WORKERS COMPENSATION GUIDEBOOK

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MESSAGE FROM

THE COMMISSIONER

The Department of Workers Claims presents the Kentucky Workers Compensation Guidebook. It is intended to assist laypersons in understanding how the workers compensation program functions in the Commonwealth. Although this guidebook is comprehensive, accurate assessment of the rights of an injured worker in any particular case may require greater knowledge of the law than this book can convey.

This Guidebook is designed to answer many of the most frequently presented questions concerning rights and obligations under the Workers Compensation Act. Should the reader not find an answer to a question in this Guidebook, help is available through the Division of Ombudsman and Workers Compensation Specialists. To contact an ombudsman or workers compensation specialist, call **1-800-554-8601** toll free.

Additional information concerning the Kentucky workers compensation program, applicable regulations, and approved claim forms can be found at our Web site:

Dwc.state.ky.us

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PREFACE

Commonwealth of Kentucky

OFFICE OF THE GOVERNOR

Dear Fellow Kentuckians:

Some eighty years ago, the Kentucky workers compensation program was founded upon the simple promise that employees who were disabled by on-the-job accidents would receive wage replacement benefits and medical treatment to speed recovery and restoration to employment. Over ensuing decades a large and complex workers compensation system has evolved. This Guidebook explains in understandable terms important features of the workers compensation law and how the system functions.

Understanding the system will alleviate some of the apprehension of both employees and employers over workers compensation claims. Working in partnership, labor and management can achieve the common goals of minimizing the occurrence of workplace injuries, while assuring prompt delivery of appropriate benefits when accidents do occur.

Sincerely,

Paul E. Patton

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NOTE: This Guidebook contains only limited summaries of Kentucky's Workers Compensation Law. The entirely of the law is contained in Chapter 342 of the Kentucky Revised Statutes and in Chapter 25 of Title 803 of the Kentucky

Administrative Regulations. Information on receiving copies of the law can be received by calling 1-800-554-8601.

OVERVIEW OF KENTUCKY'S WORKERS COMPENSATION

Kentucky's Workers Compensation Act provides benefits to employees injured in job-related accidents and to those who contract or develop diseases due to workplace exposure. Benefits include money payments for lost income, the expense of medical treatment, and new job training. If an employee's death occurs as a result of the injury, a lump-sum payment of $50,000 (for injuries occurring after July 13, 2000) is made to the employee's estate from which burial expenses are to be paid. Income benefits are also extended to the surviving spouse and dependents. Historically, workers compensation has been described as a "trade-off" between labor and industry. In exchange for the protection that workers compensation grants, employees surrender the right to sue employers in civil court for damages arising from workplace injuries.

Legal Framework

The General Assembly establishes rights and duties regarding workers compensation through statutes found in Kentucky Revised Statutes, Chapter 342—the Workers Compensation Act. The law empowers the Commissioner of Workers Claims to adopt regulations that implement the law such as those that guide the adjudication of claims and the delivery of medical and rehabilitation benefits.

Informal resolution of controversies between workers and employers as to workers

compensation matters is encouraged. Disputes are assigned to an administrative law judge (ALJ) for adjudication proceedings. The ALJ will hold a benefit review conference to discuss settlement and a hearing when necessary. Following a hearing the ALJ will make a written decision setting forth the facts which have been found and conclusions of law. An ALJ's decision may be appealed to the Workers Compensation Board, the Kentucky Court of Appeals, and ultimately to the Kentucky Supreme Court. However, throughout the various levels of appeal the factual findings of the ALJ will not be overturned unless those findings are not supported by evidence of record.

Administration of the Workers Compensation Program

The Department of Workers Claims (DWC) in the Labor Cabinet administers Kentucky's workers compensation program. A commissioner appointed by the governor heads the DWC. Among DWC functions are the following:

- Provide information concerning benefits;
- Assist informal resolution of disputes;
- Maintain records of injuries and program costs;
- Process and adjudicate claims;
- Enforce laws requiring employer coverage;
- Regulate self-insured employers;
- Implement strategies to improve carrier performance;
- Render program assessment to policy makers.

WHO IS COVERED BY THE ACT

Most Kentucky employers are subject to the Workers Compensation Act and must carry workers compensation insurance or become self-

insured, even if they have only one part-time employee.

Exempted From the Act

Some employees are exempt from mandatory workers compensation coverage. Farm workers, persons employed as domestic servants in the home of an employer who has less than two full-time employees, persons employed by homeowners for residential maintenance and repair for up to twenty (20) consecutive work days, employees protected by federal laws (i.e., railroad and maritime workers), members of certain religious sects, and those who voluntarily execute a waiver of workers compensation protection are exempt from coverage under the Workers Compensation Act.

Business partners who are owners of a business are not required to obtain coverage on themselves. However, partners must file a copy of the partnership agreement with the DWC. True partners have an ownership interest in the business and a voice in its management. Absent evidence of ownership, workers will be treated as employees subject to coverage.

Whether a worker is an employee or an independent contractor is a frequently disputed issue in workers compensation claims. The general test to make the distinction is found in the following question: Does the worker have the right to control the details of the work? Generally, an employer directly controls an employee's work activity, while an independent contractor, as a skilled trades person, works on his/her own without direct supervision.

Rejection of Coverage

Employees may reject coverage under the Workers Compensation Act by signing and filing with the employer an Employee's Notice of Rejection of Workers Compensation Act, commonly known as a Form 4 Waiver. By rejecting the Act employees surrender benefits which may be due under the Workers Compensation Act, but retain the right to sue employers for work-related injury or disease in civil court. Unlike the workers compensation process, a suit in court requires proof of negligence or wrongdoing on the employer's part in order to obtain damages. The law prohibits employers from requiring employees to sign a Form 4 Waiver as a condition of employment. Only waivers signed freely by employees — that is, when they are under no pressure to do so — are to be upheld.

Word of Caution

Some unscrupulous employers have abused partnership, independent contractor, and waiver provisions of the law to avoid the expense of obtaining workers compensation insurance. On occasion it has been falsely represented to employees that a sickness and accident insurance policy offers coverage "as good as workers compensation." In truth, there is no alternative insurance product that grants employees benefits equal to those available under the Workers Compensation Act.

