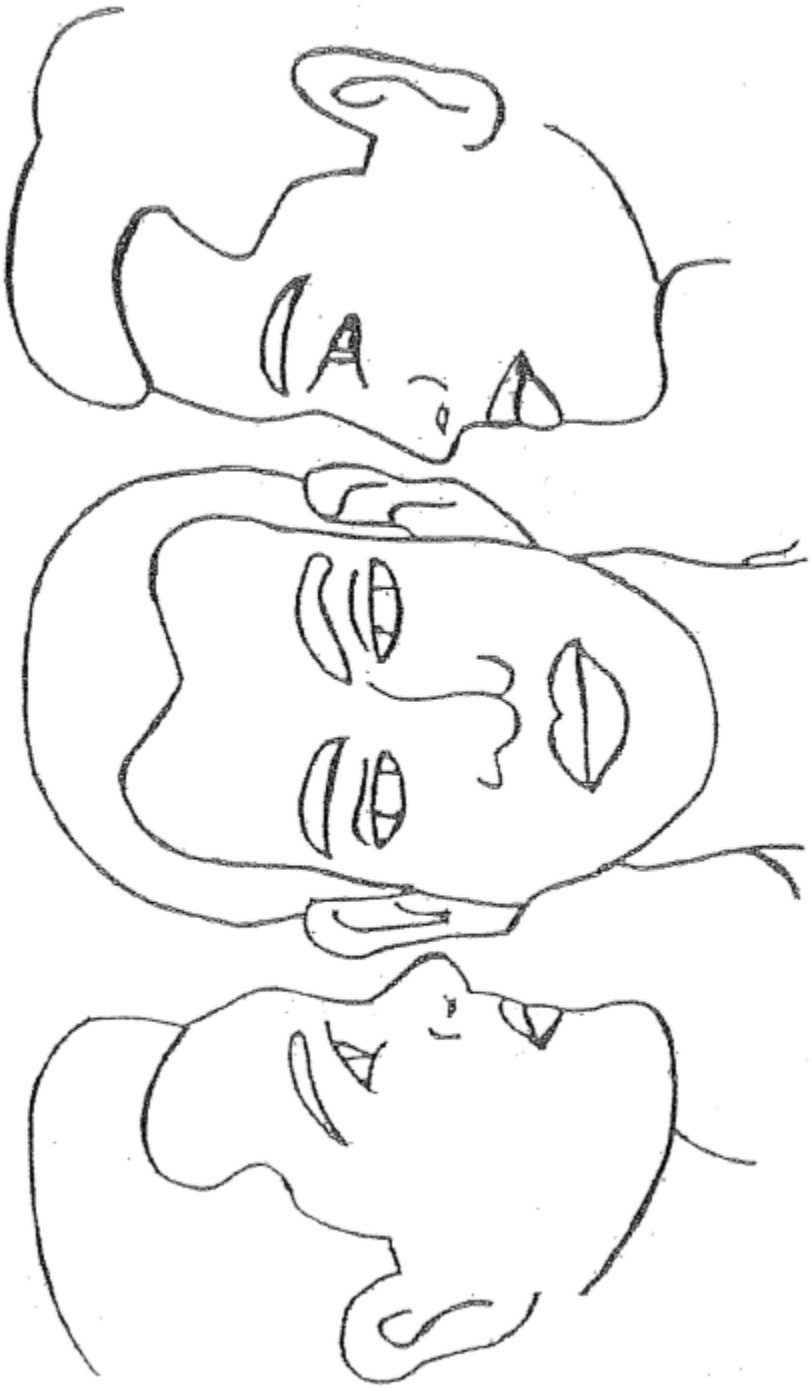
SOCIAL SECURITY NO. _____

VIEWED BY _____

SCAR VISIBLE FROM _____ FEET _____

LENGTH OF SCAR _____

COMMENTS: _____



Loss of Teeth

An injured worker who loses one or more teeth as a result of an industrial accident is entitled to compensation under A.R.S. § 23-1044(B)(22) based on the number of teeth lost- even if the teeth are replaced and there is no resulting disfigurement. *Bridgestone Retail Tire Operations v. Industrial Comm'n of Arizona,* 227 Ariz. 453, 258 P.3d 271 (App. 2011). The Commission will also award compensation if the injured worker has sustained only a *partial loss* of one or more teeth. The partial loss of one tooth is considered a total loss of that particular tooth, and compensation will be awarded accordingly.

False teeth that are damaged as a result of the industrial accident must be replaced or repaired by the payer; however, no permanent disability is applicable for the loss of false teeth. Tooth loss and implanted replacement is still considered tooth loss.

If it is determined that the injured worker has sustained a partial or complete loss of one or more teeth as a result of an industrial accident, the payer should immediately process the claim for the establishment of the average monthly wage as follows:

Medical Only Claim:

- Form 104
    - Check #1 and #3, accepting the claim as a medical only claim without temporary disability for seven consecutive days. *See* A.R.S. § 23-1062(D).
    - Check #4B adding the monthly wage in the proper space and leave blank the spaces provided for the amount of the check.
    - Mark #11 indicating that the average monthly wage is being established for permanent impairment only,
- Form 108.

Temporary Disability Claim:

- Follow standard processing, *see* Claims Adjusting Section.

Closing a Claim with Tooth Loss:

A. Form 104
    - Check #6 indicating the date of discharge from treatment.
    - Check #8. This notice must be supported by a physician's report setting forth the date of discharge.

B. Form 107
    - Check #2 indicating loss of teeth
    - Indicate the number of whole or partial teeth lost.

The Commission will make a determination and all parties of interest will be served with the Findings and Award for Scheduled Permanent Disability. *See sample Loss of Teeth chart in this section for the number of months payable as permanent compensation for complete or partial loss of teeth.*

Example: Loss of Teeth Calculation

Loss of Teeth Calculation

Formula:

Statute under which compensation is payable:
A.R.S. § 23-1044(B)(22)

1. AMW x Functional Loss Factor per Statute = Monthly Value
2. Value of Injury x % of Impairment = Total Months of Benefits
3. Monthly Value x Total Months of Benefits = Total Award

Statute under which compensation is payable:
A.R.S. § 23-1044(B) (22)

1. $4000 x 55% = $2200
2. 2 Teeth per Table = 1.28 months
3. 1.28 months x $2200 = $2816

NUMBER OF MONTHS OF PERMANENT DISABILITY COMPENSATION FOR COMPLETE OR PARTIAL LOSS OF TEETH*

1	Tooth	=	.64	Months
2	Teeth	=	1.28	Months
3	Teeth	=	1.92	Months
4	Teeth	=	2.57	Months
5	Teeth	=	3.21	Months
6	Teeth	=	3.85	Months
7	Teeth	=	4.50	Months
8	Teeth	=	5.14	Months
9	Teeth	=	5.78	Months
10	Teeth	=	6.42	Months
11	Teeth	=	7.07	Months
12	Teeth	=	7.71	Months
13	Teeth	=	8.35	Months
14	Teeth	=	9.00	Months
15	Teeth	=	9.64	Months
16	Teeth	=	10.28	Months
17	Teeth	=	10.92	Months
18	Teeth	=	11.57	Months
19	Teeth	=	12.21	Months
20	Teeth	=	12.85	Months
21	Teeth	=	13.50	Months
22	Teeth	=	14.14	Months
23	Teeth	=	14.78	Months
24	Teeth	=	15.42	Months
25	Teeth	=	16.07	Months
26	Teeth	=	16.71	Months
27	Teeth	=	17.35	Months
28	Teeth	=	18.00	Months

*A partial loss of one or more teeth is compensated for the same number of months as a total loss of one or more teeth (e.g., the complete loss of two teeth equates to 1.28 months of permanent disability compensation, while the partial loss of two teeth also amounts to 1.28 months.

Unscheduled Disabilities

A.R.S. § 23-1044(C)

A.R.S. § 23-1044(C)

A.R.S. § 23-1044(C) provides for disabilities not enumerated in A.R.S. § 23-1044(B), such as injuries resulting in permanent impairment to the shoulder, spine, or back.

There are other ways permanent impairment can result in unscheduled disabilities. See Closing with Permanent Impairment for further detail, as noted in the Scheduled v. Unscheduled Chapter.

If a physician assigns an impairment rating to two or more body parts not of the same extremity, the claim converts to an unscheduled injury. *Ossic v. Verde Central Mines*, 46 Ariz. 176, 49 P.2d 396 (1935).

- … "the combined effects of the original injury on all portions of the body should be considered. Pain, swelling, or any other impairment to an unscheduled portion of the body, if it affects function at all, transforms a scheduled injury into an unscheduled injury." *Dye v. Industrial Comm'n of Arizona*, 153 Ariz. 292, 736 P.2d 376 (1987).
- A worker has a previously scheduled injury with permanent impairment and subsequently suffers another industrial injury to a scheduled body part that results in additional impairment, then the permanent partial disability (PPD) for the second injury will be determined on an unscheduled basis. (*Ronquillo v. Industrial Comm'n* 107 Ariz. 542). This is true even if the first and second industrial claims pertain to the same extremity, as long as the second injury results in additional impairment. (*Rodgers v. Industrial Comm'n* 109 Ariz. 216)
- Prior, out-of-state industrial injuries can also potentially "unschedule" a normally scheduled injury. If the prior injury in another state was a scheduled-type injury and subject to a final award or judgement. The subsequent scheduled Arizona injury is automatically unscheduled for the determination of PPD benefits because the same conclusive presumption under *Ronquillo* applies to the first injury. (*Young v Industrial Comm'n, 204 Ariz.267).)*
  - This may not apply if the prior industrial injury was not subject to a final award or judgment by the respective state's workers' compensation administrative entity or a higher court. (*PFS v. Indus. Comm'n* 191 Ariz. 274)

When an injured worker has been medically discharged and rated with an unscheduled/general permanent impairment, the Commission has the responsibility of determining what effect, if any, the injury, or combination of injuries has on the injured worker's earning capacity.

Prior Industrial Claims

All prior claims must be closed in order to process the newest claim closure. A request for all prior claims can be requested from the Claims Division in Community or request can be faxed to 602-542-3373. When the prior's report is received, request Community access to the claims on the list (please allow 5 days). If prior claims are still open, in lieu of a closure, the payer is to issue a 104 Notice checking #11 with statement that the closure is being held in abeyance until the prior claim closes.

Protest, Stipulations and Compromise and Settlement Agreements impact regarding Loss of Earning Capacity

If a protest of the closing notice, Stipulation or Compromise and Settlement Agreement is received on a case prior to the issuance of a loss of earning capacity determination, all processing on the pending award

will cease and the file along with the stipulation or agreement will be referred to the Administrative Law Judge Division for further handling. If there is an intent to settle prior to issuance of the LEC award, please submit a letter in writing to the Claims Division requesting that the award be held. The issuance will be held a reasonable amount of time; however, it is at the discretion of the ICA as there are statutory requirements that must be met.

Issuing Closure on Claims Involving Unscheduled Permanent Impairment

After ensuring all medical conditions accepted under the industrial injury are at permanent and stationary status and rated appropriately along with all prior claims closed, the following steps can be followed to issue an unscheduled claim closure.

- All Prior Industrial Claims are closed
- Average Monthly Wage Established (even with no time loss/no restrictions), at minimum 104 #4B & 108 are issued. Closure can proceed if AMW has not been approved.
- **Form 107 is** issued indicating ***one*** of the following
    - **1. A.** Is to be checked if the injured worker has been discharged with a general unscheduled disability rating.
    - **1. B.** Is to be checked if the injured worker has been discharged with a scheduled disability as a result of the current injury and has a history of having sustained a prior industrially related scheduled disability. *See* A.R.S. § 23-1065(B).
        - If the permanent disability is the result of a current scheduled disability and a prior industrially related disability, and a credit for the prior scheduled award is being requested, the payer must provide the Commission with the prior scheduled award and prior Form 104 that terminated benefits to determine the correct amount of credit.
    - **1. C.** Is to be checked if the injured worker has been discharged with a general disability, has a history of an enumerated *pre-existing non-industrially related condition, injury or disease which resulted in an impairment equal to or exceeding 10% under the American Medical Association's Guides to the Evaluation of Permanent Impairment and has satisfied the other criteria as set forth in A.R.S. § 23-1065(C).*
        - **When requesting approval for apportionment under A.R.S. § 23-1065(C), the** *payer must submit supporting documentation with the closure for consideration by the Special Fund.*
    - **1. D**. Is to be checked if apportionment is requested for dates of injury prior to January 01, 1986.
- Supporting physician's report indicating the date of discharge*, percentage of permanent impairment, and work restrictions/limitations,* if any. *See* A.A.C. R20-5- 118.
    - If multiple body parts are accepted under the claim, a clear medical discharge for each body part is required.
- Loss Of Earning Capacity Position Paper
    - Along with the appropriate notices and medical reports, the payer is encouraged, but not required, to submit a position paper with their loss of earning capacity ("LEC") recommendation.
    - *Please refer to sample titled "What to Include in a Position Paper" within this section.*

Findings and Award for Loss of Earning Capacity (LEC)

Process for an LEC Determination

Upon receipt of Forms 104 and 107, the Commission has **30 days under** A.R.S. § 23-1047(B) to examine the claim and make an administrative determination. Furthermore, the loss of earning capacity determination may also be postponed an additional 60 days if additional medical or other information is necessary.

In making the determination regarding loss of earning capacity, consideration must be given to all the factors set forth in A.R.S. § 23-1044(D), plus any other facts relevant to a possible loss of earning capacity.

Unscheduled awards can result in:

- No loss of earning capacity
  - The ability to earn the same or more than the average monthly wage.
- Permanent partial loss
  - Partial losses are compensated at 55% of the difference between the established average monthly wage at the time of the industrial injury and the amount which represents the injured worker's reduced monthly earning capacity resulting from the disability. A.R.S. § 23-1044(C). The amount which represents the injured worker's reduced monthly earning capacity is to be rolled back to the date of injury pay scale. *Whyte v. Industrial Comm'n*, 71 Ariz. 338, 227 P.2d 230 (1951).
- Total loss of earning capacity.
  - In accordance with A.R.S. § 23-1045(B), total losses are compensated at 66 2/3% of the established average monthly wage (65% of the established average monthly wage if the date of injury is prior to August 08, 1973).

Example – Unscheduled Disability:
Injured worker sustained a back injury while employed as a Carpenter.

- The AMW was established at $4,000.00 and compensation for temporary disability was paid until the condition was determined to be medically stationary by the attending physician.
- The attending physician provided a rating of 5% impairment of the whole person with permanent work restrictions of no lifting over 50 pounds.
- The Commission determined the injured worker was unable to perform the duties of a carpenter, but the injured worker could perform the tasks of a courier and that job was readily available in the open labor market.

Best Practices:
If Form 104 terminating active medical benefits has been protested, the determination regarding loss of earning capacity will be held in abeyance until the issue of continuing benefits has been resolved.

- At the time of the claimant's injury, it was also determined that a courier was paid at the rate of $14.00 per hour or $2,426.48 monthly. As a result, the injured worker sustained a loss of $1,573.52 per month and was entitled to $865.44 in monthly compensation for permanent partial disability, payable until death or modification by a future ICA award.

L E C

Formula	Example
AMW	$4000
- Earning Capacity	-$2426.48
Loss of Earnings	$1573.52
x 55%	x55%
Monthly LEC Award	$865.44
Loss of Earnings	$1573.52
/AMW	/$4000
% Loss of Earnings	39.34% Loss

Apportionment

Injuries Sustained on or After 01-01-86 A.R.S. § 23- 1065(B) and (C)

Per A.R.S. § 23-1065(D) Notice of intent to seek reimbursement from the Special Fund for apportionment is to be made within thirty days after the injured worker's medical condition is determined to be stationary. Notice of intent to seek reimbursement from the Special Fund should be accomplished by checking the appropriate box on Form 107.

Apportionment- Second Scheduled A.R.S. § 23-1065(B)

This statute is applicable for cases wherein the injured worker has previously sustained a prior, industrially related injury that resulted in the payment of scheduled permanent disability. Subsequently, the clamant sustains another scheduled injury, whose permanent disability entitlement is determined on an unscheduled basis.

If the injured worker's second, scheduled injury results in a loss of earning capacity (LEC) determination by the ICA, then apportionment for this monetary exposure is available through the Special Fund. When approved, the payer would be able to request reimbursement from the Special Fund for 50% of the monthly LEC payments made to the injured worker. However, under A.R.S. 23-1065(B)(2), reimbursement would not be applicable until the payer has first paid the monetary amount equating to what would have been the normal, scheduled permanent disability payable had the second injury's permanent disability not been automatically "unscheduled" by the existence of the first scheduled impairment.

Only monetary amounts encompassing LEC payments made after the payers exhausted the scheduled amount of permanent disability are subject to reimbursement by the Special Fund. Per A.R.S. § 23-1065(E-F).

If the claimant's second scheduled injury does not result in a LEC determination by the Commission under A.R.S. 23-1065(B) (1), the payer pays a 'vocational rehabilitation bonus' to the claimant. This payment is made in a lump sum; it is not subject to a monetary discount to present value. The 'vocational rehabilitation bonus' equates to what normally would be paid for the claimant's scheduled injury under A.R.S. 23-1044 (B) (1-22). No reimbursement from the Special Fund is applicable in cases where no LEC entitlement was awarded by the ICA and only a 'vocational rehabilitation bonus' is payable to the injured worker.

Example: No LEC Awarded - Rehab Bonus Payable

The claimant suffered an industrial injury in 2015 that ultimately resulted in a 20% scheduled permanent impairment of the left arm. He subsequently suffered another industrial injury in 2018 which resulted in a 15% scheduled impairment to the left leg. The ICA determined that both injuries did not affect his earning capacity, so an Award was issued indicating that the claimant was not entitled to a monthly, monetary amount (i.e., a No LEC Award). However, the claimant was eligible for a 'vocational rehabilitation bonus' based on the value of the current injury's scheduled impairment rating. Significantly, the claimant's impairment from the second injury did not medically preclude him from performing his DOI occupation. As a result, the 'vocational rehabilitation bonus' was determined based on 50% of his AMW.

Credit for Prior Scheduled Awards

Entitlement to Credit for Prior Award

The payer is entitled to credit for a prior scheduled award when a subsequent industrial injury results in a loss of earning capacity award. To obtain this credit the payer, at the time Form 107 is issued, must provide the ICA with a copy of both the prior scheduled award and the Form 104 that terminated benefits. *See R.G. Roth Constr. Co. v. Industrial Comm'n,* 126 Ariz. 147, 613 P.2d 307 (App. 1980).

Formula for calculating the credit as set forth in Roth

- The life expectancy is determined at the time of the stationary date of the prior scheduled disability.
    - Multiple Roth credits for multiple prior awards are applied the same way; the age at the stationary date.
- The total amount of the scheduled award on the first claim is divided by the life expectancy in order to determine the monthly credit.
- The Commission's award approves the Payers ability to take a monthly credit until the amount of all prior awards have been captured.
    - The payer must provide documentation or credit will not be provided in the loss of earning capacity award.
- Life Table Source: The United States Life Tables, 2014, National Vital Statistics Reports, Vol. 66, number 4, August 14, 2017, Table 1, Life table for the total population: United States, 2014 (page 9 & 10)
    - The Commission will issue a substantive policy update on their website if/when this source changes.
    - Using the columns Age & Expectations of Life at Age, locate the life expectancy and divide by 12 to get the number of months. This is necessary for the calculation.

Example: Credit for Prior Claims i.e., Roth Credit

The injured worker prior injury of 3-4-11 was closed on 10-3-11 via a Notice of Claim Status. Their DOB: 9/15/1950 making him 61 at date of closure. Per a Notice of Permanent Disability or Death Benefits issued on 10-12-11, the worker was subsequently paid a scheduled award totaling $19,209.76. The worker's projected life expectancy at the time of the claim's termination (based on 61 years of age) was 22.5 years or 270 months (22.5 x 12 = 270 months). See scheduled award sections for calculations.

R O T H

Formula	Example
Value of Prior Scheduled Award/	$19,209.76/
Life Expectancy Months (source)	270
Monthly Credit	$71.15 credit per mo.
AMW	$4000 –
- Earning Capacity	$2709.93
Loss of Earnings	$1290.07
X 55%	X55%
Monthly LEC Award-	$709.54-
Monthly Credit	$71.15
Monthly Entitlement	$638.39
Loss of Earnings	$1290.07/
/AMW	$4000
% Loss of Earnings	32.25%

Apportionment under A.R.S. § 23-1065(C)

Under A.R.S. § 23-1065(C), a loss of earning capacity entitlement can be apportioned between the payer and the Special Fund if certain statutory requirements are met.

- First, the injured worker must, as a result of the current industrial injury, have sustained a permanent impairment "not of the type specified in A.R.S. § 23-1044(B)", i.e., impairments pertaining only to unscheduled injuries.
- Second, the claimant must have a pre-existing, non-industrial permanent impairment, due to an injury, disease, or congenital condition listed in the statute, equating to a ratable impairment under the *AMA Guidelines* of at least 10 percent. Examples of pre-existing impairments eligible for possible apportionment under 23-1065(C) include, but not limited to, diabetes, arthritis, cerebral palsy, and cardiac disease.
- Third, the statute states that the 10 percent or greater impairment must be "of such seriousness as to constitute a hindrance or obstacle to employment or to obtaining reemployment if the employee becomes unemployed…."
- Fourth, the employer must have had knowledge of the claimant's pre-existing impairment, either at the time of hire or afterwards – the worker's employment continued after knowledge was acquired.

If apportionment under A.R.S. § 23-1065(C) is applicable, the payer is responsible for the payment of any temporary total or temporary partial disability payable to the claimant. Any permanent compensation payable under an LEC Award is shared equally between the payer/self-insured employer and the Special Fund.

Credit for a Prior LEC Award and Apportionment under A.R.S. § 23-1044(E)
The payer may request a credit under A.R.S. § 23-1044(E) in its position paper by submitting documentation of a prior LEC award being paid to the injured worker. Without adequate documentation of the prior LEC award, the Commission cannot consider the request.

Permanent Total Disability Awards

A.R.S. § 23-1045(B-C)

Disabilities included under A.R.S. § 23-1045(B-C) (loss of sight in both eyes, loss of both feet or hands, spinal injuries resulting in paralysis of both legs or both arms or of one leg and one arm, head injuries resulting in incurable imbecility or insanity, and the loss of one hand and one foot) are by statute presumed to be total and permanent in the absence of proof to the contrary. *State Compensation Fund v. Cramer,* 13 Ariz. App. 103, 474 P.2d 462 (1970).

- The injured worker is entitled to compensation on a monthly basis equal to 66 2/3% of the average monthly wage until death or further award (65% of the average monthly wage if the date of injury is prior to August 08, 1973). Refer to sample titled "Total Loss of Earning Capacity" within this section.

Non–Enumerated Permanent Total Disability

A.R.S. § 23-1045(D)

The potential entitlement to permanent disability benefits for non-enumerated permanent total disabilities under A.R.S. § 23-1045(D) will be evaluated based on the facts of each case and in accordance with the provisions of A.R.S. § 23-1047.

Claims Prior to Date of Injury 8-13-1971

Exhaustion of Benefits for Injuries Sustained prior to 8-13-71

For claims involving injuries sustained prior to August 13, 1971, the payer must maintain an open file until the condition becomes medically stationary or until the expiration of 60 months of temporary partial disability or 100 months of temporary total disability.

- If the 60 or 100 months are exhausted before the injured worker's condition stabilizes, the payer issues Form 104 indicating the 60 or 100 months have expired.
    - If disability is covered under A.R.S. § 23-1044,
        - Issue Form 107
    - If disability is covered under A.R.S. § 23-1045 and 100 months have expired,
        - Issue Form 106 indicating the disability is covered by A.R.S. § 23-1045. The 60 months of temporary partial disability does not apply to injuries covered by A.R.S. § 23-1045.
        - The Special Fund should be notified of the need to provide ongoing treatment.

Date of Injury 8-13-71 through 8-07-73

Exhaustion of Benefits for Date of Injury 8-13-71 through 8-07-73

- For claims involving injuries sustained from August 13, 1971 through August 07, 1973, if the 60 months of temporary partial disability benefits or 100 months of temporary total disability benefits

have elapsed and the injured worker's condition has not stabilized, the Special Fund commences to pay both the temporary compensation and medical benefits until the injured worker's condition stabilizes.

- Payer Process: A Form 104 is issued indicating benefits have been exhausted and the date active benefits have been terminated. Form 107 is not required. The Special Fund should be notified prior to the issuance of Form 104.

Annual Report of Income

110A & 110B

- A *Worker's Annual Report of Income*, (Form 110-A), is to be sent by the payer to injured workers receiving permanent disability compensation benefits one month prior to the anniversary date of the LEC Award.
- If Form 110-A is not returned by the anniversary date of the award, the payer must notify the injured worker by a *Notice of Intent to Suspend* (Form 110-B) that benefits will be suspended unless the report of earnings is filed with the payer within 30 days.
- If Form 110-B is not received at the end of 30 days, the payer can then issue *Notice of Suspension of Benefits* (hereinafter referred to as Form 105) checking #3, suspending benefits for failure to submit a required *Annual Report of Income*.
- When the *Annual Report of Income* is received by the payer, benefits are to be reinstated effective as of the date of receipt.
- *See* A.R.S. § 23-1047 (D)

Best Practice:
See our YouTube Video: Unscheduled Permanent Disability Awards to supplement this chapter

Lump Sum Commutations & Other Settlements

Settlements and Lump Sum

- Upon the filing of a *Petition for Lump Sum Commutation* under A.R.S. § 23-1067 and at the discretion of the ICA's Commissioners, awards for permanent disability benefits may be commuted to a lump sum.
    - *Effective September 19, 2007, for petitions filed from and after July 30, 2007, a lump sum commutation of an unscheduled award cannot exceed $150,000, while commutation of a scheduled award cannot exceed $25,000.00.*
- Action will not be taken on a petition until the permanent disability award has become final or waivers of appeal have been signed by all parties.
- A.R.S. § 23-1067 gives the Commission jurisdiction to grant lump sum commutations of scheduled awards without the payer's authorization. However, payer authorization is required for any lump sum commutations of an unscheduled award.
    - Payers are to respond to the Commission, in writing, recommending either approval or disapproval when contacted by the Commission regarding lump sum commutations of unscheduled awards.
- On the anniversary date of a commuted unscheduled award, the Commission may conduct an inquiry to determine the actual disposition of the lump sum proceeds.
- **Note:** The final authority of approval or disapproval of a lump sum commutation rests with the Commission. The injured worker's monthly benefits shall continue until an award /order is issued.

Scheduled Award Lump Sum Commutation

Example- Scheduled Award Present Value

The present value table which is currently calculated at 1.18% is used to determine the present value of a scheduled award (A.A.C. R20-5-121). The value is determined by multiplying the amount of the monthly entitlement times the factor for the number of months remaining to be paid at the time of the lump sum request.

See "Life Tables" tab for sample of present value table.

Whenever a fraction of a month is involved, the value is determined as follows:		
Monthly Payment	=	**$1881.72** Months Due: 11.5
Factor for 11 months	10.94	
Factor for 10 months -	9.95	
Difference	=	1.00
Factor for .5 month	=	.50 (1.00 divided by 2)
Factor for 10 months	10.94	
Factor for .5 month	+	.50
Factor for 10.5 months		**11.44**
$1881.72 x 11.44 = $21,526.88 = value of scheduled award		

Unscheduled Award Lump Sum Commutation

Example Unscheduled Award Present Value

The present value table, which is currently calculated at 1.18% is used to determine the present value of an unscheduled award. The value is determined by multiplying the amount of the monthly entitlement times the factor for the number of months remaining to be paid at the time of the lump sum request. See "Life Tables" tab for sample of present value table.

Although the Commission determines the present value by determining the age of the applicant in years and months, for the sake of simplicity, our example will have the applicant request a lump sum on his birthday:

Date of Valuation:	01-19-2020
Date of Birth:	01-19-68
Age:	60
Factor	234.05
Monthly Entitlement:	$1258.73
$1258.73 x 234.05 = $294,605.76 = value of unscheduled award	

Petition for Rearrangement or Readjustment of Compensation- A.R.S.23-1044(F)

An interested party may file a *Petition for Rearrangement or Readjustment of Compensation*, with supporting documentation, which shows a change may have occurred since the last loss of earning capacity determination was made. The burden of proof for demonstrating a change in earning capacity rests with the filing party.

The following conditions warrant the filing of a *Petition for Rearrangement or Readjustment of Compensation:*

- Upon the showing of a change in the physical condition of the injured worker arising out of the injury, subsequent to the findings and award, and now resulting in the reduction or increase of earning capacity.
- Upon a showing of a reduction in the earning capacity of the injured worker arising out of the injury where there is no change in his physical condition, subsequent to the last LEC Award.
- Upon a showing of an increase in the earning capacity of the injured worker subsequent to the last LEC Award.

The following situations do not warrant rearrangement or readjustment:

- Deterioration due to a non-industrial condition(s).
- The aging process
- Rising cost of living
- Moving to an area where work is not available
- A change in economic conditions affecting work availability

The Commission Process reviewing a Rearrangement

- The Commission mails a questionnaire to the injured worker to obtain current employment information, regardless of who filed the *Petition*.
- If the injured worker is the filing party, the payer is asked to submit a position paper with its comments.
- After the Commission completes its investigation, an appropriate Award will then be issued.
- Stipulations and Compromise and Settlement Agreements Regarding Petitions for Rearrangement or Readjustment of Compensation
    - If a *Stipulation* or *Compromise and Settlement Agreement* is received by the Commission which pertains to a previously filed *Petition for Rearrangement or Readjustment of Compensation*, all processing on the *Petition* will cease and the file, along with the *Stipulation* or *Agreement*, will be referred to the Administrative Law Judge Division for further handling.

Settlements

Several types of settlements are available in the statutes.

- Disputed settlement
    - This is a settlement agreement that can be reached between the parties to resolve a disagreement. This can only be completed by a payer's legal representative and a represented/unrepresented applicant and submitted directly to the Chief ALJ.
- Settlement of Claims; Full and Final
    - This statute provides the definition of and required elements for a Carrier/Self-Insured employer to settle a claim Full and Final. The distinguishing element of a Full and Final vs a disputed settlement is that the applicant waives the right to future petitions to reopen. *See* A.R.S. § 23-941.01
        - Even though the statute provides the language to settle the claim "in part", this statute also waives the right to future benefits. A partial Full and Final settlement will not be accepted by the Administrative Law Judge pending clarification of the statutes.
- Settlement of Claims; Supportive Medical Maintenance Benefits
    - This statute provides the definition of and required elements for a Carrier/Self-Insured employer to settle the Supportive Medical Maintenance Benefits portion of a claim. A distinguishing element of a Supportive Care settlement is that the applicant is waiving their right to future supportive care. *See* A.R.S. § 23-941.03.

Best Practice:
See our YouTube Video: Lump Sum Settlements to supplement this chapter.

What to Include in a Position Paper

Injured Worker's Demographics:

- Date of injury
- Date of birth / current age
- Educational background
- Employment at date of injury/ employment history
- Location of residence at the date of injury, location where employment was being performed on the date of injury, and current location of the worker's residence
- Physical work restrictions related to the industrial injury
- Any criminal history

Vocational Rehab

Did the injured worker participate in a vocational rehabilitation program? If so, did he complete the program and in what occupation was he trained?

Return to work for Insured Employer

- If the injured worker has been offered regular duty work or modified work for the insured employer, submit the following written documentation from the insured employer verifying an offer of modified employment or regular duty work to include:
  - Occupation offered or available to injured worker.
  - Did injured worker accept return to work offer?
    - Best practices: (Include signed job offer indicating accept/decline return to work with insured employer)
  - The number of hours injured worker is working per week and rate of pay.
  - Specify if the employer is accommodating/modifying job task.

Return to work for a different employer:

- If the injured worker returned to work for a different employer, submit written documentation such as:
  - Pay stubs
  - Most Recent *Monthly Status Report Form*
  - W-2 form, or form letter filled out by the injured worker verifying:
    - Occupation injured worker is performing.
    - The number of hours injured worker is working per week and rate of pay.
    - If injured worker is working less than 40 hours per week, please explain the reason.

Unscheduled Closure Checklist

- Average Monthly Wage Established, 108 & 104 checking 4B (The AMW may be established at the time of closure, but it is recommended establishing as soon as perm known)
- Form 104, checking #6 &8. Dates are not backdated more than 30 days (Rule 20-5-118)
- Form 107 appropriately marked for the type of unscheduled closure
    - Apportionment or Credit requested? Include supporting documents
- Supporting Medical Records for *all body parts* related to this claim
- Request access to all prior claims in Community and verify they are closed for active care
- Position Paper, optional, but recommended) to include the following;
    - Birthdate/Age of the injured worker
    - The city and state of residence at date of injury
    - The city and state of residence of where injured worker performed work at date of injury
    - The city and state of the injured workers' current location of residence.
    - The injured workers educational background and criminal history
    - The injured workers employment history
    - Previous workers compensations injuries and/or non-industrial medical conditions
    - Physical work restrictions related to the industrial injury
    - Rate of pay and number of hours per week for post-injury employment
    - Current working status with date of injury employer or a different employer
    - *See "What to Include in A Position Paper" for full detail*

No Loss of Earning Capacity - Sample

A.R.S. § 23-1044(C)

DATE OF INJURY:	03-16-2023
AMW:	$5,393.37
TYPE OF INJURY:	Back
PERMANENT IMPAIRMENT:	10% whole person
OCCUPATION:	Maintenance Supervisor

After conservative medical treatment, injured worker was released from medical care with no physical work restrictions.
Upon review of this, ICA found that injured worker sustained no loss in earning capacity.

No Loss with Vocational Rehabilitation Bonus - Sample

A.R.S. § 23-1065(B)(1)

PRIOR DATE OF INJURY:	10-11-2006 5% permanent impairment of the left upper extremity
CURRENT DATE OF INJURY:	02-24-2022 10% permanent impairment of the right lower extremity
AMW:	$4,226.80
OCCUPATION:	Pipefitter

The injured worker was released from medical care with no physical work restrictions, and he could return to his DOI occupation as a pipefitter. Therefore, the Commission found that he had sustained no loss of earning capacity.

However, pursuant to A.R.S. § 23-1065(B)(1) the injured worker was found to be entitled to a vocational rehabilitation bonus, in the amount calculated pursuant to A.R.S. § 23-1044(B) (15)(21), to be paid in a **lump sum** and shall act as a credit against any permanent disability compensation benefits awarded in any subsequent proceeding.

REHAB BONUS:	10% x 50 months (A.R.S. § 23-1044{B}{15}) = 5 months $4226.80 x 50% (A.R.S. § 23-1044{21}) = $2113.40 $2113.40 x 5 = $10,567.00

Loss of Earning Capacity - Sample

A.R.S. § 23-1044(C)

DATE OF INJURY:	04-15-2023
AMW:	$ 5,393.37
TYPE OF INJURY:	Right shoulder
PERMANENT IMPAIRMENT:	15% whole person
OCCUPATION:	Fire Fighter

The injured worker was unable to return to his duties as a fire fighter; therefore, the ICA determined that he could perform the duties of a customer service representative which was readily available in the open, competitive labor market. On the date of injury, this position was found to have paid $15.86 per hour or $2,748.86 per month, which would result in a 49.03% reduction in earning capacity entitling him to the monthly sum of $1,454.48.

$ 5,393.37
- $ 2,748.86
$ 2,644.51 = 49.03% LEC
x .55 = (A.R.S. § 23-1044{C})
$ 1,454.48 = monthly LEC entitlement

Loss of Earning Capacity with Apportionment - Sample

A.R.S. § 23-1065(B)(2) AND *ROTH* CREDIT under A.R.S. § 23-1044(E)

PRIOR DATE OF INJURY:	01-03-2009 35% permanent impairment of the left lower extremity
CURRENT DATE OF INJURY:	03-10-2021 20% permanent impairment of the right (major) upper extremity
AMW:	$4,112.00
OCCUPATION:	Carpenter

LEC: The Commission determined that the injured worker was unable to return to his duties as a Carpenter. The Commission opined that he could perform the duties of a Driver which was readily available in the open, competitive labor market. On the date of injury this position was found to have paid $10.52 per hour or $1,823.33 per month which would result in a 55.66% reduction in earning capacity entitling him to the monthly sum of $1,258.77.

$ 4,112.00
$ 1,823.33
$ 2,288.67 = 55.66% LEC
X .55 = (A.R.S. § 23-1044{C})
$ 1,258.77 = monthly LEC entitlement

APPORTIONMENT: 20% x 60 months (A.R.S. § 23-1044{B}{13}) = 12 months
$4112.00 x 75%* (A.R.S. § 23-1044{B}{21}) = $3084.00
$3084.00 x 12 months = $37,008.00 value of scheduled award

*Because the applicant is unable to return to his date of injury employment due to the industrial injury, the amount the payer must pay first before being eligible for reimbursement under § 23-1065(B) is calculated using a 75% factor. If the injured worker is able to return back to his usual and customary occupation due to the industrial injury and a combination of other factors, the value of the scheduled award is to be paid at 50% of the average monthly wage.

The payer is to pay the injured worker $1,258.77 for the monthly LEC Award until the sum of $37,008.00 has been fully paid. This will take 29.4 months. Afterwards, the monthly LEC entitlement of $1,258.77 will be shared on an equal basis between the payer and the Special Fund.

Loss of Earning Capacity with Apportionment & *Roth* Credit - Sample

A.R.S. § 23-1065(B)(2) AND *ROTH* CREDIT under A.R.S. § 23-1044(E)

CREDIT: Applicant's prior injury of 1-3-09 was terminated as of 10-03-2009 in which he was paid a scheduled award of $33,300.00 per *Notice of Permanent Disability or Death Benefits* issued on 10-03-2009. His life expectancy, in accordance with the Life Tables contained in The United States Life Tables, 2014, National Vital Statistics Reports, Vol. 66, number 14, August 14, 2017, Table 1, Life Table for the total population: United States, 2014, was 35.2 years or 422.4 months based on his age of 46 years at time of the prior claim's termination. *See R.G. Roth Construction Co. v. Industrial Comm'n*, 126 Ariz. 147, 613 P.2d 307 (App. 1980).

$33,300.00 ÷ 422.4 = $78.84 credit per month for a period of 422.4 months

$ 4,112.00
- 1,823.33
$ 2,288.67 = 55.66% LEC
x .55
$ 1,258.77 = monthly LEC entitlement
- 78.84 = credit per month for a period of 422.4 months
$ 1,179.93 = monthly entitlement for a period of 422.4 months, thereafter $1,258.77

Total Loss of Earning Capacity

A.R.S. § 23-1045

DATE OF INJURY:	04-15-2023
AMW:	$5,393.37
TYPE OF INJURY:	Neck
PERMANENT IMPAIRMENT:	24% whole person
OCCUPATION:	Manager

The injured worker was unable to return to any form of gainful employment due to the industrial injury; therefore, the ICA determined that she was totally disabled.

$5,393.37
X 66.667% (A.R.S. § 23-1045)
$3,595.76 = monthly LEC entitlement

Note: The injured worker would be entitled to 65% of the average monthly wage if the date of injury is prior to 08-08-73.

Apportionment-Second Scheduled Injury Sustained Between 07-31-1980 and 12-30-1985 - Sample

A.R.S. § 23-1065(B)

PRIOR DATE OF INJURY:	04-09-1977
SCHEDULED PERMANENT IMPAIRMENT:	4% of the left ring finger
CURRENT DATE OF INJURY:	09-15-1985
SCHEDULED PERMANENT IMPAIRMENT:	25% of the right wrist
AMW:	$1,325.00
OCCUPATION:	Truck Driver

The injured worker was unable to return to his duties as a truck driver; therefore, the Commission found that he could perform the duties of a telephone solicitor which was readily available in the open, competitive labor market. On the date of injury, the position of telephone solicitor was found to have paid $3.35 per hour, or $580.62 per month, which would result in a 56.18% reduction in earning capacity entitling him to the monthly sum of $409.41.

$ 1325.00
- 580.62
$ 744.38 = 56.18% LEC
X .55 = (A.R.S. § 23-1044{C})
$ 409.41 = monthly LEC entitlement

The payer pays the first 50% reduction in earning capacity plus ½ of anything over 50%. Benefits are to be apportioned pursuant to A.R.S. § 23-1065(B) (2) as follows:

56.18% (reduction in earning capacity)
50.00% (payer's responsibility for 1st 50%)
$ 6.18% ÷ 2 = 3.09%

50.00% + 3.09% = 53.09% (portion of reduction in earning capacity insurance carrier is responsible for)
3.09% (portion of reduction in earning capacity ICA Special Fund is responsible for)

The following formula is used:
53.09% ÷ 56.18% = 94.50% x $409.41 = $ 386.89 - Carrier responsibility
3.09% ÷ 56.18% = 5.50% x $409.41 = $ 22.52 - ICA Special Fund's responsibility
$ 409.41 - Total Award

Vocational Rehabilitation A.R.S. § 23-1065(A)

ICA Vocational Rehabilitation Assistance

The Industrial Commission has offered vocational assistance to injured workers since its inception in 1925. This benefit is available as set forth in A.R.S. § 23-1065(A). The existing Commission policy for vocational rehabilitation was first established in 1970 and modified over the years since that time.

In general, it provides that the Special Fund will pay for training costs associated with an injured worker's rehabilitation program if adequate documentation is provided showing that the injured worker has sustained a permanent impairment and is unable to return to his/her regular employment.

The program consists of three distinct elements:

1. Vocational rehabilitation with wage compensation provided by the insurance carriers for injured workers that have unscheduled disability claims (aka With Carrier Involvement).
2. Vocational rehabilitation for injured workers with unscheduled disability claims without insurance carrier involvement (aka Without Carrier Involvement)
3. Vocational rehabilitation for injured workers with scheduled disability injuries (aka Scheduled).

Unscheduled Disability with Carrier Involvement

Vocational rehabilitation with wage compensation provided by the insurance carriers or self-insured employers for injured workers with unscheduled injuries is the oldest vocational rehabilitation program. The original workers' compensation statutes recognized that carriers have an economic interest in ensuring that injured workers with unscheduled injuries are rehabilitated.

1. Under this program, carriers can develop the rehabilitation program and submit it to the Special Fund for review and approval. **Upon approval, the Special Fund will pay the costs of the program including tuition, books, supplies, etc**.
    a. *In these referrals, the carrier has committed to pay temporary compensation through the completion of the program and the expense of the vocational counselor for up to two years.* This is consistent with the Commission policy. See sample Form 104 in this section.
2. If the injured worker's condition becomes stationary prior to the completion of the program.
    a. **Form 104** should be issued terminating medical benefits (with supporting medical documentation), but it must indicate that temporary partial disability benefits will continue for the duration of the training program, up to two years.
    b. Upon completion of the rehabilitation training program, **Form 107** may then be issued to complete the closing process.

It is not necessary to once again terminate medical benefits; however, form 104 should be issued indicating the date the rehabilitation program was completed and temporary compensation discontinued. Any permanent compensation awarded is payable as of the date temporary compensation was discontinued. *See* sample Form 104 in this section.

Unscheduled Disability Without Carrier Involvement

Cases in which the injured worker has sustained an unscheduled disability and is independently attempting to apply to the Special Fund for vocational rehabilitation.

1. Once a request is received, the Special Fund Division verifies that the injured worker meets the threshold requirements and refers the individual to the Department of Economic Security (DES)

Rehabilitation Services Administration (RSA). RSA then develops a vocational program and submits that program to the Special Fund Division for its review and approval.

2. Upon approval, the Special Fund will pay the costs of the program including tuition, books, supplies, and other expenses as applicable. RSA funds the vocational counselor and may make available to the injured worker additional benefits as authorized under DES programs.

