Arkansas Workers' Compensation Commission (AWCC) Treatment Parameters & Medical Management Training Guide

For medical case management, bill review, and utilization management teams
(Updated December 22, 2025)

Important scope note: Arkansas does not generally publish a single, comprehensive set of diagnosis-based medical treatment guidelines (like some states' MTGs). Instead, the key "treatment parameters" used in Arkansas workers' compensation come from statutes and AWCC rules governing medical necessity, cost containment, utilization review, preauthorization, managed care, and the drug formulary/opioid controls.

Learning objectives

- Identify the primary Arkansas authorities that govern medical treatment in workers' compensation claims.
- Apply the "reasonable and necessary" standard to common treatment requests and disputes.
- Understand how AWCC Rule 30 drives cost containment, preauthorization, and utilization review expectations.
- Apply AWCC Rule 41 drug formulary and opioid limits (MED, day-supply thresholds, prior authorization triggers).
- Use practical documentation checklists to support approvals, denials, reconsiderations, and Commission review.

1) Key authorities you must know

These are the most frequently referenced sources when evaluating treatment appropriateness, payment responsibility, and disputes:

Authority	What it governs	Why it matters in day-to-day work
Ark. Code Ann. § 11-9-508	Employer's duty to provide	This is the baseline medical

	reasonably necessary medical services and supplies for compensable injuries.	necessity standard used in most treatment disputes.
Ark. Code Ann. § 11-9-517	Commission authority to establish rules and fee schedules to control medical costs.	Foundation for Rule 30 (Medical Cost Containment) and related rules.
AWCC Rule 099.30 (Rule 30)	Medical Cost Containment Program: fee schedules, utilization review, preauthorization processes, billing rules, and dispute pathways.	Defines operational rules for payment, UR, preauth thresholds, and how disputes move through MCCD review.
AWCC Rule 099.33 (Rule 33)	Managed Care rules (MCO/IMCS certification and operation) and network-driven treatment administration.	Impacts choice of physician, referrals, and network requirements when managed care applies.
AWCC Rule 099.41 (Rule 41)	Arkansas Workers' Compensation Drug Formulary and opioid prescribing/payment controls.	Controls outpatient prescriptions, formulary compliance, opioid day-supply limits, MED thresholds, and prior authorization.
AWCC Medical Fee Schedule	Maximum allowable fees for medical services (based on Medicare RBRVS and Arkansas conversion factors).	Used for repricing, payment accuracy, and determining if billed charges exceed allowable amounts.

2) The core standard: "Reasonably necessary" medical treatment

Arkansas law requires employers/carriers to provide medical services and supplies that are reasonably necessary in connection with a compensable injury. Whether a particular service is "reasonable and necessary" is commonly treated as a fact-driven determination by the Commission.

2.1 Practical interpretation for case management

- Tie every requested service to the compensable diagnosis/accepted body part(s) and mechanism of injury.
- Look for objective findings and functional impact, not just pain reports.
- Confirm the treatment plan is time-limited, goal-oriented, and includes measurable milestones (functional improvement, work capacity, ROM/strength, etc.).

- Watch for red flags: repeated passive modalities without improvement, treatment that continues beyond expected recovery without clear justification, or services unrelated to the work injury.

2.2 Documentation you should expect (minimum)

- Current diagnosis and ICD-10 code(s); accepted vs. disputed conditions.
- Clinical exam findings and any relevant imaging/testing results.
- Treatment history to date (what has/has not worked).
- Specific request (what service, how often, for how long).
- Medical rationale and expected functional outcomes; work status/RTW plan if applicable.

3) Rule 30: Medical cost containment, UR, and preauthorization

Rule 30 implements the Commission's medical cost containment program and sets expectations for billing, fee schedules, utilization review activity, and certain preauthorization requirements.

3.1 Preauthorization triggers (high-use operational items)

Rule 30 includes preauthorization procedures for non-emergency hospitalizations, transfers between facilities, and outpatient services expected to exceed a specified billed-charge threshold for a single date of service. In practice, you should ensure requests meet Rule 30 requirements before services occur (when non-emergent).

3.2 Utilization review: "medically accepted standards"

Rule 30 considers identification of utilization that is above the usual range and evaluation of appropriateness and quality of services based on medically accepted standards. For case managers, this is the primary reason for asking: "What evidence supports this intensity/duration/frequency?"

3.3 Disputes and administrative review pathway (at a glance)

When a provider and payor disagree on Rule 30/fee schedule application or disputed charges, Rule 30 provides an administrative review process through the Medical Cost Containment Division (MCCD), with further appeal options.