Remember: The best time to question whether an employer has workers compensation insurance is before an accident occurs. Although the Uninsured Employers Fund (UEF) has been

established to pay workers compensation benefits to employees of uninsured employers, payment of lost wages and medical expenses in these cases will be delayed.

In the meantime, the injured employee may be without income and may encounter difficulty in obtaining medical treatment because physicians are not promptly paid. To determine whether an employer is insured or to report uninsured employers, call the DWC at 1-800-554-8601.

Responsibility for Benefit Payments

Employers are responsible for payment of benefits due under the Workers Compensation Act. Usually, this liability is insured through workers compensation insurance. The law imposes penalties on employers who fail to obtain workers compensation coverage. Noncomplying businesses may be closed by court action and uninsured employers are subject to civil suits for workplace injuries. Citizens are urged to report uninsured employers to the DWC by calling 1-800-554-8601.

Employee Leasing Corporations and Temporary Help Services

Employee leasing corporations must register with the DWC and demonstrate that workers compensation coverage has been secured for job sites where leased employees work. Temporary help service companies are deemed the employers of temporary employees and must secure workers compensation insurance coverage. Information concerning employee leasing is available by calling (502) 564-0905, ext. 404.

EMPLOYEES' and EMPLOYERS' RIGHTS AND RESPONSIBILITIES

Employees' Rights

All workers have certain rights within the workers compensation system. These rights include:

- The employer must furnish workers compensation insurance coverage at no cost to the employee;
- Know the identity of the worker's compensation carrier and its claim representative;
- To report injuries and occupational illnesses to the employer which in turn must report to the insurance carrier;
- Not to be discriminated against because of injury or filing of a claim;
- To receive a courteous and reasonably prompt response from the carrier upon communication regarding a claim;
- Receive temporary income benefits while recuperating from the injury and unable to perform work;
- To receive all necessary medical treatment for the occupational injury or disease without making any copayment;
- To select a physician to treat a work related injury or illness without interference by the employer;
- Receive a card for presentation to medical providers identifying the worker, the designated physician, the employer and carrier;
- Change treating physicians one time, no questions asked;

- Be reimbursed for expenses incurred accessing compensable medical treatment, including travel expenses and out of pocket payment of prescription medications;
- Receive retraining if unable to return to suitable work;
- File a claim for permanent disability benefits within two years of the injury or the termination of temporary income benefits, whichever is later.

Employees' Responsibilities

Notify Supervisors of Injuries and Diseases. Employees must immediately (or "as soon as practicable") notify their supervisors of any injury. Notification should include information about the work occurrence and the body part affected. Most employers have a written policy for reporting injuries; compliance with that policy will facilitate the payment of benefits.

A claim may involve an occupational disease or gradual injury that is not readily viewed as being caused by work. In these circumstances as soon as an employee learns a condition may be work-related, notice should be given to the employer. Often employees acquire this knowledge from a physician who advises of the work connection.

Obtaining Medical Services. As soon as possible after the work-related injury occurs, the employee should obtain necessary medical services. The employee may choose the treating physician and can change that selection one time, no questions asked. If the employer has entered into an authorized managed care program, the

employee must choose from among the participating medical providers. Employees must notify the employer and insurance carrier of the physician choice. The employer or insurance carrier should deliver to the employee a physician designation and identification card once it is known that the employee requires continuing medical care.

Employees should ask treating physicians to promptly report their status to the employer and insurance carrier. Prompt reporting speeds payment of benefits and helps employers and physicians in assisting employees to return to work.

Maintaining Open Lines of Communication. In addition to promptly reporting injuries and medical status to employers, employees should keep lines of communication with the employer open.

Generally, the employer is interested in the well being of the employee and wants workers compensation benefits extended until the employee can return to work. Being secretive about workers compensation matters often builds mistrust.

Do's and Don'ts for Employees

DO report every injury to your supervisor as soon as possible after the injury occurs.

DON'T believe there are instant cures for aches and pains from injuries. Most injuries take time to heal. In the meantime, be as active as the physician recommends.

DON'T refuse suitable employment because you believe that taking a job will hurt your compensation claim. Your claim will be decided based on evidence of what you are capable of doing. Continued unemployment may be given little weight.

DON'T believe that workers compensation benefits are a substitute for a paycheck. Disability payments are always less than the worker's actual earnings and will not be raised in the future to account for inflation. Long periods of unemployment may reduce Social Security benefits and lead to loss of health care coverage.

DON'T believe that every on-the-job injury causes disability and entitles you to disability benefits. Temporary benefits are to be paid while an employee is recovering from an injury and unable to work. For injuries occurring prior to December 12, 1996, permanent benefits are generally available only to workers who have lost some of their ability to earn wages. For injuries occurring on or after December 12, 1996, permanent disability benefits are payable only when the injury has caused a permanent impairment under American Medical Association guidelines.

DON'T sign any document concerning workers compensation that you do not understand. Doing so may result in a loss of the benefits to which you are entitled under the Workers Compensation Act.

DO cooperate with your employer, physician, and insurance carrier representatives to speed physical recovery and the delivery of benefits.

DO carefully choose a reputable physician to treat your injury and follow that physician's advice.

DO call a DWC ombudsman or workers compensation specialist at 1-800-554-8601 if you believe you are being treated unfairly in a workers compensation matter.

Employers' Responsibilities

Nonexempt employers must obtain workers compensation insurance, post a notice showing insurance coverage, and report injuries to the insurance carrier. Employers should communicate with employees after injury and attempt to informally resolve conflicts with employees. Model employers have created programs to return employees to work as soon as possible after injury.

Obtaining Insurance and Premium Charges. Employers obtain workers compensation coverage either through purchase of a policy from an insurance carrier or by joining a self-insurance group.