3. The carrier is not required to continue temporary compensation in this type of referral beyond the stationary date. If the injured worker's condition becomes medically stationary, the carrier should issue closing notices and request a determination of loss of earning capacity award per standard procedure.

Scheduled

In 1987, the Commission recognized that there was little economic incentive for the payers to provide vocational rehabilitation to injured workers with scheduled injuries. As a result, the Commission developed the third element, vocational rehabilitation for injured workers with scheduled injuries who, because of their injuries, are not able to return to their regular employment. The following is a description of the scheduled program:

- Insurance carriers and self-insured employers shall provide to the Commission's Special Fund Division the name of injured workers with scheduled type injuries who are unable to return to date of injury work because of the work injury. The Special Fund also receives notification of claims that close with a scheduled disability payable at 75% of Average Monthly Wage from the Claims Division.

- The Special Fund Division internally reviews available information to ensure that the medical documentation supports the injured worker's inability to return to date of injury work and maximum medical improvement to ensure stable work restrictions on which to base the retraining program. Medical documentation is required as part of the initial reporting and should be submitted by the insurance carrier.

- The Special Fund Division contracts with private rehabilitation firms who have counselors statewide to provide vocational counseling and development of a vocational rehabilitation plan to assist the injured worker's return to meaningful employment. Each vocational rehabilitation plan shall be submitted to the Special Fund Division for review and approval. Upon approval, the Special Fund Division will issue an award covering the cost of the program (for example; tuition, books, supplies, tools, uniforms, etc.)

- Retraining programs are uniquely designed to the injured worker's needs and individual experience, abilities, and physical limitations. A few examples of programs include empowering an injured worker to complete remaining college credits for a degree, English as a Second Language (ESL), on-the-job training programs, or job placement based on existing transferrable skills. Training programs are typically limited to two years.

- On scheduled disabilities, Commission policy does not require the carrier to continue temporary benefits past the stationary date. Form 104 and Form 106 shall be issued when the injured worker's condition is stationary.

Past provisions for the Scheduled program have included time loss over 180 days, which was amended by the Commission on March 30, 2000, to time loss over 90 days. Since that time the program has evolved to wherein all Scheduled claims where the injured worker is unable to return to Date of Injury work (paid at 75% of AMW) are evaluated for eligibility.

General Information

The Vocational Rehabilitation program is developed to assist an injured worker become more marketable in a general employment setting to empower economic stability. Over the past three calendar years the Special Fund Division has accumulated the following statistical information regarding vocational rehabilitation programs:

Scheduled 2022	162
Scheduled 2021	360
Scheduled 2020	8

Unscheduled 2022	2
Unscheduled 2021	1
Unscheduled 2020	0

The annual expenditures for the Special Fund's Vocational Rehabilitation Program for the past three fiscal years are as follows:

- **FY 2022 $216K**
- **FY 2021 $165K**
- **FY 2020 $144K**

The Commission strives to continually upgrade the vocational rehabilitation services offered to injured workers. Commission staff meet periodically with the private vocational vendors to gather their input.

For specific information, please contact the Special Fund Division at (602) 542-3294.

Best Practice:
See our YouTube Video: Vocational Rehab to supplement this chapter.

Dear Injured Worker:

If your doctor has told you that your injury has resulted in a permanent disability that will prevent you from returning to your regular employment, assistance is available through the Industrial Commission's Special Fund Division.

The Commission offers a program to help injured workers to return to meaningful employment. This could include such things as retraining, job modification, or simply job placement assistance, based upon your education or work experience skills.

If your doctor has stated that you need this assistance, contact the Special Fund Division at (602) 542-3294, or write to the Industrial Commission of Arizona, Special Fund Division, 800 West Washington St, Phoenix, Arizona 85007-2903.

AVISO:

Estimado Trabajador Lastimado:

Si su doctor le ha dicho que su lastimadura le causará una incapacitación permanente y que no le permitira regresar a su empleo actual, recuerde que existe ayuda a su alcance a través de la División de Fondos Especiales de la Comisión Industrial.

La Comisión ofrece un programa que ayuda a los trabajadores lastimados para poder regresar a trabajar. Este programa puede incluír servicios tales como nuevo entrenamiento, modificación del empleo, o simplemente asistencia para colocarlo en otro empleo tomando en consideración su experiencia de trabajo y su educación.

Si su doctor ha dicho que usted necesita esta tipo de ayuda, llame a la Division de Fondos Especiales al (602) 542-3294, o escribale a la siguiente dirección:

Industrial Commission of Arizona
Special Fund Division
800 West Washington St
Phoenix, AZ 85007-2903

INDUSTRIAL COMMISSION OF ARIZONA

THE INDUSTRIAL COMMISSION OF ARIZONA

CARRIER'S REFERRAL FOR VOCATIONAL REHABILITATION

From: Date: _____

Carrier Claim #: _____
ICA Claim No #: _____
Social Security #: _____
Date of Birth: _____
Date of Injury: _____

To: The Industrial Commission of Arizona
Attention: Special Fund
P.O. Box 19070
Phoenix, AZ. 85005

Forward with one copy of pertinent medical data, such as operative reports and medical supporting discharge from active care. A complete file is not required.

Injured Worker: _____ Telephone #: _____
Email: _____

Current Address: _____
Street City State Zip Code

Sex: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Occupation At Time of Injury: _____

Established Wage: _____ Present Monthly Compensation Amount _____ Number of Dependents: _____

Name of Date of Injury Employer: _____

Employers Address: _____
STREET CITY STATE ZIP CODE

Injured Workers Attending Physician (s): _____

Physician's Address: _____
STREET CITY STATE ZIP CODE

Does Attending Physician recommend rehabilitation? YES ☐ NO ☐
Did injured worker return to work with the date of injury employer? YES ☐ NO ☐
List current employment and earnings (if known) _____
Nature of the Injured Workers injury: _____

The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(b)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT SPECIAL FUND AT (602) 542-3294.

INDUSTRIAL COMMISSION OF ARIZONA

NOTICE OF CLAIM STATUS

Carrier or Self-Insured Name and Address
Carrier Name
Carrier Address1

Phoenix, AZ 85006

Authorized Third Party Administrator (TPA) Name and Address
Awesome TPA
TPA Street 1

Phoenix, AZ 85006

Claimant's Name and Address
Wick John
123 Awesome St

Phoenix, AZ 85006

ICA Claim No. Always enter the ICA#

Soc. Sec. No.

SSN not required if correct ICA claim number is provided

Carrier Claim No. WC101

Employer The Continental

Address 123 Awesome St

Phoenix, AZ 85006

Date of Injury 02/26/2019

- ☐ 1. Claim is accepted.
- ☐ 2. Claim is denied.
- ☐ 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.
- ☐ 4. Enclosed check for _____ for period of _____ through _____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of _____ based on the following:
  - ☐ A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
  - ☐ B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.
- ☐ 5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly. Return to regular duty effective _____.
- ☐ 6. Temporary compensation and active medical treatment terminated on _____ because claimant was discharged.
- ☐ 7. Injury resulted in no permanent disability.
- ☐ 8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, if any, will be authorized by separate Notice.
- ☐ 9. Petition to Reopen accepted.
- ☐ 10. Petition to Reopen denied.
- ☑ 11. Other: Temporary Compensation will continue to be payable until such time as the rehabilitation program has been completed or terminated.

Mailed on: 07/10/2019 By: The Best Claims Adjuster

(Authorized Representative) Tel. #: (602) 542-4661

Copy to: Industrial Commission of Arizona

The insurance carrier/employer will, upon request, provide claimant a copy of the medical report to support Findings 5, 6, 7 or 8.

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

AVISO AL RECLAMANTE: Si usted no esta de acuerdo con este AVISO, y desea una audiencia en este caso, su peticion por escrito pidiendo una audiencia debera ser recibida en cualquira de las oficinas de la Comision Industrial a las direcciones abajo indicadas dentro de NOVENTA (90) DIAS despues de la fecha de este AVISO, de acuerdo con las leyes A.R.S. 23-941 y 23-947. SI DICHA PETICION NO ESTA RECIBIDA DENTRO DEL PERIODO DE NOVENTA (90) DIAS, ESTE AVISO SERA CONSIDERADO FINAL.

Phoenix Office: Industrial Commission of Arizona
800 W Washington Street
Phoenix, Arizona 85007-2922

PO Box 19070
Phoenix, AZ 85005-9070

Tucson Office: Industrial Commission of Arizona
2675 E Broadway
Tucson, Arizona 85716-5342

NOTICE OF CLAIM STATUS

Carrier or Self-Insured Name and Address
Carrier Name
Carrier Address1

Phoenix, AZ 85006

Authorized Third Party Administrator (TPA) Name and Address
Awesome TPA
TPA Street 1

Phoenix, AZ 85006

Claimant's Name and Address
Wick John
123 Awesome St

Phoenix, AZ 85006

ICA Claim No. Always enter the ICA#

Soc. Sec. No. _____

SSN not required if correct ICA claim number is provided

Carrier Claim No. WC101

Employer The Continental

Address 123 Awesome St

Phoenix, AZ 85006

Date of Injury 02/26/2019

- ☐ 1. Claim is accepted.
- ☐ 2. Claim is denied.
- ☐ 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.
- ☐ 4. Enclosed check for _____ for period of _____ through _____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of _____ based on the following:
  - ☐ A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
  - ☐ B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.
- ☐ 5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly. Return to regular duty effective _____.
- ☐ 6. Temporary compensation and active medical treatment terminated on _____ because claimant was discharged.
- ☐ 7. Injury resulted in no permanent disability.
- ☐ 8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, if any, will be authorized by separate Notice.
- ☐ 9. Petition to Reopen accepted.
- ☐ 10. Petition to Reopen denied.
- ☑ 11. Other: Rehabilitation Program has been completed and temporary compensation has been paid through <<date>>.

Mailed on: 07/10/2019 By: The Best Claims Adjuster

(Authorized Representative) Tel. #: (602) 542-4661

Copy to: Industrial Commission of Arizona

The insurance carrier/employer will, upon request, provide claimant a copy of the medical report to support Findings 5, 6, 7 or 8.

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

AVISO AL RECLAMANTE: Si usted no esta de acuerdo con este AVISO, y desea una audiencia en este caso, su peticion por escrito pidiendo una audiencia debera ser recibida en cualquira de las oficinas de la Comision Industrial a las direcciones abajo indicadas dentro de NOVENTA (90) DIAS despues de la fecha de este AVISO, de acuerdo con las leyes A.R.S. 23-941 y 23-947. SI DICHA PETICION NO ESTA RECIBIDA DENTRO DEL PERIODO DE NOVENTA (90) DIAS, ESTE AVISO SERA CONSIDERADO FINAL.

Phoenix Office: Industrial Commission of Arizona
800 W Washington Street
Phoenix, Arizona 85007-2922

PO Box 19070
Phoenix, AZ 85005-9070

Tucson Office: Industrial Commission of Arizona
2675 E Broadway
Tucson, Arizona 85716-5342

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 0104 - Rev 6/2019

HEARINGS

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Request for Hearing

Request for Hearing or Protest

A *Request for Hearing*, signed by the interested party or the party's authorized representative, is to be filed with the Industrial Commission of Arizona ("Commission"). The request should not be filed with the Carrier. *See* A.R.S. § 23-947(B); A.A.C. R20-5-135(A).

- The signed request should indicate which notice, award or order is being protested, the grounds on which the hearing is requested and address those issues set forth in the notice or award being protested. *See* A.A.C. R20-5-135(B).

When determining the final day of protest period, review A.A.C. R20-5-105, in the event the last day of a protest period falls on a Saturday, Sunday or a legal holiday, the period runs until the end of the next working day. In addition, the day of the act or event from which the designated period of time begins to run is not included.

Disputes concerning the timeliness of a protest fall within the jurisdiction of the Administrative Law Judge Division. Request for hearing is referred by the Claims Division directly to the Administrative Law Judge Division for processing.

Request for Investigation per A.R.S. § 23-1061(J)

A.R.S. § 23-1061(J) provides injured workers with a method to request that the Commission investigate and review an injured worker's potential entitlement to benefits (such as temporary total disability compensation) which may have been or are being inappropriately denied or delayed.

This method is also informally referred to as a "J" request." While a "J" request may resulting in a formal hearing, it does not follow the same path as a hearing request pursuant to A.R.S. § 23-947.

- A.R.S. § 23-1061(J) provides that the Commission shall investigate and review any claim in which it appears that an injured worker has not been granted the benefits to which the worker is entitled. If the Commission determines that payment or denial of compensation is improper in any way, it shall hold a hearing within 60 days after such determination. A "J" request involving temporary partial disability benefits must be filed with the Commission within two years after the date the claimed entitlement to compensation accrued or within two years on which an award for benefits encompassing the entitlement period becomes final. A claim for temporary partial benefits shall not be deemed to have accrued any earlier than September 26, 2008.

- Upon receipt of a request filed under A.R.S. § 23-1061(J), a response is solicited from the applicable party and refer the "J" request to the designated duty Administrative Law Judge (ALJ) for investigation. The responding party shall have ten days to file its response to the Administrative Law Judge Division. The responding party, per A.A.C. R20-5-154, is required to send a copy of the response to the claimant or the claimant's attorney, if represented. Failure to timely respond may be considered "unfair claim processing practices" under A.A.C. R20-5-163(B)(2-3).

- The designated duty Administrative Law Judge may request additional information or documentation from either party. Failure to comply with the designated duty Administrative Law Judge's request may result in sanctions, up to and including dismissal. If the designated duty

Administrative Law Judge determines that a denial of compensation was improper in any way, the file will be assigned to a presiding Administrative Law Judge and set for an expedited hearing.

- If an injured worker files an accompanying bad faith complaint that raises the same issues as set forth in a filed (J) request, the Claims Division will hold the bad faith complaint in abeyance until the (J) request is resolved or as otherwise directed by the presiding Administrative Law Judge.

Request for Designation of Carrier Pursuant to A.R.S. § 23-1061(K):
When there is a dispute with multiple potential statutory employers over which carrier is liable for payment of benefits of a compensable claim, the ICA may, by the issuance of an award, designate one of the carriers to pay the benefits until a final determination has been made as to which carrier is actually liable for the payment of benefits.

- When it appears to the Commission, or upon application by one of the parties involved, that invoking A.R.S. § 23-1061(K) is appropriate, inquiry is made of the carriers and/or carriers' attorneys to clarify the issue of compensability.
    - If the dispute is **limited solely to which carrier is liable**, an award is issued directing one of the carriers to commence the payment of benefits within 14 days from the date of the award.
- The provisions of A.R.S. § 23-1061(K) will not be applied unless all parties, including the employers, agree in writing that the only issue is the responsible carrier.

Following litigation, the Administrative Law Judge's award will provide for the monetary adjustment or reimbursement between the parties involved. If the matter is not addressed in the Administrative Law Judge Decision, the Claims Division will issue an appropriate award.

Best Practice:
See our YouTube Video: Hearing Process to supplement this chapter.

MEDICAL RESOURCE OFFICE

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Directed Care

When Can Medical Care Be Directed?

The only entities authorized to direct care in Arizona are private self-insured employers. Employees of insured employers or public self-insured entities have the right to choose their own medical providers. See A.RS. § 23-1070(A); Southwest Gas Corp. v. Indus. Comm 'n, 200 Ariz. 292, 25 P.3d 1164 (2001).

A list of authorized self-insured employers can be found here on the Claims Division Website. Please see letter below from Chairman Schultz proving further guidance.

THE INDUSTRIAL COMMISSION OF ARIZONA
OFFICE OF THE DIRECTOR

DALE L. SCHULTZ, CHAIRMAN
JOSEPH M. HENNELLY, JR., VICE CHAIR
SCOTT P. LEMARR, MEMBER
STEVEN J. KRENZEL, MEMBER

P.O. Box 19070
Phoenix, Arizona 85005-9070

JAMES ASHLEY, DIRECTOR
PHONE: (602) 542-4411
FAX: (602) 542-7889

December 12, 2018

Directed Care in Arizona Workers' Compensation Claims

Dear Stakeholder,

The Industrial Commission of Arizona continues to receive complaints about entities that are directing care in violation of the Arizona Workers' Compensation Act. Please be advised that the ***only*** entities authorized to direct care in Arizona are private self-insured employers. Employees of insured employers or public self-insured entities have the right to choose their own medical providers. *See* A.R.S. § 23-1070(A); *Southwest Gas Corp. v. Indus. Comm'n,* 200 Ariz. 292, 25 P.3d 1164 (2001).

The Commission is aware that some workers' compensation insurance carriers and public self-insured employers use "networks" of "preferred" providers in processing workers' compensation claims. Although the appropriate use of "networks" may not violate Arizona law, any conduct that impairs or obstructs the right of injured workers to choose a medical provider or that results in a delay of medical care may constitute bad faith under A.R.S. § 23-930 and Arizona Administrative Code R20-5-163. *See* R20-5-163(A)(6) ("bad faith" includes "unreasonabl[e] interfer[ence] with or obstruct[ion of] the claimant's right to choose the claimant's attending physician except in cases involving a self-insured employer under A.R.S. § 23-1070"); R20-5-163(A)(2) ("bad faith" includes "unreasonably delay[ing]" either the "[p]ayment of benefits" or "[a]uthorization for, or receipt of, medical benefits or treatment."). Examples of improper conduct include:

- Requiring an injured worker to use a "network" or "preferred" provider.
- Communications that imply that an injured worker is required to use a "network" or "preferred" provider.
- Threatening non-payment if an injured worker treats with a "non-network" or "non-preferred" provider.
- Directing "network" or "preferred" providers to only refer injured workers to other "network" or "preferred" providers.
- Requiring "non-network" or "non-preferred" providers to join a network to be able to treat an injured worker.
- Unreasonably delaying medical payments to "non-network" or "non-preferred" providers (*see* A.R.S. § 23-1062.01).

800 West Washington Street, Phoenix, Arizona 85007
2675 East Broadway Boulevard, Tucson, Arizona 85716
www.azica.gov

This letter is intended to be a reminder of Arizona law and serve to prevent inappropriate use of directed care in the future. The Commission intends on holding insurance carriers and public self-insured employers responsible for the actions and conduct taken on their behalf by agents (including networks). To this end, the Commission will be pursuing bad faith on its own motion, where appropriate, to enforce Arizona's directed care law. *See* A.R.S. § 23-930(A); A.A.C. R20-5-163(F). If any interested party or provider believes that an entity is directing care in violation of the Arizona Workers' Compensation Act, they are encouraged to notify the Medical Resource Office at mro@azica.gov or the Claims Division at claims@azica.gov.

Sincerely,

Dale Schultz
Chairman

EVIDENCE-BASED TREATMENT GUIDELINES

Background

See A.R.S. § 23-1062.03, Title 20, Chapter 5, Article 13 of the Arizona Administrative Code ("Article 13" or the "Treatment Guidelines". The Treatment Guidelines: (1) prescribed the use of evidence-based treatment guidelines as a tool to support clinical decision making and quality health care delivery to injured workers within Arizona's workers' compensation system; (2) adopted Work Loss Data Institute's *Official Disability Guidelines – Treatment in Workers Compensation* (the "*Official Disability Guidelines*" or "ODG") as the standard reference for evidence-based medicine; (3) outlined a noncompulsory process for a medical provider or injured worker to seek preauthorization from a payer for medical services or treatment; (4) established an administrative review process to help resolve disputes between medical providers, injured workers, and payers; and (5) outlined procedures for bringing unresolved disputes to the Commission for administrative hearing.

Streamlining the Treatment Guidelines' Authorization Process

Commission approved the following methods for streamlining the Article 13 authorization process (effective October 1, 2018):

1. Mandate the use of a Medical Treatment Preauthorization Form with accompanying instructions; and
2. Reduce the time period within which a payer must respond to requests for preauthorization or reconsideration from ten business days to seven business days.
3. The Commission took formal action to modify the applicability of the *Official Disability Guidelines* to all body parts and conditions, effective October 1, 2018.

Available Resources

The following resources regarding the Treatment Guidelines are posted on the Commission's Medical Resource Office webpage: (https://www.azica.gov/divisions/medical-resource-office-mro)

- Full Text of the Treatment Guideline (A.A.C. R20-5-1301 through R20-5-1312).
- Information regarding the *Official Disability Guidelines*: https://www.mcg.com/odg
- Flowcharts regarding the Authorization, Reconsideration, and Peer Review Processes.
- Frequently Asked Questions regarding the Treatment Guidelines.
- Recorded Webinars on pertinent forms, processes, and the *Official Disability Guidelines*.
- Information regarding the MRO Portal.
- MRO Medical Treatment Preauthorization Form and Instructions.

Treatment Guidelines FAQs

Introduction to the Treatment Guidelines

Why Did the Industrial Commission Implement the Treatment Guidelines (A.A.C. R20- 5-1301 through R20-5-1312)?

In April 2012, Arizona lawmakers passed House Bill 2368, which required the Industrial Commission to "develop and implement a process for the use of evidence-based treatment guidelines, where appropriate, to treat injured workers." *See* A.R.S. § 23-1062.03.

What are the Treatment Guidelines?
The Treatment Guidelines are a series of twelve administrative rules published in Title 20, Chapter 5, Article 13 of the Arizona Administrative Code. *See* A.A.C. R20-5-1301 through R20-5-1312.

Among other things, the Treatment Guidelines: (1) prescribe the use of evidence-based medical treatment guidelines as a tool to support clinical decision making and quality health care delivery to injured employees within the context of Arizona's workers' compensation system; (2) adopt the Official Disability Guidelines–Treatment in Workers Compensation ("ODG"), by MCG, as the standard reference for evidence-based medicine; (3) outline a noncompulsory process for a medical provider or injured employee to seek preauthorization from a payer for medical services or treatment; (4) establish an administrative review process to help resolve disputes between medical providers/injured employees and payers; and (5) outline procedures for bringing unresolved disputes to the Industrial Commission for hearing.

The Treatment Guidelines and ODG are intended to improve the quality and outcomes of medical care in the context of Arizona's workers' compensation system and to improve the efficiency and effectiveness of the process under which medical care is provided to injured employees.

When did the Treatment Guidelines Go into Effect?
The Treatment Guidelines went into effect on October 1, 2016, but were initially limited to the management of chronic pain and the use of opioids for all stages of pain management. Effective October 1, 2018, the Treatment Guidelines apply to all body parts and conditions that have been accepted as compensable.

Where Can I Find the Administrative Rules About the Treatment Guidelines?
The rules may be found Title 20, Chapter 5, Article 13 of the Arizona Administrative Code.

Does the Industrial Commission Have a Flowchart of the Treatment Guidelines Administrative Process?
Yes. The preauthorization, reconsideration, and administrative review process flowcharts may be found on the MRO webpage: https://www.azica.gov/divisions/medical-resource-office-mro.

What is ODG?
ODG is a nationally recognized, evidence-based, comprehensive treatment guide that contains treatment guidelines for work related injuries and illnesses. To learn more about ODG, please visit the ODG website: https://www.mcg.com/odg/.

Why did the Industrial Commission Adopt ODG?
The Industrial Commission conducted an extensive and independent evaluation of medical treatment guidelines commonly used in workers' compensation. Public hearings were held on the subject and ultimately the Industrial Commission adopted ODG as the standard of reference for evidence-based medicine to be used in treating injured employees in the Arizona workers' compensation system. ODG has been adopted by more states and provinces than any other treatment guideline.

By adopting and referencing the most recent ODG edition (at the time of treatment), the Industrial Commission seeks to ensure that current medical evidence is used to make treatment decisions for Arizona's injured employees.

To What Extent Has the Industrial Commission Adopted ODG?
The Treatment Guidelines went into effect on October 1, 2016, but the use of ODG was initially limited to the management of chronic pain and the use of opioids for all stages of pain management. In 2017,

On December 21, 2017, following an evaluation of the study materials and stakeholder feedback, the Commission determined (at a public Commission meeting) that modifying the applicability of ODG to cover all body parts and conditions would improve medical treatment for injured workers and would make treatment and claims processing more efficient and cost effective. In addition, based upon written reviews received from board-certified physicians in Arizona (representing various specialties), the Commission determined that ODG adequately covers all body parts and conditions. Based on these determinations, the Commission took formal action to modify the applicability of ODG to all body parts and conditions, effective October 1, 2018.

Does ODG Apply to Supportive Care Awards?
As it pertains to the management of chronic pain and the use of opioids for all stages of pain management, ODG applies to medical care or services included in supportive care awards issued on or after October 1, 2016. Effective October 1, 2018, ODG applies to all other medical treatment or services included in supportive care awards.

For supportive care awards issued before October 1, 2016, that involve the management of chronic pain or the use of opioids or for supportive care awards issued before October 1, 2018, that involve other medical treatment or services, please consult an attorney to discuss whether the supportive care award may be modified.

Does ODG Apply Regardless of the Date of Injury?
Yes. ODG and the Treatment Guidelines apply to claims, regardless of the date of injury.

What is the Definition of "Chronic Pain" in the Treatment Guidelines?
For the purpose of the Treatment Guidelines, "chronic pain" is defined by ODG. ODG defines "chronic pain" as "pain that persists 30 days after the ODG Best Practice recommended disability duration for the diagnoses in question."

How Should a Medical Provider Use ODG When Treating an Injured Employee?
ODG should be used as a tool to support clinical decision making and quality health care delivery to injured employees. ODG sets forth care that is generally considered reasonable and is presumed correct if the guidelines provide recommendations related to the requested treatment or service.

Can a Medical Provider Deviate from ODG?
ODG sets forth care that is generally considered reasonable and is presumed correct if the guidelines provide recommendations related to the requested treatment or service. The presumption of correctness is rebuttable and medical care may, where appropriate, include deviations from ODG. To support a deviation from ODG, a provider must be able to produce documentation and justification that demonstrates by a preponderance of the credible medical evidence, a medical basis for departing from ODG. A "preponderance of the credible medical evidence" means that there is enough evidence to make it more likely than not that there is a medical basis for departing from ODG. Credible medical evidence may include clinical expertise and judgment.

Can a Payer Decline to Pay for Provided Treatment or Services Supported by ODG?
ODG sets forth care that is generally considered reasonable and is presumed correct if the guidelines provide recommendations related to the requested treatment or service. A payer can decline to pay for provided treatment or services supported by ODG *only if* the payer can rebut the presumption of correctness

with a medical or psychological opinion establishing by a preponderance of the evidence that there is a medical contraindication or significant medical or psychological reason not to pay for the treatment or services.

Disputes related to a payer's failure to pay for provided treatment or services may be processed as a request for investigation and hearing under A.R.S. § 23-1061(J). To request review under A.R.S.

§ 23-1061(J), the injured employee must file a request for hearing with the Industrial Commission. The request for hearing form may be found here.

How is ODG Organized?
ODG is divided into chapters, each based on specific body parts (such as "knee and leg") or general conditions (such as "pain"). Each chapter has a "Procedure Summary" section which includes a comprehensive list of treatments that might apply to an injury to the applicable body part or that might be used to treat the applicable condition. Treatment procedures are designated as "recommended," "not recommended," or "under study." All recommendations are based on comprehensive and ongoing medical literature reviews. Treatment recommendations are linked to supporting medical evidence, provided in abstract form, which has been ranked, highlighted, and indexed. Full text copies supporting medical studies are also available.

Who Develops and Authors ODG?
As part of MCG Health, the ODG editorial department analyzes and classifies peer-reviewed papers and research studies each year to develop the care guidelines. ODG's guidelines are in strict accordance with the principles of evidence-based medicine. Thousands of references and unique citations are reviewed and ranked annually. For external peer review, ODG also has an Editorial Advisory Board of physicians who are engaged for peer review on an annual basis.

How Often is ODG Updated?
ODG is continuously updated, reflecting the findings of new studies as they are conducted and released. ODG undergoes a comprehensive annual update process based on scientific medical literature review, claims data analysis, and expert panel validation. As new studies are released, the Web version of ODG is updated throughout the year.

How Can I Access ODG?
ODG is available in a subscription-based website. Individuals or companies can purchase annual licenses to access ODG on the Web. ODG is also available for integration into software platforms.

Individual practitioners and attorneys in Arizona may receive 50% off the current subscription price. Reference "Arizona" in your order inquiry.

How Do I Navigate and Use ODG?
The following training webinars introduce ODG and the Treatment Guidelines. The webinars illustrate how to navigate and interpret ODG and the ODG Drug Formulary:

October 14, 2021 ICA-ODG Training (Arizona-specific) Monthly Intro to ODG by MCG

Self-Training Tools
The recorded webinars above and links to other Treatment Guidelines resources may also be found on the MRO webpage: https://www.azica.gov/divisions/medical-resource-office-mro.

ODG Drug Formulary

Is the ODG Drug Formulary Applicable in Arizona?

Yes. Effective October 1, 2018, Appendix A, ODG Workers' Compensation Drug Formulary will be applicable to all body parts and conditions that have been accepted as compensable. A copy of the formulary can be accessed at no charge on the MRO webpage: https://www.azica.gov/divisions/medical-resource-office-mro.

What are "Y" and "N" Drugs in the ODG Drug Formulary?

The ODG Drug Formulary designates each drug class as a "Y" drug or an "N" drug. A "Y" drug is a preferred drug (*i.e.*, a first-line drug). An "N" drug is not recommended as a first-line treatment by ODG. "N" does not mean "No." Instead, "N" drugs need to be substantiated as appropriate and medically necessary.

Can a Payer Immediately Stop Authorizing Medications that are Not Supported by ODG or the ODG Drug Formulary?

The intent of the Treatment Guidelines is **not** to immediately deny employees medications already in use, **even where** the medications are not recommended by ODG. Because medications can

involve dependency and addiction issues, drug rehabilitation and/or detoxification treatment may be necessary. ODG recommends weaning when evidence exists of substance misuse, abuse, or addiction. Consult ODG for further information regarding recommended weaning protocols for particular medications.

In the event a dispute arises regarding the necessity or propriety of drug rehabilitation and/or detoxification treatment, payers should continue to provide the disputed medication until a final determination is made, either in the administrative review process or by an Administrative Law Judge. *See* A.R.S. § 23-1062.02(F).

The Preauthorization Process

Who is a "Payer" Under the Treatment Guidelines?

A "payer" includes: (1) an insurance carrier defined under A.R.S. § 23-901; (2) a self-insured employer defined under A.A.C. R20-5-102; (3) a third-party administrator; or (4) the Special Fund of the Industrial Commission.

What is Preauthorization?

Preauthorization is a written request made by a medical provider (using Section I (Provider Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form) to a payer, requesting approval to provide specified medical treatment or services to an injured employee. The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found here.

Are Medical Providers Required to Request Preauthorization Before Providing Medical Treatment or Services to an Injured Employee?

No. Preauthorization is not required to ensure payment for reasonably required medical treatment or services. Although preauthorization is not required, providers are permitted to seek preauthorization to obtain pre-approval from a payer for a medical treatment or service. Pre- approval ensures that a provider will be paid for treatment or services rendered and permits a provider to avoid the risk that a payer will deny payment on grounds that a treatment or service was not reasonably required and appropriate under

ODG or on grounds that there is a medical contraindication or significant medical or psychological reason not to pay for the treatment or services supported by ODG.

Effective October 1, 2018, requests for preauthorization must be in writing using Section I (Provider Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found here. Requests for preauthorization must be submitted **to a payer** by mail, electronically, or fax.

Which Drugs on the ODG Drug Formulary are Subject to Preauthorization?
Preauthorization is not required to ensure payment for reasonably required medical treatment or services, including medication. Although preauthorization is not required, medical providers are permitted to seek preauthorization to obtain pre-approval from a payer for prescriptions. Pre- approval ensures a provider will be paid for the medication and helps avoid the risk that a payer will deny payment on grounds that the medication was not reasonably required and appropriate under ODG or on grounds that there is a medical contraindication or significant medical or psychological reason not to pay for a medication supported by ODG, especially for medications designated as "N" drugs in the ODG Drug Formulary.

The ODG Drug Formulary designates each drug class as a "Y" drug or an "N" drug. A "Y" drug is a preferred drug (a first-line drug). An "N" drug is not recommended as a first-line treatment in ODG. "N" does not mean "No." Instead, "N" drugs need to be substantiated as appropriate and medically necessary.

As a practical matter, many pharmacies have connectivity with payers through a pharmacy benefit manager (PBM). Pharmacies will frequently request preauthorization for medications in order to confirm they will be paid for those medications before they dispense. When a request for preauthorization is received by a payer, either directly or through a PBM, the payer (or their PBM) may approve or deny the request (in whole or in part). Requests for preauthorization of medication follow the same procedure as requests for preauthorization for other medical treatment or services.

Effective October 1, 2018, requests for preauthorization must be in writing using Section I (Provider Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found here. Requests for preauthorization may be submitted **to a payer** by mail, electronically, or fax.

How Do I Submit a Preauthorization Request to a Payer?
Effective October 1, 2018, a provider **must** submit a request for preauthorization in writing using Section I (Provider Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. A provider must attach documentation to a request for preauthorization that supports the medical necessity and appropriateness of the treatment or services requested, such as office notes and diagnostic reports. Preauthorization requests may be submitted by mail, electronically, or by fax directly to a payer. **Providers should not submit preauthorization requests to the Industrial Commission**.

The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found here.

Can a Payer Deny a Preauthorization Request or Refuse to Make Payment for a Provided Treatment or Service Solely Because ODG Does Not Address the Requested Treatment or Service?
No. A payer may not deny or decline to pay for reasonably required medical treatment or services solely because ODG does not address the requested treatment or service.

Can a Payer Deny a Preauthorization Request Supported by ODG?
ODG sets forth care that is generally considered reasonable and is presumed correct if the guidelines provide recommendations related to the requested treatment or service. A payer may deny a preauthorization request supported by ODG **only if** the payer can rebut the presumption of correctness with a medical or psychological opinion establishing by a preponderance of the evidence that there is a contraindication or significant medical or psychological reason not to authorize the requested treatment or services.

Where a payer denies a preauthorization request for a treatment or service supported by ODG, the medical provider or injured worker may bypass the reconsideration process and immediately request administrative review from the Industrial Commission (unless the payer obtained an IME in support of its denial, *see* below).

If a payer obtains an IME in support of its denial, review of the payer's decision will be processed as a request for investigation under A.R.S. § 23-1061(J). To request review under A.R.S. § 23- 1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found here.

Can a Payer Authorize Requested Treatment or Services in Part and Deny Requested Treatment or Service in Part?
Yes. Where appropriate, payers should approve preauthorization requests to the extent the requested treatment or services are reasonably required. Payers should not deny entire preauthorization requests simply because some part of the requested treatment or services are not reasonably required or not supported by ODG.

Can a Payer Change a Decision to Deny Requested Treatment or Services?
Yes. A payer can reverse their decision to deny treatment or services at any time through the preauthorization and/or administrative review process. A payer's authorization of a requested treatment or service ends the preauthorization process.

What Happens After a Preauthorization Request is Submitted to a Payer?
Effective October 1, 2018, a payer is required to respond to a complete preauthorization request **within 7 business days** after the request is received. To insure timely processing, payers are encouraged to establish effective processes for receiving and reviewing preauthorization requests.

Effective October 1, 2018, a payer must respond to preauthorization requests by using Section II (Payer Decision on Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. The payer's response should be sent to the provider using the provider's preferred method of contact (as indicated by the provider in Section I of the MRO-1.1 Medical Treatment Preauthorization Form).

The payer's response to a request for preauthorization may include one of the following:

Preauthorization decision. The payer's response to a request for preauthorization can approve, deny, or partially approve and partially deny requested medical treatment or services. The decision must be made using Section II (Payer Decision on Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. A payer must attach to its response a statement of the approved treatment or services or, if not approved, the reasons supporting a denial/partial denial. If requested treatment or services are denied, the payer must provide a copy of its preauthorization decision to the injured employee or, if represented, to the injured employee's authorized representative.

Notification to the provider that the preauthorization request is incomplete. Upon receipt and identification of a deficient request for preauthorization – either because the request was not submitted using Section I (Provider Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form or because a request submitted on Section I of the MRO-1.1 Medical Treatment Preauthorization Form is incomplete – a payer may choose to either: (a) render a decision on the request (*see* (1) above); or (b) provide written notice to the provider that the request is incomplete by using Section II (Payer Decision on Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. A payer **must** either render a decision on an incomplete preauthorization request or provide notice to the provider of a deficiency **within 7 business days** after an incomplete preauthorization request is received and identified. A provider may cure a defect in a preauthorization request and resubmit a corrected request to the payer (and thereby restart the process).

Notification to the provider that an IME has been requested under Arizona Administrative Code R20-5-114. Where a payer requests an IME after receiving a preauthorization request, the payer should notify the provider **within 7 business days** after the request is received that an IME has been requested using Section II (Payer Decision on Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. Where a payer requests an IME, the time for rendering a preauthorization decision (under

(1) above) is suspended. In this circumstance, the payer's decision on a preauthorization request must be issued no later than **7 business days** after the final IME report has been received by the payer. The payer is required to provide a copy of the final IME report to the provider upon receipt of the report.

Where a payer obtains an IME in support of its decision, review of the payer's decision will be processed as a request for investigation under A.R.S. § 23-1061(J). To request review under A.R.S. § 23-1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found here.

The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found here.

Who Should Receive a Copy of the Payer's Preauthorization Decision?
A payer must provide a copy of its written preauthorization decision to the requesting provider. When requested treatment or services are denied, the payer must provide a copy to the injured employee and, if applicable, to their authorized representative.

What if a Payer Does Not Respond to a Preauthorization Request?
If a payer does not communicate its preauthorization decision **within 7 business days after the request is received**, the payer's non-action is deemed a "no response" and the provider or injured employee may bypass the reconsideration process and immediately request administrative review from the Industrial Commission.

In addition, a payer's failure to comply with the required time limits may be considered an unreasonable delay under Arizona Administrative Code R20-5-163.

Can a Payer Delegate Preauthorization Decision-Making to an Agent, Such as a Third- Party Administrator or Pharmacy Benefits Manager?
Yes. However, any preauthorization or reconsideration decision by a payer's agent, including a third-party administrator or pharmacy benefits manager, is binding on the payer. Payers cannot avoid responsibility under the Treatment Guidelines by delegating decision-making authority to an agent.

Can a Payer Require that Preauthorization Requests be Submitted Directly to an Agent of the Payer, such as a Third-Party Administrator or Pharmacy Benefits Manager?
No. Payers may ask, but cannot require medical providers to submit preauthorization requests to the payer's agent, such as a third-party administrator or pharmacy benefits manager. Payers may not reject or ignore preauthorization requests simply because they are submitted to the payer, rather than the payer's authorized agent. Payers who delegate review authority to an agent should establish an effective process for promptly forwarding preauthorization requests to the payer's designated agent. The deadlines imposed by the Treatment Guidelines are not suspended when a request is submitted to a payer who then forwards the request to its agent for review and decision.

The Reconsideration Process

If a Payer Has Denied a Preauthorization Request, is a Medical Provider or Injured Employee Required to Ask the Payer to Reconsider its Decision?
Generally, an injured employee or medical provider must seek reconsideration of a payer's decision to deny requested medical treatment or services before requesting administrative review from the Industrial Commission.

Where a payer obtained an IME in support of its decision, a request for reconsideration is permissible, but not required. Review of the payer's decision in these circumstances will be processed as a request for investigation under A.R.S. § 23-1061(J). To request review under A.R.S. § 23-1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found here.

Where the payer denies a preauthorization request for a treatment or service **supported by ODG**, the medical provider or injured worker may bypass the reconsideration process and immediately request an administrative review from the Industrial Commission (unless the payer obtained an IME in support of its denial).

If a payer does not communicate its preauthorization decision **within 7 business days** of receiving the request, the payer's non-action is deemed a "no response" and the provider or injured employee may bypass the reconsideration process and immediately request administrative review from the Industrial Commission.

How Do I Submit a Request for Reconsideration to a Payer?
Reconsideration requests must be in writing using Section III (Provider or Employee Request for Reconsideration of Payer Decision) of the MRO-1.1 Medical Treatment Preauthorization Form and must attach the specific reasons and justifications to support reconsideration. If not previously provided, the injured employee or provider must also include supporting medical documentation with a request for reconsideration. Reconsideration requests should be sent to the payer using the payer's preferred method of contact (as indicated by the payer in Section II of the MRO-1.1 Medical Treatment Preauthorization Form). **Providers should not submit reconsideration requests to the Industrial Commission.**

The MRO-1.1 Medical Treatment Preauthorization Form and Instructions can be found here.

What Happens After a Reconsideration Request is Submitted to a Payer?
Effective October 1, 2018, a payer is required to respond to a reconsideration request **within 7 business days** after the request is received. To insure timely processing, payers are encouraged to establish effective processes for receiving and reviewing reconsideration requests.

Effective October 1, 2018, a payer must respond to a reconsideration request by using Section IV (Payer Decision on Request for Reconsideration) of the MRO-1.1 Medical Treatment Preauthorization Form. The payer's response should be sent to the provider using the provider's preferred method of contact (as indicated by the provider in Section I of the MRO-1.1 Medical Treatment Preauthorization Form).

The payer's response to a request for reconsideration may include one of the following:

Reconsideration decision. The payer's response to a request for reconsideration may approve, deny, or partially approve and partially deny requested medical treatment or services. The decision must be made using Section IV (Payer Decision on Request for Reconsideration) of the MRO-1.1 Medical Treatment Preauthorization Form. A payer must also attach to its response a statement of the approved treatment or services or, if not approved, the reasons supporting a denial/partial denial. If requested treatment or services are denied, the payer must provide a copy of its decision to the injured employee or, if represented, to the injured employee's authorized representative.

Notification to the provider that an IME has been requested under Arizona Administrative Code R20-5-114. Where a payer requests an IME after receiving a reconsideration request, the payer should notify the provider **within 7 business days** after the request is received that an IME has been requested using Section IV (Payer Decision on Request for Reconsideration) of the MRO-1.1 Medical Treatment Preauthorization Form. Where a payer requests an IME, the time for rendering a reconsideration decision (under (1) above) is suspended. In this circumstance, the payer's decision on a reconsideration request must be issued no later than **7 business days** after the final IME report has been received by the payer. The payer is required to provide a copy of the final IME report to the provider upon receipt of the report.

Where a payer obtains an IME in support of its decision, review of the payer's decision will be processed as a request for investigation under A.R.S. § 23-1061(J). To request review under A.R.S. § 23-1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found here.

The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found here.

Who Should Receive a Copy of the Payer's Reconsideration Decision?
A payer must provide a copy of its written reconsideration decision to the requesting provider. When requested treatment or services are denied, the payer must provide a copy to the injured employee and, if applicable, to their authorized representative.

What if a Payer Does Not Respond to a Reconsideration Request?
If a payer fails to communicate its reconsideration decision to the requesting provider **within 7 business days** after the request is received, the provider or injured employee may immediately request administrative review from the Industrial Commission.

In addition, a payer's failure to comply with the required time limits may be considered to be an unreasonable delay under Arizona Administrative Code R20-5-163.

Can a Payer Delegate Reconsideration Decisions to an Agent, Such as a Third-Party Administrator or Pharmacy Benefits Manager?
Yes. However, any preauthorization or reconsideration decision by a payer's agent, including a third-party administrator or pharmacy benefits manager, is binding on the payer. Payers cannot avoid responsibility by delegating decision-making authority to an agent.

Can a Payer Require that Reconsideration Requests be Submitted to an Agent of the Payer, Such as a Third-Party Administrator, Review Organization, or Pharmacy Benefits Manager?
No. Payers may ask, but cannot require injured employees or medical providers to submit reconsideration requests to the payer's agent, such as a third-party administrator, review organization, or pharmacy benefits manager. Payers may not reject reconsideration requests simply because they are submitted to the payer, rather than the payer's agent. Payers who delegate review authority to an agent should establish an effective process for promptly forwarding reconsideration requests to the payer's designated agent. The deadlines imposed by the Treatment Guidelines are not suspended when a request is submitted to a payer who then forwards the request to an agent for consideration and decision.