4) Rule 41: Drug Formulary and opioid parameters

For dates of injury on or after July 1, 2018, Rule 41 applies to all FDA-approved drugs prescribed and dispensed for outpatient use in Arkansas workers' compensation claims. It

adopts the Public Employee Claims Division (PECD) Workers' Compensation Drug Formulary maintained/updated by the UAMS College of Pharmacy Evidence Based Prescription Program.

4.1 Formulary compliance workflow

1. Confirm the date of injury (Rule 41 applies to DOIs on/after July 1, 2018).

2. Verify whether the prescribed medication is on the approved formulary.

3. If non-formulary: pharmacist must contact the payor for approval; any switch to a formulary alternative must be coordinated with the prescriber.

4. Compounded medications require preauthorization and certification that the patient cannot tolerate non-compounded alternatives.

4.2 Opioid limits and prior authorization triggers (Rule 41)

Operationally, Rule 41 sets tight controls on both day-supply and Morphine Equivalent Dose per day (MED) for opioid prescriptions, including prior authorization thresholds and documentation requirements for continuation beyond early phases.

- Initial opioid prescriptions: limited to a 5-day supply and must not exceed 50 MED/day without prior authorization.
- Subsequent opioid prescriptions: limited to a 90-day maximum supply and must not exceed 50 MED/day without prior authorization.
- With prior authorization: a subsequent prescription may exceed 50 MED/day but must not exceed 90 MED/day.
- Payors are not held financially responsible for opioids in excess of 50 MED/day or beyond 90 days without prior authorization (for DOIs on/after July 1, 2018).
- Before prescribing opioids or benzodiazepines, prescribers must check the PDMP (per Ark. Code § 20-7-604).
- Continuation beyond the initial 5 days requires documented follow-up evaluation and medical necessity, including evidence the medication is effective for pain control related to the work injury.
- Continuation beyond 90 days requires written certification of medical necessity including: documented improved function, a urine drug screening plan, a detailed weaning plan, documentation of conservative care focused on function/RTW, and why alternatives were ineffective/contraindicated.

4.3 Dispute resolution and expedited appeals (Rule 41)

Rule 41 includes a reconsideration process (using a Reconsideration Form to the reviewing pharmacist/PBM) and an appeal path to MCCD. MCCD determinations are issued quickly for

expedited disputes, and parties may appeal to an Administrative Law Judge for an expedited hearing.

5) Rule 33: Managed care considerations

When an employer/carrier is operating under a Commission-certified managed care arrangement, network rules can affect initial physician choice, referrals, and where services are obtained. Always confirm whether managed care applies to the claim before authorizing out-of-network care.

6) Practical checklists

6.1 Treatment request review checklist

- Accepted body part/condition? Diagnosis matches accepted injury?
- Objective findings support the request?
- Prior conservative care attempted when appropriate?
- Clear frequency/duration/total visits and measurable goals?
- Work status addressed and RTW plan considered?
- If preauthorization applies (Rule 30/Rule 41), was it obtained before service?
- If medication: formulary status checked; opioid limits and PDMP requirements satisfied?

6.2 Denial/reduction documentation checklist

- State the exact service being denied/reduced and the date(s) of service.
- Cite the governing rule/standard (e.g., Rule 30 preauth requirement; Rule 41 opioid/MED/day-supply; medical necessity under § 11-9-508).
- Explain the clinical rationale in plain language and what documentation is missing.
- Offer a path forward: what evidence would support reconsideration (updated exam, functional measures, imaging, prior treatment response, etc.).
- Track deadlines for reconsideration/administrative review to avoid procedural issues.

7) Common scenarios and how to handle them

7.1 Physical therapy that continues without objective improvement

Ask for updated functional measures and a progression plan. If progress is plateaued, consider a transition to home exercise, work conditioning/work hardening, or a focused re-evaluation.

7.2 MRI/advanced imaging requests

Confirm conservative care has been tried when appropriate and that exam findings justify imaging. Ensure the request is tied to accepted conditions and that any Rule 30 preauthorization triggers are addressed.

7.3 Opioid continuation beyond early post-injury period

Apply Rule 41. Ensure follow-up evaluation is documented, functional improvement is addressed, PDMP checks are completed, and that the MED/day and day-supply thresholds are met or supported by prior authorization.

References (primary sources)

1. Arkansas Code Annotated § 11-9-508 (Medical services and supplies; reasonably necessary medical treatment).

2. Arkansas Code Annotated § 11-9-517 (Medical services and supplies - rules; Commission authority).

3. Arkansas Workers' Compensation Commission Rule 099.30 (Medical Cost Containment Program) (Rule 30).

4. Arkansas Workers' Compensation Commission Rule 099.41 (Arkansas Workers' Compensation Drug Formulary) (Rule 41) (effective for DOIs on/after July 1, 2018).

5. Arkansas Department of Labor and Licensing, Workers' Compensation Commission: Rules, Advisories, and Medical Fee Schedules.