What an employer pays as premium to secure workers compensation insurance is dependent upon the industrial job classifications of the employer, the amount of payroll, and the loss history of that employer. Good workplace safety practices, modified duty programs for injured employees, and a managed care program to deliver necessary medical services reduce workers compensation losses. A source of workers compensation insurance for all Commonwealth employers was assured through

the creation of Kentucky Employers Mutual Insurance Company (KEMI) in 1994.

KEMI is a competitive state fund, which insures employers previously in the Assigned Risk Plan and also writes policies in the so-called "voluntary market."

Self-insurance

Major employers may qualify to become individually self-insured by demonstrating financial soundness to the DWC. Self-insured employers pay their own workers compensation losses directly and do not carry primary insurance coverage.

Employers may join together and form associations known as self-insurance groups to insure member workers compensation liability. Self-insurance groups may offer a lower premium than that available from insurance carriers. To obtain coverage from a self-insurance group, an employer must be a group member and must agree to be liable for assessments that may be necessary to pay the group's workers compensation losses.

To maintain self-insurance certificates, self-insured groups and individually self-insured employers must be members of a guaranty fund. Guaranty funds will help meet obligations should a self-insured employer or self-insured group become insolvent.

Posting Notices. The law requires all employers to post a notice containing information regarding

workers compensation coverage. This information includes: the name of the workers compensation insurance carrier and the policy number, the means to obtain medical care for injuries, and an emphasis that notice of accidents must be given to supervisors. Insurance carriers must provide copies of the workers compensation notice to employers for posting at job sites where employees report for payroll and personnel matters.

Securing Building Permits. Before issuing building permits, local building officials must either obtain from the applicant proof of workers compensation coverage or a certification that the contractor is exempt from mandatory coverage.

Safeguarding and Communicating with Employees. Employers can also reduce losses by delivering workers compensation benefits quickly and facilitating the injured employee's return to work as soon as medically feasible.

Do's and Don'ts for Employers

DO report every injury to your carrier immediately and make sure the carrier reports the injury to the DWC. Failure to report injuries may result in penalties assessed against noncomplying employers and insurance carriers.

DO investigate each and every workplace accident but not for the purpose of casting blame. Enlist both supervisors and workers in the effort to prevent recurrent injuries.

DON'T treat injured workers as if they are "fakers," too lazy to work. Most employees are honest and want to return to work as soon as possible.

DON'T believe that your insurance carrier is going to solve your workers compensation cases alone. Establish direct lines of communication with injured workers. Encourage prompt payment of benefits when justly due.

DO keep in contact with an injured employee. Offer encouragement and a job within the employee's physical capabilities.

DO cooperate with your carrier in developing a safe workplace and a modified duty program for impaired workers. Involve line employees as well as supervisors in the design of these programs.

DON'T use workers compensation as a vehicle to rid your business of employees who are personnel problems.

DO make sure treating physicians and your carrier are familiar with job requirements and the return-to-work strategies you have implemented.

DO insist that your carrier have in place an arrangement for managed care to be provided by an organization certified by the DWC.

DON'T tolerate workers compensation fraud. Report all suspicious activities to your insurance carrier and to the DWC.

CARRIER RESPONSIBILITIES

All insurers, including self-insurance groups and individually self-insured employers, are considered to be carriers under the workers compensation law. All carriers have certain duties and responsibilities.

Notice of Coverage

Carriers are required to electronically file with the DWC on behalf of the employer evidence that an employer has obtained workers compensation insurance coverage. In addition, the carrier shall immediately notify the DWC of any cancellation, termination, or lapse in the coverage.

Once insurance coverage is obtained, the carrier must provide the employer with a notice to post at the principal personnel office of the employer. The notice shall set forth all pertinent workers compensation insurance information, including the name of the carrier, the policy number, a contact name and telephone number that can be accessed by injured employees, and other matters concerning employee rights.

Reporting Injuries

Carriers must report to the DWC any injury that causes an employee to miss more than one day of work. The report shall be filed electronically through an approved trading partner and must be made within one week of the carrier receiving notice of injury from the employer.

Carriers must also file supplemental reports covering payment of temporary disability benefits and settlements. If TTD extends for a period of 60 days, the carrier must submit a supplemental report. Within one week of TTD being terminated, changed, or resumed, the carrier must notify DWC.

Claims Management Practices

The claims management and settlement practices of carriers are closely monitored by the DWC. All carriers have certain duties and responsibilities once an injury has been reported. These include the duty to:

- Diligently investigate a claim for facts warranting acceptance or denial;
- Advise in writing an injured employee of acceptance or denial of the claim as soon as practicable or inform the employee of the need for additional information;
- Attempt in good faith to promptly pay a claim where liability is clear;
- Do not compel an injured worker to institute formal proceedings to recover benefits where liability is clear;

Promptly and appropriately respond to communication from an injured worker the correct amount;

- Maintain claim records which show the basis of claims management decisions.

Penalties

The Department of Workers Claims acts swiftly to investigate allegations that a carrier has committed an unfair claims settlement practice. If a violation is found, the Commissioner may issue penalties against the carriers ranging from $1000 to $5000 per offense.

Fraud

It is unlawful to knowingly make a misrepresentation of a material fact to obtain workers compensation benefits. Likewise, it is unlawful to misrepresent important facts to avoid responsibility under the law. Incidents of suspected fraud should be reported to a DWC ombudsman or specialist at 1-800-554-8601. Through its Insurance Fraud Unit, the Department of Insurance actively investigates and prosecutes workers compensation insurance fraud.

DEFINITION OF INJURY

The purpose of workers compensation is to provide benefits for workplace injuries and occupational diseases. Through the statutory definition of injury, the legislature describes what "injuries" are recognized as being compensable under the workers compensation law.

The definition of injury specifically includes cumulative trauma. Since 1996 the statute has emphasized that the work must be the proximate cause of an abnormality demonstrated by "objective medical findings." Current law also states that "the effects of the natural aging process" are not to be considered an injury. Occupational diseases remain covered by the workers compensation law. Generally, a physician's opinion is required to establish that an injury or disease that has occurred is causally connected to the work. Objective medical findings are the results of tests or are symptoms which the

physician observes that are not entirely dependent upon what the patient says.