The Administrative Review Process

What is an Administrative Review?
Administrative review is a process that includes a peer review of a denied or partially denied request for preauthorization/reconsideration. The administrative review process is administered by the Industrial Commission's Medical Resource Office.

Effective October 1, 2018, the administrative review process applies to medical treatment or services related to all body parts and conditions that have been accepted as compensable.

Who Can Request Administrative Review from the Industrial Commission?
A medical provider, injured employee, or their authorized representative may request administrative review by the Industrial Commission in the following circumstances:

- The payer failed to timely respond to a medical provider's preauthorization or reconsideration request.
- The payer denied a preauthorization request for a medical treatment or service supported by the ODG.
- The payer denied a reconsideration request for a medical treatment or service.
- If a payer obtained an IME in support of its decision, administrative review is not available. Review of a payer's decision in these circumstances will be processed as a request for investigation under

What is Required to Request Administrative Review?
The Industrial Commission's Medical Resource Office will screen all requests for administrative review to determine whether administrative review is appropriate. To qualify for administrative review, the following criteria must be satisfied:

- The requesting party is either the medical provider or an injured employee.
- The relevant body part and/or condition has been accepted as compensable.
- A preauthorization request has been submitted to the payer.
- The preauthorization request has been denied, in whole or in part, or the payer has failed to respond to the preauthorization request in a timely manner.
- A request for reconsideration has been submitted to the payer (**only required if**: (1) the payer timely responded to the preauthorization request; and (2) the preauthorization denial was supported by ODG).
- The payer's preauthorization or reconsideration decision was not supported by an IME. If any of the foregoing requirements are not satisfied, administrative review is unavailable.

Can Payers Request Administrative Review?
No. Only an injured employee, their authorized representative, or a provider may seek administrative review. Payers have the authority to render decisions regarding requested medical treatment or services and may not seek administrative review to resolve disputes regarding requested medical treatment or services. Payers, however, may request IMEs to assist in rendering decisions regarding requested medical treatment or services.

Can Administrative Review Be Requested When a Payer's Decision is Supported by an IME?
No. If the payer obtains an IME in support of its decision, administrative review is not available. Review of the payer's decision in these circumstances will be processed as a request for investigation under A.R.S. § 23-1061(J). To request review under A.R.S. § 23-1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found here.

How Do I Submit a Request for Administrative Review?
Requests for administrative review must be in writing using Section V (Provider or Employee Request for Administrative Review) of the MRO-1.1 Medical Treatment Preauthorization Form, and must attach: (1) copies of all relevant medical records and (if applicable) documentation related to the payer's non-response; and (2) copies of all documentation and statement previously attached to Sections I-IV of the MRO-1.1 Medical Treatment Preauthorization Form. The MRO-

1.1 Medical Treatment Preauthorization Form and Instructions can be found here.

Requests for administrative review may be submitted electronically through the MRO Portal.

Alternatively, requests for administrative review may be faxed to (602)-542-4797,

e-mailed to MRO@azica.gov, or mailed to:
Industrial Commission of Arizona Medical Resource Office
800 West Washington Street
Phoenix, AZ 85007

What Happens After a Request for Administrative Review is Submitted to the Industrial Commission?
Upon receipt for a request for administrative review, the Industrial Commission's Medical Resource Office will screen the request to determine whether administrative review is available. To qualify for administrative review, the following criteria must be satisfied:

- The requesting party is either the medical provider or an injured employee.
- The relevant body part and/or condition has been accepted as compensable.
- A preauthorization request has been submitted to the payer.
- The preauthorization request has been denied, in whole or in part, or the payer has failed to respond to the preauthorization request in a timely manner.
- A request for reconsideration has been submitted to the payer (only required if: (1) the payer timely responded to the preauthorization request; and (2) the preauthorization denial was supported by ODG).
- The payer's preauthorization or reconsideration decision was not supported by an IME.
- If any of the foregoing requirements are not satisfied, administrative review is unavailable and the Industrial Commission will send a notice to the injured employee and payer (within three business days), advising that administrative review is not available.

- If the foregoing requirements are satisfied, the Industrial Commission will send a notice to the payer within three business days advising that it has received the request for administrative review. The notice will provide information on how to participate in the administrative review process.

Who Performs an Administrative Review?
Administrative review consists of a peer review performed by an individual that holds an active, unrestricted license or certification to practice medicine or a health profession. The peer reviewer must have actively practiced medicine or a health profession during the five preceding years. "Active practice" means performing patient care for a minimum of eight hours per week in one of the five preceding years. The peer reviewer must also be in the same profession and the same specialty or subspecialty as typically performs or prescribes the medical treatment or services requested. Finally, the peer reviewer must be licensed in Arizona, unless the Industrial Commission or its peer review contractor is unable to find such an individual.

Currently, the Industrial Commission contracts with Maximus, a URAC accredited peer-review vendor.

The Industrial Commission has utilized a robust conflict check to ensure that administrative review determinations are fair and impartial.

Who Pays for an Administrative Review?
The payer is responsible for paying the costs of the peer review performed by the URAC accredited peer-review vendor.

What is the Cost of an Administrative Review?
The current fee schedules for peer review are as follows:
Expedited Reviews Up to 60 pages: $350.00
Up to 199 pages: $350.00 Over 200 pages: $350 .00
Standard Reviews
Up to 60 pages: $250.00 Up to 199 pages: $350.00 Over 200 pages: $350.00
Peer reviews terminated or dismissed before forwarding to a medical reviewer: $100.00.

What is Involved in a Peer Review?
The peer review will consist of a records review and, when possible, a consultation between the medical provider and the peer reviewer. The peer reviewer must make a good faith effort to contact the provider requesting the preauthorization. The good faith effort must include making telephone contact during the provider's normal business hours and offering to schedule the peer review at a time convenient for the provider.

Can a Provider Bill a Payer for Time Spent Participating in a Peer-to-Peer Conversation with the Individual Conducting the Peer Review?
Yes. Arizona's Physicians' Fee Schedule includes codes for time spent participating in a peer-to- peer consultation with an individual conducting a peer review. Code AZ099-001 should be used for a peer-to-peer consultation lasting between 5-10 minutes. Code AZ099-002 should be used for a peer-to-peer consultation lasting between 11-30 minutes.

During the Administrative Review, Can the Industrial Commission or Peer Review Vendor Request Additional Information or Documentation from the Provider, Injured Employee, or Payer?
Yes. A medical provider, injured employee, their authorized representative, or payer must cooperate and provide the Industrial Commission or the peer-review vendor with any necessary medical information, including information pertaining to the payer's decision.

What is the Timeframe for Completing an Administrative Review?
Administrative review determinations should be issued within two to three weeks from the date of receipt of the request for administrative review. The peer review vendor will send the administrative review determination to the injured employee (or their representative), the provider, and the payer.

What is Included in the Administrative Review Determination?
An administrative review determination must include the information listed in Arizona Administrative Code R20-5-1311(K).

Who Should Receive a Copy of an Administrative Review Determination?
The payer, injured employee, their authorized representative (if applicable), and the provider should be provided a copy of the administrative review determination.

Post-Administrative Review

Can an Administrative Review Determination Be Contested?
Yes. An interested party (defined by A.R.S. § 23-901 to include the employer, employee, and insurance carrier [or their representative]) dissatisfied with the administrative review determination may request that the dispute be referred to the Industrial Commission's Administrative Law Judge Division for hearing.

The request for hearing must be in writing, be filed no later than 10 business days after the administrative review determination is issued, and state whether the party requests to participate in the Fast Track ALJ Dispute Resolution Program by stipulation. The request for hearing form may be found here.

What is the Effect of the Administrative Review Determination if it is Contested?
If a timely request for hearing is filed, the administrative review determination is deemed null and void and will serve no evidentiary purpose. The administrative review determination will be inadmissible and testimony concerning the administrative review determination will have no evidentiary value.

ODG is generally considered reasonable and is presumed correct. In practice, if denied medical treatment or services are supported by ODG, the payer will have the burden of rebutting the presumption of correctness with documentation and justification that demonstrates by a preponderance of the credible medical a medical basis for departing from ODG.

The same is true for denied medical treatment or services not supported by ODG. In these circumstances, the injured employee will have the burden of rebutting the presumption of correctness by demonstrating by a preponderance of the credible medical evidence a medical basis for deviating from ODG. Credible medical evidence may include clinical expertise and judgment.

What is the Fast Track ALJ Dispute Resolution Program?
The Fast Track ALJ Dispute Resolution Program is a voluntary dispute-resolution program designed to expedite review of contested administrative review determinations. The following are elements of the program:

- Parties must agree to participate in the program with the understanding that a short form

decision will be issued.

- Review by the presiding Administrative Law Judge (ALJ) will be limited to the treatment or service dispute considered during the administrative review process.
- The presiding ALJ will issue a notice of hearing within ten business days of the receipt of the fully-executed agreement to participate and certificate of readiness.
- The hearing will be held within 30 calendar days from the day that the notice of hearing is issued, to the extent practicable.
- Discovery will be limited to five interrogatories and no depositions will be permitted.
- The presiding ALJ shall take all lay witness testimony at the time of the hearing and will not hold further hearings.
- The presiding ALJ shall consider documentary medical evidence only; no medical testimony will be taken.
- Medical file review opinions will be deemed to constitute substantial evidence to support the requested treatment or service.
- All documentary evidence must be submitted no later than ten business days before the scheduled hearing.
- The hearing will be recorded, but not transcribed, unless a party files a request for review under A.R.S. §§ 23-942 and 23-943.
- The presiding ALJ will issue a short-form decision within five business days after the matter is deemed submitted.

FORMS

Table of Contents

Forms

The majority of the following forms are available online through ICA Community at https://azicawc.force.com/claims/. Those not available online as a webform are able to be uploaded directly into the Claims and Hearing files.

Resources on how to use and join Community are available on our website at https://www.azica.gov/resources/resources-ica-community

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise our of or in the course of employment. ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX. ARIZONA 85005-9070

MAIL TO: (CARRIER NAME & ADDRESS)

FOR CARRIER USE ONLY

FOR OSHA PURPOSES ONLY

OSHA Case #:

RECORDABLE INJURY

NON-RECORDABLE INJURY

EMPLOYEE

1. LAST NAME | FIRST | M.I. | 2. SOCIAL SECURITY NUMBER * | 3. BIRTH DATE

4. HOME ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 5. TELEPHONE

6. SEX ☐ MALE ☐ FEMALE | 7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER

8. EMPLOYER'S NAME | 9. POLICY NUMBER | 10. NATURE OF BUSINESS (MANUFACTURING, ETC.)

11. OFFICE ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 12. TELEPHONE

ACCIDENT

13. DATE OF INJURY OR ILLNESS | 14. TIME OF EVENT ☐ A.M. ☐ P.M. | 15. TIME EMPLOYEE BEGAN WORK ☐ A.M. ☐ P.M. | 16. DATE EMPLOYER NOTIFIED OF INJURY

17. LAST DAY OF WORK AFTER INJURY | 18. DATE OF RETURN TO WORK | 19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED

20. CLASS CODE ON PAYROLL REPORT | 21. EMPLOYEE'S ASSIGNED DEPARTMENT | 22. DEPARTMENT NUMBER | 23. DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO

24. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE

25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

26. PART OF BODY INJURED | 27. FATAL ☐ YES ☐ NO | 28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH

29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO | NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL | ADDRESS (STREET, CITY, STATE & ZIP CODE)

30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ NO | IF HOSPITALIZED, HOSPITAL NAME | ADDRESS (STREET, CITY, STATE & ZIP CODE)

31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON

CAUSE OF ACCIDENT

32. **WHAT HAPPENED?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*

34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ☐ YES ☐ NO | 37. HOURS PER DAY EMPLOYEE WORKED FROM A.M. P.M. THRU A.M. P.M. | 38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ☐ YES ☐ NO | 39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY

IMPORTANT

IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE | 41. WAS WORKER PAID FOR DAY OF INJURY? ☐ YES ☐ NO IF YES, $ | 42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ☐ YES ☐ NO

43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR | 44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE $ PER HOUR ☐ DAY ☐ WEEK ☐ MONTH ☐ | 45. IS EMPLOYEE FURNISHED ☐ LODGING ☐ BOARD ☐ BOTH VALUE $

46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)

47. DOES EMPLOYEE CLAIM DEPENDENTS? ☐ YES ☐ NO

IMPORTANT

IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR | 49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK

50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY FROM THRU $

51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $

52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY | 53. WAGE BEFORE INCREASE $ | 54. WAGE AFTER INCREASE $ | 55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE

DATE | AUTHORIZED SIGNATURE | TITLE

NOTE TO EMPLOYER:

1. Mail one copy to the Industrial Commission within 10 days.
2. Mail one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

Form ICA 04-0101 (Rev. 7/01)

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Information for Completing Worker's and Physician's Report of Injury

Detach this Sheet and Give to Patient

Answer all questions in full. Use ball point pen or typewriter.

Injured worker:
This is the claim that will be used to notify the Industrial Commission, your employer and your employer's insurance carrier of your claim for workers' compensation benefits.

This form must be completed in full and all questions answered. Your claim for benefits cannot be promptly processed without the following:

Full Name of Your Employer
Employer's Complete Address
Employer's Phone Number
Your Exact Date of Injury (Month-Day-Year)
Your Signature
Social Security Number *

Right to choose physician:
When an injury occurs an employer has the right to have an injured worker seen by a doctor of the employer's choice one time. **(If you return to that physician a second time, that physician would become your attending physician)**. After the one visit to the employer's designated physician you may report to a physician of your choice. **Exception:** if your employer is self-insured you must follow the self-insured employer's directed care program. To determine if your employer is self-insured, you may contact the Industrial Commission of Arizona Claims Division at (602) 542-4661.

If you wish to change physicians after your initial selection, please contact the Industrial Commission of Arizona at (602) 542-4661

Medical provider:
The worker's and physician's report of injury must be filed within eight (8) days after first rendering treatment. Mail the original to the Industrial Commission of Arizona at P.O. Box 19070, Phoenix, AZ 85005 and one (1) copy to the employer and one (1) copy to the employer's insurance carrier.

Form available in alternative format:
The Industrial Commission complies with the Americans with Disabilities Act of 1990.
If you need this document in alternative format, contact Claims at (602) 542-4661.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7 (a)(2)(b) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

REV 4/2014

IMMEDIATELY UPON COMPLETION PLEASE
MAIL COPIES AS SHOWN BELOW

WORKER'S & PHYSICIAN'S REPORT OF INJURY
INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070 • PHOENIX, ARIZONA 85005

INJURED WORKER'S RIGHT TO CHOOSE DOCTOR

An employer who is not self-insured can direct you to a doctor of their choice for ONE visit. After the **ONE** visit, you may report to a doctor of your choice. **REMEMBER:** If you make a **SECOND** visit to the employer's doctor, you have established that doctor as your treating doctor. If your employer is self-insured, you may not be allowed to change doctors. **SEE INFORMATION SHEET ATTACHED TO THIS FORM FOR FURTHER INSTRUCTIONS.**

WORKER'S REPORT

NAME OF INJURED WORKER
LAST NAME FIRST M.I.

SOCIAL SECURITY NO.

PHONE NO.

I C A USE ONLY
INJURY CODE:

1. _____
2. ADDRESS _____ CITY _____ STATE _____ ZIP _____
3. DATE OF BIRTH _____ (MO. DAY YR.) 4. SEX: MALE ☐ FEMALE ☐
5. SINGLE ☐ WIDOWED ☐ DIVORCED ☐ MARRIED ☐ IF SO, IS SPOUSE EMPLOYED YES ☐ NO ☐
6. OCCUPATION WHEN INJURED _____ DATE OF INJURY (MO. DAY YR.) _____ TIME OF INJURY _____ A.M. P.M.
7. EMPLOYER'S NAME _____ PHONE NO. _____
8. OFFICE ADDRESS _____ CITY _____ STATE _____ ZIP _____
9. EMPLOYER'S INSURANCE CARRIER _____ POLICY NO. _____
10. MAILING ADDRESS _____
11. DESCRIBE **WHERE** AND **HOW** ACCIDENT OR CAUSE OF DISABILITY OCCURRED (INCLUDING LOCATION AND/OR DEPARTMENT) _____

BY THIS INSTRUMENT I MAKE APPLICATION FOR ALL BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE LAW AND I DO HEREBY CERTIFY, WITH FULL KNOWLEDGE THAT IT IS A CRIME TO MAKE WILLFUL, FALSE STATEMENTS TO OBTAIN COMPENSATION, THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE. I UNDERSTAND I MUST FOLLOW THE INSTRUCTIONS OF MY DOCTOR AND MUST HAVE WRITTEN APPROVAL FROM THE INDUSTRIAL COMMISSION TO LEAVE THE STATE OF ARIZONA OR MY LOCALITY FOR MORE THAN 14 DAYS, FAILURE TO DO SO MAY CAUSE FORFEITURE OF COMPENSATION BENEFITS.

DATE OF SIGNING (MO. DAY YR.) _____ AT _____ (CITY) _____ (STATE)

IMPORTANT: INJURED WORKER'S SIGNATURE REQUIRED HERE **X** _____

PHYSICIAN'S INITIAL REPORT

12. DATE FIRST TREATMENT (MO. DAY YR.) _____ HOUR _____ A.M. P.M. 13. LOCATION: HOSPITAL ☐ OFFICE ☐ OTHER ☐ _____
14. DATE WORKING DISABILITY BEGAN (MO. DAY YR.) _____ 15. WHO ENGAGED YOUR SERVICES? PATIENT ☐ EMPLOYER ☐ OTHER ☐ _____
16. WAS PATIENT TREATED BY ANYONE ELSE? YES ☐ NO ☐ IF YES, BY WHOM? _____
17. COMPLAINTS AND PHYSICAL FINDINGS IN DETAIL:

18. ICD- CODE _____: DIAGNOSIS:
19. DESCRIBE ANY PRE-EXISTING IMPAIRMENT OR DISEASE AFFECTING PRESENT CONDITION _____
20. PATIENT IS RIGHT ☐ LEFT ☐ HANDED
21. DESCRIBE TREATMENT GIVEN BY YOU:

22. WERE X-RAYS TAKEN? YES ☐ NO ☐ IF YES, BY WHOM? _____ WHEN (MO. DAY YR.) _____
23. WAS LABORATORY WORK DONE? YES ☐ NO ☐ IF YES, BY WHOM _____ WHEN (MO. DAY YR.) _____
24. X-RAY DIAGNOSIS (ATTACH ROENTGENOLOGICAL REPORT FORM)

25. WAS PATIENT HOSPITALIZED? YES ☐ NO ☐ IF YES, WHERE _____
26. DATE OF ADMISSION TO HOSPITAL (MO. DAY YEAR) _____ 27. DATE OF DISCHARGE (MO. DAY YEAR) _____
28. IS FURTHER TREATMENT NEEDED? YES ☐ NO ☐ IF YES, FOR HOW LONG _____
29. IS PATIENT, AS A RESULT OF CONDITIONS DUE TO THIS ACCIDENT: (A) SUBJECT TO SUSTAIN A PERMANENT DEFECT OF IMPAIRMENT? YES ☐ NO ☐
(B) ABLE TO DO THE SAME TYPE OF WORK HE PERFORMED AT TIME OF INJURY? YES ☐ NO ☐ IF YES, DATE ABLE (MO. DAY YR.) _____ IF NOT, ANTICIPATED DATE (MO. DAY YR.) _____
(C) ABLE TO DO A LIGHTER OR DIFFERENT TYPE OF WORK THAN PERFORMED AT TIME OF INJURY? YES ☐ NO ☐ IF YES, DATE ABLE (MO. DAY YR.) _____
IF NOT, ANTICIPATED DATE ABLE (MO. DAY YR.) _____
30. REMARKS:

NAME OF PHYSICIAN _____ BILLING CODE NO. _____
ADDRESS _____ ZIP _____ PHONE _____
IRS. NO. _____ PROFESSIONAL CORP? YES ☐ NO ☐
DATE OF THIS REPORT (MO. DAY YR.) _____ PHYSICIAN'S SIGNATURE REQUIRED HERE **X** _____

FORM ICA 04-0102 76 (REV 4/2014) THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE.

WORKER'S REPORT OF INJURY

MAIL TO: Industrial Commission of Arizona, P.O. Box 19070, Phoenix, AZ. 85005-9070

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the Industrial Commission of Arizona claims and hearing process are available at the Industrial Commission offices and through the ICA web-site located at: www.azica.gov

ANSWER ALL QUESTIONS FULLY (Use the back of this form to indicate any further information.)

1. NAME OF INJURED WORKER: _____ (LAST) _____ (FIRST) _____ (M.I.)
   SOCIAL SECURITY # *: _____ BIRTH DATE: _____ PHONE #: ( ) _____
2. ADDRESS: _____ (CITY) _____ (STATE) _____ (ZIP CODE)
3. MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ DEPENDENTS AT TIME OF INJURY: YES ☐ NO ☐
4. EMPLOYER'S FULL NAME: _____ PHONE #: _____
5. ADDRESS: _____ (CITY) _____ (STATE) _____ (ZIP CODE)
6. DATE HIRED: _____ WHERE HIRED: _____ OCCUPATION: _____
7. HOURS WORKED PER DAY: _____ PER WEEK: _____ HOURLY WAGE: _____
8. DID YOU RECEIVE FOOD OR LODGING IN ADDITION TO WAGE? YES ☐ NO ☐
9. DATE OF INJURY (MO/DAY/YEAR): _____ TIME OF INJURY: _____ AM ☐ PM ☐
10. ADDRESS OR LOCATION OF ACCIDENT: _____
11. DID YOU STOP WORK IMMEDIATELY? _____ WHEN DID YOU STOP? _____
12. WHEN DID YOU REPORT THE INJURY? _____ TO WHOM? _____ TITLE: _____
13. WHEN DID YOU RETURN TO WORK? _____ REGULAR WORK _____ OTHER WORK _____
14. NAMES OF PERSONS WHO SAW THE ACCIDENT.
    1. NAME: _____ ADDRESS: _____ PHONE #: _____
    2. NAME: _____ ADDRESS: _____ PHONE #: _____
15. WAS ACCIDENT CAUSED BY ANOTHER PERSON? _____ IF SO, BY WHOM? _____
16. NAME OF MACHINE OR TOOL WHICH MAY HAVE CAUSED THE ACCIDENT: _____
17. STATE HOW ACCIDENT HAPPENED: _____
18. BODY PART INJURED: _____ DESCRIBE THE INJURY (CUT, BRUISE, ETC.): _____
19. WHERE WERE YOU FIRST TREATED: NAME: _____ ADDRESS: _____
20. WHO TREATED YOU FOR THIS INJURY: NAME: _____ ADDRESS: _____
21. OTHER THAN THIS INJURY, HAVE YOU LOST TIME FROM WORK DUE TO AN ACCIDENT IN THE PAST 12 MONTHS? YES ☐ NO ☐
    NAME OF STATE WHERE ACCIDENT HAPPENED: _____ WORK INJURY: YES ☐ NO ☐
22. OTHER THAN THIS INJURY, HAVE YOU EVER RECEIVED ANY PERMANENT DISABLING INJURY? YES ☐ NO ☐
    DATE OF INJURY: _____ WORK INJURY: YES ☐ NO ☐
    NAME OF STATE WHERE ACCIDENT HAPPENED: _____
23. OTHER THAN THIS INJURY, ARE YOU RECEIVING COMPENSATION FOR ANY DISABLING CONDITIONS? YES ☐ NO ☐
    IF SO, FROM WHOM? _____ AMOUNT? _____ WHY? _____

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge that it is a crime to make willful, false statements to obtain compensation and that all of my statements on this form are true, accurate and complete.

_____ _____
Signature of injured worker or injured worker's authorized representative is REQUIRED. **Date**

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT CLAIMS AT (602 542-4661).

ICA 04-0407 REV 5/02

NOTICE OF SUPPORTIVE MEDICAL MAINTENANCE BENEFITS

Carrier or Self-Insured Name and Address	ICA Claim No.
	Soc. Sec. No.
	Carrier Claim No.
	Employer
Authorized Third Party Administrator (TPA) Name and Address	Address
	Date Injured
Claimant's Name and Address	

SUPPORTIVE MEDICAL MAINTENANCE BENEFITS ARE AUTHORIZED BY THE ABOVE-NAMED INSURANCE CARRIER AS SET FORTH BELOW WHILE THE NEED FOR SUCH SUPPORTIVE CARE CONTINUES OR UNTIL FURTHER NOTICE.

Supportive Medical Maintenance:

Treating Physicians(s):

Duration of Supportive Medical Maintenance:

IF CONDITION WORSENS REQUIRING ACTIVE MEDICAL CARE, A PETITION TO REOPEN MUST BE FILED WITH THE INDUSTRIAL COMMISSION. A.R.S. 23-1061(H).

MAILED ON:

BY:
(Authorized Representative) Tel. #:

Copy to: Industrial Commission of Arizona

NOTICE TO CLAIMANT: If you do not agree with this NOTICE or wish to have the Commission investigate and review the benefits provided in this NOTICE, you must file a request for investigation under A.R.S 23-1061(J) with either office of the Industrial Commission listed below. A request for investigation seeking review of a Notice of Supportive Medical Maintenance Benefits may be filed at any time under A.R.S. 23-1061(J).

AVISO AL RECLAMANTE: Si usted no esta de acuerdo con este AVISO, o si desea que la Comision investigue y haga una revision de los beneficios que se proveen en este AVISO, usted debera someter una solicitud de investigacion, de conformidad con A.R.S. 23-1061(J), en cualquiera de las oficinas de la Comision Industrial que se indican a continuacion. De conformidad con A.R.S. 23-1061(J), usted en cualquier momento puede someter una solicitud de investigacion para lograr que se revise un Aviso de Beneficios de Apoyo para Mantenimiento Medico.

Phoenix Office: Industrial Commission of Arizona
800 W Washington Street
Phoenix, Arizona 85007-2922

PO Box 19070
Phoenix, AZ 85005-9070

Tucson Office: Industrial Commission of Arizona
2675 E Broadway
Tucson, Arizona 85716-5342

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 0103 - Rev 6/2019

NOTICE OF CLAIM STATUS

Carrier or Self-Insured Name and Address	ICA Claim No. _____ Soc. Sec. No. _____ **SSN not required if correct ICA claim number is provided**
Authorized Third Party Administrator (TPA) Name and Address	Carrier Claim No. _____ Employer _____
Claimant's Name and Address	Address _____ _____ Date of Injury _____

☐ 1. Claim is accepted.

☐ 2. Claim is denied.

☐ 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.

☐ 4. Enclosed check for _____ for period of _____ through _____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of _____ based on the following:

- ☐ A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
- ☐ B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.

☐ 5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly. Return to regular duty effective _____.

☐ 6. Temporary compensation and active medical treatment terminated on _____ because claimant was discharged.

☐ 7. Injury resulted in no permanent disability.

☐ 8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, if any, will be authorized by separate Notice.

☐ 9. Petition to Reopen accepted.

☐ 10. Petition to Reopen denied.

☐ 11. Other: _____

Mailed on: _____ By: _____

Copy to: Industrial Commission of Arizona (Authorized Representative) Tel. #: _____

The insurance carrier/employer will, upon request, provide claimant a copy of the medical report to support Findings 5, 6, 7 or 8.

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

AVISO AL RECLAMANTE: Si usted no esta de acuerdo con este AVISO, y desea una audiencia en este caso, su peticion por escrito pidlendo una audiencia debera ser recibida en cualquira de las oficinas de la Comision Industrial a las direcciones abajo indicadas dentro de NOVENTA (90) DIAS despues de la fecha de este AVISO, de acuerdo con las leyes A.R.S. 23-941 y 23-947. SI DICHA PETICION NO ESTA RECIBIDA DENTRO DEL PERIODO DE NOVENTA (90) DIAS, ESTE AVISO SERA CONSIDERADO FINAL.

Phoenix Office:
Industrial Commission of Arizona
800 W Washington Street
Phoenix, Arizona 85007-2922

PO Box 19070
Phoenix, AZ 85005-9070

Tucson Office:
Industrial Commission of Arizona
2675 E Broadway
Tucson, Arizona 85716-5342

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 0104 - Rev 6/2019

NOTICE OF SUSPENSION OF BENEFITS

Carrier or Self-Insured Name and Address	ICA Claim No. _____
	Soc. Sec. No. _____
Authorized Third Party Administrator Name and Address	Carrier Claim No. _____
	Employer _____
Claimant's Name and Address	Address _____
	Date Injured _____

All compensation and medical payment benefits suspended by the above-named insurance carrier effective _____ because claimant:

☐ 1. Left the State of Arizona without the written approval of the Industrial Commission of Arizona.

☐ 2. Refused to submit to obstructed a medical examination.

☐ 3. Failed to submit a required annual report of income.

☐ All compensation benefits suspended by the above-named insurance carrier effective _____ because claimant is incarcerated. Medical benefits will continue. Any court-ordered child support payments are to continue.

Mailed On: _____ By: _____

Copy to: Industrial Commission of Arizona (Authorized Representative) Tel. #: _____

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

AVISO AL RECLAMANTE: Si usted no esta de acuerdo con este AVISO, y desea una audiencia en este caso, su peticion por escrito pidlendo una audiencia debera ser recibida en cualquira de las oficinas de la Comision Industrial a las direcciones abajo indicadas dentro de NOVENTA (90) DIAS despues de la fecha de este AVISO, de acuerdo con las leyes A.R.S. 23-941 y 23-947. SI DICHA PETICION NO ESTA RECIBIDA DENTRO DEL PERIODO DE NOVENTA (90) DIAS, ESTE AVISO SERA CONSIDERADO FINAL.

Phoenix Office:
Industrial Commission of Arizona
800 W Washington Street
Phoenix, Arizona 85007-2922

PO Box 19070
Phoenix, AZ 85005-9070

Tucson Office
Industrial Commission of Arizona
2675 E Broadway
Tucson, Arizona 85716-5342

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 0105 - Rev 6/2019

NOTICE OF PERMANENT DISABILITY OR DEATH BENEFITS

Carrier or Self-Insured Name and Address	ICA Claim No. _____
	Soc. Sec. No. _____
Authorized Third Party Administrator Name and Address	Carrier Claim No. _____
	Employer _____
Claimant's Name and Address	Address _____
	Date Injured _____

You are hereby notified that the above-named insurance carrier has determined that you are entitled to the following Permanent Disability or Death Benefits:

1. Statute under which compensation is payable: § A.R.S. 23- 1044(B)( )( )

2. Percentage and type of disability: _____

3. Amount of compensation and method of payment:

_____ Months x _____ Impairment = _____ Months

AMW: _____ x _____ % = _____

Total Award: _____

Other Details:

Mailed On: _____ By: _____

(Authorized Representative) Tel. #: _____

Copy to: Industrial Commission of Arizona

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

AVISO AL RECLAMANTE: Si usted no esta de acuerdo con este AVISO, y desea una audiencia en este caso, su peticion por escrito pidlendo una audiencia debera ser recibida en cualquira de las oficinas de la Comision Industrial a las direcciones abajo indicadas dentro de NOVENTA (90) DIAS despues de la fecha de este AVISO, de acuerdo con las leyes A.R.S. 23-941 y 23-947. SI DICHA PETICION NO ESTA RECIBIDA DENTRO DEL PERIODO DE NOVENTA (90) DIAS, ESTE AVISO SERA CONSIDERADO FINAL.

Phoenix Office: Industrial Commission of Arizona
800 W Washington Street
Phoenix, Arizona 85007-2922

PO Box 19070
Phoenix, AZ 85005-9070

Tucson Office: Industrial Commission of Arizona
2675 E Broadway
Tucson, Arizona 85716-5342

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 0106 - Rev 6/2019

NOTICE OF PERMANENT DISABILITY OR DEATH BENEFITS

Carrier or Self-Insured Name and Address	ICA Claim No. _____
	Soc. Sec. No. _____
Authorized Third Party Administrator Name and Address	Carrier Claim No. _____
	Employer: _____
Claimant's Name and Address	Address: _____
	Date Injured: _____

You are hereby notified that the above-named insurance carrier has determined that you are entitled to the following Permanent Disability or Death Benefits:

1. Statute under which compensation is payable: A.R.S. 23 - 1046
2. Percentage and type of disability: Fatality
3. Amount of compensation and method of payment:

Mailed On: By:
Copy to: Industrial Commission of Arizona (Authorized Representative) Tel. #:

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.

AVISO AL RECLAMANTE: Si usted no esta de acuerdo con este AVISO, y desea una audiencia en este caso, su peticion por escrito pidlendo una audiencia debera ser recibida en cualquira de las oficinas de la Comision Industrial a las direcciones abajo indicadas dentro de NOVENTA (90) DIAS despues de la fecha de este AVISO, de acuerdo con las leyes A.R.S. 23-941 y 23-947. SI DICHA PETICION NO ESTA RECIBIDA DENTRO DEL PERIODO DE NOVENTA (90) DIAS, ESTE AVISO SERA CONSIDERADO FINAL.

Phoenix Office:
Industrial Commission of Arizona
800 W Washington Street
Phoenix, Arizona 85007-2922

PO Box 19070
Phoenix, AZ 85005-9070

Tucson Office
Industrial Commission of Arizona
2675 E Broadway
Tucson, Arizona 85716-5342

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 0106 - Rev 6/2019

NOTICE OF PERMANENT DISABILITY AND REQUEST FOR DETERMINATION OF BENEFITS

Carrier or Self-Insured Name and Address	ICA Claim No. _____
	Soc. Sec. No. _____
Authorized Third Party Administrator Name and Address	Carrier Claim No. _____
	Employer _____
Claimant's Name and Address	Address _____
	Date Injured _____

You are hereby notified of a permanent disability, pursuant to the provisions of A.R.S. 23-1047. The Industrial Commission of Arizona is hereby requested to examine this claim to determine the amount of further compensation, if any, to which claimant may be entitled. Copies of all pertinent reports necessary to make such a determination are herewith forwarded to the Commission.

The type of disability is:

1. Unscheduled permanent partial disability.

- ☐ a. Pursuant to A.R.S. 23-1044-C
- ☐ b. Pursuant to A.R.S. 23-1065-B (Submit proof of prior scheduled award and termination date)
- ☐ c. Pursuant to A.R.S. 23-1065-C (Substantiating medical and employer verification attached)
- ☐ d. Pursuant to pre-1-1-86 apportionment statutes (Specify which section)

☐ 2. Permanent facial disfigurement or loss of teeth (Specify which category)

☐ 3. Fatal with non-enumerated dependents.

☐ 4. Fatal where dependents are only partially dependent upon deceased's earnings for support at time of injury.

☐ 5. Non-enumerated permanent total disability.

☐ 6. Advance payments voluntarily made will be credited against permanent compensation awarded. Advance payments will be as follows:

Please Provide Details: _____

Mailed On: _____ By: _____

(Authorized Representative) Tel. #: _____

Copy to: Industrial Commission of Arizona

Phoenix Office: Industrial Commission of Arizona, 800 W Washington Street, Phoenix, Arizona 85007-2922

PO Box 19070, Phoenix, AZ 85005-9070

Tucson Office: Industrial Commission of Arizona, 2675 E Broadway, Tucson, Arizona 85716-5342

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 04-107-86 (Rev 93) INDUSTRIAL COMMISSION OF ARIZONA

RECOMMENDED AVERAGE MONTHLY WAGE CALCULATION OF CARRIER

(Subject to final determination by the Industrial Commission Upon issuance of Notice of Average Monthly Wage)

ITEMS #1 THRU 9 AND #14 MUST BE COMPLETED (IF WAGE NOT ESTABLISHED AT MAXIMUM)

Date Mailed: _____
ICA Case No: _____
Soc. Sec. No. _____
_____
Employer _____
Date Injured: _____

1. CLAIMANT: _____ 2. OCCUPATION: _____

3. DATE OF HIRE: _____ 4. DEPENDENTS? ☐ YES ☐ NO

5. EMPLOYMENT STATUS: ☐ STEADY ☐ INTERMITTENT ☐ SEASONAL ☐ PART-TIME ☐ MONTHS PER YEAR

5.(A) AT TIME OF INJURY, WAS THERE MULTIPLE EMPLOYMENT? ☐ YES ☐ NO **IF YES, SEE #11.**

6. BASE RATE OF PAY: $ _____ PER: HOUR ☐ DAY ☐ WEEK ☐ MONTH ☐ PIECE RATE ☐

PER ABOVE: $ _____ x _____ x _____ = $ _____ AVG.

7. ACTUAL EARNINGS 30 DAYS BEFORE INJURY: $ _____

8. EARNINGS WITH INSURED EMPLOYER: FROM: _____ THRU: _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

9. DATE OF LAST PAY INCREASE: _____ IF WITHIN LAST YEAR, COMPLETE #9A

9(A) EARNINGS SINCE INCREASE WITH INSURED EMPLOYER: FROM _____ THRU _____

AMOUNT: $ _____ ÷ _____ (DAYS) = $ _____ x **30.416*** = $ _____ AVG.

10. WAGE PATTERNS OF OTHER EMPLOYEES OF INSURED EMPLOYER:

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

11. CLAIMANT'S EARNINGS, OTHER EMPLOYERS: (SIMILAR OR DISSIMILAR EMPLOYMENT)

_____ FROM _____ THRU _____ $ _____ AMT.

_____ FROM _____ THRU _____ $ _____ AMT.

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

12. COMBINED EARNINGS FROM ITEMS: _____ + _____ + _____ + _____

TOTAL OF ABOVE: $ _____ ÷ _____ (DAYS) = $ _____ X **30.416*** = $ _____ AVG.

13. OTHER MONTHLY REMUNERATION FROM INSURED EMPLOYER:

BOARD & LODGING: $ _____ OTHER: $ _____ = $ _____

DETAILS OF CALCULATIONS OR OTHER NOTES:

14. AVERAGE MONTHLY WAGE ESTABLISHED ON BASIS OF ITEMS: _____ + _____ + _____ = $ _____

NOTE: Additional information which you believe should be considered by The Industrial Commission in making its determination should be submitted to the commission within ten (10) days.

***NOTE:** 1 year = 365 days; 365 days = 12 months = 30.416 days per average month
(Daily Rate: Average Monthly Wage x .021918 [66 2/3% ÷ 30.416] + dependent allowance, if indicated)

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 0108 - Rev 6/2019

WORKER'S ANNUAL REPORT OF INCOME

Return to: Carrier or Self-Insured Employer Address

Claimant's Name and Address

Date Mailed: _____

ICA Claim No.: _____

Soc. Sec. No.: _____

SSN not required if correct ICA claim number is provided

Carrier Claim No. _____

Employer: _____

Date of Injury: _____

To the Claimant: You are required to report annually on the anniversary date of your award of permanent compensation benefits ALL OF YOUR EARNINGS for the 12 months prior. This report must be fully and accurately completed and signed by you and promptly returned to the Carrier or Self-Insured Employer at the address shown above. A.R.S. § 23-1047

Failure to submit an annual report within 30 days of the date of this notice shall result in the suspension of benefits by the carrier or self-insured employer.

MO. DAY YEAR	MO. DAY YEAR
Period	Through

Name and Address of Employer *(Include Self Employment)*	Period Worked From	Period Worked Through	Total Wages and other Earnings	Describe Work
			$	
			$	
			$	
			$	
			$	

MY TOTAL GROSS EARNINGS FOR THE ABOVE PERIOD WERE: $ _____

Any person who knowingly makes a false statement or representation to obtain any compensation, benefit or payment is guilty of a class 6 felony and is subject to up to one and one-half years in prison, a fifty thousand dollar fine and forfeiture of benefits. By my signature below, I am applying for all benefits to which I may be entitled and I swear that the statements made on this application are true, correct and complete to the best of my knowledge.

Claimant's signature required _____ Date _____

Email address: _____

Current Residence _____

Phone: _____

Address to which mail should be sent::

Street _____

City _____ State _____ Zip Code _____

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 04—110-A (Rev 6/2015)

NOTICE OF INTENT TO SUSPEND

Return to: Carrier or Self-Insured Employer Address

Claimant's Name and Address

Date Mailed: _____

ICA Claim No.: _____

Soc. Sec. No.: _____

SSN not required if correct ICA claim number is provided

Carrier Claim No. _____

Employer: _____

Date of Injury: _____

To the Claimant: You are required to report annually on the anniversary date of your award of permanent compensation benefits ALL OF YOUR EARNINGS for the 12 months prior. This report must be fully and accurately completed and signed by you and promptly returned to the Carrier or Self-Insured Employer at the address shown above. A.R.S. § 23-1047

Payment of further benefits will be suspended unless information called for in the space provided below is received in this office within THIRTY (30) DAYS from this date.

	MO.	DAY	YEAR		MO.	DAY	YEAR
Period				Through			

Name and Address of Employer *(Include Self Employment)*	Period Worked From	Period Worked Through	Total Wages and other Earnings	Describe Work
			$	
			$	
			$	
			$	
			$	

MY TOTAL GROSS EARNINGS FOR THE ABOVE PERIOD WERE: $ _____

Any person who knowingly makes a false statement or representation to obtain any compensation, benefit or payment is guilty of a class 6 felony and is subject to up to one and one-half years in prison, a fifty thousand dollar fine and forfeiture of benefits. By my signature below, I am applying for all benefits to which I may be entitled and I swear that the statements made on this application are true, correct and complete to the best of my knowledge.

Claimant's signature required _____ Date _____

Email address: _____

Current Residence _____

Phone: _____

Address to which mail should be sent::

Street _____

City _____ State _____ Zip Code _____

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 04—110-B (Rev 6/2015)

INDUSTRIAL COMMISSION OF ARIZONA

IMPORTANT: **This completed form must be filed at an Industrial Commission office. (See addresses below.)**

REQUEST FOR HEARING

_____ **Injured Worker**

vs.

_____ **Defendant Employer**

_____ **Defendant Insurance Carrier**

Social Security No. * _____

ICA Claim No. _____

Ins. Carrier Claim No. _____

Date of Injury _____

Person Requesting Hearing: _____

A hearing is requested on: *(Check appropriate box)*

☐ **Notice of Claim Status dated:** _____ MONTH/DAY/YEAR

or

☐ **Notice, Award, Order or Decision by The Industrial Commission of Arizona dated:** _____ MONTH/DAY/YEAR

or

☐ **A.R.S. §23-1061(J)** **or** ☐ **Other:** _____

State reason for the request: _____

Hearing requested at city or town of: _____ Estimated length of hearing: _____

I request that subpoenas be issued for the following witnesses to appear and testify at hearing:

(a) _____ (Name) / _____ (Address)

(b) _____ (Name) / _____ (Address)

(c) _____ (Name) / _____ (Address)

☐ **Interpreter requested** **Specify Language:** _____

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the Industrial Commission of Arizona claims and hearing process are available at the Industrial Commission offices and through the ICA web-site located at: www.ica.state.az.us

_____ **Signature of person or the person's authorized representative requesting hearing is REQUIRED.**

_____ **Date:**

_____ **(Address of Injured Worker Only)**

_____ **Telephone No.**

_____ **City** **State** **Zip**

IMPORTANT: **You will be notified of hearing date in writing by mail. You must keep the Administrative Law Judge advised of any address change.**

Phoenix:
Mailing address: **Industrial Commission of Arizona**
P.O. Box 19070
Phoenix, Arizona 85005-9070

Street address: **800 W. Washington Street**
Phoenix, Arizona 85007-2922

Tucson Office: **Industrial Commission of Arizona**
2675 E. Broadway
Tucson, Arizona 85716-5342

The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT CLAIMS AT (602) 542-4661.

Form ICA 04-0446-75 (Rev. 5/02)

INDUSTRIAL COMMISSION OF ARIZONA

IMPORTANT: This completed form must be filed at an Industrial Commission of Arizona (ICA) office. (See addresses below.) The form must be accompanied by a current medical report supporting the reopening of the claim.