Relationship between Work and Injury

An injury must be caused by the employee's work in order to be compensable. Common legal phrases used to describe this requirement are that the injury is “work-related” or that it “arises out of and in the course of employment”.

Employees are clearly entitled to benefits if injured while performing normal duties during regular working hours. Difficult questions of compensability arise if employees are injured in circumstances not typical of the normal working environment in terms of time, place, or performance of duties. Workers compensation is generally not allowed for injuries due to horseplay, intentional self-infliction, intoxication, or incurred while traveling to and from work.

Occupational Disease

An occupational disease is a condition caused by an exposure to a hazard in the workplace and usually develops over a lengthy period of time. The employer where the worker was last exposed to the hazards of the disease is responsible for payment of benefits.

The most common occupational disease in Kentucky is coal workers pneumoconiosis (black lung). This disease is caused by breathing coal dust. Black lung claims are subject to special statutory rules.

Intentional Violation of Safety Laws or Regulations

Although benefits are granted even if an employee's mistake or carelessness caused the accident, disability payments are reduced by 15% where the worker's intentional violation of a safety law or regulation caused the injury. Likewise, if the employer's intentional violation of a safety law or regulation caused an injury, a safety penalty is imposed against the employer. Effective July 14, 2000, the safety penalty imposed against employers was increased from 15% to 30% of disability payments.

BENEFITS for DISABILITY

The majority of workplace injuries do not result in the payment of income benefits as a substitute for lost wages. Most on-the-job accidents are classified as "no lost time." Injured employees usually obtain whatever medical treatment is required for minor injuries and promptly return to work. Income benefits are only paid during periods of "disability." In the context of both temporary total and permanent total benefits, this means only while the employee is unable to perform any suitable work, especially in regard to permanent disability benefits. Inability to return to the same work is not the determining factor.

Types of Disability

The law recognizes three types of disability—temporary total, permanent partial, and permanent

total, — and prescribes disability benefits (income payments) for each.

Temporary Total Disability. Temporary total disability (TTD) benefits are paid during the period in which the worker is recovering from an injury or disease and is unable to return to work. TTD is not payable unless the employee is unable to work for more than seven (7) days. If an employee's disability continues for more than seven (7) days due to a work-related injury, the employee is entitled to benefits for each additional day thereafter he or she is unable to work. If the employee exceeds two (2) weeks off, he or she is entitled to the payment of benefits for the first seven (7) days as well. Kentucky law makes no allowance for temporary partial disability benefits.

Usually, in instances of severe injury, TTD benefits are voluntarily paid by the carrier. Payment of TTD is customarily stopped when the employee recovers sufficiently to return to work or when a physician reports that the worker has reached maximum medical improvement, or is able to return to employment.

Permanent Partial Disability. Permanent partial disability is payable when "an employee...has a permanent disability rating but retains the ability to work." The term permanent refers to a physical disability expected to last into the future. However, use of the word "permanent" to describe the period of payment is misleading, as payment periods for partial disability are fixed, usually at 425 weeks.

Injuries occurring between 4/4/94 and 12/11/96. For injuries between April 4, 1994, and December 11, 1996, payment is limited to a period of 425 weeks for partial disability of 50% or less and 520 weeks for partial disability exceeding 50%. Prior to April 4, 1994, most permanent partial disability benefits were payable for a maximum of 425 weeks.

The amount of permanent partial disability, expressed as a percentage, is also limited for injuries occurring between April 4, 1994, and December 11, 1996. The percentage awarded is restricted to the degree of functional impairment assigned by physicians under the AMA guidelines if the injured worker returns to work at wages equal to or greater than those earned at the time of injury. If it is determined that the injured employee has a disability greater than the functional impairment, permanent partial disability benefits may be increased to a maximum of twice the AMA functional impairment. If an individual is not able to return to work or returns at a lower wage, the percentage of permanent partial disability is not limited to the functional impairment rating assigned by physicians.

Injuries occurring between 12/12/96 and 7/14/00. Injured employees who recover to the degree that they are able to return to work but retain a permanent impairment as determined by the AMA Guides to Evaluation of Permanent Impairment are entitled to permanent partial disability benefits. The duration of payments depends on the disability rating, 425 weeks for 50% or less and 520 weeks for greater than 50%.

Weekly benefits are determined by the amount of the AMA impairment rating multiplied by a factor established by law. The impairment ratings and multiplying factors for injuries occurring between December 12, 1996 and July 14, 2000 is listed in Table 1.

TABLE 1 - AMA IMPAIRMENT RATINGS and FACTORS

AMA Impairment Rating	Factor	AMA Impairment Rating	Factor
0-5%	0.75	21-25%	1.75
6-10%	1.00	26-30%	2.00
11-15%	1.25	31-35%	2.25
16-20%	1.50	36% and above	2.50

To illustrate how to read and use this table, consider the following example: An injured worker has an AMA functional impairment of 15% due to injury.

Using the figures in Table 1, this worker's disability rating is calculated as follows:
15% (AMA Impairment Rating) × 1.25 (Factor) = 18.75%

Since this worker's disability rating is less than 50%, the duration of payments will be 425 weeks.

Injuries occurring on or after July 15, 2000. The impairment ratings and factors for injuries occurring after July 14, 2000 are listed in Table 2.

TABLE 2 – AMA IMPAIRMENT RATINGS and FACTORS

AMA Impairment Rating	Factor
0-5%	0.65
6-10%	0.85
11-20%	1.00
21-25%	1.15
26-30%	1.35
31-35%	1.50
36% and above	1.70

To illustrate how to read and use this table, consider the following example: An injured worker has an AMA functional impairment of 10% due to a work injury.

Using the figures in Table 2, this worker's disability rating is calculated as follows: 10% x .85=8.50%.

Average Weekly Wage

The amount of disability benefits depends on the employee's average weekly wage (AWW) and on the extent of disability stated in a percentage. A number of special rules govern the determination of the average weekly wage (AWW) applicable to an injury. In most instances an employee's average weekly wage is calculated by using the highest calendar quarter of earnings during the year preceding the injury with the employer in whose service the injury occurred. Earnings for the highest quarter are divided by thirteen (13) and the result is the employee's average weekly wage. Overtime is included, but only at regular hourly wage rates.

Permanent Total Disability. Permanent total disability is payable when "an employee...has a complete and permanent inability to perform any type of work as a result of an injury."

Permanent total disability benefits are paid if the employee is so incapacitated by the injury that a job cannot be obtained and held on a regular and sustained basis in a competitive economy. These benefits are not awarded until after the worker has reached maximum medical improvement, which means the physical condition of the employee has stabilized and no significant improvement is anticipated in the foreseeable future. The fact that an employee has not returned to work after an injury does not require a finding of permanent total disability.

Except in cases where it is obvious that an employee has been severely injured, employers usually do not volunteer to pay permanent total disability benefits. It is often necessary to seek resolution of permanent total disability claims by an administrative law judge through filing of a workers compensation claim with the Department of Workers Claims. An award of permanent total disability benefits can be reopened to reduce the benefits if it is shown that the employee has recovered sufficiently to return to work.

AMOUNT of BENEFITS

Total Disability

Weekly benefits for total disability are two-thirds (2/3) of the AWW up to the maximum state average weekly wage (SAWW). For example, a

worker who had an average weekly wage of $350 would be paid $233.33 per week for total disability. The maximum allowable weekly benefit is $487.20 for injuries occurring in 1999 and $509.03 for injuries occurring in 2000. The ceiling upon total disability benefits comes into play only if the worker's AWW exceeds $730.80 per week for 1999 and $763.55 for 2000. Benefits are paid as long as total disability continues, subject to offset/termination as discussed later in this text.

Permanent Partial Disability

The maximum benefit for permanent partial disability is 75% of the SAWW—$365.40 for 1999 and $381.77 for 2000. There is no minimum benefit. Prior to December 12, 1996, the weekly benefit for permanent partial disability is two-thirds (2/3) of the employee's AWW (subject to a statutory maximum) multiplied by the extent of the occupational disability. For injuries occurring between December 12, 1996 and July 14, 2000, weekly benefits are determined by multiplying two-thirds (2/3) of the employee's AWW (subject to a statutory maximum) by the AMA impairment rating multiplied by the factor set forth in Table 1. If the employee does not retain the "physical capacity" to return to the type of work performed at the time of the injury, the weekly benefit is multiplied times 1.5. However, if the employee returns to work at the same or greater wages, then the weekly benefit is reduced by one-half (1/2).

For instance, consider an injured worker who has an AMA functional impairment rating of 15% due

to injury and has an average weekly wage of $350. (See Table 1.)

$350 × 66 2/3% = $233.33 $233.33 × 15% (AMA impairment rating) = $35.00

$35.00 × 1.25 (Factor) = $43.75 per week

If this worker does not retain the physical capacity to return to the type of work performed at the time of injury, weekly benefits will be: $43.75 × 1.5 = $65.63

If this worker returns to work at the same or greater wages, weekly benefits will be: $43.75 × 50% = $21.88

Injuries on or after July 15, 2000. If the employee does not retain the physical capacity to return to the type of work performed at the time of injury, the weekly benefit is multiplied by three (3).

If the employee returns to work at an equal to or greater wage and at some point there is a cessation of that employment, the weekly benefit will be multiplied by two (2) during the period of cessation of that employment.

Consider an injured worker with an AMA rating of 10% with the average wage of $350.00:
$350 x 66 2/3% = $233.33
$233.33 x 10% = $23.33
$23.33 x .85 = $19.83

If the worker does not retain the physical capacity to return to the type of work performed at

the time of injury, weekly benefits will be multiplied by three (3):

$19.83 x 3 = $59.49

Limited education and advancing age as of the time of injury will increase benefits for injuries on or after July 14, 2000.

If an employee has less than eight (8) years formal education, (0.4) will be added to the 3 multiplier. If the employee had less than twelve (12) years of education or a GED diploma, the multiplier is increased by two-tenths (0.2).

Depending on the age of the employee at the time of injury, the multiplied will be increased as follows:

TABLE 3 - AGE MULTIPLEX TABLE

AGE at INJURY	MULTIPLIER INCREASED BY:
49 or less	0
50 – 54	0.2
55 – 59	0.4
60 or older	0.6

Consider an injured worker with an AMA rating of 10% and an average weekly wage of $350.00. The worker does not retain the physical capacity to return to the type of work performed at the time of injury. The worker was 57 years old at the time of injury and had 11 years of formal education.

$350 x 66 2/3 = $233.33
$233.33 x 10% = $23.33
$23.33 x .85 = $19.83

The multiplier (3) will be increased by (0.4) for age and (0.2) for education.

$19.83 x 3.6 = $71.39

Black Lung Benefits
(Coal Workers Pneumoconiosis)

For Kentucky workers compensation purposes, the presence of black lung (also known as coal workers pneumoconiosis or CWP) is determined by interpretation of chest X-rays. The extent of benefits for black lung depends on the X-ray classification of the disease (Category 1, 2, or 3) and the amount of breathing impairment attributed to black lung. Respiratory impairment is determined by pulmonary function tests administered by a physician, specifically the forced vital capacity test (FVC) and the forced expiratory volume in one second measurement (FEV1).

For Last Exposure Prior to 12/12/96. A miner with Category 1 black lung who has no respiratory impairment is entitled to retraining incentive benefits (RIB). This one-time benefit is equal to 50% of the permanent partial disability rate payable over 208 weeks. RIB benefits are payable for working miners only as reimbursement of expenses incurred while attending an approved job-training program. Benefits are paid directly to miners who leave the mining industry through no fault of their own.

An individual who is found to have Category 1 black lung with spirometric tests values of 55%-79% of predicted normal values is declared 75%

occupationally disabled. It must be shown that the respiratory impairment is the result of exposure to coal dust. An individual found to have Category 1 black lung with breathing capacity of less than 55% of predicted normal values, Category 2 black lung, or Category 3 black lung is presumed to be totally disabled. In these circumstances, benefits are paid for permanent total disability.