PETITION TO REOPEN BASED ON NEW, ADDITIONAL OR PREVIOUSLY UNDISCOVERED DISABILITY OR CONDITION

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the ICA claims and hearing process are available at the ICA offices and through the ICA web-site located at: www.ica.state.az.us

_____ **Injured Worker**

vs.

_____ **Defendant Employer**

_____ **Defendant Insurance Carrier**

Social Security No. * _____

Date of Injury: _____

ICA Claim No.: _____

Ins. Carrier Claim No.: _____

Reopening is requested based on the new, additional or previously undiscovered disability or condition listed below related to this claim:

_____

1. Check one of the following:

☐ Attached is a medical report to support this Petition to Reopen.

or

☐ Dr. _____ will submit a report to support this Petition to Reopen.

2. The following physicians have examined or treated me within the past two years for the conditions listed:

DOCTOR'S NAME	ADDRESS	CONDITION AND DATE OF TREATMENT
A.		
B.		

3. I have worked for the following employers within the past two years.

NAME	ADDRESS	JOB DESCRIPTION
A.		
B.		

I have read this Petition to Reopen and the information contained is true and correct to the best of my knowledge.

_____ **Signature of person or the person's authorized representative requesting reopening is REQUIRED.**

_____ **Date**

_____ **Address**

_____ **Telephone No.**

_____ **City** **State** **Zip**

Phoenix: Mailing address: **Industrial Commission of Arizona, P.O. Box 19070, Phoenix, Arizona 85005-9070**

Street Address: **800 W. Washington Street, Phoenix, Arizona 85007-2922**

Tucson Office: **Industrial Commission of Arizona, 2675 E. Broadway, Tucson, Arizona 85716-5342**

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

MEDICAL AUTHORIZATION

By this medical authorization or reproduction, I authorize and request each physician and person in the medical or related fields and each hospital, clinic, establishment or place rendering me any medical or related service to allow The Industrial Commission of Arizona or its authorized representative, my employer or its insurance carrier and each person and physician appointed by them to have, examine and/or copy any and all information, records and X-rays, regarding my physical condition and treatment.

_____ **Signature of person or the person's authorized representative requesting reopening.**

_____ **Date**

_____ **Address**

_____ **Telephone No.**

_____ **City** **State** **Zip**

THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT CLAIMS AT (602) 542-4661.

Form ICA 04-0528-83 (Rev. 5/02)

INDUSTRIAL COMMISSION OF ARIZONA

PETITION FOR REARRANGEMENT OR READJUSTMENT OF COMPENSATION

Copies of the Arizona Workers'Compensation Laws and Rules of Procedure and information about the ICA claims and hearing process are available at the ICA offices and through the ICA website located at: www.azica.gov with a link to the Arizona Workers'Compensation Law and Rules of Procedure.

vs. Injured Worker Last Name | First Name | MI

Defendant Employer

Defendant Insurance Carrier

Social Security No.

Date of Injury:

ICA Claim No.:

Ins. Carrier Claim No.:

Injured Worker ◯ Carrier ◯ Requests rearrangement or readjustment of compensation for the following reasons:

1. State below all employment of injured worker within the past two years:

NAME & ADDRESS OF EMPLOYER INCLUDING SELF-EMPLOYMENT	PERIOD WORKED FROM (MO. DAY YR.)	PERIOD WORKED THROUGH (MO DAY YR)	TYPE OF WORK	TOTAL WAGES EARNED	REASON FOR TERMINATION
A.					
B.					
C.					

2. List all other income or compensation received within the last two years:

RECEIVED FROM / ADDRESS	TOTAL AMOUNT
A.	$
B.	$

3. Has the injured worker had any other accident, injury or illness since this claim was closed? YES ◯ NO ◯ If yes, explain:

4. The following physicians have examined or treated the injured worker within the past two years for the conditions listed:

DOCTOR'S NAME	ADDRESS	CONDITION AND DATE OF TREATMENT
A.		
B.		

I have read this Petition for Rearrangement or Readjustment of Compensation and the information contained is true and correct to the best of my knowledge.

Signature of petitioner or petitioner's authorized representative is REQUIRED.

Date

Address

Telephone No.

City | State | Zip

Submitter Email Address

Phoenix: Industrial Commission of Arizona
Mailing address: P.O. Box 19070
Phoenix, Arizona 85005-9070

Street Address: 800 W. Washington Street
Phoenix, Arizona 85007-2922

Tucson Office: Industrial Commission of Arizona
2675 E. Broadway
Tucson, Arizona 85716-5342

The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT SPECIAL SERVICES AT (602) 542-1829.

Claims ICA 0529-Rev 06.01.00

NOTICE OF PERMANENT COMPENSATION PAYMENT PLAN

Carrier or Self-Insured Name and Address	ICA Claim No. _____ Soc. Sec. No. _____ Carrier Claim No. _____
Claimant's Name and Address	Employer _____ Address _____ Date Injured _____

1. As a result of this industrial accident, you have been awarded Permanent Disability Compensation in the sum of $ _____ payable on the _____ of each month.

2. _____ has contracted for those compensation payments
(Workers' Compensation Insurance Carrier)
beginning on _____ to be made by _____
(Annuity Company)
on behalf of _____.
(Worker's Compensation Insurance Carrier)

3. This payment plan does not relieve _____ of its primary
(Worker's Compensation Insurance Carrier)
responsibility should _____ fail to timely make
(Annuity Company)
payment to you as reflected by item #1 above.

4. This payment plan in no way jeopardizes your future rights to reopen your claim for new, additional, or previously undiscovered disability or the adjustment of your permanent disability award up or down as provided by the Workers' Compensation Law.
_____, the Workers' Compensation Carrier, remains
(Workers' Compensation Insurance Carrier)
responsible for your claim and future benefits.

5. Any supportive care, to which you have been found entitled, will continue to be the monitoring and processing responsibility of
_____
(Workers Compensation Insurance Carrier)

6. Any questions concerning this method of payment should be directed to _____
(Workers Compensation
_____, telephone number _____.
Insurance Carrier)

7. This notice is provided to the worker and filed with the Industrial Commission solely to give notice of action by the carrier/self-insured employer in the processing of this claim.

MAILED ON: _____ BY: _____
(Authorized Representative) Tel. # _____

Copy to: Industrial Commission of Arizona

Phoenix Office: Industrial Commission of Arizona, 800 W Washington Street, Phoenix, Arizona 85007-2922
PO Box 19070, Phoenix, AZ 85005-9070

Tucson Office: Industrial Commission of Arizona, 2675 E Broadway, Tucson, Arizona 85716-5342

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Form ICA 04-111-84 (Rev. 94)

ATTENTION: DELETE/COMBINE fax: (602) 542-3373

ICA Notification Date: _____

ICA Claim Number: _____

Name of injured worker: _____

Date of injury: _____ Social security number: _____

REQUESTING DELETION OF NOTIFICATION FOR THE FOLLOWING REASON(S):

_____ No coverage for this insured: _____

_____ Policy # _____ Expired/Cancelled on: _____

_____ We believe the correct insurance carrier is: _____

_____ Duplicate notification (see below)

_____ Other: _____

DUPLICATE NOTIFICATION: Please combine the above file with the file below:

ICA Notification Date: _____

ICA Claim Number: _____

Claimant name: _____

Date of Injury: _____

REQUESTING THE FOLLOWING CHANGE(S) AND/OR CORRECTION(S)

Name of injured worker: _____

Date of injury: _____

Social security number: _____

Other: _____

FROM: (Carrier or tpa) _____

_____ **Phone:** _____

Signature

20-DAY LETTER

Letter to injured worker to which he needs to respond within 20 days:

Our records indicate you were last seen by _____ on _____. Please advise the date of your next appointment.

If we do not hear from you within 20 days, we will proceed to close your claim. Please complete and sign as indicated below.

___ I am in need of further treatment. The date of my next appointment is: _____.

(or)

___ I feel I have recovered and do not need any further treatment.

_____

Signature of injured worker

REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS OR OTHER INFECTIOUS MATERIAL

(This form is not a claim form, but a report of exposure. Forms to report a claim to the Industrial Commission are available at: www.azica.gov .)

1. Exposed Employee _____ Birth Date _____ Job Title _____
   Last Name First M.I.
2. Address _____ Phone No. _____
3. Employer's Full Name _____
4. Employer's Address _____
5. Date of Exposure _____ Time of Exposure _____ A.M. _____ P.M. _____
6. Address or Location of Exposure _____
7. Describe the circumstances surrounding the exposure, including (if applicable) personal protective equipment worn and the names of any witnesses to the exposure (be specific) _____

8. What were you exposed to? (Directly or indirectly via bandages, personal items, etc.) Check all that apply.
   - ☐ Blood
   - ☐ Vaginal fluid
   - ☐ Broken skin
   - ☐ Urine
   - ☐ Any other fluid(s) containing blood or infectious material (Describe) _____
   - ☐ Semen
   - ☐ Surgical fluid(s)
   - ☐ Mucous membrane
   - ☐ Feces
   - ☐ Airborne/Respiratory/Oral Secretions
   - ☐ Other (specify): _____
   - ☐ Saliva
   - ☐ Vomitus
   - ☐ Skin infection (e.g. abscesses, boils, or pus-filled/red/swollen/painful skin lesions)

9. Source person(s) information ☐ Unknown ☐ Known
   Name _____ DOB _____ Phone No. _____
   Address _____ City _____ State _____ Zip _____
10. What part(s) of your body was exposed to bodily fluids/infectious material? Did exposure take place through your skin or mucous membrane (be specific)? _____
11. Did you have any open cuts, sores, rashes, or other breaks/ruptures in your skin or mucous membrane that were exposed to bodily fluids/infectious material (please describe)? _____

I HAVE GIVEN THIS FORM TO MY EMPLOYER AND HAVE RECEIVED A COPY OF THIS COMPLETE FORM.

EMPLOYEE SIGNATURE _____ DATE _____

Other Required Steps to Establish Prima Facie Claim for HIV, AIDS or Hepatitis C (A.R.S. §§ 23-1043.02, -03; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **You must have blood drawn no later than ten (10) calendar days after exposure.**
3. **You must have blood tested for HIV or Hepatitis C by Antibody Testing no later than thirty (30) calendar days after exposure and test results must be negative.**
4. **You must be tested or diagnosed as HIV positive no later than eighteen (18) months after the exposure, or tested and diagnosed as positive for the presence of Hepatitis C within seven (7) months after the exposure.**
5. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis or positive blood test if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for MRSA (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than thirty (30) days after your exposure.**
2. **For a claim involving MRSA, you must be diagnosed with MRSA within fifteen (15) days after you report in writing to your employer the details of the exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for Spinal Meningitis or TB (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **For a claim involving spinal meningitis, you must be diagnosed within two (2) to eighteen (18) days of the possible significant exposure and for a claim involving tuberculosis, you must be diagnosed within twelve (12) weeks of the possible significant exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**

Employer: Keep Original (Notify Carrier) Employee: Keep Copy
THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA

REV. 7/11

INDUSTRIAL COMMISSION OF ARIZONA
800 W WASHINGTON STREET
PHOENIX, ARIZONA 85007
(602) 542-4661

CARRIER'S REFERRAL FOR VOCATIONAL REHABILITATION

From **Date:**

Carrier Name: **Carrier Claim #:**
Carrier Contact First Name: **ICA Claim No #:**
Carrier Contact Last Name: **Social Security #:**
Carrier Email Address: **Date of Birth:**
Date of Injury:

To: **The Industrial Commission of Arizona**
Attention: Special Fund
P.O. Box 19070 Phoenix,
AZ. 85005

Forward with one copy of pertinent medical data, such as operative reports and medical supporting discharge from active care. A complete file is not required.

Injured Worker: **Telephone #:**
Email:

Current Address:
STREET CITY STATE ZIP CODE

Sex: **Male** ◯ **Female** ◯ **Marital Status:** **Single** ◯ **Married** ◯ **Divorced** ◯ **Widowed** ◯

Occupation At Time of Injury:

Established Wage: **Present Monthly Compensation Amount** **Number of Dependents:**

Name of Date of Injury Employer:

Employers Address:
STREET CITY STATE ZIP CODE

Injured Workers Attending Physician (s):

Physician's Address:
STREET CITY STATE ZIP CODE

Does Attending Physician recommend rehabilitation? **YES** ◯ **NO** ◯ **UNKNOWN** ◯
Did injured worker return to work with the date of injury employer? **YES** ◯ **NO** ◯ **UNKNOWN** ◯
List current employment and earnings (if known)
Nature of the Injured Workers injury:

Signature of Authorized Representative
of Carrier/Self-Insured Employer/Third-Party Administrator:

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THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT SPECIAL FUND AT (602) 542-3294.

SpecFunds ICA 5528 - REV 10-15-17

REFERENCE

Table of Contents

INTRODUCTION

This section SAAM establishes policies and procedures for travel-related matters that are infrequently encountered. All rates cited are for reimbursement of actual costs or mileage incurred while traveling on State business.

Mileage rates and lodging rates, under A.R.S. §§ 38-623 and 38-624, respectively, are established by the ADOA, reviewed by the JLBC, and published in SAAM by the GAO.

Effective dates of rates and other policy matters are shown in parentheses following section titles.

1. PERSONAL VEHICLE MILEAGE REIMBURSEMENT RATE (01/09/23)

Sixty-two and one-half cents (**62.5¢)** per mile.

2. PRIVATELY-OWNED AIRCRAFT MILEAGE REIMBURSEMENT RATE (11/15/06)

Ninety-nine and one-half cents (**99.5¢)** per mile.

Rate is based upon the shortest air routes from origin to destination. Landing and parking fees are reimbursable except those incurred at the location the aircraft is normally based.

Use of a privately-owned aircraft for State business requires the prior approval of the State Comptroller.

3. AIRPORT PARKING (01/09/23)

General Airport Parking Guidelines

While it is impractical to list parking rates for every airport in the country or even in the State, there are some general guidelines that all State travelers are to follow when parking at airports.

- Economy, long-term, off-premises parking serviced by shuttle is to be chosen when available.
- The State will not reimburse upcharges for covered or inside parking.
- Receipts with details will be required.

- In addition to base parking charges, employees will be reimbursed for any taxes, one-time fuel charges, or other non-optional fees that are imposed.

- Reservation fees are not reimbursable.

- Airport parking coupons may be available at a parking vendor's website and should be used when they result in a lower cost to the State.

Phoenix Airport Parking Facilities

For airport parking in Phoenix, a State employee may park wherever he finds it convenient to do so, but will only be reimbursed the lesser of the actual amount incurred or six dollars and fifty cents ($6.50) per day **base** parking charges.

The ParkingSpot2—4040 E. Van Buren St., Phoenix, AZ (602) 286-9212, 24/7 service — and The Parking Spot South—3025 S. 48th St., Phoenix, AZ (602) 244-8888, 24/7 service — currently offers rates that comply with State reimbursement limits. Travelers must present or acquire a Spot Club Card to take advantage of the discounted rate. They can do so by joining the vendor's Spot Club online before any anticipated travel at (https://theparkingspot.com/spot-club/sign-up?gCode=Stat1898).

State employees may also obtain the Club Card from the parking lot cashier by showing their official State picture identification badge when leaving the parking lot; the traveler will then be given a Spot Club Card and the appropriate discount. This newly issued Spot Club Card is to be registered online (https://theparkingspot.com/spot-club/sign-up) within two business days of the card having been issued.

A State employee with a smart phone and a personal credit card can also sign up for the Parking Spot App (https://theparkingspot.com/spot-club/sign-up?gCode=Stat1898), using the company code Stat1898. The State employee is to use a personal credit card, not the Employee Travel Card (ETC) in connection with the Parking Spot App (this is because the Parking Spot App can be used for personal as well as official State business parking.

An employee's failure to acquire a Spot Club Card will not justify the granting of an exception from the reimbursement limitation.

Tucson Airport Parking Facilities

For airport parking in Tucson, a State employee may park wherever he finds it convenient to do so, but will only be reimbursed the lesser of the actual amount incurred or five dollars ($5.00) per day **base** parking charges. The facilities listed below offer rates that comply with State reimbursement limits.

Quick Park Quick Shuttle

• 6448 and 6550 South Tucson Blvd., Tucson, AZ (520) 294-9000, 24/7 Service.

• 6840 and 6920 South Tucson Blvd., Tucson, AZ (520) 294-9000, 24/7 Service.

Tucson International Airport Parking -- Economy Parking

• 3034 E. Corona Rd. Tucson, AZ, 24/7 Service.

4. LONG-TERM SUBSISTENCE RATES (08/01/16)

Long-term subsistence involves at least thirty (30) days in travel status outside of a fifty (50) mile radius of both one's residence and duty post.

The lodging and meal reimbursement rates for the appropriate season and location may be reimbursed for up to the first seven (7) days of travel if arrangements for housing cannot be made before travel.

After this initial seven-day (7-day) period, meals will be reimbursed at the rate of fifty percent (50%) of the amounts allowed for full days contained elsewhere in this section of SAAM.

> For example: A State employee is on a long-term assignment to Los Angeles, CA. The daily meal allowance in effect at the time for Los Angeles is fifty-four dollars ($54). The amount of meal reimbursement that would be allowed while qualifying for a long-term subsistence allowance (i.e., after the initial 7-day period) in Los Angeles would be twenty-seven dollars ($27) per day ($54 x 50% = $27).

After this initial seven-day (7-day) period, daily long-term lodging will be reimbursed at the rate of twenty-five percent (25%) of the amount allowed for a day's short-term lodging. The rate that will be allowed is that which is in effect at the location on the first day of the agreement or lease. The calculation is to be based on a thirty-day (30-day) month for each month of the lease.

> For example: A State employee is on long-term assignment to Los Angeles, CA. After his initial seven (7) days in Los Angeles, he enters into a six-month (6-month) lease for an apartment. The lease begins on March 1 and runs through August 31. The lodging rate in effect on March 1 is one-hundred fifty-seven dollars ($157) a night. The monthly rent the traveler may pay is one thousand one hundred seventy-seven dollars and fifty cents ($1,177.50) per month ($157 x 25% x 30). This amount may be reimbursed during the course of the lease even though the short-term lodging allowance decreases by seven dollars ($7) per night on April 1.

Amounts requested or required in excess of those derived in accordance with the formulas established herein require the approval of the State Comptroller.

5. LODGING AND FULL-DAY MEAL AND INCIDENTAL EXPENSE REIMBURSEMENT RATES FOR DESTINATIONS LOCATED IN ALASKA AND HAWAII OR OUT-OF-COUNTRY (01/09/23)

For the current Alaska, Hawaii and out-of-country rates, you may contact the GAO at gaotravel@azdoa.gov or visit the US Department of Defense (DoD) website. Go to the GAO Website travel page at https://gao.az.gov/travel/welcome-gao-travel and click on the "Current Out-of-Country / Alaska, Hawaii---Lodging and Meal Index" link to find the rates for the appropriate location.

To determine the allowable reimbursement rates using the DoD website, the following adjustments and computations must be made:

- Lodging rates, as posted on the DoD website, apply as a room rate without further modification. To these rates may be added any taxes or other charges imposed by local governmental jurisdictions.

- To determine the reimbursement limitations on meals and incidentals in Alaska, Hawaii and out-of-country locations, add the DoD Local Meal Rate (not the Proportional Meal Rate) to the Local Incidental Rate and subtract ten dollars ($10) from that sum.

- The breakdown for partial day meals for Alaska, Hawaii and out–of–country locations can be done using the following percentages of the full-day limitations:

Breakfast	**20%**
Lunch	**25%**
Dinner	**55%**

6. MEAL & INCIDENTAL EXPENSE REIMBURSEMENT RATES, BY MEAL, FOR TRAVEL IN THE CONTINENTAL US (as they correspond to their applicable full day rates). (01/09/23)

Full Day Rate	**$ 49.00**	**$ 54.00**	**$ 59.00**	**$ 64.00**	**$ 69.00**
Partial Day Rates					
Breakfast	**$ 10.00**	**$ 11.00**	**$ 12.00**	**$ 13.00**	**$ 14.00**
Lunch	**$ 12.00**	**$ 13.00**	**$ 15.00**	**$ 16.00**	**$ 17.00**
Dinner	**$ 27.00**	**$ 30.00**	**$ 32.00**	**$ 35.00**	**$ 38.00**
	$ 49.00	**$ 54.00**	**$ 59.00**	**$ 64.00**	**$ 69.00**
75% of Full Day Rates	**$ 36.75**	**$ 40.50**	**$ 44.25**	**$ 48.00**	**$ 51.75**

When travel involves an entire day, the full day meal reimbursement may be used without allocation between breakfast, lunch and dinner. When a meal is provided, the amount allowed for the meal provided is to be subtracted from the full day rate. For days of departure involving an overnight stay, the meal and incidental reimbursement limitation is 75% of the full day rate of the night's destination; for days of return, the meal and incidental limitation is 75% of the full day rate for the location in which the traveler stayed the previous night.

7. SINGLE DAY AND EXTENDED DAY MEAL REIMBURSEMENT LIMITS FOR TRAVEL NOT INVOLVING AN OVERNIGHT STAY (01/09/23)

Single Day Reimbursement Limit	**$ 15.00**
Extended Day Meal Reimbursement Limit	**$ 27.00**

The Single and Extended Day Meal Reimbursement Limits may be used without allocation between breakfast, lunch or dinner. The Single and Extended Day Meal Reimbursement Limits are reduced by any meals provided to the traveler (using the amounts set forth in Meal & Incidental Expense Reimbursement Rates, by Meal, for Travel in the Continental US).

Single Day and Extended Day Reimbursements represent taxable payments to the traveler and will be treated as such in the State's automated systems.

The limits are for actual costs incurred; they are not per diems or fixed allowances.

8. MEAL AND INCIDENTAL REIMBURSEMENT LIMITS FOR DAYS OF DEPARTURE AND RETURN FOR TRAVEL INVOLVING AN OVERNIGHT STAY (10/22/18)

The Meal Reimbursement Limits for Days of Departure and Return for Travel Involving an Overnight Stay equal seventy-five percent (75%) of the applicable Full-Day Meal and Incidental Expense Reimbursement Limits. For days of departure, the applicable Full-Day Meal and Incidental Expense Limit is the rate in effect for that day's final destination (where one will sleep for the night), whether that destination is in-state, out-of-state, or out-of-country; for days of return, the rate in effect is the rate for the location in which the traveler last stayed the night, prior to his returning to his regular duty post and/or home. Days of Departure and Return Reimbursement Limits may be used without allocation between breakfast, lunch or dinner. The Days of Departure and Return Limits reduced by any meals provided to the traveler (using the amounts set forth in Meal & Incidental Expense Reimbursement Rates, by Meal, for Travel in the Continental US or the appropriate computation and allocation of Federal rates applicable to destinations or originations outside of the CONUS).

Irrespective of the above, a traveler may not be reimbursed for more than the Full-Day Reimbursement Rate in any period of twenty-four (24) or fewer consecutive hours. In such cases, the rate to be used is the higher of the rates that might otherwise apply to the day of departure and the day of return.

Meal reimbursements paid for days of departure and return do not represent taxable income to the recipient and will be so treated in the State's automated systems.

The limits are for actual costs incurred; they are not per diems or fixed allowances.

9. LEGISLATIVE SUBSISTENCE RATE (10/01/22)

Rates effective 10/1/22-9/30/23

Members of the State Legislature shall be paid subsistence for each day they are in regular or special session based on the following:

For the first 120 days of regular session:

Location of Permanent Residence	Daily Subsistence Rate
Within Maricopa County	$ 35.00
Outside of Maricopa County	$238.00

For session days beyond the first 120 days of regular session:

Location of Permanent Residence	Daily Subsistence Rate
Within Maricopa County	$ 10.00
Outside of Maricopa County	$119.00

10. LODGING AND FULL-DAY MEAL AND INCIDENTAL EXPENSE PAYMENT AND/OR REIMBURSEMENT LIMITS THAT INVOLVE OVERNIGHT STAYS FOR DESTINATIONS LOCATED IN THE CONTINENTAL UNITED STATES (01/09/23)

For out-of-state locations treated as in-state, use the rates appropriate to the location. For example, if lodging is in Las Vegas, NV, and Las Vegas is treated as in-state, Las Vegas rates are to be applied.

Lodging rates are "room" or "rack" rates; taxes and other charges that are imposed by the applicable government authority may be reimbursed in addition to amounts shown.

The rates shown for meals and incidental are reimbursement limits for actual costs incurred, not per diems or fixed allowances.

For leap years, Feb 28 becomes Feb 29.

Except for AZ, which is listed first, the table is arranged in the order of a given state's abbreviation, not its name. So, Iowa, for example, comes before Illinois because its abbreviation, IA, comes before that of Illinois, IL.

State	Location	County	Begin	End	Lodging	M&IE
If a city is listed, then the city's rate applies. If a city not listed is located in a county whose rate is listed, then the county's rate applies. Otherwise, within the Continental United States, the rates to the immediate right apply.					**$98**	**$49**
Arizona						
AZ	Grand Canyon / Flagstaff	Coconino / Yavapai less the city of Sedona	Oct 01	Oct 31	$138	$64

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AZ	Grand Canyon / Flagstaff	Coconino / Yavapai less the city of Sedona	Nov 01	Feb 28	$103	$64
AZ	Grand Canyon / Flagstaff	Coconino / Yavapai less the city of Sedona	Mar 01	Apr 30	$127	$64
AZ	Grand Canyon / Flagstaff	Coconino / Yavapai less the city of Sedona	May 01	Sep 30	$138	$64
AZ	Kayenta	Navajo	Oct 01	Oct 31	$134	$54
AZ	Kayenta	Navajo	Nov 01	Feb 28	$115	$54
AZ	Kayenta	Navajo	Mar 01	Sep 30	$134	$54
AZ	Phoenix / Scottsdale	Maricopa	Oct 01	Jan 31	$151	$59
AZ	Phoenix / Scottsdale	Maricopa	Feb 01	Mar 31	$205	$59
AZ	Phoenix / Scottsdale	Maricopa	Apr 01	May 31	$151	$59
AZ	Phoenix / Scottsdale	Maricopa	Jun 01	Aug 31	$103	$59
AZ	Phoenix / Scottsdale	Maricopa	Sep 01	Sep 30	$151	$59
AZ	Sedona	City limits of Sedona	Oct 01	Dec 31	$247	$69
AZ	Sedona	City limits of Sedona	Jan 01	Feb 28	$198	$69
AZ	Sedona	City limits of Sedona	Mar 01	Apr 30	$310	$69
AZ	Sedona	City limits of Sedona	May 01	Aug 31	$215	$69
AZ	Sedona	City limits of Sedona	Sep 01	Sep 30	$247	$69
AZ	Tucson	Pima	Oct 01	Dec 31	$104	$54
AZ	Tucson	Pima	Jan 01	Mar 31	$145	$54
AZ	Tucson	Pima	Apr 01	Sep 30	$104	$54
Alabama						
AL	Birmingham	Jefferson	Oct 01	Sep 30	$113	$59
AL	Gulf Shores	Baldwin	Oct 01	Feb 28	$137	$59
AL	Gulf Shores	Baldwin	Mar 01	May 31	$161	$59
AL	Gulf Shores	Baldwin	Jun 01	Jul 31	$237	$59
AL	Gulf Shores	Baldwin	Aug 01	Sep 30	$137	$59
AL	Mobile	Mobile	Oct 01	Dec 31	$100	$49
AL	Mobile	Mobile	Jan 01	Mar 31	$114	$49
AL	Mobile	Mobile	Apr 01	Sep 30	$100	$49
Arkansas						
AR	Hot Springs	Garland	Oct 01	Sep 30	$103	$54
California						
CA	Antioch / Brentwood / Concord	Contra Costa	Oct 01	Sep 30	$165	$64

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CA	Bakersfield / Ridgecrest	Kern	Oct 01	Sep 30	$123	$54
CA	Barstow / Ontario / Victorville	San Bernardino	Oct 01	Sep 30	$120	$54
CA	Death Valley	Inyo / NAWS China Lake	Oct 01	Oct 31	$130	$59
CA	Death Valley	Inyo / NAWS China Lake	Nov 01	Jan 31	$116	$59
CA	Death Valley	Inyo / NAWS China Lake	Feb 01	Sep 30	$130	$59
CA	Eureka / Arcata / McKinleyville	Humboldt	Oct 01	May 31	$118	$59
CA	Eureka / Arcata / McKinleyville	Humboldt	Jun 01	Aug 31	$169	$59
CA	Eureka / Arcata / McKinleyville	Humboldt	Sep 01	Sep 30	$118	$59
CA	Fresno	Fresno	Oct 01	Sep 30	$113	$59
CA	Los Angeles	Los Angeles / Orange / Ventura / Edwards AFB less the city of Santa Monica	Oct 01	Oct 31	$182	$64
CA	Los Angeles	Los Angeles / Orange / Ventura / Edwards AFB less the city of Santa Monica	Nov 01	Dec 31	$168	$64
CA	Los Angeles	Los Angeles / Orange / Ventura / Edwards AFB less the city of Santa Monica	Jan 01	Sep 30	$182	$64
CA	Mammoth Lakes	Mono	Oct 01	Nov 30	$138	$69
CA	Mammoth Lakes	Mono	Dec 01	Jun 30	$156	$69
CA	Mammoth Lakes	Mono	Jul 01	Sep 30	$138	$69
CA	Mill Valley / San Rafael / Novato	Marin	Oct 01	Oct 31	$189	$64
CA	Mill Valley / San Rafael / Novato	Marin	Nov 01	May 31	$166	$64
CA	Mill Valley / San Rafael / Novato	Marin	Jun 01	Sep 30	$189	$64
CA	Monterey	Monterey	Oct 01	May 31	$166	$64
CA	Monterey	Monterey	Jun 01	Aug 31	$240	$64
CA	Monterey	Monterey	Sep 01	Sep 30	$166	$64
CA	Napa	Napa	Oct 01	Nov 30	$231	$69
CA	Napa	Napa	Dec 01	Feb 28	$189	$69
CA	Napa	Napa	Mar 01	Sep 30	$231	$69
CA	Oakhurst	Madera	Oct 01	Apr 30	$111	$59
CA	Oakhurst	Madera	May 01	Sep 30	$139	$59
CA	Oakland	Alameda	Oct 01	Sep 30	$189	$64
CA	Palm Springs	Riverside	Oct 01	Apr 30	$165	$59

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CA	Palm Springs	Riverside	May 01	Sep 30	$126	$59
CA	Point Arena / Gualala	Mendocino	Oct 01	Sep 30	$133	$69
CA	Sacramento	Sacramento	Oct 01	Sep 30	$145	$59
CA	San Diego	San Diego	Oct 01	Jan 31	$161	$64
CA	San Diego	San Diego	Feb 01	May 30	$181	$64
CA	San Diego	San Diego	Jun 01	Aug 31	$186	$64
CA	San Diego	San Diego	Sep 01	Sep 30	$161	$64
CA	San Francisco	San Francisco	Oct 01	Dec 31	$288	$69
CA	San Francisco	San Francisco	Jan 01	Mar 31	$333	$69
CA	San Francisco	San Francisco	Apr 01	Aug 31	$270	$69
CA	San Francisco	San Francisco	Sep 01	Sep 30	$288	$69
CA	San Luis Obispo	San Luis Obispo	Oct 01	May 31	$149	$64
CA	San Luis Obispo	San Luis Obispo	Jun 01	Aug 31	$191	$64
CA	San Luis Obispo	San Luis Obispo	Sep 01	Sep 30	$149	$64
CA	San Mateo / Foster City / Belmont	San Mateo	Oct 01	Sep 30	$222	$64
CA	Santa Barbara	Santa Barbara	Oct 01	Jun 30	$214	$64
CA	Santa Barbara	Santa Barbara	Jul 01	Aug 31	$289	$64
CA	Santa Barbara	Santa Barbara	Sep 01	Sep 30	$214	$64
CA	Santa Cruz	Santa Cruz	Oct 01	May 31	$128	$59
CA	Santa Cruz	Santa Cruz	Jun 01	Aug 31	$172	$59
CA	Santa Cruz	Santa Cruz	Sep 01	Sep 30	$128	$59
CA	Santa Monica	City limits of Santa Monica	Oct 01	May 31	$239	$69
CA	Santa Monica	City limits of Santa Monica	Jun 01	Aug 31	$284	$69
CA	Santa Monica	City limits of Santa Monica	Sep 01	Sep 30	$239	$69
CA	Santa Rosa	Sonoma	Oct 01	Sep 30	$157	$64
CA	South Lake Tahoe	El Dorado	Oct 01	Dec 31	$148	$64
CA	South Lake Tahoe	El Dorado	Jan 01	Jun 30	$121	$64
CA	South Lake Tahoe	El Dorado	Jul 01	Sep 30	$148	$64
CA	Stockton	San Joaquin	Oct 01	Sep 30	$140	$64
CA	Sunnyvale / Palo Alto / San Jose	Santa Clara	Oct 01	Sep 30	$245	$64
CA	Tahoe City	Placer	Oct 01	Sep 30	$124	$64
CA	Truckee	Nevada	Oct 01	Feb 28	$154	$69
CA	Truckee	Nevada	Mar 01	May 31	$126	$69

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CA	Truckee	Nevada	Jun 01	Aug 31	$160	$69
CA	Truckee	Nevada	Sep 01	Sep 30	$154	$69
CA	Visalia	Tulare	Oct 01	Sep 30	$125	$59
CA	West Sacramento / Davis	Yolo	Oct 01	Sep 30	$133	$59
CA	Yosemite National Park	Mariposa	Oct 01	Nov 30	$127	$69
CA	Yosemite National Park	Mariposa	Dec 01	Aug 31	$141	$69
CA	Yosemite National Park	Mariposa	Sep 01	Sep 30	$127	$69
Colorado						
CO	Aspen	Pitkin	Oct 01	Nov 30	$188	$69
CO	Aspen	Pitkin	Dec 01	Mar 31	$375	$69
CO	Aspen	Pitkin	Apr 01	May 31	$147	$69
CO	Aspen	Pitkin	Jun 01	Aug 31	$235	$69
CO	Aspen	Pitkin	Sep 01	Sep 30	$188	$69
CO	Boulder / Broomfield	Boulder / Broomfield	Oct 01	Apr 30	$128	$59
CO	Boulder / Broomfield	Boulder / Broomfield	May 01	Aug 31	$160	$59
CO	Boulder / Broomfield	Boulder / Broomfield	Sep 01	Sep 30	$128	$59
CO	Colorado Springs	El Paso	Oct 01	May 31	$121	$59
CO	Colorado Springs	El Paso	Jun 01	Aug 31	$178	$59
CO	Colorado Springs	El Paso	Sep 01	Sep 30	$121	$59
CO	Cortez	Montezuma	Oct 01	Oct 31	$134	$54
CO	Cortez	Montezuma	Nov 01	Apr 30	$98	$54
CO	Cortez	Montezuma	May 01	Sep 30	$134	$54
CO	Crested Butte / Gunnison	Gunnison	Oct 01	Nov 30	$147	$64
CO	Crested Butte / Gunnison	Gunnison	Dec 01	Mar 31	$175	$64
CO	Crested Butte / Gunnison	Gunnison	Apr 01	May 31	$106	$64
CO	Crested Butte / Gunnison	Gunnison	Jun 01	Sep 30	$147	$64
CO	Denver / Aurora	Denver / Adams / Arapahoe / Jefferson	Oct 01	Oct 31	$199	$69
CO	Denver / Aurora	Denver / Adams / Arapahoe / Jefferson	Nov 01	Dec 31	$153	$69
CO	Denver / Aurora	Denver / Adams / Arapahoe / Jefferson	Jan 01	Mar 31	$162	$69
CO	Denver / Aurora	Denver / Adams / Arapahoe / Jefferson	Apr 01	Sep 30	$199	$69
CO	Douglas	Douglas	Oct 01	May 31	$115	$59
CO	Douglas	Douglas	Jun 01	Aug 31	$140	$59
CO	Douglas	Douglas	Sep 01	Sep 30	$115	$59

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CO	Durango	La Plata	Oct 01	May 31	$116	$64
CO	Durango	La Plata	Jun 01	Sep 30	$179	$64
CO	Fort Collins / Loveland	Larimer	Oct 01	Sep 30	$113	$59
CO	Grand Lake	Grand	Oct 01	Nov 30	$164	$69
CO	Grand Lake	Grand	Dec 01	Mar 31	$278	$69
CO	Grand Lake	Grand	Apr 01	May 31	$121	$69
CO	Grand Lake	Grand	Jun 01	Sep 30	$164	$69
CO	Montrose	Montrose	Oct 01	May 31	$106	$59
CO	Montrose	Montrose	Jun 01	Sep 30	$131	$59
CO	Silverthorne / Breckenridge	Summit	Oct 01	Nov 30	$185	$69
CO	Silverthorne / Breckenridge	Summit	Dec 01	Mar 31	$332	$69
CO	Silverthorne / Breckenridge	Summit	Apr 01	May 31	$132	$69
CO	Silverthorne / Breckenridge	Summit	Jun 01	Sep 30	$185	$69
CO	Steamboat Springs	Routt	Oct 01	Nov 30	$135	$69
CO	Steamboat Springs	Routt	Dec 01	Mar 31	$181	$69
CO	Steamboat Springs	Routt	Apr 01	May 31	$98	$69
CO	Steamboat Springs	Routt	Jun 01	Sep 30	$135	$69
CO	Telluride	San Miguel	Oct 01	Nov 30	$197	$69
CO	Telluride	San Miguel	Dec 01	Mar 31	$418	$69
CO	Telluride	San Miguel	Apr 01	Sep 30	$197	$69
CO	Vail	Eagle	Oct 01	Nov 30	$208	$69
CO	Vail	Eagle	Dec 01	Mar 31	$485	$69
CO	Vail	Eagle	Apr 01	Sep 30	$208	$69
Connecticut						
CT	Bridgeport / Danbury	Fairfield	Oct 01	Sep 30	$125	$59
CT	Hartford	Hartford	Oct 01	Sep 30	$132	$59
CT	New Haven	New Haven	Oct 01	Sep 30	$114	$59
CT	New London / Groton	New London	Oct 01	Sep 30	$107	$59
District of Columbia (Washington DC)						

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DC	District of Columbia	Washington DC (also the cities of Alexandria, Falls Church and Fairfax, and the counties of Arlington and Fairfax, in Virginia; and the counties of Montgomery and Prince George's in Maryland)	Oct 01	Oct 31	$257	$69
DC	District of Columbia	Washington DC (also the cities of Alexandria, Falls Church and Fairfax, and the counties of Arlington and Fairfax, in Virginia; and the counties of Montgomery and Prince George's in Maryland)	Nov 01	Feb 28	$188	$69
DC	District of Columbia	Washington DC (also the cities of Alexandria, Falls Church and Fairfax, and the counties of Arlington and Fairfax, in Virginia; and the counties of Montgomery and Prince George's in Maryland)	Mar 01	Jun 30	$258	$69
DC	District of Columbia	Washington DC (also the cities of Alexandria, Falls Church and Fairfax, and the counties of Arlington and Fairfax, in Virginia; and the counties of Montgomery and Prince George's in Maryland)	Jul 01	Aug 31	$172	$69
DC	District of Columbia	Washington DC (also the cities of Alexandria, Falls Church and Fairfax, and the counties of Arlington and Fairfax, in Virginia; and the counties of Montgomery and Prince George's in Maryland)	Sep 01	Sep 30	$257	$69

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Delaware						
DE	Lewes	Sussex	Oct 01	Apr 30	$113	$54
DE	Lewes	Sussex	May 01	Jun 30	$174	$54
DE	Lewes	Sussex	Jul 01	Aug 31	$279	$54
DE	Lewes	Sussex	Sep 01	Sep 30	$113	$54
DE	Wilmington	New Castle	Oct 01	Sep 30	$131	$54
Florida						
FL	Boca Raton / Delray Beach / Jupiter	Palm Beach / Hendry	Oct 01	Nov 30	$134	$59
FL	Boca Raton / Delray Beach / Jupiter	Palm Beach / Hendry	Dec 01	Apr 30	$209	$59
FL	Boca Raton / Delray Beach / Jupiter	Palm Beach / Hendry	May 01	Sep 30	$134	$59
FL	Bradenton	Manatee	Oct 01	Jan 31	$129	$54
FL	Bradenton	Manatee	Feb 01	Mar 31	$208	$54
FL	Bradenton	Manatee	Apr 01	Sep 30	$129	$54
FL	Cocoa Beach	Brevard	Oct 01	Jan 31	$144	$64
FL	Cocoa Beach	Brevard	Feb 01	Mar 31	$183	$64
FL	Cocoa Beach	Brevard	Apr 01	Sep 30	$144	$64
FL	Daytona Beach	Volusia	Oct 01	Jan 31	$116	$59
FL	Daytona Beach	Volusia	Feb 01	Mar 31	$156	$59
FL	Daytona Beach	Volusia	Apr 01	Jul 31	$135	$59
FL	Daytona Beach	Volusia	Aug 01	Sep 30	$116	$59
FL	Fort Lauderdale	Broward	Oct 01	Dec 31	$183	$59
FL	Fort Lauderdale	Broward	Jan 1	Apr 30	$221	$59
FL	Fort Lauderdale	Broward	May 1	Sep 30	$150	$59
FL	Fort Myers	Lee	Oct 01	Nov 30	$124	$54
FL	Fort Myers	Lee	Dec 01	Jan 31	$164	$54
FL	Fort Myers	Lee	Feb 01	Mar 31	$252	$54
FL	Fort Myers	Lee	Apr 01	Sep 30	$124	$54
FL	Fort Walton Beach / De Funiak Springs	Okaloosa / Walton	Oct 01	Oct 31	$186	$59
FL	Fort Walton Beach / De Funiak Springs	Okaloosa / Walton	Nov 01	Feb 28	$109	$59
FL	Fort Walton Beach / De Funiak Springs	Okaloosa / Walton	Mar 01	May 31	$191	$59
FL	Fort Walton Beach / De Funiak Springs	Okaloosa / Walton	Jun 01	Jul 31	$305	$59
FL	Fort Walton Beach / De Funiak Springs	Okaloosa / Walton	Aug 01	Sep 30	$186	$59

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FL	Gulf Breeze	Santa Rosa	Oct 01	Feb 28	$130	$49
FL	Gulf Breeze	Santa Rosa	Mar 01	May 31	$162	$49
FL	Gulf Breeze	Santa Rosa	Jun 01	Jul 31	$252	$49
FL	Gulf Breeze	Santa Rosa	Aug 01	Sep 30	$130	$49
FL	Key West	Monroe	Oct 01	Nov 30	$289	$59
FL	Key West	Monroe	Dec 01	Apr 30	$429	$59
FL	Key West	Monroe	May 01	Jul 31	$329	$59
FL	Key West	Monroe	Aug 01	Sep 30	$255	$59
FL	Miami	Miami-Dade	Oct 01	Nov 30	$146	$59
FL	Miami	Miami-Dade	Dec 01	Mar 31	$215	$59
FL	Miami	Miami-Dade	Apr 01	May 31	$151	$59
FL	Miami	Miami-Dade	Jun 01	Sep 30	$142	$59
FL	Naples	Collier	Oct 01	Nov 30	$157	$59
FL	Naples	Collier	Dec 01	Jan 31	$246	$59
FL	Naples	Collier	Feb 01	Apr 30	$316	$59
FL	Naples	Collier	May 01	Sep 30	$157	$59
FL	Orlando	Orange	Oct 01	Dec 31	$129	$59
FL	Orlando	Orange	Jan 01	Mar 31	$159	$59
FL	Orlando	Orange	Apr 01	Sep 30	$129	$59
FL	Panama City	Bay	Oct 01	Feb 28	$146	$54
FL	Panama City	Bay	Mar 01	May 31	$165	$54
FL	Panama City	Bay	Jun 01	Jul 31	$258	$54
FL	Panama City	Bay	Aug 01	Sep 30	$146	$54
FL	Pensacola	Escambia	Oct 01	Feb 28	$133	$54
FL	Pensacola	Escambia	Mar 01	May 31	$152	$54
FL	Pensacola	Escambia	Jun 01	Jul 31	$214	$54
FL	Pensacola	Escambia	Aug 01	Sep 30	$133	$54
FL	Punta Gorda	Charlotte	Oct 01	Jan 31	$98	$54
FL	Punta Gorda	Charlotte	Feb 01	Mar 31	$191	$54
FL	Punta Gorda	Charlotte	Apr 01	Sep 30	$98	$54
FL	Sarasota	Sarasota	Oct 01	Jan 31	$130	$59
FL	Sarasota	Sarasota	Feb 01	Apr 30	$197	$59
FL	Sarasota	Sarasota	May 01	Sep 30	$130	$59
FL	Sebring	Highlands	Oct 01	Jan 31	$104	$54
FL	Sebring	Highlands	Feb 01	Mar 31	$186	$54
FL	Sebring	Highlands	Apr 01	Sep 30	$104	$54