For Last Exposure on and after 12/12/96. Working miners may file claims, but they may not receive benefits while working. Miners who have no pulmonary impairment are not eligible for benefits, except when progressive massive fibrosis is present.

Income benefits for black lung with last exposure on December 12, 1996, or later are paid equally by the employer and the State Coal Workers Pneumoconiosis Fund. Table 2 shows the relationship among the X-ray diagnosis, pulmonary function, percentage of disability, and the duration of payment of benefits.

Under current law, RIB (retraining incentive benefits) payments do not begin on the date of the employee's last coal mine exposure. Rather, payment begins when the employee enrolls and participates in an approved vocational training program on a full-time basis (24 instructional hours per week). RIB benefits will be paid at the rate of 66 2/3% of the employee's AWW, not to exceed 75% of SAWW, for up to 104 weeks. If the full RIB award has not been paid while the miner is in retraining, $3,000 in retraining incentive benefits is payable as a cash relocation allowance for movement greater than fifty (50) miles to obtain a job in the employee's area of new training.

In addition to weekly benefits, the employer must pay tuition and material costs (not to exceed $5,000) directly to the educational institution conducting the training program.

TABLE 4 - CWP: RELATIONSHIP AMONG X-RAY DIAGNOSIS, PULMONARY FUNCTION, PERCENTAGE OF DISABILITY, AND DURATION OF BENEFIT PAYMENTS

ILO Category (x-ray)	Pulmonary Function (FVC or FEV1)	Percent of Disability	Duration of Benefit Payments
Category 1, 2 or 3	80%-100%	0%	0 weeks
Category 1	55%-79%	RIB	104 weeks (maximum)
Category 1	Less than 55%	50%	425 weeks
Category 2	55%-79%	50%	425 weeks
Category 2	Less than 55%	75%	520 weeks
Category 3	55%-79%	75%	520 weeks
Category 3	Less than 55%	100%	Lifetime
Progressive massive fibrosis		100%	Lifetime

Vocational Rehabilitation

Employees may be entitled to vocational rehabilitation if the injury prevents return to work. Rehabilitation includes an evaluation to determine

the feasibility of retraining. Most efforts in rehabilitation are aimed at returning individuals to work performed in the past. Retraining will generally not exceed fifty-two (52) weeks but, in some cases, may be extended for additional periods.

Employees who actually enroll and participate in an appropriate training program may elect to accelerate the income benefits awarded and receive weekly during retraining up to 66 2/3% of their average weekly wage, not to exceed 100% of the SAWW. However, accelerated benefits cannot exceed the total of benefit payments originally awarded. When an employee completes retraining, accelerated benefits previously paid will be deducted on a dollar-for-dollar basis without any discount from the remaining weekly benefits. If an employee does not complete the training program, the sum total of the accelerated payments will be discounted and deducted from future payments on a dollar-for-dollar basis.

If an employee who has been awarded permanent total disability participates in a rehabilitation program under an ALJ's order, the weekly benefit is increased to 80% of the average weekly wage (subject to the state maximum) during retraining. Information on and assistance in obtaining rehabilitation benefits can be obtained by calling 1-800-554-8601.

Death Benefits

If an employee's death occurs within four (4) years of and as a result of a work-related injury, a lump-sum payment of $25,000 is paid to the employee's estate if the injury is prior to 7/14/2000

and $50,000 if on or after 7/14/2000. This amount includes burial expenses. The surviving spouse and certain dependents will also be entitled to income benefits. These benefits will terminate, however, when the deceased worker would have qualified for Social Security retirement benefits.

Settlement

Most claims for workers compensation benefits are resolved by a settlement between the employer and employee. Settlements must be approved by an ALJ. Settlements may include payment of a lump sum instead of weekly benefits. Usually this process involves discounting for the immediate value of future payments. Unless expressly stated, a settlement does not release the employer from the obligation to pay future medical expenses for treatment of the injury.

An ALJ will not approve agreements for lump-sum payments of future income benefits over $100 per week, unless "reasonable assurance" is shown that the employee will have an adequate source of income during disability.

Reduction of Benefits at Retirement

For injuries occurring between April 4, 1994, and December 11, 1996 (to workers younger than 65), income benefits are reduced when the employee reaches age 65. Payment is reduced by 10% each year beginning with age 65 and extending through age 70. At the end of this "tier-down" of benefits, the employee retains 40% of the original award.

Offsets

For injuries occurring after December 12, 1996, any unemployment insurance payments that the injured worker receives during the period of temporary total or permanent total disability will offset the workers compensation disability benefits. Offsets to workers compensation benefits will be made for an employer-funded disability or sickness and accident plan covering the same disability unless the plan has an internal offset provision to the contrary.

Termination of Benefits

For injuries occurring on or after December 12, 1996, benefits for permanent partial disabilities will terminate on the date on which the employee qualifies for normal old-age Social Security retirement benefits, or after two (2) years, whichever occurs last.

Similarly, all income benefits payable to spouses and dependents will terminate when they qualify for Social Security retirement benefits based upon the earnings of the diseased employee.

If an employee unreasonably refuses medical treatment, benefits may be terminated even if the employee remains disabled. Benefits may also be discontinued when an employee fails to appear for scheduled independent medical examinations or when the employee refuses to be questioned at depositions or hearings.

MEDICAL CARE

Kentucky employers are required to pay medical expenses that employees incur for treatment of work-related injuries. This includes the services of medical doctors, chiropractors, hospitals, and other licensed providers. Employers are liable only for reasonable and necessary services.

Designation of Physician

Employers or their insurance carriers must mail Form 113 to employees for designation of a treating physician within ten (10) days following notice of a work-related injury or disease which requires continuing medical care. Employees are to designate their physician on the card and return it within ten (10) days. After the employee returns the Form 113, the insurance carrier will mail to the employee a printed card indicating:

- The employee's name, Social Security number, and date of birth, and the date of the work injury or exposure;
- The name and telephone number of the designated physician;
- The name and telephone number of the medical payment obligor (insurance carrier);
- General information concerning Form 113 on the reverse side of the card.