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FL	St. Augustine	St. Johns	Oct 01	Nov 30	$139	$59
FL	St. Augustine	St. Johns	Dec 01	Mar 31	$159	$59
FL	St. Augustine	St. Johns	Apr 01	Sep 30	$139	$59
FL	Stuart	Martin	Oct 01	Jan 31	$126	$59
FL	Stuart	Martin	Feb 01	Mar 31	$192	$59
FL	Stuart	Martin	Apr 01	Sep 30	$126	$59
FL	Tallahassee	Leon	Oct 01	Dec 31	$111	$54
FL	Tallahassee	Leon	Jan 01	Mar 31	$148	$54
FL	Tallahassee	Leon	Apr 01	Sep 30	$111	$54
FL	Tampa / St. Petersburg	Pinellas / Hillsborough	Oct 01	Dec 31	$133	$59
FL	Tampa / St. Petersburg	Pinellas / Hillsborough	Jan 01	Apr 30	$173	$59
FL	Tampa / St. Petersburg	Pinellas / Hillsborough	May 01	Sep 30	$133	$59
FL	Vero Beach	Indian River	Oct 01	Nov 30	$150	$59
FL	Vero Beach	Indian River	Dec 01	Apr 30	$204	$59
FL	Vero Beach	Indian River	May 01	Sep 30	$150	$59
Georgia						
GA	Athens	Clarke	Oct 01	Sep 30	$107	$49
GA	Atlanta	Fulton / Dekalb	Oct 01	Sep 30	$163	$64
GA	Augusta	Richmond	Oct 01	Sep 30	$107	$49
GA	Jekyll Island / Brunswick	Glynn	Oct 01	Feb 28	$161	$69
GA	Jekyll Island / Brunswick	Glynn	Mar 01	Jul 31	$206	$69
GA	Jekyll Island / Brunswick	Glynn	Aug 01	Sep 30	$161	$69
GA	Marietta	Cobb	Oct 01	Sep 30	$121	$54
GA	Savannah	Chatham	Oct 01	Feb 28	$130	$59
GA	Savannah	Chatham	Mar 01	Apr 30	$147	$59
GA	Savannah	Chatham	May 01	Sep 30	$130	$59
Iowa						
IA	Dallas	Dallas	Oct 01	Dec 31	$105	$59
IA	Dallas	Dallas	Jan 01	Aug 31	$111	$59
IA	Dallas	Dallas	Sep 01	Sep 30	$105	$59
IA	Des Moines	Polk	Oct 01	Sep 30	$111	$54
Idaho						
ID	Coeur d'Alene	Kootenai	Oct 01	May 31	$105	$54
ID	Coeur d'Alene	Kootenai	Jun 01	Aug 31	$179	$54
ID	Coeur d'Alene	Kootenai	Sep 01	Sep 30	$105	$54
ID	Sun Valley / Ketchum	Blaine / Elmore	Oct 01	Nov 30	$165	$64

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ID	Sun Valley / Ketchum	Blaine / Elmore	Dec 01	Mar 31	$288	$64
ID	Sun Valley / Ketchum	Blaine / Elmore	Apr 01	May 31	$149	$64
ID	Sun Valley / Ketchum	Blaine / Elmore	Jun 01	Sep 30	$275	$64
Illinois						
IL	Bolingbrook / Romeoville / Lemont	Will	Oct 01	Sep 30	$105	$54
IL	Chicago	Cook / Lake	Oct 01	Nov 30	$218	$69
IL	Chicago	Cook / Lake	Dec 01	Mar 31	$134	$69
IL	Chicago	Cook / Lake	Apr 01	Jun 30	$216	$69
IL	Chicago	Cook / Lake	Jul 01	Aug 31	$187	$69
IL	Chicago	Cook / Lake	Sep 01	Sep 30	$218	$69
IL	East St. Louis, O'Fallon / Fairview Heights	St. Clair	Oct 01	Sep 30	$141	$54
IL	Oak Brook Terrace	Dupage	Oct 01	Sep 30	$114	$54
Indiana						
IN	Bloomington	Monroe	Oct 01	Apr 30	$98	$54
IN	Bloomington	Monroe	May 01	Aug 31	$106	$54
IN	Bloomington	Monroe	Sep 01	Sep 30	$98	$54
IN	Ft. Wayne	Allen	Oct 01	Sep 30	$108	$54
IN	Hammond / Munster / Merrillville	Lake	Oct 01	Sep 30	$102	$54
IN	Indianapolis / Carmel	Marion / Hamilton	Oct 01	Sep 30	$127	$59
IN	Lafayette / West Lafayette	Tippecanoe	Oct 01	Jul 31	$100	$54
IN	Lafayette / West Lafayette	Tippecanoe	Aug 01	Sep 30	$118	$54
Kansas						
KS	Kansas City / Overland Park	Wyandotte / Johnson / Leavenworth	Oct 01	Sep 30	$123	$54
KS	Wichita	Sedgwick	Oct 01	Sep 30	$103	$54
Kentucky						
KY	Boone	Boone	Oct 01	Sep 30	$114	$54
KY	Kenton	Kenton	Oct 01	Sep 30	$151	$64
KY	Lexington	Fayette	Oct 01	Sep 30	$110	$54
KY	Louisville	Jefferson	Oct 01	Oct 31	$131	$54
KY	Louisville	Jefferson	Nov 01	Jan 31	$113	$54
KY	Louisville	Jefferson	Feb 01	May 31	$139	$54
KY	Louisville	Jefferson	Jun 01	Sep 30	$131	$54
Louisiana						

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LA	Alexandria / Leesville / Natchitoches	Allen / Jefferson Davis / Natchitoches / Rapides / Vernon Parishes	Oct 01	Sep 30	$105	$54
LA	Baton Rouge	East Baton Rouge Parish	Oct 01	Sep 30	$106	$59
LA	New Orleans	Orleans / Jefferson Parishes	Oct 01	Dec 31	$136	$64
LA	New Orleans	Orleans / Jefferson Parishes	Jan 01	May 31	$158	$64
LA	New Orleans	Orleans / Jefferson Parishes	Jun 01	Sep 30	$136	$64
Massachusetts						
MA	Andover	Essex	Oct 01	Sep 30	$123	$54
MA	Boston / Cambridge	Suffolk, city of Cambridge	Oct 01	Oct 31	$309	$69
MA	Boston / Cambridge	Suffolk, city of Cambridge	Nov 01	Feb 28	$185	$69
MA	Boston / Cambridge	Suffolk, city of Cambridge	Mar 01	Jun 30	$281	$69
MA	Boston / Cambridge	Suffolk, city of Cambridge	Jul 01	Aug 31	$264	$69
MA	Boston / Cambridge	Suffolk, city of Cambridge	Sep 01	Sep 30	$309	$69
MA	Burlington / Woburn	Middlesex less the city of Cambridge	Oct 01	Oct 31	$168	$59
MA	Burlington / Woburn	Middlesex less the city of Cambridge	Nov 01	Apr 30	$142	$59
MA	Burlington / Woburn	Middlesex less the city of Cambridge	May 01	Sep 30	$168	$59
MA	Falmouth	City limits of Falmouth	Oct 01	Apr 30	$171	$59
MA	Falmouth	City limits of Falmouth	May 01	Jun 30	$231	$59
MA	Falmouth	City limits of Falmouth	Jul 01	Aug 31	$383	$59
MA	Falmouth	City limits of Falmouth	Sep 01	Sep 30	$171	$59
MA	Hyannis	Barnstable less the city of Falmouth	Oct 01	Jun 30	$126	$59
MA	Hyannis	Barnstable less the city of Falmouth	Jul 01	Aug 31	$232	$59
MA	Hyannis	Barnstable less the city of Falmouth	Sep 01	Sep 30	$126	$59
MA	Martha's Vineyard	Dukes	Oct 01	May 31	$202	$69

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MA	Martha's Vineyard	Dukes	Jun 01	Sep 30	$411	$69
MA	Nantucket	Nantucket	Oct 01	May 31	$217	$69
MA	Nantucket	Nantucket	Jun 01	Sep 30	$459	$69
MA	Northampton	Hampshire	Oct 01	Sep 30	$128	$59
MA	Pittsfield	Berkshire	Oct 01	May 31	$125	$54
MA	Pittsfield	Berkshire	Jun 01	Aug 31	$155	$54
MA	Pittsfield	Berkshire	Sep 01	Sep 30	$125	$54
MA	Plymouth / Taunton / New Bedford	Plymouth / Bristol	Oct 01	Sep 30	$113	$59
MA	Quincy	Norfolk	Oct 01	Oct 31	$150	$59
MA	Springfield	Hampden	Oct 01	Sep 30	$115	$54
MA	Worcester	Worcester	Oct 01	Sep 30	$125	$59
Maryland (see District of Columbia for Washington D.C. rates applicable to Maryland)						
MD	Aberdeen / Bel Air / Belcamp	Harford	Oct 01	Sep 30	$104	$54
MD	Annapolis	Anne Arundel	Oct 01	Oct 31	$139	$59
MD	Annapolis	Anne Arundel	Nov 01	Apr 30	$108	$59
MD	Annapolis	Anne Arundel	May 01	Sep 30	$139	$59
MD	Baltimore City	Baltimore City	Oct 01	Feb 28	$137	$59
MD	Baltimore City	Baltimore City	Mar 01	Jun 30	$151	$59
MD	Baltimore City	Baltimore City	Jul 01	Sep 30	$137	$59
MD	Baltimore County	Baltimore	Oct 01	Sep 30	$101	$54
MD	Cambridge / St. Michaels	Dorchester / Talbot	Oct 01	May 31	$123	$54
MD	Cambridge / St. Michaels	Dorchester / Talbot	Jun 01	Aug 31	$184	$54
MD	Cambridge / St. Michaels	Dorchester / Talbot	Sep 01	Sep 30	$123	$54
MD	Centreville	Queen Anne	Oct 01	Sep 30	$126	$54
MD	Columbia	Howard	Oct 01	Sep 30	$106	$59
MD	Frederick	Frederick	Oct 01	Sep 30	$100	$54
MD	Ocean City	Worcester	Oct 01	Jun 30	$130	$59
MD	Ocean City	Worcester	Jul 01	Aug 31	$325	$59
MD	Ocean City	Worcester	Sep 01	Sep 30	$130	$59
Maine						
ME	Bar Harbor / Rockport	Hancock / Knox	Oct 01	Oct 31	$219	$64
ME	Bar Harbor / Rockport	Hancock / Knox	Nov 01	Jun 30	$127	$64
ME	Bar Harbor / Rockport	Hancock / Knox	Jul 01	Aug 31	$268	$64
ME	Bar Harbor / Rockport	Hancock / Knox	Sep 01	Sep 30	$219	$64
ME	Kennebunk / Kittery / Sanford	York	Oct 01	Oct 31	$150	$59
ME	Kennebunk / Kittery / Sanford	York	Nov 01	Jun 30	$105	$59

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ME	Kennebunk / Kittery / Sanford	York	Jul 01	Aug 31	$206	$59
ME	Kennebunk / Kittery / Sanford	York	Sep 01	Sep 30	$150	$59
ME	Portland	Cumberland / Sagadahoc	Oct 01	Oct 31	$176	$54
ME	Portland	Cumberland / Sagadahoc	Nov 01	Jun 30	$117	$54
ME	Portland	Cumberland / Sagadahoc	Jul 01	Aug 31	$208	$54
ME	Portland	Cumberland / Sagadahoc	Sep 01	Sep 30	$176	$54
Michigan						
MI	Ann Arbor	Washtenaw	Oct 01	Apr 30	$118	$59
MI	Ann Arbor	Washtenaw	May 01	Aug 31	$134	$59
MI	Ann Arbor	Washtenaw	Sep 01	Sep 30	$118	$59
MI	Detroit	Wayne	Oct 01	Sep 30	$133	$54
MI	East Lansing / Lansing	Ingham / Eaton	Oct 01	Sep 30	$106	$54
MI	Grand Rapids	Kent	Oct 01	Sep 30	$114	$54
MI	Holland	Ottawa	Oct 01	Apr 30	$120	$54
MI	Holland	Ottawa	May 1	Jun 30	$122	$54
MI	Holland	Ottawa	Jul 1	Sep 30	$120	$54
MI	Kalamazoo / Battle Creek	Kalamazoo / Calhoun	Oct 01	Sep 30	$104	$54
MI	Mackinac Island	Mackinac	Oct 01	Jun 30	$114	$64
MI	Mackinac Island	Mackinac	Jul 01	Aug 31	$180	$64
MI	Mackinac Island	Mackinac	Sep 01	Sep 30	$114	$64
MI	Midland	Midland	Oct 01	Sep 30	$119	$49
MI	Muskegon	Muskegon	Oct 01	May 31	$98	$54
MI	Muskegon	Muskegon	Jun 01	Aug 31	$130	$54
MI	Muskegon	Muskegon	Sep 01	Sep 30	$98	$54
MI	Petoskey	Emmet	Oct 01	Jun 30	$132	$54
MI	Petoskey	Emmet	Jul 01	Aug 31	$226	$54
MI	Petoskey	Emmet	Sep 01	Sep 30	$132	$54
MI	Pontiac / Auburn Hills	Oakland	Oct 01	Sep 30	$117	$54
MI	South Haven	Van Buren	Oct 01	May 31	$98	$54
MI	South Haven	Van Buren	Jun 01	Aug 31	$121	$54
MI	South Haven	Van Buren	Sep 01	Sep 30	$98	$54
MI	Traverse City	Grand Traverse	Oct 01	Jun 30	$125	$54
MI	Traverse City	Grand Traverse	Jul 01	Aug 31	$234	$54

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MI	Traverse City	Grand Traverse	Sep 01	Sep 30	$125	$54
Minnesota						
MN	Duluth	St. Louis	Oct 01	Oct 31	$194	$69
MN	Duluth	St. Louis	Nov 01	May 31	$140	$69
MN	Duluth	St. Louis	Jun 01	Sep 30	$194	$69
MN	Eagan / Burnsville / Mendota Heights	Dakota	Oct 01	Sep 30	$100	$59
MN	Minneapolis / St. Paul	Hennepin / Ramsey	Oct 01	Sep 30	$148	$69
MN	Rochester	Olmsted	Oct 01	Sep 30	$133	$54
Missouri						
MO	Kansas City	Jackson / Clay / Cass / Platte	Oct 01	Sep 30	$123	$54
MO	St. Louis	St. Louis / St. Louis City / St. Charles	Oct 01	Sep 30	$141	$54
Mississippi						
MS	Oxford	Lafayette	Oct 01	Sep 30	$103	$54
MS	Southaven	Desoto	Oct 01	Sep 30	$111	$49
MS	Starkville	Oktibbeha	Oct 01	Sep 30	$106	$54
Montana						
MT	Big Sky / West Yellowstone	Gallatin	Oct 01	May 31	$151	$69
MT	Big Sky / West Yellowstone	Gallatin	Jun 01	Sep 30	$279	$69
MT	Helena	Lewis and Clark	Oct 01	Sep 30	$107	$54
MT	Kalispell / Whitefish	Flathead	Oct 01	Jun 30	$118	$54
MT	Kalispell / Whitefish	Flathead	Jul 01	Aug 31	$243	$54
MT	Kalispell / Whitefish	Flathead	Sep 01	Sep 30	$118	$54
MT	Missoula	Missoula	Oct 01	May 31	$106	$59
MT	Missoula	Missoula	Jun 01	Sep 30	$167	$59
North Carolina						
NC	Asheville	Buncombe	Oct 01	Dec 31	$130	$54
NC	Asheville	Buncombe	Jan 01	Mar 31	$106	$54
NC	Asheville	Buncombe	Apr 01	Sep 30	$130	$54
NC	Atlantic Beach / Morehead City	Carteret	Oct 01	Feb 28	$111	$54
NC	Atlantic Beach / Morehead City	Carteret	Mar 01	Aug 31	$148	$54
NC	Atlantic Beach / Morehead City	Carteret	Sep 01	Sep 30	$111	$51
NC	Chapel Hill	Orange	Oct 01	Sep 30	$113	$64

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NC	Charlotte	Mecklenburg	Oct 01	Sep 30	$129	$59
NC	Durham	Durham	Oct 01	Sep 30	$115	$54
NC	Fayetteville	Cumberland	Oct 01	Sep 30	$118	$54
NC	Greensboro	Guilford	Oct 01	Apr 30	$112	$54
NC	Greensboro	Guilford	May 01	Sep 30	$103	$54
NC	Kill Devil Hills	Dare	Oct 01	Mar 31	$113	$64
NC	Kill Devil Hills	Dare	Apr 01	Sep 30	$212	$64
NC	Raleigh	Wake	Oct 01	Sep 30	$123	$54
NC	Wilmington	New Hanover	Oct 01	Sep 30	$124	$49
North Dakota						
ND	All Cities and Towns	All Counties	Oct 01	Sep 30	$98	$49
Nebraska						
NE	Omaha	Douglas	Oct 01	Sep 30	$110	$54
New Hampshire						
NH	Concord	Merrimack	Oct 01	Sep 30	$114	$54
NH	Conway	Caroll	Oct 01	Feb 28	$133	$59
NH	Conway	Caroll	Mar 01	Jun 30	$116	$59
NH	Conway	Caroll	Jul 01	Aug 31	$164	$59
NH	Conway	Caroll	Sep 01	Sep 30	$133	$59
NH	Durham	Strafford	Oct 01	Jun 30	$110	$49
NH	Durham	Strafford	Jul 01	Aug 31	$143	$49
NH	Durham	Strafford	Sep 01	Sep 30	$110	$49
NH	Laconia	Belknap	Oct 01	Oct 31	$171	$54
NH	Laconia	Belknap	Nov 01	May 31	$136	$54
NH	Laconia	Belknap	Jun 01	Sep 30	$171	$54
NH	Lebanon / Lincoln / West Lebanon	Grafton	Oct 01	Sep 30	$146	$49
NH	Manchester	Hillsborough	Oct 01	Feb 28	$124	$54
NH	Manchester	Hillsborough	Mar 01	Apr 30	$111	$54
NH	Manchester	Hillsborough	May 01	Sep 30	$124	$54
NH	Portsmouth	Rockingham	Oct 01	Oct 31	$154	$54
NH	Portsmouth	Rockingham	Nov 01	Jun 30	$116	$54
NH	Portsmouth	Rockingham	Jul 01	Aug 31	$184	$54
NH	Portsmouth	Rockingham	Sep 01	Sep 30	$154	$54
New Jersey						
NJ	Cherry Hill / Moorestown	Camden / Burlington	Oct 01	Sep 30	$102	$59
NJ	Eatontown / Freehold	Monmouth	Oct 01	Sep 30	$127	$59

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NJ	Edison / Piscataway	Middlesex	Oct 01	Sep 30	$116	$59
NJ	Flemington	Hunterdon	Oct 01	Sep 30	$126	$59
NJ	Newark	Essex / Bergen / Hudson / Passaic	Oct 01	Sep 30	$147	$59
NJ	Parsippany	Morris	Oct 01	Sep 30	$161	$59
NJ	Princeton / Trenton	Mercer	Oct 01	Sep 30	$137	$59
NJ	Somerset	Somerset	Oct 01	Sep 30	$153	$54
NJ	Springfield / Cranford / New Providence	Union	Oct 01	Sep 30	$126	$59
NJ	Toms River	Ocean	Oct 01	Jun 30	$129	$59
NJ	Toms River	Ocean	Jul 01	Aug 31	$181	$59
NJ	Toms River	Ocean	Sep 01	Sep 30	$129	$59
New Mexico						
NM	Albuquerque	Bernalillo	Oct 01	Sep 30	$121	$59
NM	Carlsbad	Eddy	Oct 01	Sep 30	$212	$54
NM	Santa Fe	Santa Fe	Oct 01	Dec 31	$141	$59
NM	Santa Fe	Santa Fe	Jan 01	Feb 28	$109	$59
NM	Santa Fe	Santa Fe	Mar 01	Sep 30	$141	$59
NM	Taos	Taos	Oct 01	Sep 30	$112	$54
Nevada						
NV	Incline Village / Reno / Sparks	Washoe	Oct 01	Jun 30	$114	$59
NV	Incline Village / Reno / Sparks	Washoe	Jul 01	Aug 31	$150	$59
NV	Incline Village / Reno / Sparks	Washoe	Sep 01	Sep 30	$114	$59
NV	Las Vegas	Clark	Oct 01	Sep 30	$120	$59
New York						
NY	Albany	Albany	Oct 01	Sep 30	$114	$59
NY	Binghamton	Broome	Oct 01	Sep 30	$101	$54
NY	Buffalo	Erie	Oct 01	Sep 30	$106	$59
NY	Floral Park / Garden City / Great Neck	Nassau	Oct 01	Sep 30	$150	$64
NY	Glens Falls	Warren	Oct 01	Jun 30	$119	$59
NY	Glens Falls	Warren	Jul 01	Aug 31	$198	$59
NY	Glens Falls	Warren	Sep 01	Sep 30	$119	$59
NY	Ithaca	Tompkins	Oct 01	Nov 30	$134	$64
NY	Ithaca	Tompkins	Dec 01	Jan 31	$106	$64
NY	Ithaca	Tompkins	Feb 01	Sep 30	$134	$64

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NY	Kingston	Ulster	Oct 01	Sep 30	$119	$59
NY	Lake Placid	Essex	Oct 01	Feb 28	$145	$69
NY	Lake Placid	Essex	Mar 01	Jun 30	$123	$69
NY	Lake Placid	Essex	Jul 01	Aug 31	$207	$69
NY	Lake Placid	Essex	Sep 01	Sep 30	$145	$69
NY	New York City	Bronx / Kings / New York / Queens / Richmond	Oct 01	Dec 31	$ 286	$69
NY	New York City	Bronx / Kings / New York / Queens / Richmond	Jan 01	Feb 28	$ 159	$69
NY	New York City	Bronx / Kings / New York / Queens / Richmond	Mar 01	Jun 30	$ 258	$69
NY	New York City	Bronx / Kings / New York / Queens / Richmond	Jul 01	Aug 31	$ 220	$69
NY	New York City	Bronx / Kings / New York / Queens / Richmond	Sep 01	Sep 30	$ 286	$69
NY	Niagara Falls	Niagara	Oct 01	May 31	$98	$59
NY	Niagara Falls	Niagara	Jun 01	Aug 31	$133	$59
NY	Niagara Falls	Niagara	Sep 01	Sep 30	$98	$59
NY	Nyack / Palisades	Rockland	Oct 01	Sep 30	$117	$59
NY	Poughkeepsie	Dutchess	Oct 01	Sep 30	$108	$59
NY	Riverhead / Ronkonkoma / Melville	Suffolk	Oct 01	Sep 30	$147	$59
NY	Rochester	Monroe	Oct 01	Sep 30	$114	$59
NY	Saratoga Springs / Schenectady	Saratoga / Schenectady	Oct 01	Jun 30	$116	$54
NY	Saratoga Springs / Schenectady	Saratoga / Schenectady	Jul 01	Aug 31	$183	$54
NY	Saratoga Springs / Schenectady	Saratoga / Schenectady	Sep 01	Sep 30	$116	$54
NY	Syracuse / Oswego	Onondaga / Oswego	Oct 01	Sep 30	$101	$54
NY	Tarrytown / White Plains / New Rochelle	Westchester	Oct 01	Sep 30	$142	$64
NY	Troy	Rensselaer	Oct 01	Sep 30	$108	$54
NY	West Point	Orange	Oct 01	Sep 30	$118	$54
Ohio						
OH	Akron	Summit	Oct 01	Sep 30	$99	$54
OH	Canton	Stark	Oct 01	Jun 30	$98	$54
OH	Canton	Stark	Jul 01	Aug 31	$114	$54
OH	Canton	Stark	Sep 01	Sep 30	$ 98	$54
OH	Cincinnati	Hamilton / Clermont	Oct 01	Sep 30	$151	$64
OH	Cleveland	Cuyahoga	Oct 01	Sep 30	$137	$59

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OH	Columbus	Franklin	Oct 01	Sep 30	$122	$54
OH	Dayton / Fairborn	Greene / Montgomery	Oct 01	Sep 30	$109	$54
OH	Hamilton	Butler / Warren	Oct 01	Sep 30	$117	$49
OH	Mentor	Lake	Oct 01	Sep 30	$ 105	$49
OH	Sandusky	Erie	Oct 01	Feb 28	$111	$54
OH	Sandusky	Erie	Mar 01	Aug 31	$152	$54
OH	Sandusky	Erie	Sep 01	Sep 30	$111	$54
OH	Wooster	Wayne	Oct 01	Sep 30	$101	$49
Oklahoma						
OK	Oklahoma City	Oklahoma	Oct 01	Sep 30	$104	$54
Oregon						
OR	Beaverton	Washington	Oct 01	Sep 30	$136	$54
OR	Bend	Deschutes	Oct 01	May 31	$120	$54
OR	Bend	Deschutes	Jun 01	Aug 31	$173	$54
OR	Bend	Deschutes	Sep 01	Sep 30	$120	$54
OR	Clackamas	Clackamas	Oct 01	May 31	$115	$54
OR	Clackamas	Clackamas	Jun 01	Aug 31	$138	$54
OR	Clackamas	Clackamas	Sep 01	Sep 30	$115	$54
OR	Eugene / Florence	Lane	Oct 01	Sep 30	$122	$54
OR	Lincoln City	Lincoln	Oct 01	Jun 30	$131	$59
OR	Lincoln City	Lincoln	Jul 01	Aug 31	$202	$59
OR	Lincoln City	Lincoln	Sep 01	Sep 30	$131	$59
OR	Portland	Multnomah	Oct 01	Oct 31	$182	$64
OR	Portland	Multnomah	Nov 01	Mar 31	$152	$64
OR	Portland	Multnomah	Apr 01	Sep 30	$182	$64
OR	Seaside	Clatsop	Oct 01	Jan 31	$121	$59
OR	Seaside	Clatsop	Feb 01	Jun 30	$131	$59
OR	Seaside	Clatsop	Jul 01	Aug 31	$222	$59
OR	Seaside	Clatsop	Sep 01	Sep 30	$121	$59
Pennsylvania						
PA	Allentown / Easton / Bethlehem	Lehigh / Northampton	Oct 01	Sep 30	$109	$54
PA	Bucks	Bucks	Oct 01	May 31	$108	$54
PA	Bucks	Bucks	Jun 01	Jul 31	$116	$54
PA	Bucks	Bucks	Aug 01	Sep 30	$108	$54
PA	Chester / Radnor / Essington	Delaware	Oct 01	Sep 30	$119	$54
PA	Erie	Erie	Oct 01	Sep 30	$106	$49

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PA	Gettysburg	Adams	Oct 01	Oct 31	$107	$54
PA	Gettysburg	Adams	Nov 01	Mar 31	$98	$54
PA	Gettysburg	Adams	Apr 01	Sep 30	$107	$54
PA	Harrisburg	Dauphin County excluding Hershey	Oct 01	Sep 30	$117	$54
PA	Hershey	Hershey	Oct 01	Oct 31	$144	$64
PA	Hershey	Hershey	Nov 01	May 31	$119	$64
PA	Hershey	Hershey	Jun 01	Aug 31	$184	$64
PA	Hershey	Hershey	Sep 01	Sep 30	$144	$64
PA	Lancaster	Lancaster	Oct 01	Sep 30	$109	$49
PA	Malvern / Frazer / Berwyn	Chester	Oct 01	Sep 30	$129	$54
PA	Montgomery	Montgomery	Oct 01	Sep 30	$126	$59
PA	Philadelphia	Philadelphia	Oct 01	Nov 30	$198	$69
PA	Philadelphia	Philadelphia	Dec 01	Feb 28	$149	$69
PA	Philadelphia	Philadelphia	Mar 01	Jun 30	$210	$69
PA	Philadelphia	Philadelphia	Jul 01	Aug 31	$166	$69
PA	Philadelphia	Philadelphia	Sep 01	Sep 30	$198	$69
PA	Pittsburgh	Allegheny	Oct 01	Sep 30	$124	$54
PA	Reading	Berks	Oct 01	Sep 30	$111	$49
PA	State College	Centre	Oct 01	Sep 30	$100	$59
Rhode Island						
RI	East Greenwich / Warwick	Kent	Oct 01	Sep 30	$106	$59
RI	Jamestown / Middletown / Newport	Newport	Oct 01	Oct 31	$194	$54
RI	Jamestown / Middletown / Newport	Newport	Nov 01	May 31	$120	$54
RI	Jamestown / Middletown / Newport	Newport	Jun 01	Aug 31	$243	$54
RI	Jamestown / Middletown / Newport	Newport	Sep 01	Sep 30	$194	$54
RI	Providence / Bristol	Providence / Bristol	Oct 01	Sep 30	$155	$54
South Carolina						
SC	Charleston	Charleston / Berkeley / Dorchester	Oct 01	Nov 30	$227	$69
SC	Charleston	Charleston / Berkeley / Dorchester	Dec 01	Feb 28	$195	$69
SC	Charleston	Charleston / Berkeley / Dorchester	Mar 01	May 31	$238	$69
SC	Charleston	Charleston / Berkeley / Dorchester	Jun 01	Sep 30	$227	$69
SC	Columbia	Richland / Lexington	Oct 01	Sep 30	$112	$54

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SC	Hilton Head	Beaufort	Oct 01	Oct 31	$162	$59
SC	Hilton Head	Beaufort	Nov 01	Feb 28	$122	$59
SC	Hilton Head	Beaufort	Mar 01	May 31	$172	$59
SC	Hilton Head	Beaufort	Jun 01	Aug 31	$235	$59
SC	Hilton Head	Beaufort	Sep 01	Sep 30	$162	$59
SC	Myrtle Beach	Horry	Oct 01	Mar 31	$104	$59
SC	Myrtle Beach	Horry	Apr 01	May 31	$129	$59
SC	Myrtle Beach	Horry	Jun 01	Aug 31	$203	$59
SC	Myrtle Beach	Horry	Sep 01	Sep 30	$104	$59
South Dakota						
SD	Deadwood / Spearfish	Lawrence	Oct 01	May 31	$98	$64
SD	Deadwood / Spearfish	Lawrence	Jun 01	Sep 30	$157	$64
SD	Hot Springs	Fall River / Custer	Oct 01	May 31	$98	$54
SD	Hot Springs	Fall River / Custer	Jun 01	Sep 30	$149	$54
SD	Rapid City	Pennington	Oct 01	May 31	$98	$54
SD	Rapid City	Pennington	Jun 01	Aug 31	$169	$54
SD	Rapid City	Pennington	Sep 01	Sep 30	$98	$54
Tennessee						
TN	Brentwood / Franklin	Williamson	Oct 01	Sep 30	$125	$59
TN	Chattanooga	Hamilton	Oct 01	Sep 30	$109	$54
TN	Knoxville	Knox	Oct 01	Sep 30	$103	$54
TN	Memphis	Shelby	Oct 01	Sep 30	$123	$59
TN	Nashville	Davidson	Oct 01	Nov 30	$234	$69
TN	Nashville	Davidson	Dec 01	Jan 31	$187	$69
TN	Nashville	Davidson	Feb 01	Jun 30	$230	$69
TN	Nashville	Davidson	Jul 01	Aug 31	$207	$69
TN	Nashville	Davidson	Sep 01	Sep 30	$234	$69
Texas						
TX	Arlington / Fort Worth / Grapevine	Tarrant County / City of Grapevine	Oct 01	Sep 30	$167	$54
TX	Austin	Travis	Oct 01	Oct 31	$158	$54
TX	Austin	Travis	Nov 01	Jan 31	$140	$54
TX	Austin	Travis	Feb 01	Jun 30	$161	$54
TX	Austin	Travis	Jul 01	Aug 31	$131	$54
TX	Austin	Travis	Sep 01	Sep 30	$158	$54
TX	Big Spring	Howard	Oct 01	Sep 30	$136	$54

State	Location	County	Begin	End	Lodging	M&IE
If a city is listed, then the city's rate applies. If a city not listed is located in a county whose rate is listed, then the county's rate applies. Otherwise, within the Continental United States, the rates to the immediate right apply.					**$98**	**$49**
TX	Corpus Christi	Nueces	Oct 01	Sep 30	$104	$54
TX	Dallas	Dallas	Oct 01	Nov 30	$161	$59
TX	Dallas	Dallas	Dec 01	Aug 31	$154	$59
TX	Dallas	Dallas	Sep 01	Sep 30	$161	$59
TX	Galveston	Galveston	Oct 01	May 31	$99	$54
TX	Galveston	Galveston	Jun 01	Jul 31	$139	$54
TX	Galveston	Galveston	Aug 01	Sep 30	$99	$54
TX	Houston	Montgomery / Fort Bend / Harris	Oct 01	Sep 30	$122	$59
TX	Midland / Odessa	Midland / Andrews / Ector / Martin	Oct 01	Sep 30	$183	$54
TX	Pecos	Reeves	Oct 01	Sep 30	$134	$49
TX	Plano	Collin	Oct 01	Sep 30	$122	$54
TX	Round Rock	Williamson	Oct 01	Sep 30	$102	$54
TX	San Antonio	Bexar	Oct 01	Sep 30	$124	$54
TX	South Padre Island	Cameron	Oct 01	Feb 28	$99	$49
TX	South Padre Island	Cameron	Mar 01	Jul 31	$115	$49
TX	South Padre Island	Cameron	Aug 01	Sep 30	$99	$49
TX	Waco	McLennan	Oct 01	Feb 28	$107	$54
TX	Waco	McLennan	Mar 01	Apr 30	$123	$54
TX	Waco	McLennan	May 01	Sep 30	$107	$54
Utah						
UT	Moab	Grand	Oct 01	Oct 31	$208	$59
UT	Moab	Grand	Nov 01	Feb 28	$105	$59
UT	Moab	Grand	Mar 01	Sep 30	$208	$59
UT	Park City	Summit	Oct 01	Nov 30	$182	$69
UT	Park City	Summit	Dec 01	Mar 31	$342	$69
UT	Park City	Summit	Apr 01	Sep 30	$182	$69
UT	Provo	Utah	Oct 01	Sep 30	$101	$54
UT	Salt Lake City	Salt Lake / Tooele	Oct 01	Sep 30	$128	$54
Virginia (see District of Columbia for Washington D.C. rates applicable to Virginia)						
VA	Blacksburg	Montgomery	Oct 01	Oct 31	$123	$49
VA	Blacksburg	Montgomery	Nov 01	Jun 30	$105	$49
VA	Blacksburg	Montgomery	Jul 01	Sep 30	$123	$49
VA	Charlottesville	City of Charlottesville / Albemarle	Oct 01	Sep 30	$126	$59

State	Location	County	Begin	End	Lodging	M&IE
If a city is listed, then the city's rate applies. If a city not listed is located in a county whose rate is listed, then the county's rate applies. Otherwise, within the Continental United States, the rates to the immediate right apply.					**$98**	**$49**
VA	Loudoun	Loudoun	Oct 01	Sep 30	$116	$59
VA	Lynchburg	Campbell / Lynchburg City	Oct 01	Sep 30	$105	$54
VA	Richmond	City of Richmond	Oct 01	Sep 30	$145	$54
VA	Roanoke	City limits of Roanoke	Oct 01	Sep 30	$122	$49
VA	Virginia Beach	City of Virginia Beach	Oct 01	May 31	$117	$54
VA	Virginia Beach	City of Virginia Beach	Jun 01	Aug 31	$222	$54
VA	Virginia Beach	City of Virginia Beach	Sep 01	Sep 30	$117	$54
VA	Wallops Island	Accomack	Oct 01	Jun 30	$124	$54
VA	Wallops Island	Accomack	Jul 01	Aug 31	$244	$54
VA	Wallops Island	Accomack	Sep 01	Sep 30	$124	$54
VA	Williamsburg / York	James City / York Counties / City of Williamsburg	Oct 01	Dec 31	$114	$54
VA	Williamsburg / York	James City / York Counties / City of Williamsburg	Jan 01	Mar 31	$103	$54
VA	Williamsburg / York	James City / York Counties / City of Williamsburg	Apr 01	Aug 31	$130	$54
VA	Williamsburg / York	James City / York Counties / City of Williamsburg	Sep 01	Sep 30	$114	$54
Vermont						
VT	Burlington	Chittenden	Oct 01	Oct 31	$154	$59
VT	Burlington	Chittenden	Nov 01	May 31	$111	$59
VT	Burlington	Chittenden	Jun 01	Sep 30	$154	$59
VT	Manchester	Bennington	Oct 01	Oct 31	$215	$69
VT	Manchester	Bennington	Nov 01	Jul 31	$172	$69
VT	Manchester	Bennington	Aug 01	Sep 30	$215	$69
VT	Montpelier	Washington	Oct 01	Oct 31	$179	$59
VT	Montpelier	Washington	Nov 01	Jul 31	$134	$59
VT	Montpelier	Washington	Aug 01	Sep 30	$179	$59
VT	Stowe	Lamoille	Oct 01	Nov 30	$152	$69
VT	Stowe	Lamoille	Dec 01	Feb 28	$167	$69
VT	Stowe	Lamoille	Mar 01	Sep 30	$152	$69
VT	White River Junction	Windsor	Oct 01	Oct 31	$118	$54
VT	White River Junction	Windsor	Nov 01	May 31	$103	$54

State	Location	County	Begin	End	Lodging	M&IE
If a city is listed, then the city's rate applies. If a city not listed is located in a county whose rate is listed, then the county's rate applies. Otherwise, within the Continental United States, the rates to the immediate right apply.					**$98**	**$49**
VT	White River Junction	Windsor	Jun 01	Sep 30	$118	$54
Washington State (See District of Columbia for Washington, D.C. rates.)						
WA	Everett / Lynnwood	Snohomish	Oct 01	May 31	$116	$64
WA	Everett / Lynnwood	Snohomish	Jun 01	Aug 31	$139	$64
WA	Everett / Lynnwood	Snohomish	Sep 01	Sep 30	$116	$64
WA	Ocean Shores	Grays Harbor	Oct 01	Jun 30	$111	$64
WA	Ocean Shores	Grays Harbor	Jul 01	Aug 31	$146	$64
WA	Ocean Shores	Grays Harbor	Sep 01	Sep 30	$111	$64
WA	Olympia / Tumwater	Thurston	Oct 01	Oct 31	$120	$64
WA	Olympia / Tumwater	Thurston	Nov 01	Aug 31	$140	$64
WA	Olympia / Tumwater	Thurston	Sep 01	Sep 30	$120	$64
WA	Port Angeles / Port Townsend	Clallam / Jefferson	Oct 01	Jun 30	$113	$64
WA	Port Angeles / Port Townsend	Clallam / Jefferson	Jul 01	Aug 31	$206	$64
WA	Port Angeles / Port Townsend	Clallam / Jefferson	Sep 01	Sep 30	$113	$64
WA	Richland / Pasco	Benton / Franklin	Oct 01	Sep 30	$105	$59
WA	Seattle	King	Oct 01	Oct 31	$232	$69
WA	Seattle	King	Nov 01	Apr 30	$176	$69
WA	Seattle	King	May 01	Sep 30	$232	$69
WA	Spokane	Spokane	Oct 01	Sep 30	$114	$64
WA	Tacoma	Pierce	Oct 01	Sep 30	$126	$59
WA	Vancouver	Clark / Cowlitz / Skamania	Oct 01	Oct 31	$182	$64
WA	Vancouver	Clark / Cowlitz / Skamania	Nov 01	May 31	$152	$64
WA	Vancouver	Clark / Cowlitz / Skamania	Jun 01	Sep 30	$182	$64
Wisconsin						
WI	Appleton	Outagamie	Oct 01	Sep 30	$103	$49
WI	Brookfield / Racine	Waukesha / Racine	Oct 01	Sep 30	$103	$54
WI	Madison	Dane	Oct 01	Oct 31	$131	$54
WI	Madison	Dane	Nov 01	Mar 31	$109	$54
WI	Madison	Dane	Apr 01	Sep 30	$131	$54
WI	Milwaukee	Milwaukee	Oct 01	May 31	$128	$54
WI	Milwaukee	Milwaukee	Jun 01	Jul 31	$149	$54
WI	Milwaukee	Milwaukee	Aug 01	Sep 30	$128	$54
WI	Sturgeon Bay	Door	Oct 01	Oct 31	$121	$64

State	Location	County	Begin	End	Lodging	M&IE
If a city is listed, then the city's rate applies. If a city not listed is located in a county whose rate is listed, then the county's rate applies. Otherwise, within the Continental United States, the rates to the immediate right apply.					**$98**	**$49**
WI	Sturgeon Bay	Door	Nov 01	May 31	$98	$64
WI	Sturgeon Bay	Door	Jun 01	Sep 30	$121	$64
WI	Wisconsin Dells	Columbia	Oct 01	May 31	$104	$49
WI	Wisconsin Dells	Columbia	Jun 01	Aug 31	$132	$49
WI	Wisconsin Dells	Columbia	Sep 01	Sep 30	$104	$49
West Virginia						
WV	Charleston	Kanawha	Oct 01	Sep 30	$109	$54
WV	Morgantown	Monongalia	Oct 01	Sep 30	$99	$49
Wyoming						
WY	Cody	Park	Oct 01	May 31	$162	$59
WY	Cody	Park	Jun 01	Sep 30	$282	$59
WY	Jackson / Pinedale	Teton / Sublette	Oct 01	May 31	$207	$69
WY	Jackson / Pinedale	Teton / Sublette	Jun 01	Sep 30	$383	$69

TO BE POSTED BY EMPLOYER **POLICY NUMBER** _____

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: _____

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

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PARA SER COLOCADO POR EL PATRON **NUMERO DE POLIZA** _____

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patron ha cumplido con las provisiones de la Ley de Compensacion para los Trabajadores de Arizona (Titulo 23, Capitulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las regias y ordenanzas de La Comision Industrial de Arizona hechas en cumplimiento de esta, y ha asegurado el pago de compensacion a los empleados garantizando el pago de dicha compensacion por medio de:

_____

Ademas, a todos los empleados se les notifica por este medio que en caso de que especificadamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerara bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensacion bajo estos terminos; tambien bajo estos terminos los empleados tienen el derecho de rechazar la misma por medio de una notificacion por escrito antes de que sufran alguna lesion, todos los formularios o formas en blanco para tal notificacion por escrito estaran disponibles para todos los empleados en la oficina de este patron.

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KEEP POSTED IN A CONSPICUOUS PLACE.

COLOQUESE EN LUGAR VISIBLE.

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. **NO LATER THAN TEN (10) CALENDAR DAYS** after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. **NO LATER THAN TEN (10) CALENDAR DAYS** after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.

4. **NO LATER THAN EIGHTEEN (18) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN SEVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES

THIS NOTICE IS APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

AVISO A LOS EMPLEADOS

Re: El Virus de la Inmunodeficiencia Humana (VIH),
Síndrome de la Inmundeficiencia Adquirida (SIDA) y Hepatitis C

Se les notifica a los empleados que se puede hacer una reclamación por una condición, infección, enfermedad o incapacidad relacionada con o derivada del Virus de Inmunodeficiencia Humana (VIH), Síndrome de Inmunodeficiencia Adquirida (SIDA), o Hepatitis C bajo lo provisto por la Ley de Compensación para los Trabajadores de Arizona y las reglas de La Comisión Industrial de Arizona. Tal reclamación debe incluír el suceso de una exposición importante en el trabajo, la que por lo general significa contacto de alguna ruptura de la piel o mucosa del empleado con la sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido de una persona que contenga sangre. **EL EMPLEADO DEBE CONSULTAR A UN MEDICO PARA CONFIRMAR SU RECLAMACION.** Las reclamaciones no pueden resultar de actividad sexual o uso ilícito de drogas.

Ciertas clases de empleados pueden establecer más fácilmente una reclamación relacionada con el VIH, SIDA O Hepatitis C si reúnen los requisitos siguientes:

1. El curso regular del empleo del empleado requiere el manejo de o la exposición a sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido que contenga sangre. Incluídos en esta categoría son los proveedores de cuidados de la salud, trabajadores de laboratorios forenses, bomberos, agentes policiales, técnicos médicos de emergencia, paramédicos y agentes correccionales.

2. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una possible exposición importante que resulta de y en el curso de su trabajo, el empleado reporta a su patrón por escrito los detalles de la exposición como lo proveen las reglas de la Comisión. Las formas de reporte están disponibles en la oficina de este patrón o de la Comisión Industrial de Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 o 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. Si un empleado elige no llenar la forma de reporte, ese empleado corre el riesgo de perder una reclamación de prima facie.

3. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposción importante el empleado va a que le saquen sangre, y **NO MAS DE TREINTA (30) DIAS DE CALENDARIO** la sangre es analizada para **VIH O HEPATITIS C** por medio de análisis de anticuerpos y el análisis resulta negativo.

4. **NO MAS DE DIECIOCHO (18) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevemente y los resultados del análisis son positivos por VIH o el empleado ha sido diagnosticado como positivo por la presencia de VIH, o **NO MAS DE SIETE (7) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por la presencia de Hepatitis C o el empleado ha sido diagnosticado como positivo por la presencia de Hepatitis C.

MANTENER FIJO EN UN LUGAR SOBRESALIENTE JUNTO AL AVISO A LOS EMPLADOS SOBRE COMPENSACION PARA TRABAJADORES

ESTE AVISO HA SIDO APROBADO POR LA COMISION INDUSTRIAL
DE ARIZONA PARA USO DE LAS ASEGURADORAS

Este documento es una traduccion del texto original escrito en ingles. Esta traduccion no es oficial y no es vinculante para este estado o para una subdivision politica de este estado.

WORK EXPOSURE TO METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA), SPINAL MENINGITIS, OR TUBERCULOSIS (TB)

Notice to Employees

Employees are notified that a claim may be made for a condition, infection, disease or disability involving or related to MRSA, spinal meningitis, or TB within the provisions of the Arizona Workers' Compensation Law. (A.R.S. § 23-1043.04) Such a claim shall include the occurrence of a significant exposure at work, which is defined to mean an exposure in the course of employment to aerosolized MRSA, spinal meningitis or TB bacteria. Significant exposure also includes exposure in the course of employment to MRSA through bodily fluids or skin.

Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;

2. No later than thirty (30) calendar days after a possible significant exposure, the employee reports in writing to the employer the details of the exposure;

3. A diagnosis is made within the following time-frames:

    a. For a claim involving MRSA, the employee must be diagnosed with MRSA within fifteen (15) days after the employee reports pursuant to Item No. 2 above;

    b. For a claim involving spinal meningitis, the employee must be diagnosed with spinal meningitis within two (2) to eighteen (18) days of the possible significant exposure; and

    c. For a claim involving TB, the employee is diagnosed with TB within twelve (12) weeks of the possible significant exposure.

Expenses for post-exposure evaluation and follow-up, including reasonably required prophylactic treatment for MRSA, spinal meningitis, and TB is considered a medical benefit under the Arizona Workers' Compensation Act for any significant exposure that arises out of and in the course of employment if the employee files a claim for the significant exposure or the employee reports in writing the details of the exposure. Providing post-exposure evaluation and follow-up, including prophylactic treatment, does not, however, constitute acceptance of a claim for a condition, infection, disease or disability involving or related to a significant exposure.

Employers must post this notice in a conspicuous place next to the Workers' Compensation Notice to Employees.

REV 7/11

THE FAIR WAGES AND HEALTHY FAMILIES ACT

Effective January 1, 2023, Arizona's Minimum Wage Is:

$13.85 per hour

EXEMPTIONS:	The Fair Wages and Healthy Families Act (the "Act") does not apply to any person who is employed by a parent or a sibling; any person who is employed performing babysitting services in the employer's home on a casual basis; any person employed by the State of Arizona or the United States government; or any person employed in a small business that grosses less than $500,000 in annual revenue, if that small business is exempt from having to pay a minimum wage under section 206(a) of title 29 of the United States Code.
TIPS AND GRATUITIES:	For any employee who customarily and regularly receives tips or gratuities, an employer may pay tipped employees a maximum of $3.00 per hour less than the minimum wage if the employer can establish by its records that for each week, when adding tips received to wages paid, the employee received not less than the minimum wage for all hours worked. Certain other conditions must be met.
RETALIATION & DISCRIMINATION PROHIBITED:	Employers are prohibited from discriminating against or subjecting any person to retaliation for: (1) asserting any claim or right under the Act; (2) assisting any person in doing so; or (3) informing any person of their rights under the Act.
ENFORCEMENT:	Any person or organization may file a complaint with the Industrial Commission's Labor Department alleging that an employer has violated the Act. Certain time limits apply. A civil action may also be filed as provided in the Act. Violations of the Act may result in penalties.
INFORMATION:	For additional information regarding the Act, you may refer to the Industrial Commission's website at www.azica.gov or contact the Industrial Commission's Labor Department: 800 W. Washington, Phoenix, Arizona 85007-2022; (602) 542-4515.

THIS POSTER MUST BE CONSPICUOUSLY DISPLAYED IN A PLACE THAT IS ACCESSIBLE TO EMPLOYEES

LEY GENERAL DE SALARIOS JUSTOS Y FAMILIAS SANAS

A partir del 1 de enero del 2023, el salario mínimo en Arizona será:

$13.85 la hora

EXEPCIONES:	La Ley General de Salarios Justos y Familias Sanas (la "Ley General") no tendrá vigencia para las personas que sean empleadas por padres de familia o hermanos; cualquier persona que trabaje informalmente en el hogar de los patrones proporcionando servicios de cuidado de menores; cualquier persona que sea empleada por el Estado de Arizona o el gobierno de los Estados Unidos; o cualquier persona que sea empleada por una pequeña empresa que genere menos de $500,000 en ingresos anuales, si dicha pequeña empresa estuviera excempta de pagar un salario mínimo de conformidad con la fracción 206(a) del Título 29 del Código Estatutario de los Estados Unidos.
PROPINAS:	Para todos los empleados que acostumbren a recibir propinas, las entidades patronales podrán pagarles a tales empleados hasta un máximo de $3.00 menos por la hora que el salario mínimo, si tales entidades patronales puedan comprobar con sus constancias que, por cada semana, al sumar las propinas a los sueldos pagados, los empleados recibieron no menos del sueldo mínimo por todas las horas trabajadas. Deberá cumplirse con ciertas otras condiciones.
REPRESALIAS Y DISCRIMINACION PROHIBIDOS:	Se les prohíbe a las entidades patronales discriminar contra otras personas o someterlas a represalias por: (1) afirmar sus reclamaciones o derechos de conformidad con la Ley General; (2) ayudar a cualquier otra persona a afirmar esto; o (3) informarle a cualquier otra persona sus derechos de conformidad con la Ley General.
EJECUCIÓN:	Cualquier persona u organización podrá presentar una queja ante el Departamento del Trabajo de la Comisión Industrial en la que se alegue que una entidad patronal ha quebrantado la Ley General. Hay que cumplir con ciertos límites de tiempo. También se puede interponer una demanda civil en conformidad con la Ley General. Las trasgresiones de la Ley General pudieran resultar en sanciones.
INFORMACIÓN:	Para obtener más información sobre la Ley General, deberá buscar en la página de Internet de la Comisión: www.azica.gov; también podrá comunicarse con el Departamento del Trabajo de la Comisión Industrial: Industrial Commission's Labor Department: 800 W. Washington, Phoenix, Arizona 85007-2022; o llamar al teléfono (602) 542-4515.

ESTE AVISO DEBERÁ PUBLICARSE MUY VISIBLEMENTE EN UN SITIO AL QUE LOS EMPLEADOS TENGAN ACCESO

THE FAIR WAGES AND HEALTHY FAMILIES ACT

Earned Paid Sick Time

EXEMPTIONS: The Fair Wages and Healthy Families Act (the "Act") does not apply to any person who is employed by a parent or a sibling; any person who is employed performing babysitting services in the employer's home on a casual basis; or any person employed by the State of Arizona or the United States government.

ENTITLEMENT AND AMOUNT: Beginning July 1, 2017, employees are entitled to earned paid sick time and accrue a minimum of one hour of earned paid sick time for every 30 hours worked, subject to the following limitations:

- Employees whose employers have less than 15 employees may only accrue or use 24 hours of earned paid sick time per year.
- Employees whose employers have 15 or more employees may only accrue or use 40 hours of earned paid sick time per year.

Employers are permitted to select higher accrual and use limits.

TERMS OF USE: Earned paid sick time may be used for the following purposes: (1) medical care or mental or physical illness, injury, or health condition; or (2) a public health emergency; and (3) absence due to domestic violence, sexual violence, abuse, or stalking. Employees may use earned paid sick time for themselves or for family members. *See* Arizona Revised Statutes § 23-373 for more information.

RETALIATION & DISCRIMINATION PROHIBITED: Employers are prohibited from discriminating against or subjecting any person to retaliation for: (1) asserting any claim or right under the Act, including requesting or using earned paid sick time; (2) assisting any person in doing so; or (3) informing any person of their rights under the Act.

ENFORCEMENT: Each employee has the right to file a complaint with the Industrial Commission's Labor Department alleging that an employer has violated the Act. Certain time limits apply. A civil action may also be filed as provided in the Act. Violations of the Act may result in penalties.

INFORMATION: For additional information regarding the Act, you may refer to the Industrial Commission's website at www.azica.gov or contact the Industrial Commission's Labor Department: 800 W. Washington, Phoenix, Arizona 85007-2022; (602) 542-4515.

THIS POSTER MUST BE CONSPICUOUSLY POSTED IN A PLACE THAT IS ACCESSIBLE TO EMPLOYEES

LEY GENERAL DE SALARIOS JUSTOS Y FAMILIAS SANAS (*FAIR WAGES AND HEALTHY FAMILIES ACT*)

Tiempo Pagado por Enfermedad Devengado

EXENCIONES: La Ley General de Salarios Justos y Familias Sanas (la "Ley General") no tendrá vigencia para las personas que sean empleadas de padres de familia o hermanos; cualquier persona que trabaje informalmente en el hogar de los patronos proporcionando servicios de cuidado de menores; o cualquier persona que sea empleada del Estado de Arizona o del gobierno de los Estados Unidos.

DERECHOS Y CANTIDADES: A partir del 1 de julio del 2017, los empleados tendrán derecho a tiempo pagado por enfermedad devengado y acumularán por lo menos una hora de tiempo pago por enfermedad devengado por cada 30 horas que trabajen, a tenor con las limitaciones siguientes :

- Los empleados cuyos patronos tengan menos de 15 empleados podrán acumular o usar 24 horas de tiempo pago por enfermedad devengado al año.
- Los empleados cuyos patronos tengan 15 empleados o más sólo podrán acumular o usar 40 horas de tiempo pagado por enfermedad devengado al año.

Se les permitirá a los patronos escoger límites mayores de acumulación y uso.

CONDICIONES DE USO: El tiempo pagado por enfermedad devengado podrá usarse para los propósitos siguientes: (1) atenciones médicas o mentales o enfermedades, lesiones o condiciones de salud física; o (2) emergencia de salud pública; y (3) ausencias debidas a violencia intrafamiliar, violencia sexual, maltrato o acosamiento. Los empleados podrán usar el tiempo pagado por enfermedad devengado para sí mismos o para familiares. *Véase* la fracción § 23-373 de las Leyes Actualizadas de Arizona (*Arizona Revised Statutes*) para más información.

REPRESALIAS Y DISCRIMEN PROHIBIDOS: Se les prohíbe a las entidades patronales discriminar contra otras personas o someterlas a represalias por: (1) afirmar sus reclamaciones o derechos de conformidad con la Ley General; (2) ayudar a cualquier otra persona a afirmar esto; o (3) informarle a cualquier otra persona sus derechos de conformidad con la Ley General.

EJECUCIÓN: Cualquier persona u organización podrá presentar una querella ante el Departamento del Trabajo de la Comisión Industrial en la que se alegue que una entidad patronal ha quebrantado la Ley General. Hay que cumplir con ciertos límites de tiempo. De conformidad con la Ley General, también se pudiera interponer una demanda civil. Las trasgresiones de la Ley General pudieran redundar en sanciones.

INFORMACIÓN: Para obtener más información sobre la Ley General, deberá buscar en la página de Internet de la Comisión: www.azica.gov; también podrá comunicarse con el Departamento del Trabajo de la Comisión Industrial: *Industrial Commission's Labor Department: 800 W. Washington, Phoenix, Arizona 85007-2022*; o llamar al teléfono (602) 542-4515.

ESTE AVISO DEBERÁ PUBLICARSE MUY VISIBLEMENTE EN UN SITIO AL QUE LOS EMPLEADOS TENGAN ACCESO

EMPLOYEE SAFETY AND HEALTH PROTECTION

The Arizona Occupational Safety and Health Act of 1972 (Act), provides safety and health protection for employees in Arizona. The Act requires each employer to furnish his employees with a place of employment free from recognized hazards that might cause serious injury or death. The Act further requires that employers and employees comply with all workplace safety and health standards, rules and regulations promulgated by the Industrial Commission. The Arizona Division of Occupational Safety and Health (ADOSH), a division of the Industrial Commission of Arizona, administers and enforces the requirements of the Act.

As an employee, you have the following rights:

You have the right to notify your employer or ADOSH about workplace hazards. You may ask ADOSH to keep your name confidential.

You have the right to request that ADOSH conduct an inspection if you believe there are unsafe and/or unhealthful conditions in your workplace. You or your representative may participate in the inspection.

If you believe you have been discriminated against for making safety and health complaints, or for exercising your rights under the Act, you have a right to file a complaint with ADOSH within 30 days of the discriminatory action. You are also afforded protection from discrimination under the Federal Occupational Safety and Health Act and may file a complaint with the U.S. Secretary of Labor within 30 days of the discriminatory action.

You have the right to see any citations that have been issued to your employer. Your employer must post the citations at or near the location of the alleged violation.

You have the right to protest the time frame given for correction of any violation.

You have the right to obtain copies of your medical records or records of your exposure to toxic and harmful substances or conditions.

Your employer must post this notice in your workplace.

The Industrial Commission and ADOSH do not cover employers of household domestic labor, those in maritime activities (covered by OSHA), those in atomic energy activities (covered by the Atomic Energy Commission) and those in mining activities (covered by the Arizona Mine Inspector's office). To file a complaint, report an emergency or seek advice and assistance from ADOSH, contact the nearest ADOSH office:

Phoenix:
800 West Washington
Phoenix AZ. 85007
602-542-5795
Toll free: 855-268-5251

Tucson:
2675 East Broadway
Tucson, AZ. 85716
520-628-5478
Toll free: 855-268-5251

Industrial Commission web site: www.ica.state.az.us

Note: Persons wishing to register a complaint alleging inadequacy in the administration of the Arizona Occupational Safety and Health plan may do so at the following address:

U.S. Department of Labor – OSHA
230 N. 1st Ave., Ste. 202
Phoenix, AZ 85003
Telephone: 602-514-7250

Revised 10/11

PROTECCION DE SEGURIDAD Y SANIDAD PARA EL EMPLEADO

El Acta de Seguridad y Sanidad Ocupacional de 1972 (Acta) provee protección de seguridad y sanidad para los empleados en Arizona. El Acta requiere que cada patron les ofrezca a sus empleados un lugar de empleo libre de riesgos reconocidos que puedan causar daño o muerte. El Acta también requiere que los patrones y empleados cumplan con las normas, y los reglamentos de seguridad y sanidad promulgados por la Comisión Industrial. La ejecución de esta ley se lleva a cabo por la División de Seguridad y Sanidad Ocupacional, un brazo de la Comisión Industrial de Arizona.

Como empleado, Ud. tiene los derechos siguientes:

Tiene el derecho de notificar a su patron o a ADOSH sobre peligros en su lugar de trabajo. Puede pedir a ADOSH que mantenga su nombre confidencialmente.

Tiene el derecho de solicitar una inspección por parte de ADOSH si cree que existen condiciones peligrosas o poco saludables en su lugar de trabajo. Usted o su representante puede participar en la inspección.

Si cree que su patron lo ha discriminado por presentar reclamos de seguridad y sanidad o por ejercer sus derechos bajo el Acta, puede presentar una queja a ADOSH durante un plazo de 30 dias después de la acción de discriminación. También tiene protección de discriminación bajo el acta federal de seguridad y sanidad ocupacional y puede archivar una queja con el Secretario de Labor de los Estados Unidos dentro de 30 dias después de la discriminación alegada.

Tiene el derecho de ver las citaciones enviadas a su empleador. Su empleador debe colocar las citaciones en un lugar visible en el sítio de la supuesta infracción o cerca de el.

Tiene el derecho de protestar el tiempo dado para correjir una violación.

Tiene el derecho de recibir copias de su historial médico o de los registros de su exposición a sustancias o condiciones tóxicas y peligrosas.

Su empleador debe colocar este aviso en su lugar de trabajo.

La ley de seguridad y sanidad en el trabajo no aplica a aquellos patrones que emplean a servicio doméstico, a patrones de actividades marítimas (protejidos bajo OSHA), a patrones en actividades de energia atómica (protegidos bajo la Comisión de Energia Atómica), o a patrones en actividades mineras (protegidos por la Oficina del Inspector de Minas del Estado de Arizona). Para registrar una queja, reportar una emergencia o pedir asistencia de ADOSH, póngase en contacto con la oficina más cercana :

Phoenix:
800 West Washington
Phoenix AZ. 85007
602-542-5795
Llamada gratis: 855-268-5251

Tucson:
2675 East Broadway
Tucson, AZ. 85716
520-628-5478
Llamada gratis: 855-268-5251

Industrial Commission web site: www.ica.state.az.us

Nota: Personas que deseen registrar quejas alegando falta de adecuadez en la administración del plan de seguridad y sanidad ocupacional de Arizona pueden dirigirlas a la siguiente dirección:

U.S. Department of Labor – OSHA
230 N. 1st Ave., Ste. 202
Phoenix, AZ 85003
Teléfono: 602-514-7250

Revisado 10/11

Industrial Commission of Arizona
Special Fund

PRESENT VALUE OF $1 OF MONTHLY FIXED PERIOD AWARD

Mortality: **None**
Interest: **1.67%**

Number of Months	Reserve Factor	Number of Months	Reserve Factor
1	1.00	31	30.35
2	2.00	32	31.31
3	3.00	33	32.27
4	4.00	34	33.22
5	4.99	35	34.17
6	5.98	36	35.12
7	6.97	37	36.07
8	7.96	38	37.02
9	8.95	39	37.97
10	9.94	40	38.92
11	10.93	41	39.87
12	11.91	42	40.81
13	12.89	43	41.75
14	13.87	44	42.69
15	14.85	45	43.63
16	15.83	46	44.57
17	16.81	47	45.51
18	17.79	48	46.45
19	18.76	49	47.38
20	19.73	50	48.31
21	20.70	51	49.24
22	21.67	52	50.17
23	22.64	53	51.10
24	23.61	54	52.03
25	24.58	55	52.96
26	25.55	56	53.89
27	26.51	57	54.81
28	27.47	58	55.73
29	28.43	59	56.65
30	29.39	60	57.57

Industrial Commission of Arizona
Special Fund

PRESENT VALUE OF $1 OF MONTHLY PERMANENT AWARD

Mortality: **U.S. Life 2003**
Interest: **1.67%**

Age	Reserve Factor	Age	Reserve Factor	Age	Reserve Factor
1	520.14	36	369.20	71	151.41
2	516.78	37	364.30	72	145.06
3	513.39	38	358.32	73	139.45
4	509.91	39	352.76	74	133.78
5	506.71	40	347.12	75	127.23
6	503.11	41	341.40	76	121.44
7	499.50	42	335.04	77	115.59
8	495.78	43	329.11	78	110.54
9	492.04	44	323.65	79	104.59
10	488.20	45	317.56	80	99.43
11	484.33	46	311.37	81	94.24
12	480.37	47	305.09	82	89.01
13	476.36	48	299.87	83	84.61
14	472.62	49	293.40	84	79.29
15	468.47	50	286.84	85	74.83
16	464.27	51	280.18	86	70.33
17	459.96	52	274.65	87	66.71
18	456.35	53	267.80	88	63.07
19	451.91	54	261.48	89	58.49
20	447.80	55	254.43	90	55.73
21	443.24	56	248.58	91	52.03
22	438.98	57	241.99	92	48.31
23	434.28	58	235.98	93	46.45
24	429.88	59	229.21	94	42.69
25	425.01	60	222.35	95	40.81
26	420.50	61	216.09	96	37.02
27	415.46	62	209.05	97	35.12
28	411.21	63	202.63	98	33.22
29	406.04	64	196.13	99	30.35
30	401.20	65	190.29	100	29.39
31	395.85	66	182.88	101	28.48
32	390.88	67	176.88	102	27.77
33	385.36	68	170.05	103	27.07
34	380.20	69	163.90	104	26.45
35	374.50	70	157.69	105	25.82

LEGISLATIVE CHANGES IN THE WORKERS' COMPENSATION LAW

1970

23-901 (Effective 08-11-70)
Members of volunteer sheriff's reserve brought under the Law with a fixed wage of $400.

23-1067 (Effective 08-11-70)
Maximum lump sum commutation changed from $6,500 to $25,000

1971

23-1241 ODC (Effective 08-13-71)
Temporary total compensation: no limitation. (Previously limited to 2/3 of the average monthly wage = $40 a week and a maximum of $7,500.)

Temporary partial compensation was provided without limitation.

Death benefits were increased. (Was previously a maximum of $25 a week to the surviving spouse and $5 for each dependent to a maximum of $15, for a maximum total of $40 a week, not to exceed $7,500. All temporary total compensation advanced was to be deducted.)

Total permanent compensation: no provisions for "partial" loss of earning capacity.

ODC and Injury Claims (Effective 08-13-71)
Funeral expenses increased from $300 to $800 for a deceased worker and dependents.

1972

23-901 (Effective 08-13-72)
Volunteer policemen, firemen, and the Highway Patrol were removed from the fixed wage of $400 to a regular rate.

23-1041 (Effective 08-13-72)
Reduced the age of majority from 21 to 18.

23-1042 (Effective 08-13-72)
Changed the age in this section from 21 to 18, for determining the average monthly wage for permanent disability benefits of a minor worker.

1973

23-908.C (Effective 08-08-73)
Hospital records are no longer privileged information.

23-1044 (Effective 08-08-73)
A. Partial temporary compensation payment increased from 65% to 66 2/3% of the average monthly wage.
B. Eliminated the 60 month maximum.

23-1045 (Effective 08-08-73)
A. Temporary total compensation payment increased from 65% to 66 2/3% of the average monthly wage.
B. Eliminated the 100 month maximum.

23-1046 (Effective 08-08-73)
Death benefits changed to include coverage of either surviving spouse.

23-1065 (Effective 08-08-73)
Required the carrier to pay supportive medical consistent with changes in 23-1044, 1045 and 1046.

Chapter 7 (Effective 08-08-73)
The ODC Law was repealed.

23-901 (Effective 01-01-74)
Working members of a partnership brought under the Law.

Arizona National Guard members brought under the Law with a fixed wage of $400.

23-902 (Effective 01-01-74)
Coverage was required if there were one or more employees (previously exempt if there were less than three employees.)

Agricultural workers were brought under the Law.

1974

23-947.A (Effective 05-17-74)
To include 10 day protest clause on “all other awards” of the Commission. (Previously ICA used discretionary 5 day clause.)

23-1046 (Effective 05-17-74)
Increased burial expenses from $800 to $1,000 for the deceased worker only.

23-1046.A7 (Effective 05-17-74)
Deleted.

23-1062.C (Effective 05-17-74)
Compensation shall be made by a negotiable instrument payable immediately upon demand.

23-901.F (Effective 08-08-74)
Rehabilitation: Persons placed by DES for evaluation or retraining are considered to be employees of DES.

23-901.G (Effective 08-08-74)
Fixed wage of $400 was removed to the regular wage for the volunteer sheriff’s reserve.

23-901.J & K (Effective 08-08-74)
Volunteer certified ambulance drivers and attendants and volunteer workers of health care institutions both now covered under worker’s compensation, with a fixed wage of $400.

1975

23-952 (Effective 09-12-75)
Payment of permanent compensation set forth in Order or Award of ICA shall continue pending hearing or appeal.

1976
No significant changes in 1976: only grammatical corrections.

1977

23-906 (Effective 08-27-77)
Employer no longer required to file a notice of an employee rejecting the provisions of the Workers’ Compensation Law with the Commission, but rather, file the notice with the insurance carrier or self-insured employer within five (5) days of receipt from a rejecting employee.

23-907 (Effective 08-27-77)
On no-insurance claims, allows the Commission to speed up payment of compensation benefits to claimants be paying directly from the Special Fund when the claim is accepted as compensable and then seeking reimbursement from the non-insured employer. The employer is then assessed an automatic 10% penalty.

23-1041 (Effective 08-27-77)
Average monthly wage maximum raised from $1,000 to $1,250.

23-1047 (Effective 08-27-77)
Deleted requirement that a claimant receiving permanent compensation benefits make an annual report of income to the **Industrial Commission**. The report is to be made to the insurance carrier or self-insured employer instead.

1978

23-906 (Effective 10-01-78)
Corrects instructions for filing Rejections from triplicate to **duplicate**.

23-908.F (Effective 10-01-78)
Employer must file Employer’s Report of Injury with the Commission and the insurance carrier instead of the carrier only. Non-compliance changed from a misdemeanor to a petty offense.

23-941.K (Effective 10-01-78)
Added. Allows ICA to dispose of exhibits for hearing purposes.

23-961 (Effective 10-01-78)
Requires carriers to give ICA a 30-day notice of non-renewed policies.

23-1066 (Effective 10-01-78)
Permits ICA to appoint a Guardian Ad Litem for an injured worker determined to be incompetent.

23-1068 (Effective 09-03-78)
Allows employer credit for benefits paid to injured workers if the claim is questionable, and later found compensable.

1980

23-901 (Effective 07-31-80)
Paragraphs 2, 7, 10 and 15 were added to define Co-employee; Heart-related or Perivascular injury or

disease; Mental injury, Illness or Condition and the remaining paragraphs were appropriately renumbered. (Substantive)

23-906 (Effective 07-31-80)
Liability under chapter or under common law of employer securing compensation; carriers; service representatives; right of employee to make election; procedure for making election. (Procedural)

A. Amended to exclude Insurance Carriers or Administrative Service Representatives from liability for damages at common law.

23-941 (Effective 07-31-80)
D. Ten day prior notice of the time and place of hearing is no longer applicable for hearings pertaining to 23-1047, Subsection D, concerning annual report of income. (Procedural)

23-947 (Effective 07-31-80)
A. Amends the sixty day filing time of Requests for Hearing to **ninety** days.

B. Added: Requires that the Request for Hearing be in the possession of the Industrial commission within 90 days with limited exceptions.

23-1022 (Effective 07-31-80)
A. Re-establishes co-employee immunity, **subject to constitutional amendment** by a vote of the people.

Removes the following two exceptions to exclusive remedy

a. Motion Picture exemption (covered by 23-909)
b. Employer's posting of compliance notice (Section 23-964)

C. Added: Immunity excluded for medical malpractice suits against employees of a hospital maintained by employers pursuant to 23-1070. (Procedural)

23-1024 (Effective 07-31-80)
A. Extends immunity to Co-Employee, Insurance Carrier or Administrative Service Representative. (Procedural)

23-1041 (Effective 07-31-80)
E. Maximum average monthly wage increased from $1,250 to $1,325. (Substantive)

23-1043 (Effective 07-31-80)
2. Rebuttable presumption that hernias are not real traumatic hernias and all will be treated as non-traumatic unless proven otherwise. (Substan- tive)

Added:

23-1043.01 (Effective 07-31-80)
A. Heart-related or perivascular injuries are compensable when employment-related injury, stress or exertion was a substantial contributing cause.

B. Mental stress cases are compensable when employment-related and unexpected, unusual or extraordinary stress was a substantial contributing cause.

C. The employer liable for heart-related and mental cases is the last for who the injured worker was employed while meeting requirements specified by Subsections A or B.

23-1044 (Effective 07-31-80)
G. In its determination of earning capacity, the Commission may consider the following:

a. Employ**ee** evidence that the inability to obtain suitable work is due in part or in whole to the injury or its limitations.
b. Employ**er** evidence concerning economic conditions or other factors unrelated to injury.

H. Rescinds holding of *Langbell v. Industrial Commission decision.* (Odd Lot Doctrine).

ALL single scheduled injuries, as defined in Subsection B, which are not otherwise, by statute, converted to unscheduled, shall be compensated as scheduled injuries regardless of effect on earning capacity.

23-1061 (Effective 01-01-81)
A. Limits time for filing compensation claim to one year jurisdictional period with minor exceptions; i.e., misrepresentation on the part of the Industrial Commission, employer or insurance carrier; insanity or legal incompetence of party entitled to file claim.

B. Provides for extension of filing time for a claim where the carrier or employer has paid **compensation**; such extension is not applicable where the carrier or employer has paid funeral expenses in death claims or benefits pursuant to 1065-A.

23-1065 (Effective 07-31-80)
(B, C, D, and E added and the remaining paragraphs appropriately renumbered.)

B. 1 and 2 Successive scheduled injury where pre-existing scheduled injury is industrially related shall be processed as unscheduled with the Industrial Commission's Special Fund responsible for one-half of any compensation awarded in excess of 50% loss in earning capacity.

C. 1 and 2 Successive scheduled injury where pre-existing scheduled injury is not industrially related, shall be processed as unscheduled if that pre-existing condition was affecting earning capacity at the time of the subsequent industrially related scheduled injury. The Industrial Commission's Special Fund shall assume one-half of all compensation awarded for earning capacity in excess of 50%.

D. Provides for expenditures from the Industrial Commission's Special Fund for such purposes as may be necessary to determine its liability.

E. Requires the Insurance Carrier or Employer to pay the entire amounts awarded pursuant to ei ther Subsection B or C and for the Special Fund to make annual reimbursements of their proportionate liability.

The title of Hearing Officer has been changed to Administrative Law Judge in all sections where they are referenced in the Workers' Compensation Law.

1981

23-910.5 (Effective 07-25-81)

Definitions for "Employee"

L. **Added:** Personnel who participate in a search or rescue operation that carriers a mission identifier assigned by the Division of Emergency Services as provided in Section 35-192.01 and who serve without compensation as volunteer State employees. The basis for computation of wages for premium purposes and compensation benefits is the total volunteer man-hours recorded by the Di- vision of Emergency Services in a given quarter multiplied by the average base hourly wage of a starting sheriff's deputy.

23-981.E (Effective 07-25-81)
State compensation fund; purpose; administration; function; purchase of real property and construction of buildings.

The operating and capital outlay budget of the State Compensation fund shall be subject to review AND APPROVAL by the joint legislative budget committee.

23-1023.B (Effective 04-27-81)
Liability of third person to injured employee; election of remedies. A worker's compensation claim assigned to an insurance carrier because the covered employee did not pursue his remedy within the one year time limit can be reassigned to the employee and treated as if the claim had been filed within the first year.

23-1065.A (Effective 07-25-81)
Payment where no dependent survives; special fund; purpose. The Industrial Commission's Special Fund consists of property and securities and interest acquired by use of fund money in addition to premiums, assessments and penalties paid into the fund. A five member investment committee (three members ap- pointed by the Governor) replaces the Commission Director as the investing authority. The percentage of premiums that the Commission can order diverted to the Special fund is decreased to 1.5% from 2%.

Organizational change of agency not affecting the Workers' Compensation Law.

(Effective midnight, 12-31-81)
Provides for a transfer of the office of Fire Marshall from the Industrial Commission to the Department of Emergency Services.

1982

23-901.5 (Effective 07-24-82)

Definitions for "Employee"

M. **Added:** Regular member of the Arizona Game and Fish Department reserve, organized pursuant to Section 17-214. The basis for computing wages for premium payments and compensation benefits for a member of the reserve is the salary received by game rangers and wildlife managers of the Arizona Game and Fish Department for their first month of regular duty.

23-901.6 (Effective 04-09-82)

Volunteer workers

In addition to persons defined as employees under Section 23-901, paragraph 5, volunteer workers of a county, city, town, or other political subdivision of the state may be deemed to be employees and entitled to the benefits provided by this chapter upon the passage of a resolution or ordinance by the political subdivision defining the nature and type of volunteer work and workers to be entitled to such benefits. The basis for computing compensation benefits and premium payments shall be four hundred dollars ($400) per month.

1983

23-906; 907; 962.A; 962.B (Effective 04-12-83)
Permits the State of Arizona to self-insure for workers' compensation.

23-910 (Effective 07-27-83)
Added: Excludes real estate licensees paid primarily on a commission or contractual basis from the definition of "employee" for workers' compensation purposes.

23-961.G; 961.H (Effective 02-11-83)
Requires quarterly payments of some workers' compensation premium tax.

Added:

23-981.A - D; 981.01.H; 985.D - G; 986; 987; 1006.B (Effective 01-01-84)
Expands the State Compensation Fund's operation to conform with private carriers of workers' compensation insurance.

Added:

23-1022.D (Effective 07-27-83)
Employees of public agencies who have intergovernmental agreements with other such agencies are considered employees of both (absent the appropriate filing of rejection), with the primary employer having sole liability for workers' compensation benefits.

1984 (Effective 08-03-84)

The designation of Title 23, Chapter 6, Article 1, is changed to "Scope of Workers' Compensation" with confirming changes in the various sections.

1985

23-901 (Effective 08-07-85)
Permits sole proprietors to be considered employees for purposes of coverage under the workers' compensation law. Providing coverage to sole proprietors is subject to the discretion of the carrier.

The basis for computing premium payment and compensation benefits for working members of partnerships will be based in most cases on an assumed monthly wage agreed to by the insurance carrier and the partnership.

Workers' compensation coverage is extended to volunteers who participate in search and rescue training operations or emergency management training, exercises or drills.

23-905.B (Effective 08-07-85)
An injured minor who is illegally employed is entitled to additional compensation benefits in an amount equal to 50% of the compensation the minor would have otherwise received.

23-907.C (Effective 08-07-85)
Provides for an alternative penalty of $500 against uninsured employers if such figure is higher than the 10% statutory penalty in cases of compensable claims. Interest accrues on Special Fund judgments in the same manner as is otherwise provided for judgments in general. The ICA is authorized to recover attorney fees which are incurred in collecting on a judgment.

23-907.E (Effective 08-07-85)
Permits the exchange of information among governmental agencies concerning uninsured employers.

23-907.F (Effective 08-07-85)
Permits the ICA to levy a $500 civil penalty against an uninsured employer in cases where although an employee's compensation claim is denied, an employment relationship requiring insurance coverage is found.

23-926.A (Effective 08-07-85)
Clarifies ICA access to non-confidential records of employers on file with other governmental agencies.

23-926.B (Effective 08-07-85)
The penalty for refusal to comply with ICA inspections is increased to $500 and the ICA is authorized to recover attorney fees incurred in any civil actions brought pursuant to this section.

23-932 (Effective 08-07-85)
The criminal penalty for failure to comply with workers' compensation laws is increased from a class 2 misdemeanor to a class 6 felony.

23-961.H (Effective 08-07-85)
Prescribes a procedure for refunds of overpayment of quarterly taxes collected from private insurance carriers.

23-961.I (Effective 08-07-85)
Provides a penalty for late payment of Administrative Fund, State Compensation Fund and self-insurer taxes similar to penalties imposed for other premium taxes collected by the Department of Insurance.

23-967 (Effective 08-07-85)
The criminal penalty for illegal deduction of employee wages for compensation premiums was increased from a petty offense to a class 6 felony.

23-1025 (Effective 08-07-85)
The criminal penalty for intentionally collecting or receiving premiums from an employee for workers' compensation insurance is made a class 6 felony.

23-1065.A (Effective 08-07-85)
The $1,150 death benefit payment to the Special Fund is omitted.

1986

23-1065.H (Effective 04-11-86)
Rent prescribed by special fund investment committee must be at least equal to or greater than that determined for other state buildings by joint committee on capitol review.

23-418.01 (Effective 08-13-86)
Provides that determination of certain occupational safety and health violations may be consolidated with and considered in the injured employee's worker's compensation hearing.

23-907.G (Effective 08-13-86)
Provides that the Commission can levy a civil penalty of up to $500 on employers who fail to secure worker's compensation insurance. The penalty can be imposed regardless of whether a claim is filed. Hearing procedures are also prescribed.

23-1065 (Effective 08-13-86; applies retroactively to 01-01-86)
(Subsections A, B, C, D and E are amended; Subsection F is added; remaining subsections relettered to conform.)

The second-injury apportionment provisions are completely revised. The existing 5 situations in which apportionment is possible are replaced by the following:

1. Apportionment will apply if there is a pre-existing industrially related scheduled injury followed by another industrially related scheduled injury and there is a loss in earning capacity. The carrier/self-insured employer will pay the fully awarded LEC until the scheduled permanent benefits are paid and thereafter, payment are shared equally with the Commission Special fund. If there is no LEC, the carrier/self-insured employer pays the scheduled permanent compensation in a lump sum as a "rehabilitation bonus" to be credited against future LEC.
2. Apportionment will apply if there is a pre-existing physical impairment, not industrially related, either congenital or due to enumerated injury/disease, with 10% or more disability. The employer must have knowledge of pre-existing disability at time of hire or employment continued after employer had such knowledge. The carrier/self-insured employer pays all temporary compensation and then the payments for LEC or permanent total disability are shared equally with the Commission Special Fund.

Notification and reimbursement procedures are also prescribed. Procedures to increase the special fund premium tax are prescribed. Approval of the Special fund is required in third party settlements made in apportionment cases.

1987

Regular Session Legislation

23-901.07 (Effective 08-18-87)
Provides that a client of a non-profit organization which provides vocational training to handicapped persons is an employee for worker's compensation purposes if the non-profit organization elects to so treat the employee.

23-947.A (Effective 08-18-87)
Provides that Requests for hearing by uninsured employers must be made within 30 days of a determination by the Commission.

23-961.E (Effective 08-18-87)
Provides that a carrier must promptly notify the Industrial Commission of new coverage.

23-962.A (Effective 08-18-87)
Removes the requirement for a mandatory contract between state risk management and the State Compensation Fund for processing of state employee workers' compensation claims.

Special Session Legislation

23-110 (Effective 07-01-88)
Adds new section to require Commission to establish an ombudsman position to provide information about the workers' compensation system and Commission Rules and Procedures.

23-906 (Effective 10-21-87)
Amended to require employer posting of workers' compensation rejection notices in English and Spanish.

23-930 (Effective 01-01-88)
Adds new section mandating exclusive ICA jurisdiction over complaints of unfair claim process and practices or bad faith actions by carriers or self-insured employers.

23-947 (Effective 10-21-87)
Amended to clarify late filing excuses by defining the term "justifiable reliance".

23-1026 (Effective 10-21-87)
Amends definition of "reasonable convenient place" with regard to independent medical examinations and requires claimants to submit to periodic IME's. Provides for Protective Order if examination is unnecessary.

23-1041 (Effective 10-21-87)
Amended to increase limit on Average Monthly Wage in three steps as follows:

1. For injuries occurring before 01-01-88, AMW remains $1,325.
2. For injuries occurring between 01-01-88 and 06-30-89, AMW is increased to $1,650.
3. For injuries occurring between 07-01-89 and 06-30-91, AMW is increased to $1,800.
4. For injuries occurring after 06-30-91, AMW is increased to $2,100.

23-1044 (Effective 10-21-87)
Amended to legislatively overturn the Dutra decision. Subsection B, Paragraph 21 defines "loss of use" and if employee cannot return to former occupation, compensation will be calculated at 75% of AMW.

23-1048 (Effective 10-21-87)
Adds section to establish Wage Advisory Commission, members to be appointed 01-01-91.

23-1067 (Effective 10-21-87)
Amended to provide that ceiling on lump sum commutation requests on unscheduled awards be increased to $50,000 for requests made after 06-30-87.

23-1071 (Effective 10-21-87)
Amended to provide that if Administrative Law Judge approves request to leave state after request is initially denied by the Claims Division, employee is entitled to forfeited benefits from date of first requested Commission approval.

Temporary Session Law (Effective 10-21-87) Provides a cost of living increase for workers who are on total permanent disability status or who are receiv- ing benefits as a surviving spouse of an injured work- er for claims made between 01-01-20 and 12-31-49.

1988

11-952.01
Provides that worker compensation pools formed by contractors doing business with the state are subject to ICA self-insurance requirements.

23-908
Provides that the ICA medical fee schedule shall also set fees charged by physical therapists in workers' compensation cases.

23-961
Removes carrier capital asset which conflicted with state insurance code. Changes the security deposit requirement for workers' compensation carriers. Provides that carrier bonds are subject to annual ICA approval.

23-1065
Statutory references are confirmed to changes made to A.R.S. §23-961.

41-621.01
Provides that worker compensation pools formed by political subdivisions are subject to ICA self-insurance requirements.

1989

23-1046 (Effective 09-15-89)
Increased burial expense reimbursement from $1,000 to $3,000. Two non-substantive technical corrections were also made.

1990

23-907 (Effective 09-27-90)

Adds Subsection I. Provides a mechanism for compromise and settlements and/or stipulations with uninsured employers whereby they are given notice and the opportunity to participate; duty of uninsured employer to keep ICA informed of current mailing address; reimbursement to ICA from uninsured employer.

23-930 (Effective 09-27-90)
Amends Subsection B. Imposes a minimum $500 penalty for unfair claim processing or bad faith for cases in which the 25% of benefits penalty does not reach the $500 level.

23-1043.02 (Effective 09-27-90)
Adds new section to the Workers' Compensation Law. States that a claim can be made for a condition, infection, disease or disability involving or related to the human immunodeficiency virus or acquired immune deficiency syndrome but shall include the occurrence of a "significant exposure" which is defined in the statute.

Provides that certain classes of workers enumerated in the statute who satisfy certain conditions as outlined in the statute present a prima facie claim which may be rebutted.

Contains confidentiality provision. Mandates the Commission by rule to prescribe the requirements and forms regarding employee notification of the requirements of the statute and the proper documentation of a significant exposure.

23-1045 (Effective 09-27-90)
Amends Subsection A, paragraphs 1 and 2 effective for dates of injury from and after 12-31-90. Deletes the word "totally" preceding "dependent", thereby allowing a dependent allowance to be added to the average monthly wage in a situation where the injured worker is not the sole source of support. This permits a spouse to work without the family jeopardizing its dependent allowance. Increases the dependent allowance from $10 per month to $25 per month per family.