Employees must present this card when they seek medical services.

Employees have the right to choose a treating physician who, depending on the nature of the injury, may be a physician, surgeon, psychologist,

optometrist, dentist, podiatrist, osteopath, or chiropractor. The employee's selected physician is to serve as a "gatekeeper" responsible for referring the employee to additional providers as necessary. Employees have the one-time right to change designation of their "gatekeeper" physician. Additional changes require permission from the employer or its insurance carrier or approval by an ALJ.

Co-Payments and Balance Billing

Employers are required to pay the cost of all reasonably necessary medical treatment. The Department of Workers Claims has adopted fee schedules which set forth the amount which physicians, hospitals, and pharmacists may charge. Requiring employees to make co-payments for treatment of work-related injuries or occupational diseases is unlawful. Likewise, medical providers may not engage in "balance billing" by charging employees separately for amounts in excess of those set forth in the medical fee schedules.

Reimbursement for Expenses

Employees are entitled to reimbursement for expenses incurred while accessing medical compensable medical treatment, including reasonable travel expenses and out of pocket payment of prescriptions and similar items. The employee must submit the request for reimbursement to the carrier or self-insured employer within sixty (60) days of incurring the expense. Employees may obtain the Form 114 from the insurance carrier or from the Department

of Workers Claims to claim out of pocket medical and travel expenses.

Medical Fee Payment

If medical provider charges are greater than the medical fee schedule permits, payment will be reduced to the allowable charges. Medical providers must submit statements for services to employers or their insurers within forty-five (45) days after treatment is initiated and every forty-five (45) days thereafter. If a final award or order has been issued granting the employee medical benefits, the employer must within thirty (30) days after presentment of the bill pay the bill or contest it through a motion to reopen.

Should an employer dispute medical bills prior to a final award or order, it must notify both the medical provider and the employee of the factual basis of the denial of payment (and perhaps all future bills) within thirty (30) days after receiving a complete statement for services. The denial should include a statement of the reasons for denial and summarize the utilization review and audit procedures which have been applied.

Utilization Review and Medical Bill Audit

Insurance carriers, individual self-insured employers, and group self-insured employers must have utilization review and medical bill audit programs in place, which have been approved by DWC. Utilization review is an evaluation of the medical necessity and appropriateness of treatment and services. Medical bill audit is an examination of medical bills to assure compliance

with the adopted fee schedules. No medical service dispute may be filed prior to timely completion of utilization review. However, the findings of utilization reviewer are not binding upon an administrative law judge. Utilization review for employers who have approved managed care programs is conducted by the managed care organization. Utilization review is required when:

- Medical bills exceed $3,000 during one (1) year;
- An employee misses thirty (30) days of work due to the injury;
- A medical provider requests pre-certification;
- A treatment plan is required.

Only licensed medical personnel may conduct utilization review, and the process must grant reconsideration of an initial denial. Utilization review generally does not address the issue of work-relatedness of the condition being treated.

Managed Care

Managed care has been authorized for the treatment of work-related injuries and diseases since April 4, 1994. Employees subject to managed care plans are required to choose "gatekeeper" physicians from the managed care plan network.

A managed care organization must demonstrate that it meets standards established by the DWC in order to be approved. Managed care programs must have sufficient specialty providers to treat common work-related conditions. If a plan physician recommends surgery, employees may obtain a second opinion from an outside physician at the expense of the employer.

Employees may also obtain medical services outside the plan when:

- Emergency care is not available through the plan;
- Referral is made by a plan physician;
- Necessary treatment is unavailable through the plan;
- Continued treatment by a non-network physician for injuries or illnesses incurred prior to the plan's implementation.

Medical Evaluations

To resolve workers compensation claims, the Commissioner or an ALJ may direct that an employee be evaluated by physicians at either the University of Louisville Medical School or the University of Kentucky Medical School. If an employee does not submit to the evaluation, the claim will be delayed and benefits may be denied.

At least one (1) week prior to a scheduled medical evaluation, the employer is required to send the employee travel expenses for attending the evaluation. Mileage is paid at the rate of thirty cents ($.30) per mile for the distance from the employee's home city to the medical evaluation site.

CLAIM RESOLUTION PROCEDURES

During the time that an employer or its insurance carrier voluntarily pays medical bills and income benefits for work-related injuries or occupational diseases, an employee rarely needs to file a workers compensation claim. However,

there are occasions when people disagree in good

faith. Before filing a claim, the parties to a workers compensation dispute should try to resolve the conflict. DWC encourages conflict resolution through voluntary mediation.

Lines of communication among the employee, employer, and insurance carrier should remain open at all times before and after an injury.

This will facilitate the resolution of any claim disagreements and will help assure prompt return to work.

Division of Ombudsman and Workers Compensation Specialists. Ombudsman and Workers Compensation Specialists assist citizens in workers compensation matters by answering questions and attempting to resolve conflicts. Although most requests for assistance are made by workers, DWC specialist and ombudsman services are equally available to employers, medical providers, and insurance carriers. The Division can be contacted at 1270 Louisville Rd., Perimeter Park West, Building C, Frankfort, KY 40601.

Voluntary Mediation Program. The DWC offers workers compensation mediation services to speed the resolution of claims and expedite the delivery of benefits to injured employees. Intervention by a neutral third party may result in quick, low-cost dispute resolution. Ombudsman and Workers Compensation Specialist services are provided at the request of a party to a dispute and are commenced after other parties agree to

take part in mediation. If a claim is already on file with the DWC, the request for mediation must be in writing. The mediator assigned to the dispute will attempt to achieve resolution through telephone conference calls.

Requests for mediation can be made by phone, fax, or in writing. Phone 1-800-554-8601, send a fax (502-564-9533), or write to: Division of Ombudsman and Workers Compensation Specialist Services, 1270 Louisville Rd., Perimeter Park West, Building C, Frankfort, KY 40601. If necessary, a face-to-face mediation conference may be scheduled at one of the DWC hearing sites.

The request for or participation in mediation services does not affect time limits established by applicable statute of limitations for filing of claims.