23-1046 (Effective 09-27-90)
Amends Subsection A, paragraph 3. Extends dependent death benefits from age 18 to age 22 if the child is enrolled as a full-time student in any accredited educational institution for dates of injury on or after 09-27-90.

23-1061 (Effective 09-27-90)
Amends Subsection H. Allows for the payment of surgical benefits incurred not more than seven days prior to filing a Petition to Reopen if a bona fide emergency precluded a prior filing; no compensation is payable, however, for this period.

23-1064 (Effective 09-27-90)
Amends Subsection A, paragraph 3. Extends the definition of "dependent" to include a child up to the age of 22 if enrolled as a full-time student in any accredited educational institution for dates of injury on or after 09-27-90.

1991

No changes

1992

23-901 (Effective 09-30-92)
Amends paragraph 5(e) by deleting the word "Regular" preceding "Members"; by substituting "department of public safety" for "Arizona highway patrol"; by substituting "41-1715" for "41-1744"; addresses the basis of computing wages for DPS reserves who are peace officers and those who are not peace officers.

Non-substantive changes to paragraphs 5(a), 5(b) (ii), 5(c), 5(m), 5(n), 6, 11, 14.

23-987 (Effective 06-30-92, retroactively effect-ive to 01-01-90)
Amends by requiring the State Compensation fund to determine the amount of its federal tax based on all sources of "income" rather than "on all premiums collected or contracted for" and then to transmit this amount to the state treasurer for deposit into the state general fund; provides for a minimum payment of five hundred thousand dollars.

1993

23-961 (Effective 06-15-93)
Amends Subsection G by setting a floating tax rate of not more than 3% as opposed to the previous fixed rate of 3%; the floating tax rate to be set annually by the Industrial Commission; the rate to be no more than is necessary to cover the actual expenses of the Commission in carrying out its powers and duties under Title 23.

23-963.01 (Effective 07-17-93)
Adds new section to Title 23 which authorizes workers' compensation insurers to offer deductible coverage policies to employers; benefits to be paid first by

the carrier with reimbursement from the employer to the carrier for the deductible amounts; non-payment of deductible by employer does not relieve the carrier from payment of benefits; prohibits termination of policy by the carrier retroactively for non-payment of deductible amounts by the employer.

23-987 (Effective retroac-tively to 04-14-92)
Repeals provision requiring the State Compensation Fund to transmit to the state general fund annually the greater of five hundred thousand dollars or the amount equivalent to its federal tax based on all sources of the SCF's "income".

23-1081 (Effective 06-15-93)
Amends Subsection A by giving the Industrial Commission the authority to annually fix the rate of the premium tax referenced in A.R.S. §23-961.G., such rate not to exceed 3%; the amount generated by the premium tax rate is to be no more than is necessary to fund Commission expenses; amounts generated to be paid to the State Treasurer for credit to the Administrative Fund.

Amends Subsection B by removing the provision which mandated that any surplus in the Administrative Fund was to be transferred at the end of each fiscal year to the Special Fund; provides that any surplus or deficit in the Administrative Fund at the end of each fiscal year is now to be included in the calculation of the rate to be fixed for the following year.

1994

23-901 (Effective 01-01-96)
Amends Subsection (5)(d) by correcting the statutory reference to the organization of regular firemen of volunteer fire department or private fire service organizations.

23-902 (Effective 07-17-94)
Non-substantive changes made to Subsection A.

Amends Subsection B by defining the phrase "part or process in the trade or business of the employer" to mean a particular work activity that in the context of an ongoing and integral business process is regular, ordinary or routine in the operation of the business or is routinely done through the business' own employees.

Adds Subsection D to provide that the employer of a sole proprietor who has waived his rights to workers' compensation benefits pursuant to A.R.S. §23-961 is not liable for workers' compensation coverage or the payment of premiums for the sole proprietor.

23-961 (Effective 07-17-94)
Adds Subsection K to provide that neither the State Compensation Fund nor an insurance carrier authorized to write workers' compensation insurance may assess any premiums for services provided by a contractor alleged to be a 23-902(B) or (C) employee unless a written audit or investigation establishes that employment status has been met pursuant to criteria set forth in 23-902 and the employer has been given a copy of the findings in advance of being assessed a premium.

Adds Subsection L to permit a sole proprietor who is licensed with the Registrar of Contractors to waive his rights to workers' compensation coverage and benefits, provided the sole proprietor and insurance carrier for the employer sign the appropriate form. This waiver provision does not apply to employees of the sole proprietor for whom workers' compensation must be maintained.

23-984 (Effective 07-17-94)
Amends and Adds Subsection A to provide that it is unlawful for an employer to willfully misrepresent to an insurance carrier the job description or job function of an employee or the employer class listing.
Adds Subsection B to provide that an employer who violates Subsection (A) is guilty of a class 6 felony.

Amends Subsection C to allow the imposition of both a civil penalty and a criminal penalty for a violation of this section.

23-1028 (Effective 07-17-94)
Amends Subsection A to provide that an employee who makes false statements or representations to obtain compensation is guilty of a class 6 felony.

Adds Subsection B to provide that the fine for violation of this section shall not exceed fifty thousand dollars.

1995

No changes

1996

23-902 (Effective 07-20-96)
Amends Subsection A for non-substantive, grammatical changes.

Amends Subsection C to substitute the word "business" for "employer" in order to conform to the language in the new Subsection D.

Adds new Subsection D to permit the use of a written agreement between a business and an independent contractor which, if executed pursuant to the terms of this subsection, creates a rebuttable presumption of an independent contractor relationship. Unless the rebuttable presumption is overcome, no premium may be collected by the carrier on payments by the business to the independent contractor.

Renumbers old Subsection D to E and changes the phrase "an employer" to "a business that uses the services."

Adds new Subsection F to provide that the agreement described in Subsection D is null and void, and creates no presumption of an independent contractor relationship if the consent of either party is obtained through misrepresentation, false statements, fraud, intimidation, coercion or duress. The carrier may also collect a premium where the agreement is found to be null and void.

23-907 (Effective 07-20-96)
Amends Subsection C to provide that civil penalties and interest collected from uninsured employers on No Insurance claims be deposited in the state's General Fund instead of the Special Fund; reimbursement for medical benefits and disability payments remain deposited in the Special Fund.

Amends Subsection H to provide that civil penalties collected by the Commission against uninsured employers pursuant to A.R.S. §23-907(F) and 23-907(G) are payable to the state's General Fund instead of to the Special Fund.

23-926 (Effective 07-20-96)
Amends Subsection B to provide that penalties collected for failure of an employer to submit the employer's books, records and payroll for ICA inspection upon request shall be paid to the state's General Fund instead of the Special Fund.

23-930 (Effective 07-20-96)
Amends Subsection C to provide that penalties against an employer, self-insured employer, insurance carrier or claims processing representative for a history or pattern of repeated bad faith or unfair claims processing be transmitted to the state Trea- surer for deposit into the state's General Fund instead of to the Special Fund.

23-961 (Effective 07-20-96)
Amends Subsection G for non-substantive and grammatical changes.

Amends Subsection L to expand the application of the voluntary waiver of workers' compensation coverage provision to all sole proprietors, not just those licensed by the Registrar of Contractors.

23-1021 (Effective 07-20-96)
Adds new Subsection C to provide for a non-compensable worker's compensation claim when the impairment of an employee is due to an employee's use of alcohol or the unlawful use of any controlled substance proscribed by Title 13, Chapter 34, and is a substantial contributing cause of an employee's injury or death. The subsection does not apply if an employer had actual knowledge of and permitted, or condoned, an employee's use of alcohol or the unlawful use of a controlled substance.

23-1065 (Effective 07-20-96)
Amends Subsection I to exclude from deposit in the Special Fund any penalties assessed pursuant to Title 23, Chapter 6.

1997

23-961 (Effective 07-21-97)
Amends Subsection (A)(2) to expand the "self-insurance" option to employers that are part of a workers' compensation pool created pursuant to §23-961.01.

23-961.01 (Effective 07-21-97)
Adds new section to permit two or more employers, engaged in similar industries, to enter into contracts to establish workers' compensation pools subject to criteria of statute and Commission rules and subject to the approval of the Commission. Exempts these pools from taxation under Title 43. [See §43-1201(16)]

Mandates the Commission to promulgate rules necessary to carry out the purposes of this section. The rules are to include, at a minimum, the enumerated items in the statute.

No pool, employer within a pool, or agent of any pool or employer within a pool may require an employee to be treated or directed to any specific medical provider subsequent to the initial visit to treat an industrial injury or illness, except as to an independent medical exam.

23-963 (Effective 07-21-97)
Amends paragraph 4 to include that the bankruptcy of an employer or his discharge thereon shall not relieve the workers' compensation pool for payment of compensation for claims attributed to that employer during the employer's period of membership in the pool.

23-1028 (Effective 4-29-97)
Adds new Subsections C and D which subject violations of §23-1028 to the additional penalties prescribed by the new §20-466.02 and 20-466.04 in Title 20 which are under the jurisdiction of the Arizona Department of Insurance ("ADOI").

Section 20-466.02 enables ADOI, through the Attorney General, to petition the superior court for injunctive relief, affirmative relief and/or additional civil penalties. Additionally, the provision also permits the awarding of general costs, investigative costs and reasonable attorney fees.

Section 20-466.04 permits the Director of ADOI to forward to the appropriate professional licensing agency the name of any person who is convicted of, enjoined from or penalized for violation(s) of §23-1028.
Section 23-1028 defines "statement" (for purposes of §23-1028) as "any notice, proof of injury, bill for services, payment for services, hospital or doctor records, x-rays, test reports, medical or legal expenses, or other evidence of loss or injury, or other expense or payment."

23-1031 (Effective 12-01-97)
Renumbered from §23-1028.01. Adds new section to provide for the suspension of workers' compensation benefits to a person (convicted of a crime or adjudicated delinquent) while incarcerated in any state, federal, county or city jail or correctional facility.

An exception applies to garnishment for child support obligations.

46-349 (Effective 07-21-97)
As part of **new Article 9** (Arizona Works Program) to Title 46, Chapter 2, Arizona Revised Statutes, Subsection H of this section states that participants in Level Three or Level Four of the Arizona Works Program will not be considered employees for purposes of Title 23, Chapters 4 (Employment Security) and 6 (Workers' Compensation).

Level Three placement is described in Subsection (B)(3) as "… in a trial job that is an unsubsidized, unpaid position …" Level Four placement is described in Subsection (B)(4) as "a community referral … designed to improve the employability of persons by providing work experience and training to assist them to move promptly to unsubsidized employment…"

46-352 (Effective 07-21-97)
Employers (public and private) choosing to participate in the subsidized employment program of the Arizona Works Program shall provide workers compensation coverage pursuant to Subsection H of this section for each participant so employed.

1998

23-1021.01 (Effective retro-actively from and after 1-3-97 and operative immedi-ately)
Adds a new section to include that a peace officer or a firefighter as defined in §1-215 who is injured or killed while traveling directly to or from work shall be considered to be in the course and scope of employment solely for the purposes of workers' compensation, provided that the peace officer or firefighter is not engaged in criminal activity.

Limits civil damages liability of the peace officer's or firefighter's employer.

46-349 (Effective 08-21-98)
Amends Subsection H of this section of the Arizona Works Program by inserting an exception clause which provides that even though Level Three (unsubsidized, unpaid) and Level Four (community referral, grant money) participants are not considered employees for purposes of the Workers' Compensation Act, the Arizona Works Agency shall provide, pursuant to §46-352.H., workers' compensation benefits from temporary assistance for needy families monies.

46-352 (Effective 08-21-98)
Amends Subsection H of this section of the Arizona Works Program to mandate that employers shall provide workers' compensation coverage for participants in Level One (full-time, unsubsidized employment) and Level Two (subsidized, paid employment) as determined in §46-349; mandates the Arizona Works Agency provide workers' compensation to participants in Levels Three and Four as determined in §46-349.

1999

23-108.02 (Effective 08-06-99)
Amends Subsection A relating to administrative law judges to change state personnel "commission" to "board;" other non-substantive stylistic changes.

23-901 (Effective 08-06-99)
Amends paragraph 5(d) of the "Definitions" section by substituting the words, "Chapters 24 through 40" for "chapter 22" of title 10 relating to private fire protection service organizations.

23-908 (Effective 08-06-99)
Amends Subsection A by inserting the words, "the report;" deleting the words, "and regulations;"

Amends Subsection B by adding occupational therapists to the list of health care providers subject to the Commission's schedule of fees when attending injured employees;

Amends Subsection C by deleting the words, "the provisions of."

23-953 (Effective 08-06-99)
Adds new section that provides benefits to continue on a protested scheduled award issued pursuant to §23-1044(B) pending finality; any overpayment shall be credited against any future compensation liability on the same claim.

23-961.01 (Effective 08-06-99)
Deletes Subsection C of this "self-insurance pools" section that references §10-2305(B);

Reletters succeeding subsections to conform;

Amends the old Subsection G (now "F") to change the word "groups" to "pools;" other non-substantive changes.

23-1021 (Effective 08-06-99)
Amends Subsections A through C by making non-substantive changes;

Adds new Subsections D through H addressing circumstances under which an employee's injury or death may or may not be compensable where alcohol or illegal drugs are suspected to be a contributing cause of the employee's injury or death; provides for annual filing with the Commission by an employer that has in place a policy of drug testing or alcohol impairment testing; defines "substantial contributing cause" as "anything more than a slight contributing cause."

23-1025 (Effective 08-06-99)
Amends Subsections A and B for only non-substantive changes relating to agreements to waive compensation and relating to the unlawful collection of premiums.

23-1041 (Effective 08-07-99)
Amends this section by reorganizing and re-lettering some subsections; raises the statutory maximum average monthly wage to $2,400. per month.

23-1043.03 (Effective 08-06-99)
Adds new section relating to workers' compensation claims for Hepatitis C; mirrors, in large part, the language of §23-1043.02 relating to human immunodeficiency virus or acquired immune deficiency syndrome; mandates the Commission to prescribe, by rule, requirements and forms regarding employee notification of the requirements of this section and the proper documentation of a significant exposure.

23-1044 (Effective 08-06-99)
Amends Subsection A to add that during the period of temporary partial disability, 50% of retirement and pension benefits received from the insured or self-insured employer shall be considered wages able to be earned;

Amends Subsection B(21) by adding the consideration of "total" loss of use to the present partial loss of use in calculating the benefits under a scheduled award based on 75% of average monthly wage when the employee is unable to return to the work the employee was performing at the time of injury; other non-substantive changes;

Amends Subsections C and F for non-substantive changes;

Amends Subsection G by eliminating references to subsections C, E and F and adding a reference to §23-1061(J) disability compensation cases, thereby treating all cases under §23-1044 (except for Subsection B cases) and §23-1061(J) disability compensation cases in the same manner when determining whether an injured employee has suffered a loss in earning capacity because of an inability to obtain or retain suitable work; other changes are non-substantive.

Amends Subsection H for non-substantive changes only.

23-1045 (Effective 08-06-99)
Amends Subsection A, paragraphs 1 and 2, by removing the references to dependents residing or not residing in the United States; changes the word "chapter" to "section."

23-1046 [applies retro- actively to from and after 02-28-99 (this means deaths - a surviving spouse with no children to receive 66-2/3% of the deceased's average monthly wage occurring on or after 03-01-99)

Amends (A)(1) to increase burial expenses from $3,000 to $5,000; (A)(2) as follows:

- a surviving spouse with children to receive 35% of the deceased's average monthly wage until death or remarriage with two years compensation in one sum upon remarriage with the surviving children to receive 31-2/3% share and share alike under various circumstances; full benefits of 66-2/3% average monthly wage to revert back to surviving spouse when all surviving children are no longer eligible for benefits; once surviving spouse dies or remarries, benefits to surviving children are to be paid pursuant to the new paragraph 3 (replacing old paragraph 4);

Deletes paragraph (A)(3) and renumbers subsequent paragraphs in Subsection A to conform;

Amends old paragraph (A)(4) [new paragraph (A)(3)] to add "or remarriage" as a circumstance in calculating benefits to surviving children; allows benefits to continue to age 22 for surviving children if enrolled in any accredited educational institution;

Amends Subsection A for non-substantive changes.

Deletes Subsection C which referenced death benefits to aliens not residing in the United States;

Reletters old Subsection D to "C."

23-1048 (repealed from and after 12-31-99)
Repeals the Workers' Compensation Wage Advisory Commission established pursuant to §23-1048 from and after 12-31-99.

23-1061 (Effective 08-06-99)
Amends Subsections A and B for non-substantive changes;

Amends Subsection H to provide that a claim shall not be reopened because of increased subjective pain if the pain is not accompanied by a change in objective physical findings nor shall it be reopened solely for additional diagnostic or investigative medical tests; provides that expenses for any reasonable and necessary diagnostic or investigative tests that are causally related to the injury shall be paid by the employer or insurance carrier if the claim is reopened as provided by law and if these expenses are incurred within 15 days after [sic] the date the petition to reopen is filed. [The Commission has been informed that the word "after" in the legislation as noted above is in error and should have read "of."]; other non-substantive changes;

Amends subsection K for non-substantive change;

Amends Subsection M for non-substantive changes.

23-1065 (Effective 08-06-99)
Amends Subsection C(2) to delete the written records requirements by which an employer can establish knowledge of a pre-existing enumerated permanent impairment.

12-741 et seq.[emergency (operative immediately); approved and filed 04-26-99]
Adds new article 14 to Title 12, Chapter 6, Arizona Revised Statutes, relating to "Liability for Year 2000 Failures;" Section 12-742 relating to "Applicability" notes in Subsection B(1) that this article does not apply to actions to collect workers' compensation benefits under Title 23; Subsection C of §12-742 provides that if a conflict exists between this article and Chapter 6, Article 9 (Product Liability) of Title 12, this article controls.

32-1451 (Effective 08-06-99)
Adds new Subsection R to this section relating to grounds for disciplinary action for doctors of medicine; provides that a physician who submits an independent medical examination pursuant to an order by a court or by the Industrial Commission is not subject to a complaint for unprofessional conduct unless a complaint is made or referred by a court or the Industrial Commission to the Arizona Board of Medical Examiners; defines the term "independent medical examination" to mean a professional analysis of medical status on a person's past and present physical and psychiatric history conducted by a licensee or group of licensees on a contract basis for a court or for the Industrial Commission.

41-1005 (Effective 08-06-99)
Amends Subsection A by adding a new paragraph 27 which states that the Administrative Procedures Act regarding rule-making does not apply to the schedule of fees prescribed by §23-908.

2000

11-952.01 (Effective 07-18-00)
Adds new Subsection E stating that Section 10-11301 does not apply to nonprofit corporations formed under §11-952.01 (public agency pools)

Amends Subsection G by reducing the required number of trustees of public agency pools, including workers' compensation, from five persons to three persons.

Amends Subsection (H)(11) by removing the requirement that a public agency pool, including workers' compensation, requires the written permission of the state treasurer to enter into financial agreements with a bank and to issue checks in its own name.

Contains some non-substantive changes.

23-901 (Effective 07-18-00)
Amends paragraph 5(f) of the "Definitions" section by adding to the definition of "employee" for purposes of workers' compensation coverage, persons in Level Three (unsubsidized, unpaid) or Level Four (community referral) of the Arizona Works Program as well as persons in the Department of Economic Security's temporary assistance for Needy Families Program.

Other changes to Section 23-901 are non-substantive.

23-907 (Effective 07-18-00)
Amends Subsection C by removing the reference to the "state treasurer" for transmission of No Insurance civil penalties and interest and substituting cross-references to Sections 35-146 and 35-147 in the "Public Finances" title of A.R.S.

23-930 (Effective 07-18-00)
Amends Subsection C by removing the reference to the "state treasurer" for transmission of No Insurance civil penalties and substituting cross-references to Sections 35-146 and 35-147 in the "Public Finances" title of A.R.S.

23-1091 (Effective 07-18-00)
Establishes only one workers' compensation assigned risk plan in this state.

Provides for an Assigned Risk Plan Administrator.

Provides for a charge to all insurers of a shared "reasonable fee" to administer the plan.

Provides for oversight authority of the plan by the Director of the Department of Insurance.

Enumerates criteria for the plan's operations.

Addresses the rates used to determine the premiums of risks in the assigned risk plan.

Also contains non-substantive changes to Section 23-1091.

41-621.01 (Effective 07-18-00)
Subsection A dealing with workers' compensation pools of two or more contractors licensed to do work for this state has been amended to include subcontractors as well. Additionally, the work can also be done for any political subdivision of this state, as well as for the state.

2001

23-901.01 (Effective 08-09-01)
Adds Subsections B, C, D and E to the occupational disease statute; establishes a presumption (if certain criteria are met) that a disease, infirmity or impairment caused by certain cancers or leukemia resulting in disability or death to a firefighter is an occupational disease as defined in §23-901(12)(c) and is deemed to arise out of employment;

Amends Subsection (A)(4) to change "workmen" to "workers."

23-902 (Effective 08-09-01)
Amends Subsections A, B, C, E and G for non-substantive grammatical and/or stylistic changes.

23-947 (Effective 08-09-01)
Amends Subsection A for non-substantive grammat- ical and/or stylistic changes;

Amends Subsection C by deleting the provision which had not excused a late filing of a request for hearing if the sender could show by clear and convincing evidence that the notice was either sent or delivered to the last known mailing address or residence as shown on Industrial Commission records; other non-substantive grammatical and/or stylistic change.

23-961 (Effective 08-09-01)
Adds new Subsection B that states an employer's obligation to secure workers' compensation for its employees may only be done through the mechanisms authorized under the Workers' Compensation Act; any other mechanisms may not be marketed, offered or sold as workers' compensation;

Re-letters succeeding subsections to conform;

Amends old Subsection F (new subsection G) by deleting the provision which had required the employer, prior to any cancellation or nonrenewal of workers' compensation, to notify the Industrial Commission;

Amends remaining subsections for non-substantive grammatical and/or stylistic changes.

23-1047 (Effective 08-09-01)
Amends Subsection C by substituting "ninety" days for "sixty" days as the time in which a request for hearing may be filed to a determination made under Subsection B (permanent disability)

Amends remaining subsections for non-substantive and/or stylistic changes.

23-1061 (Effective 08-09-01)
Amends Subsection H relating to reopened claims by substituting the word "of" for the word "after" to provide that reasonable and necessary medical, hospital, and lab work expenses incurred within 15 days of the filing of the petition to reopen shall be paid by the employer or the employer's insurance carrier;

Amends other subsections for non-substantive grammatical and/or stylistic changes.

23-1065 (Effective 08-09-01)
Amends Subsection A by conforming references in this subsection to the newly re-lettered subsections of §23-961.

23-1081 (Effective 08-09-01)
Amends this subsection by conforming references in this subsection to the newly re-lettered subsections of §23-961.

32-1451 (Effective 08-09-01)
Amends Subsection Q by removing references to the "Industrial Commission"; this subsection relates to disciplinary grounds for physicians licensed by the Arizona Board of Medical Examiners in the context of independent medical examinations.

2002

23-901 (Effective 08-22-02)
Amends Subsection 5(f) by deleting the reference to "level three or four of the Arizona works program." This was part of a bill dealing with changes to the welfare laws.

23-963.01 (Effective 08-22-02)
Amends by adding language to Subsection (A) that a benefits deductible endorsement attached to a policy shall specify whether loss adjustment expenses are to be treated as advancements within the deductible to be reimbursed by the employer.

23-986 (Effective 08-22-02)
Amends Subsection (E) by adding language that exempts the State Compensation Fund from Title 41, Chapter 39 (Access to State Agency Web Site Records and Privacy).

2003

23-901 (Effective 09-18-03, with a delayed effective date of 01-01-04 for amendment of 23-901 by Laws 2002, chapter 331, section 1)
Adds a new subsection two to define the word "client."

Adds to the definition of "employee" as found in subsection six (formerly subsection five), a new subsection (p) that includes every person employed pursuant to a professional employer agreement.

Adds a new subsection 14 that defines "professional employer agreement" to mean a written contract between a client and a professional employer organization that meets the criteria set forth in the new subsection.

Adds a new subsection 15 that defines "professional employer organization" to mean any person engaged in the business of providing professional employer services.

Adds a new subsection 16 that defines "professional employer services" to mean the services of entering into co-employment relationships with covered employees.

Re-numbers succeeding definitions to conform.

23-901.01 (Effective 09-18-03)
Amends subsections A and B to conform to the newly re-numbered subsections of §23-901.

Amends subsections B, C, D and E to include peace officers within the presumption granted under this section for a disease, infirmity or impairment caused by certain cancers or leukemia.

Amends subsection (B)(3) to add the word "and" between the first and second requirements of that subsection.

Adds a new subsection (E)(2) to define "peace officer" to mean a full-time peace officer who was regularly assigned to hazardous duty as part of a special operations, special weapons and tactics, explosive ordinance disposal or hazardous materials response unit.

23-901.04 (Effective 09-18-03)
Amends subsection A to conform to the newly re-numbered subsections of §23-901.

23-901.05 (Effective 09-18-03)
Amends this Section to conform to the newly re-numbered subsections of §23-901.

23-901.06 (Effective 09-18-03)
Amends this Section to conform to the newly re-numbered subsections of §23-901.

23-901.08 (Effective 09-18-03)
Adds a new Section titled "Professional Employer Organization" ("PEO").

New subsection A provides that a person provid- ing professional employer services is subject to the Workers' Compensation Act regardless of the term or name to which that person refers to the service.

New subsection B provides that a PEO shall be regarded as a co-employer of an employee as long as a professional employer agreement with a client remains in force.

New subsection C provides that both a PEO and its client shall be considered an employer under the Workers' Compensation Act for purposes of coverage and the protections of the exclusive remedy of §23-1022. Both are required to comply with §§ 23-906 and 23-964. Compliance with §23-1021(F) can be satisfied if either the PEO or client files the written certification with the Commission.

New subsection D requires a PEO to notify its workers' compensation insurance carrier and the Commission when the PEO enters into a professional employer agreement with a client in Arizona. The notification shall be on a form approved by the commission that includes information set forth in subsections one, two and three, of new subsection D.

New subsection E provides that if a professional employer agreement is terminated, the PEO shall immediately provide written notice to its workers' compensation insurance carrier and the Commission of the name of the client and date the agreement was terminated.

23-902 (Effective 09-18-03)
Amends subsection A to include as an employer a person who employs covered employees under a professional employer agreement.
Amends subsection B for non-substantive grammatical changes.

23-907 (Effective 09-18-03)
Amends subsections throughout this Section for non-substantive grammatical and/or stylistic changes.

Amends subsection B to add that, except for a protest to compensability, an employer designated as an "uninsured employer" under this Section, shall provide proof of compliance with 23-961 with any subsequent protest to a determination or action of the Special Fund.

Adds a new subsection C to permit the Special Fund to begin the payment of medical or compensation benefits pending finality of a claim, condition, or other matter accepted by the Special Fund. A protest, petition for hearing, request for review, or appeal shall not interrupt payments made under this Section. Any overpayment shall be credited or adjusted against future liability on the same claim, except if the claim is finally determined to be noncompensable, in which case the overpayment shall be borne by the Special Fund.

Adds a new subsection D to authorize the Special Fund to spend monies that relate to a claim processed under this Section and to include such expenditures under the employer's liability to the Special Fund.

Amends new subsection E (old subsection C) to increase the civil penalty from $500 to $1,000.

Amends new subsection H (old subsection F) to increase the civil penalty from $500 to $1,000.

Amends new subsection I (old subsection G) to increase the civil penalty from $500 to $1,000 and to require an employer that protests an order of civil penalty to specify the facts and grounds of the objection. A decision following a hearing on a protest to a civil penalty order is now required to be served by "first class" mail on the employer, rather than "regular" mail.

Adds a new subsection J to provide for increased civil penalties for repeat failures to obtain workers' compensation insurance. For a second violation within the previous 5 years, the Commission may assess a penalty not to exceed $5,000. For a third or subsequent violation within the previous 5 years, the Commission may assess a penalty not to exceed $10,000.

Adds a new subsection K that sets forth the factors the Commission may consider in assessing a civil penalty under subsections H, I or J. The factors include the employer's history of non-compliance to ob-

tain workers' compensation coverage or history of no insurance claims filed with the Commission, whether the employer's failure to obtain coverage was inadvertent, or whether the failure to obtain coverage was because the employer was a victim of fraud, misrepresentation or gross negligence by an insurance agent or broker or a person believed to be an insurance agent or broker.

Re-letters subsections throughout to conform Section.

23-961 (Effective 09-18-03)
Amends subsection B for non-substantive grammatical changes.

Amends subsection F to permit cancellation of a workers' compensation insurance policy if one or both of the parties to a professional employer agreement terminate the agreement.

Amends subsection M to conform to the newly renumbered subsections of §23-901.

23-1021 (Effective 09-18-03)
Amends subsection F to eliminate the requirement to file with the Commission on or before January 15 of each year written certification of an employer's policy of drug testing or alcohol impairment testing (initial filing of written certification retained).

Amends subsection H for non-substantive grammatical changes.

23-1065 (Effective 09-18-03)
Adds a new subsection H to authorize the special fund to spend monies that relate to the processing, payment, or determination of liability of the Special Fund under the Workers' Compensation Act.

Re-letters subsections throughout to conform Section.

Amends subsections throughout this Section for non-substantive grammatical and/or stylistic changes.

2004

23-107 (Effective 08-25-04)
Adds new subsections (A)(7), (A)(8), and (A)(9) to authorize and establish criteria for the exchange of non-public information between the Commission and other state, local or federal regulatory agencies for the purpose of the legitimate administrative needs of the Commission and exchanging agencies.

Adds a new subsection (D) to provide confidentiality to financial information received from a private entity that applies to self-insure or that renews its self-insurance authority if the information is kept confidential by the private entity in its ordinary and regular course of business.

23-902 (Effective 08-25-04)

Amends subsection (E) to conform to the newly relettered subsections of §23-961.

23-908 (Effective 08-25-04)

Amends subsection (B) to add to the list of fees set by the Commission, prescription medicines required to treat an injured employee.

Adds a new subsection (C) to require that if a schedule of fees for prescription medicine is adopted under subsection (B) and includes provisions regarding the use of generic equivalent drugs, that those provisions comply with §32-1963.01 subsections (A) and (C) through (K). Additionally, if the Commission considers the adoption of a fee schedule that involves specif- ic prices, values, or reimbursement for prescription drugs, then the Commission shall base the adoption on studies or practices that are validated and accepted in the industry, including the applicability of formulas that use average wholesale price, plus a dispensing fee, and that have been made publicly available for at least 180 days before any hearing conducted by the Commission.

Amends Section throughout for grammatical/stylistic changes.

Re-letters subsections throughout to conform Section.

23-961 (Effective 08-25-04)
Amends subsection (C) to substitute the words "insurance carriers that transact" for "corporations or associations transacting." Deletes all other language in the subsection except the language providing that insurance carriers are subject to the rules of the director of insurance.

Amends subsection (D) for non-substantive grammatical/stylistic changes.

Amends subsections (D)(2), (D)(2)(a), and (D)(2)(b), to add that the Department of Insurance may request that the computations set forth in those subsections use information from a period other than the preceding December 31.

Amends subsections (D)(2)(a) and (D)(2)(b)(ii) to substitute the word "the" for "all" immediately preceding the phrase "determined and estimated future direct reported loss…"

Adds a new subsection (E) that requires an insurance carrier to file with the Department of Insurance, on or before April 15 and any other time specifically requested by the Department, information necessary to compute the required deposit.

Adds a new subsection (F) that requires a carrier to maintain at all times a deposit of cash or securities, through the Director of Insurance, in an amount not less than what is required under this Section.

Amends old subsection (E)(now subsection G) to eliminate the use of a bond in lieu of cash or securities. Adds language providing that the Director of Insurance shall hold the cash or securities posted by an insurance carrier acting as a reinsurer for fulfillment of the obligations of the carrier. Adds language that the Commission shall have a lien against the cash or securities deposited to the extent the Special Fund is liable to pay the obligations secured by the cash or securities. Amends throughout for non-substantive grammatical/stylistic changes.

Re-letters subsections throughout to conform Section.

23-966 (Effective 08-25-04)
Amends subsection (A) to add that the Commission may assign the claims of an "other employer authorized by the Commission to process or pay claims directly under this Chapter." Adds language providing that the claims assigned to the State Compensation Fund under this Section shall be processed and paid "on behalf of and under the direction of the Special Fund established by Section 23-1065." Eliminates the right of the State Compensation Fund to assert a claim and collect against the deposit posted under §23-966 for amounts paid on assigned claims. Adds language that the Special Fund shall periodically, but not less than quarterly, reimburse the State Compensation Fund for amounts paid under this Section. Amends throughout for non-substantive grammatical/stylistic changes.

Amends old subsection (B) to delete reimbursement of State Compensation Fund's net loss incurred. Re-letters the remaining language as subsection (D).

Adds a new subsection (B) to authorize the Special Fund to pay, in addition to any reimbursement authorized under subsection (A), any expense or service that is necessary to assist in the determination of liability of a claim assigned under the Section or collection against the deposit posted under §23-966.

Adds a new subsection (C) to provide that the Special Fund shall have a claim against the insurance carrier or employer for all monies that are spent or anticipated to be spent under this Section, which claim shall be made upon the cash, securities or bond posted under §23-961 or other assets of the insurance carrier or employer.

Amends subsection (D) to substitute the word "Special" for "State Compensation."

23-1021 (Effective 08-25-04)
Amends subsection (G) to conform to re-lettering of 23-908.

23-1043.02 (Effective 08-25-04)
Amends subsection (E) to conform to re-lettering of 23-908.

23-1043.03 (Effective 08-25-04)
Amends subsection (E) to conform to re-lettering of 23-908.

23-1061 (Effective 08-25-04)
Amends subsection (A) to conform to re-lettering of 23-908.

23-1065 (Effective 08-25-04)
Amends subsection (A) to conform to re-lettering of 23-961.

Amends subsection (H) for non-substantive grammatical/stylistic changes.

23-1081 (Effective 08-25-04)
Amends subsections (A) and (B) to conform to re-lettering of 23-961.

2005

23-1081 (Effective 08-12-05)
Amends subsections (B) to permit surplus in the administrative fund to be transferred to the special fund when the special fund is not actuarially sound.

2006

No changes in 2006.

2007

23-901 (Effective 09-19-07)
Adds a new subsection (6)(q) to include within the definition of "employee" members of the Department of Administration Capitol Police Reserve organized under A.R.S. §41-794 and to provide the basis for computing wages under the Act for these individuals.

23-902 (Effective 09-19-07)
Amends subsection (A) for non-substantive grammatical changes.

Amends subsection (E) to conform to the newly relettered subsections of §23-961

23-961 (Effective 09-19-07)
Adds a new subsection K that permits an insurance carrier to reduce the premium paid by an employer up to 5% if certain drug testing conditions apply.

Re-letters subsections throughout to conform Section.

Amends throughout for non-substantive grammatical changes.

23-1023 (Effective 09-19-07)
Amends subsection (B) to address the third party claim rights of an insurance carrier or self-insured employer if an employee or the employee's dependents do not pursue a third party claim or if, after instituting a third party claim, the employee or employee's dependents fail to fully prosecute the third party claim and the claim is dismissed.

Adds a new subsection (C) to impose notice requirements concerning the third party claim upon an employee or the employee's dependents and to give the insurance carrier or self-insured employer the right to intervene in the third party action to protect their interests.

Adds a new subsection (E) to give the Commission the same rights as an insurance carrier or self-insured employer under this Section.

Amends throughout for non-substantive grammatical changes.

Re-letters subsections throughout to conform Section.

23-1041 (Effective 09-17-07)
Amends subsection (D)(4) to state the actual effective dates of that subsection (statutory cap of $2,100 applies to employees injured from and after June 30, 1991, but before August 6, 1999).
Amends subsection (D)(5) to state the actual effective dates of that subsection (statutory cap to $2,400 applies to employees injured on or after August 6, 1999, but before January 1, 2008.

Adds a new subsection (D)(6) increasing the statutory cap to $3,000 for employees injured from and after December 31, 2007, but before January 1, 2009.

Adds a new subsection (D)(7) increasing the statutory cap to $3,600 for employees injured from and after December 31, 2008, but before January 1, 2010.

Adds a new subsection (D)(8) establishing the statutory cap at an amount adopted by the Commission under a new subsection (E).

Adds a new subsection (E) requiring the Commission, not later than August 1 of each calendar year beginning August 1, 2009, to adopt an amount that adjusts the statutory cap from the prior year to reflect the annual percentage increase in the Arizona Mean Wage published by the Department of Economic Security using the Bureau of Labor Statistics Occupational Employment Statistics coded for all occupations for the prior calendar year. The amount adopted by the Commission shall be effective for the following calendar year and shall apply to all injuries occurring during that calendar year. In adopting the amount under this subsection, the Commission shall not decrease the amount from the prior year or increase the amount more than 5% from the prior year.

23-1043.04 (Effective 09-19-07)
Adds a new Section titled "Methicillin-resistant staphylococcus aureus; spinal meningitis; tuberculosis; establishing exposure; definitions" that addresses claims for a condition, infection, disease or disability involving methicillin-resistant staphylococcus aureus, spinal meningitis, or tuberculosis. This new Section includes the requirement for a significant exposure, criteria for establishing a prima facie claim, reporting requirements, confidentiality provisions, and payment for post-exposure evaluation, follow-up, and prophylactic treatment. For purposes of this new Section, employees that may establish a prima facia claim are limited to firefighters, law enforcement officers, corrections officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution as defined in §36-401.

23-1046 (Effective 09-19-07)
Amends subsection (A)(3) to adjust the percentage of benefits available to a single surviving child from 25% to 66 2/3% of the average monthly wage of the deceased and to provide that multiple surviving children divide equally the 66 2/3%.

23-1062.01 (Effective 09-19-07)
Adds a new Section titled "Timely payment of medical, surgical and hospital benefits billing; content of bills; contracts between providers and carriers; exceptions; definitions" This new Section includes:

- Time-frames for processing and payment of medical bills by an insurance carrier, self-insured employer or claim processing representative;
- Payment of interest, at the legal rate, to medical providers for untimely paid bills;
- Criteria for billing denials;
- Information required to be included in a billing;
- A provision that an insurance carrier, self-insured employer or claims processing representative is not responsible to pay a medical bill unless the billing is received within 24 months from the date on which the service was rendered or from the date on which the health care provider knew or should have known that service was rendered on an in- dustrial claim, whichever is later;
- A provision that an injured worker is not responsible for payment of any portion of a medical bill for services rendered on an accepted claim and is not responsible for payment of any disputed amount between a health care provider and insurance carrier, self-insured employer or claims processing representative;
- A provision that an insurance carrier, self-insured employer, or claims processing representative may establish an internal system for resolving payment disputes and other contractual grievances with health care providers;
- A provision that this Section does not apply to a health care provider that enters into an express written contract with an insurance carrier, self-insured employer or claims processing representative that specifies the period in which approved bills shall be paid and contractual remedies for untimely bill payment. This provision further provides that the Commission does not have jurisdiction over disputes involving timely payment of billings under a contract between a health care provider and an insurance carrier, self-insured employer or claims processing representative; and
- Definitions applicable to this new Section.

23-1065 (Effective 09-19-07)
Amends subsection (A) to conform to the newly re-lettered subsections of §23-961.

23-1067 (Effective 09-19-07)
Amends subsection (B) to increase the maximum amount of a lump sum commutation to $150,000 (from $50,000) for request made from and after June 30, 2007.

2008

23-901 (Effective 09-26-08)
Amends subsection (2) for non-substantive grammatical changes.

Amends subsection (10) to add "the employee's estate" to the definition of "interested party."

23-1061 (Effective 09-26-08)
Amends subsection (H) to prohibit the filing of a petition to reopen a previously denied claim if the denial was allowed to become final and no exception applies under A.R.S § 23-947 excusing a late filing to request a hearing. An intent section states that this amendment is only intended to overrule the court decision in *Gerhardt v. Industrial Commission,* 181 Ariz. 215, 889 P.2d 8 (1994) and is not intended to overrule any other court decision.

Amends subsection (J) to require that a claim for temporary partial disability benefits be filed with the Commission within two years after the date the claimed entitlement to compensation accrued or within two years after the date on which an award for benefits encompassing the entitlement period becomes final. The amendment includes a definition of "accrue" for purposes of this subsection.

2009

23-357 (Effective 09-30-09)
Amends subsection (B) to change the effective date for licensed rating organization rate filings to January 1. The effective date had been October 1.

23-359 (Effective 09-30-09)
Amends subsection (B) to change the expiration date for deviations from filed rates to December 31. The expiration date had been September 30.

23-371 (Effective 09-30-09)
Amends subsection (F) to change the effective date for statewide workers' compensation rates to January 1. The effective date had been October 1.

Amends subsection (G) to change the reference to the effective date for statewide workers' compensation rates, now January 1. The reference had been to October 1.

Amends subsections (A) and (B) for non-substantive grammatical changes.

23-901.08 (Effective 09-30-09)
Amends subsection (C) to delete a reference to 23-1021(F) as that subsection has been repealed.
Amends subsection (C) for a non-substantive grammatical change.

23-984 (Effective 09-30-09)
Amends subsection (C) to:

- Decrease the penalty for an employer that willfully misrepresents the amount of payroll, the job description or job function of an employee, or the employer's loss history to an insurance carrier, to "up to three" times the difference in premium paid and the amount the employer would have paid. The statute had provided for a penalty amount of 10 times the difference;
- Clarify that the penalty is in addition to any other damages the carrier may incur including costs and attorneys' fees;
- Establish a four-year statute of limitations for the carrier to initiate a civil action to recover the penalty and other damages;
- Explain that the carrier may initiate the civil action regardless of whether a criminal action is brought against the employer.

Amends throughout for non-substantive grammatical changes.

23-1021 (Effective 09-30-09)
Repeals subsections (C) through (H), to eliminate the provisions that stated a work-related injury death was not compensable if the employee was impaired due to alcohol or controlled substances and that impairment was a substantial contributing cause of the injury, and eliminated the provisions for an employer to have a policy of drug or alcohol testing.

23-1044 (Effective 09-30-09)
Amends subsection (D) to allow the Commission to consider the wages an employee could have earned from employment that has been terminated for reasons unrelated to the industrial accident in determining earning capacity. An intent section states that the amendment is intended to overrule *Arizona Department of Public Safety v. Industrial Commission,* 176 Ariz. 318, 861 P.2d 603 (1993); to clarify that the employee retains all rights to rearrange; and to give the Commission broad discretion to determine an injured worker's earning capacity, including whether and to what extent to consider relevant evidence of wag- es earned in employment that has been terminated. Another section states that the amendments to 23-1044(D) apply to injuries that occur on or after the effective date of the amendment.

Amends subsection (F) for a non-substantive grammatical change (changes the location of the word "shall.")

23-1062.02 (Effective 09-30-09)
Adds a new section titled "Off-label prescription of controlled substances; prescription of schedule II controlled substances; reports; treatment plans; definition." This new section requires physicians, upon the request of an interested party, to:

- Include information in the physician's report about the off-label use of a narcotic, opium-based controlled substance, or Schedule II controlled substance by an employee, including the justification for the use of the controlled substance;
- Specify a treatment plan that includes measures to monitor and prevent substance abuse, dependence, addiction or diversion by the employee;
- Include in the treatment plan a medication contract, a plan for subsequent follow-up visits and drug testing, as well as documentation that the medication regime is providing relief that is demonstrated by improved function.

The new section also provides that the interested party is not responsible for payment for the physician's services until the physician complies with the new section.

The new section also defines off-label use.

2010

No changes in 2010.

2011

23-901 (Effective 07-20-11)
Deletes subsection (6)(q) which had included a member of the Arizona Department of Administration

Capitol Police Reserves within the definition of an "employee." As a result of other legislation, the Capitol Police have merged with and became part of the Department of Public Safety.

23-901 (Effective 01-01-13)
Amends subsection (6)(f) to delete a provision that specified that any dividend from the State Compensation Fund to the Department of Economic Security vocational rehabilitation program shall be non-reverting.

Note: As a result of 2010 legislation, the State Compensation Fund, a quasi-state agency, is scheduled to become a private mutual insurance company as of January 1, 2013. The 2011 Legislature adopted conforming legislation in anticipation of this transition, including the amendments described herein.

Amends subsection 18 to delete the definition of the State Compensation Fund.

Re-numbered succeeding subsections to conform.

Amends throughout to delete references to the State Compensation Fund.

Amends throughout for non-substantive grammatical changes.

23-941.01 (Effective 07-20-11)
Adds a new section titled "Final settlement agreement; definition." Note: Original legislation had section heading as "Settlement of claims; definition." Section heading was changed, pursuant to authority of § 41-1304.02, to "Final settlement agreement; definition."

New subsection A states that no final settlement agreement involving a workers' compensation claim is valid until the agreement is approved by the Commission.

New subsection B describes the requirements to settle undisputed supportive medical maintenance benefits.

New subsection C requires the employer or carrier to notify the attending physician of the approval of a final settlement that terminates entitlement to supportive medical maintenance benefits.

New subsection D defines a "final settlement."

23-961 (Effective 01-01-13)
Amends subsection D to delete the requirement that the State Compensation Fund deposit cash or securities before transacting business.

Amends subsection J to specify the in-lieu tax for self-insured employers be based on the premium that would have been paid if the employer had been insured by an insurance carrier authorized to transact workers compensation insurance in Arizona instead of the prior reference to a plan available from the State Compensation Fund. The Commission is required to adopt rules to specify the premium plans to be used in calculation of rates and premiums used as the basis for the taxes assessed to self-insured employers.

Amends throughout to delete references to the State Compensation Fund.

Temporary Session Law

Specifies the deviation rate (10%) for use in calculating the in-lieu tax for self-insured employers for calendar years 2013, 2014 and 2015.

23-962 (Effective 01-01-13)
Amends subsection A to specify that the reserves established and held by the State Compensation Fund prior to June 30, 1983 for all claims against the state be credited to the state's general fund. The department of administration may procure excess coverage from an insurance carrier rather than from the State Compensation Fund.

Amends subsections B and C to change references to the "State Compensation Fund" to "an insurance carrier."

Amends throughout for non-substantive grammatical changes.

23-963 (Effective 01-01-13)
Amends to delete a reference to the State Compensation Fund.

23-966 (Effective 01-01-13)
Amends title of the subsection to delete "of compensation" and change "fund" to "funds"

Amends subsection A to direct that claims be assigned to the Commission's Special Fund, instead of the State Compensation Fund, where the carrier or self-insured employer does not properly process or pay benefits. Authorizes the Special Fund to use

third-party processors and others to assist in the processing and paying of assigned claims and directs the Special Fund to reimburse the Commission's administrative fund for expenses the administrative fund may incur related to the processing and payment of assigned claims.

23-970 (Effective 01-01-13)
Adds a new section titled "Misrepresentation of payroll, job description, job function, or loss history affecting premium payment; violation; classification; penalty; civil action."

New subsection A states that it is unlawful for an employer to willfully misstate payroll, job descriptions, or loss history to an insurance carrier.

New subsection B states that a violation of subsection A is a class six felony.

New subsection C provides for civil penalties and the recovery of attorneys' fees and costs against an employer who violates subsection A, and provides for a four-year statute of limitations.

23-986 (Effective 07-20-11)
Amends throughout for non-substantive grammatical changes.

Re-numbered subsection E for style and to correct references

23-1005 (Effective 01-01-13)
Repealed this subsection that authorized the State Compensation Fund to reinsure risks.

23-1006 (Effective 01-01-13)
Repealed this subsection that authorized the State Compensation Fund to make contracts of insurance.

23-1021 (Effective 01-01-13)
Amends to delete subsection B and deletes letter- ing for subsection A (subsection A and B were virtu- ally identical with subsection B applying to the State Compensation Fund and subsection A applying to all other carriers and self-insured employers).

23-1026 (Effective 01-01-13)
Amends subsection A to delete a reference to the State Compensation Fund.

23-1029 (Effective 01-01-13)
Amends to delete subsection B and deletes lettering for subsection A.

23-1043.04 (Effective 07-20-11)
Amends subsection A to increase the reporting period from ten days to 30 days after a possible significant exposure and, for a claim involving Methicillin-Resistant Staphylococcus Aureus (MRSA), to require that the employee must be diagnosed with MRSA within 15 days after reporting an exposure.

23-1048 (Effective 07-20-11)
Adds a new section titled "Reasonable accommodations; earning capacity determination; definitions."

New subsection A specifies wages payable for a modified job position be included in any determination of earning capacity where an employer has provided accommodations to an employee even if the modified job is not available in the open and competitive labor market.

New subsection B(1) defines "Americans with Disabilities Act."

New subsection B(2) defines "reasonable accommodations."

23-1062.02 (Effective 07-20-11)
Amends subsection A to add substances that a physician is required to include in the report required by Commission rule. Subsection B authorizes an interested party to request the physician submit an inquiry regarding an employee's prescription information to the Arizona State Board of Pharmacy's Controlled Substances Prescription Monitoring Program.
Amends to add subsection C(2) that enables an employer, carrier, or the Commission to request a change of physicians if the physician does not comply with this section.

Adds subsection D that specifies that an employer, carrier, or the Commission may request the information required by subsection A notwithstanding a prior medical maintenance benefits award and states that an employer or carrier is not liable for bad faith or unfair claims processing for any act taken in compliance of and consistent with this section.

23-1065 (Effective 01-01-13)
Amends subsection A to delete a reference to the State Compensation Fund.

Amends throughout for non-substantive grammatical changes.

23-1070 (Effective 01-01-13)
Amends subsection E to substitute the Commission's Special Fund for the State Compensation Fund.

Amends throughout to delete references to the State Compensation Fund.

Amends throughout for non-substantive grammatical changes.

23-1091 (Effective 01-01-13)
Amends subsection A to delete a reference to the State Compensation Fund. This amendment results in an employer qualifying for the assigned risk plan if declined by two carriers rather than the prior requirement of the State Compensation Fund and two carriers.

Amends throughout to delete references to the State Compensation Fund.

Amends throughout for non-substantive grammatical changes.

23-1101 *et seq*.
Adds new Article 12 that requires any person who advocates a legislative proposal comply with certain requirements if the proposal establishes a presumption of compensability for a disease or condition or substantially modifies a statute that establishes a presumption of compensability for a disease or condition; delineates procedures and contents for report to be submitted to Joint Legislative Budget Committee.

2012

23-108.02 (Effective 09-28-12)

23-986 (Effective 08-02-12)
Amends subsection B to remove language that prohibited marketing representatives of the State Compensation Fund from being licensed to sell any insurance other than workers' compensation insurance.

23-1023 (Effective 08-02-12)
Amends subsection A to allow a workers' compensation claimant to pursue a remedy against another person whose negligence or wrong further aggravates the employee's existing industrial injury.
Amends subsection D to provide for and limit the carrier's lien to amounts expended for compensation and treatment of the aggravation of the existing industrial injury.

23-1026 (Effective 08-02-12)
Adds subsection G to allow an IME physician to disclose data obtained from the Arizona State Board of Pharmacy's Controlled Substances Prescription Monitoring Program to the employee, employer, insurance carrier, and the Industrial Commission.

23-1041 (Effective 08-02-12)
Amends subsection E to change the specific index used to adjust the maximum average monthly wage from the "Arizona mean wage" to the "employment cost index."

23-1062 (Effective 08-02-12)
Amends subsection A for a non-substantive grammatical change.

Amends subsection C to allow an employee to elect payment of workers' compensation benefits using electronic fund transfers and prepaid debit cards in addition to a negotiable instrument.

23-1062.02 (Effective 08-02-12)
Amends subsection A to clarify that an interested party to a workers' compensation claim may request an IME physician both request, and report the results of, an inquiry to the Arizona State Board of Pharmacy's Controlled Substances Prescription Monitoring Program.

23-1062.03 (Effective 08-02-12)
Adds a new section titled "Evidence-based medical treatment guidelines." This new section directs the Industrial Commission to develop and implement a process for the use of evidence-based treatment guidelines by December 31, 2014 and mandates certain progress reports describing the status of the development and implementation of the process.

2013

23-904 (effective 09-13-13)
Repeals entire section

23-904 (Effective 09-13-13, see Note below)
Adds new section titled "Arizona Worker Injuries in Other State; Injury to Foreign Worker in this State; Evidence of Insurance; Judicial Notice of Other State's Laws

New subsection A restates prior subsection A with minor non-substantive grammatical/stylistic changes.

New subsection B provides that a worker who is em-

ployed in Arizona and sustains an industrial injury while temporarily in another state incidental to employment is entitled to benefits as though the injury occurred in Arizona.

New subsection C provides that a worker and his or her employer from another state are exempt from Chapter 6 (the Workers' Compensation Act) while the worker is temporarily performing work for the employer in Arizona if all of the following are true:

- The employer has workers' compensation coverage in another state that covers the worker while working in Arizona;
- The other state recognizes Arizona's extraterritorial provisions in Chapter 6;
- Employers and workers who are covered in Arizona are likewise exempted from the workers' compensation insurance act or similar laws of the other state (reciprocity); and
- The benefits under the workers' compensation act or similar law of the other state are the exclusive remedy against the employer for an injury or death sustained by the worker while temporarily working in Arizona.

New subsection D provides that a certificate issued by the Commission, Department of Insurance, or similar department of another state certifying that an employer is insured in that state is prima facie evidence the employer had workers' compensation insurance.

New subsection E states that courts shall take judicial notice of the laws of other states where construction of the other state's laws is required.

New subsection F defines "temporarily in a state doing work for an employer" to mean where the worker performs fewer than ninety continuous days of required services under the direction and control of the employer during the 365 days immediately preceding the injury or injurious exposure.

New subsection G requires a credit for compensation paid in another state against the compensation due under the Arizona workers' compensation laws; directs that a worker is entitled to the full amount of compensation due under the laws of Arizona; and provides that an insurer shall pay any unpaid compensation to a worker up to the amount required by the claim under Arizona law where the compensation under Arizona law is more than the compensation under the laws of the other state or where the compensation paid under the other state is recovered from the worker.

New subsection H states that the new section applies to claims made after the effective date of this section regardless of the date of injury. (see Note below).

Note: New 23-904 is contained in Senate Bill 1148 (Chapter 34). However, Senate Bill 1310 contains a section that states that Chapter 34 (Senate Bill 1148) applies to any claim that has not been accepted as compensable or adjudicated as compensable as of the effective date of Chapter 34 (which is September 13, 2013). The Legislature enacted Senate Bill 1310 as a Session Law and there is no Title 23 citation.

2014

23-901.04 (effective 07-24-2014)
Amends subsection B(2) to substitute "a person with a disability" for the word "disabled."

23-901.07 (effective 07-24-2014)
Amends subsection A to substitute "with disabilities" for the word "handicapped."

Amends subsection B to substitute "for the purposes of" for the word "in" that begins the subsection and substitutes "with a disability" for the word "handicapped."

23-902 (effective 06-30-2015)
Amends subsection E to conform to re-lettering of 23-961.

23-908 (effective 07-24-2014)
Amends subsection C to conform to newly re-lettered subsection of § 32-1963.01.

Amends throughout for non-substantive grammatical changes.

23-961 (effective 06-30-2015)
Deletes existing subsection D, E, F, and G.

Adds new subsection D to authorize the Director of Insurance to release all or part of the cash or securities that an insurance carrier deposited before the effective date of the amendment and identifies the factors the Director of Insurance shall consider in determining whether to release all or part of the deposit.

Re-letters subsections throughout to conform Section.

23-966 (effective 06-30-2015)
Amends subsection A, B, and C to remove insurance

carrier claims from the types of claims the Commission can assign to the Special Fund in the event of non-payment of the claims and the associated authority to recover from the carrier's deposit and other assets.

Deletes subsection D which removes the Commission's assessment authority to reimburse the Special Fund for payments made on claims of non-paying self-insured and other employers.

23-1023 (effective 07-24-2014)
Amends subsection B to specify that the third-party claim rights are assigned to the insurance carrier or self-insured employer if the employee or employee's dependents do not institute an action within one year or if the employee or employee's dependents fail to fully prosecute the third-party claim and the claim is dismissed.

23-1062.01 (effective 07-24-14)
Amends subsection C to add a provision that any court action for the payment of medical billings be commenced within twenty-four months and to state that a subsequent billing or corrective billing does not restart the limitations period.

Amends subsection F to clarify that the interest penalty under subsection A applies to any late payment.

23-1062.02 (effective 07-24-14)
Amends subsection A to require a physician to report certain information for off-label and prescription use of narcotic, opium-based controlled substances, and scheduled II controlled substances rather than only when requested by an interested party.

Amends subsection B to specify that a physician who prescribes narcotic, opium-based controlled substances, and scheduled II controlled substances shall include in the treatment plan random drug testing and further reporting requirements if the drug testing produces inconsistent results and requires the physician document that the medication regime is providing relief demonstrated by clinically meaningful improvement in function.

Adds a new subsection C requiring a physician to submit an inquiry within two days after writing or dispensing an initial prescription of more than a thirty-day supply of an opioid to the Arizona State Board of Pharmacy and report the results to the carrier, self-insured employer, or the Commission as soon as reasonably practicable but no later than thirty-days from the date of the inquiry.

Adds a new subsection D that requires a physician to report to the carrier, self-insured employer, or the Commission within five days if the result of the inquiry reveals that the employee is receiving opioids from another undisclosed health care provider.

Amends subsection E(1) to replace the phrase "interested party" with "carrier, self-insured employer or Commission."

Amends subsection E(2) to specify the process a carrier, self-insured employer or the Commission must follow to request a change of physician where a physician does not comply with this Section.

Adds subsection F to require drug rehabilitation and detoxification treatment where medically necessary to treat an employee dependent on or addicted to opioids prescribed for a work-related injury.

Adds subsection G to specify that a carrier, self-insured employer or the Commission is not responsible for providing medications subject to this section if the employee resides out of state and the out of state medical provider fails to comply with this section and requires the out of state medical provider to submit an inquiry to that state's controlled substances monitoring database, if one exists.

Adds subsection H to state that this section does not apply to medication administered while receiving inpatient hospital treatment.

Adds subsection J to define "clinically meaningful improvement in function."

Re-letters subsections throughout to conform Section.

23-1065 (effective 07-24-2014)
Amends subsection A to substitute "with disabilities" for the word "disabled."

Amends subsection O and P to substitute reference to A.R.S. § 38-719 with A.R.S. § 38-718.

23-1065 (effective 06-30-2015)
Amends subsection A to reduce the Commission's assessment authority from one and one-half percent to one percent.

Re-letters subsections throughout to conform to relettering of 23-961.

23-1081 (effective 06-30-2015)
Re-letters subsections throughout to conform to re-lettering of 23-961.

Temporary Session Law

Requires the Industrial Commission transfer the sum of $222,848,153 from the Special Fund to the Arizona Property and Casualty Insurance Guaranty Fund no less than thirty days before June 30, 2015.

Temporary Session Law

Specifies the deviation (10%) for use in calculating the in-lieu tax for self-insured employers for calendar years 2013 through 2020.

2015

23-1026 (effective 07-03-2015)
Amends subsection D to specify that a physician who performs a medical examination is not subject to a complaint for unprofessional conduct to the physician's licensing board if the complaint is based on a disagreement with the physician's findings and opinions resulting from the examination.

Amends throughout for non-substantive grammatical changes.

23-1028 (effective 07-03-2015)
Amends subsection A to specify that if a claimant knowingly makes a false statement or representation to obtain benefits, the forfeiture provision applies to all future disability compensation and the forfeiture provision does not terminate if a conviction is subsequently designated as a misdemeanor.

Adds new subsection D to require that a claimant for compensation personally sign any monthly or annual income status report and that a specific statement be included on any such reporting document.

Amends throughout for non-substantive grammatical changes.

Re-letters subsections throughout to conform Section.

2016

23-101 (effective August 6, 2016)
Amends subsection B. Deletes the reference to the termination date of the originally-appointed Commission members. Clarifies the termination date of a Commission member's term. Clarifies that Commission members must be residents of Arizona for "at least" five years prior to appointment.

Amends subsection C. States what a Commissioner must do to receive the per diem salary of $50. Provides that salary is only available on days that a Commissioner "prepares for or attends a Commission meeting." Describes the documentation a Commissioner must submit to the Commission director before receiving a salary.

23-108 (effective August 6, 2016)
Amends subsection A. Clarifies the nature of the director's employment with the Commission. Deletes the requirement that the director be "subject to confirmation by Senate." Provides that the governor will appoint the director pursuant to § 38-211 and states that the director will serve at the pleasure of the governor. Deletes Title 23, Chapter 3, Article 2 (Private Employment Agents) from the scope of the Commission's duties.

Amends subsection B to delete "The director shall serve at the pleasure of the governor," as this language was moved to subsection A.

Amends subsection A for non-substantive stylistic changes.

23-108.01 (effective August 6, 2016)
Amends the section title to be "Powers and duties of director"

Amends newly-lettered subsection A (formerly not lettered) to delete Title 23, Chapter 3, Article 2 (Private Employment Agents) from the scope of the Commission's powers and duties.

Adds new subsection B to permit the director to deny a per diem salary to a Commissioner if the requirements of § 23-101(C) are not satisfied.
Amends subsection A for non-substantive stylistic changes.

23-108.03 (effective August 6, 2016)
Amends subsection B to delete Title 23, Chapter 3, Article 2 (Private Employment Agents) from the scope of the Commission's duties and powers.
Amends subsection B for non-substantive stylistic changes.

23-908 (effective December 31, 2016)
Amends subsection C to state that provisions regarding the use of "interchangeable biological products"

that are included in a "schedule of fees for prescription medicines" are subject to specified requirements of § 32-1963.01. Re-letters references to applicable subsections of § 32-1963.01.

Amends subsection F for non-substantive stylistic changes.

23-941 (effective August 6, 2016)
Adds new subsection I. Grants interested parties a one-time right to a change of administrative law judge (ALJ) without cause in a workers' compensation hearing. Discusses the timing and procedure for exercising the right to change ALJ and sets forth the requirements of the Notice of Change of ALJ.

Amends former subsection I (re-lettered subsection J). As amended, former subsection I (re-lettered subsection J) applies only to changes of a "presiding" ALJ "for cause." Deletes the limitation of only one change ("for cause") of ALJ per party. Deletes the words "Within thirty days after the date of notice of hearing" and adopts the time frames provided in new subsection I. Requires the Chief ALJ to immediately transfer a matter to another ALJ upon receipt of an affidavit for change of ALJ for cause. Permits an interested party's authorized agent to file an affidavit for change of ALJ for cause.

Amends former subsection J (re-lettered subsection K) to identify permissible grounds for changing an ALJ "for cause" under re-lettered subsection J.
Adds new subsection L to clarify that, for purposes of new subsection I and re-lettered subsection J, the employer and employer's insurance carrier will be considered as a single party unless their interests are in conflict.

Amends former subsection K(2) (re-lettered subsection M(2)) by deleting the words "surplus property division."

Amends throughout for non-substantive stylistic changes.

Re-letters subsections throughout to conform section.

23-941.02 (effective August 6, 2016)
Adds new section titled "Vexatious litigants; designation; definitions." Permits the Chief ALJ or an ALJ designated by the Chief ALJ to designate a pro se litigant as a "vexatious litigant." Sets forth the procedure and timeline for a party to request a "vexatious litigant" designation. Provides that the "vexatious litigant" designation applies only to the claim at issue and states that the pro se litigant may not file a new request for hearing, pleading, motion or other document without leave of the ALJ. Provides examples of vexatious conduct.

23-954 (effective August 6, 2016)
Adds new section titled "Payment of interest on awards." Requires interest payments on: (1) awards entered by the Commission or by Notice of Claim Status awarding permanent partial disability or permanent total disability benefits pursuant to § 23-1044(B) or (C) and § 1045 (B) or (C), if benefits are not paid within ten days after the date the award or notice becomes final; and (2) claims for dependent benefits, if the claim is denied and subsequently accepted or found compensable by award of the Commission, from the date the claim for benefits was filed. Provides that interest on benefits be paid at the annual rate of 1% plus the prime rate (as published in Statistical Release H.15), not to exceed 10%.

23-1044 (effective August 6, 2016)
Amends subsection A to delete "and fifty per cent of retirement and pension benefits received from the insured or self-insured employer during the period of temporary partial disability" from what may be "considered wages able to be earned" during the period of temporary partial disability.

Amends throughout for non-substantive stylistic changes.

23-1062 (effective August 6, 2016)
Amends the section title to include "translation services"

Adds new subsection B, which provides that "medical, surgical, and hospital benefits" include translation services, if needed. Authorizes a carrier, self-insurance pool or employer that does not direct care to choose the translator if the translator is certified by an outside agency and not employed by the carrier, self-insured pool or employer. Provides that the par- ties may agree on a non-certified translator where a certified translator cannot be located.

Amends former subsection B (re-lettered subsection (C)) for non-substantive stylistic changes.

Re-letters subsections throughout to conform section.

23-1070.01 (effective August 6, 2016)
Amends subsection A (2) by adding the words "Notice or," and "or J" to reflect the amendments made to § 23-941.

Amends throughout for non-substantive stylistic changes.

2017

23-722.04 (effective August 9, 2017)
Amends subsection A to include the Industrial Commission of Arizona, Department of Insurance, and Attorney General as entities permitted to receive unemployment insurance information from the Department of Economic Opportunity for use in the prevention, investigation, and prosecution of workers' compensation fraud.

Amends throughout for non-substantive stylistic changes.

23-901 (effective August 9, 2017)
Amends definition of "occupational disease" in subsection 13(c) to include heart-related, perivascular, and pulmonary cases involving firefighters under new section A.R.S. § 23-1043.05.

Amends throughout for non-substantive stylistic changes.

23-901.01 (effective August 9, 2017)
Amends subsection B. Moves part of former subsection (B) to new subsection (B)(1). Adds new subsection (B)(2) which creates a presumption of an "occupational disease" (as defined in A.R.S. § 23-901(13)(c)) arising out of employment for firefighters who contract a disease, infirmity, or impairment caused by buccal cavity and pharynx, esophagus, large intestine, lung, kidney, prostrate, skin, stomach, or testicular cancer or non-Hodgkin's lymphoma, multiple myeloma, or malignant melanoma that result in disability or death.

Amends part of former subsection B (re-lettered subsection C). As amended, re-lettered subsection C outlines the three existing criteria for applying the subsection B presumptions and adds a new forth criteria for applying the new subsection (B)(2) presumption. To apply the new subsection (B)(2) presumption, a firefighter must (in addition to the other three crite- ria) receive a physical examination that is reasonably aligned with the National Fire Protection Association Standard on Comprehensive Occupational Medical Program for Fire Departments (NFPA 1582).

Amends former subsection C (re-lettered subsection D). As amended, re-lettered subsection D provides that the subsection B presumptions apply to former firefighters or peace officers who are: (1) sixty-five years of age or younger and (2) diagnosed with a cancer that is listed in subsection B not more than fifteen years after the firefighter's or peace officer's last date of employment as a firefighter or peace officer.

Amends former subsection D (re-lettered subsection E). Deletes language that strictly prohibited application of the subsection B presumptions to respirato- ry tract cancers if a firefighter or peace officer had "smoked tobacco products." As amended, re-lettered subsection E increases the evidentiary showing required to preclude application of the subsection B presumptions for cancers of the respiratory tract. To preclude application of the subsection B presumptions for cancers of the respiratory tract, evidence must exist to show that the firefighter's or peace officer's exposure to cigarettes or tobacco products outside of the scope of the firefighter's or peace officer's official duties is a substantial contributing cause in the development of the cancer.

Adds new subsection F to make clear that the subsection B presumptions may be rebutted by a preponderance of the evidence that there is a specific cause of the cancer other than an occupational exposure to a carcinogen as defined by the International Agency for Research on Cancer.

Amends throughout for non-substantive stylistic changes.

Re-letters subsections throughout to conform section.

23-941.01 (effective October 31, 2017)
Repeals former section titled "Final settlement agreements; definition."

Adds new section titled "Settlement of accepted claims; exception; definitions."

- Subsection A permits interested parties to a workers' compensation claim to: (1) settle and release all or any part of an accepted claim for compensation, benefits, penalties, or interest; or (2) negotiate a full and final settlement in claims where the period of disability has been terminated.

- Subsection B states requirements for a full and final settlement.

- Subsection C requires a claimant who is represented by counsel to include certain attestations in a full and final settlement.

- Subsection D requires the Administrative Law

Judge Division of the Industrial Commission to perform the following functions before approving a full and final settlement involving an unrepresented claimant: (1) hold a hearing with the unrepresented claimant; (2) make specific factual findings regarding that the requirements in subsection B and C(2)-C(5); and (3) make a finding that the settlement is fair and reasonable to the claimant.

- Subsection E states that approval of a full and final settlements by the Industrial Commission is required and directs the Industrial Commission to consider whether a full and final settlement is "in the best interest of the employee" before approving a full and final settlement.

- Subsection F requires that lump sum settlement payments be made within 15 days after the award approving the settlement becomes final.

- Subsection G requires a carrier, Special Fund, or a self-insured employer to notify attending physicians of the approval of a full and final settlement if the settlement terminates the employee's entitlement to medical benefits. Subsection G also clarifies that a carrier, Special Fund, or a self-insured employer remain responsible for payment of medical benefits rendered before approval of a full and final settlement unless the medical benefits are subject to a dispute or were included in the settlement.

- Subsection H prohibits full and final settlements in cases that have resulted in "total and permanent disability" under A.R.S. § 23-1045(C) & (D).

- Subsection I prohibits full and final settlement of claims unrelated to the applicable claim for compensation, benefits, penalties, and interest.

- Subsection J precludes settlement under the section for claims that have been denied.

- Subsection K defines "full and final settlement" and "Special Fund."

23-1043.05 (effective August 9, 2017)
Adds new section titled "Heart-related, perivascular and pulmonary cases; firefighters; definition."

- Subsection A provides that a heart-related, perivascular, or pulmonary injury, illness or death of a firefighter is presumed a compensable "occupational disease" (as defined in A.R.S § 23-901(13)(c)) if the firefighter: (1) passed a physical examination before employment, which did not indicate evidence of a heart-related, perivascular, or pulmonary injury or illness; (2) received a physical examination reasonably aligned with the National Fire Protection Association Standard on Comprehensive Occupational Medical Program for Fire Departments (NFPA 1582); and (3) was exposed to a known event and the injury, illness, or death occurred within 24 hours after the exposure and was reasonably related to the exposure.

- Subsection B states that the subsection A presumption may be rebutted by a preponderance of the evidence that the cause of the injury, illness, or death was other than the employment.

- Subsection C precludes application of the subsection A presumption if evidence exists to show that the firefighter's exposure to cigarettes or tobacco products outside of the scope of the firefighter's official duties is a substantial contributing cause in the development of the injury, illness, or death.

- Subsection D defines "firefighter."

23-1062 (effective August 9, 2017)
Adds new subsection C. Adds reimbursement for reasonable travel expenses to compensation for medical, surgical, and hospital benefits if a claimant must travel more than 25 miles from the claimant's place of residence.

Amends subsection A for non-substantive stylistic changes.

Re-letters subsections throughout to conform section.

23-1604 (effective August 9, 2017)
Adds new section titled "Franchisor and franchisee; owner or a mark and licensee; employment relationship, definitions." States that, for purposes of Title 23: (1) a franchisor is not an employer or co-employer of a franchisee or employee of a franchisee unless the franchisor agrees in writing to assume the role of employer or co-employer; and (2) a trademark owner is not an employer or co-employer of a licensee or employee of a licensee unless the mark owner agrees in writing to assume the role of employer or co-employer.

2018

23-901 (amendments apply to workers' compensation policies issued or renewed on or after July 1, 2019)
Amends the definition of "employee," "workman," "worker," and "operative" to include:

- A working member of a limited liability company who owns less than fifty percent of the membership interest in the company.
- A working member of a limited liability company who owns fifty percent or more of the membership interest in the company *if* the company's workers' compensation insurance carrier has issued an endorsement covering the working member.
- A working shareholder of a corporation who owns less than fifty percent of the beneficial interest in the corporation.
- A working shareholder of a corporation who owns fifty percent or more of the beneficial interest in the corporation *if* the corporation's workers' compensation insurance carrier has issued an endorsement covering the working shareholder.

As amended, subsections (6)(r) and (6)(t) set forth the basis for computing wages for premium payments and compensation benefits for working members of limited liability companies and working shareholders of corporations who elect to secure workers' compensation insurance coverage.
Amends throughout for non-substantive stylistic changes.

23-908 (effective August 3, 2018)
Amends subsection B to authorize the Industrial Commission to include reimbursement guidelines in the Arizona Physician's and Pharmaceutical Fee Schedule related to medications dispensed in settings that are not accessible to the general public, including physician-dispensed medications.
Amends throughout for non-substantive stylistic changes.

23-941.01 (effective August 3, 2018)

Amends subsection (A)(2) to permit negotiation of a full and final settlement of an accepted claim *if* the period of temporary disability has been terminated by a final notice of claim status, an award of the Industrial Commission, or a stipulation of the interested parties.
Amends subsection B to clarify the requirements for a full and final settlement, including the requirement that parties attach certain information when submitting a full and final settlement for review by the Industrial Commission.
Amends subsection C to clarify the "signed attestations" that must be included in *all* full and final settlements. As amended, subsection (C)(2) requires an attestation that the carrier, Special Fund, or self-insured employer has disclosed the amount of the settlement that represents the settlement of future medical, surgical, and hospital benefits. As amended, new subsection (C)(3) requires an attestation that the carrier, Special Fund, or self-insured employer has disclosed the total amount of the future indemnity benefit, the employee's rated age, if applicable, the employee's life expectancy, the source of the employee's life expectancy, the present value of future indemnity benefits, the discount rate used to calculate present value, and the amount of the settlement that represents the settlement of future indemnity benefits. As amended, former subsection (C)(5) (re-lettered subsection (C)(6)) requires an attestation that the parties have conducted a search for and taken reasonable steps to satisfy unpaid medical charges. As amended, new subsection (C)(7) requires an attestation that coercion, duress, fraud, misrepresentation, and undisclosed additional agreements were not used to achieve the full and final settlement.
Adds new subsection D, which directs an administrative law judge of the Industrial Commission to approve a full and final settlement where the requirements of subsection B are satisfied, the attestations of subsection C are present, and the employee is represented by counsel.
Amends former subsection D (re-lettered subsection E) to eliminate the requirement that the Industrial Commission evaluate full and final settlements involving unrepresented employees using a "fair and reasonable" standard. As amended, former subsection D (re-lettered subsection E) requires administrative law judges of the Industrial Commission to make specific factual findings regarding whether the requirements of subsections B and C are satisfied when an employee is unrepresented. As amended, former subsection D (re-lettered subsection E) requires that the administrative law judge conduct a hearing and perform a detailed inquiry into the attestations provided by an unrepresented employee pursuant to subsection C and provides instructions regarding the scope of the hearing.
Removes former subsection E to eliminate the

requirement that the Industrial Commission evaluate full and final settlements using a "best interests of the employee" standard.
Adds new subsection F, which prohibits the Commission from approving a full and final settlement if the requirements of subsections B and C are not satisfied.
Amends throughout for non-substantive stylistic changes.
Re-letters subsections throughout to conform section.

23-941.03 (effective August 3, 2018)
Reinstates former section 23-941.01 titled "Final settlement agreements; definition" regarding final settlements involving undisputed entitlement to supportive medical maintenance benefits. Clarifies that the section does not prohibit settlements that do not constitute "final settlements," as defined in the section.
Amends former section 23-941.01 for non-substantive stylistic changes.

23-1062.02 (effective August 3, 2018)
Adds new subsection A that requires physicians who prescribe schedule II controlled substances to an employee to comply with Title 32, Chapter 32, Article 4, which establishes requirements, restrictions, and exceptions related to the prescribing of controlled substances.
Amends former subsection A (re-lettered subsection B) to clarify content that must be included in reports required under A.A.C. R20-5-112 (Physician's Initial Report of Injury) and R20-5-113 (Physician's Duty to Provide Signed Reports) related to the use of narcotic or opium-based controlled substances listed in schedule II or the prescription of any opioid medication.
Amends former subsection C (re-lettered subsection D) to eliminate the requirement that a physician submit an inquiry to the Arizona state board of pharmacy within two business days of writing or dispensing an initial prescription order of at least a thirty-day supply of an opioid medication for an employee. As amended, former subsection C (re-lettered subsection D) now requires that a physician, before prescribing an opioid analgesic or benzodiazepine controlled substance listed in schedule II, III, or IV, and at least quarterly while the prescription remains a part of treatment, obtain a patient utilization report regarding the employee from the controlled substances prescription monitoring program's central database tracking system as required by A.R.S. § 36-2606. As amended, former subsection C (re-lettered subsection D) also permits a carrier, self-insured employer, or the Industrial Commission to request that a physician obtain a patient utilization report regarding an employee not more than once every two months.
Amends former subsection D (re-lettered subsection E) to replace the "result of an inquiry to the Arizona state board of pharmacy" with the "patient utilization report from the controlled substances prescription monitoring program's central database tracking system."
Amends former subsection (E)(2) (re-lettered subsection (F)(2)) to eliminate the requirement that an employee who has been ordered to change physicians due to non-compliance must select a new physician "whose practice includes pain management."
Amends former subsection G (re-lettered subsection H) to provided that a carrier, self-insured employer, and the Industrial Commission are not responsible for providing medications subject to the section if an employee resides out of state and the out-of-state physician fails to comply with the section.
Deletes former subsection H, which stated that the section did not apply to medications administered to the employee while the employee is receiving inpatient hospital treatment.
Amends subsection I to clarify that a carrier or self-insured employer is not liable for bad faith or unfair claims processing for any act reasonably necessary to monitor or assess the appropriateness and effectiveness of an employee's opioid use.
Amends the definitions in subsection J, including the definition of "clinically meaningful improvement in function." Deletes the definition of "off-label use." Adds new definitions for "substance use risk assessment" and "traumatic injury."

2019

23-966 (effective August 27, 2019)

Amends subsection C to designate the Special Fund as the successor in interest to all excess insurance policies in effect at the time of an assignment under § 23-966(A) that insure any part of the self-insured employer's financial obligations under Arizona's workers' compensation laws. Provides that the Special Fund has direct recovery rights against excess insurers for all covered amounts spent under § 23-966, subject to applicable coverage terms and policy limits.

2020

No changes in 2020.

2021

23-901 (effective September 29, 2021)
Amends definition of "personal injury by accident arising out of and in the course of employment" to include an occupational disease under new section 23-901.09.
Adds new definition or "serve" or "service," which includes mailing to a last-known address or transmitting by other means, including electronically, with written consent of the receiving party.
Amends throughout for non-substantive stylistic changes.

23-901.01 (effective September 29, 2021)
Amends subsections B through G to apply only to "peace officers;" removes all references to firefighters and all language applicable to firefighters.
Amends subsection C, which states the criteria for applying the subsection B presumption and deletes the following requirement: "The peace officer was exposed to a known carcinogen as defined by the international agency for research on cancer and informed the department of this exposure, and the carcinogen is reasonably-related to the cancer."
Amends subsection D to make the subsection B presumption applicable to peace officers currently in service.
Amends subsection F to require "clear and convincing evidence," rather than "a preponderance of the evidence" to rebut a presumption established under subsection B.

23-901.09 (effective September 29, 2021)
Adds new section titled "Presumption; cancers; firefighters and fire investigators; applicability; definition."

- Subsection A(1) establishes a presumption of an occupational disease deemed to arise out of employment for any disease, infirmity or impairment of a firefighter's or fire investigator's health that is caused by brain, bladder, rectal or colon cancer, lymphoma, leukemia or adenocarcinoma or mesothelioma of the respiratory tract and that results in disability or death.
- Subsection A(2) establishes a presumption of an occupational disease deemed to arise out of employment for any disease, infirmity or impairment of a firefighter's or fire investigator's health that is caused by buccal cavity, pharynx, esophagus, large intestine, lung, kidney, prostate, skin, stomach, ovarian, breast or testicular cancer or non-Hodgkin's lymphoma, multiple myeloma or malignant melanoma and that results in disability or death.
- Subsection B states the criteria that must be satisfied to be granted a presumption in Subsection A(1) or (A)(2), including: (1) the firefighter or fire investigator must have passed a physical examination before employment that did not indicate evidence of cancer; (2) the firefighter or fire investigator was assigned to hazardous duty for at least five years; and (3) (only for the presumption under (A)(2) and only for firefighters), the firefighter must have received a physical examination that is reasonably aligned with the national fire protection association standard on comprehensive occupational medical program for fire departments (NFPA 1582).
- Subsection C provides that the presumptions in Subsection A apply to firefighters or fire investigators currently in service and former firefighters and fire investigators who are sixty-five years of age or younger and who are diagnosed with a cancer listed in Subsection A not more than 15 years after the last date of employment as a firefighter or fire investigator.
- Subsection D provides that the presumptions in Subsection A do not apply to cancers of the respiratory tract if there is evidence that exposure to cigarettes of tobacco products outside the scope of official duties is a "substantial contributing cause" of the cancer.
- Subsection E provides that the Subsection A presumptions may be rebutted by "clear and convincing evidence that there is a specific cause of the cancer other than an occupational exposure to a carcinogen as defined by the International Agency for Research on Cancer."
- Subsection F defines "firefighter" and "fire investigator."

23-908 (effective April 9, 2021)
Amends subsection B to clarify that the definition of "settings that are not accessible to the general public" do not include mail order pharmacies delivering pharmaceutical services to workers' compensation claimants, if both of the following apply: (1) the pharmacy does not limit or restrict access to claimants with an affiliation to a medical

provider or other entity; and (2) any medical provider or other entity referring a claimant to the pharmacy does not receive or accept any rebate, refund, commission, preference or other consideration as compensation for the referral.
Adds new subsection J to state that the Commission's Fee Schedule does not prohibit: (1) a healthcare provider or pharmacy from entering into a separate contract or network that governs fees, in which case reimbursement shall be made according to the applicable contracted charge or negotiated rate; or (2) an employer from directing medical, surgical or hospital care pursuant to the provisions of section 23-1070.
Amends throughout for non-substantive stylistic changes.

23-941 (effective September 29, 2021)
Amends subsection D to require that a notice of hearing be "served" on all parties in interest, as the term is defined in 23-901.
Amends throughout for non-substantive stylistic changes.

23-942 (effective September 29, 2021)
Amends subsections C and D to require "service" of an award, as the term is defined in 23-901.
Amends throughout for non-substantive stylistic changes.

23-943 (effective September 29, 2021)
Amends subsections B, D, G and H to require "service" of a request for review, notice of review, decision on review, as the term is defined in 23-901.
Amends throughout for non-substantive stylistic changes.

23-971 (effective September 29, 2021)
Adds new section titled "Firefighter and fire investigator cancer claim information; data sharing; definitions."

- Subsection A requires all insurance carriers and self-insured employers who cover firefighters and fire investigators to "compile and report to the Commission claim and claim reserve information for all cancer-related claims filed by or on behalf of firefighters and fire investigators."
- Subsection B identifies the specific information that must be reported under Subsection A, including: (1) type of cancer; (2) total claim costs; (3) claim reserves; and (4) other information requested by the Commission.
- Subsection C prohibits the Commission from obtaining personally-identifiable information.
- Subsection D requires the Commission to compile and publish the claim-related information to assist with rate setting and reserving.
- Subsection E defines "firefighter" and "fire investigator."

23-1026 (effective May 5, 2021)
Amends subsection B to provide that a medical examination requested by the commission, an employer, or an insurance carrier may be conducted via telehealth with the consent of both the employee and the requesting party.
Amends throughout for non-substantive stylistic changes.

23-1047 (effective September 29, 2021)
Amends subsection C to require "service" of an ALJ determination on compensation for permanent partial disability, as the term is defined in 23-901.
Amends throughout for non-substantive stylistic changes.

23-1061 (effective September 29, 2021)
Amends subsection F to require "service" of a denial of a claim, any change in the amount of compensation, or the termination of a claim, as the term is defined in 23-901.
Amends throughout for non-substantive stylistic changes.

23-1701 (effective Sept. 29, 2021, retroactive to June 30, 2021)
Adds new section titled "Definitions;" defines terms pertaining to the Municipal Firefighter Cancer Reimbursement Fund.

23-1702 (effective Sept. 29, 2021, retroactive to June 30, 2021)
Adds new section titled "Municipal firefighter cancer reimbursement fund; exemption, rulemaking; annual report;" establishes the Municipal Firefighter Cancer Reimbursement Fund and how the Fund will operate.

23-1703 (effective Sept. 29, 2021, retroactive to June 30, 2021)
Adds new section titled "Assessment;" outlines the procedure for the Commission to conduct annual assessments related to the Municipal Firefighter Cancer Reimbursement Fund.

2022

23-908 (effective March 24, 2022)
Amends subsection C to prescribe specific procedural steps associated with adoption of annual updates to the Physicians' and Pharmaceutical Fee Schedule.
Amends subsection J for non-substantive stylistic changes.

23-908 (effective September 24, 2022)
Amends subsection A to narrow the scope of workplace injuries that must be reported to the Commission by an employer or treating physician. As amended, only workplace injuries that require "medical treatment," as defined in subsection A, must be reported.

23-963.01 (effective September 24, 2022)
Adds new subsection E to require application of experience rating adjustments to reduce the impact of medical-only claims on an employer's experience modification calculation.
Amends throughout for non-substantive stylistic changes.

23-1061 (effective September 24, 2022)
Amends subsection H to clarify that an insurance carrier or self-insured employer is responsible for paying medical, hospital, and laboratory expenses if a claim is reopened and the expenses were incurred within the 15-dayperiod before the petition to reopen was filed.
Adds new subsection N and amends subsection A to require an insurance carrier or self-insured employer who receives written notification of an injury from a worker who intends to file a claim for workers' compensation to: (1) forward the written notification to the Commission within seven business days, and (2) inform the worker of the requirement to file a claim. Specifies that the one-year period within which to file a claim in subsection A is suspended from the date that a carrier or self-insured employer receives the written notice until the date the written notice is provided to the Commission. Directs the Commission, upon receipt of such written notice, to notify the employee of the responsibility to file a claim.
Amends throughout for non-substantive stylistic changes.

23-1702 (effective September 24, 2022)
Amends subsection C to clarify that the annual distribution from the Municipal Firefighter Cancer Reimbursement Fund may not exceed the statewide aggregate of all compensation and benefits paid by Municipal Payers to municipal firefighters and fire investigators pursuant to A.R.S. § 23-901.09 for the relevant fiscal year.
Amends subsection C to clarify that undistributed monies in the Municipal Firefighter Cancer Reimbursement Fund at the end of a fiscal year will remain in the Fund for distribution in future years.
Amends subsection F to clarify that the commission does not "approve" reimbursement claims.
Amends subsection E for non-substantive stylistic changes.

23-1703 (effective September 24, 2022)
Amends subsection A to direct the Commission to collect $15,000,000 each fiscal year from cities and towns.
Amends subsection B to resolve an internal inconsistency between subsections B and C regarding withholding of shared revenues.
Amends throughout for non-substantive stylistic changes.

2023

23-1066
Amends to clarify that a Guardian Ad-Litem represents the best interest of a minor or incapacitated person, and eliminates “trustee” from the statute.
Amends to make clear that all references to a Guardian are in fact references to a Guardian Ad Litem.
Amends throughout for non-substantive stylistic changes.

23-934
Adds a new section directing the Commission to establish a fraud unit for the purpose of investigating fraudulent activities, statements or representations made in connection with workers' compensation claims.

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