Time Limits for Filing Claims

A written claim for workers compensation benefits must be filed with the DWC within two (2) years of the date of injury or last voluntary payment of disability income benefits, whichever is later. Note that payment of medical expenses does not extend the time for filing a claim.

Occupational disease claims must be filed within three (3) years after diagnosis or after symptoms first appear which are sufficient to inform the employee of the disease, whichever is earlier. A claim may also be filed within three (3) years after death caused by an occupational disease. The maximum period to file most occupational disease claims is five (5) years after the employee was last exposed to the

occupational hazard responsible for causing the disease.

Special rules apply to human immunodeficiency virus (AIDS), asbestosis, and conditions caused by radiation exposure. AIDS claims must be filed within five (5) years after exposure to the virus. The time to file a claim involving an asbestos or radiation related disease is twenty (20) years after last exposure, but filing must occur within three (3) years of when a worker knows of the development of the disease.

Filing a Claim

To file a workers compensation claim, most employees secure the services of an attorney as the claims adjudication process and the workers compensation law is complex. Employees may choose to represent themselves but will be held to the same standards as attorneys who present workers compensation claims.

Attorneys. Attorney fees for employee representatives are on a contingency fee basis meaning that a recovery must be obtained before fees are payable to the attorney. For attorney/client employment contracts made on or after December 12, 1996, the maximum fee an injured worker's counsel can charge is 20% of an award, not exceeding, in all, $12,000. Only attorneys licensed to practice law in Kentucky may represent parties in workers claims proceedings.

Claim Application. A claim application recites basic information identifying the employee and describes the nature and cause of the work-related injury or disease. The applications must be filled

out completely, typewritten, notarized, and then filed with the DWC.

Application claim forms are of three types:
Form 101 - Application for Resolution of Injury Claim
Form 102 - Application for Resolution of Occupational Disease Claim
Form 103 - Application for Resolution of Hearing Loss Claim

Additional Forms. In addition to the appropriate application for resolution of claim, the employee must file the following completed forms:

Form 104 - Plaintiff's Employment History
Form 105 - Plaintiff's Chronological Medical History
Form 106 - Medical Waiver and Consent
Form 115 - Social Security Release Form
(Not required for Form 101 applications)
A medical report

The employee and witnesses (if applicable) must sign and date these forms. All of these forms are available by contacting DWC at 1-800-554-8601 or may be obtained from DWC's Web site:

http://dwc.state.ky.us/

Events after Claim is Properly Filed

A properly filed claim initiates a series of events:

1. Once the application has been filed with the DWC, the employee, employer, and insurance carrier will be notified that the claim has been

assigned to an ALJ and of time frame for presentation of proof.

2. Within forty-five (45) days of the date of this notice, employers/insurance carriers are required to file a Notice of Claim Denial or Acceptance stating specifically what parts of the claim are acknowledged and what are denied.

3. The parties have ninety (90) days after a claim is assigned to an ALJ to file medical reports and depositions in support of their positions. All parties can submit proof during the first 45 days, followed by 30 for the defendant and 15 for the rebuttal.

4. ALJs have sixty (60) days following a hearing to issue a decision addressing all issues.

5. Within fourteen (14) days of the ALJs written decision, a party may file a petition for reconsideration.

Appeals

Within thirty (30) days after the ALJ files a final decision, appeal may be taken to the Workers Compensation Board (WCB). No new evidence will be considered. Where the ALJ was presented with conflicting evidence, the decision will be upheld if any portion of the evidence supports the ALJ's decision.

Appeal from the WCB will take the claim into the Kentucky appellate courts. These courts grant deference to WCB decisions and will affirm the WCB unless it has made a significant misinterpretation of the law.

Reopenings

A settlement or judgment in civil court usually prevents any further action involving the claim. Unlike a civil suit, a final settlement or award in workers compensation is generally subject to a "motion to reopen" for further proceedings. This motion can be filed within four (4) years after an award or settlement.

Grounds for reopening include:
- Change in disability shown by objective medical evidence
- Mistake
- Fraud
- Newly discovered evidence
- Seeking TTD benefits during the period of an award

Reopening is a two-way street, which can result in either an increase or reduction of benefits. A claim cannot be reopened more than four (4) years after the original award was entered; and a party cannot file a motion to reopen within one (1) year of any previous motion to reopen by the same party. The four (4)-year limitation does not apply to reopenings regarding medical issues, return to work after receiving a total disability award, fraud, seeking TTD benefits, or increase in or reduction of benefits to conform with the employee's current work status under impairment model awards for injuries occurring after December 12, 1996.

Note: For awards made prior to December 12, 1996, the opportunity to reopen ceases four (4) years after December 12, 1996.

APPENDIX A

WORKERS COMPENSATION RATES
(MAXIMUM, 1980-2000)

Year	Total Disability	Permanent Partial Disability (PPD)	Retraining Incentive Benefits (RIB)	Total Disability (Minimum)
2001	$530.07	$397.55	$397.55	$106.01
2000	$509.03	$381.77	$381.77	$101.81
1999	$487.20	$365.40	$365.40	$97.44
1998	$465.36	$349.02	$349.02	$93.07
1997	$447.03	$335.27	$167.64	$89.41
1996	$415.94	$311.96	$155.98	$83.19
1995	$415.94	$311.96	$155.98	$83.19
1994	$415.94	$311.96	$155.98	$83.19
1993	$394.39	$295.79	$147.90	--
1992	$380.00	$285.00	$142.50	--
1991	$362.03	$271.52	$135.76	--
1990	$353.24	$264.93	$132.47	--
1989	$343.02	$257.27	$128.64	--
1988	$330.53	$247.90	$123.95	--
1987	$322.19	$241.64	$120.82	--
1986	$316.54	$237.41	--	--
1985	$304.80	$228.60	--	--
1984	$294.87	$221.15	--	--
1983	$277.66	$208.25	--	--
1982	$254.33	$190.75	--	--
1981	$233.26	$174.95	--	--
1980 (7/15 and	$216.99	$162.74	--	--

after)				

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